

# **Long Term Care Ombudsman: A Fifty State Study**

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## **Introduction**

In response to recent nursing home issues in Rhode Island regarding quality of care and patient satisfaction, we have conducted an evaluative study on the Long-Term Care Ombudsman Programs in each of the fifty United States, Washington, D.C., and Puerto Rico. The Office of the Long-Term Care Ombudsman serves as an advocate on behalf of nursing home residents. The Office functions to investigate cases, receive complaints, and promote the rights and care of elderly residents. Therefore, we selected the Long-Term Care Ombudsman Program because it plays an integral role between nursing home administrators, regulators, and residents. Using data from the National Long-Term Care Resource Center, we ran multivariate regression analysis studying the association between resources available to the Office and the effectiveness of the program.

## **Background**

The State of Rhode Island is currently making efforts toward nursing home reform after five Rhode Island nursing homes have gone into receivership in the last three years (“Fogarty Establishes Task Force,” 2004). The most highly publicized case is the June 2004 closing of Hillside Health Center after the facility could no longer afford to pay its bills and had debts of \$4 million to vendors. Inspectors levied heavy fines and froze admission to Hillside after citing 14 violations, including skin ulcers and bed sore patients. Lieutenant Governor Charles Fogarty, Chairman of the Rhode Island Long-Term Care-Coordinating Council, later established a task force to investigate the circumstances surrounding the closure of Hillside and to issue recommendations aimed at addressing what the task force has deemed “systemic failures” (“Fogarty Releases Hillside State Task Force Report,” 2004).

Findings from the state task force and recent articles in the *Providence Journal* reveal evidence of failures in Rhode Island nursing home enforcement, citing the many complaints issued by the Rhode Island state Long-Term-Care Ombudsman regarding Hillside which went un-investigated. Complaints from the ombudsman and families, many of which were observed first-hand by ombudsman staff, ranged considerably from staff sleeping while on duty, patients going without water, and patients being unnecessarily restrained (“Fogarty Releases Hillside State Task Force Report,” 2004). According to a *Providence Journal* article written November 22, 2004, “The Alliance for Better Long Term Care, which holds a state contract to act as ombudsman for the elderly, warned the Health Department at least six times about poor care and financial problems at Hillside Health Center in Providence” (Levitz, 2004).

Among the findings in the task force report was the story of Roberta Hawkins, the executive director of the Alliance, who started complaining to the Health Department in 2001 about the shaky finances and alarming conditions at Hillside regarding staffing and conditions in the Alzheimer’s unit. On August 8, 2002, Hawkins notified the Health Department, the Department of Human Services, and the attorney general’s office that vendors at Hillside were complaining about past due accounts. Six days later she reported complaints to the Alliance for Better Long Term Care received from family members regarding the quality of care at the facility to the Health Department. However, it was not until one year later after additional

complaints by the ombudsman had not been filed, that the Health Department stopped Hillside from accepting admissions (Levitz, 2004).

The role of long-term care ombudsman programs is defined in federal and state legislation. Title VII of the Older Americans Act (OAA) of 1965, as amended, enumerates advocacy programs designed to foster activities to assist vulnerable older people to exercise their rights, to secure the benefits to which they are entitled and to be protected from abuse, neglect, and exploitation (Older Americans Act, 2000). The Long-Term Care Ombudsman Program was incorporated into the Older Americans Act in 1978, which required that every state have an ombudsman program and set the statutory definition of ombudsman functions and responsibilities (Elder Rights: LTC Ombudsman, 2004). The Long-Term Care Ombudsman Program requires states to establish and operate an Office of the State Long-Term Care Ombudsman, headed by the State Long-Term Care Ombudsman. The Ombudsman Program identifies, investigates, and resolves complaints made by or on behalf of residents of nursing, board and care, and similar adult care homes. The program works to educate residents, nursing home personnel and the public about residents' rights and other matters affecting residents, and performs other functions specified in the OAA to protect the health, safety, and welfare of residents (Older Americans Act, 2000). Thus, the state Long-Term Care Ombudsman Program is governed by the OAA provisions, the Administration on Aging Office of Long-Term Care Ombudsman Programs, and the individual state's statutes that outline the relation of the ombudsman program to other area agencies.<sup>1</sup>

## **Literature Review**

Despite the recent public outcry against the quality of care in Rhode Island nursing homes and the growing need for legislation on facility regulation, there has been little research done. There have, however, been a number of state specific studies that focused on the roles long-term care ombudsman play within the nursing home setting. A Missouri study published in 1993 in the *Journal of Health and Social Behavior* studied long-term care ombudsman programs in relation to quality of care. The study hypothesizes that "ombudsman programs will be associated with measures of quality of care for nursing home residents" (Cherry, 1993). This study focused on a multivariate analysis of a random sample of 210 nursing homes in Missouri. The study concludes that "the presence of an ombudsman in intermediate care facilities is significantly related to both process and outcome measures of quality of nursing care" (Cherry, 1993).

