Ombudsman Philosophy

The Long Term Care Ombudsman Program is a resident focused advocacy program. The resident is always considered the client, regardless of who contacts the program. The Ombudsman must assist, represent, and intervene on behalf of the client only as mutually agreed upon between the client and the Ombudsman within the boundaries of the law. The Ombudsman will uphold his responsibility to act in situations involving vulnerable individuals. The Ombudsman carries out his advocacy role through the activity of providing information to assist in problem solving, and by promoting individual and group self-advocacy skills.

What is the Long Term Care Ombudsman Program?

Long Term Care Ombudsmen are advocates for residents of nursing homes, board and care homes, assisted living facilities and similar adult care facilities. They work to resolve problems of individual residents and to bring about changes at the local, state and national levels to improve care. While most residents receive good care in long term care facilities, far too many are neglected, and unfortunate incidents of psychological, physical and other kinds of abuse do occur. Thousands of trained volunteer Ombudsmen regularly visit long term care facilities, monitor conditions and care, and provide a voice for those unable to speak for themselves.

Created in 1972 as a demonstration program, the Ombudsman Program is currently established in all states under the Older Americans Act, which is administered by the Administration on Aging (AOA). Local Ombudsmen
work on behalf of residents in hundreds of communities throughout the country.

According to the AOA, approximately one thousand paid and 14,000 volunteer staff (8,000 certified) Ombudsmen investigate over 260,000 complaints each year. They provide information to more than 280,000 people on a myriad of topics including how to select and pay for a long-term care facility. The most common complaints involve lack of resident care due to inadequate staffing (www.aoa.gov, accessed 9/28/04)

**RESIDENTS’ RIGHTS**

Ombudsmen help residents and their families and friends understand and exercise rights that are guaranteed by law, both at the federal level and in many states. Residents have the right to:

- be treated with respect and dignity;
- be free from chemical and physical restraints;
- manage their own finances;
- voice grievances without fear of retaliation;
- associate and communicate privately with any person of their choice;
- send and receive personal mail;
- have personal and medical records kept confidential;
- apply for state and federal assistance without discrimination;
- be fully informed prior to admission of their rights, services available and all charges; and
- be given advance notice of transfer or discharge.

*Webster’s Dictionary* defines the Swedish word *ombudsman* as “a public official appointed to investigate citizens’ complaints against local or national government agencies that may be infringing on the rights of individuals.”
Historical Overview

NURSING HOME CARE: HISTORICAL BACKGROUND

Healthcare practices can be traced back to the very earliest history of mankind. In the 13th century B.C. the terms physician, nurse, medicine, and patient were first used. Over time, healthcare moved from medicinal watering holes, sacred groves and caves to religious temples in Egypt and Greece.

Various types of facilities for the aged and the sick were established in Asia, Southern Europe, and North Africa. However, the health care institutions of today apparently had their beginnings in 325 A.D. in the Roman Empire. Constantine I, who with his mother Helena had been converted to Christianity, wanted the sick, the poor, the lame, and the aged removed from the streets. Believing that Christians were the only people who kept their word and who could be trusted to do what they promised, Constantine authorized the Council of Nicea to direct the Christian bishops to build and operate health care facilities. Subsequently the bishops required that some type of hospitals be attached to each bishopric, cathedral, and monastery.

Early hospitals were financed by voluntary almsgiving. The practice of almsgiving was extremely popular since it was considered a guaranteed “ticket to heaven” for the donor. Alms were given for the benefit of the donor, not primarily to help the poor and the sick. The government did not give any financial support to the early hospitals, although Constantine did restore confiscated property to Christians so they could build facilities.

The hospitals were not hospitals as they are known today. Physicians did not practice in these institutions. The clergy and religious orders operated the hospitals and took care of the sick. They were not trained in health care, although they became proficient in dressing wounds and sores and in giving comfort to their patients.
Physicians first attended patients in health care institutions around 1850. With the many advances in science after 1875, these institutions truly became treatment facilities for the first time. Physicians used the hospital’s laboratory and other diagnostic facilities, operating rooms and treatment facilities. The poor, chronically ill, disabled and the aged who needed long term care were relegated to such care-giving institutions as almshouses and the workhouses first established in England. Once again, they were in facilities that only offered food and shelter and whatever human comforts the institution could afford. The able-bodied poor, or paupers, were required to work to provide relief for the disabled who had no relatives to provide for them.

The concept of almshouses and workhouses spread from England to America. Municipalities and communities farmed out to the lowest bidder the care of the poor and elderly who had no family to provide such care. Since America was largely rural, these facilities became known as poor farms. These institutions were run by municipalities, churches, or philanthropic organizations as a way of collectively meeting the needs of those who couldn’t provide for themselves. The “county poor farm” image developed as a result of this means of providing services. It still carries a very strong negative connotation for many elderly people receiving services today.

