

Long-Term Care Ombudsman Report FY 1998

**With Comparisons of National Data
For FY 1996-98**

**Administration on Aging
Department of Health and Human Services**



FY 1998 Long Term Care Ombudsman Report

With Comparisons of National Data for FY 1996-98

Introduction

Long-Term Care Ombudsmen are advocates for residents of long-term care facilities. They work to help resolve individuals' problems and to bring about changes at the local, state and national levels to improve care for all residents. Established under Section 712 of the Older Americans Act (OAA), ombudsman programs in every state and 587 local or regional areas carry out a variety of activities to assist residents and their loved ones to obtain a good quality of life and care in nursing homes, assisted living, and other types of long-term care facilities. Thousands of trained volunteer ombudsmen provide an on-going presence in long-term care facilities, monitoring care and conditions and providing a voice for those who are unable to speak for themselves.

Ombudsman responsibilities outlined in Title VII of the OAA include:

- identify, investigate and resolve complaints made by or on behalf of residents;
- provide information to residents about long-term care services;
- represent the interests of residents before governmental agencies and seek administrative, legal and other remedies to protect residents;
- analyze, comment on and recommend changes in laws and regulations pertaining to the health, safety, welfare and rights of residents;
- educate and inform consumers and the general public regarding issues and concerns related to long-term care and facilitate public comment on laws, regulations, policies and actions;
- promote the development of citizen organizations to participate in the program; and
- provide technical support for the development of resident and family councils to protect the well-being and rights of residents.

The National Long-Term Care Ombudsman Resource Center, operated by the National Citizens' Coalition for Nursing Home Reform in conjunction with the National Association of State Units on Aging, provides on-call technical assistance and intensive annual training to assist ombudsmen in their demanding work. The Center is supported with funds appropriated by Congress and awarded by the Administration on Aging.

This report provides national and state data and other information from the state ombudsman reports for FY 1998 and comparisons of national ombudsman data for FY 1996-1998. Some data from previous years is also provided.

Summary of Highlights: FY 1998 and Multi-Year Comparisons

- ▶ In FY 1998, ombudsmen nationwide opened 136,424 cases and closed 121,686 cases involving 201,053 individual complaints.
- ▶ Most complaints were filed by residents or friends and relatives of residents.
- ▶ Eighty-two percent of cases were in nursing home settings; 17 percent involved board and care, assisted living and similar facilities; and one percent were in non-facility settings.
- ▶ The top five nursing home complaints were in categories involving poor resident care, lack of respect for residents and physical abuse.
- ▶ A three-year comparison of the top twenty nursing home complaints indicates the greatest increases in complaints about physical abuse, toileting, personal hygiene and unheeded requests for assistance, all of which point to persistent problems with lack of care for residents and the need for increased numbers of trained staff to assist residents.
- ▶ The top five board and care complaints were about menu quality, medication management, discharge/eviction, lack of respect for residents and physical abuse; the greatest increases over a three-year period were in the first three of these categories.
- ▶ Seventy-two percent of nursing home complaints and 67 percent of board and care complaints were resolved or partially resolved to the resident's or complainant's satisfaction.
- ▶ FY 1998 program funding totaled \$47,404,557, \$4.35 million more than in FY 1997. While program funding rose in FY 1998, it was relatively level for the period FY 1995 to 1998. Resources are still inadequate to meet the need for ombudsman services and volunteer coverage in all facilities covered by the program.
- ▶ About 58 percent of the program funding was from federal sources, especially Title III of the OAA; states provided about 28 percent of funding; 14 percent was from private sources. Federal funding in FY 1998 was a lower percentage of total funding than the 63 and 62 percent in FY 1996 and 1997, respectively.
- ▶ There were 587 local and regional ombudsman programs in FY 1998, essentially the same as in FY 1997; most of these programs were located in area agencies on aging.
- ▶ The number of paid ombudsman staff increased from 887 full-time equivalents (FTEs) in FY 1997 to 927 FTEs in FY 1998, with 679 paid staff working full-time on the program.

- ▶ The number of volunteers who are trained and certified to investigate complaints increased from 6,795 in FY 1997 to 7,359 in FY 1998.
- ▶ Most state ombudsman programs are located in state agencies on aging, but programs in 15 states are located in other types of organizational settings, a slight increase since FY 1997.
- ▶ Ombudsmen reported that there were 18,227 nursing homes and 1.83 million beds in FY 1998, a slight decrease in the number of facilities but not of beds from previous years.
- ▶ Ombudsmen reported that 41,292 licensed board and care, assisted living and similar homes, with 797,036 beds, were operating nationwide. This is an *18% increase* over the number of beds in such facilities reported in FY 1996, with over three-fourths of the increase occurring between FY 1997 and 1998. Some of this increase is due to an increase in the number of facilities which are licensed, but much of it is due to an increase in the sheer numbers of such facilities and beds.
- ▶ The ratio of paid ombudsman FTEs to long-term care facility beds was 2,832 in FY 1998.
- ▶ Ombudsman staff and volunteers visited almost 80 percent of nursing homes and 45 percent of board and care homes on a regular basis, not in response to a complaint.
- ▶ Insufficient numbers of staff to care for residents was the major institutional long-term care concern most frequently identified by the states in their FY 1998 reports. Ombudsmen linked low staffing to low wages and benefits and labor shortage and described how lack of staff relates directly to poor care for residents, which was cited as a major issue by a number of states. This correlates with the top five nursing home complaints, all of which relate to inadequate or poor care.
- ▶ As in previous years, discharge and transfer issues were identified as a major problem area by a large number of states, as was inadequate regulation of assisted living and similar non-nursing home facilities.

About This Report

As stated in the introduction, this report provides data for FY 1998 from all state ombudsman programs on the types of problems reported by those who turn to the program for assistance and on other activities carried out by ombudsmen. In addition, the report reviews trends in national data from FY 1996 (and FY 1995 as available) through FY 1998.¹ The report also lists the major systemic issues affecting residents and the institutional long-term care system identified by the states and states' recommendations and actions to address these issues.

Cases and Complaints

Each inquiry brought to, or initiated by, the ombudsman on behalf of a resident or a group of residents is defined as a case. Each case may involve one or more problems, which are referred to as complaints. Except for reporting on the number of cases opened, all data submitted by the states in their annual reports to AoA are for closed cases.

In FY 1998 ombudsmen opened 136,424 new cases and closed 121,686 cases, involving 201,053 complaints, in FY 1998.² Figure 1 shows the trends for FY 1996-1998 in cases opened and closed and in complaints associated with cases closed. There was a three percent increase in cases opened each year from 1996 to 1998 and a five to six percent increase in complaints each year. The number of closed cases increased eight percent from 1997 to 1998.

As shown in Table 1 on the next page, for all years, most complaints were filed by residents of facilities or friends or relatives of residents, with little change in percentage for these categories over the last three years. The next highest groups filing complaints for all three years were ombudsmen and facility managers and staff. The 1998 distribution of complainant (case) data for nursing homes versus board and care-type facilities is illustrated in Figure 2 on the next page.

