The New York State Long Term Care Ombudsman Program

An Assessment of Current Performance, Issues & Obstacles

By:

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We would like to express our appreciation to the LTC ombudsmen across New York State who took the time to participate in the survey and, of course, for the valuable and important work that they do to protect nursing home residents, assisted living residents and others who rely on long term care services.

For more information on LTCCC visit our websites: www.ltccc.org, www.nursinghome411.org and www.assisted-living411.org or contact us by email: info@ltccc.org, phone: 212-385-0355 or US Mail: Long Term Care Community Coalition, One Penn Plaza, Suite 6252, NY, NY 10019. Follow us on Twitter: @LTCconsumer.

Please consider making a tax-deductible contribution to support our work to protect nursing home residents & other LTC consumers: ltccc.org/ltccc.orgsupport.shtml.

Executive Summary

Background

New York's elderly and disabled nursing home residents are among our most vulnerable citizens. They depend on their nursing homes for twenty-four hour a day care and monitoring, and for providing them with the good quality of life and dignity that everyone deserves and which, under federal and state laws, nursing homes are mandated to provide. Unfortunately, as is well known, too often nursing homes fail to meet these standards. For instance, a February 2014 report from the US Inspector General assessed, for the first time ever, what happens to people who go to a nursing home for short-term rehab. The IG found that one out of every three suffered harm in the facility within 35 days due to problems like inadequate care and monitoring, inappropriate medication management and neglect. Close to 60% of the time this harm was determined to have been preventable. Six percent of those who were harmed died as a result.

Approximately 40% of us who live to age 65 will reside in a nursing home at some point.

Given the nursing home industry's reputation for providing poor care and quality of life, consumers are increasingly turning to assisted living and home care when they need long term care (LTC). However, given our aging population, and increasing numbers of people living longer with Alzheimer's Disease and other serious conditions, nursing home care will continue to be an important setting for the foreseeable future. Currently, close to 110,000 people reside in New York State nursing homes. Approximately 40% of us who live to age 65 will reside in a nursing home at some point.

Monitoring and oversight of nursing home care is likely to become even more salient and urgent now, as New York is embarking on sweeping changes to its long term care system. This year (2014) New York is implementing a major policy change, mandating that everyone who needs access to long term nursing home care under Medicaid join a managed care plan. This will essentially, for the first time, privatize access to nursing home care for Medicaid beneficiaries (who comprise a significant majority of our nursing home residents). New Yorkers will effectively be limited to the nursing homes with which their Managed Long Term Care (MLTC) plan chooses to contract. While the plan includes numerous incentives for cost-cutting in care, and financial protections for nursing homes and MLTC plans, it provides no protections to ensure that residents receive decent care, or even that nursing homes have, at a minimum, safe staffing levels.

Study Overview

This study was undertaken in response to reports we received that the number of nursing home resident complaints handled by the New York State LTC Ombudsman Program (LTCOP) had dropped significantly in recent years. Over the years, LTCCC has received reports from individual ombudsmen that they were impeded in their work, but this was the first time that we had received reports (from different sources) that there was a significant decrease in complaint handling system wide. In addition, our and other studies over the years have indicated that many ombudsmen face significant challenges in undertaking the public or systemic advocacy that is part of their mandate under the federal Older Americans Act.

Given the persistence of serious problems in nursing home care in New York and the inability of the state enforcement agency, the New York State Department of Health, to ensure that residents are protected from abuse, neglect and other harm, we felt that it was important to find out what, if anything, was going on with the Program. Specifically, we undertook this study to (1) assess the performance of the NYS LTCOP and document strengths and weaknesses that might exist; (2) identify the obstacles that ombudsmen themselves perceive as having in trying to fulfill the responsibilities outlined in the Older Americans Act; and (3) develop recommendations, based on our findings, for both the LTCOP (to strengthen its work to protect nursing home residents and other LTC consumers) and for the state as it creates a new and separate ombudsman program for managed long term care.

There were two components to this study:

1. **Quantitative assessment of the New York State LTC Ombudsman Program staffing and complaint handling performance**. We collected state and national data from the National Ombudsman Reporting System (NORS), which contains data for the years 2000-2012. These data were assessed longitudinally as well as comparatively.

2. **Quantitative and qualitative assessment of New York State ombudsmen's experiences and perceptions**. We conducted an anonymous survey of LTC Ombudsman Program paid program and volunteer staff across New York State in November-December 2013.

Results: NYS LTCOP Performance over Time

Both complaints handled and problems resolved by NYS ombudsmen fell every year from 2007 to 2012. Altogether, the drop over these years is astounding: nursing home complaints handled by ombudsmen fell over 80% and the number of nursing home complaints and problems that reached a "satisfactory resolution" fell over 85%. In addition, the percentage of problems resolved to cases handled also dropped significantly, from 77% of cases in 2007 to 60% in 2012.

Results: Comparing the Two Largest States, New York vs. California

We identified a number of significant issues that appear to undermine the strength, independence and viability of the NY State program as a whole. When we compared New York to California (whose nursing home population is closest in size to New York's and which, similarly, has a diverse population in terms of ethnicity, economics and rural/suburban/urban) we found that, although New York's nursing home population is larger than California's, its Ombudsman Program is dwarfed by California's in significant ways. California far surpassed New York in terms of staffing, complaints handled, cases closed and funding every single year from 2007-11 (the period for which information is available on the NORS website). For instance, in 2007, California's LTCOP closed three times as many cases as did New York's. By 2011, that gap had widened: California closed close to 10 times as many cases as New York did that year.

We identified a number of significant issues that appear to undermine the strength, independence and viability of the NY State program….

Results: New York LTCOP vs. Other States' LTCOPs

New York has almost twice as many LTC facility beds per paid LTCOP staff person than the national average. This means that that they have to "cover" many more nursing home residents than do professional ombudsman staff in other states. Yet the NYS LTCOP is the 5th lowest in the entire U.S. in terms of percentage of state support and the 16th lowest in terms of actual dollar amounts of state funding. Given New York's size, these figures together indicate a serious lack of support by the state in ensuring that nursing home residents have meaningful access to LTCOP services (and, conversely, that state LTC ombudsmen are supported in their vital work).

Overall for the country, states contributed an average of just under 40% of their total LTCOP budgets in 2012. New York contributed just eight percent (8%). Furthermore, NY State support for the LTCOP has literally flat-lined over the last decade.

Approximately 10% of US nursing home residents had a complaint handled by an ombudsman in 2012. In California, this figure was close to 25%. In New York, on the other hand, less than three percent (3%) of residents had a complaint handled by the LTCOP.

Our findings in respect to many of the critical components of resident care and quality of life were striking. For example, in 2012 there were 9,999 cases of resident abuse, neglect and exploitation handled by ombudsmen in the US. Yet New York, with close to 10% of all the nation's nursing home residents, only handled 65 of these cases according to the NORS data (less than 1%). That same year, New York handled 336 complaints regarding improper admission, discharge or eviction while the total for the US was 11,091 (i.e., New York handled approximately 3% of these complaints). New York's LTCOP handled less than half the complaints relating to resident autonomy, rights and dignity than did California's LTCOP in 2012. For complaints relating to poor care, New York's LTCOP handled a total of 1,126 case, less than 3% of US cases (43,044) and less than 20% of California's cases (6,361).

When problems are not recorded, there is not even a public record that they happened. Worse than suffering in silence, the resident's suffering has been effectively silenced and there is no way for anyone to know what may be going on in a facility.

LTC Ombudsman Survey Results

Only about half of the respondents to our anonymous survey indicated that they are aware of, and participate in, the following two ombudsman activities delineated in the Older Americans Act: speaking to policymakers or advocating for systemic change. Less than 20% speak to or have contact with the news media.

Slightly over one-third of the respondents reported that their (or their office's) ability to handle problems has changed in recent years. When asked to identify their top three challenges, 90% chose a category that related to being explicitly or implicitly prevented from performing certain activities by the state office, their sponsoring organization or their local program office. Lack of time or resources was the biggest single challenge cited by ombudsmen, followed closely by a perceived lack of clarity in the law relating to ombudsmen activities.

Recommendations for the LTCOP

The State/NYS LTCOP should:

1. Immediately address the state funding imbalance and provide sufficient financial support to the LTCOP to fulfill its mandate to protect nursing home and assisted living residents. Minimally, New York should rise to the level that California provides for its LTCOP program, taking into account New York's higher nursing home population. Thus, New York should provide, minimally, $3,436,971 annually.[1]
2. Immediately and substantively address the low rate of complaint handling and resolution. In addition to adequate funding, this should include concrete steps to ensure that the state office is independent and that its leadership is willing and able to vigorously carry out the full range of important ombudsman activities (and ensure that local programs are as well).
3. Take affirmative steps to ensure that Ombudsman Coordinators –who oversee the programs on the local level – are clearly authorized and supported to speak to the press and policymakers and undertake systemic advocacy. This includes the following criteria:
   a. Coordinators have clear authority to speak to the press, including: writing letters to the editor or op-eds, appearing on radio or tv programs, etc….
   b. Coordinators have clear authority to oversee and designate these activities within their organizations and the area that they cover geographically.
   c. Host or sponsoring organizations – which house local programs – are neither permitted to represent the LTCOP publically nor interfere with the Coordinators role and authority.
4. Implement a system of information sharing and coordination between the new Medicaid LTC Ombudsman Program and the existing LTC Ombudsman Program.

The NYS LTC Ombudsman should:

1. Provide training and resources to the local Program Coordinators on systemic advocacy and speaking to the press/policymakers.
2. Provide an annual report on these activities to NYS Senate and Assembly Aging and Health Committee chairs, said report to be posted on the NYS LTCOP website.

Recommendations for NY State for the new MLTC Ombudsman Program

1. Ensure that the MLTCOP is completely independent of both government (state and local) and industry (including providers, insurance companies, worker unions and associations).
2. Ensure that the MLTCOP is sufficiently funded to carry out its mission.
3. Authorize the MLTCOP to provide vigorous advocacy for consumers.
4. Ensure that the MLTCOP is culturally competent to work with diverse consumers.
5. Develop a mandatory case handling reporting form for use by the MLTCOP.
6. Require that the MLTCOP collect data on case handling and issue an annual public report, including the data, on program activities.
7. Permit and provide resources for the MLTCOP to undertake public and systemic advocacy.

[1] California provided $3,212,122 in support of its LTCOP in 2012; as noted earlier New York's nursing home population is 107% of California's.

Introduction

New York's elderly and disabled nursing home residents are among our most vulnerable citizens. They depend on their nursing homes for twenty-four hour a day care and monitoring, and for providing them with the good quality of life and dignity that everyone deserves and which, under federal and state laws, nursing homes are mandated to provide.

Unfortunately, as is well known, too often nursing homes fail to meet these standards. Facilities are paid to monitor and assess for the development of pressure sores, yet pressure sores are a wide-spread and sometimes deadly problem in nursing homes. Since implementation of the 1987 federal Nursing Home Reform Law, nursing homes have been required – and paid – to provide dementia care that is tailored to meet the needs of the many residents who have Alzheimer's Disease and other dementia, by using non-pharmacological approaches. Yet, in 2011 the federal Office of Inspector General (OIG) found that 83% of Medicare claims for atypical antipsychotic drugs for elderly nursing home residents were associated with off-label conditions, despite the black box warning that they are extremely dangerous for the elderly and not indicated for dementia related psychosis.[2] In 2014, the OIG released a report on the findings of the first ever assessment of outcomes for people who go to a nursing home for short-term rehab. The OIG found that one in three of these residents suffered harm in the facility within thirty five days. Close to 60% of the time this harm was determined to have been preventable.[3]

Despite these problems, and the growing movement to obtain care outside of nursing homes, they continue to be a primary provider of care for frail elderly and disabled individuals and are expected to continue in this role in the future as our population ages and people of all ages live longer with Alzheimer's Disease and other serious chronic conditions and disabilities. Currently, close to 110,000 people reside in New York State nursing homes. Approximately 40% of people who reach age 65 will reside in a nursing home at some point in their lives.

In fact, these quality and safety issues are likely to become even more salient and urgent in the near future, as New York undertakes sweeping changes to its long term care system. This year (2014) New York is implementing a major policy change, mandating that anyone who needs access to long term nursing home care under Medicaid join a managed long term care plan. This will have enormous repercussions on nursing home financing, oversight, access and, needless to say, quality.

Given the increasing evidence of widespread failure by nursing homes to protect residents and provide decent care, and the systemic changes taking place this year, the need for effective monitoring and oversight of nursing home has never been more critical. Unfortunately,

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[2] *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, OEI-07-08-00150, Office of Inspector General, May 2011 (http://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf).