SOCIAL SECURITY ACT OF 1935-1965

The Social Security Act is indirectly responsible for the nursing home industry as it exists today. Social Security’s original and sole purpose was to provide a supplemental retirement for working people and their dependents. It also provided Old Age Assistance to needy people aged 65 and older who lived in the community. The Social Security Act prohibited Old Age Assistance money going directly to residents in public institutions. This signaled a beginning of the end for the public poor houses and provided a need for new alternatives for the aged without families who could care for them. From 1935 to 1960, private rooming houses, private institutions, church-sponsored, and other non-profit, institutions
and homes flourished and were paid for by the residents’ Social Security money. Many of the homes began employing nurses and physicians to care for the aged and chronically ill.\(^4\)

The origin of the term nursing home is not clear. In 1936, the Chicago area had an association of nursing homes. The Detroit area used the title nursing home in 1939. It appeared in the Illinois Legislature for the first time in 1945. The convalescent home was defined as a facility commonly called a nursing home by the Ohio Legislature in 1946.

In 1950, amendments to the Social Security Act extended Old Age Assistance to residents of public medical institutions (except tuberculosis and mental hospitals). This accelerated the exodus of older people. Many took up residence in boarding homes now that they could afford to pay for their support. These 1950 amendments required states to establish a standard setting or licensing agency for nursing homes. This gave official status to nursing homes as facilities to provide long term care.

The Kerr-Mills act of 1960 established medical aid to the aged to be administered by the states. It required a means test to ensure that funds went only to health care for the needy. The Kerr-Mills Act was the predecessor of Medicaid which began July 1, 1965.\(^5\)

The most important factor in the development of nursing homes today was the creation of the federal Medicare and Medicaid programs in 1965. Medicare is a federal insurance program for persons over age 65. Medicare will pay for skilled nursing home care on a limited basis. Medicaid is a medical assistance program for the poor, including individuals over age 65, the blind, the disabled and members of families with dependent children. It is financed by a federal-state partnership. The purpose of this legislation was to provide financial assistance to the poor and the aged so that they would receive adequate medical care, both in and out of an institutional setting. Due to the availability of federal funds to help pay for nursing home services, demand for these services increased dramatically.
GROWTH OF THE NURSING HOME INDUSTRY

While the proportion of elderly residing in nursing homes increased continually throughout the first half of this century, the advent of Medicare in the 1960’s followed by Medicaid brought an even greater growth to the nursing home industry. The outlay of federal dollars to support eligible seniors in participating homes far exceeded even the most generous projections.

A look at statistics reveals the size of the nursing home industry:

- One of the initial inventories of the nursing home industry was done by the Bureau of Census in 1939. It counted 1,200 facilities with 25,000 beds. By 1960, there were 9,600 homes with 330,000 beds. In 1970, there were 23,000 facilities with 1.1 million beds. By 1980, there were 30,000 facilities with 1.5 million beds.

- It was estimated that by the year 2000, there would be 2.8 million nursing home beds; but with the expansion of home health care in the 1980’s, there were only 1.8 million beds, with only 87%, or 1.5 million filled.

- The nursing home industry, with $27.3 billion in revenues in 1984, was the fastest growing major segment of the health care field. By 1996, the total cost of nursing home care soared to $78.5 billion.

- For-profit corporations owned or controlled 80% of the nation’s nursing homes in 1984, and by 1997, ownership had dropped to 66%.

- There are more nursing home beds in the United States than general and surgical beds;

- There are more than three times as many nursing homes as hospitals; and

- More in-patient days of care are given in long term care facilities than in short term general hospitals.
In addition to the enormous impact of Medicare and Medicaid, more than 50 federal programs have aided the nursing home industry. The Department of Health and Human Services has trained nurses, stimulated research projects, and provided funds for the construction of nonprofit homes. The Department of Agriculture assists through its commodities program. The Department of Housing and Urban Development insures loans for the construction of nursing homes. The Small Business Administration issues loans to commercial homes. The Veterans Administration provides nursing services to veterans.

There are a number of reasons why nursing homes have flourished in the past twenty years. First, the number of people reaching age 70 or greater has increased dramatically. Life expectancy has continued to increase. Health care professionals have devoted greater attention to the physical process of aging, as well as, the psychosocial aspects of aging. Increased standards of living, availability of better care and improved technology for diagnosis and treatment are in part responsible for individuals living longer.

The decline of the extended family unit is also in part responsible for the growth of long term care facilities. Society today is increasingly mobile, with children often living great distances away from parents. The number of women in the work force has also increased dramatically during this time period, leaving no one in the home to assume the role of full-time caretaker.

The high cost of in-home health care also becomes a factor in the capacity of families to care for aging parents.\(^6\)

In addition, immigration patterns and mid-20th century baby booms followed by decreasing birth rates have and will continue to result in an expanded population of senior citizens.
QUESTIONS OF QUALITY OF CARE

The nursing home industry in this environment grew dramatically with little direction or regulation. Many operators were well-meaning but misinformed; some unscrupulous homes did indeed swindle their residents and poor care resulted in some deaths. Unfortunately, the opportunists and some of the more aggressive dishonest operators gave the industry a bad reputation. A climate of mistrust and misunderstanding that is still prevalent today developed between the industry and consumers.