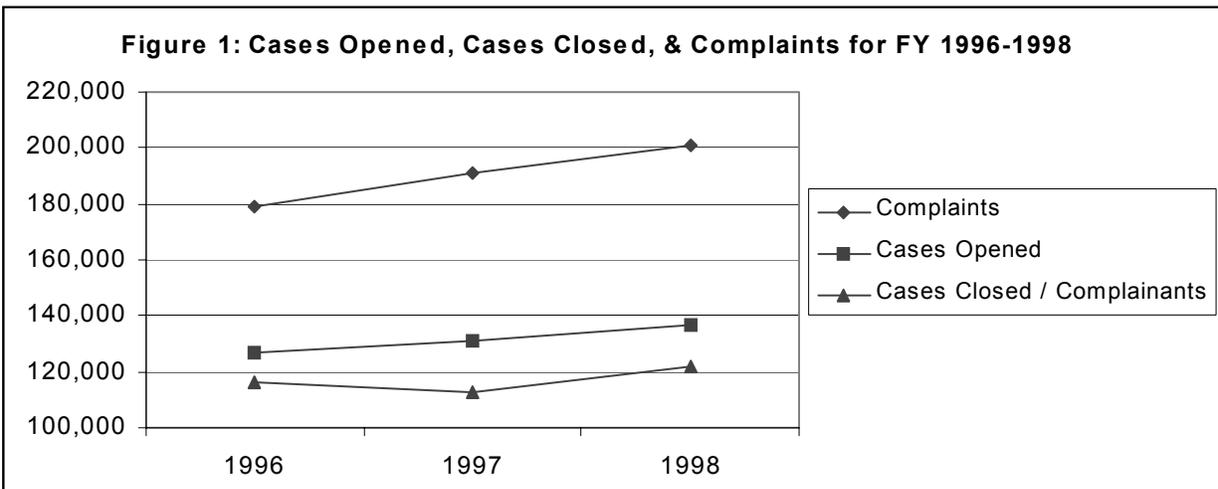
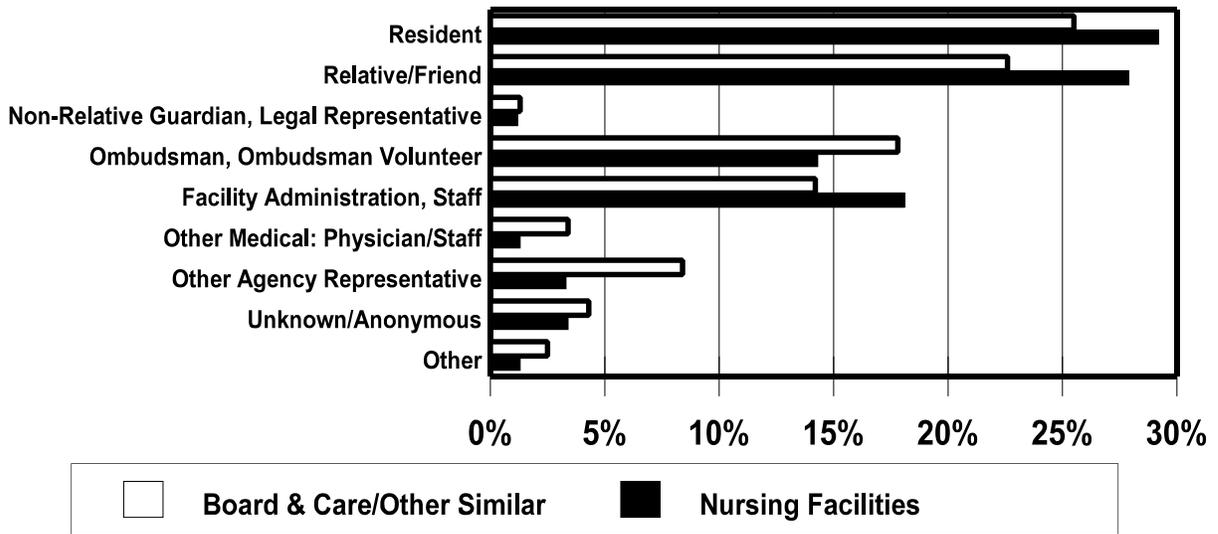


Table 1: Types of Complainants for Cases Closed for FY 1998				
	All Facilities /Settings	Nursing Facilities	Board & Care/Other Similar	Non-Facility Settings
Total Complainants	121,686	99,585	20,028	2,073
Resident	28.7%	29.2%	25.5%	32.6%
Relative/ Friend	27.1%	27.9%	22.6%	35.3%
Non-Relative Guardian, Legal Representative	1.2%	1.2%	1.3%	1.6%
Ombudsman, Ombudsman Volunteer	14.7%	14.3%	17.8%	3.3%
Facility Administration, Staff	17.3%	18.1%	14.2%	8.2%
Other Medical: Physician/ Staff	1.6%	1.3%	3.4%	3.1%
Other Agency Representative	4.3%	3.3%	8.4%	11.0%
Unknown/ Anonymous	3.5%	3.4%	4.3%	1.3%
Other	1.5%	1.3%	2.5%	3.5%

Figure 2: Types of Complainants for Cases Closed FY 1998



The vast majority of cases closed — 82 percent — were in nursing homes settings. Seventeen percent were in board and care, assisted living and similar facilities, and one percent were about problems in non-facility settings.

The five most frequent nursing home complaints concerned:

- unheeded requests for assistance;
- neglected personal hygiene;
- improper handling and accidents;
- lack of respect for residents, poor staff attitudes; and
- physical abuse.

The five most frequent complaints involving board and care, assisted living and similar facilities concerned:

- quality, quantity, variation and choice of food;
- administration and organization of medications;
- inadequate or no discharge/eviction notice or planning;
- lack of respect for residents, poor staff attitudes; and
- physical abuse.

As illustrated in Figure 3 below, the major complaint group *Residents' Rights* is cited most frequently in complaints for all settings. However, as Tables 2 and 3 on the next page indicate, the sub-group with the highest percentage of complaints is *care* under the group *Resident Care*. This is consistent over all three years for both nursing homes and board and care settings.

