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Research Brief

# Strengthening the Aging and Disability Networks: Promising Practices of Long-Term Care Ombudsman Programs

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This research brief highlights examples of promising practices that Long-Term Care Ombudsman programs are undertaking to strengthen program operations and improve the quality of life and care of long-term care residents. While not exhaustive, the selection is intended to reflect the range of activities that Ombudsman programs carry out, including education/outreach, individual advocacy, systems advocacy, and program quality assurance. Based on a preliminary review, these activities show potential to improve processes or outcomes for consumers and stakeholders that may be of interest to other programs for adoption. Findings presented in this brief are drawn from multiple data sources. These include data that 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); narrative data from the National Ombudsman Reporting System (NORS; the program's administrative reporting tool); and The National Consumer Voice for Quality Long-Term Care Conference in 2018.

## EDUCATION FOR PROSPECTIVE CONSUMERS: HELPING CONSUMERS FIND THE RIGHT FACILITY

**Educating Prospective Residents and Families.** The Illinois State Ombudsman program has worked since 2015 with their state's information technology (IT) department to develop the Illinois Department on Aging Ombudsman Consumer Choice Search, a website that enables consumers and families to search for licensed long-term care facilities based on their particular needs and preferences. Prior to that time, consumer requests for information about facility services were not publicly available. With the development of the website, consumers can search facilities based on location, services provided, and populations served.

The Consumer Choice Search website was made possible through the Illinois General Assembly's 2008 passage of the Residents' Right to Know Act, P.A. 95-0823, that requires the state's long-term care facilities to complete the Consumer Choice Information Report questionnaire on an annual basis. Developed in collaboration with the Illinois Attorney General's Office, the Illinois Department on Aging (including the Illinois Ombudsman program), long-term care professional associations, and advocacy organizations, the Consumer Choice Information Report contains information about facility services; special services and amenities; facility and resident profiles; meals and nutrition; rooms/apartments, furnishing and equipment; family, volunteer, and visitation provisions; safety and security; staffing; and ownership and administration. These data are used to populate the website. Although all long-term care facilities are listed on the website, only those that have completed the questionnaire have their information posted. The Illinois program continues to encourage the remaining facilities to participate.

**Resource**

Consumer Choice Search: https://webapps.illinois.gov/AGE/OmbudsmanSearch

# EDUCATION FOR RESIDENTS AND INDIVIDUAL ADVOCACY: MAKING IT EASIER FOR CONSUMERS TO UNDERSTAND AND PROTECT THEIR RIGHTS

**Educating and Empowering Residents Living in Residential Care Homes.** As community-based residential options continue to grow in popularity, Ombudsman programs are working to ensure that residents of these communities understand their rights. In partnership with Connecticut Legal Services, Inc., the Connecticut Ombudsman program developed a Residential Care Home (RCH) Tool Kit in 2016. The tool kit provides residents with information about their rights, steps to advocate on their own behalf, and resources that they can access. The tool kit covers a broad range of resident rights, including those related to quality of life, finances, privacy, personal property, visitation, community, physical surroundings, choice of physician, room-to-room transfers, emergency transfers, discharge, and readmission. For each topic, a "house rule" that residents may hear from facility staff is presented (e.g., "We are not responsible for any of your personal property that is missing or taken."). Citing relevant state statutes, the house rule is followed by a description of resident rights that dispels the given house rule. Should a resident believe that their rights have been violated after having received education on the facts, the tool kit advises residents on steps to take to protect their rights. The resource also includes information about home and community-based services, resident councils, a complaint form, a personal belongings inventory list, and contact information for legal services and other helpful resources.