In the late 1960’s and early 1970’s, there were many publications written about abuse, neglect and substandard conditions in nursing homes. Several congressional committees convened to hear testimony, compile data and propose reforms for the nursing home industry.

Robert Butler illustrates this neglect:

Hearings before the United States Senate on February 26, 1970, brought out the fact that it was the carpeting in a Marietta, Ohio, nursing home that speared the flames in the January 9th fire that resulted in the deaths of 32 of 46 patients from asphyxiating from the acrid, deadly smoke.

Twenty-five residents of a commercial Baltimore nursing home died in a salmonella food poisoning epidemic in August, 1970 after delays in seeking medical help. When twelve patients had died, the Washington Post stated that “in a telephone interview, Gould [the owner] complained about the focus of the news media on the 12 deaths over the weekend, saying “is it really that big?”

Ample publicity attesting to poor care and personal profit for owners created a climate in which more rigid federal regulations for standards of care were enacted in the early 1970’s.

PRESIDENT NIXON’S EIGHT POINT INITIATIVE

As a result of a 1971 directive by President Nixon, the Health, Education and Welfare Department (HEW) established a new office to oversee all HEW programs relating to nursing homes. The Office of Nursing
Home Affairs (ONHA) was to be responsible for coordinating efforts by different agencies in the department to upgrade standards nationwide for the benefit of nursing home patients. Establishment of ONHA and the appointment of Mrs. Marie Callender as its head presumably meant that for the first time a single official was responsible for pulling together different HEW nursing home efforts into a single coordinated program. Two hundred twenty-seven (227) new personnel were added to federal enforcement. Furthermore, President Nixon formulated an eight-point nursing home program, announced in 1971.

1. Training of 2,000 state nursing-home inspectors.
2. Complete (100 percent) federal support of state inspections under Medicaid.
3. Consolidation of enforcement activities.
4. Strengthening of federal enforcement of standards.
5. Short-term training for 41,000 professional and paraprofessional nursing home personnel.
6. Assistance for state investigative “Ombudsman” units.
8. Crackdown on substandard nursing homes: cut-off federal funds to them.\(^8\)

By January, 1974, there was five-day registered-nursing coverage (but no medical director) for Intermediate Care Facilities (ICF). In December, 1974, came approval of significant regulations for skilled nursing facilities, including a “patient’s bill of rights,” a medical director (as of January 1, 1976), a registered nurse seven days a week and a discharge planning program. More than half a million dollars in contracts to test Ombudsman programs for patients in nursing homes were awarded by HEW in 1972.\(^9\)

In summary, the rapid growth of nursing homes and a concern for the quality of care and quality of life experienced by the residents of these facilities were in part responsible for the creation of the nursing home Ombudsman programs that exist today.
LTCOP HISTORY

The Long Term Care Ombudsman Program was initiated by former President Nixon through his 1971 Eight Point Initiative to improve the quality of care in America’s nursing homes and to respond to complaints submitted to the White House and the Department of Health, Education and Welfare about abuse and neglect of nursing home residents. President Nixon directed HEW “to assist the States in establishing investigative units which would respond in a responsible and constructive way to complaints made by or on behalf of individual nursing home patients.”

An interdepartmental task force was formed under the direction of the Health Services and Mental Health Administration to develop models for investigative/ombudsman units; and in the Supplemental Appropriations Act of December, 1971, Congress made funds available for the establishment of nursing home Ombudsman demonstration projects.

On June 30, 1972, five contracts were awarded by the Health Services and Mental Health Administration. Four were with State Governments to establish a State level office linked to a local unit. The States were Idaho, Pennsylvania, South Carolina and Wisconsin. A fifth contract was awarded to the National Council of Senior Citizens to test the effectiveness of an independent nursing home ombudsman project operating outside government jurisdiction and to assess the feasibility of linking of national voluntary organization to State and local units. The National Council selected Michigan as the site of their demonstration.

Additional projects were started in Massachusetts and Oregon in July of 1973, increasing the total number to seven projects.

Funding levels for the project were:

- Idaho: $161,067 for 3 years
- Massachusetts: 92,564 for 2 years
- Oregon: 60,000 for 2 years
- Pennsylvania: 270,000 for 3 years
- South Carolina: 191,250 for 3 years
In 1973 the Health Services and Mental Health Administration was reorganized, and the Nursing Home Ombudsman Program was transferred to the Administration on Aging (AOA). Assignment of the program to AOA was consonant with the Commissioner on Aging’s responsibility for serving as an advocate for older persons.

An impressive record of complaint resolution was submitted by the demonstration projects in quarterly reports and program assessments provided at the end of the demonstration period. Other prominent program accomplishments included the identification of problems related to long term care and bringing them to the attention of the public, agencies, and providers; a variety of changes in nursing residents; the interjection of the needs and perspectives of residents into the deliberations of policy makers; and the design, organization and implementation of training programs and informational forums for the public and for staff of nursing homes. Details of these accomplishments can be found in an assessment of the ombudsman demonstration projects available from AOA.