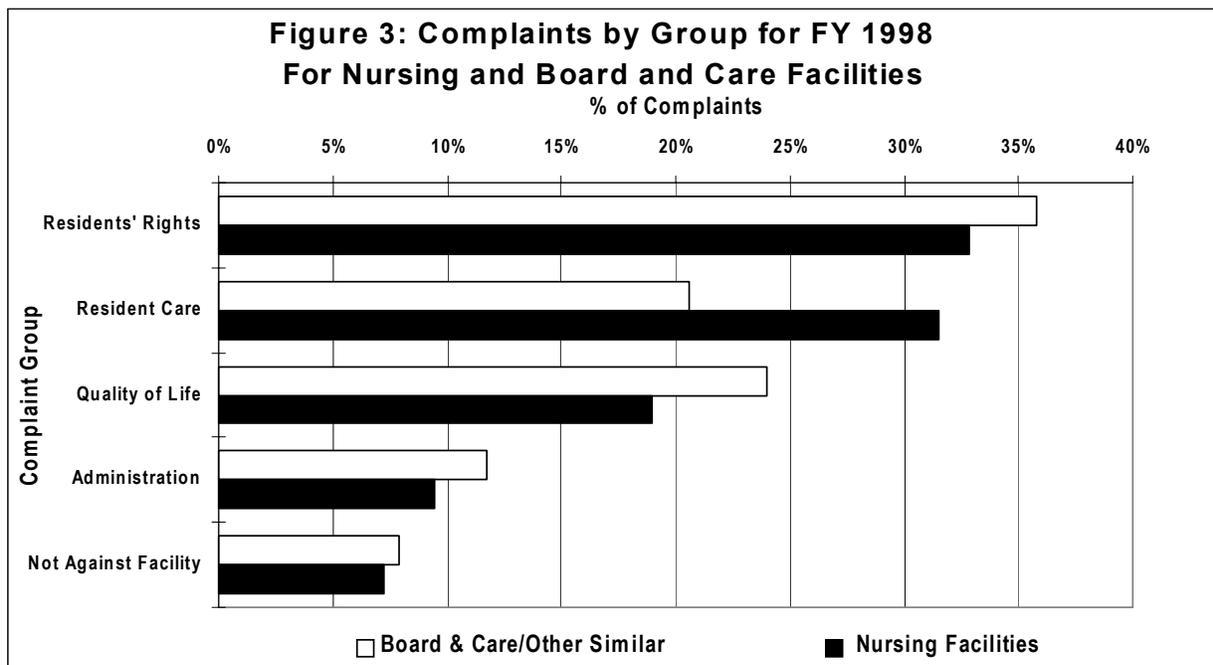


Table 2: Number of Complaints By Group and Sub-Group for Fiscal Year 1998

Groups	Sub-Groups	Nursing Facilities		Board & Care/Other Similar		Non-Facility Settings
Total Complaints		163,540		34,696		2,817
Residents' Rights	Total	53,665	32.8%	12,419	35.8%	Data on types of complaints collected for non-facility settings.
	A. Abuse, Gross Neglect, Exploitation	15,501	9.5%	3,548	10.2%	
	B. Access to Information	3,630	2.2%	946	2.7%	
	C. Admission, Transfer, Discharge, Eviction	9,679	5.9%	1,985	5.7%	
	D. Autonomy, Choice, Exercise of Rights, Privacy	16,401	10.0%	3,481	10.0%	
Resident Care	E. Financial, Property (Except for Financial	8,454	5.2%	2,459	7.1%	
	Total	51,538	31.5%	7,152	20.6%	
	F. Care	43,849	26.8%	6,274	18.1%	
	G. Rehabilitation or Maintenance of Function	5,847	3.6%	526	1.5%	
Quality of Life	H. Restraints - Chemical and Physical	1,842	1.1%	352	1.0%	
	Total	30,992	19.0%	8,319	24.0%	
	I. Activities & Social Services	5,244	3.2%	1,271	3.7%	
	J. Dietary	11,681	7.1%	3,048	8.8%	
Administration	K. Environment	14,067	8.6%	4,000	11.5%	
	Total	15,480	9.5%	4,073	11.7%	
	L. Policies, Procedures, Attitudes, Resources	2,522	1.5%	1,647	4.7%	
Not Against Facility	M. Staffing	12,958	7.9%	2,426	7.0%	
	Total	11,865	7.3%	2,733	7.9%	
	N. Certification/ Licensing Agency	563	0.3%	153	0.4%	
	O. State Medicaid Agency	1,727	1.1%	184	0.5%	
	P. System/ Others	9,575	5.9%	2,396	6.9%	

Table 3: Percentages of Complaints By Group and Sub-Group

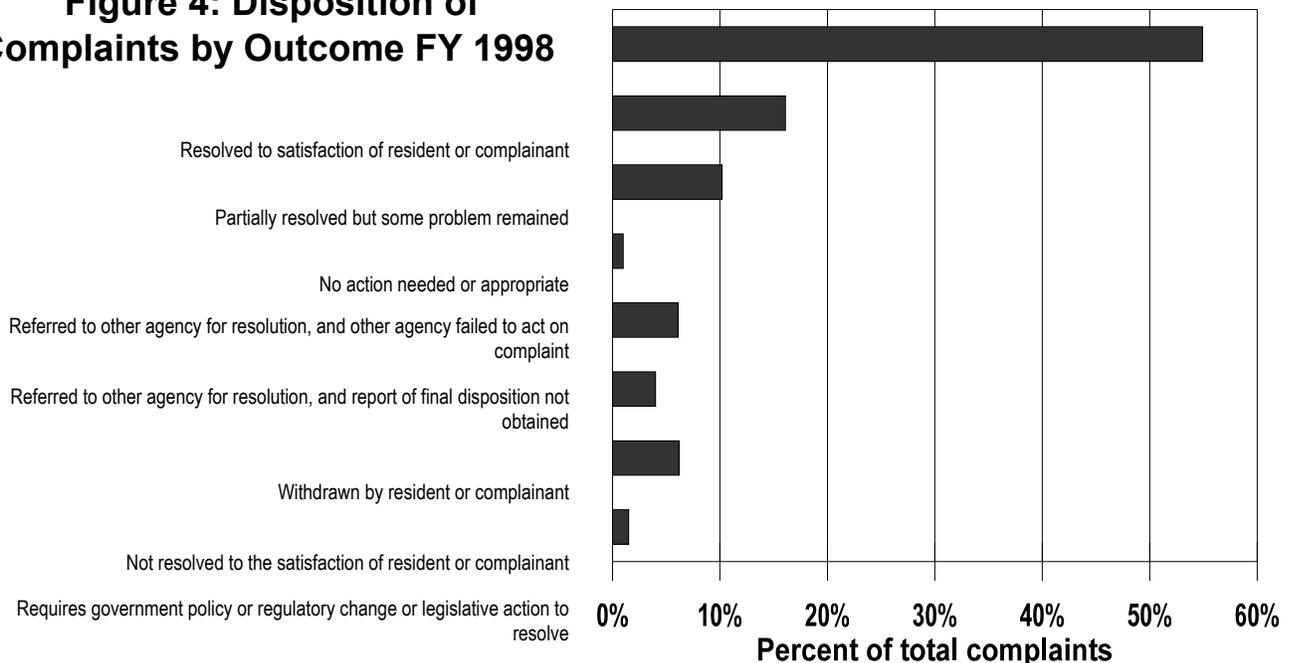
Groups	Sub-Groups	Nursing Facilities			Board & Care/Other Similar		
		1996	1997	1998	1996	1997	1998
Residents' Rights	Total	32.4%	32.7%	32.8%	36.8%	35.6%	35.8%
	A. Abuse, Gross Neglect, Exploitation	9.3%	8.9%	9.5%	11.7%	10.6%	10.2%
	B. Access to Information	2.2%	2.7%	2.2%	3.0%	2.8%	2.7%
	C. Admission, Transfer, Discharge, Eviction	5.7%	5.8%	5.9%	4.9%	5.6%	5.7%
	D. Autonomy, Choice, Exercise of Rights,	9.9%	10.2%	10.0%	10.1%	9.8%	10.0%
Resident Care	E. Financial, Property (Except for Financial	5.4%	5.0%	5.2%	7.1%	6.8%	7.1%
	Total	30.7%	30.1%	31.5%	20.5%	20.1%	20.6%
	F. Care	26.1%	25.4%	26.8%	17.7%	17.2%	18.1%
	G. Rehabilitation or Maintenance of Function	3.5%	3.6%	3.6%	1.7%	1.7%	1.5%
Quality of Life	H. Restraints - Chemical and Physical	1.2%	1.2%	1.1%	1.1%	1.1%	1.0%
	Total	18.9%	19.5%	19.0%	21.8%	23.8%	24.0%
	I. Activities & Social Services	3.0%	3.2%	3.2%	3.2%	3.6%	3.7%
	J. Dietary	7.3%	6.9%	7.1%	8.1%	8.2%	8.8%
Administration	K. Environment	8.6%	9.3%	8.6%	10.5%	12.0%	11.5%
	Total	9.7%	10.0%	9.5%	11.0%	11.5%	11.7%
	L. Policies, Procedures, Attitudes, Resources	2.0%	1.9%	1.5%	4.3%	4.7%	4.7%
Not Against Facility	M. Staffing	7.7%	8.1%	7.9%	6.7%	6.8%	7.0%
	Total	8.3%	7.8%	7.3%	9.8%	9.1%	7.9%
	N. Certification/ Licensing Agency	0.5%	0.6%	0.3%	0.5%	0.5%	0.4%
	O. State Medicaid Agency	1.2%	1.2%	1.1%	0.6%	0.7%	0.5%
	P. System/ Others	6.6%	6.0%	5.9%	8.7%	8.0%	6.9%

