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Research Brief

Protecting Rights and Preventing Abuse: Handling Resident Complaints in Long-Term Care Facilities

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As the only Older Americans Act program authorized to have direct, unimpeded access to residents of long-term care facilities, the Long-Term Care Ombudsman program is uniquely positioned to identify and resolve complaints made by, or on behalf of, residents. This brief describes the Ombudsman program's approach to complaint handling and the types of complaints that are commonly addressed. It then describes factors that affect Ombudsmen's ability to investigate and resolve complaints, including program resources; coordination with entities that have responsibilities for the health, safety, welfare, and rights of residents; relationships with facility staff; and regulations governing the operation of long-term care facilities. Findings suggest that while limited fiscal and staffing resources have prevented Ombudsman programs from conducting routine visits to nursing homes and board and care homes, inter-organizational relationships, the commitment of program staff and volunteers, and strong regulations are critical for supporting the successful resolution of resident complaints. Data used for this brief were collected as part of the *Process Evaluation and Special Studies Related to the Long-Term Care Ombudsman Program* conducted by NORC at the University of Chicago (NORC) on behalf of the Administration for Community Living (ACL)

BACKGROUND

In response to widely reported problems involving poor quality of care in nursing homes, the Long-Term Care Ombudsman program (LTCOP, or Ombudsman program) began in 1972 as a Public Health Service demonstration project in five states to respond to complaints made by, or on behalf of, residents. The Older Americans Act (OAA, or the Act) established the Ombudsman program nationwide in 1978, and expanded the program's scope to include board and care homes and similar adult care facilities in 1981. The 2006 OAA amendments expanded the definition of board and care to include assisted living facilities. Today the Ombudsman program is administered by the Administration on Aging (AoA), within the Administration for Community Living (ACL) of the United States Department of Health and Human Services (DHHS). Envisioned as an independent, person-centered consumer protection service, the program aims to provide a voice for long-term care residents.

To protect and promote the health, safety, welfare, and rights of residents living in long-term care facilities, the OAA charges the Ombudsman program with advocating for residents by identifying, investigating, and resolving individual complaints;

DATA COLLECTION

As part of the *Process Evaluation and Special Studies Related to the Long-Term Care Ombudsman Program*, NORC collected qualitative and quantitative data from program staff and stakeholders in two phases. Interview data were collected from federal staff, national stakeholders, and State Ombudsmen in 2017. Survey data were collected from State Ombudsmen and a sample of local Ombudsmen and volunteers in 2018. For local data collection, a multistage stratified sampling approach was used. The sampling began with stratifying programs by the 10 ACL regions. To ensure that the diversity of programs was captured, a sample of 27 states was identified, and in these states, all local Ombudsman entities were included. Within each local Ombudsman entity, all local Ombudsmen were invited to participate, and half of volunteer Ombudsmen were randomly sampled and invited to participate. In centralized programs, staff who serve at the local level were included. More information about the study methods can be found in the Final Report that is available on ACL's website (https://acl.gov).

making systemic improvements to the long-term care system; and providing outreach and education to residents and other stakeholders. These key functions are performed by a State Long-Term Care Ombudsman who heads an Office of the State Long-Term Care Ombudsman (Office or Office of the SLTCO), in coordination with the state or territorial unit on aging (SUA) in all 50 states, the District of Columbia, Puerto Rico, and Guam. The State Ombudsman is responsible for statewide program administration and oversight of designated representatives of the Office, which includes both paid staff and volunteers.

According to the National Ombudsman Reporting System (NORS; the program's administrative reporting system), in federal fiscal year (FFY) 2017, the Ombudsman program was responsible for advocating on behalf of over 3 million residents in 16,376 nursing homes and 58,031 board and care homes. During this period, 1,319 full-time equivalent workers (FTEs) and 6,625 certified volunteer Ombudsmen who donated 591,362 hours of their time supported the program.

The remainder of this brief describes the Ombudsman program's complaint handling activities, and the factors that support as well as impede the Ombudsmen's ability to successfully investigate and resolve complaints.

COMPLAINT HANDLING

Since its inception, the Long-Term Care Ombudsman program's primary responsibility has focused on resident complaint resolution. According to the OAA, the Ombudsman or through representatives of the Office (staff and volunteers) shall:

- "Identify, investigate, and resolve complaints that are made by, or on behalf of, residents" and that "relate to action, inaction, or decisions" of providers, public agencies or health and social service agencies "that may adversely affect the health, safety, welfare, or rights of the residents." [Section 712(a)(3)(A)]
- "Provide services to assist the [long-term care facility] residents in protecting the health, safety, welfare, and rights of the residents." [Section 712(a)(3)(B)]
- "Ensure that residents have regular, timely, private, and unimpeded access to the services provided through the Office and that the residents and complainants receive timely responses from representatives of the Office to complaints." [Section 712(a)(3)(D)]

EXAMPLE COMPLAINTS RECEIVED BY OMBUDSMEN

- I've been waiting for someone to answer my call light for the last hour.
- My mother wants to sleep late in the morning but staff gets her up and dressed early.
- My aunt was transferred to the hospital but the nursing home won't take her back now.
- The staff handles my roommate too roughly whenever they take her to the bathroom, but she's afraid to say anything.
- There's not enough staff during the evenings. They work hard but I often have to wait to get my medication on time.
- No one knocks before they enter my room. They don't understand this is my home too.
- We rarely get to leave the facility. They say it's not safe for us.
- One of our residents has a guardian, but the guardian never responds when we contact her or participates in care plan meetings
- My grandmother seems drowsy and overly medicated when I visit.
- The staff say they can't do anything when I tell them I prefer to bathe at night.
- I want to see my own doctor who I've known for the last 20 years.
- My father complains that he doesn't have enough privacy to make phone calls when his roommate is there.

Complaint handling is central to not only the Ombudsman's function, but in large part the foundation upon which all other OAA mandated activities rest. By investigating and resolving complaints made by, or on behalf of, residents, Ombudsman programs are then positioned to identify trends and underlying problems in the long-term care system to target advocacy and education efforts.

The individual reporting the complaint, referred to the as the complainant, may be the resident, a family member or friend, facility staff person, an Ombudsman, or other individual raising a concern on behalf of the resident. Once a complaint is received, Ombudsmen investigate and develop a strategy for resolution and follow-up.