In May of 1975, former Commissioner on Aging Arthur S. Flemming invited all State Agencies on Aging to submit proposals for grants “to enable the State Agencies to develop the capabilities of the Area Agencies on Aging to promote, coordinate, monitor and assess nursing home ombudsman activities within their service areas.” The primary goal of the program was to inaugurate in as many areas as possible community action programs dedicated to identifying and dealing with the complaints of older persons, or their relatives, regarding the operation of nursing homes.

One year grants ranging from $18,000 in most states to $57,900 in the state with the then largest elderly population (New York) were made to the State Agencies on Aging which submitted proposals designed to meet this goal.
All states except Nebraska and Oklahoma received grants the first year and hired a nursing home ombudsman developmental specialist, frequently working out of the State Office on Aging.

In a technical assistance memorandum dated January 13, 1976, the AOA recommended approaches to State and Area Agencies on how to develop the State and sub-state programs. This memorandum stated, “The success of this effort in the first year will be judged solely on the basis of the number of community action programs (community-based ombudsman programs) that are launched and the effectiveness of these programs in receiving complaints and then resolving them in an effective and constructive manner.”

In expanding this goal, Commissioner Flemming stated,

> Our nation has been conducting investigations, passing new laws and issuing new regulations relative to nursing homes at a rapid rate during the past few years. All of this activity will be of little avail unless our communities are organized in such a manner that new laws and new regulations utilized to deal with the individual complaints of older persons who are living in nursing homes. The individual in the nursing home is powerless. If the laws and regulations are not being applied to her or to him, they might just as well not have been passed or issued.

The program from 1975 through 1978 was a departure from the demonstration program in two particularly significant ways:

1. Where the demonstration program had focused on complaint resolution from one (and in some cases two or three) central points in the State, the 1975-78 program stressed development of local/area programs throughout the State.

2. Where the directors of the demonstration projects had been called ombudsmen and had worked directly on complaints, the individuals hired under the 1975-78 grants were designated “ombudsman developmental specialists,” and were charged by AOA with de-
veloping sub-State programs, rather than working directly on complaints.

In addition, the early nationwide program stressed reliance on volunteer, rather than paid, Ombudsmen.

These changes in approach were made because the AOA believed that locally-based complaint resolution and resident advocacy programs would provide the most effective services to those who needed them. The demonstrations had indicated that a small staff operating an ombudsman program out of one central location in a State would have great difficulty in responding to the volume and variety of needs of individuals throughout the State. Given the limited funding available, the “developmental” approach was seen as the only means by which the goal of statewide ombudsman coverage could be attained. This approach was to have a significant impact on the direction of the program after passage of the ombudsman legislative mandate in 1978.

THE OMBUDSMAN PROGRAM AND ADVOCACY ASSISTANCE

In June of 1978, AOA Commissioner Benedict announced that he was combining the Ombudsman and legal services efforts into a common framework “in order to maximize their interrelationship, improve coordination, and more effectively deal with the concerns of institutionalized and non-institutionalized vulnerable elderly.”

To support this effort, AOA made available to State Agencies on Aging model projects grants ranging from $50,000 for most States to $135,390 for California, the State with the largest number of older persons.

In addition to providing continuing support for the State’s Ombudsman and legal services development activities, the advocacy assistance grants were intended to assure more legal back-up for the Ombudsman program in particular, and for dealing with the problems of the institutionalized elderly in general and to encourage the increased use of advocacy by non-lawyers to serve the elderly. The focus was both on advocacy for
individual older persons (personal advocacy) and advocacy that affects large numbers of older persons (issues advocacy).

These grants were continued at the same level of funding in 1979 and 1980. The 1980 guidelines (for FY ‘81; See AOA-PI-80-15) provided considerably more focus on the development of the Ombudsman and legal services programs as required in the 1978 Amendments to the Older Americans Act than had the guidelines for the two previous years.

To support the State and Area Agencies and other community agencies and organizations in carrying out their advocacy functions, AOA awarded contracts in 1979 and 1980 for five Bi-Regional Advocacy Assistance Resource and Support Centers and a national center. Under these awards, the contractors have provided training for State and local advocacy programs and technical assistance in the design and implementation of advocacy delivery systems, including statewide Ombudsman programs and resource and support services on legislative and administrative advocacy and litigation.

Also in 1979, AOA awarded a grant to the National Citizens’ Coalition for Nursing Home Reform to promote and organize citizen involvement to improve the quality of life for nursing home residents. One of the objectives of the grant was to strengthen and maintain Coalition linkages with the Ombudsman network. In its activities to meet this objective, the Coalition provided considerable information and technical assistance to those involved in the Ombudsman Program and training for local Ombudsmen.14

THE OMBUDSMAN PROGRAM UNDER THE OLDER AMERICANS ACT

The 1978 Amendments to the Older Americans Act, passed in October 1978, considerably strengthened the Ombudsman Program. Title III, Section 307(a) (12) required every State to have a program and specifically defined Ombudsman functions and responsibilities.
The 1978 Amendments to the Older Americans Act elevated the Nursing Home Ombudsman Program to a statutory level. The statute and subsequent regulations required all state agencies on aging to establish an Ombudsman program which would carry out the following activities.