[3] *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, OEI-06-11-00370, Office of Inspector General, February 2014 (http://oig.hhs.gov/oei/reports/oei-06-11-00370.asp). Hereinafter OIG Report on Adverse Events.

previous research by LTCCC and others indicate that the government agencies responsible for monitoring, oversight and accountability are failing to adequately identify and stop nursing home resident abuse and neglect. The purpose of this report is to assess the status and effectiveness of one of the two principal agencies responsible for monitoring nursing homes and assuring good care, quality of life and dignity for residents: the Long Term Care Ombudsman Program.[4]

Nursing Home Oversight and the Role of the LTC Ombudsman

As noted above, there are two entities charged with monitoring nursing home care and ensuring resident safety and dignity on a regular basis: the state survey agency (in New York, the New York Department of Health (DOH)), and the Long Term Care Ombudsman Program (LTCOP). DOH surveys (inspects) nursing homes approximately annually and has regulatory enforcement powers to fine and otherwise penalize nursing homes when they fail to meet minimum standards.

The LTCOP advocates for the health, safety, welfare, and rights of residents. While they do not possess regulatory authority (and thus cannot penalize nursing homes), LTCOPs operate in every state under statutorily mandated functions and responsibilities delineated in Title VII of the Older Americans Act (OAA).[5] These include: (1) identifying and resolving complaints made by or on behalf of residents, (2) representing the needs of residents to policy makers and the public, (3) advocating for systemic change by advocating or seeking to change laws and systems on behalf of residents, (4) providing information and educational materials about LTC, and (5) advocating for the health, safety, welfare, and rights of people residing in LTC settings. State ombudsman programs are responsible for training new and existing staff. The OAA contains only basic requirements for training. In the absence of specific federal training requirements and/or required training materials, many states have developed their own standards.

In New York State, the program is operated under the direction of the State Ombudsman and administratively housed within the State Office for the Aging (NYSOFA). It provides its services through a network of 38 local programs, which are individually sponsored by various agencies and not-for-profit organizations, and 976 volunteers statewide. Each local ombudsman program has a designated paid ombudsman coordinator who recruits, trains and supervises

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[4] In addition to DOH and the LTCOP, the Medicaid Fraud Control Unit (MFCU) and the Office of the Medicaid Inspector General are tasked with ensuring Medicaid program integrity, including resident safety. While the MFCU in particular has undertaken a number of successful and important nursing home investigations across the state that have uncovered serious abuse and/or neglect, neither agency has a constant and comprehensive monitoring role in all nursing homes.

[5] The State Long Term Care Ombudsman Program was established by Title III of the Older Americans Act (OAA) in 1978 as a demonstration program and was transferred to a new Title VII of the OAA (which also includes other programs) in 1992. *See* H.R. 782--106th Congress: Older Americans Act Amendments of 2000 (http://www.govtrack.us/congress/bills/106/hr782). Henceforth OAA.

volunteers that provide a regular presence in nursing homes and assisted living facilities. Over 88% of the funding comes from the federal government.

The Ombudsman Program is crucial: it is mandated to advocate for everyone that lives in a Medicare or Medicaid funded residential facility (i.e., nursing homes, adult homes, licensed assisted living, etc…). Whereas the NYS Department of Health inspects nursing homes approximately once a year, the ombudsmen generally visit and monitor nursing homes on a weekly basis, spending on average four to six hours in the home. Thus, while they do not have the authority to levy sanctions against facilities, they are truly the grassroots constituency that is "on the front" lines on a consistent basis to monitor care, advocate for residents and speak out on the issues that make a difference in the lives of residents in these facilities.

Statement of the Problem

More than any other entity, the LTCOPs have the advantage of being "on the scene" and, as the law mandates, should have a strong voice in representing the needs of residents to policy makers and advocating for systemic change as well as handling individual problems and complaints. Despite the fact that federal law requires that LTCOPs are to be strong and independent, in reality many of the programs in New York State are not permitted or are otherwise unable to carry out many of their statutorily defined functions. Studies, as well as our knowledge and experience, indicate that this occurs for a variety of reasons, including: pressure from the agencies in which they are housed, lack of understanding of their role and mandate by the ombudsmen themselves, their political environment, lack of training to effectively carry out the mandated functions and inadequate resources.

A study published in 2010 indicated that a number of local ombudsmen in New York did not believe they were effective in fulfilling their advocacy and policy mandates.[6] LTCCC's 2011 study on assisted living indicated that many of the ombudsman respondents did not seem as familiar with policy issues or rules about sanctions as would be necessary to effectively advocate.[7] Also, over the years, LTCCC has been asked by local ombudsmen to undertake advocacy that they believe they cannot do themselves, such as speak to the press about an issue or follow-up on residents' problems that they have reported but which have been unaddressed.

Purpose of this Study

Given the importance of the LTCOP, especially as the state is on the brink of implementing mandatory managed care, and the many challenges to the Program's effectiveness, we undertook this study to (1) assess the performance of the NYS LTCOP and document strengths

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[6] Estes, C., Lohrer, S., Goldberg, S., Grossman, B., Nelson, M., Koren, M., and Hollister, B., *Factors Associated With Perceived Effectiveness of Local Long-Term Care Ombudsmen Programs in New York and California*, Journal of Aging and Health, 2010 22:772.

[7] *Care and Oversight of Assisted Living,* LTCCC, May 2011. See, http://www.ltccc.org/publications/documents/assistedlivingreportMay26a.pdf.

and weaknesses that might exist; (2) identify the obstacles that ombudsmen themselves perceive as having in trying to fulfill the responsibilities outlined in the Older Americans Act; and (3) develop recommendations, based on our findings, for both the LTCOP (to strengthen its work to protect nursing home residents and other LTC consumers) and for the state as it creates a new and separate ombudsman program for managed long term care.

Study Description and Methodology

There were two components to this study:

1. **Quantitative assessment of the New York State LTC Ombudsman Program staffing and complaint handling performance**. We collected state and national data from the National Ombudsman Reporting System (NORS), which contains data for the years 2000-2012.[8] These data were assessed longitudinally as well as comparatively.[9]

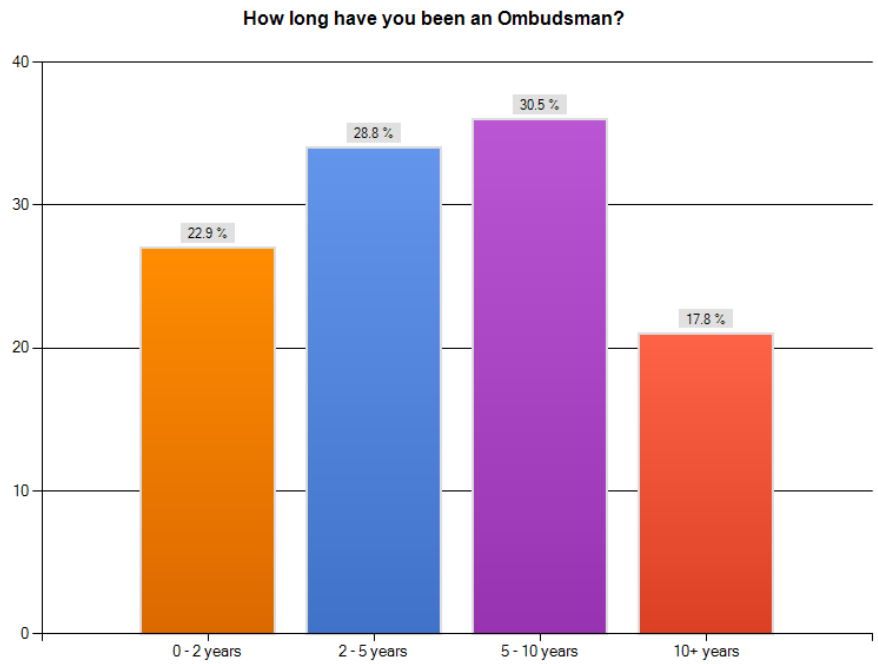
2. **Quantitative and qualitative assessment of New York State ombudsmen's experiences and perceptions**. We conducted an anonymous survey of LTC Ombudsman Program paid program and volunteer staff across New York State in November-December 2013. The survey was distributed to all LTCOP offices across New York State and, in addition, to the individual ombudsmen for whom we have contact information. It was publicized in our newsletter and through our New York State consumer-stakeholder network.

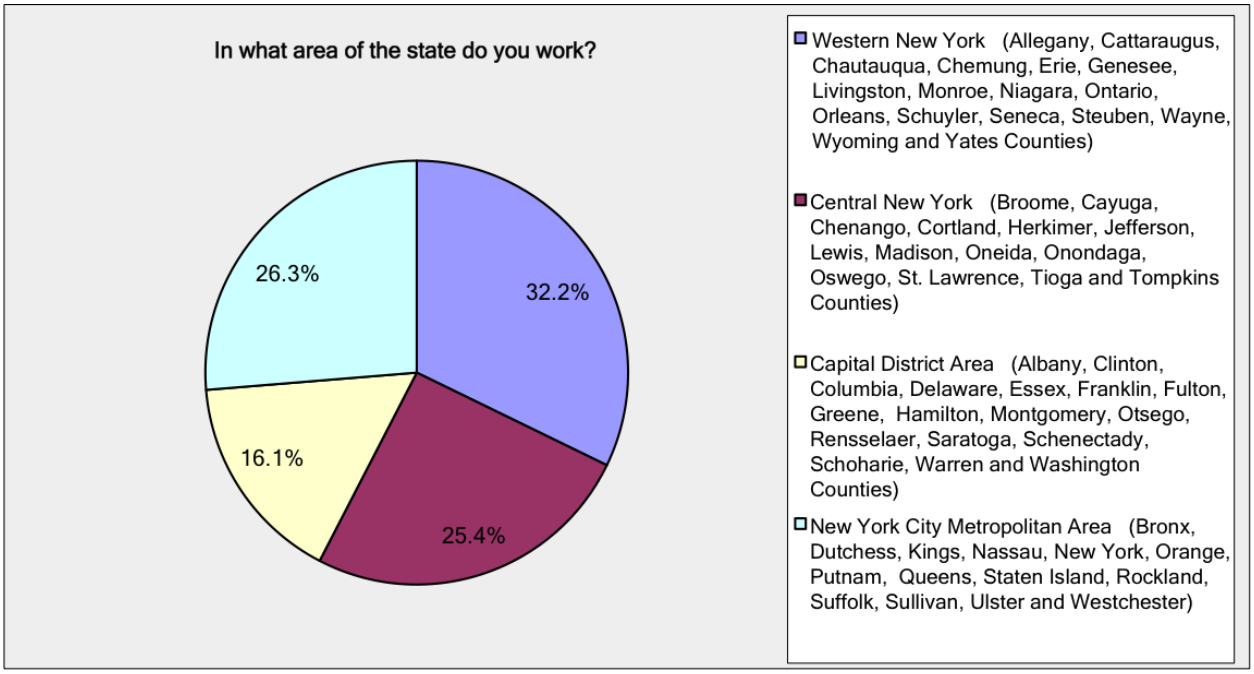
   A total of 119 ombudsmen participated in the survey. Approximately three quarters of them were volunteer ombudsman and one quarter paid staff.[10] As the two graphs below show, respondents were quite diverse in terms of both the length of their experience as an ombudsman and geographically (the area of the state in which they work).

[8] As of March 2014.

[9] Every state LTCOP is required to report information on its work, including numbers and types of complaints and cases handled, into the NORS system.

[10] Ombudsman Volunteer = 72.4%, Ombudsman Coordinators = 24.1%, Other = 3.4%.





While LTCOPs are authorized to work in a variety of settings, including nursing homes and assisted living (under federal law) and home and community based settings (in some states), nursing homes are the only long term care setting with rules and requirements that are, generally, both comprehensive and consistent from state to state across the U.S. Thus, we

focused our assessment principally on LTCOPs' work in nursing homes in order to make the most accurate and useful comparisons possible.[11]

Assessment of the NYS LTCOP - Quantitative Findings

Background

As noted above, under federal law the LTC ombudsmen are authorized to visit, monitor and advocate for residents in both nursing homes and assisted living. While our assessment focuses on nursing homes, following is a brief description of both of these settings, to provide a context for understanding the scope of the NY LTCOP's work.

New York State has more nursing home residents than any other state in the country, with approximately eight percent (107,480) of the nation's 1,366,390 nursing home residents residing in the state.[12] The state with the second highest number of residents is California, with 100,065 residents.[13] While there have been considerable efforts to enable people to access LTC outside of nursing homes, the number of residents has remained steady over the last decade. New York, in fact, has slightly more residents now than it did in 2003 (107,095). New York's nursing homes are much larger, on average, than those in other states. Thus, though New York's nursing home resident population is higher than California's, it has about half as many nursing home (631 vs. 1,205).[14]

Numbers of assisted living residents are much more difficult to compute, due to the fact that these facilities are much more loosely defined and regulated than are nursing homes. According to the National Center for Health Statistics (NCHS), there are 713,300 people living in adult care facilities in the U.S., though the authors note that "[t]his sum is an approximation and likely an undercount."[15] Data from the NCHS indicate that there are 22,750 people *over the age 65*

[11] In addition to the fact that different states' LTCOPs cover non-nursing home settings (such as assisted living and home care) to different degrees, there is wide diversity in how states categorize and/or license non-nursing home residential care settings such as assisted living, board and care, etc….