The study also brings up many key points regarding the roles of ombudsman within the long-term care facility including "advocate and mediator, as well as therapeutic supporter" (Cherry, 1993). They posit that "this breadth of possible tasks allows ombudsman to individualize their roles and thereby heighten their commitment to residents' quality of life" (Cherry, 1993). The study also concludes that "ombudsman may dilute their effectiveness by not being specialized enough, particularly if they are working with minimal resources and large caseloads" (Cherry, 1993). Because this study used nursing homes as their unit of analysis and not states, as we have, the author cautions not to over-generalize the study's findings "to states with quite different systems of ombudsman services" (Cherry, 1993).

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<sup>1</sup> Please refer to Appendix A

A similar study on the Long-Term Care Ombudsman Program was conducted in Connecticut and published in 2003 in the *Research on Aging* journal. This study used complaint data from all of Connecticut's 261 nursing facilities; using facility characteristics that are correlated with resident complaints (Allen, Klein, and Gruman, 2003). The study asks many vital questions when assessing their results. Some of which include, "What are the complaints trying to tell us? Are higher rates of complaints alerting us to more serious conditions for residents, or a higher comfort level in exercising their right to access an outside agency that may be facilitated by the increased presence of volunteer resident advocates?" (Allen et al., 2003). They conclude that "we should look to the future of consumer satisfaction in nursing homes with added interest, closely listening to nursing home consumers to understand their feelings behind complaint filing" (Allen et al., 2003). They also conclude that "improved consistency among states in reporting and resolving the problems of residents is paramount in upholding the mission of the Long-Term Care Ombudsman Program and in illuminating the rights of residents on a national basis" (Allen et al., 2003).

In 2000, a study investigated the role of the Long-Term Care Ombudsmen in nursing home closures and natural disasters. Voluntary or involuntary nursing home closures forced 1.6 million residents in 18,900 nursing homes to relocate in 1999 (Murtiashaw, 2000). Long-term care ombudsmen witnessed the problems, frustrations, and deaths resulting from the impact of transfer trauma (Murtiashaw, 2000). The study recommends that as the resident's advocate, ombudsmen are the ideal people to educate individuals on the characteristics and ways to minimize transfer trauma (Murtiashaw, 2000). Moreover, the study finds that local and state ombudsmen have the ability to be proactive and work toward preventing nursing home closure along with the assistance of community agencies and individuals (Murtiashaw, 2000). Ombudsmen should play a pivotal role in nursing home closures because their regular visits facilitate a unique look at the operation and quality of care at facilities, as well as the ability to follow-up with residents who are transferred and assess the impact that the transfer has on the resident (Murtiashaw, 2000).

The Ombudsman Desk Reference from May 2001 provided information regarding how many ombudsmen there are and whom they serve. There are 52 State Long-Term Care Ombudsman Programs (in the 50 states, D.C., and Puerto Rico) and their statewide networks included 587 regional (local) programs (Okrent, 2001). In 1999, Ombudsmen handled 215,650 complaints made by more than 130,255 individuals, including residents, family members, friends, and facility staff; 80% of the cases were in nursing homes, and 18% in Board and Care, Assisted Living and similar facilities (Okrent, 2001). In 1999, Ombudsman Programs utilized approximately 974 paid staff and 14,000 volunteers more than 8,400 of whom were trained and certified (Okrent, 2001).

### **Hypothesis**

After reviewing previous research and literature in the area of long-term care ombudsman programs, we hypothesize that *the more resources available to an ombudsman program office, the more effective the program*. Funding resources and the ombudsman program staff are directly related to the number of cases that can be adequately resolved. The expenditures of an

ombudsman program, the ombudsman program staff, and the certified volunteer ombudsman are directly related to the number of complaints received.

### **Data Collection and Methodology**

Our evaluation of the long-term care ombudsman program is an impact assessment, defined as “an evaluative study that answers questions about program outcomes and impact on the social conditions it is intended to ameliorate” (Rossi, Lipsey, and Freeman, 2004). Our research design unit of analysis for this research is states. Overall, we have studied the fifty American states, Washington D.C., and Puerto Rico.