To ensure that residents are aware of and have access to free and confidential Ombudsman advocacy services, programs employ several approaches. These include posting the program's contact information (and sometimes a photo of the assigned Ombudsman) in a visible location in long-term care facilities, having a dedicated phone line to which callers can report complaints, disseminating brochures or delivering presentations about the program's services, and visiting nursing homes and board and care homes (including assisted living facilities and other adult care homes) on a routine and unannounced basis.

Ombudsman Approach to Complaint Handling

When complaints or concerns are brought to the program's attention, Ombudsmen's first priority is typically to empower residents by guiding and supporting them to resolve problems on their own, such as through speaking with facility staff, using the facility's grievance mechanisms (if available), or enlisting the support of fellow residents and families through resident and family councils. If residents do not feel equipped to directly raise their concerns to whomever the complaint is directed, they may authorize an Ombudsman to advocate on their behalf.

It should be noted that when Ombudsmen receive complaints from someone other than the resident, they must obtain the resident's consent to address the complaint(s). Ombudsman programs use the term resident-directed to describe this investigation process. The goal is to advocate for the resident's wishes and help them exercise self-determination, regardless of how others wish the complaint to be addressed.

The Ombudsman program's approach to problem-solving is distinct in important ways from survey and certification agencies that monitor facilities and investigate complaints to determine compliance. The Ombudsman program is characterized by the absence of enforcement and regulatory oversight authority and consequently, an inability to sanction facilities for poor performance. Instead, Ombudsmen complement the work of federal and state surveyors to address quality of care in facilities by resolving complaints on an informal level and by their regular presence in nursing homes and board and care homes. By offering informal options for addressing concerns, complainants who are hesitant to use formal mechanisms (for fear of reprisals or other reasons) may be more likely to come forward. In addition, the OAA and Long-Term Care Ombudsman Programs Final Rule (hereafter, Final Rule), require that the Office of the SLTCO coordinate Ombudsman services with certain entities with responsibilities for the health, safety, well-being, and rights of residents in order to facilitate complaint handling. These entities include protection and advocacy systems (P&As) for individuals with developmental disabilities

EXAMPLE COMPLAINTS RECEIVED BY OMBUDSMEN

- The resident's son holds power of attorney and is trying to stop his sister from visiting.
- Her daughter keeps coming by at night and asking her for money.
- I found my dad with bed sores the last two times I visited.
- None of the residents want to room with the new resident because she identifies as LGBT.
- I just got a discharge notice but don't know how to appeal it.
- The staff want to move me to a different room but I'm afraid to tell them that I like where I am.
- Every time I visit, my wife has new bruise and when I ask how she got them the staff say they don't know.
- When food is delivered to my mom's room, it is always cold.
- Can you help us with transitioning residents? Our facility is closing.
- I'm concerned that a staff member is stealing money from me.
- My husband's facility is no longer offering physical therapy. Can you help us find another facility that provides that service?
- My father's bill has been increasing each month, but the facility won't tell me why the costs are increasing. Staff are now refusing to answer my questions.
- I am ready to live on my own again and would like to move closer to my family.

and mental illnesses, legal assistance, state and local law enforcement agencies, courts of competent jurisdiction, area agencies on aging (AAAs), Aging and Disability Resource Centers (ADRCs), Adult Protective Services (APS), facility and long-term care provider licensure and certification programs, the State Medicaid fraud control unit, and victim assistance programs.

Facility Visits

As the only OAA program authorized to have direct, unimpeded access to residents, routine facility visits uniquely position Ombudsmen to identify and resolve resident complaints. Regular visitation enables Ombudsmen to develop relationships with residents and facility staff, understand residents' preferences, and build trust so that residents as well as facility staff feel comfortable expressing concerns. Ombudsmen's routine presence in facilities also supports their sentinel role in identifying potential issues and addressing resident concerns before they rise to the level requiring outside intervention. These visits are particularly important for reaching residents who have no other means to contact the Ombudsman, or would be unaware of the program's services, absent these visits.

Visits to facilities are unannounced and conducted on a regular basis, as well as in response to information about facility problems and resident complaints. During these visits, Ombudsmen typically interact with residents; observe the general conditions of the facility and daily activities of residents; share information about Ombudsman program services to residents, family members, and staff; support resident and family councils; provide information about long-term care options; identify and address complaints; and empower residents to speak up on their own behalf or voice concerns for those who are unable to do so. A majority of State Ombudsmen (94%) reported that staff and volunteers vary the timing of their visits in order to observe different shifts and activities. This allows Ombudsmen to speak with different staff members, and observe how they interact with residents at different times of the day. A resident may also feel more comfortable making a complaint if a particular staff person is not present. Forty-seven percent of State Ombudsmen reported that Ombudsmen visit during times when family members are most likely to be visiting.

Ombudsmen at all levels conduct visits to long-term care facilities, but routine visits are primarily conducted by local and volunteer Ombudsmen, rather than State Ombudsmen. Local and volunteer Ombudsmen may be assigned to facilities based on a number of considerations (such as geographic region or facility size) for routine visits, or they may be asked to visit facilities based on a reported complaint or other need. With respect to assignments, there is wide variation in the number of long-term care facilities for which staff are responsible. In our sample, local Ombudsmen are assigned to a median of 33 facilities, with a range from one to 1,700 facilities. For paid staff, the number of assigned facilities reflects both the number of facilities that they are personally responsible for visiting as well as those that they oversee, particularly if they manage other staff or volunteers. By contrast, volunteer assignments are limited to facilities that they are personally responsible for visiting. On average, volunteer Ombudsmen are assigned to a median of two facilities, with a range of one to 60 facilities.

Although ACL does not specify a frequency for facility visits, NORS defines "regular basis" to mean facility visits that occur no less than quarterly and that are not in response to a complaint. Because of these reporting requirements, quarterly visits are the only standard on which programs currently report data. In FFY 2017, paid and volunteer Ombudsmen visited 11,416 nursing facilities and 17,721 board and care facilities on at least a quarterly basis. This represents 68% of nursing homes and 30% of board and care homes under the LTCOP's purview.