[12] Total Number of Residents in Certified Nursing Facilities, Kaiser Family Foundation State Health Facts (Note: "Reference period is January 2011 through February 2012"). Accessed at http://kff.org/other/state-indicator/number-of-nursing-facility-residents/.

[13] *Id*. Because NY nursing homes tend to be larger than other states, including California, that state has more facilities than does NY.

[14] Kaiser Commission on Medicaid and the Uninsured analysis of 2011 Online Survey, Certification, and Reporting system (OSCAR) data. Available at http://kff.org/other/state-indicator/number-of-nursing-facilities/.

[15] Harris-Kojetin L, Sengupta M, Park-Lee E, Valverde R., Long-Term Care Services in the United States: 2013 Overview, National Center for Health Statistics, 2013.

living in a residential care facility in New York.[16] Resident census data (including residents of all ages) from the state indicate that there are 493 licensed residential care facilities (including adult homes, enriched housing and assisted living) providing residential care to just over 33,000 individuals.[17]

Staffing & Basic Activities

While New York has far more nursing home residents than any other state, the state's Long Term Care Ombudsman Program is not the largest in the country. In fact, the LTCOP in the second biggest state, California, dwarfs New York's in several important ways, as Figure 1 shows.[18]

Profile of State OAA Programs: New York

Compare to: California

PART B. LONG TERM CARE OMBUDSMAN PROGRAM		2007	2008	2009	2010	2011
# of Designated Local Ombudsman Entities	New York	44	41	41	39	37
	California	35	35	35	35	35
# of Paid Staff FTEs (state/local)	New York	41.85	39.44	43.73	40.67	40.54
	California	193.00	194.00	110.00	78.00	102.14
# of Designated Local Ombudsman Entities	New York	1,041	990	943	976	1,000
	California	994	858	835	886	823
Number of Cases Closed	New York	12,439	13,151	6,419	4,436	3,269
	California	37,479	40,372	33,061	30,922	30,443
Number of Complaints (for cases closed)	New York	18,428	14,918	8,039	6,139	4,569
	California	51,990	54,032	43,528	40,287	40,146
Total Program Funding	New York	$2,707,018	$2,762,120	$2,998,813	$2,794,770	$2,894,573
	California	$12,216,002	$11,555,477	$8,242,988	$10,023,881	$8,060,470

Figure 1. California LTCOP vs. New York LTCOP

[16] *Id*. at p. 93. This report provides data on number of residents per 1000 people in the state population over age 65. The estimation of 22,770 is based on the population for that age group reported on the U.S. Census Bureau's website for 2010.

[17] Adult Care Facility Annual Bed Census Data: 2011, NY State Department of Health, available at https://health.data.ny.gov/download/ddnn-kxm4/application/vnd.ms-excel.

[18] Administration on Aging, Aging Integrated Database (AGID). Accessed at http://www.agid.acl.gov/StateProfiles/. Hereinafter AGID.

Despite concerted efforts by then California Governor Arnold Schwarzenegger to undermine the California LTCOP during this time period, including substantial defunding in 2009, California far surpassed New York in terms of staffing, complaints handled, cases closed and funding every single year from 2007-11 (the period for which this information is available on the federal website).[19] In 2007, California's LTCOP closed three times as many cases as did New York's. By 2011, that gap had widened: California closed close to 10 times as many cases as New York that year.

Comparisons to other states and national averages also indicate that New York's LTCOP is less than robust in terms of several key criteria. For instance, as Figure 2 indicates, New York has almost twice as many LTC facility beds per paid LTCOP staff person than the national average. Higher numbers of beds per staff person means that LTCOP are spread thinner in terms of "coverage" of nursing home residents. While the fact that NY State nursing homes tend to be much larger than the national average somewhat ameliorates this problem (since the nursing homes themselves might have equivalent "coverage" between the states), it is important to keep in mind that, by law, all nursing home requirements, as well as monitoring and oversight functions, relate to each individual resident, not to the system (or a nursing home) generally.[20]

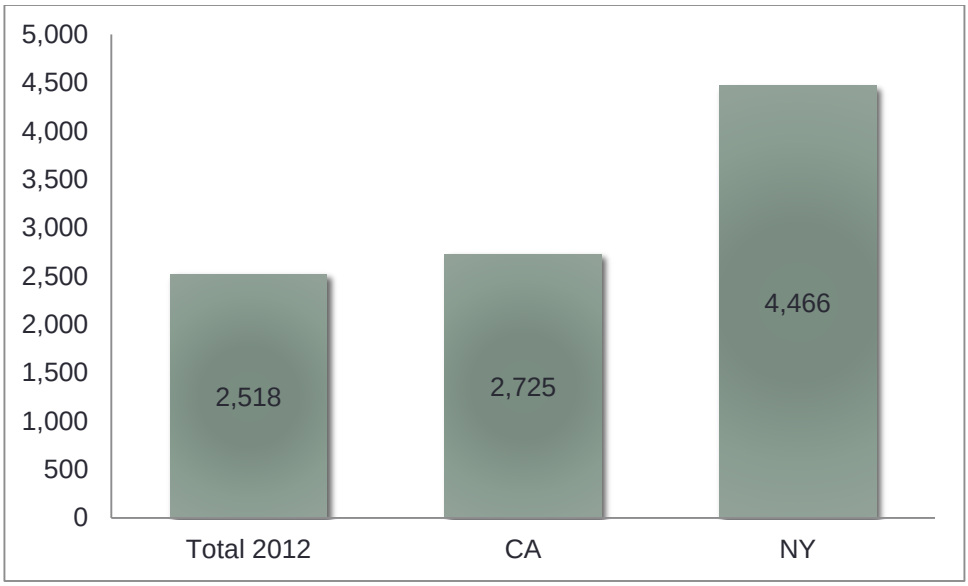


Figure 2. Number of Facility Bed Per Paid LTCOP Staff: US, CA & NY

[19] Adkisson J, Hill J, Korber D and Vogel N, *California's Elder Abuse Investigators: Ombudsmen Shackled by Conflicting Laws and Duties*, California Senate Office of Oversight and Outcomes, November 2009 (p. 24).

[20] So, for instance, it is not sufficient that a nursing home simply purchases enough food to feed the number of residents in its facility but, rather, that it have both sufficient and appropriate food to meet the nutritional needs and individual preferences of each of its residents.

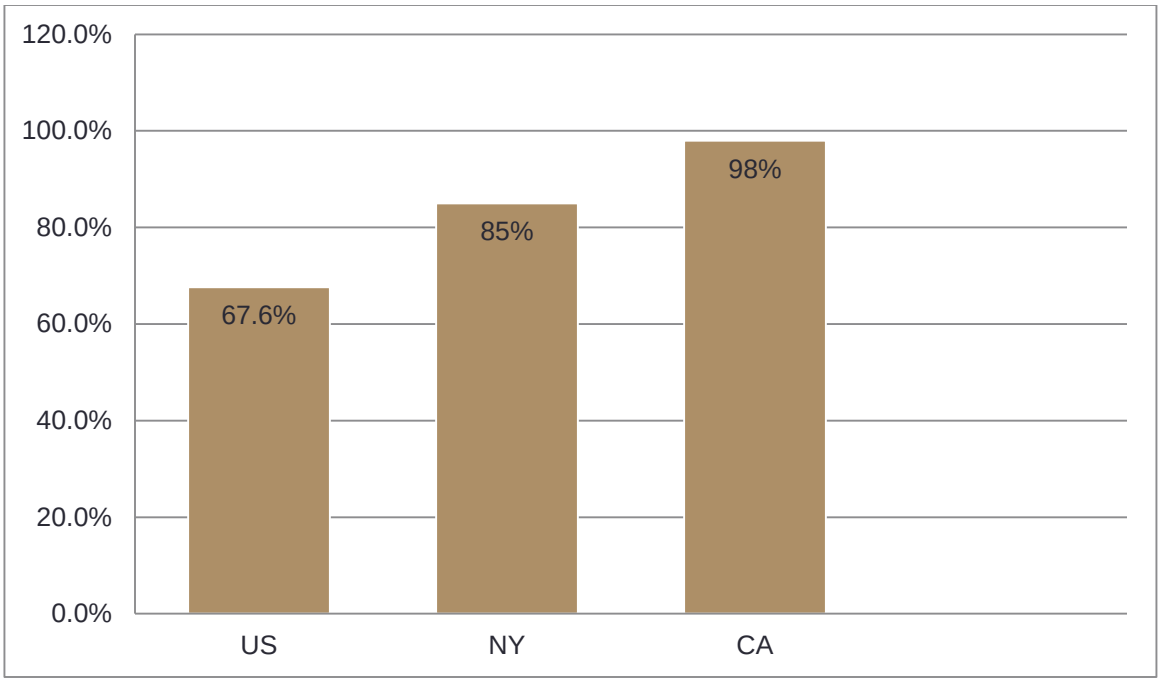


Figure 3. Percentage of Nursing Homes Visited: US, NY & CA

Interestingly, while (as noted above) New York's LTCOP is comparatively understaffed and underfunded, the National Ombudsman Reporting System (NORS) data in Figure 3 indicate that LTCOP nursing home visits in NY State are conducted to an extent higher than the national average. Over the years, LTCCC has heard from several Ombudsman Coordinators that they were being pressured to increase their numbers of volunteers. In addition, given that the typical NY State nursing home is significantly larger than both U.S. and California averages, percentage of facilities visited may not be indicative of the percentage of residents who have access to LTCOP services.

Funding Levels & Financial Supports

Sufficient financial resources are, of course, essential for the effective operation of any type of organization. In addition, in the context of government programs, sufficient funding on an ongoing basis is critical to ensure that a program is independent of political pressures and the vagaries of annual allocations and procurements.

We compared the NY State LTCOP against other states in several ways to assess funding levels and the bases for financial support. In particular, we were interested in levels of state vs. federal funding for the programs. As the following charts show, not only is total funding for the NY LTCOP comparatively very low (as Figure 1 (above) shows, the NY State Program has less than half the annual funding as the California Program), it is critically low in terms of state support.[21]

[21] The following data are from the AGID database for 2012.