- Investigate and resolve long term care facility residents’ complaints;
- Promote the development of citizens’ organizations and train volunteers;
- Identify significant problems by establishing a statewide reporting system for complaints, and work to resolve these problems by bringing them to the attention of appropriate public agencies;
- Monitor the development and implementation of federal, state, and local long term care laws and policies;
- Gain access to long term care facilities and to residents’ records;
- Protect the confidentiality of residents’ records, complainants’ identities, and Ombudsman files.

The 1981 reauthorization of the Older Americans Act resulted in a further expansion of Ombudsman duties. In addition to nursing homes, personal care homes were included in the Ombudsman realm of responsibilities. The name was changed from the Nursing Home Ombudsman Program to Long Term Care Ombudsman (LTCOP) to reflect this change. Other duties remained substantially the same.

The 1987 Amendments to the OAA made substantive changes related to the Long Term Care Ombudsman Program resulting in a significant improvement in the program’s ability to advocate on behalf of residents of LTC facilities. The changes required states to provide for:

- Ombudsman access to residents and residents’ records.
- immunity to Ombudsmen for the good faith performance of their duties.
prohibitions against willful interference with the official duties of an Ombudsman and/or retaliation against an Ombudsman, resident, or other individual for assisting the Ombudsman program in the performance of their duties.

SUMMARY

From President Nixon’s pronouncements in 1971 to the Ombudsman Program’s reauthorization in 1987, the program’s purpose has remained constant: to represent the needs and interest of present and potential long term care facility residents. Within that overall purpose, however, the role of the State Ombudsman has changed considerably:

- The model projects’ Ombudsman was a sort of lone ranger, investigating residents’ complaints, examining systemic problems, and working to resolve problems in the long term care system.
- When the State Ombudsman became an Ombudsman developmental specialist, he became primarily an administrator and program developer, while a growing number of local programs arose to investigate individuals’ complaints.
- When Congress mandated the program through the Older Americans Act, the State Ombudsman retained his program development responsibilities but was again directed to investigate complaints and to identify significant problems in the long term care system.

LTCOP HISTORY IN NEW YORK STATE

The New York State Long Term Care Ombudsman Program (LTCOP) provides opportunities for residents of long term care facilities and their families to voice problems and concerns that have an impact on their quality of life and care. In 1975 the program became operational with continuing one year grants from the Department of Health, Education and Welfare, and became permanent in 1977. There are now 51 substate Long Term Care Ombudsman programs serving 59 counties in New York State.
The structure of the program has six interrelated parts:

- The volunteer Ombudsman
- The sponsoring agency (usually an AAA)
- The Local LTCOP Program Coordinator
- The Assistant State Ombudsman
- The State Ombudsman
- The New York State Office for the Aging

The specific goals of the program are:

- To integrate volunteers, advocacy groups, residents, resident families, health and social welfare professionals, and facility staff and administrators into an effective working relationship that will insure the quality of life for all residents of long term care facilities. To insure that all resident’s rights are maintained.

- Administrative grants are issued to all Substate Programs, generally bound by the geographical confines of each county in New York State. Individual programs determined the distribution of funds for paid staff, as well as volunteer trainings and in-services.

**Program Highlights**

1977 New York State Office for the Aging (NYSOFA) establishes the program and appoints a State Ombudsman Specialist. The first local programs established are Ulster and Greene counties, in that order.

1978 Amendments to the Older American’s Act (OAA) elevates the program to statutory status and changes the name of the program from the Nursing Home Patient Ombudsman Program to the Long Term Care Ombudsman Program. The program was now mandated to the states that chose to receive any funding from the OAA.
1981  Amendments to OAA provide mandate to serve Adult Care Facilities.

1981  NYSOFA hires three regional Ombudsmen for the purpose of expanding the Ombudsman Program.

1987  Amendments to OAA provide for immediate access to residents and their records. Also provided for immunity to Ombudsman for the good faith performance of their duties.

1992  Amendments to the OAA transfers the program to a new title, VII, Elder Rights.

1993-94  Ombudsman Program funded under Title VII and IIIB.

1994  Paul Vanas Award established. Sharon Boyd of Monroe County becomes the first recipient.


1995-96  Federal requirements for Ombudsman Program codified into NYS Law.