Over the three years, there was little change in the percent of complaints resolved or partially resolved to the satisfaction of the resident or complainant. In 1998 this figure was 72 percent for nursing homes, 67 percent for board and care homes and 71 percent for all settings. In 1998, 69 percent of all complaints were verified.³

Table 4: Complaint Verification & Disposition

	FY 1996	FY 1997	FY 1998
Total Complaints	179,111	191,005	201,053
Complaints Verified			
Number	132,491	137,339	138,494
Percent	74.0%	71.9%	68.9%
Disposition			
Requires government policy or regulatory change or legislative action to resolve	1.7%	1.5%	1.5%
Not resolved to the satisfaction of resident or complainant	6.6%	7.1%	6.2%
Withdrawn by resident or complainant	3.6%	3.5%	4.0%
Referred to other agency for resolution, and report of final disposition not obtained	5.6%	6.5%	6.1%
Referred to other agency for resolution, and other agency failed to act on complaint	0.5%	0.8%	1.0%
No action needed or appropriate	9.9%	9.8%	10.2%
Partially resolved but some problem remained	14.5%	16.3%	16.1%
Resolved to satisfaction of resident or complainant	57.7%	54.5%	54.9%

Figure 4: Disposition of Complaints by Outcome FY 1998



Analysis of complaint data

A three-year comparison of the top twenty specific complaints for nursing homes (Table 5) indicates an increase in the numbers and percentages for all but three of these complaints. In particular, there were significant increases in complaints on physical abuse, toileting issues, personal hygiene problems, unheeded requests for assistance and unresponsive staff. Overall, these data point to persistent problems with lack of care for residents and the need for increased levels of trained, caring staff to assist residents with their personal care needs.

Table 5: Top 20 Complaints by Category for Nursing Facilities

			1996			1997			1998		
Complaint Categories			Total	Percent	Rank	Total	Percent	Rank	Total	Percent	Rank
Group	See Table B-1 for Codes		144,680			157,380			163,540		
F.	41	Requests for assistance unheeded	5,441	3.76%	2	6,189	3.93%	1	7,026	4.30%	1
F.	45	Neglected personal hygiene	5,301	3.66%	3	5,299	3.37%	5	6,411	3.92%	2
F.	40	Improper handling and accidents	6,661	4.60%	1	5,701	3.62%	2	6,032	3.69%	3
D.	26	Lack of respect for residents, poor staff attitudes	4,882	3.37%	4	5,318	3.38%	4	5,710	3.49%	4
A.	1	Physical abuse	4,321	2.99%	7	4,080	2.59%	9	5,426	3.32%	5
C.	19	Inadequate or no discharge/eviction planning, notice, procedure	4,110	2.84%	9	4,794	3.05%	6	5,407	3.31%	6
F.	42	Inadequate or no care plan/resident assessment	4,453	3.08%	5	5,445	3.46%	3	5,242	3.21%	7
M.	97	Shortage of staff	4,332	2.99%	6	4,351	2.76%	7	4,887	2.99%	8
J.	71	Quantity, quality, variation, choice of food	4,295	2.97%	8	4,082	2.59%	8	4,554	2.78%	9
E.	38	Personal property lost, stolen, used by others, destroyed	3,598	2.49%	10	3,621	2.30%	10	3,993	2.44%	10
F.	44	Administration, organization of medications	3,123	2.16%	12	3,366	2.14%	12	3,885	2.38%	11
F.	48	Symptoms unattended, no notice to others of change in condition	3,198	2.21%	11	3,529	2.24%	11	3,818	2.33%	12
M.	10	Staff unresponsive, unavailable	2,376	1.64%	15	3,050	1.94%	13	3,248	1.99%	13
K.	78	Lack of cleanliness, pests	2,242	1.55%	19	2,919	1.85%	14	3,123	1.91%	14
D.	27	Denied exercise of choice and/or civil rights	2,211	1.53%	20	2,375	1.51%	22	2,851	1.74%	15
F.	49	Toileting issues	2,070	1.43%	23	2,193	1.39%	26	2,720	1.66%	16
F.	52	Other: Care	2,275	1.57%	17	2,543	1.62%	18	2,717	1.66%	17
A.	3	Verbal/mental abuse	2,431	1.68%	14	2,676	1.70%	15	2,598	1.59%	18
A.	6	Resident to resident abuse	2,532	1.75%	13	2,565	1.63%	17	2,577	1.58%	19
A.	5	Gross neglect	2,123	1.47%	22	2,648	1.68%	16	2,551	1.56%	20
K.	83	Odors	1,874	1.30%	26	2,515	1.60%	19	2,493	1.52%	21
E.	36	Billing/charges notice, approval, questionable, accounting wrong or denied	2,254	1.56%	18	2,419	1.54%	20	2,428	1.48%	22
P.	12 2	Legal-guardianship, conservatorship, power of attorney, wills	2,338	1.62%	16	2,275	1.45%	24	2,268	1.39%	24

For board and care and similar facilities, there have been significant increases in the occurrence

of the top 3 complaints — menu quality, variation and choice, medication administration and organization, and lack of adequate discharge/eviction planning — from FY 1996-98 (Table 6). In addition, there were increases in complaints of inadequate care planning/resident assessment and failure to accommodate or monitor wandering. These increases are likely related to increasing disability levels noted in residents of these non-nursing home facilities.