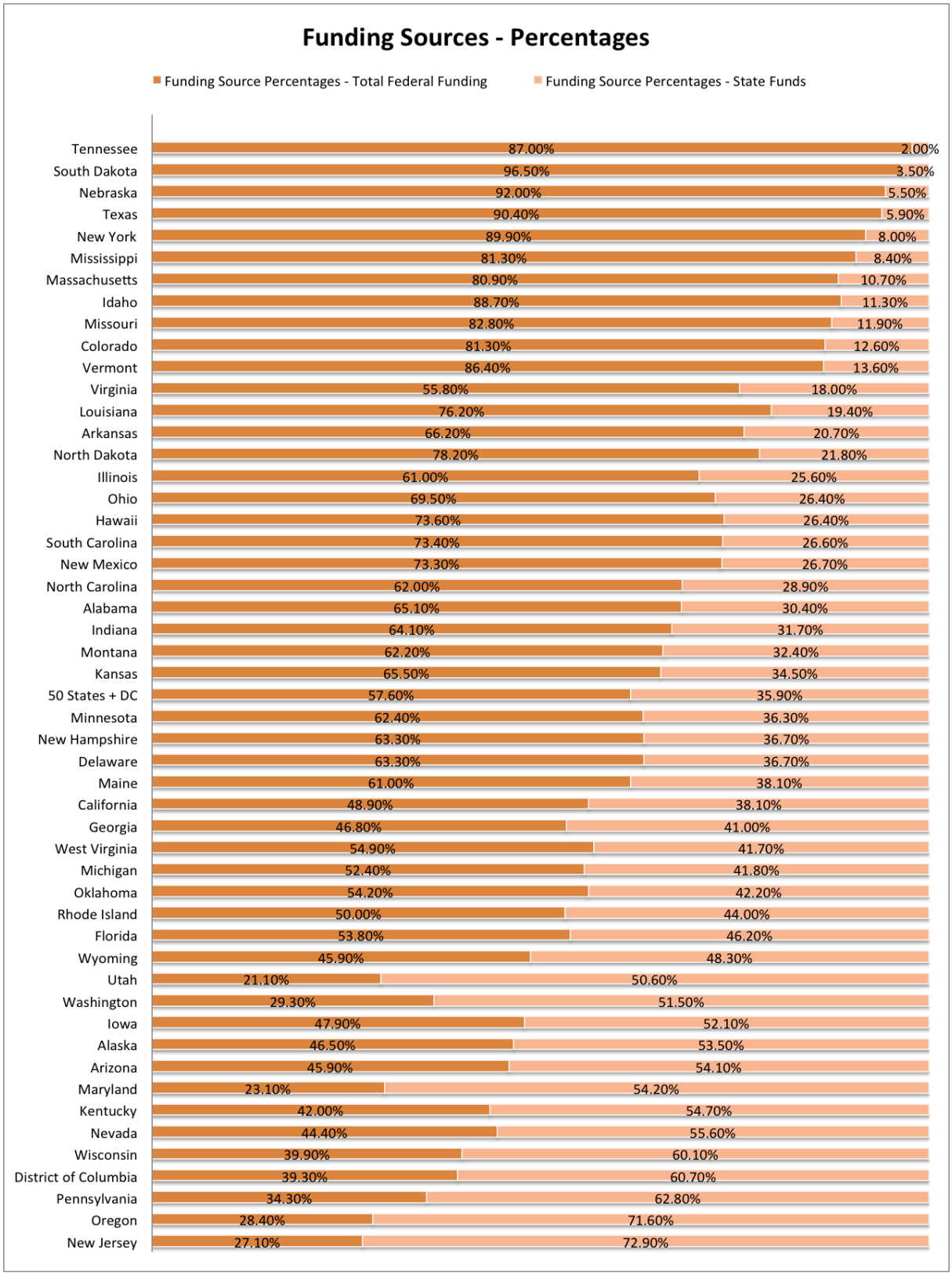


Figure 4. State LTCOP Funding Sources: State vs. Federal Percentages

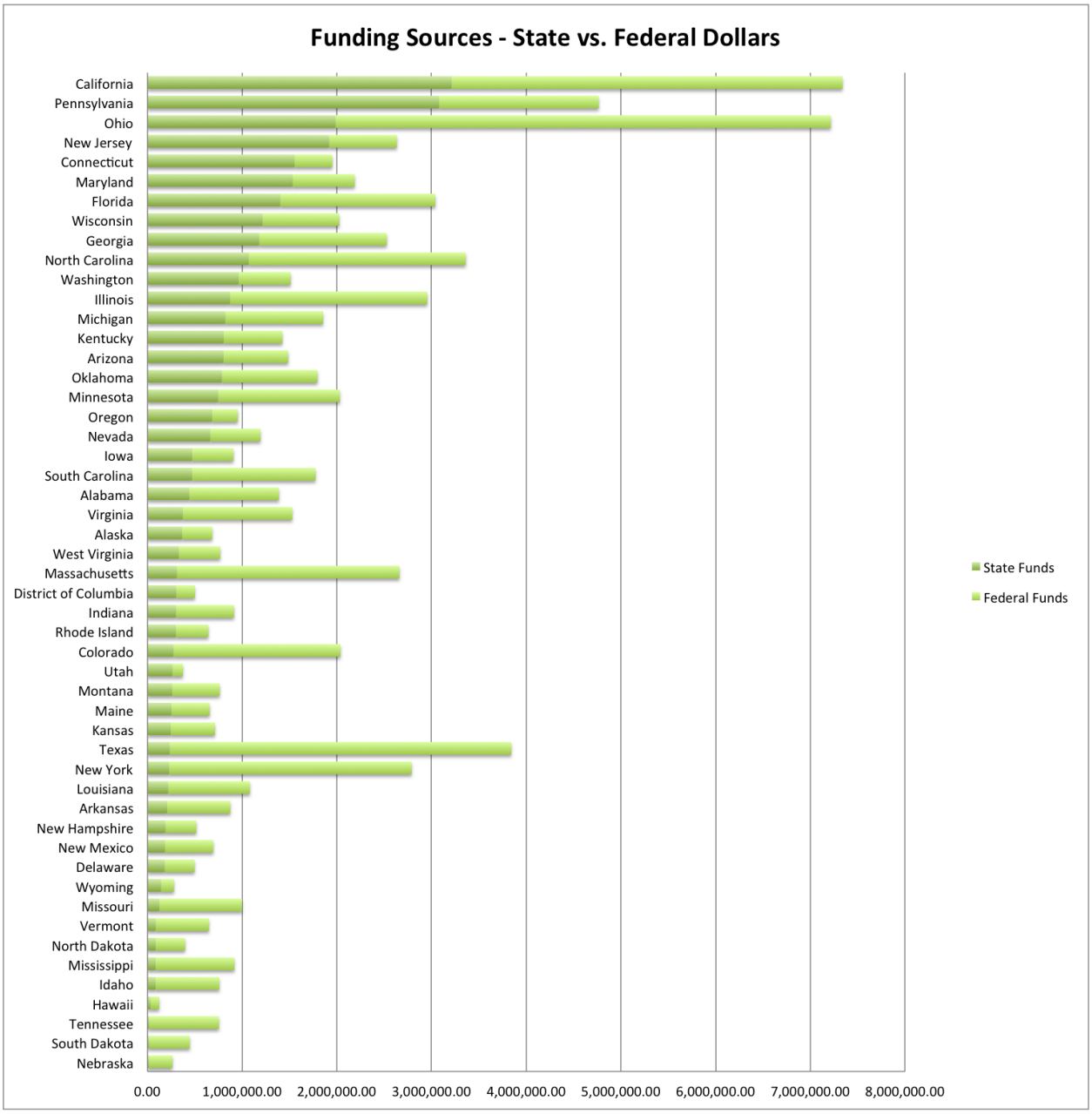


Figure 5. State LTCOP Funding Sources: State vs. Federal Dollar Amounts

The NYS LTCOP is the fifth lowest in the entire U.S. in terms of percentage of state support (Figure 4) and the 16th lowest in terms of actual dollar amounts of state funding (Figure 5).[22] Given New York's size, and the fact that it has, by far, the largest nursing home population in the country, these figures together indicate a serious lack of support by the state in ensuring that nursing home residents and families have meaningful access to LTCOP services (and,

[22] Note: As adding up the percentages in Figure 4 would indicate, state and federal funding makes up the overwhelming majority, if not entirety, of state LTCOP funding. Since our focus here is on assessing levels of state support, other sources, where they exist, are not included here.

conversely, that our state LTC ombudsmen are supported in their vital work). NY State funding for the LTCOP in 2012 was $229,236. The closest states, in terms of state dollar amounts, are Texas ($235,690), Louisiana ($219,233), Arkansas ($208,326) and Kansas ($247,117). According to the NORS data, NY has 189,120 facility beds, TX has 78,104, LA has 16,615, AR has 12,755 and KS has 14,944.[23]

Taken together, the states closest to NY in terms of state dollars allocated to support the LTCOP spent an average of $227,592 in 2012 for 30,605 residential care facility beds. NY spent $229,236 for 189,120 beds. In short, New York is dedicating roughly one-sixth the amount per resident beds as are these states. California, the state most comparable to NY in terms of size, allocated $3,212,122 in state funding in 2012. This is over 14 times the amount New York State dedicated (despite the fact that NY's nursing home population is seven percent (7%) higher than California's). Overall for the country, states contributed $32,423,473 in 2012 to their LTCOPs and the federal government provided $52,039,430, an average of just under 40% of the total state LTCOP budgets. New York contributed just eight percent (8%) to its LTCOP.

Furthermore, as Figure 6 shows, New York State support for the LTCOP has literally flat-lined over the last decade. Overall program funding has increased slightly, but that is entirely reflective of increased federal support over the years.

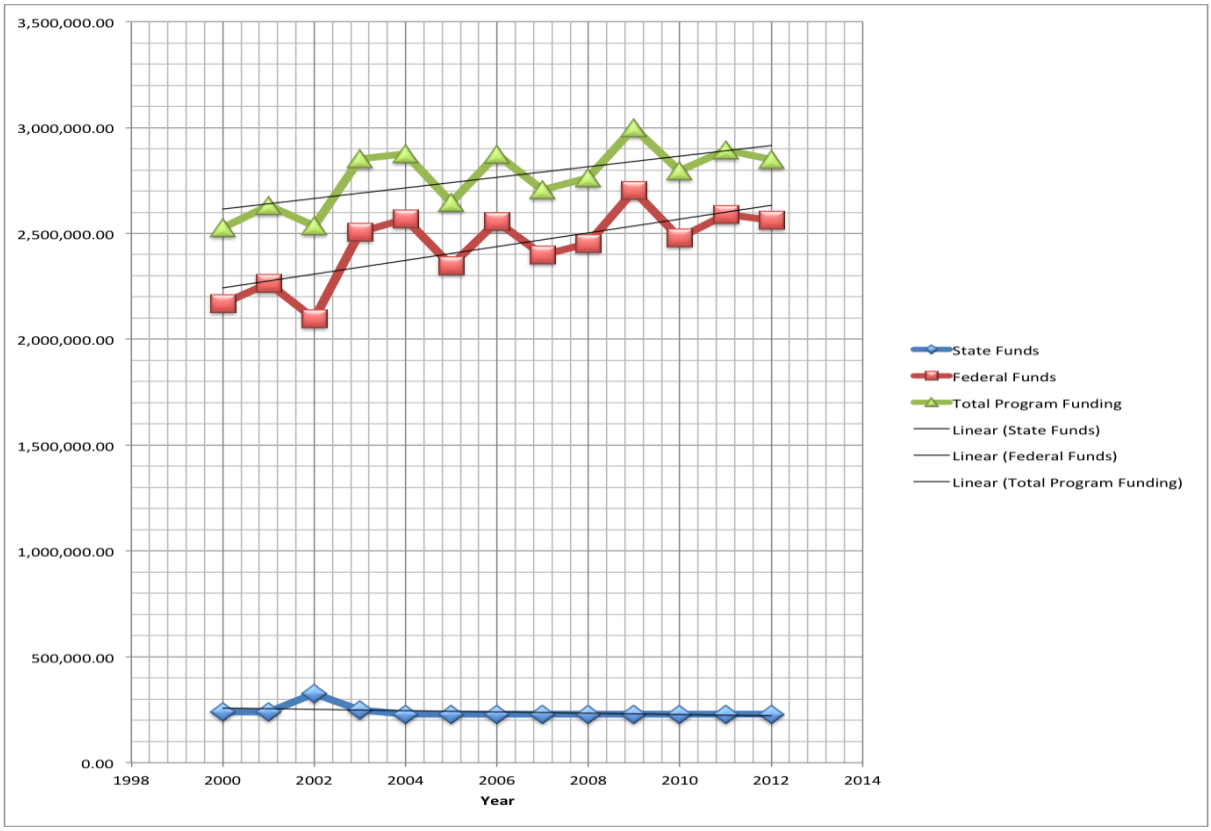


Figure 6. New York LTCOP Funding Sources 2000-2012

[23] AGID.

Handling Nursing Home Problems & Complaints

Funding is critical, but the most important questions, from the perspective of residents and families, relate to whether or not the LTCOP is an effective monitor and advocate for protecting residents and ensuring that they receive appropriate care and are able to live with dignity. In order to evaluate New York's LTCOP performance, we collected and assessed a range of data from the National Ombudsman Reporting System (NORS).[24]

In light of concerns expressed to us that the Program's complaint handling was dropping significantly (which were the impetus for this study), we first looked to see if this is true and, if so, to what extent. Unfortunately, the NORS data show that there has in fact been a precipitous drop in complaints handled and problems resolved by the NY State Program. As Figure 7 shows, both complaints handled and problems resolved fell every year from 2007 to 2012. Over those years, nursing home complaints handled by NY ombudsmen fell over 80% and the number of nursing home complaints and problems that reached a "satisfactory resolution" fell over 85%. In addition, the percentage of problems resolved to cases handled also dropped significantly, from 77% of cases in 2007 to 60% in 2012.[25]