1999  First State Funding Appropriation to the Ombudsman program.

2002  The final local program established through the Red Cross of North Eastern New York in Albany providing services to residents of Albany, Schenectady, and Montgomery counties.
Chronology of Counties with Established LTCOP Programs

Ulster 1977
Greene 1977
Westchester 1978
Saratoga 1978
Rensselaer 1978
Columbia 1978
Wayne 1978
New York City 1978
Monroe 1978
Oneida 1978
Rockland 1979
Steuben – 1980
Montgomery 1981
Dutchess – 1982
Niagara – 1982
Chenango – 1982
Wyoming – 1982
Seneca – 1982
Genesee – 1982
St. Lawrence – 1982
Schuyler – 1982
Orleans – 1982
Cattaraugus – 1982
Erie – 1983
Yates – 1984
Ontario -1984
Nassau – 1985
Jefferson – 1985
Chautauqua – 1985
Chemung – 1986
Allegany – 1986
Livingston – 1986
Cayuga – 1987
Warren/Hamilton – 1987
Suffolk – 1989
Fulton – 1990
Lewis – 1990
Onondaga – 1991
Franklin – 1992
Broome – 1992
Ostego – 1993
Schoharie – 1993
Essex – 1994
Madison – 1994
Putnam – 1994
Cortland – 1995
Tompkins – 1995
Tioga – 1997
Clinton – 1998
Herkimer – 1998
Orange – 2001
Sullivan – 2001
Delaware – 2001
Albany – 2002
Schenectady – 2002
Montgomery - 2002
The Role of the Ombudsman

The role of the Ombudsman is governed by two basic principles:

1. **There can be no conflict of interest for a Long Term Care Ombudsman.**

   An Ombudsman cannot be employed in any capacity by a long term care facility. An Ombudsman cannot have direct commercial dealings with long term care facilities. Having a relative or friend as a resident in a long term care facility is not a conflict of interest as long as the Ombudsman is not assigned to that facility. Please inform your coordinator whenever you have a relative or close friend in a long term care facility, and your assignment will be arranged accordingly.

   An Ombudsman cannot accept gifts, gratuities, or remuneration of any kind, including meals. Avoid lunch rooms for family meetings where someone might want to buy you coffee or food. Always graciously decline.

2. **Long Term Care Ombudsmen are unique. Often people do not understand our role, so they try to fit us into something that is familiar to them such as a friendly visitor or volunteer for the facility**

   The term friendly visiting is frequently used to describe the time volunteers spend establishing rapport. Ombudsmen do not perform as a friendly visitor for the facility. We do not run errands for patients or staff. For example, Ombudsmen do not bring in yarn for crafts, do not write letters for residents or buy them newspapers. If an Ombudsman sees the need for someone to write letters for a resident, etc., he can mention that need to the contact person, or suggest volunteer groups that may perform these tasks if called upon. Remember, every person who comes into the life of a resident expands that resident’s world. If an Ombudsman did assume responsibility for writing a letter, it would limit the opportunity for someone else to visit that resident.
It is easy to reason why Ombudsman do not want to be perceived as workers or volunteers for the facility. Residents and their families have to feel free to speak with an Ombudsman knowing that she will maintain confidentiality, that there is no need to fear reprisals for complaining or vocalizing issues, and that Ombudsmen are neutral and can be trusted to remain so.

- **Ombudsmen do not provide hands on care**
  - Do not push wheel chairs.
  - Do not help with meals, beverages, etc.
  - Do not help people take medicine.

*Note:* If an Ombudsman were ever sued for performance of Ombudsman duties, the State could not provide for a defense if the Ombudsman had acted outside of the job description.

- **Ombudsmen do not volunteer for the facility.**
  - Do not lead sing-a-longs.
  - Do not run errands, etc.

An Ombudsman may volunteer, but not be employed, at a facility that she is not assigned to as an Ombudsman. For instance, a volunteer can be an Ombudsman at Happy Days Nursing Home, but can volunteer to play the piano at the Golden Hours Adult Home.

- **Ombudsmen are not part of the facility staff.**
  - Do not join the staff in coffee gatherings.
  - Do not eat food at the facility unless we pay for it.
  - Do not get sociable with the staff.

The Ombudsman may eat refreshments provided by the facility if it is at a function for the general public.

*To help residents remember you, try wearing the same outfit for several visits. You might be remembered as the man in the yellow shirt. Long Term Care Ombudsmen must wear their badge at all times.*
3. **Confidentiality is the cornerstone of the Ombudsman Program.**

*There must be no fear of reprisal or loss of dignity for the resident.*

- The Ombudsman must always ask permission to use the resident’s name. If the resident doesn’t give permission, do not divulge his or her identity. Sometimes this means you can not continue resolving the case.

- It may be more effective, in some cases, to speak in generalities. For instance, you have observed the same situation:

  - “I’ve noticed that many people are leaving most of their dinners uneaten. I’ve talked to several people and they tell me the food is cold.”

- Or, when talking to the resident the next week, when perhaps he is more confident of you, he may say you may use his identity.

However, even if the resident refuses to consent to share information, state regulations specifically require the Ombudsman to report complaints or suspected issues of physical abuse, mistreatment or neglect as defined in the Public Health Law. When complying with the requirement to report abuse, Ombudsmen are not required to disclose the identity of the complainant or resident except under conditions outlined in section 712(d) of the Older Americans Act.

These regulations also permit an Ombudsman to share file/record information about a complaint or issue with the Department of Health, even without consent of the resident. This regulatory language authorizes the “referral of information contained in the record to any agency which licenses, investigates or regulates the facility in which the patient or resident resides.”