In our study, most local and volunteer Ombudsmen reported visiting each assigned nursing home and board and care home on at least a quarterly basis (Exhibit 1). Volunteer Ombudsmen, however, reported more frequent visits to both types of facilities, compared to local Ombudsmen. Over three quarters (79%) of volunteers reported that they visit nursing homes on a weekly (53%) or monthly basis (26%) and 62% reported visiting board and care homes on at least a weekly (22%) or monthly basis (40%).

Exhibit 1: Frequency of Local and Volunteer Ombudsman Visits to Long-Term Care Facilities

Frequency of Visits	Local Ombudsmen Nursing Homes N=442[a]	Volunteer Ombudsmen Nursing Homes N = 555[b]	Local Ombudsmen Board and Care Homes N=373[c]	Volunteer Ombudsmen Board and Care Homes N=350[d]
Weekly	11%	53%	2%	22%
Less than weekly but at least once a month	28%	26%	16%	40%
Less than monthly but at least once a quarter	33%	14%	48%	31%
Twice a year	4%	1%	7%	2%
Once a year	1%	0%	7%	1%
As needed	14%	3%	13%	3%
Other (please specify)	9%	3%	7%	1%

[a] Missing=2, Not applicable=53; [b] Missing=11, Not applicable=145; [c] Missing=6, Not applicable=118; [d] Missing=15, Not applicable=346

During routine visits, local and volunteer Ombudsmen generally spent less than two hours per visit (with one to two hours being the most common visit duration), although they were more likely to spend less than an hour for each board and care home visit, compared to each nursing home visit (Exhibit 2). Overall, Ombudsmen spent less time in board and care homes compared to nursing homes, likely because many of these homes have fewer residents on average than in nursing homes. According to NORS data, nursing homes had an average of 103 beds per facility compared to 25 beds in board and care homes in FFY 2017.

Exhibit 2: Average Time Ombudsmen Spent in Facilities for Each Routine Visit

Amount of Time	Local Ombudsmen Nursing Homes N=405[a]	Volunteer Ombudsmen Nursing Homes N=554[b]	Local Ombudsmen Board and Care Homes N=348[c]	Volunteer Ombudsmen Board and Care Homes N=342[d]
Less than an hour	13%	9%	43%	41%
Between 1 to 2 hours	65%	56%	49%	46%
Between 2 to 3 hours	19%	28%	7%	10%
More than 3 hours	3%	7%	1%	3%

[a] Missing=5, Not applicable=87; [b] Missing=9, Not applicable=148; [c] Missing=6, Not applicable=143; [d] Missing=23, Not applicable=346

Types of Complainants

Ombudsman programs receive complaints about resident-related issues from a variety of sources. Multiple complaints from the same source are included in an individual case. Exhibit 3 shows the number and percent of cases that were reported in NORS by type of complainant. Of the 128,091 cases closed by the Ombudsman program in FFY 2017, 40% of cases were submitted by residents. Almost one-fifth of complaints made on behalf of residents were initiated by facility staff (19%). As with other complainants, facility staff may reach out to Ombudsmen to assist with both resident concerns (e.g., care concerns) and facility issues (e.g., closures). Ombudsmen may also initiate complaints based on their observations during facility visits, with such complaints accounting for 11% of cases.

Exhibit 3: Type of Complainant and Number and Percentage of Cases Closed (FFY 2017)

Type of Complainant	Number of Cases Closed	Percent of Cases Closed
Resident	51,350	40%
Relative/Friend	23,409	18%
Non-Relative, guardian, legal representative	1,294	1%
Ombudsman, volunteer Ombudsman	13,332	11%
Facility administration, staff	24,008	19%
Other medical - physician/staff	3,539	3%
Other agency representative	5,808	4%
Unknown/Anonymous	3,337	3%
Other	2,014	2%

Complaint Investigation Process

Once a complaint investigation is initiated, Ombudsmen generally undertake the following steps: (1) gather information relevant to the complaint (through interviews, observations, and/or review of documents such as resident medical records, regulations, facility policies, etc.); (2) assess the validity of the complaint (determining whether the circumstances described in the complaint are accurate); and (3) seek resolution of the complaint through identified strategies and alternative solutions. Over the course of the investigation, Ombudsmen will identify and speak with relevant participants and agencies related to the case, such as facility staff, legal assistance, family members, and representatives of APS, law enforcement, or the state's survey and certification agency. Given the number of individuals that are potentially involved in a case, obtaining cooperation among various parties and skillfully navigating sometimes sensitive relationships is an important part of Ombudsmen's work.

Using these methods, Ombudsmen have been fairly successful at addressing resident complaints, insofar as the problem is within their purview. According to NORS data, out of the 201,460 complaints the program received in 2017, Ombudsmen resolved or partially resolved 73.5% of complaints to the satisfaction of the resident. In a small number of cases, Ombudsmen are not in a position to achieve the outcomes that the resident is seeking and will refer the complainant to the relevant agency to address their concerns (3.9%). Other times, resolution of a complaint requires more systems level efforts, such as changes in policies, regulations, or laws (0.2%).

Exhibit 4: Complaint Dispositions by Setting

Complaint Dispositions	Nursing Homes	Board and Care Homes	Other Non-Facility Settings	All Settings
Total Complaints	**144,003**	**53,984**	**3,473**	**201,460**
Complaints requiring regulatory changes/legislative action	0.1%	0.4%	0.2%	0.2%
Complaints unsatisfactorily resolved	4.7%	5.7%	2.8%	5.0%
Complaints withdrawn	4.8%	4.9%	3.1%	4.8%
Complaints referred to other agencies	3.4%	5.1%	3.6%	3.9%
Complaints with no action needed	12.5%	13.7%	7.0%	12.7%
Complaints partially resolved	15.7%	14.4%	19.6%	15.4%
Complaints satisfactorily resolved	58.7%	55.9%	63.8%	58.1%

Common Types of Complaints

The types of complaints that Ombudsmen receive range in severity and complexity, from reports about cold food being repeatedly served at meal times, to not being permitted to manage personal finances, to allegations of abuse and neglect. To facilitate the prioritization of complaints, the Final Rule requires that programs have policies and procedures that include "standards to assure prompt response to complaints…which prioritize abuse, neglect, exploitation and time-sensitive complaints which consider the severity of the risk to the resident, the imminence of the threat of harm to the resident, and the opportunity for mitigating harm to the resident through provision of Ombudsman program services" [45 CFR § 1324.11(e)(1)(v)].