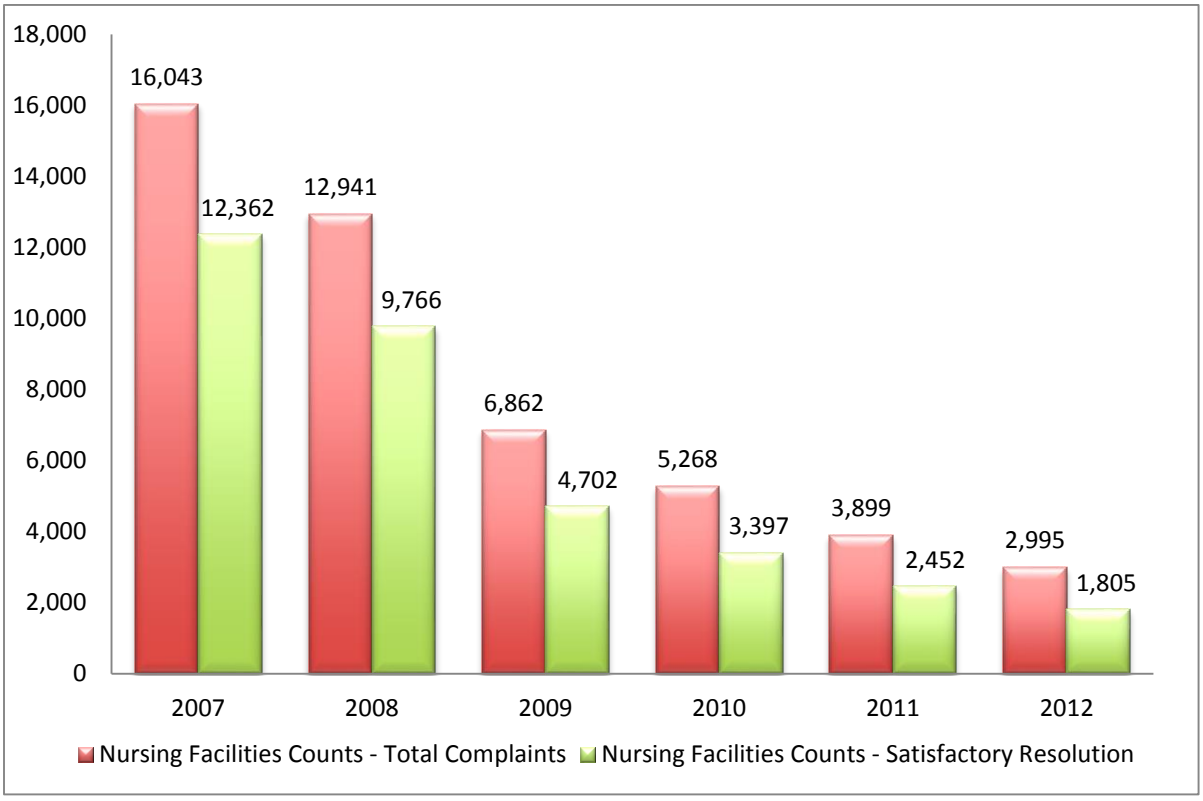
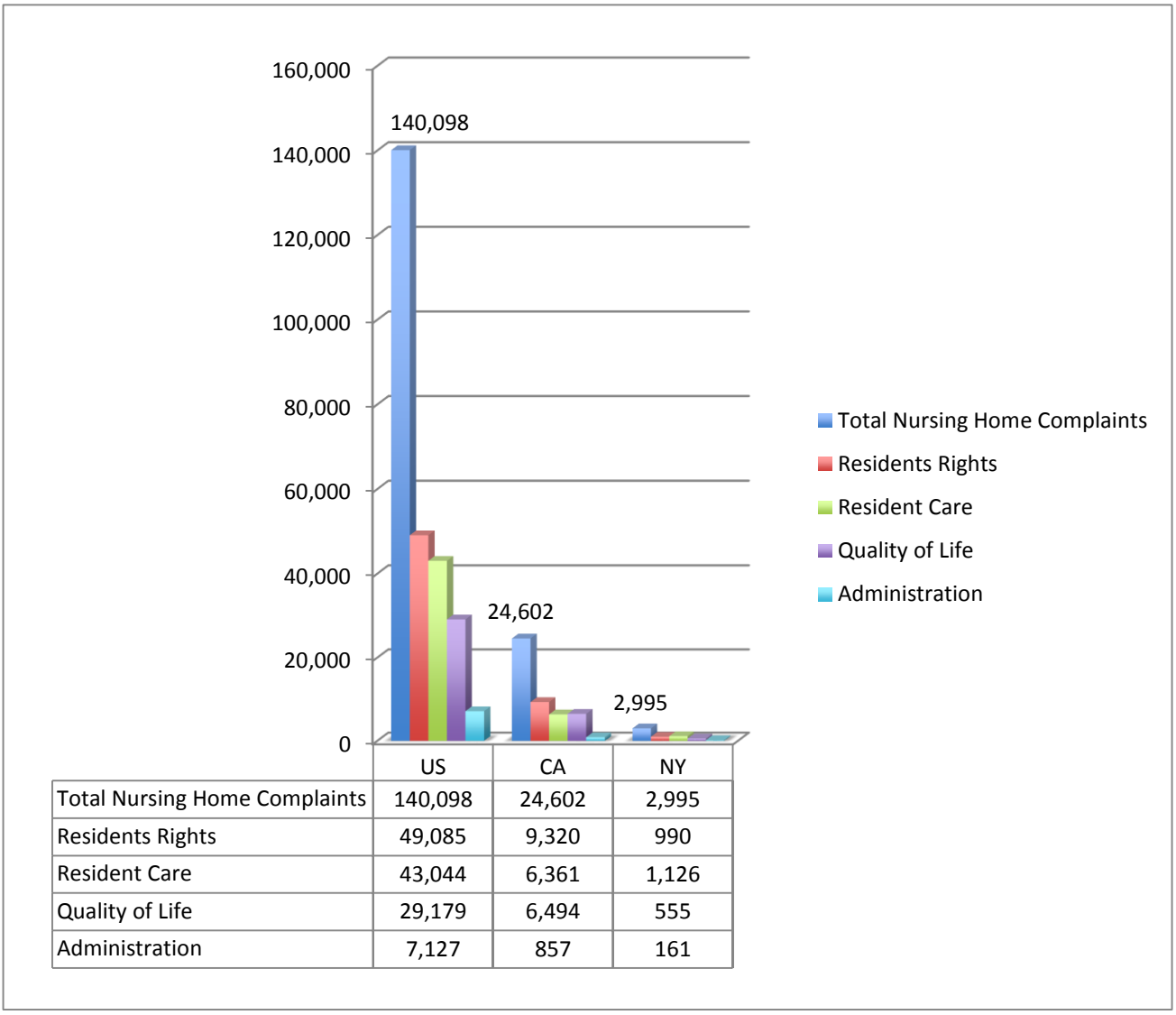


Figure 7. NYS LTCOP Nursing Home Counts 2007-12

[24] AGID. Unless otherwise noted, all data are for 2012 (the latest available as of March 2014).
[25] Note that these figures differ from those presented in Figure 1, which relate to all complaints, not solely those in nursing homes.



	US	CA	NY
Total Nursing Home Complaints	140,098	24,602	2,995
Residents Rights	49,085	9,320	990
Resident Care	43,044	6,361	1,126
Quality of Life	29,179	6,494	555
Administration	7,127	857	161

Figure 8. Nursing Home Complaints US, CA, NY

The data in Figure 8 show the disparity in complaint handling between New York and the US as a whole and California in particular. Though New York's nursing home population is seven percent larger than California's, California's LTCOP resident complaint handling dwarfs that of the NY State LTCOP both overall and on critical issues relating to resident rights, quality of care and quality of life. Total LTCOP nursing home complaints handled in the US in 2012 was 140,098, which means that approximately one out of ten (10.25%) US nursing home residents had a complaint handled by the LTCOP. In California, almost one in four (24.59%) residents had a complaint handled by the state LTCOP. In New York, on the other hand, less than three percent (2.79%) of residents had a complaint handled by the LTCOP.

The following figures show the comparative complaints handled on several important issues.

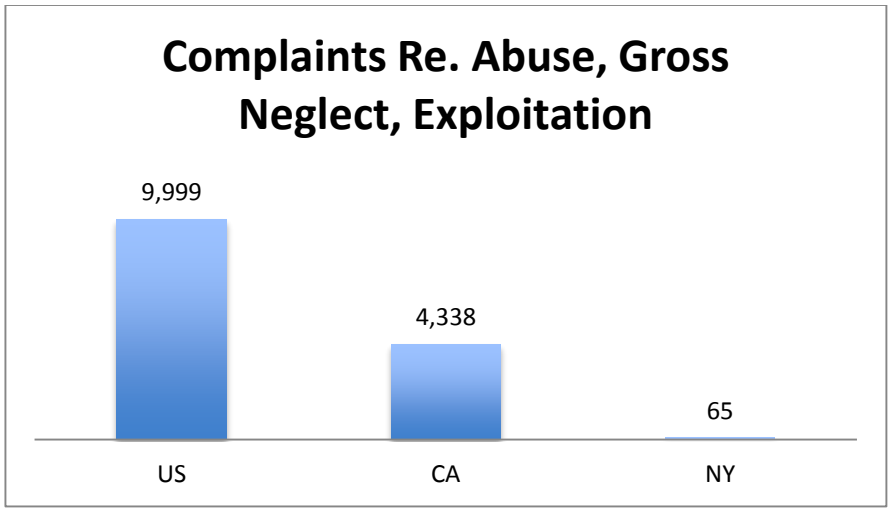


Figure 9. Nursing Home Complaints: Resident Abuse

Complaints in this category include physical abuse; verbal/psychological abuse (incl. punishment, seclusion); financial exploitation and "gross" neglect.

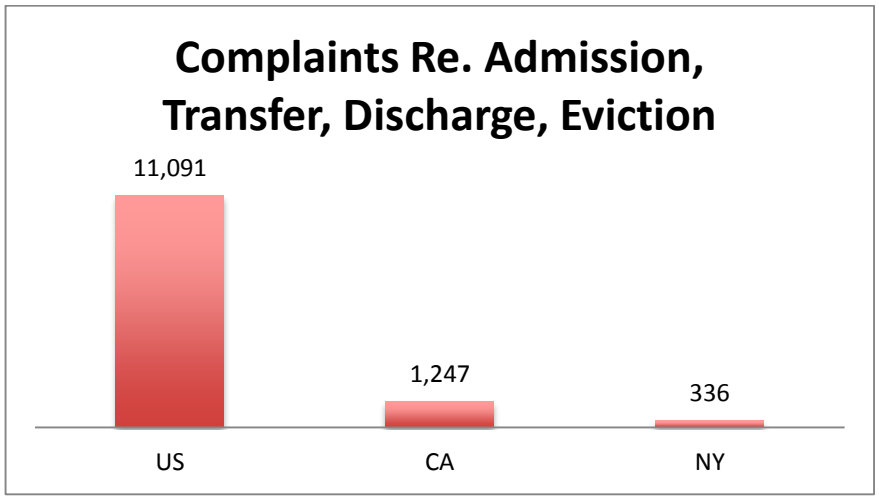


Figure 10. Nursing Home Complaints: Admission & Discharge

This category includes complaints relating to discharge/eviction planning; discrimination in admission due to condition, disability or Medicaid status; bed hold - written notice, refusal to readmit; and undesired room assignments, room changes or transfers within a facility.

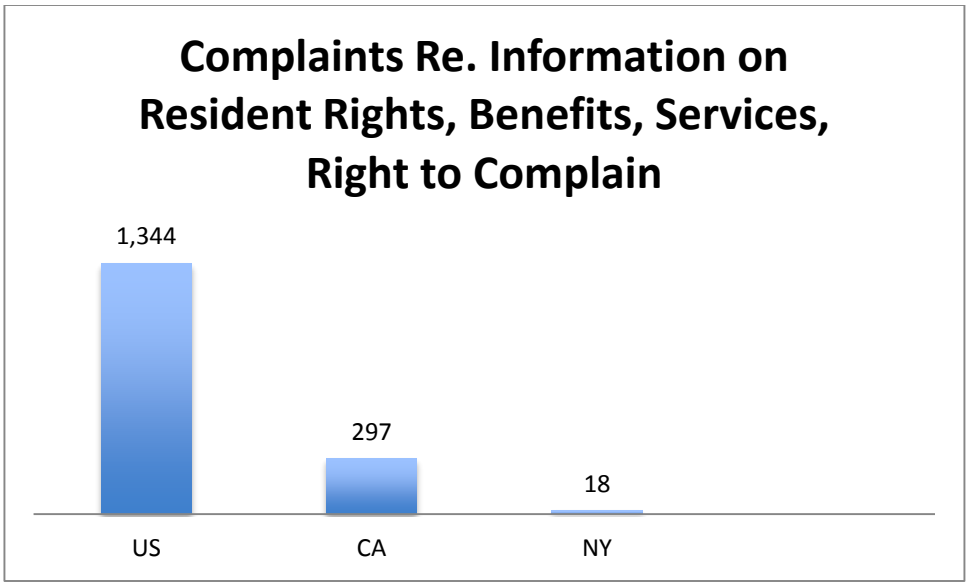


Figure 11. Nursing Home Complaints: Resident Access to Information

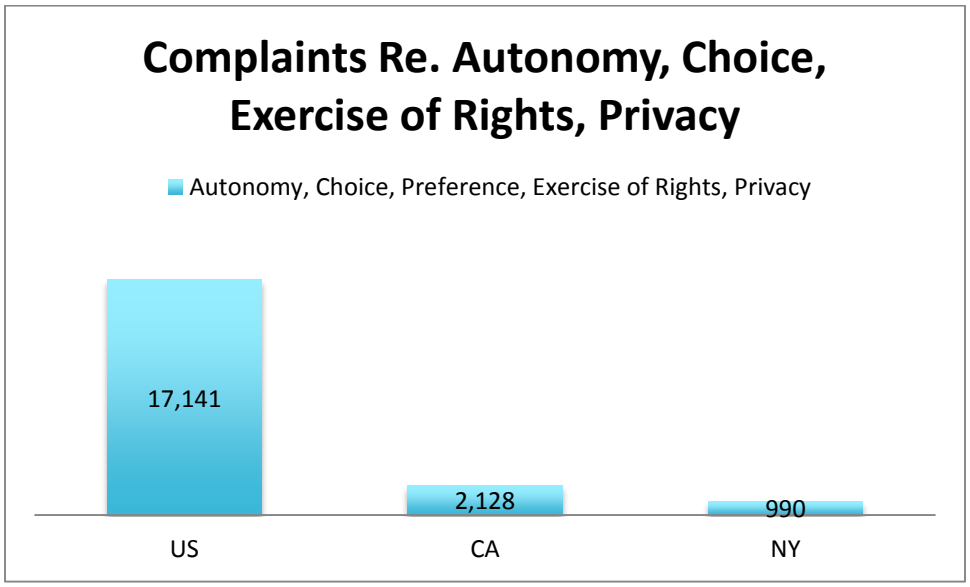


Figure 12. Complaints Re. Autonomy, Choice & Dignity

This broad category includes the following sub-categories (listed in order of number of number of complaints for the US): “Dignity, respect - staff attitudes;” “Exercise pref./ choice &/or civil/ religious rights, right to smoke;” “Privacy - telephone, visitors, couples, mail;” “Confinement in facility against will (Illegally);” “Response to complaints;” “Exercise right to refuse care/ treatment;” “Privacy in treatment, confidentiality;” “Participate in care planning by resident &/or surrogate;” “Reprisal, retaliation;” “Choose physician, pharmacy/ hospice/ other health care provider;” and “Language barrier in daily routine.”