**Resource**

Residential Care Home Tool Kit: https://ltcombudsman.org/uploads/files/support/ct-toolkit.PDF

**Empowering Residents to Self-Advocate and Empower Others.** In 2002, the Pennsylvania Ombudsman program initiated the Pennsylvania Empowered Expert Residents (PEER) program to encourage partnerships among residents, facility staff, and local Ombudsmen to address resident concerns before they become more serious problems. Developed in response to residents who said, "I want to be an Ombudsman," the PEER program helps residents donate their time and expertise to address issues that will resonate with peers. The program offers five two-hour empowerment training sessions that train residents to self-advocate and empower fellow residents to improve their care and quality of life in long-term care facilities. A two-hour session is also delivered to facility staff to orient them to the PEER concept. Open to all residents of nursing homes, personal care and assisted living homes, and other adult daily living centers, participating residents not only support their own communities, but are also connected to PEERs statewide. Since the program's inception, over 2,600 residents in more than 225 facilities have completed the training.

**Resource**

PEER Brochure: https://www.swpa-aaa.org/pdfs/PEER%20brochure.pdf

Residents who complete the program are invited to attend a graduation ceremony and receive a certificate. In some participating facilities, the State Ombudsman observed that complaints increased because residents became aware that they could report complaints. To confirm these observations and other anecdotal evidence supporting the program's success, the Pennsylvania State Ombudsman intends to contract with an evaluator to assess whether the PEER program has been effective.

# EDUCATION FOR FACILITY STAFF: SUPPORTS TO INCREASE STAFF ENGAGEMENT AND PERSON CENTERED CARE

**Engaging Facility Staff in Effective Staff Practices and Person-Centered Care.** Although adequate numbers of well-trained staff are fundamental to high-quality resident care, staffing shortages due to high vacancy and turnover continue to impede the ability of many long-term care facilities to meet residents' needs. To help recruit and retain paid caregivers (known as state-tested nurse aides, or STNAs, in Ohio) in nursing homes, Ohio's Office of the State Long-Term Care Ombudsman sought to bolster a key reason that STNAs report staying committed to their work – a sense of feeling valued that is derived from positive relationships with residents for whom they care. Building on the Pioneer Network's *Engaging Staff in Individualizing Care* starter tool kit, the Ohio Ombudsman program, in partnership with B&F Consulting, implemented the *Person-Centered Staff Engagement Project.* Funded with Civil Monetary Penalty funds, the grant project aimed to increase staff engagement through person-centered care and help build an infrastructure at facilities that promotes communication and teamwork. Between June 2017 and March 2019, the project advanced two practices that the Pioneer Network project found improved clinical, staff, and organizational outcomes: (1) 15 minute daily huddles among staff about the status of current and new residents, and (2) consistent assignment of staff to the same residents to strengthen relationships between STNAs and residents as well as STNAs' familiarity with residents' preferences.

To implement the project, B&F Consulting led the statewide learning collaborative and Ombudsman liaisons in each of the 12 Ohio regions provided technical support to the 129 facilities that participated in the project. These efforts included leading workgroups and providing individual consultation and coaching to facility staff. In addition, the Ohio Ombudsman program contracted with Scripps Gerontology Center at Miami University of Ohio to evaluate the project with the ultimate goal of replicating it throughout the state. Study findings showed that compared to non-participating facilities, those that participated in the intervention had positive and significant changes in staff communication and person-centered care practices. For example, more nurses and STNAs engaged in care planning and received information about new residents in a timely manner. Various groups of staff participated in huddles for the first time, and huddles occurred more frequently and among more staff than before the program was implemented. Person-centered care improved in 14 of the 16 areas that were measured, with the greatest improvements observed in residents deciding when to eat, staff having the time to learn about residents' histories, having supervisors that consider staff preferences when making care decisions, and having enough time to allow residents to do things for themselves. Another benefit of the project included expertise developed within Ohio Ombudsman program that could be used to provide information and ongoing assistance to homes.