Note that while the incident of abuse itself must be reported, this reporting requirement does not override the protection of the resident’s identity as set out in the OAA and state regulations.
**Resident Protection**

- Please be very careful with your notes and keep them in a secure place. The files are kept locked in the Ombudsman Program office. Only the coordinator and the Ombudsman involved have access to a file.

- Do not discuss your work with anyone (including family) outside of the Ombudsman Program.

- Never discuss one resident with another, not even in general terms. This compromises the trust and confidence placed in your by the resident.

4. **The Ombudsman volunteer maintains a professional attitude.**

   **Example:** Mrs. Jones has had her call bell on for fifteen minutes and no one has answered. What will the reaction be if you storm up to the nurse’s station and ask what people are doing and don’t they know that there is an old lady waiting for someone to take her to the bathroom?

   First ask Mrs. Jones if she would like you to get someone to help her. Then state the facts as you know them. “I have been with Mrs. Jones for the last fifteen minutes. She has had her call light on for that entire time and needs someone to help her to the bathroom.” If there isn’t an immediate response ask, “When will someone be there?” If there isn’t a response soon, go back and repeat what has happened; you may have to go to the charge nurse. By all means let your contact person know about the length of time before the bell was answered. (Being short staffed is not our problem; it is a problem of the facility.)

- An Ombudsman does not promote his own political or religious views.

- An Ombudsman does not distribute political or religious material.

- An Ombudsman does not sell or purchase raffle tickets in the long term care facility.
Treat staff as professionally as you wish to be treated.

Never interrupt a staff person at the facility unless it is an emergency. Instead, ask when would be a good time to talk with that person about a concern. If the staff person has a secretary, set up an appointment or leave a note saying that you will call to set up a time to talk. Do not stop staff in the hall and then proceed to discuss a case. You may say something like, “Hello, Mrs. Smith. I’ll be calling you later today to set up an appointment to discuss some concerns.” Or, “Hello, Mrs. Smith. I really need to speak with you for a few moments today. When would be a good time to stop by your office?”

5. **The Ombudsman does not give information to the media or those in political office.**

When there is a situation that makes the news, you might be contacted by the media or an elected official. You do not give interviews about facilities or cases. Ask the newspaper, TV station, or Senator’s office to call your supervisor. Your supervisor will not discuss the case either, but will tell how the Ombudsman Program operates. If the media or politician is persistent, your supervisor will ask him to call the State Ombudsman.

Sometimes you might be interviewed about your role as a volunteer. That is fine. Talk about the Ombudsman Program in generalities. Explain your role. Explain the benefits to you and to the residents. Explain how anyone interested can learn more about the Program.

6. **The Ombudsman is non-judgmental.**

Ombudsmen are not asked to decide if the resident is right or wrong. If the resident has a complaint, you are to investigate to verify that there is a complaint. Then do your best to resolve the complaint or concern.

If an Ombudsman is in a situation that is difficult for him or her, seek assistance from the coordinator. For example, the resident may have refused to take nutrition. That is his right. You are his advocate in this decision. Your responsibility is to be sure that the resident has been fully informed.
in terms he can understand of the consequences of his decision, and then to advocate for his wishes being carried out. If you have difficulty in this situation, ask your coordinator for help or reassignment.

Sometimes you will be working with a person who may not be the most pleasant individual you have encountered. You do not have to take verbal abuse, but you must advocate for her to the best of your ability. State that you find the language offensive and you can return at a better time to hear about his problem.

Remember, Ombudsmen investigate for facts and use facts as the base for developing a workable solution for all problems.

7. What does an Ombudsman do?

Ombudsmen:

- Establish rapport with residents. This takes time and patience, good listening skills and empathy.
- Respect privacy. Always knock and ask permission before entering a room.
- Respect the dignity of the individual. We do not use first names unless invited to do so. Never call someone “Hon,” or other familiar terms.
- Follow the wishes of the resident. If the resident does not give permission to investigate or to contact people, do not!
- Verify and check things out. It may take an hour, a week or months. Ombudsmen are persistent.
- Investigate. In all investigations confidentiality is preserved. Facts are discovered.
- Involve the resident as much as possible in the problem solving process. Ask the resident what he wants as the next step and what he can do to help solve the problem. Ombudsmen do not decide what is best for the resident. Work to empower the resident and
build his self-esteem. Urge the resident to speak up for himself, offering to accompany him if he will be present to verify that what you are saying is correct. This may not always be possible.

- Maintain and preserve the confidentiality of the resident. Seek permission to reveal her identity. Whenever possible, general groups are mentioned, (i.e. many people have commented on the food being cold).

- Are professional, courteous, and friendly. Utilize the contact person at the facility except in cases when immediate attention is sought.

- Are impartial observers, skilled interviewers, educators, advocates, and mediators.

- Are very special people linking an often isolated population to the community. You are ears to listen, eyes to see, and a voice for those no longer heard.