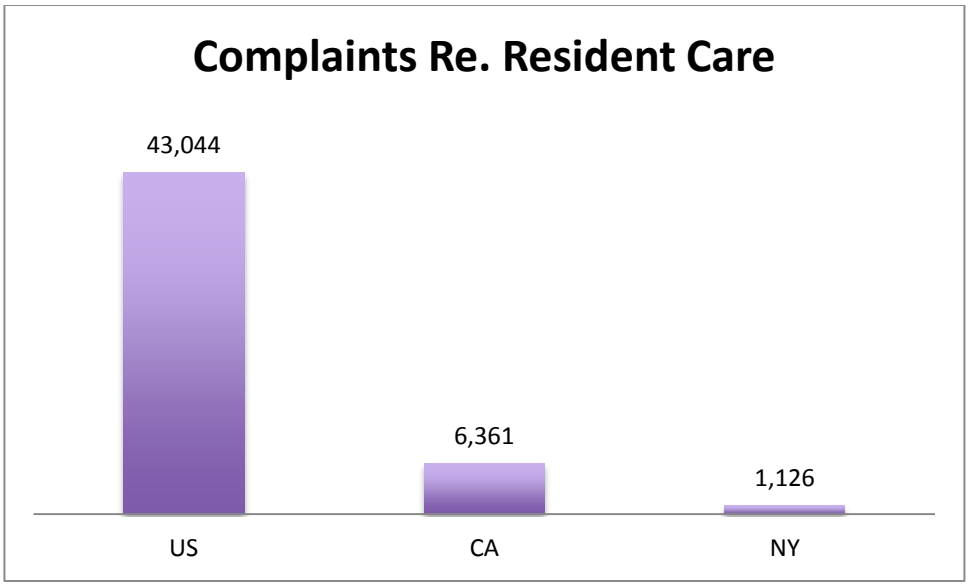


Figure 13. Nursing Home Complaints: Resident Care

In addition to complaints about problems with the basic care they are receiving in their nursing home, this included residents' complaints about issues such as: accidents and injuries, improper handling, failure to respond to requests for assistance, problems with medication administration, failure to address pain and other symptoms, development of pressure sores (including, specifically, failure to turn the resident to avoid the development of pressure sores), inadequacy of help with personal hygiene (including dental and nail care and grooming) and improper and/or insufficient toileting and incontinence care.

While all of the standards relating to resident care and quality of life are important, care issues relate to fundamental aspects of what facilities are paid to provide and what our oversight agencies are mandated to ensure. The widespread failure of state and federal survey agencies to ensure that minimum standards of care are met is a principal reason why these problems persist, year after year, in facilities across the country. While, as noted earlier, the LTCOP does not have regulatory authority to penalize providers who fail their residents, the fact that ombudsman have a more frequent presence in facilities and are authorized to take and record complaints, and advocate for residents, means that their work is essential. When they are not there to handle problems, those problems are likely to persist unabated. When problems are not recorded, there is not even a public record that they happened. Worse than suffering in silence, the resident's suffering has been effectively silenced and there is no way for anyone to know what may be going on in a facility.

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Care complaints comprised 22% of all nursing home complaints to ombudsman, nationally, and 38% of all nursing home complaint in New York in 2012. This indicates that, while complaint

handling is significantly lower overall for the New York Program, the work that the ombudsmen are able to do appears to be targeted at addressing the fundamental resident care issues. This might signify a state of "triage" on the ground, in which limited staff and resources are focused on what are viewed as the most serious problems.

Results of the NYS LTC Ombudsman Survey

Awareness of Rights Under the Older Americans Act

As noted in the beginning of this report, the state LTC Ombudsman Programs exist and operate under the authority of the federal Older Americans Act. Their responsibilities include: (1) identifying and resolving complaints made by or on behalf of residents, (2) representing the needs of residents to policy makers and the public, (3) advocating for systemic change by advocating or seeking to change laws and systems on behalf of residents, (4) providing information and educational materials about LTC, and (5) advocating for the health, safety, welfare, and rights of people residing in LTC settings.[26]

Our first question for ombudsman was to ask them about their awareness of these rights and responsibilities under federal law.

[26] OAA.

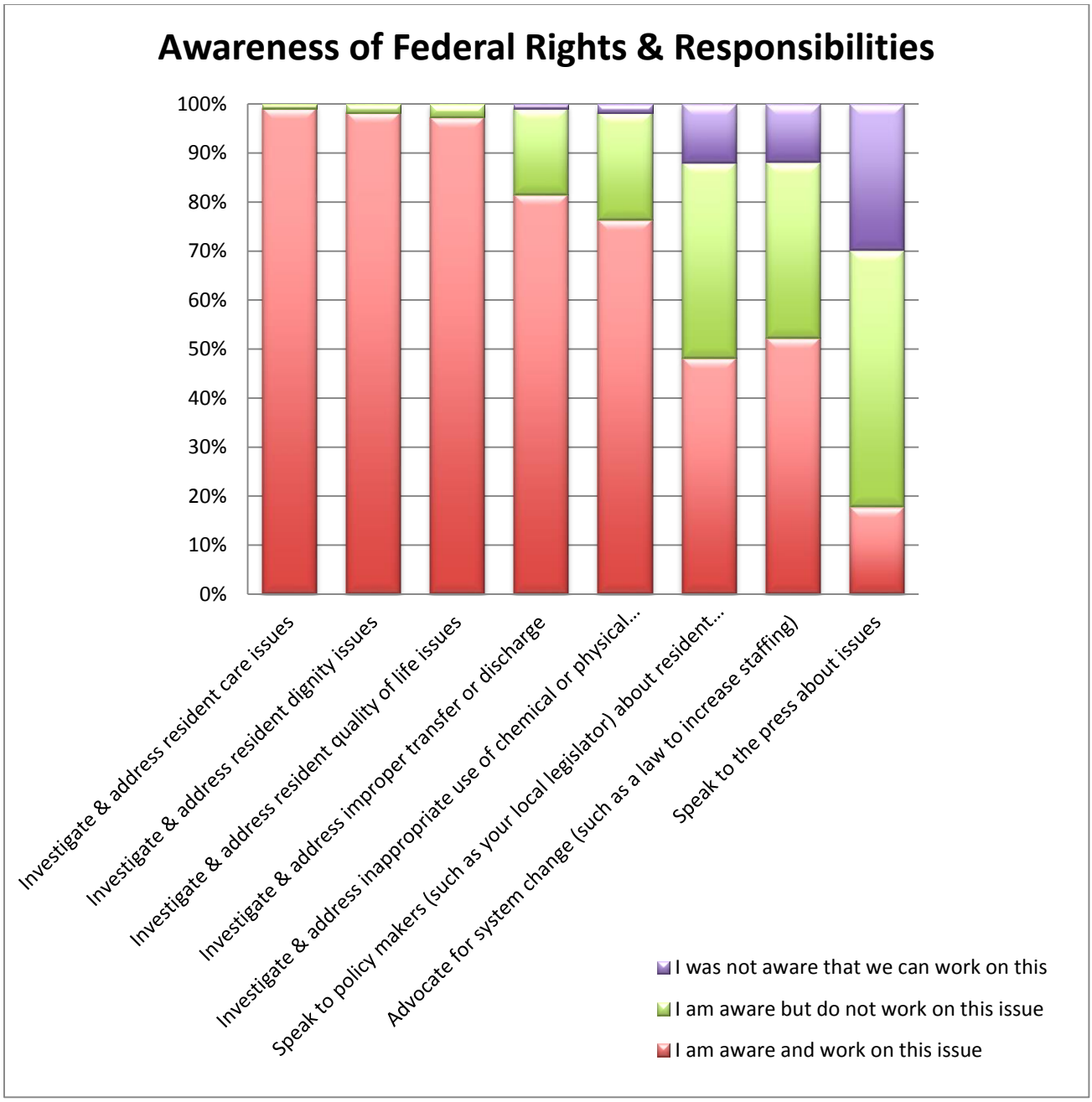


Figure 14. LTCOP Survey: Awareness of Ombudsmen's Federal Rights

Responses to this question showed a wide gap between ombudsmen's knowledge of, and work on, the basic and fundamental resident care issues and their knowledge and work on more complex or systemic issues. Of the 110 people who answered this question, all but one indicated that they work on resident care issues. As the chart above shows, this large majority decreases only slightly in regard to the numbers of ombudsmen who work on resident dignity and quality of life issues. However, in respect to two serious (but perhaps more complex) resident issues, improper transfer or discharge and the use of chemical or physical restraints, the numbers dropped significantly: approximately one in five respondents indicated that they do not investigate and address transfer/discharge problems (17.59%) or the use of

chemical/physical restraints (21.82%). Given in particular the high rate of inappropriate antipsychotic drugging in New York State nursing homes, and its disastrous implications for resident care and quality of life, it is unlikely that ombudsmen do not work on these problems because they do not exist but, rather, for other reasons.

The last three questions in this section relate to components of ombudsman rights and responsibilities that are important but more systemic in nature and less directly related to individual residents. Here we find an enormous shift in both activities and knowledge. Only about half of the ombudsmen indicated that they are aware of, and participate in, speaking to policymakers (48.15%) or advocating for systemic change (52.29%). Less than one in five (17.76%) speak to the press about issues.

Approximately 25% of respondents added written comments, which were wide-ranging and thoughtful, indicative of a significant personal investment by the ombudsman respondents in the program and understanding of its value, or potential value. Several ombudsmen said they are not free to speak to the press, while a few stated that they have spoken about issues to television and print news media. Several respondents indicated that they are new and thus have had limited opportunities to undertake different activities.

Selected comments: [27]

Systems change is a difficult and complex issue. It seems there is a societal decision on the resources available to care for the elderly….

As an Ombudsman I would like to see the program work on more systemic advocacy, the individual work that we perform day in and out at our assigned nursing homes needs to be identified on a more systemic platform.

It would be good to have some training or basic info regarding some of these 'rights.'

[27] Comments have been edited in places to ensure the anonymity of the commentators and/or for clarity.

