Ombudsman Programs: Advocacy in Board & Care
1981- Present

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A quick journey of 32 years..

• Review history and evolution of board and care & assisted living
• Older American’s Act as it relates to Board & Care
• Ombudsman Advocacy efforts
• The current landscape and resident issues
• Ombudsman best practices
Older American’s Act: 1981-Present

The 1981 reauthorization of the expanded the ombudsman duties. In addition to nursing homes, board and care homes were included and the name was changed from Nursing Home Ombudsman to Long-Term Care Ombudsman (LTCO) to reflect this change.

The term “board and care facility” means an institution regulated by a State pursuant to section 1616(e) of the Social Security Act (42 U.S.C. 1382e(e)).
Older American’s Act (continued)

• The term “long-term care facility” means...

(C) for purposes of sections 307(a)(12)\(^1\) and 712, a board and care facility; and

D) any other adult care home, including an assisted living facility, similar to a facility or institution described in subparagraphs (A) through (C).

OAA gives a broad brush to the definition of Board and Care
Older American’s Act (continued)

- Section 712 - ADMINISTRATION.—The State agency shall require the Office to—
  - (1) prepare an annual report—
  - (E)(i) analyzing the success of the program including success in providing services to residents of board and care facilities and other similar adult care facilities; (1987)
  - Congress Directed AoA to study impact of ombudsmen programs on board and care residents and report to Congress by December 31, 1989
The Landscape - Media attention in the 1980’s one described Board and Care as “modern-day warehouse” for “adult orphans” and the “forgotten elderly”
Publicized conditions in board and care homes, including conditions found in unannounced visits conducted by the Subcommittee on Health and Long Term Care – (March 1989)

1989 – investigated 47 facilities in 10 States – findings ... illegal administration of drugs, filth and misappropriation of resident’s funds

DC resident Alice L – “leaking roof over her bedroom, no heat, hot water, vermin, one resident was murdered”

Sacramento – resident John S. – owner was arrested for the murder of seven residents
Ombudsman Involvement – 1980’s

- **DC Ombudsman** – Ann Hart – provided key testimony in Congressional hearing as well as local Ombudsmen Julie Oetting - **Alabama**, Michael Coonan - **California**, Mary Beth Africa - **Pennsylvania** and Ms. Pat Murphy - **New York**

**Reports:**

- GAO “Board & Care: Insufficient Assurance That Residents’ Needs are Identified and Met” February 1989
- Congressional Subcommittee Report: Health & Long-Term Care and House Subcommittee report which includes a discussion of Ombudsman Program
Report Findings

- GAO – States’ Ombudsman Programs “have varying degrees of oversight of board and care homes”
- References a previous report by AARP & NASUA(D) that 48 of 54 Ombudsmen believe that it is just as important to visit board and care homes as nursing homes but
- Half felt unsuccessful in maintaining a presence in B & C
- Sub-committee report notes “that the only active or effective advocate for board and care residents discovered in many States was the LTC Ombudsman program” – this is likely still true today.
Findings Continued

• House subcommittee surveyed 50 State Ombudsmen
• On average the Subcommittee found that ombudsmen spent about 16% of their time dealing with board and care issues and complaints
• 60% of LTCO reporting increasing number of problems

Other Ombudsmen Work:
Region V – 1990 Work plan included a “Board & Care Initiative”

➤ Issues & Findings: Concerns and Opportunities – no consistency in regulation and oversight, potential community option; no required training of facility staff
Region V (continued)

• IL - lack of oversight; unlicensed homes but also a potential alternative to nursing homes
• MI – Staffing & staff training; aging in place & related challenges; ability to pay for B & C
• MN – Run like mini nursing homes; large & growing number housing older persons with mental illness, unregulated
• OH – Maintaining Quality but not “over regulating;” important resource in the long-term care continuum
Region V (continued)

- WI – Need a reliable funding source to raise quality of life; need sufficient number of surveyors to monitor; implement proposed regulations allowing sanctions including fines and forfeitures

The 1990’s - Growth of Assisted Living

- Dramatic growth – as of 1999 one-third of facilities calling themselves assisted living had been in business five or fewer years
- Initially developed in the absence of regulation or public financing.
Assisted Living