**Acknowledging and Understanding Residents' Fears of Retaliation.** Prompted by findings from the 2005 VOICES Forum[1] about residents' fear of retaliation, the Connecticut Ombudsman program initiated a statewide work group and commissioned the University of Connecticut Health Center to study retaliation among residents in skilled nursing facilities. The study found that fear of retaliation is a reality for residents in

**Resource**

Scripps Gerontology Center's Evaluation Report: https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/6536/straker-person-centered-staff-engagement-project-evaluation-9-10-19-bt.pdf?sequence=1&isAllowed=y

Ohio Ombudsman Program Proposal: https://medicaid.ohio.gov/Portals/0/Resources/CMP/StaffEngagementProjectProposal.pdf

Pioneer Network's Starter Toolkit for Engaging Staff in Individualizing Care: https://www.pioneernetwork.net/resource-library/resource-libraryengaging-staff-individualizing-care/

[1] The VOICES Forum is a statewide annual event that offers an opportunity for resident counsel presidents, legislators, and other public officials to engage and identify the most pressing issues facing Connecticut nursing home residents.

various supportive housing situations. As one component of a larger awareness initiative, the Connecticut Ombudsman program developed a *Voices Speak Out Against Retaliation* training video to bring attention to the issue. The curriculum aims to help facility staff be conscious of how their behaviors are perceived by others and may be unintentionally viewed as retaliatory. The training is also designed to encourage residents to voice their concerns or address them through available resources (e.g., resident council, Ombudsman program, social worker, etc.) as well as encourage visitors to raise concerns to appropriate staff. The instructor's guide includes information on the history of the project, definitions of retaliation and fear of retaliation that were developed by the workgroup, a list of required materials (e.g., video monitor or laptop), video highlights, facilitation tips, a step-by-step guide on organizing the session and facilitating the discussion, and handouts (pre-activity questions about participants' perceptions of retaliation and video discussion questions). After piloting the curriculum in several nursing homes, the State Ombudsman reported that the training was well-received by staff. Other state Ombudsman programs and higher education programs have requested to use the curriculum for their own trainings.

**Resource**

Voices Speak Out Against Retaliation Training Guide: https://www.ct.gov/ltcop/cwp/view.asp?Q=473774&A=3821

## SYSTEMS ADVOCACY: OVERSIGHT MECHANISMS TO ENSURE CONTINUITY OF SERVICE

**Anticipating Harm to Residents' Welfare and Safety with Third-Party Notification of Utility Disconnection.** Facilities that are resource-constrained not only place their financial viability at risk, but also residents' safety and well-being. The Office of the District of Columbia (DC) Long-Term Care Ombudsman identified a facility's inability to make timely payments on utility bills as a critical sign that it may be struggling financially. In the past, the DC Ombudsman program observed these issues with some smaller facilities, particularly community residential facilities (CRF). In at least one instance, a CRF's gas service was shut off during the winter months due to non-payment. Termination of gas service meant no stove cooking, hot water for bathing, or heat. The facility was using portable heaters that posed a potential fire hazard. Given the impact of terminating utility services on residents' welfare and safety, the State Ombudsman coordinated with the District's Office of the People's Counsel (which represents utility customers) and utility companies serving the District to develop a 'Third-Party Notice of Utility Disconnection' bill. This legislation requires a number of changes to the late-payment notification process. Under the new law, utility companies are responsible for implementing the notification program while facilities are required to enroll in the program and designate their regulatory agency as its third party contact. This authorizes the regulatory agency to receive a duplicate notification of any termination of service. The regulatory agency then forwards the notification to the State Ombudsman so the program can represent the residents' interests and protect their health, safety, and welfare. This law, officially titled the Community Residential Facilities Third-Party Notice of Utility Disconnection Requirement Act of 2018 [D.C. Law 22-104], was passed in 2018.

**Resource**

Legislative Code: https://code.dccouncil.us/dc/council/laws/22-104.html

**Enhancing Services for Residents with Alzheimer's Disease and Related Dementias.** Recognizing the need to better serve residents with Alzheimer's disease and related dementias, the Oregon Ombudsman program implemented the Memory Care Initiative in 2016. A review of internal data revealed that significantly fewer requests for Ombudsman assistance from residents and their family members were generated from regular visits to memory care settings. Until that time, the minimal data collected on

memory care settings prevented an informed enhancement of Ombudsman services in these settings.