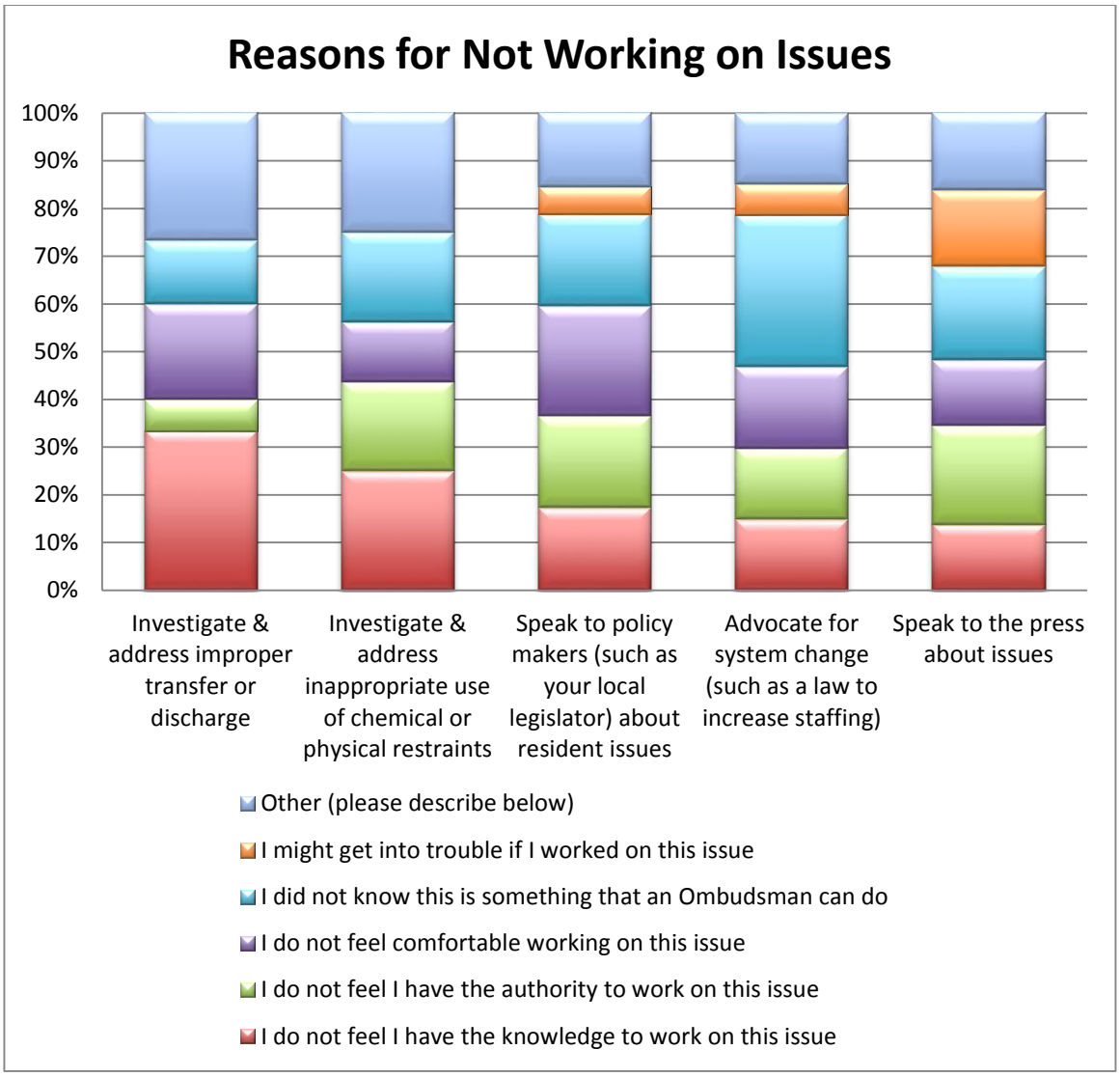


Figure 15. LTCOP Survey: Reasons for Not Working on Certain Issues

We followed up by asking "If you answered that you do NOT work on any of the above please tell us more here." Because almost all ombudsmen indicated that they work on resident care, dignity and quality of life issues we have not included those responses in the chart above.

Reasons for not working on residents' transfer/discharge or chemical/physical restraint problems. In terms of the two individual resident issues, ombudsman who have not participated in these activities indicated a range of reasons. One-third (33.33%) indicated that they did not have the knowledge to work on transfer/discharge issues and one-fourth (25%) indicated that they did not have the knowledge needed to work on chemical/physical restraint issues.

While the numbers of ombudsmen who responded to these two questions was not high enough to be statistically valid (15 for discharge, 16 for restraints) they are quite meaningful, nevertheless, in terms of providing insights into ombudsmen's perceptions of their roles and

abilities. Forty percent of these respondents indicated that they did not get involved with transfer or discharge problems that their residents have because either they don't feel comfortable, don't feel that they have the authority or did not know that this was something that ombudsmen could do. Fifty percent of respondents cited one of these reasons for not working on restraint issues. Given the extraordinarily high use of dangerous antipsychotics to chemically restrain nursing home residents, this is particularly unfortunate.

Reasons for not speaking to the press or policymakers or advocating for systemic change. Many more ombudsmen responded to these questions, which is reflective of the greater numbers who indicated that they could not perform these types of more public and systemic advocacy in the first set of questions. Across the board, there were significantly fewer people (in terms of percentages) who indicated that they did not perform these activities due to lack of sufficient knowledge than who indicated that for the earlier questions. At the same time, these three questions were the only ones that any ombudsmen responded that they did not perform the activity because they were afraid they would get in trouble. Not speaking to the press also garnered the most responses of the three (76), followed by speaking to policy makers (47) and systemic advocacy (44). While to a certain extent this makes sense and is likely appropriate – many ombudsmen are volunteers who typically work limited hours in a specific facility – it speaks to the need, minimally, to ensure that this important LTCOP function is better defined and supported so that ombudsmen who can and should be speaking to the press are able to do so.[28]

Selected comments:

All contact with the press or media is handled through… our sponsoring agency. This is the agency policy.

I would like to speak to policy makers about resident issues and advocate for system change but don't know how to go about taking action on these matters.

I understand that my role as an ombudsman is limited to investigation of resident specific complaints or concerns which the resident or his legal spokesman have identified to me and with their permission investigate. Since many residents cannot speak for themselves, nor do they have a spokesman on hand... I feel that my role as an ombudsman is limited.

Perceptions of Nursing Home Issues

We asked the ombudsmen to indicate their perceptions of nursing home quality of care, quality of life and staffing, and the ability of the NYS Department of Health and the LTC Ombudsman Program to address nursing home problems.

[28] See section on recommendations at the end of the report.

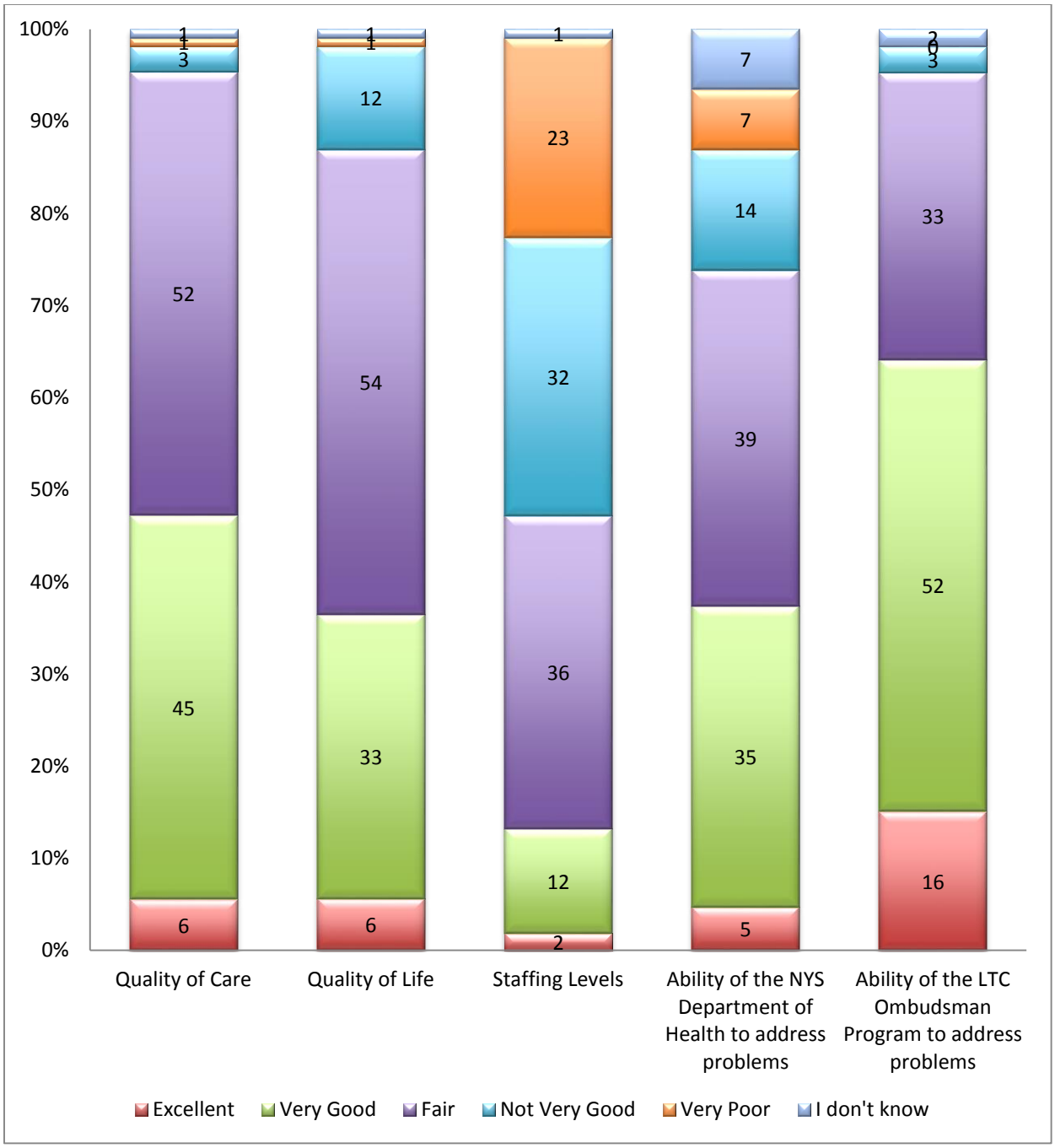


Figure 16. LTCOP Survey: Perceptions of Nursing Home Issues

As the chart above shows, the ombudsmen were almost evenly divided on whether nursing homes are providing good care (first column).[29] This was an unexpected result, given the high rates of persistent nursing home care problems, such as pressure sores, inappropriate antipsychotic drugging and other indicators of resident abuse and neglect. In light of the OIG's

[29] Note that the numbers in the columns in the above chart represent numbers of ombudsman responses while the vertical axis indicates percentages of responses.

recent findings[30] that one-third of short term residents are harmed within 35 days of entering a nursing home, it seems striking that so many ombudsmen rate nursing home care positively.

Responses re. nursing home quality of life were markedly less enthusiastic. Four times as many ombudsman indicated that quality of life was "not very good" as had indicated that for quality of care. Interestingly, respondents were much more inclined to rate the LTCOP favorably than the Department of Health. This may of course be due to an institutional bias, but it may also be indicative of the well known problems that exist with DOH oversight and ability to respond to residents' complaints, and the LTCOP's role in resolving problems that the Department of Health has failed to identify and/or adequately address.

Selected comments:

I find that many residents are unwilling to voice complaints to me for fear of staff retaliation...i.e., "I do not want to be a trouble-maker." Resident counsel is weak and poorly attended.

I believe definition of a complaint has changed and they have gone down because of that. Something I feel is a complaint… [the] State Ombudsman does not!

They are treated as a bother rather than a dignified human being often.

Some facilities are better than others, but as a whole population, complaints remain at the same level and I feel that staffing shortages truly contribute the most to this frustrating issue!

Nursing home complaints

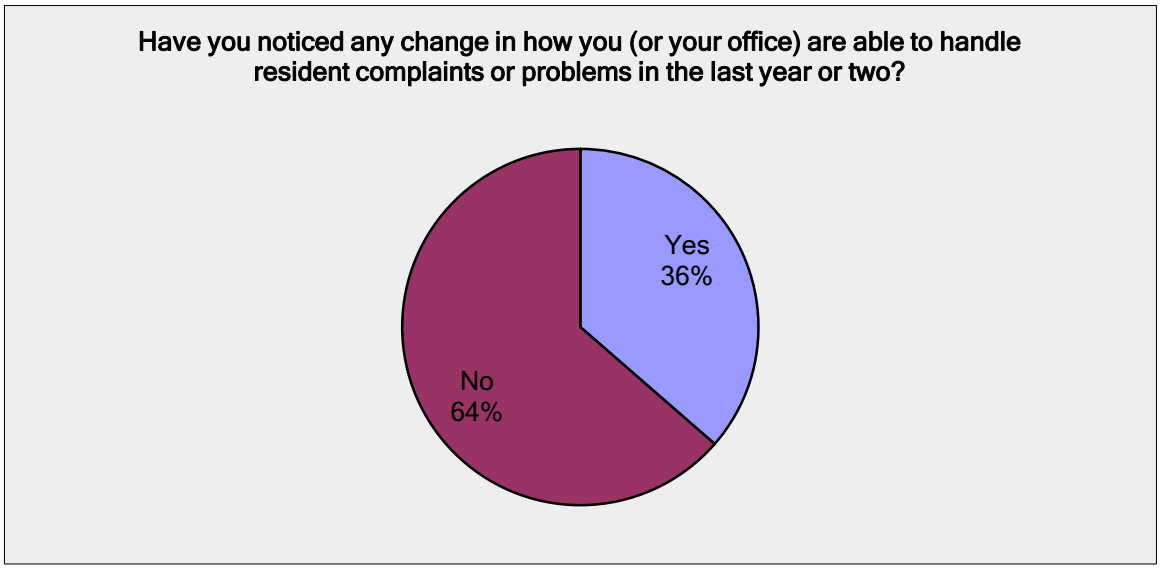


Figure 17. LTCOP Survey: Nursing Home Complaints

[30] OIG Report on Adverse Events.