Exhibit 5 shows the ten most frequent types of complaints that Ombudsmen received in FFY 2017 according to NORS. In both nursing homes and board and care homes, the most common type of complaint was related to discharge/eviction.

Exhibit 5: Top Ten Most Frequent Complaint Types (FFY 2017)

Complaint Ranking	Nursing Homes	Board and Care Homes
1	Discharge/eviction – planning, notice, procedure, implementation, including abandonment	Discharge/eviction – planning, notice, procedure, implementation, including abandonment
2	Failure to respond to requests for assistance	Medications – administration, organization
3	Dignity, respect – staff attitudes	Food service – quantity, quality, variation, choice, condiments, utensils, menu
4	Medications – administration, organization	Dignity, respect – staff attitudes
5	Resident conflict, including roommates	Equipment/building – disrepair, hazard, poor lighting, fire safety, not secure
6	Personal hygiene (includes nail care & oral hygiene) and adequacy of dressing & grooming	Cleanliness, pests, general housekeeping
7	Food service – quantity, quality, variation, choice, condiments, utensils, menu	Resident conflict, including roommates
8	Care plan/resident assessment – inadequate, failure to follow plan or physician orders	Accidental or injury of unknown origin, falls, improper handling
9	Symptoms unattended, including pain, pain not managed, no notice to others of changes in condition	Personal property lost, stolen, used by others, destroyed, withheld from resident
10	Accidental or injury of unknown origin, falls, improper handling	Care plan/resident assessment – inadequate, failure to follow plan or physician orders

According to historical NORS data, complaints that the Ombudsman program currently handles are more complex and challenging than in the past – moving away from requests for assistance with daily needs to more urgent concerns such as discharges/evictions. The most common type of complaint addressed by Ombudsmen in nursing homes between 1997 and 2010 were failures to respond to requests for assistance (such as transfers to chairs/bed), followed by discharges/evictions. For the last seven years, discharges/evictions have topped the list of the most frequently reported complaints handled by the program in nursing homes. In board and care homes, the most common complaints addressed by Ombudsmen in recent years (2017, 2016, and 2014) were discharges/evictions. Prior to that time, the most frequent complaints concerned medications or food service (1996-2013, 2015).

Exhibit 6 shows the types of complaints most frequently cited by lead local Ombudsmen as the most challenging and time consuming as well as those that their local entity is most effective at resolving.[1] Of the broader complaint categories, those related to "admission, transfer, discharge, and eviction" and "staffing" were reported to be the most challenging to resolve in both settings, yet the reasons for their difficulty differ. Complaints related to admission, transfer, discharge, and eviction can be challenging as well as time consuming for a number of reasons. State Ombudsmen reported that these

[1] Note that of the 16 broad complaint categories that NORS uses, we only present the top five complaint categories that were reported. For this reason, the percentages will not total to 100%.

cases often involve residents with mental health conditions or behavioral challenges, or those who can no longer pay for their long-term care. Such factors can make it difficult to find a new placement for the resident. These complaints also require coordination with multiple entities to bring the complaint to resolution, including facility staff, legal assistance providers, licensure and certification, and others. Should a nursing home resident contest the involuntary discharge or transfer, he or she must file an appeal of the discharge notice and wait for an administrative hearing to be scheduled. Pending the outcome of the hearing officer's decision, the resident has a right to remain in the facility. For residents of board and care homes, addressing discharge complaints can be more complicated. Unlike in nursing homes, standards for board and care homes vary widely across states. Only a minority of states, furthermore, provide formal adjudication mechanisms, including fair hearings, upon which Ombudsmen can draw upon to resolve residents' complaints.[2]

Exhibit 6: Complaints that are Most Challenging, Time Consuming, and Effective for Local Ombudsman Entities to Resolve (Lead Local Ombudsmen with Managerial Responsibilities)

Complaint Category (Nursing Homes)	Most Challenging to Resolve N=186[a]	Most Time Consuming to Resolve N=188[b]	Most Effective at Resolving N=187[c]
Abuse, gross neglect, exploitation	11.8%*	11.7%*	3.7%
Admission, transfer, discharge, eviction	16.1%*	28.2%*	27.8%*
Autonomy, choice, preference, exercise of rights, privacy	4.3%	9.0%	32.1%*
Care	9.7%	27.1%*	24.1%*
Staffing	38.2%*	10.6%	0.5%
Complaint Category (Board and Care Homes)	**Most Challenging to Resolve N=176[d]**	**Most Time Consuming to Resolve N=174[e]**	**Most Effective at Resolving N=177[f]**
Admission, transfer, discharge, eviction	21.6%*	18.4%*	13.0%*
Autonomy, choice, preference, exercise of rights, privacy	8.0%	16.1%*	30.5%*
Financial, property (except for financial exploitation, which is included in the first response option)	4.5%	5.7%	2.3%
Care	12.5%*	18.4%*	23.2%*
Staffing	18.2%*	11.5%	1.7%

[a] Missing=3; [b] Missing=1; [c] Missing=2; [d] Missing=13; [e] Missing=15; [f] Missing=12

*The top three responses out of the 16 complaint categories are noted with an asterisk.

With respect to staffing-related complaints, these grievances often involve lack of appropriate staff training to meet residents' needs or facility shortages of direct care workers. Whereas the former may be addressed with education, Ombudsmen are often constrained in the strategies that can be used to address staffing shortages. In certain instances, Ombudsmen have been able to resolve these challenges by assisting facility administrators identify shifts where residents need more support, but not all facilities have the flexibility or resources to reassign or add staff. Ultimately, when the underlying problem of complaints concerns staff shortages, its resolution may require policy, regulatory, or legislative changes to resolve, such as advocating for minimum staffing levels in federal or state legislation.

In addition to the growing complexity of complaints, Ombudsmen described limitations in their ability to fully resolve certain types of complaints at the individual level, particularly when solutions are outside the program's control. This includes cases involving lack of available long-term care facilities located near residents' families, staff shortages (described earlier), and lack of available services (such as those to address mental health or rehab needs) to which to refer residents.