According to our hypothesis, we will analyze how the resources for an ombudsman office relate to the effectiveness of the ombudsman program. We operationalized the term “resources” as three distinct independent variables: program spending or federal funding, paid program staff, and certified volunteer ombudsman. We operationalized the effectiveness of an ombudsman program as the number of complaints the program receives and the success of resolving cases. Therefore, we believe that these three input measures of resources will affect the outcome measures of ombudsman program effectiveness.

Our variables were derived from the National Long Term Care Ombudsman Resource Center. We utilized the compiled data from the year 2000 survey on state ombudsman offices to operationalize variables consistent with our hypothesis. We operationalized the following independent variables for the purpose of expressing ombudsman program resources on a per nursing home bed basis. We altered the data to develop independent variables on a per bed basis in order to understand the effectiveness of an ombudsman program on individual nursing home residents. This modification also allows comparison between the states, eliminating any significant differences in state population size.

Our first measure of resources is financial resources which may be expressed as “spending per bed” or “federal funding.” The term “spending per bed” is defined as: the total expenditures of the ombudsman program divided by the number of nursing home beds in the state.

**Spending per Bed = Total expenditures of the ombudsman program**

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**Number of nursing home beds in a state**

Alternatively, we measured financial resources as “federal funding,” which is defined as: the percentage of the ombudsman program funding provided by the federal government pursuant to the Older Americans Act.

Our second measure of resources is “paid staff per bed” defined as: the number of paid ombudsman program staff divided by the number of nursing home beds in the state.

$$\text{Paid Staff Rate} = \frac{\text{Number of paid ombudsman program staff}}{\text{Number of nursing home beds in a state}}$$

Our third measure of resources is “certified volunteer ombudsman per bed” defined as: the number of certified volunteer ombudsman divided by the number of nursing home beds in the state.

$$\text{Certified Volunteer Ombudsman Rate} = \frac{\text{Number of certified volunteer ombudsman}}{\text{Number of nursing home beds in a state}}$$

Our two outcome measures of the impact of ombudsman program are the number of complaints and the success of closing cases. The first dependent variable is “complaint rate” defined as: the number of complaints recorded divided by the number of nursing home beds in a state.

$$\text{Complaint rate} = \frac{\text{Number of complaints recorded}}{\text{Number of nursing home beds in a state}}$$

The second dependent variable is “case success rate” defined as” the number of cases opened divided by the number of cases closed.

$$\text{Case success rate} = \frac{\text{Number of cases opened}}{\text{Number of cases closed}}$$

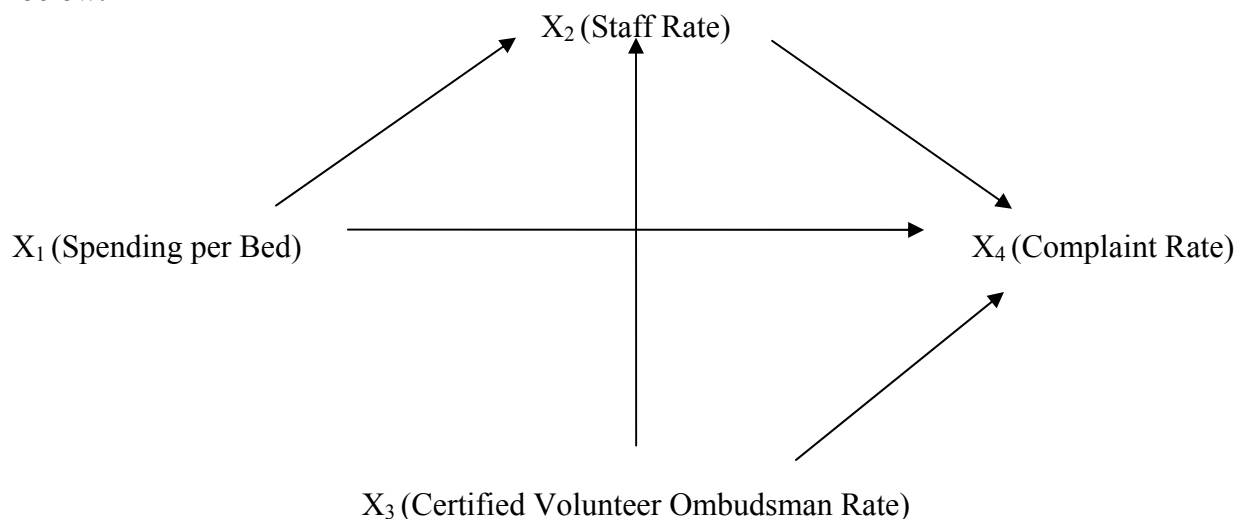
The research design we utilized for our impact assessment is a reflexive design. Due to the collection of data at the interval level of measurement, we utilized regression analysis. This type of analysis enabled us to use causal models, which express our hypotheses and test our independent variables while controlling for the effects of other independent variables. Reflexive designs are characterized by low internal validity and high external validity. Validity is the extent to which a measure actually measures what it is intended to measure, low internal validity implies that our findings cannot establish a cause and effect relationship and high external validity implies that our findings can be extended beyond the immediate study (Hyde, and Carlson, 2003).