To improve advocacy on behalf of residents who are unable to fully communicate their needs and concerns, the Oregon Ombudsman program focused the initiative's efforts on having volunteer Ombudsmen collect data on their observations when visiting memory care settings and providing them with additional training on key topics. This included an overview of memory care endorsed facilities; best practices in memory care; the role of the memory care administrator; observation techniques; requirements for staffing and meal and food times; recognizing chemical restraints; and working with families, including establishing family councils. More than 30 Ombudsmen who completed the training were designated as Memory Care Specialists (MCSs). These MCSs visited their assigned facility at least weekly for six months, varying their visitation times, and completed a report after each visit. MCSs also agreed to participate in the same training program that facility staff in their memory care attend. Of the 185 memory care units operating in the state of Oregon, 45 (or 24%) of memory care units had an assigned MCS for the purposes of this study.

During visits, the MCSs observed a number of issues in memory care units such as staffing shortages and limited staff interactions with residents, inadequate meal time procedures (e.g., excessive wait times or lack of appropriate silverware), and absence of meaningful activities, particularly in facilities where an Activities Director position was vacant. To supplement these findings and better understand the challenges in memory care settings, the State Office reviewed facility incident reports and redacted investigation reports from Adult Protective Services (APS). The Ombudsman program compiled its findings in a report that was developed in 2017 and continues to use these findings to inform program practices. This includes an increased focus on memory care related consumer education, improving training for certified volunteer Ombudsmen serving memory care settings, and continuing efforts with legislative partners and stakeholders to address the concerns of residents in specialized memory care settings.

**Interagency Efforts to Challenge Facility-Initiated Discharges and Transfers.** Based on a review of involuntary discharge notices received (a requirement in Maryland since 1995), the Maryland Ombudsman program observed a sharp increase in involuntary discharge notices from a single private nursing home corporation. Although the company operated only five nursing homes with 782 beds in Maryland (representing less than three percent of all nursing home beds in Maryland), these facilities accounted for approximately 67% of the state's involuntary discharges between January 2015 and May 2016. In May of 2015, the State Ombudsman as well as local Ombudsmen met with the provider in an attempt to resolve the issue, highlight the importance of adequate discharge planning, and encourage the provider to assist residents and families with understanding payment options, including Medicaid and how to apply for it. After no improvements were observed, the State Ombudsman sought assistance from the Office of the Attorney General (OAG) to address the provider's discharge practices. In May of 2016, the OAG initiated a civil investigation under the Maryland False Health Claims Act, including pre-dispute litigation requests. The investigation included reviews of deficiency statements, interviews with evicted residents and their family members, a statewide review of the involuntary discharge notices, and an analysis of length-of-stay data using the Minimum Data Set.[2] The investigation yielded numerous examples of inappropriate discharges of vulnerable residents to homeless shelters (both in and out of state), motels,

**Resource**

Summary of Findings from Oregon's Memory Care Initiative: https://assets.website-files.com/594add07a0707c3191615e9f/5bc12f9c05f212f64a95848b_Memory%20Care%20in%20Oregon.pdf

**Resource**

Presentation Slides from The National Consumer Voice for Quality Long-Term Care Conference: https://theconsumervoice.org/2018-conference/conference-materials

Court Filing: http://www.marylandattorneygeneral.gov/News%20Documents/State_v_NMS_Complaint.pdf

[2] The Minimum Data Set (MDS) is a health status and screening tool used for all residents of Medicare and Medicaid certified nursing homes.

and "predatory" unlicensed personal care homes, as well as multiple evictions of residents with mental illness or intellectual disabilities. In December of 2016, the OAG filed a suit in circuit court against the provider, alleging it had engaged in unfair, unsafe, and unlawful discharge practices in violation of the Patient's Bill of Rights (a Maryland law that protects nursing home residents) and that it submitted false claims to the State's Medicaid program. The OAG complaint also alleged that the provider identified residents for eviction based on the source of their public health insurance (replacing Medicaid long-term care recipients with prospective residents who are covered by Medicare). After the filing, one of the company's nursing homes closed and another provider organization assumed responsibility for the remaining facilities. In October of 2018, the provider settled with the State, agreeing to cease operating nursing facilities and pay $2.2 million to the State.