Table 6: Top 20 Complaints by Category for Board and Care Facilities

Complaint Categories		1996			1997			1998		
		Total	Percent	Rank	Total	Percent	Rank	Total	Percent	Rank
Group	See Table B-1 for Codes	31,660			30,783			34,696		
J. 71	Quantity, quality, variation, choice of food	1,459	4.61%	1	1,499	4.87%	1	1,792	5.16%	1
F. 44	Administration and organization of medications	1,154	3.64%	3	1,113	3.62%	2	1,433	4.13%	2
C. 19	Inadequate or no discharge/eviction planning, notice, or procedure	915	2.89%	6	1,000	3.25%	5	1,216	3.50%	3
D. 26	Lack of respect for residents, poor staff attitudes	978	3.09%	4	918	2.98%	7	1,129	3.25%	4
A. 1	Physical abuse	1,291	4.08%	2	938	3.05%	6	1,044	3.01%	5
K. 79	Equipment/building-disrepair, hazard, poor lighting, fire safety	952	3.01%	5	1,058	3.44%	4	1,023	2.95%	6
F. 45	Neglected personal hygiene	912	2.88%	7	1,093	3.55%	3	940	2.71%	7
K. 78	Lack of cleanliness, pests	718	2.27%	10	909	2.95%	8	927	2.67%	8
E. 37	Personal funds-mismanaged, access denied, deposits & other money not returned	812	2.56%	9	728	2.36%	9	887	2.56%	9
A. 3	Verbal/mental abuse	822	2.60%	8	652	2.12%	12	797	2.30%	10
E. 36	Billing/charges notice, approval, questionable, accounting wrong or denied	649	2.05%	12	676	2.20%	11	724	2.09%	11
M. 97	Shortage of staff	636	2.01%	13	614	1.99%	13	720	2.08%	12
F. 40	Improper handling and accidents	676	2.14%	11	546	1.77%	16	698	2.01%	13
E. 38	Personal property lost, stolen, used by others, destroyed	627	1.98%	14	576	1.87%	14	691	1.99%	14
F. 42	Inadequate or no care plan or resident assessment	531	1.68%	17	505	1.64%	18	664	1.91%	15
D. 27	Lack of choice and/or civil rights	574	1.81%	15	539	1.75%	17	644	1.86%	16
F. 48	Symptoms unattended, no notice to others of change in condition	565	1.78%	16	464	1.51%	20	577	1.66%	17
A. 5	Gross neglect	500	1.58%	18	705	2.29%	10	562	1.62%	18
F. 51	Failure to accommodate/monitor residents who wander	363	1.15%	31	379	1.23%	26	539	1.55%	19
K. 77	Problems with air temperature, quality of air	480	1.52%	20	477	1.55%	19	536	1.54%	20
L. 93	Offering residents inappropriate level of care	484	1.53%	19	571	1.85%	15	518	1.49%	21

A word about abuse complaints

We caution those who would use the ombudsman abuse data as a gauge to measure the extent of abuse which occurs in long-term care facilities. The data for physical and other kinds of abuse in this report represent only those complaints made to the ombudsman program. Many abuse complaints are reported to other state agencies, not to the ombudsman program. In most states, either the agency which licenses and certifies nursing homes to participate in Medicaid and Medicare or the adult protective services agency which investigates complaints of adult abuse in all settings is responsible for investigating abuse complaints in long-term care facilities. Thus,

the same abuse complaint may be filed with either of these agencies, in addition to the ombudsman program, or the complaint may be missing from the ombudsman data. In the few states where the ombudsman program is the agency designated to receive abuse complaints, facilities may report all incidents of injury as physical abuse, including resident-to-resident abuse, which has a different category in the ombudsman documentation system. For these reasons, the statistics on resident abuse in this report provide only part of the picture of abuse in long-term care facilities and should not be relied upon to measure the incidence of such abuse. Also, the numbers of abuse complaints for each year should not be used to measure trends, since the overall numbers of complaints made to the ombudsman programs increase each year. Multi-year trends on abuse complaints as a percentage of overall complaints made to the ombudsman program is probably a more reliable gauge of abuse trends than actual numbers of complaints.

Program Operations

Resources for ombudsman program operations have increased over the years, but they are still inadequate to meet the need for ombudsman services and volunteer coverage of all facilities serving older residents.

Funding for the ombudsman program nationwide totaled \$47,404,557 in FY 1998, an increase of \$4.35 million above FY 1997. The largest proportion of this increase was from state sources. The federal government continued to provide the most program funding in FY 1998 — \$27.55 million, about 58% of total funding — but this was notably less than the 63 and 62 percent of total funding provided from federal sources in FY 1996 and 1997, Figure 5 below shows the percentages of funding, by source, for FY 1998.

Figure 5: Sources of Funding for FY 1996 Long-Term Care Ombudsman Program

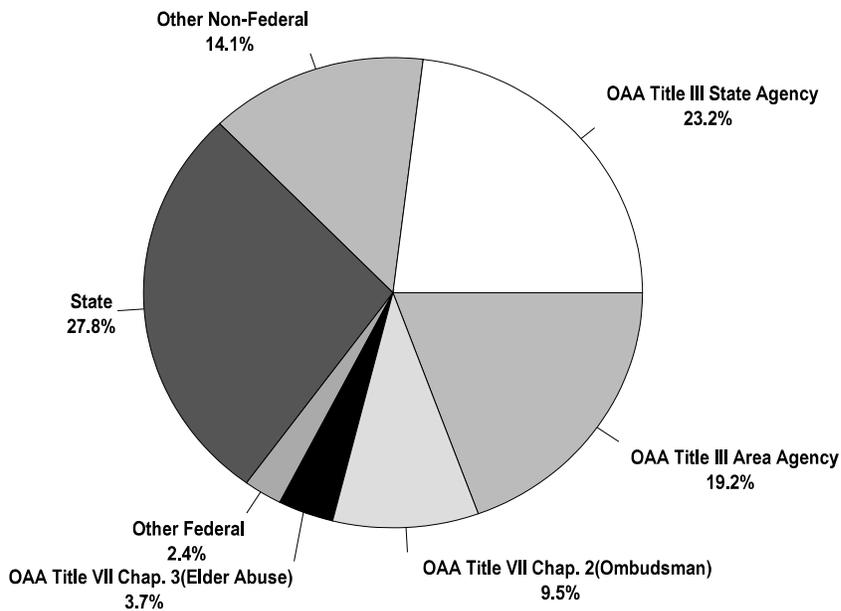


Figure 6 and Tables 7-9 on the next page show amounts and percentages from all sources for FY 1995-98. While program funding rose in FY 1998, it was relatively level for

the period 1995 to 1998.

**Table 7: Selected National Information
FY 1995 through FY 1998**

(Note: Comparison of complaints and complainants is not included)

because of inconsistencies due to switch to the new system.)