## **Data Analysis**

### ***Quantitative Analysis for 50 states and DC***

We first came up with a hypothetical causal model to explain the relationship of the independent variables, resources, effects on the dependent variable complaint rate. We hypothesized that complaint rate would be directly affected by spending per bed, staff rate and certified volunteer ombudsman rate. We also hypothesized that complaint rate would be

indirectly affected by spending per bed through the variable staff rate and certified volunteer ombudsman rate through the variable staff rate. In order to analyze these relationships we will use a multiple path regression model. The model designed, prior to data analysis, appears below:



We then ran the regressions to examine the relationships between the independent variables and the dependent variable. The results of the regressions produced beta weights, also known as standardized correlation coefficients, which allow the researcher to be able to directly compare variables originally measured in different units. The researcher may interpret beta weights as an expression of the relationship between independent variables and a dependent variable, where by the stronger the relationship between the variables, the higher the beta weight. Statistical significance is the likelihood that an observed relationship found in a probability sample has occurred by chance and is not present in the population from which the sample was drawn (Hyde, and Carlson, 2003).

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### Multiple path Regression Model and Mathematical Calculations for Complaint Rate

*Variables:*

- $X_1$  = total program expenditures / total number of nursing home beds
- $X_2$  = total ombudsman paid program staff / total number of nursing home beds
- $X_3$  = total certified ombudsman volunteers / total number of nursing home beds
- $X_4$  = number of complaints received / total number of nursing home beds

*Equations:*

- $X_1 = e$
- $X_2 = f(X_1) + f(X_3) + e$
- $X_3 = e$
- $X_4 = f(X_1) + f(X_2) + f(X_3) + e$

*Regression Analysis 1:*

Dependent Variable: Staff Rate

Independent Variable: Spending per Bed  
 Independent Variable: Certified Volunteer Ombudsman Rate

Equation:  $X_2 = f(X_1) + f(X_3) + e$

Beta Coefficient ( $X_1$ ) = .918 (.000)

Beta Coefficient ( $X_3$ ) = .074 (not significant)

*Regression Analysis 2:*

Dependent Variable: Complaint Rate  
 Independent Variable: Spending per Bed  
 Independent Variable: Staff Rate  
 Independent Variable: Certified Volunteer Ombudsman Rate

Equation:  $X_4 = f(X_1) + f(X_2) + f(X_3) + e^2$

Beta Coefficient ( $X_1$ ) = -.100 (not significant)

Beta Coefficient ( $X_2$ ) = 1.081 (.000)

Beta Coefficient ( $X_3$ ) = .014 (not significant)