- Oregon passed first licensure regulation specifically directed at assisted living in 1989

  *Hawes & Phillips report on Assisted Living 2000*

Resident perceptions:

- Generally felt treated with respect
- Concerned about staffing & turnover
- Rarely asked about activity preferences
- 12% help with some type of ADL
- 26% help using the toilet & reported unmet needs
Hawes & Phillips (continued)

- Nine of ten believed they would be able to stay as long as they wished
- Most were uninformed about facility policies on retention & discharge

Assisted Living Workgroup

Result of the April 2001 hearing held by the U.S. Senate Special Committee on Aging, committee staff members asked assisted living stakeholders to develop recommendations designed to ensure more consistent quality in assisted living services nationwide
Composed of a balance of “diverse stakeholders for maximum effectiveness”

NASOP represented in Resident Rights and Resident Direct Care Services Committees (Joani Latimer, VA LTCO and Jerry Kasunic, DC LTCO)

Directed to develop a uniform definition of assisted living that would “provide consumers a clear understanding of what kinds of services they should expect in assisted living.” Not able to reach consensus
Policy Principles for Assisted Living  (April 2003)

Supported by NASOP & NALLTCO

1. Strengthen Standards
2. Define Assisted Living in a Meaningful Way
3. Establish more than one level of AL licensure – one size does not fit all
4. Should be subject to the same non-discrimination rules as nursing homes
5. The federal government should take an active role in assuring quality care
The Current Landscape — National Survey of Residential Care Facilities

- Approximately **one-half** of RCFs were small facilities with 4–10 beds. The rest were medium facilities with 11–25 beds (16%), large facilities with 26–100 beds (28%), and extra large facilities with more than 100 beds (7%).
- 38% chain affiliated and 82% private, for-profit
- Most located in the West — 42% (small facilities) and least common in the Northeast (8%) mostly large.
- Midwest & South more even distribution of small, medium & large
- Primarily private pay but 43% had at least one resident who had some or all of services paid by Medicaid
Ombudsman Data: Who is the Complainant?

Complainant = Resident

Complainant = Family
Complainant?

Complainant = Ombudsman

Complainant = Staff
Complainant – All others
Complaint Trends -2012

Nursing Home

- improper eviction, inadequate or no discharge planning;
- unanswered requests for assistance;
- lack of respect for residents, poor staff attitudes;
- quality of life, specifically resident/roommate conflict
- medications – their administration and organization;

Board & Care

- medications – their administration and organization;
- improper eviction, inadequate or no discharge planning;
- quality, quantity, variation and choice of food;
- lack of respect for residents, poor staff attitudes and
- equipment or building hazards
Snapshot of Ombudsman Activity 2012

Complaints:
• 2012 data – B&C complaints range from 7 to 11, 673
• Complaints per 100 beds ranged from .09 to 33 with an average of 4 and a median of 3 (half states below and half above)

Visits:
• 24 states at 25% or less routine visits compared to NH where only 7 states are at 25% or less
• 24 states visit NH at 90% or above; 13 states visiting B&C at 90% or above
Visits: 2002 - 2012
B & C Systems Advocacy Reported in 2012

• Montana – Developed an Assisted Living Toolkit for consumers

• Oregon – in 2011 developed a handbook for providers which outlines specific process around resident rights “move out” rules – report decrease in related complaints in 2012

• Minnesota - Housing With Services/Assisted Living Study: 1. Research the existence of differential treatment based on source of payment in assisted living settings; 2. Convene stakeholders to provide technical assistance in studying and addressing these issues and 3. Submit a report of findings
Systems Advocacy – (continued)

• Georgia - Unlicensed Personal Care Homes - Legislation to combat the problem.

• Oklahoma - Freedom of Choice in Assisted Living facilities. Worked to pass legislation to allow for Residents’ freedom of choice for pharmacy services.

• Texas - Sought state funds to support hiring 28 assisted living long-term care ombudsmen statewide and one state office professional to provide routine visits to ALFs and identify and respond to complaints.
Systems Advocacy (continued)

- Florida - working on legislation & regulatory reform in assisted living for better resident protection and quality of life.