Category	FY 1995	FY 1996	FY 1997	FY 1998	
Total Program Funding	\$40,870,107	\$41,519,334	\$43,052,321	\$47,404,557	
Local Ombudsman Entities	565	570	586	587	
Paid Program Staff (FTEs)	913	847	887	927	
Volunteers					
Certified Volunteer Ombudsmen ¹	6,421	6,622	6,795	7,359	
Other Volunteers	5,159	6,035	6,049	5,645	
Total Volunteers	11,580	12,657	12,844	13,004	
Licensed Facilities (National Totals)					
Nursing Facilities	Number	18,911	18,066	18,244	18,227
	Beds	1,819,069	1,845,791	1,853,245	1,827,212
Board & Care/Similar Facilities ²	Number	35,304	39,369	38,910	41,292
	Beds	662,199	673,903	700,821	797,036
All Facilities	Number	54,215	57,435	57,154	59,519
	Beds	2,481,268	2,519,694	2,554,066	2,624,248
Number of LTC Facility Beds per Paid Program Staff (FTEs)		2,718	2,973	2,878	2,832

¹ Individuals who have completed a training course prescribed by the state ombudsman and are approved by the state ombudsman to participate in the statewide ombudsman

² Includes only those types of facilities which state ombudsman programs include within purview under the requirement of Section 102(34)(D) of the OAA.

Table 8: Trends in the Ombudsman Program—FY 1987–1998

	FY87	FY88	FY89	FY90	FY91	FY92	FY93	FY94	FY95	FY96	FY97	FY98
Total Number Local Programs ¹	557	578	570	578	551	571	549	559	565	570	586	587
Local Programs in AAA's ²			435	412	395	406	386	414	374	366	370	366
Total Number Complainants (Cases) (000s)	Data not comparable with FY 96 data due to changes in reporting									116.	113.	121.
Total Number Complaints (000s)										179.	191.	201.
Funding (in millions of dollars)												
Title III-B Funding³												
Allotted by State & Area Agencies	11.6	12.7	13.6	14.5	15.4	15.6	16.5	17.4	19.8	20.5	20.0	20.1
Allotted by State Agencies									9.7	10.1	10.7	11.0
Allotted by Area Agencies									10.1	10.4	9.3	9.1
Title III Ombudsman Allotment ⁴					2	3.3	0.6					
Title III-G Abuse Prevention ⁴					0.8	1.8						
Title VII Chapter Two ⁵							3.5	4.2	4.4	3.8	4.2	4.5
Title VII, Chapter Three ⁵							2.1	2.9	1.9	1.5	1.7	1.8

All other Federal	1	1.1	0.8	1.1	0.9	1	0.9	1	0.4	0.5	0.9	1.1
All State ⁶	7.7	9.5	7.1	7.4	8.1	8.3	7.9	8.2	8.9	9.4	10.4	13.2
All Other Non-Federal ⁶			3.7	4.9	6.8	5.1	5.8	8.1	5.5	5.8	5.9	6.7
Total Funding	20.3	23.3	25.2	27.9	34	35.1	37.4	41.8	40.9	41.5	43.1	47.4

¹ The reduced number in area agency on aging-sponsored programs may be due to more refined definitions in the NORS rather than to an actual drop in the number of programs located in AAAs.

² This information was not collected prior to FY 1989.

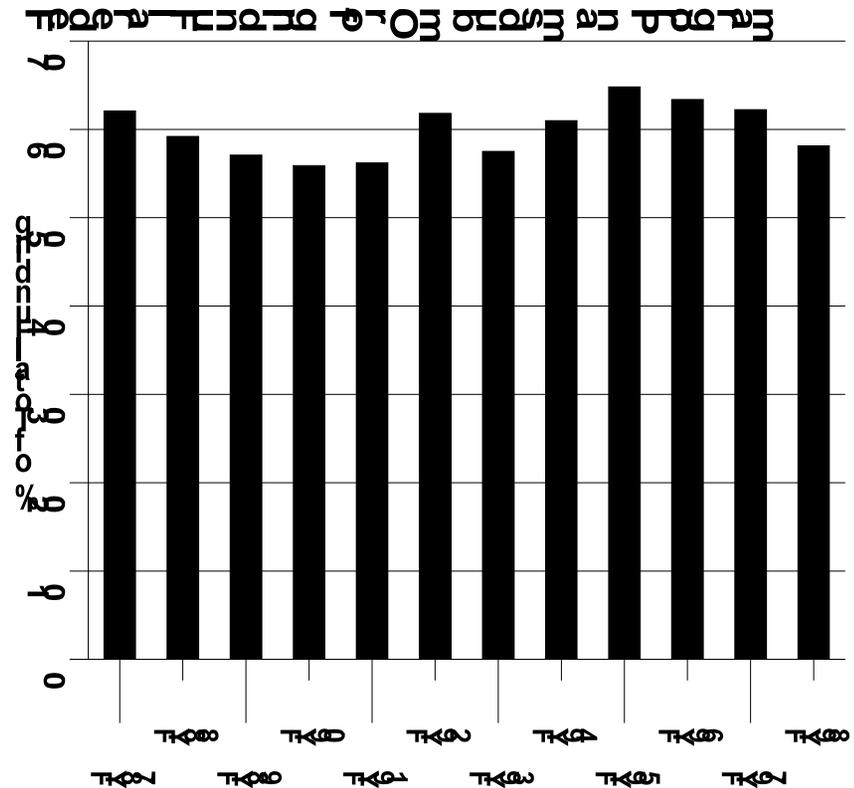
³ A breakdown on the source of Title III funding between State and Area Agencies on Aging was

⁴ These allotments for ombudsmen and abuse prevention activities were provided for FY 1991-

⁵ Beginning in FY 1996, Congress provided these funds for Title VII programs as an earmark in

⁶ Data in FY 1987-8 not collected separately for All State and All Other Non-Federal

**Figure 6: Sources of Funds
for FY 1987 to FY 1998
Federal vs. Non-Federal**



	FY87	FY88	FY89	FY90	FY91	FY92	FY93	FY94	FY95	FY96	FY97	FY98
Total Funds (000,000)	20.3	23.3	25.2	27.9	34	35.1	35.2	41.8	40.9	41.52	43.05	47.40
Source of Funds												
Federal (000,000)	12.6	13.8	14.4	15.6	19.1	21.7	21.5	25.5	26.5	26.31	26.79	27.55
Non-Federal (000,000)	7.7	9.5	10.8	12.3	14.9	13.4	13.7	16.3	14.4	15.21	16.26	19.85
Federal (%)	62.1	59.2	57.1	55.9	56.2	61.8	57.5	61.0	64.8	63.37	62.23	58.12
Non-Federal (%)	37.9	40.8	42.9	44.1	43.8	38.2	38.9	39.0	35.2	36.63	37.77	41.88

Most state long-term care ombudsman programs continued to be physically and organizationally located in the state units on aging, but programs in 15 states (CO, DC, FL, KS, ME, MI, NH, NJ, OR, RI, VA, VT, WA, WI and WY) are either free-standing programs or are located in private, non-profit agencies or a larger government ombudsman program. (In the FY 1996 National Long-Term Care Ombudsman Report, 12 programs were listed as being located outside the state units on aging.)