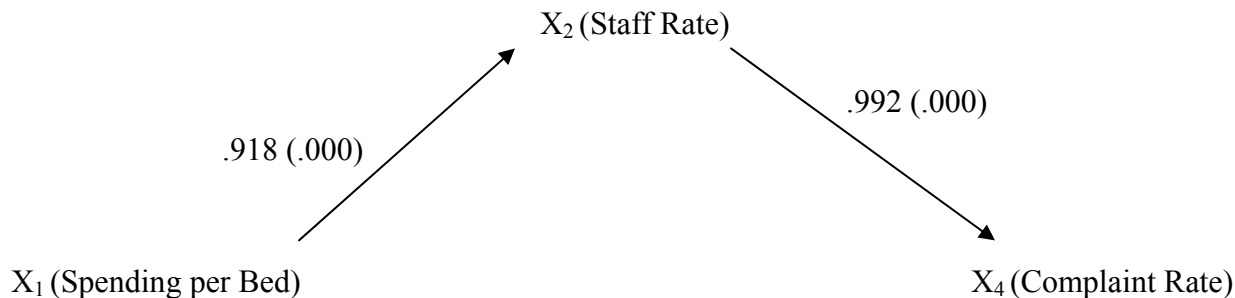
Direct Effects

$X_2 \rightarrow X_4 = .992 (.000)$

Indirect Effects

$X_1 \rightarrow X_2 \rightarrow X_4 = .911$

**Multiple Path Regression Model for Complaint Rate after Mathematical Calculations**



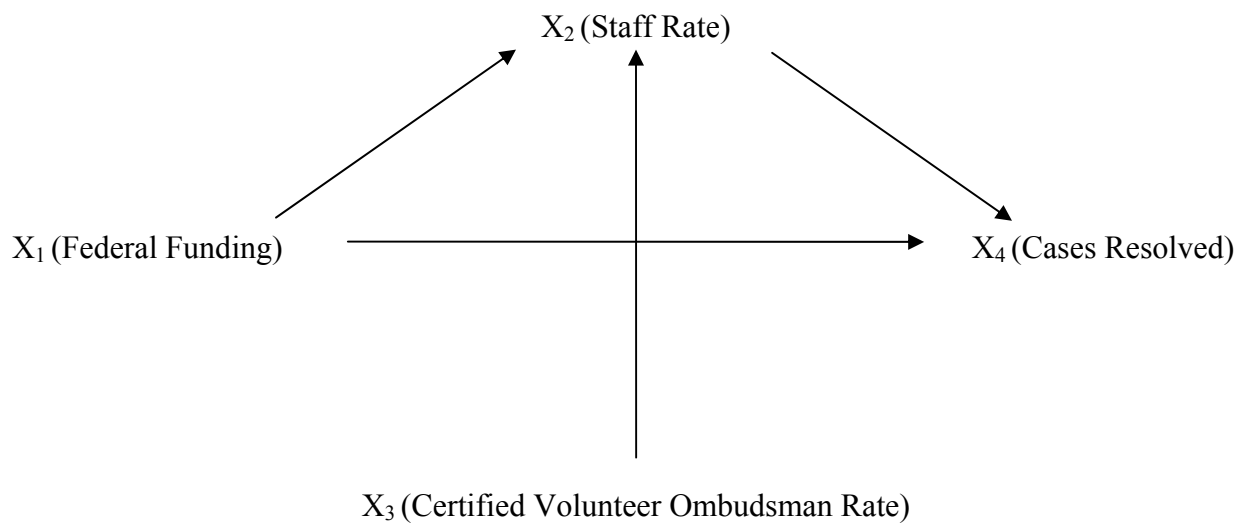

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<sup>2</sup> Interestingly this equation has a  $R^2$  of .986, which is the coefficient of determination that shows 98.6% of the variance in Complaint Rate is accounted for by the independent variables of Spending, Volunteer Rate, and Staff Rate.



As the above multiple path regression model shows, the certified ombudsman rate has neither a direct nor an indirect effect on complaint rate as we had hypothesized. Staff rate has a direct effect on complaint rate with a beta weight of .992 and is statistically significant at the .000 level. Therefore, the resource of the ombudsman program staff is the only variable that has a direct effect on the number of complaints an ombudsman office receives. The indirect effects are calculated by multiplying the beta coefficients along the paths. Spending per bed has an indirect effect on complaint rate through the independent variable of staff rate at .911. Interestingly, spending per bed is correlated to staff rate at .918, which was found to be statistically significant at the .000 level. Thus, the higher the expenditures of an ombudsman program, the more staff the program has to take in complaints.

We also came up with a hypothetical causal model to explain the relationship of resources on the percentage of cases resolved to the satisfaction of the resident of complainant, which we employ as a measure of success in closing cases. We hypothesized cases resolved would be directly affected by the percentage of federal funding to the ombudsman program and program staff rate. We also hypothesized that cases resolved would be indirectly affected by federal funding through staff rate and certified volunteer ombudsman rate through staff rate. In order to analyze these relationships we will use a multiple path regression model. The model designed, prior to data analysis, appears below:



We then ran regressions to determine the relationships between the dependent variable of cases resolved and the independent variables.

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### **Multiple path Regression Model and Mathematical Calculations for Complaint Rate**

*Variables:*     $X_1$  = total percent of federal funding for the program from Older Americans Act  
                    $X_2$  = total ombudsman paid program staff / total number of nursing home beds  
                    $X_3$  = total certified ombudsman volunteers / total number of nursing home beds  
                    $X_4$  = percentage of cases resolved to the satisfaction of the resident of complainant

*Equations:*     $X_1 = e$

$$\begin{aligned} X_2 &= f(X_1) + f(X_3) + e \\ X_3 &= e \\ X_4 &= f(X_1) + f(X_2) + e \end{aligned}$$

*Regression Analysis 1:*

Dependent Variable: Staff Rate  
Independent Variable: Federal Funding  
Independent Variable: Certified Volunteer Ombudsman Rate

Equation:  $X_2 = f(X_1) + f(X_3) + e$

Beta Coefficient ( $X_1$ ) = .200 (not significant)  
Beta Coefficient ( $X_3$ ) = .558 (.000)