Slightly over one-third of the respondents felt that their (or their office's) ability to handle problems has changed in recent years. Of the 99 individuals who responded to this question, 51 left a comment, an unusually high rate. These comments were mixed, indicating that there may not be a specific pattern of change but, rather, that there are a range of experiences. Specifically, the responses indicated a high level of diversity among ombudsmen's' experience in New York State: some felt that they were not well supported by their local program while others felt that their county program was strong and supportive of their work. A couple of comments expressed disappointment with the state office, citing a lack of direction and support at that level. This would validate perceptions that there are significant differences between the different local programs in terms of ability and independence. In addition, a number of ombudsmen stated that they had not been ombudsmen long enough to see if there had been a change. This likely means that, of ombudsmen who have been employed more than two years, the numbers who have seen a change in complaint handling are actually higher that overall responses to this question indicate.

Selected comments:

I bring issues to our director's attention and [he/she] does not encourage me to make the violations known. I have to… very carefully insist I will be addressing the issues and assure [him/her] I will give… a 'heads-up" before taking action. This is so frustrating and makes my role as the Ombudsman VERY DIFFICULT. I am "in the trenches" – [the director] is not and therefore does not "see" or "experience" the real problems.

Awareness of ombudsman services and authority has increased.

Our ombudsman coordinator does an excellent job with in-service training, availability to be reached if we need [him/her] and [his/her] knowledge of the rules.

I think our program is stronger and better respected by local facilities so we are able to handle issues more effectively.

The more we know of our 'rights' and 'empowerment' as ombudsmen, we can be more assertive as advocates. Many facilities are willing to discuss residents; while others are very guarded, for many reasons, and need some 'prodding' before they will recognize their responsibilities.

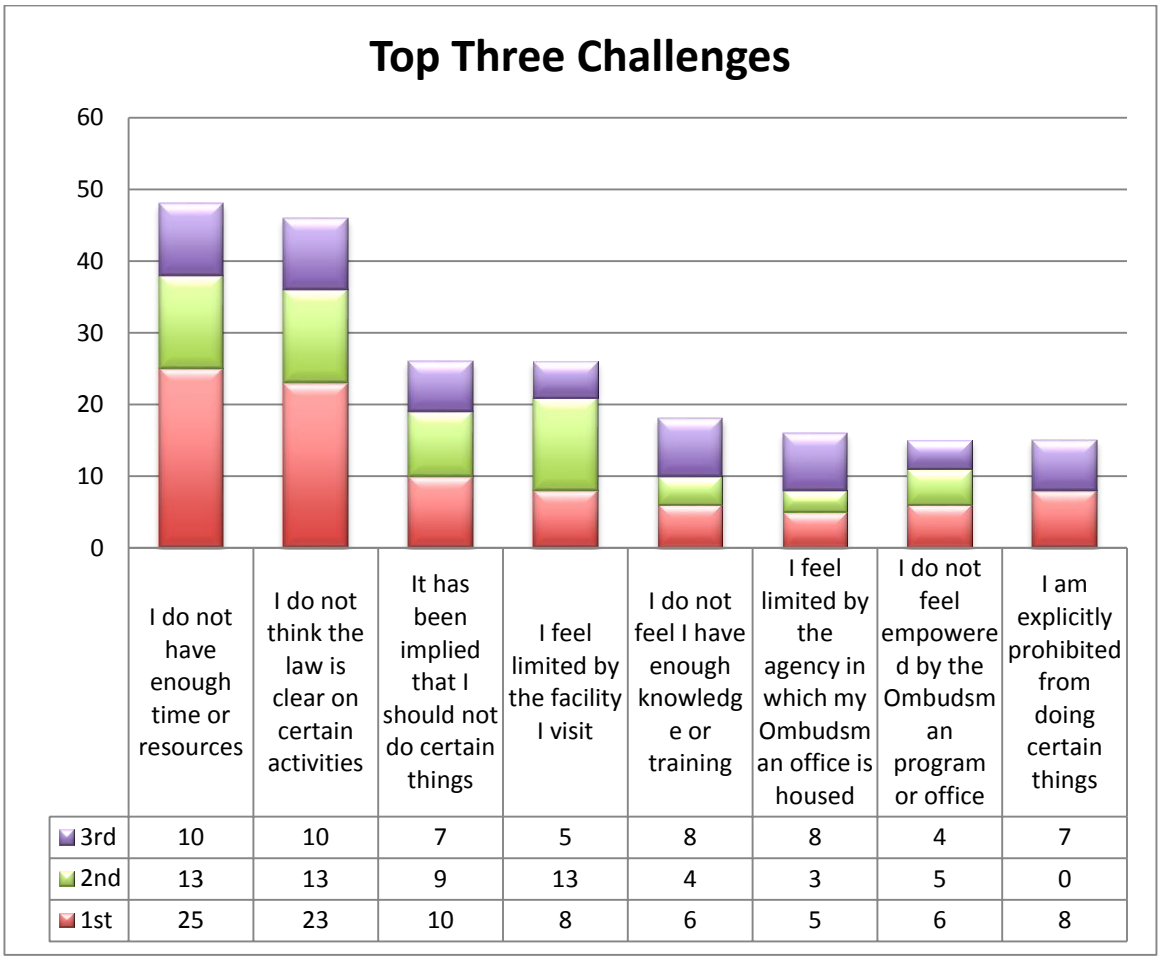
I believe the ability to handle the tougher complaints is going down. This job, in the more difficult aspects should be handled by a trained investigator/attorney of which many of our Advocates are not.

I believe that the investigation process and how we are trained to investigate complaints has become very complex and not clear…. I am concern about our ability to be effective in documenting what the program needs and expects concerning complaints when the standard on what's a complaint and what is not is not consistent. Furthermore I find that parts of the Ombudsman training modules does not always support the work that we do (e.g., nursing home regulations are not provided in the certification training).

Internal reorganization and triage of requests for services has improved our ability to respond. However, there is a serious lack of leadership and support at the state level regarding this work. We have worked diligently to expand our support system and to access resources on our own. Support at the state level has been completely absent in regard to systemic issues like managed care implementation and health reform.

I find when there is an issue that needs extra care that the administration will call me and ask me to attend a meeting with the family and administration. The administrator is not afraid to call if he/she feels that my attendance will be of help in resolving an issue. Being comfortable with the administrators and staff as well as the residents is very helpful.

There is not a consistency in data reporting or a clarity as to the state's definition of activities or complaints. Therefore our work is not accurately reflected and our volunteers are frustrated by the paperwork and inconsistency on how things are to be reported or investigated and opt out of completing necessary paperwork.



	I do not have enough time or resources	I do not think the law is clear on certain activities	It has been implied that I should not do certain things	I feel limited by the facility I visit	I do not feel I have enough knowledge or training	I feel limited by the agency in which my Ombudsman office is housed	I do not feel empowered by the Ombudsman program or office	I am explicitly prohibited from doing certain things
3rd	10	10	7	5	8	8	4	7
2nd	13	13	9	13	4	3	5	0
1st	25	23	10	8	6	5	6	8

Figure 18. LTCOP Survey: Top Challenges

The chart above lists the top challenges that the ombudsmen identified, in the order in which they were most identified as being among the top three. In addition to the challenges we named, ombudsmen could write in their own in a comments box; approximately half did (80 responses to the question plus 42 comments). Lack of time or resources was the biggest single problem cited by ombudsmen, followed closely by lack of clarity in the law relating to ombudsmen activities. Columns three, six, seven and eight all relate to what the ombudsmen are hearing – explicitly or implicitly – from their host agency, program office or the State LTCOP office. Taken together, 90% of respondents (72 of the 80) identified these types of interference as a top challenge.

The comments we received in response to this question ranged from identification of challenges to more general comments on the challenges and problems that the ombudsmen face. Several of the commentators expressed concern for the facility, for instance stating that their facility was struggling with funding, which indicates that there might be some level of co-option of the ombudsmen by their facilities. A number of ombudsmen cited paperwork as being an issue for them and a number identified low staffing in the nursing homes or assisted living that they work in as being their greatest challenge.

Selected comments:

We could do SO much more with more time. Many issues are not able to be addressed as thoroughly as I would like….

It seems that the biggest underlying issues relates to staffing (staff ratio to residents).

I enjoy being an ombudsman. Our training in [program name deleted] has been consistently excellent and is ongoing.

The job to Volunteer as an Advocate is best left at a Trained Investigator. Also the job is gargantuan to handle, coupled with the fact we are NOT compensated for mileage. I have sometimes [travelled hundreds of] miles a week. I had to stop because the gasoline prices are too high. I think volunteering my time is enough but cutting into my cash is unacceptable. Please institute a reimbursement for mileage.

The Education/Training has allowed me the opportunity to Evaluate Patient/Resident concerns and participate in remediation.

I have not felt directly or personally affected by our sponsoring agency, but there is a clear conflict of interest there.

At a time when fundamental changes within our healthcare and Long Term Care Systems are occurring that have a profound impact on the current and future quality of life for seniors and the disabled, the State LTCOP office has not even been a player. Decisions are being made on a daily basis that will impact the system of care for many years to come, and the ombudsman program has had minimal to virtually no involvement. At the local level, this has been extremely difficult to understand. Perhaps they are not allowed to speak up. If so, that must be changed. Regardless the reason, ombudsman are in a totally unique position, day in and day out, to provide critical input. Our voices desperately need to be heard.

Recommendations

Recommendations for the LTCOP

The State/NYS LTCOP should:

1. Immediately address the state funding imbalance and provide sufficient financial support to the LTCOP to fulfill its mandate to protect nursing home and assisted living residents. Minimally, New York should rise to the level that California provides for its LTCOP program, taking into account New York's higher nursing home population. Thus, New York should provide, minimally, $3,436,971 annually.[31]
2. Immediately and substantively address the low rate of complaint handling and resolution. In addition to adequate funding, this should include concrete steps to ensure that the state office is independent and that its leadership is willing and able to vigorously carry out the full range of important ombudsman activities (and ensure that local programs are as well).
3. Take affirmative steps to ensure that Ombudsman Coordinators –who oversee the programs on the local level – are clearly authorized and supported to speak to the press and policymakers and undertake systemic advocacy. This includes the following criteria:
   a. Coordinators have clear authority to speak to the press, including: writing letters to the editor or op-eds, appearing on radio or tv programs, etc….
   b. Coordinators have clear authority to oversee and designate these activities within their organizations and the area that they cover geographically.
   c. Host or sponsoring organizations – which house local programs – are neither permitted to represent the LTCOP publically nor interfere with the Coordinators role and authority.
4. Implement a system of information sharing and coordination between the new Medicaid LTC Ombudsman Program and the existing LTC Ombudsman Program.

The NYS LTC Ombudsman should:

1. Provide training and resources to the local Program Coordinators on systemic advocacy and speaking to the press/policymakers.
2. Provide an annual report on these activities to NYS Senate and Assembly Aging and Health Committee chairs, said report to be posted on the NYS LTCOP website.

Recommendations for NY State for the new MLTC Ombudsman Program

1. Ensure that the MLTCOP is completely independent of both government (state and local) and industry (including providers, insurance companies, worker unions and associations).
2. Ensure that the MLTCOP is sufficiently funded to carry out its mission.
3. Authorize the MLTCOP to provide vigorous advocacy for consumers.
4. Ensure that the MLTCOP is culturally competent to work with diverse consumers.
5. Develop a mandatory case handling reporting form for use by the MLTCOP.
6. Require that the MLTCOP collect data on case handling and issue an annual public report, including the data, on program activities.
7. Permit and provide resources for the MLTCOP to undertake public and systemic advocacy.

[31] California provided $3,212,122 in support of its LTCOP in 2012; as noted earlier New York's nursing home population is 107% of California's.

Appendix 1: Definitions for National Ombudsman Reporting System Terms

NOTE: For more information on the National Ombudsman Reporting System (NORS) and forms/instructions for the ombudsmen, visit http://www.aoa.gov/aoa_programs/elder_rights/Ombudsman/NORS.aspx.

Case: Each inquiry brought to, or initiated by, the ombudsman on behalf of a resident or group of residents involving one or more complaints which requires opening a case and includes ombudsman investigation, strategy to resolve, and follow-up.

Closed Case: A case where none of the complaints within the case require any further action on the part of the ombudsman and every complaint has been assigned the appropriate disposition code.

Complaint: 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.

Verified: It is determined after work [interviews, record inspection, observation, etc.] that the circumstances described in the complaint are generally accurate.

Resolved: The complaint/problem was addressed to the satisfaction of the resident or complainant.

Statewide Coverage means that residents of both nursing homes and board and care homes (and similar adult care facilities) and their friends and families throughout the state have access to knowledge of the ombudsman program, how to contact it, complaints received from any part of the State are investigated and documented, and steps are taken to resolve problems in a timely manner, in accordance with federal and state requirements.

Certified Volunteer: An individual who has completed a training course prescribed by the State Ombudsman and is approved by the State Ombudsman to participate in the statewide Ombudsman Program.

Consultation to facilities: providing information and technical assistance, often by telephone.

Appendix 2: Table of Figures