There were 587 local and regional ombudsman programs in FY 1998, essentially the same as in FY 1997. As shown in Table 10, most regional programs continued to be located in area agencies on aging.

Table 10: Designated Local Ombudsman Entities for FY 1995-8

Year	Total	Area Agency on Aging	Other Local Government Entity	Legal Services Provider	Social Services Non-profit Agency	Freestanding Ombudsman Program	Regional Office of State Ombudsman Program	Other
FY 1998	587	366	18	30	79	18	46	30
FY 1997	586	370	18	27	77	16	45	35
FY 1996	570	366	3	28	88	22	47	16
FY 1995	565	374	9	29	81	13	44	15

The number of ombudsman staff increased from 887 full-time equivalents (FTEs) in FY 1997 to 927 FTEs in FY 1998, with 679 people working full-time on the program, up from 627 in FY 1997. Overall, there has been about a four percent increase in staff FTEs each year since 1996.

The number of volunteers who are trained and certified to investigate complaints has also increased significantly — from 6,795 in FY 1997 to 7,359 in FY 1998. The total number of volunteers in FY 1998 was just over 13,000. Table 11 on the next page shows trends in staff and volunteer levels from FY 1995 through FY 1998.

**Table 11: National Staff and Volunteers
Totals for FY 1995-8**

	FY1995	FY1996	FY1997	FY1998
Paid program staff (FTEs)	913	847	887	927
working at state level	179	187	175	174
working at local level	734	661	713	752
Paid individuals working full-time on program	598	551	627	679
at state level	155	147	141	143
at local level	443	404	486	536
Volunteer ombudsmen trained and certified to investigate complaints	6,421	6,622	6,795	7,359
working at state level	380	304	158	217
working at local level	6,041	6,318	6,637	7,142
Other Volunteers (not involved in complaint work)	5,159	6,035	6,049	5,645
working at state level	157	298	15	66
working at local level	5,002	5737	6034	5579

In their annual reports, ombudsmen provide the number of licensed long-term care facilities and beds serving primarily older residents in their state. According to these reports, summarized in Table 7 on page 12, the number of licensed nursing homes declined and the number of nursing home beds increased slightly from the first year ombudsmen reported this data (1995) to 1998, with a total of 18,227 homes and 1.83 million beds reported in FY 1998.

During the same period, the number of licensed board and care-type facilities and beds, including assisted living, adult care, residential care and similar homes, increased ever more dramatically, from 35,304 facilities with 662,199 beds in FY 1995 to 41,292 facilities with 797,036 beds in FY 1998. *The number of beds in these facilities increased 18 percent from FY 1996 to FY 1998, with over three fourths of the increase occurring between FY 1997 and 1998.* The number of beds per facility shows only modest changes over the same time span. Comparing these totals with earlier data⁴ on licensed facilities of this type demonstrates the growing importance of this segment of the long-term care continuum.

The ratio of paid ombudsman FTEs to total number of long-term care facility beds was one to 2,832 in FY 1998. While this is an improvement over the figures for 1996 and 1997, it is still over 40 percent greater than the ratio of “one full-time equivalent paid staff working as an authorized, designated ombudsman per 2,000 beds” which the Institute of Medicine, in their 1995 study of the Long-Term Care Ombudsman Program,⁵ said was the level that would permit ombudsman programs to “perform their current functions adequately.”

Tables A-1 and A-6 through A-10 in the appendix provide program operations data for FY 1996-98 and FY 1998 data, by state.

Other Ombudsman Activities

Ombudsmen perform numerous functions in addition to investigating and resolving complaints. These include visiting facilities on a regular basis (not in response to complaints), participating in facility surveys conducted by state regulatory agencies, working with resident and family councils, providing community education, working with the media, training ombudsman staff and volunteers, training and consulting with managers and staff of long-term care facilities, and providing information and consultation to individuals. In addition to these activities, ombudsmen also monitor and work on laws, regulations, and government policies and actions.

These activities are listed in Table 12, below, with national totals measuring the extent of ombudsman work on each of the activities, nationwide, for FY 1996-98. As the data indicate, the ombudsman programs have increased visitation, particularly to board and care and similar facilities, with almost 80 percent of nursing homes and 45 percent of board and care facilities being visited regularly. There have also been significant increases in interviews with the media and work with resident councils.

A breakdown of these activities, by state, is in Appendix A-10. The types of information requests which state and local programs receive from the public and the types of training and consultation ombudsmen provide to facility staff are listed by state in Appendices E and F.

Ombudsman work on laws, regulations and government policies and actions is referred to as issues advocacy, which is discussed in the next section. Appendix A-10 shows the amount of state ombudsman staff time each state estimated spending on this aspect of ombudsman work. Almost half (eight) of the twenty states reporting that state ombudsman staff spend 25 percent or more of their time on issues advocacy are among the 15 states whose state ombudsman programs are either free-standing, independent programs or are located in agencies where ombudsmen are independent in carrying out issues advocacy activities (CO, DC, MI, NH, NJ, VT, WA, and WY).

Table 12: Other Ombudsman Activities				
		1996	1997	1998
Percent of all facilities visited not in response to complaints	<i>nursing homes</i>	70.7%	72.6%	78.3%
	<i>board & care</i>	28.1%	41.5%	44.6%
Participation in facility surveys	<i>surveys:</i>	9,776	9,568	9,533
Working with resident and family councils (attendance at meetings)	<i>resident council meetings:</i>	11,942	14,540	18,239
	<i>family council meetings:</i>	4,685	5,996	5,768
Providing community education	<i>sessions:</i>	8,985	8,559	9,307
Working with the media	<i>interviews:</i>	3,406	2,965	4,015
	<i>press releases issued:</i>	3,252	5,624	4,755
Providing training and technical assistance to staff and volunteers in the statewide ombudsman program	<i>training sessions:</i>	9,199	8,510	8,847
	<i>hours:</i>	46,015	45,153	44,235
	<i>ombudsman trainees:</i>	27,568	29,709	30,717

Providing training and consultation to managers and staff of long-term care facilities	<i>training sessions:</i>	7,321	6,606	7,298
	<i>consultations:</i>	62,962	66,286	68,066
Providing information and consultation to individuals (usually by telephone)	<i>consultations:</i>	188,067	206,087	209,476

Major Long-Term Care Issues

Issues advocacy involves ombudsman work on laws, regulations and government policies and actions to bring about changes to improve care and secure rights for all or large number of long-term care residents in the state. States were asked to describe the priority issues which their program had identified and/or worked on during the reporting period; barriers to resolution; and recommendations for system-wide changes needed to resolve the issue, or how the issue was resolved in their state. Thirty-seven states responded to this question. As in previous state reports, the issues were almost always interconnected. Issues identified by the states are listed in Table 13, with the states which identified them in the right column.

Insufficient numbers of staff to care for residents was the major issue identified most frequently by the states in their FY 1998 reports. Lack of staff training was a related major concern. Ombudsmen linked low staffing to low wages and benefits and labor shortage and described how lack of staff relates directly to poor care for residents, which was cited as a major issue by a number of states. This correlates with the top five nursing home complaints, all of which relate to inadequate or poor care.