*Regression Analysis 2:*

Dependent Variable: Case Success Rate  
Independent Variable: Federal Funding  
Independent Variable: Staff Rate

Equation:  $X_4 = f(X_1) + f(X_2) + e$

Beta Coefficient ( $X_1$ ) = -.034 (not significant)  
Beta Coefficient ( $X_2$ ) = .333 (.019)

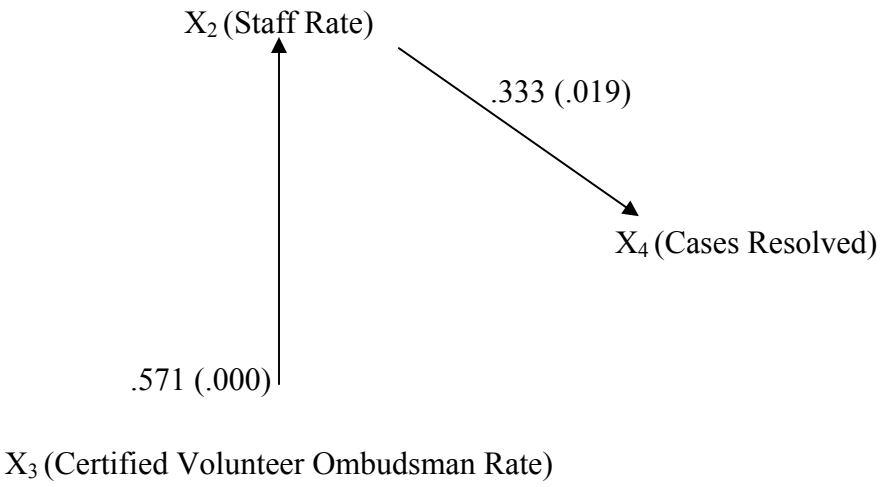
Direct Effects

$X_2 \rightarrow X_4 = .333 (.019)$

Indirect Effects

$X_3 \rightarrow X_2 \rightarrow X_4 = .186$

**Multiple Path Regression Model for Cases Resolved after Mathematical Calculations**



As the above multiple path regression model shows, the percentage of federal funding has neither a direct nor an indirect effect on cases resolved as we had hypothesized. Staff rate has a direct effect on cases resolved with a beta weight of .333 and is statistically significant at the  $p < .05$  level. Therefore, the resource of the ombudsman program staff is the only variable that has a direct effect on the percentage of cases resolved to the satisfaction of the resident or complainant. The certified volunteer ombudsman rate has an indirect effect on cases resolved through the independent variable of staff rate at .186. Interestingly, the volunteer rate is correlated to staff rate at .571, which was found to be statistically significant at the .000 level. Thus, the higher the certified volunteer ombudsman rate, the more successful the paid ombudsman staff in satisfactorily resolving cases.

### ***Qualitative for 6 New England states***

We then conducted a qualitative analysis of the long-term care ombudsman programs in the six New England states for the purpose of comparing the role of the Rhode Island long-term care ombudsman program relative to similar states. We analyzed only the state enabling statutes governing the long-term care ombudsman program for New England states and synthesized this data into a chart, which can be found in the Appendix. The state enabling laws legitimize the long-term care ombudsman program by giving it legal standing and clarify for the individuals the program serves, the public, providers and other agencies the role and responsibilities of the program and the scope of those responsibilities (“Long-Term Care Ombudsman Program: A Summary of State Enabling Statutes,” 2002).

Utilizing findings from a study entitled: “Long-Term Care Ombudsman Program: A Summary of State Enabling Statutes” we were able to analyze the authority of the long-term care ombudsman in each of the New England states. Survey responses in the study revealed three major issues regarding state enabling statutes. They are: (1) access to residents, facilities and residents’ records; (2) willful interference; and (3) legal representation of the program (“Long-Term Care Ombudsman Program: A Summary of State Enabling Statutes,” 2). Potential linkages between these three elements are important to infer power of a long-term care ombudsman’s office.