With respect to the effectiveness of Ombudsman programs in resolving complaints, lead local Ombudsmen commonly reported being most effective at resolving complaints related to "autonomy, choice, preference, exercise of rights, and privacy" in both nursing homes and board and care homes. These types of complaints can often be resolved by

[2] https://ncler.acl.gov/pdf/LTC%20and%20Evictions%20Issue%20Brief.pdf

coordinating with facility staff or administrators and are generally focused on an individual resident. Resident rights are also governed by federal and state laws which provide Ombudsmen additional tools to advocate on behalf of residents.

Although lead local Ombudsmen reported that "admission, transfer, discharge, and eviction" complaints are the most challenging and time consuming to address, they also reported that these types of complaints are among those that they are most effective at resolving. Given the frequency with which programs receive admission, transfer, discharge, and eviction complaints, Ombudsman staff may also have become well-versed in how to best address these issues. In addition, the availablilty of formal channels (i.e., fair hearings) to challenge involuntary discharges and transfers provided by federal law also likely supports Ombudsmen's ability to resolve these types of complaints.

Areas of Ombudsman Expertise

In terms of areas of expertise, half of local Ombudsmen reported having expertise in addressing involuntary discharges/transfers (Exhibit 7). Although volunteer Ombudsmen were less likely to report this as an area of expertise, compared to local Ombudsmen, volunteer Ombudsmen are also more likely to refer relatively more complicated complaints to other program staff (such as a local Ombudsman). Similarly, State Ombudsmen are more likely than local or volunteer Ombudsmen to report having expertise in providing support during bankruptcy proceedings because these cases are typically assigned to the State Ombudsman by the court.[3] On the other hand, local and volunteer Ombudsmen are more likely to engage in addressing family conflicts, compared to State Ombudsmen.

Exhibit 7: Areas of Expertise

Area of Expertise	State Ombudsmen (statewide program) N=52	Local Ombudsmen* (personal expertise) N=308	Volunteer Ombudsmen (personal expertise) N=711
Addressing involuntary discharges/transfers	79%	50%	18%
Serving residents of board and care facilities	52%	30%	28%
Culture change (for example, person-centered service planning, dementia-competent care, etc.)	50%	25%	15%
Elder abuse	46%	27%	17%
Assisting residents in transitioning out of facilities	44%	26%	13%
Supporting residents with end of life care	40%	22%	19%
Providing support during bankruptcy proceedings	27%	3%	1%
Providing advocacy around inappropriate drug use	17%	9%	8%
Managing family conflicts	0%	39%	21%

* In this table, local Ombudsmen refer to those Ombudsmen without managerial responsibilities.

Populations that the Ombudsman Program Has Difficulty Serving

Related to the challenging nature of certain types of complaints are key shifts in sub-populations that long-term care facilities serve. These groups include older adults who have specialized or complex care needs, such as those with Alzheimer's disease or related dementias, or behavioral health issues, including substance abuse disorders. The specialized and complex care that these adults require can be challenging for facilities that lack the resources and/or staff knowledge to best serve these individuals. State and local Ombudsmen also reported having difficulty serving these populations, particularly residents with mental illness (with some reporting a desire for more training on how to address their needs), people who were formerly incarcerated, and those with substance abuse disorders (Exhibit 8). State

[3] One of the provisions of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 is for the appointment of a patient advocate when a health care business files for bankruptcy. If the health care business provides long-term care services, the Bankruptcy Court may appoint the State Ombudsman as the "Patient Care Ombudsman."

Ombudsmen reported that these groups experience high rates of involuntary discharge by facilities because of their challenging behaviors and often face difficulty finding a long-term care facility that can provide needed care. Once a facility is identified and the resident is admitted, they are also likely to face involuntary discharge or transfer again in the future.

Difficulties in serving residents are especially pronounced among programs that cover remote regions. Nearly a third of State Ombudsmen (29%) reported difficulty providing Ombudsman services to individuals who live in rural areas, noting that it can be difficult to recruit and train sufficient numbers of volunteers in these regions, and the time and cost associated with traveling to remote locations can impede frequent visitation. State Ombudsmen also reported that fewer specialized services (such as those addressing mental health) are available to residents in rural regions compared to metropolitan areas of the state. The shortage of services further exacerbates challenges to Ombudsmen's ability to meet residents' needs.

Another group that State and local Ombudsmen reported having difficulty serving are residents who speak a language other than English. Inadequate resources have prevented some programs from hiring translators to assist with meeting the needs of diverse populations, such as American Indian tribes and predominantly Spanish-speaking communities. Given population aging trends, the Ombudsman program is expected to continue serving increasingly diverse groups of residents living in long-term care facilities.

Exhibit 8: Populations that Ombudsman Programs have Difficulty Serving

Does your program have particular difficulty serving any of the following populations?	State Ombudsmen N=52	Local Ombudsmen N=497
People who live in rural areas	29%	13%
People who have physical disabilities or communication disabilities (for example, deafness, blindness)	8%	11%
People with intellectual and developmental disabilities	8%	11%
People with mental illness (for example, depression, bipolar disorder, schizophrenia)	38%	27%
People with substance abuse disorders	15%	16%
People with cognitive limitations, such as Alzheimer's or other types of dementia, and related diseases	10%	15%
People who speak a language other than English	23%	32%
People of diverse cultural backgrounds	4%	6%
People from the lesbian, gay, bisexual, and transgender (LGBT) community	0%	2%
Veterans	2%	3%
Tribal elders	8%	3%
People who were formerly incarcerated	23%	9%
Individuals under 60	6%	11%

FACTORS AFFECTING COMPLAINT HANDLING

State Ombudsmen reported that a number of factors contribute to their programs' ability to identify, investigate, and resolve complaints. These include program resources (both in terms of funding and staff), coordination with entities, relationships with facility staff, and the strength of federal and state regulations.

Program Resources. Exhibit 9 shows key program resources that impact the program's ability to carry out its broad responsibilities. Only 23% of State Ombudsmen and 26% of lead local Ombudsmen reported that their program's fiscal resources were sufficient to meet federal mandates. The percentages of State and lead local Ombudsmen who reported sufficient numbers of paid staff and volunteers were also low. Of programs that utilize volunteers, 73% of State

Ombudsmen and 58% of lead local Ombudsmen reported difficulty recruiting and supporting this segment of their workforce.