- Washington – Continued legislative work on quality assurance and oversight in adult family home settings – issued a report in December 2012

These are some highlights that were reported in 2012 NORS. You may have your own success stories – please share them!
The Ombudsman Re-balance Challenge

Ombudsman Programs are challenged to meet growing resident needs (in all settings) often with fewer resources, an increase in complicated complaints and other pressures of an evolving long-term care system.

Addressing board and care can be overwhelming – due to a lack of dedicated staff, volunteers, addressing special needs, regulatory inconsistencies...

If your state is one with low activity in board and care consider what can you do systemically to promote quality of life and rights for persons living in these settings.
Finally a “Shout Out” to former LTCO & Current Assistant State LTCO

State doing little to stop neglect, abuse of elderly

Ombudsman says despite new laws, problems continue in adult boarding homes in state

Advocates push state to protect society’s most vulnerable people

Package of boarding home fixes draws fire

Homes: Hyre backs DSHS bill

Our View

The lack of progress in adult boarding home regulation about a need for legislative response.

Ombudsman’s advice is sound

- If the state is going to regulate an activity, it ought to do so with both a clear purpose and the will to serve it.
- The Washington Legislature, therefore, should act positively on the state Long-Term Care Ombudsman Program’s latest recommendations about adult boarding homes.
- For the third time since 1995, the Ombudsman’s report pointed out problems with the way such facilities are staffed as well as the way the state regulates them.
- Adult boarding homes are a form of living facility for senior citizens who no longer can live independently but don’t need as intensive care as nursing homes provide.
- The Ombudsman’s reports have stressed that most boarding homes do a fine job.
- But what the reports don’t do is to highlight the issues of individuals and families who are dealing with the older person’s emotional stress of leaving familiar surroundings, losing independence and coping with increasing physical and sometimes mental limitations.

Unfortunately, the Ombudsman report noted, even when regulators discover problems, the follow-up is often slow and insufficient.

Part of the problem is the convoluted regulatory structure itself.
- Although the Department of Social and Health Services oversees nursing homes and adult family homes, the Department of Health was given responsibility for boarding homes in 1999. DSHS, however, still plays a role in the care of boarding home residents who get Medicaid.

The Ombudsman report criticized not only that structure but also the Department of Health, for responding slowly to complaints and for failing to impose sanctions when problems are found.

In fairness to the Department of Health, DSHS has more manpower to deal with complaints.

The Ombudsman suggests resuming boarding home regulation to DSHS, requiring penalties for boarding homes with repeat violations and requiring higher training standards for workers at such facilities.

The state ought not to overreact, of course. One of the purposes of such facilities is to provide moderate assistance to at least that most intensive care programs charge. It would defeat that purpose to impose stiffer than necessary requirements on providers.

Overall, the Ombudsman recommendations are sound. Lawmakers asked for the information and should take it seriously. After those negative reports, it’s time for a change.

Doug Ford/For the editorial board
References/Resources

Ombudsmen Specific:

- Oregon – “guidance for Successful Transitions in Oregon Assisted Living and Residential Care
- Montana – Assisted Living Rights Brochure
- Washington State Adult Family Home Quality Assurance Report

Studies & Policy Papers:

- Centers for Disease Control Study: Residential Care Facilities: A Key Sector in the Spectrum of Long-term Care Providers in the U.S. – HHS/CDC
- Policy Principles in Assisted Living (NASOP & NALLTCO participated)
  [http://www.ltcombudsman.org/sites/default/files/norc/PolicyPrinciplesforAL0403_0.pdf](http://www.ltcombudsman.org/sites/default/files/norc/PolicyPrinciplesforAL0403_0.pdf)
References/Resources (continued)

- High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a National Survey – Hawes & Phillips – November 2000
  

**Consumer Websites:**

- Long-Term Care Community Coalition:  [http://www.assisted-living411.org/](http://www.assisted-living411.org/)

**Industry related websites:** Both offer a clearinghouse for all things Assisted Living

- National Center for Assisted Living (NCAL) – 2013 Assisted Living State Regulatory Review
  [http://www.ahcancal.org/ncal/resources/Pages/AssistedLivingRegulations.aspx](http://www.ahcancal.org/ncal/resources/Pages/AssistedLivingRegulations.aspx)
- Center for Excellence in Assisted Living (CEAL)  [http://www.theceal.org/](http://www.theceal.org/)