As in previous years, discharge and transfer issues were identified as a major problem area by a large number of states, as was inadequate regulation of assisted living and similar non-nursing home facilities. Some states noted a problem in 1998 that ombudsmen report anecdotally has now become a trend: over-extension in the building of assisted living facilities and the resulting need to keep beds filled, even when the level of care which a resident might need could not be provided in the facility. This trend, combined with inadequate or no regulation of these facilities, has led to inadequate care for many residents. Emergency closure of facilities, now a major problem in a number of states because residents are dislocated, often moved far from family members, and can suffer transfer trauma, was noted as an emerging problem in some states in FY 1998. States' descriptions of these issues, actions they have taken to address them, and recommendations to resolve them are provided in Appendix C.

Table 13: Long-Term Care Issues for 1998

Access to Facilities and Services	States
Discharge or Transfer	
Board & Care	IL, MS, NE, OH
Medicaid	GA, IN, NE, TN
Emergency Closures	GA, MI, PA, WA
Special Needs	DC, TN
Procedures	FL, NY, NC
Admissions	
Medicaid	GA, VT, WY
Medicare	VT
Low Staff	MN
Special Needs	CO, VT
Access to Services	

Medicaid	CO
Young Adults	CO, WY
Lacked in Community	GA, PA
Lack Alternatives/Money	GA, ME
Special Needs	MS, WA

Table 13: Long-Term Care Issues for 1998 (continued)

Enforcement	
Related to Regulations	
Board & Care	IL, ME, MS, NE, NM, OH, OR, VT, VA, WA
Lack of Nursing Home Regulations	MI
Changing Regulations	OH
Survey Related	
Fragmented Responsibilities	GA, MD, NM, VA
Role (help vs. oversight)	CO, DC, OH, VA
Measure Outcome vs Cause	CO, IN, OH
Insufficient Survey Staff	GA, OH, VA
Ineffective Sanctions	MI
Survey Predictable	VA
Fraud: Medicaid and Medicare	CA, FL, GA, PA
Staffing	
Job Related	
Insufficient Staff	CO, DC, FL, GA, IN, KY, LA, ME, MD, MA, MN, MS, MO, OH, OR, TX, UT, VA, WA
Lack Training	CO, DC, GA, IN, MD, MA, MS, NC, OH, VA, WA
Low Wages/Benefits	CO, IN, MN, MS, NC, TX, UT
High Turnover	CO, IN, MS, UT, VA
Difficult Work	CO, IN, NC, UT
Lack of Recognition	CO, IN, NC
No Career Advancement	UT, WA
Injuries	CO, UT
Lack Supervision	GA, MS
Increased Patient Acuity	CO, UT
Labor pool issues	CO, IN, MN, MS, NC, OR, UT
Allocation of Reimbursement \$ to Staffing	CO, DC, IN, OH, OR
Resistance to Staffing Ratios	CO, IN, MN, UT, WA
Patient Care (see Staffing)	
Malnutrition or Dehydration	DC, GA, IN, KY, MA, OH
Quality	CO, DC, IN, MD, MA, MS, NJ, VA
Sores	DC, GA, IN
Response Time	CO, IN, LA

Medications	CO, FL
Accidents	DC, MD
Hygiene	MD
Care Planning	MD
Staff/Abuse Registry	DE, FL, NJ

Table 13: Long-Term Care Issues for 1998 (continued)

Residents Rights	
General Rights	
	DE, FL
Culture Change	DC, MN, WA
Education on Rights	MT, VA
Representation	
Guardian Issues	MO, OR, RI, UT
Legal	KY
DNR/End of Life	NJ, OH
Neglect/Abuse	
Abuse	CO, DE, MD, NJ, VA
Restraints	MN, RI, WA
Drug and Alcohol Misuse	MD
Financial Issues	
Personal Needs Allowance	OH, RI
Exploitation/Loss of Property	FL, MD, OH
Due Process	NY, NC
Ombudsman Program Operations	
Program Support	
Financial	AL, CO, IL, MD, VA, VT, WA
Insufficient Staffing	AR, CA, ID, MD, NJ, WA
Increased volume of complaints	CO, MD, VA
Political Issues	CA, PR, WA
Need Legislative Support	AL, PR
Requirements Hard to Implement	MD
Visibility/Role	
General Visibility	AL, ID, IL, PA
Coordination with Licensing	CO, NM
Insufficient Presence in Facilities	CO, PR
Info. not accessible when needed	IL
Role re Assisted Living unclear	MD
Conflict of Interest/Dual Role	ID

Endnotes

1. The main body of this report provides observations on some of the 1998 and trend data reported at the national level through the state ombudsman programs. Appendices A and B provide national totals from US FY 1996 through 1998 for **all** data reported by the states, as well as details of FY 1998 data, by state.

The case and complaint data in the appendices is provided by facility type as well as for all facilities. Because of the vast differences in state populations, the most reliable information on cases and complaints can be obtained by comparing percentages or ratios between the states or with national data, rather than comparing straight numbers. For example, Appendix A-2, "Cases Closed by Type of Complainant," has four tables of actual count of types of complainants, by facility, followed by four tables of percentages of types of complainants cases. The latter tables will yield more reliable data for comparison. Selected ratios are provided in Appendix A-1, "Selected Information by State."

Comparison of data on "Board and Care and Similar Facilities" is further complicated by the fact that there are no national standards on what constitutes this type of facility, so numbers of facilities included are based on state licensure standards, which vary considerably.

State-by-state data for years 1996 through 1998 is available on the Administration on Aging's ombudsman Web site <http://www.aoa.gov/ltombudsman>.

Appendix D gives samples of complaints filed with the ombudsman programs.

2. In the National Ombudsman Reporting System (NORS) *case* is synonymous with *complainant* and is defined as "each inquiry brought to, or initiated by, the ombudsman on behalf of a resident or group of residents involving one or more complaints or problems which requires opening of a case file and includes ombudsman investigation, fact gathering, setting of objectives and/or strategy to resolve, and follow-up." *Complaint* is defined as "a concern brought to, or initiated by, the ombudsman for investigation and action by or on behalf of one or more residents of a long-term care facility relating to health, safety, welfare or rights of a resident. One or more complaints constitute a case."

3. Definition of *verified*: "It is determined after work (interviews, record inspection, observation, etc.) that the circumstances described in the complaint are substantiated or generally accurate." Ombudsmen are clear that just because a complaint cannot be verified does not mean that it did not happen or that there is not a problem which requires explanation or resolution.

4. In 1990 there were approximately 34,000 licensed board and care homes with more than 613,000 beds. (Results from the 1990 National Health Provider Inventory, cited in "Analysis of the Effect of Regulation on the Quality of Care in Board and Care Homes, Research Triangle Institute and Brown University Study sponsored by the U.S. Department of Health and Human Services, July 10, 1995.)

5. *Real People, Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act*, Institute of Medicine, 1995.