Access to facilities, residents, and residents’ records when appropriate and necessary to investigate client specific complaints is a critical component in the long-term care ombudsman’s ability to successfully resolve cases. An attempt to restrict the program’s access to a facility and residents may constitute willful interference in regards to an ombudsman’s responsibilities. “Willful interference is considered any action or inaction, or pattern of actions or inactions, on the part of a provider or other entity intended to obstruct, inhibit, or in any way prevent a representative of the Ombudsman Program from fulfilling his or her duties as specified under the Older Americans Act or state code to protect the health, safety, welfare and rights of a long-term care facility resident” (“Long-Term Care Ombudsman Program: A Summary of State Enabling Statutes,” 2002). The program’s legal counsel may be consulted when providers present challenges to an ombudsman’s right of access to the premises. Therefore, adequate and available legal representation for the Ombudsman Program is another significant element for accessing the authority of a long-term care ombudsman program. (“Long-Term Care Ombudsman Program: A Summary of State Enabling Statutes,” 2002)

Recognizing the critical importance of these three elements in an Ombudsman Program's ability to act on behalf of residents, we used these elements as assessment measures in our qualitative analysis of state enabling statutes between the six New England states.

### **Access to Residents, Facilities and Residents' Records**

An analysis of state enabling statutes pertaining to the access to residents, facilities and residents' records reveals that the states of Connecticut and Vermont provide more access than the state of Rhode Island's long-term care ombudsman program. In the enabling statute regarding access to facilities, Rhode Island's statute may be summarized as: "shall have access and enter facilities after notifying of presence." While the Rhode Island program must notify facilities of its presence, the statutes governing Connecticut and Vermont provide enforcement measures if a facility refuses access to a long-term care ombudsman program. The statute in Connecticut may be summarized as: "refusal of entry or access to residents subjects facility to penalty." The statute in Vermont may be summarized as: "LTC facilities shall provide access—may obtain access orders from judge if access denied." Thus, the programs in Vermont and Connecticut are provided more access to facilities than Rhode Island because their programs have recourse if denied access.

Another state enabling statute pertaining to a long-term care ombudsman program's rights of entry is the access to records. The Rhode Island provision regarding access to records may be summarized as: "shall inspect any books, files, medical or other records that pertain to resident & required by law to be maintained by facility." While Rhode Island is the only New England state that does not explicitly require "consent" or "written consent," Vermont permits the program to obtain access from a judge if access is denied by the facility. The Massachusetts statute also provides the program access to records of any public agency, including abuse complaints.

### **Willful Interference**

An analysis of state enabling statutes regarding willful interference shows that Rhode Island prohibits retaliation but does not specify a penalty or sanction related to interference with the long-term care ombudsman program. Rhode Island is one of seven states with enabling statutes containing provisions that prohibit discrimination or retaliation against a resident or other individual who files a complaint, provides information or in some other way cooperates with the ombudsman program. The following New England states have statutes explicitly containing such provisions:

- Rhode Island- interference provision summarized as "no provision— retaliation prohibited"
- New Hampshire- interference provision summarized as "no provision— discrimination & retaliation prohibited"

Rhode Island, however, is not one of the thirty-three states that have an enabling statute or regulation that addresses interference with an ombudsman's duties. Of such states, twenty eight states specify a penalty or sanction related to interference with the ombudsman program. The forms of penalty or sanction include civil, misdemeanor and monetary fines. A review of the enabling statutes for the New England states revealed that the following states include provisions:

- Connecticut- interference provision summarized as “willful interference by any entity subject to penalty for refusal to cooperate”
- Massachusetts- interference provision summarized as “no person shall willfully interfere— may petition court for injunction/relief”
- Vermont- interference provision summarized as “person intentionally hinders, subject to prison/fine”

Thus, while the state of Rhode Island prohibits retaliation against an individual who complains or provides information to an ombudsman program, Rhode Island does not establish any enforceable measures to penalize those individuals who engage in willful interference.

### **Legal Representation**

Our qualitative analysis on the legal representation provision between the six New England states’ state enabling statutes reveals that the Rhode Island program is entitled to much less legal representation and has no authority to assist residents in seeking remedies. Rhode Island is the only New England state not to have a provision outlining the role of the program in representing residents to seek remedies. Connecticut permits the facilitation of private legal action and both Maine and Massachusetts enable the program to assist residents in asserting their legal rights. Vermont’s statute permits the program to pursue administrative, judicial, and other remedies on behalf of residents.

Rhode Island’s state enabling statute also does not specify a provision on the legal representation of the office. Our review of the New England states finds the following:

- Vermont is one of two states that have statutes requiring the contracting agency to ensure provision of legal counsel. Vermont utilizes a legal services agency and Washington employs a private non-profit organization to provide legal counsel.
  - legal representation of office provision summarized as “statute requires contractee to provide legal representation and advice, if the State Ombudsman and ombudsman representatives are not state employees”
- Connecticut is the only state that requires the Attorney General and an independent legal counsel to represent the long-term care ombudsman program. Therefore, while other New England states provide long-term care ombudsman programs with access to legal counsel and the authority to seek remedies, Rhode Island’s statutes make no mention of legal representation.<sup>3</sup>

### **Conclusion**

Our research has found that the independent variable of staff rate is the only variable to have a direct effect on complaint rate and cases resolved. We demonstrated that the independent

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<sup>3</sup> Please refer to Appendix C

variable of spending per bed had an indirect effect on complaint rate and the independent variable of certified volunteer ombudsman rate has an indirect effect on cases resolved.