With respect to individual advocacy activities, many Ombudsmen reported that lack of resources prevented the program from achieving regular visits to facilities. Fewer State and local Ombudsmen, however, reported that lack of resources affected complaint investigation and resolution activities compared to other activities, indicating that responding to complaints is prioritized over non-complaint visits. When resources are constrained, some State Ombudsmen described triage methods to prioritize their daily work, such as responding first to cases where a resident's health or safety is at risk. Others reported prioritizing visits based on facility characteristics. This includes prioritizing visits to nursing homes over board and care homes because more residents can be reached in the former than the latter, and prioritizing visits to geographically accessible facilities over those that are hard to reach or located in remote areas, due to their inaccessibly as well as cost (e.g., airfare, long travel times).

Exhibit 9: Resource Challenges

Resources that are Sufficient to Enable the Program to Meet Federal Mandates	State Ombudsmen N=52	Lead Local Ombudsmen N=189
Fiscal resources	23%	26%
# of paid staff	27%	37%
# of volunteers	15%	21%
Activities Not Carried Out Fully Due to a Lack of Resources	**State Ombudsmen N=52**	**Lead Local Ombudsmen N=189**
Complaint investigation and resolution activities	23%	32%
Regular nursing home visits, not in response to a complaint	50%	45%
Regular board and care home visits, not in response to a complaint	67%	44%
Challenges	**State Ombudsmen N=52**	**Lead Local Ombudsmen N=188[a]**
Insufficient funding	75%	77%
High turnover of paid staff	17%	16%
High turnover of volunteers	31%	28%
Difficulty hiring qualified paid staff	27%	26%
Difficulty recruiting and supporting volunteers	73%	58%

[a] Not applicable. My program does not face any challenges=1

Resource limitations also highlight the importance of the volunteers in assuring that advocacy services are accessible to residents. Many State Ombudsmen reported that without volunteers, programs would struggle to maintain a routine presence in facilities. According to NORS data, volunteers contributed 591,362 hours to Ombudsman programs in FFY 2017. Using the national standard for full-time workers (2,087 hours per year) according to the U.S. Office of Personnel Management, this equals more than 280 people working full-time.[4]

State Ombudsmen reported that committed staff and volunteers are among the program's most valuable resources. Key reasons that motivate Ombudsmen to join the program include its mission (75% of State Ombudsmen, 63% of local Ombudsmen, and 55% of volunteers) as well as personal fulfillment (65% of State Ombudsmen, 65% of local Ombudsmen, and 68% of volunteers). Ombudsmen's average tenure with the program (across all levels) is about six years. Tenure, however, varied widely, with some Ombudsmen being recent hires while others have served the program for up to 32 years.

[4] https://www.opm.gov/policy-data-oversight/pay-leave/pay-administration/fact-sheets/computing-hourly-rates-of-pay-using-the-2087-hour-divisor/

Many Ombudsmen reported a strong commitment to improve the lives of residents and the gratification they derived from being able to make meaningful change, both large and small. One State Ombudsman described a lengthy two-year process to overturn a resident's guardianship to restore her right to make her own decisions. The resident was then able to leave the nursing facility and transition to a rest home where she ultimately celebrated her 100th birthday. Other interventions may be brief but highly consequential to residents. When one resident's belongings were destroyed by a fire, a local Ombudsman facilitated a referral for a resident to obtain clothes at a local clothing bank to help the resident manage her transition to a new facility. Others reported the rewarding experience of seeing residents feeling empowered to take action on their own behalf.

Relationships with Coordinating Entities. Given the broad range of complaints that relate to residents' health, safety, welfare, and rights, Ombudsmen must coordinate with an extensive and diverse array of entities to resolve issues on behalf of long-term care residents. As described earlier, the OAA and Final Rule require that Ombudsman services are coordinated with 10 key entities to enhance the program's capacity to carry out its functions. Under the Final Rule, State Ombudsmen are further required to demonstrate evidence of coordination with each of these entities. This requirement can be met with memoranda of understanding (MOUs), policies and procedures outlining coordination requirements, joint participation in working groups or standing meetings, cross-training opportunities, and referral protocols. Among the 10 entities with which the program is required to coordinate, most programs report regular interaction with APS, the licensure and certification agencies, and the State legal assistance developer and legal assistance/legal aid programs when conducting individual advocacy, and many reported that these relationships enable their programs to meet residents' needs.

Ombudsman programs, however, also face challenges that impede them from establishing or optimizing key partnerships. These include insufficient resources, misunderstandings about roles and responsibilities, and differing perspectives or priorities. State and local Ombudsmen reported that inadequate resources for both the Ombudsman program and/or the entities with which they work, can affect the ability of both parties to foster relationships. For example, State Ombudsmen reported that decreased funding for legal services at the local level makes addressing resident needs increasingly challenging. The combination of resource constraints and heavy workloads limit the assistance that legal aid can provide. Other reasons may include a lack of clarity about the roles of each entity in serving residents, or differing approaches to addressing an issue. Several State Ombudsmen reported confusion about the types of cases that fall under APS's authority and those for which the Ombudsman program is responsible. State Ombudsmen also perceived some agencies as having different priorities (e.g., advocating in the interests of state agencies rather than long-term care residents) which may impede efforts to collaborate. Since implementation of the Final Rule, however, some State Ombudsmen reported that the regulation helped strengthen key relationships by providing much needed clarity around roles and expectations, and requiring coordination. Ombudsmen reported that clearly defining responsibilities in a formal agreement helped expedite the resolution of resident complaints. In addition, the regulation's clarification regarding Ombudsmen's role in handling abuse and neglect complaints helped to better define protocols between the Ombudsman program and APS, particularly with respect to sharing information, maintaining confidentiality, and delineating responsibilities for responding to, and investigating complaints.

Relationships with Facility Staff and Providers. To effectively address residents' complaints, State Ombudsmen reported the importance of developing productive relationships with facility administrators and staff to help identify and resolve problems. They also clarified that these relationships do not mean that interactions with facility staff are without conflict, but building trust and credibility with administrators and staff supports their receptiveness to the program's services. When facility staff view the Ombudsman program as a resource, State Ombudsmen reported that issues can be successfully addressed through informal channels before they rise to the level where a formal complaint is needed. Others noted that if Ombudsmen are not seen as antagonistic, facility staff are more likely to discuss resident concerns and share information that helps to resolve complaints quickly. At the same time, Ombudsmen also must be acutely aware of perceived or actual conflicts of interest in forming these relationships in order to ensure that they remain credible sources of help and support for residents and families.