**Legislative Session Bill Tracking.** To monitor the development and implementation of proposed state laws related to long-term care supports and services including licensed facilities, the Washington State Ombudsman program developed a legislative bill tracking system to inform stakeholders about long-term care legislation in the state. Proposed bills are monitored and tracked each day. The online tracking system includes a link to the proposed bill, the subject of the bill, the name of the sponsor, the Ombudsman program's position on the bill, comments (such as links to companion bills), and the bill's current status. Consumers, advocates, and stakeholders may also elect to receive daily updates of these bills during the legislative session.

**Resource**

Legislative Bill Tracking System: https://www.waombudsman.org/news/2016-legislative-bill-tracking/

## STRENGTHENING PROGRAM OPERATIONS: NEW PROCESSES AND APPROACHES

**Managing Involuntary Discharge Notifications.** In September of 2016, the Center for Medicare & Medicaid Services (CMS) issued the "Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities." One requirement stipulated that nursing homes send discharge and transfer notices to Ombudsman programs. Because the regulation did not specify whether notification was limited to involuntary discharges, facility staff widely interpreted this requirement to include all transfers and discharges, regardless of reason. This resulted in an influx of notices received by many Ombudsman programs (particularly in those states that did not already have state notification requirements), diverting staff attention to managing the flood of paperwork.

CMS later issued a clarification that only notices of involuntary (or facility-initiated) transfers or discharges must be provided. Despite this clarification, some Ombudsmen reported continuing to receive large numbers of unnecessary notifications and working with facility staff to promote understanding of these requirements and reduce unnecessary work for both nursing homes and the Ombudsman program. Given the influx of notices, some State Ombudsmen developed new processes and tools to handle the tremendous increase in discharge notices and provide training and education to nursing home facility staff on the requirements under the new regulations.

**Database Tracking.** In Michigan, the Ombudsman program developed a database to track involuntary discharge notifications. The database is used to guide program activities in specific locations, identify potential triggers that may lead to a facility's closure, examine trends that may be statewide or specific to a region or provider group, and highlight possible concerns that should be brought to the attention of the state agency or the state Medicaid agency.

**Offering Additional Submission Options.** In North Dakota, the State Ombudsman developed a protocol for nursing homes to submit involuntary discharge notices to the Ombudsman program. In addition to sending notices through secure or regular mail, the State Ombudsman created a secure fax line that allows nursing homes to transfer notices electronically to a secure email inbox. Nursing home staff found the approach to be easier and less time consuming than earlier practices, and the electronic option was in closer compliance with record retention rules. Similarly, the Tennessee Ombudsman program established a secure email address for receiving discharge notices and likewise found that the approach improved the notification process.

Given the number of questions from facility staff regarding the new federal regulation and state-level protocols, programs nationwide also needed to provide technical assistance to facility staff and direct them to relevant resources. To address this need, the North Dakota Ombudsman program revised their Questions and Answers document on admission, discharge, and transfer rights to reflect the new guidance.

**Resource**

North Dakota's Question and Answer Booklet: https://www.ndhealth.gov/hf/PDF_files/Nursing%20Home/Adm_Transfer_Discharge_Q&As_12-2016.pdf

**ABOUT NORC**

NORC at the University of Chicago is an independent research organization headquartered in downtown Chicago with additional offices on the University of Chicago's campus, the DC Metro area, Atlanta, Boston, and San Francisco. NORC also supports a nationwide field staff as well as international research operations. With clients throughout the world, NORC collaborates with government agencies, foundations, educational institutions, nonprofit organizations, and businesses to provide data and analysis that support informed decision-making in key areas, including health care, education, economics, crime, justice, and energy. NORC's decades of leadership and experience in data collection, analysis, and dissemination—coupled with deep subject matter expertise—provide the foundation for effective solutions.