Our findings appear to support our hypothesis that the more resources available to the long-term care ombudsman program, the more effective the program. In particular, our data analysis reports that paid long-term care ombudsman staff has the strongest relationship with the dependent variable of complaint rate and cases successfully resolved to the satisfaction of the resident or complainant. The paid staff includes the state long-term care ombudsman, local long-term care ombudsman, and office staff. The role of the paid staff is to receive complaints, investigate cases, and resolve cases. For example, the state of Rhode Island has fourteen paid staff members, including the state long-term care ombudsman and eight ombudsmen. The critical importance of paid staff is reflected in the Older Americans Act, as it requires one staff person for every two thousand nursing home beds in the state.

We focused our analysis of the long-term care ombudsman program on the state of Rhode Island. Our qualitative analysis of the long-term care ombudsman programs in the six New States compared the measures of access, willful interference, and legal representation in relation to the Rhode Island program. We concluded that when problems with access arise, ombudsman programs need the tools to resolve these issues quickly. The tools include the authority of the program or some other entity to take action against providers that interfere with Ombudsman Program's ability to act on behalf of residents. Ombudsman programs also need access to legal counsel to provide support, guide, and necessary legal representation when such situations arise. Thus, after assessing the Rhode Island program in terms of the New England states' state enabling statutes, Rhode Island's program does not have as much authority as other states. Rhode Island's program does not have recourse if facilities deny access to residents and records, nor does it address willful interference or legal representation.

After assessing the limited capacity for the Rhode Island Long-Term Care Ombudsman Program to adequately resolve cases, we recommend that the Rhode Island state enabling statutes be amended to:

- Allow the long-term care ombudsman program to obtain access from a judge if access is denied by the facility
- Consider provisions that penalize those individuals who engage in willful interference (e.g. penalties, prison, fine) and allow the long-term care ombudsman program to petition a court for an injunction/relief
- Consider specifying a provision on the legal representation of the office

We also focused on the Rhode Island program by interviewing Paula Moreau, the volunteer coordinator for the Alliance of Better Long-Term Care.<sup>4</sup> Moreau emphasized the impact of certified volunteer ombudsman being in the nursing home because volunteers can deal with problems as they arise before there is a large enough issue to warrant a complaint. Another benefit of certified volunteer ombudsman is that residents feel safe and have a relationship with the volunteers so they feel more comfortable expressing their concerns. This is a positive aspect of the program because one of the objectives is to advocate in order to help the elderly in long term facilities.

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<sup>4</sup> Please refer to Appendix B

The Rhode Island program could be improved by increasing the level of power the certified volunteers have in the facility. They currently investigate cases and if they need information off the medical charts, a nurse or CNA (Certified Nursing Assistant) reads them the information. As Paula told us, this is a potential problem because nurses and other health care personnel can quickly change what actually happened by adding parts, or leaving out parts, of the medical chart. The reader will attempt to portray themselves in the best light and therefore will not disclose negative aspects of their behavior. If Rhode Island could change this current procedural glitch and allow the certified volunteers to have access if evidence supports the necessity to see records, the Office would run smoother and be more confident in the findings of the investigations.

We also asked Moreau what changes she would make to the program if the Office had more money. She responded that staff would be the most significant change because the more people the program has the more in depth they could go in their objectives. With more staff, the Office could go into facilities and look for areas that seem to be at a high risk. The program could also look at issues in facilities that pose potential hazards and have them corrected before a problem arises. Also, not all the facilities in the state have a certified volunteer assigned to them, and Moreau feels that the Certified Volunteer being a constant face in the facility provides a confidante for the residents and allows the Office to keep a better eye on what is going on.

Thus, our quantitative findings show direct correlation between staff rate and our measures of an effective program, complaint rate and cases resolved to the satisfaction of the resident or complainant. Our qualitative analysis of the New England states reflects the importance of the strength of a program to adequately resolve cases. Our conclusions demonstrate that the long term care ombudsman program staff and the strength of a program influence the effectiveness of a program. Our findings also apply specifically to Rhode Island because the state long term care ombudsman program could have more authority given to the program and could have a larger program staff in order to be more effective. Hopefully, this study will contribute to a greater understanding of the resources needed for an effective state long term care ombudsman program.

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