In addition to their assistance with investigating and resolving complaints, facility staff are also important sources for identifying and reporting problems involving residents. As noted earlier, almost one-fifth of complaints received by the program were reported by facility administrators or staff in 2017. Although the share of complaints from these sources varies across states, one State Ombudsman attributed the large number of complaints from facility staff to their comfort in involving Ombudsmen in resident concerns. The State Ombudsman explained that facility staff may report a complaint to an Ombudsman to help diffuse conflict with a resident or a resident's family member. In other cases, facility staff may submit a complaint about facility practices that may undermine residents' interests.

Many local and volunteer Ombudsmen reported that the key to developing effective relationships with facility staff is their ability to have a regular presence in facilities. Routine visits and frequent interactions engender trust among facility staff and residents to voice concerns. Inadequate program resources, however, also limit some programs from visiting facilities on a regular basis to nurture these relationships.

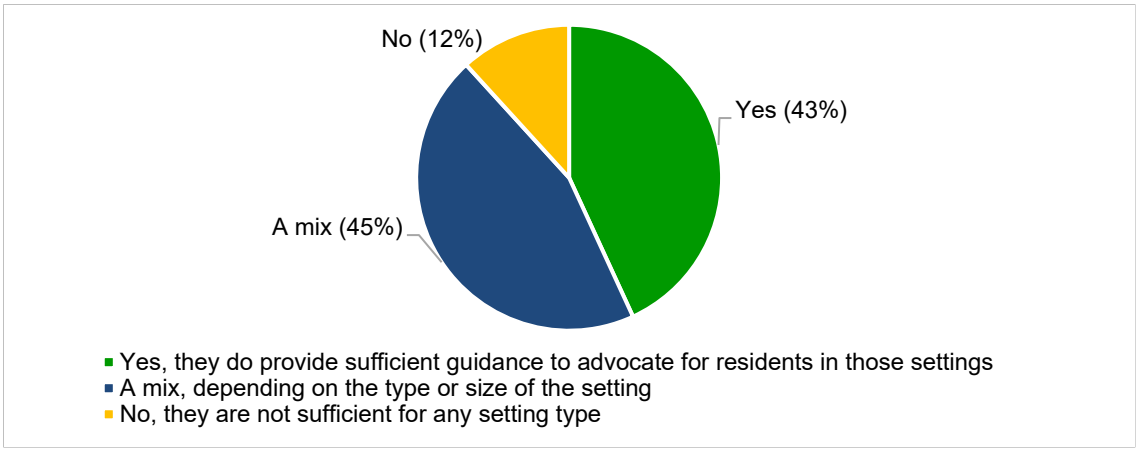
Federal and State Regulations. Federal and state regulations governing the operations of long-term care facilities provide important tools that Ombudsmen can use to advocate on behalf of residents. The stringency and implementation of these regulations, however, differ by setting. Whereas nursing homes that participate in Medicare or Medicaid are regulated by the federal government,[5] assisted living facilities[6] are largely regulated by states, and these regulations vary widely.[7] Nursing homes must abide by requirements and quality standards set forth in the Nursing Home Reform Act of 1987 (with subsequent regulations revised in 2016) to receive funding through Medicaid and Medicare. To monitor compliance with these standards, the Centers for Medicare & Medicaid Services (CMS) contracts with state survey agencies to conduct standard, on-site inspections and investigate abuse allegations and other complaints in nursing homes. Residents also have a Bill of Rights[8] that outlines a wide range of rights entitled to residents that are related to their independence, dignity, privacy, and care.

By contrast, other than what is required in states' Medicaid plans, there has been virtually no federal oversight of board and care homes, including assisted living and similar residental care facilites. In 2014, however, federal home and community-based services (HCBS) setting requirements were established to provide a regulatory framework for quality and resident protections in HCBS settings (a subset of which includes certain types of board and care homes) that receive certain Medicaid funding.[9]

In the absence of broader federal guidance, regulations governing board and care homes are set by individual state laws which vary considerably, from relatively lax to stringent. Given enormous state-level variation, State Ombudsmen differed in their perceptions of the extent to which their state regulations facilitated efforts to advocate for board and care home residents. Exhibit 10 shows that 43% of State Ombudsmen reported that regulations for board and care homes in their state were adequate. Another 45% found them adequate in some circumstances and settings, while 12% felt that they were not sufficient for any setting type.

[5] States also have laws governing nursing homes but these vary in stringency.
[6] In NORS, assisted living facilities are included under the broad category of "board and care homes and similar facilities" which comprise residential care facilities, adult congregate living facilities, foster care homes, and other adult care homes similar to a nursing facility or board and care home which provide room, board, and personal care services to a primarily older residential population.
[7] Office of the Assistant Secretary for Planning and Evaluation. 2015. "Compendium of Residential Care and Assisted Living Regulations and Policy: 2015 Edition."
[8] https://downloads.cms.gov/medicare/Your_Resident_Rights_and_Protections_section.pdf
[9] Medicaid.gov. Home & Community Based Services Final Regulation. https://www.medicaid.gov/medicaid/hcbs/guidance/hcbs-final-regulation/index.html

Exhibit 10: Do state board and care home regulations provide sufficient provider guidance to enable LTCOP to advocate for residents? (State Ombudsmen, N=51[a])



[a] Missing=1

About one-quarter of State Ombudsmen reported that lack of strong regulations for board and care homes makes serving those residents more challenging compared to nursing home residents. Whereas federal nursing home regulations enable programs to refer facility staff to requirements they must follow, state board and care and similar assisted living regulations are relatively less stringent, making it harder for programs to protect residents and resolve their complaints. One State Ombudsman noted weaknesses in regulations for the required level of care in assisted living facilities, particularly for special needs populations, such as those with Alzheimer's disease or other dementias. This ambiguity allows board and care homes to accept residents for whom they may not be able provide adequate care. Other reported weaknesses may result from board and care regulations that attempt to cover a wide range of facility sizes. One State Ombudsman noted that their state's regulation is written to address both the small, six-bed homes, as well as the larger assisted living facilities.

SUMMARY

Under the authority of the OAA, the Ombudsman program is positioned to provide a distinct advocacy approach for addressing complaints on behalf of residents. These provisions include having direct, unimpeded access to residents, resident-directed complaint investigations, informal and confidential complaint resolution, and coordination with entities with responsibilities that are relevant to the health, safety, well-being, and rights of residents. As an alternative dispute resolution method, the Ombudsman program complements formal channels that are in place, and offers residents an opportunity to address their concerns in an accessible, supportive, and confidential manner. This is especially important for vulnerable older adults who may be unable to express their needs or face barriers to self-advocacy, such as those who have cognitive impairments, are fearful of staff retaliation, or are socially isolated.

Ultimately, the goal of the Ombudsman program's approach is to support residents' engagement in self-directed problem solving and to assist facility staff to better respond to residents' needs. By identifying and resolving residents' complaints, Ombudsman

STATE OMBUDSMEN'S PERSPECTIVES ON RESIDENT ADVOCACY

- "We are in many cases, the contact of last resort, when someone just doesn't know who else to go to, and we are always quick to respond. We are quick to provide suggestions on how to resolve the concerns, and we often get letters from the families thanking us for the impact that we've had on the lives of their loved ones."
- "It can't be what we as outside agencies feel is best for the person. It has to be what the person really wants. I think that's the most important aspect of this program is if it's not meaningful for the resident, then we're really only trying to satisfy ourselves and not them."

programs ensure that the rights of long-term care residents are both understood and honored.

According to NORS data, the Ombudsman program's approach to complaint handling has been fairly successful in addressing resident complaints. Out of the 201,460 complaints the program received in FFY 2017, Ombudsmen resolved or partially resolved 73.5% of complaints to the satisfaction of the resident. Many Ombudsmen at all levels attributed their ability to have effective relationships with facility staff to their regular presence in facilities. At the same time, limited fiscal and staffing resources have prevented Ombudsman programs from conducting routine visits to nursing homes and board and care homes. State Ombudsmen reported that regular visits to nursing homes (50%) and board and care homes (67%) are among the activities that programs do not carry out fully due to a lack of resources. In FFY 2017, Ombudsman programs visited 68% of nursing homes and 30% of board and care homes on at least a quarterly basis. NORS data also indicate that complaints that the Ombudsman program handles are more complex and challenging than in the past – moving away from requests for assistance with daily needs to more urgent concerns such as involuntary discharge, transfers, and evictions. The growth of diverse populations in need of complex care has also presented challenges with obtaining adequate training and available services to meet these residents' needs. Furthermore, State Ombudsmen reported that weaker regulations in board and care homes, compared to nursing homes, prevent programs from effectively advocating on behalf of these residents.

Against the backdrop of these challenges, State Ombudsmen reported relying on inter-organizational relationships as well as the program's committed staff and volunteers to support advocacy services for residents. Relationships with coordinating entities enable Ombudsmen to address the wide range of resident complaints that the program receives, including improving their quality of care, transitioning eligible residents back to the community, and assisting residents who have been involuntarily discharged.

State Ombudsmen also reported that the dedication of staff and volunteers to improve the lives of residents is vital to program operations. One State Ombudsman explained that "every Ombudsman has one case, or one situation that they can point to that really made a significant impact in a resident's life…our success is oftentimes at the individual level." Another State Ombudsman noted, "When a local Ombudsman develops those relationships with individuals, sometimes they're the only reason the individual is alive."

STATE OMBUDSMEN'S PERSPECTIVES ON RESIDENT ADVOCACY

- "So many of the calls we get are from family members and friends that are completely overwhelmed and baffled by the long term care system. What we can offer people in those instances is a whole lot of relief because we can simplify things as best we can, explain steps and resources and ideas that I don't think, at least in [our state], there really is any other organization that can do that. We don't have other advocacy groups in [our state] like some of the larger states have, so I just think we are it. People are just, when they contact us sometimes they're just so overwhelmed. Residents are resigned to, "This is the way it's going to be," until they find out that we might be able to help them."
- "Our presence in the facility…gives the residents more of a voice and more confidence that they will be supported if there is a need."
- "We've got a very vulnerable population that we serve and maybe the most vulnerable out there. I'm talking about whether you're medically frail or if you are a long term substance abuser who is now dealing with the mental illness ramifications of all of that or if you're developmentally disabled and need that daily assistance...so I hope by those folks just knowing that we're out there and can help them or can try to help them, I hope that that is just intrinsically valuable just by itself."
- "What I think is very successful [about the program] is, because we are very visible in the nursing facilities, the resident now feel more comfortable with advocating. They feel more empowered to advocate for themselves at times than they did in the past. A lot of the times they felt like they were going to be retaliated against or nothing was going to be done."

Ombudsmen also reported deriving satisfaction when residents feel empowered to advocate for themselves. Others note the impact their work can have on residents' family members and friends, who are often the ones that call the Ombudsman program for help. One State Ombudsman described their role as providing "a whole lot of relief because we can simplify things as best we can and explain steps and resources, and there really isn't any other organization that can do that."

Although many programs struggle to visit facilities on a quarterly basis, State Ombudsmen also recognized the need to exceed those standards. If not for resource constraints, some State Ombudsmen expressed the desire to perform more frequent visits in order to more fully develop relationships with residents and facility staff and to become viewed as a trusted resource. To improve access, State Ombudsmen reported pursuing multiple strategies, including recruiting more volunteers, nurturing new or existing partnerships, and identifying additional sources of funding or resources to support their presence in long-term care facilities.

STATE OMBUDSMAN PERSPECTIVES HANDLING COMPLAINTS

- "[The program] gives voice to residents in a safe non-threatening way. Residents are very, very hesitant to complain to the director of nursing, to the administrator, or even to a staff person and the best thing about having a general routine of stopping by at nursing homes and not a specific appointment helps to break down the resistance of residents to talk about issues or talk about problems that they probably wouldn't necessarily pick up the phone and call."
- "I think…the people that we help makes [the program] valuable. The fact that my staff, they will push, and they fight to get someone what they need, or right a wrong."