Thank you for caring.
Responsibilities

Ombudsman responsibilities are outlined in Title VII of the Older Americans Act. The responsibilities outlined include:

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

By its very nature, Ombudsman advocacy involves working with the most frail nursing and board and care facility residents. Often, questions are raised about the capacity of such physically frail residents to make informed decisions about their care, where they will live, and how their money will be spent. In addition, long term care residents sometimes have someone who acts as a legal representative on their behalf, such as a guardian, power of attorney, or even a family member. The types of problems Ombudsmen might encounter in this arena include: questions about a resident’s capacity to make decisions; facility staff making decisions for a resident whose capacity to make decisions is questioned but who has no family, friend or appointed decision-maker to act on her behalf; concerns about a legal representative’s activities; and conflicts between a resident and her legal representative.

- If the facility and the resident are in conflict over the resident’s wish to go home or the resident’s decision not to take medication or accept a particular course of treatment, questions are sometimes raised about the resident’s capacity to make decisions.

In such situations, the resident may ask the Ombudsman for help to fight a family member’s or the facility’s efforts to have a legal representative appointed to make decisions for her. Such cases are a fundamental part of the Ombudsman’s advocacy in the resident’s rights arena. In these cases, the Ombudsman’s actions would include working to ensure that the resident’s functional strengths are thoroughly assessed, that all options for meeting the resident’s care needs are explored, and that the resident is connected to community case managers and service providers, as appropriate.

- If the resident appears to lack capacity to make decisions, the facility may act in what it considers the resident’s best interest because no one is available to serve as a surrogate decision-maker.
In these situations, the Ombudsman should first work to ensure the resident’s functional strengths are assessed and facilitate the resident’s active involvement in decision-making to the greatest extent possible. If it appears the resident needs someone to act for her, the Ombudsman should advocate for the appointment of someone other than facility staff to make decisions for the resident.

- Complaints about a legal representative’s activities include complaints alleging the guardian or other legal representative:
  - is not paying for nursing home or other care;
  - is using the resident’s personal needs allowance or other funds inappropriately;
  - does not visit or fails to monitor the resident’s care;
  - verbally, physically or sexually abuses the resident;
  - does not try to ascertain the resident’s wishes or preferences in given situations;
  - fails to respect the resident’s rights to dignity, privacy and choice;
  - fails to help the resident maximize decisionmaking.

Such cases may require the Ombudsman to work with the resident’s legal representative, public and private providers of guardianship services, entities which monitor the performance of guardians or other legal representatives, and other programs which have the authority to intervene, including Adult Protective Services, the Social Security Administration, and the courts.

- A resident’s wishes may be in conflict with the legal representative’s decisions, such as the decision to place/keep her in the nursing home.

Ombudsmen may be embroiled in conflicts between a resident and her legal representative or the legal representative and the facility. These
situations often hinge on whether or not the resident needs a legal representative at all. Sometimes they involve personality conflicts that might be resolved by the appointment of someone else to act as the resident’s legal representative. When these conflicts involve multiple family members or major differences over what the resident would have wanted in the circumstances, Ombudsmen may find themselves trying to determine who speaks for the resident.

Situations such as those described above are usually complex, requiring the Ombudsman to utilize all his skills as a trained observer, skilled negotiator and problem solver. They cut to the heart of the program’s advocacy mission to act on behalf of the most vulnerable elders.

**WHAT OMBUDSMEN NEED TO KNOW ABOUT LEGAL REPRESENTATIVES**

*Definitions*

Basically, there are two types of legal representatives: involuntary surrogate decision-makers, such as guardians, and voluntary representatives, such as agents appointed under powers of attorney. The term legal representative will be used throughout this document to include legal guardians, as well as other types of arrangements whereby an agent is given authority to make decisions on a resident’s behalf.

Legal representatives with whom Ombudsmen may come in contact include: guardians, agents appointed under financial powers of attorney, representative payees, and agents appointed under health care advance directives such as medical powers of attorney and living will statutes. Other “representatives” might include individuals who sign the nursing home admissions contract on the resident’s behalf, and family members and friends who make decisions for the resident, even though the resident has not signed any legal documents nor has she been adjudicated incompetent or incapacitated. To further complicate matters, a resident might have one or more legal representatives, i.e., a resident could have...
a court-appointed guardian of the person and a representative payee who handles her Social Security check.

- A guardian is appointed by a court of law to make financial and/or personal decisions for an individual found by the court to be incapable of making informed decisions. Other types of surrogate decision-makers usually recognized in state law include:
  - Agents appointed under financial powers of attorney. These arrangements are made voluntarily by an adult who appoints an agent to act on her behalf, usually to handle financial matters.
  - Agents appointed, under health care proxy and living will statutes. These arrangements are made voluntarily by an adult who appoints an agent to act on his/her behalf, usually to handle specific kinds of health care decisions.
  - Durable powers of attorney specify that the appointed agent is authorized to continue making decisions for the individual in the event she becomes incapacitated.
  - In some states, health or mental health care consent laws identify a priority list of persons, including specified family members, who are empowered to act as surrogate decision-makers under particular circumstances, usually when consent to health or mental health care is needed. Such laws usually require an assessment process to be used to ascertain the person’s capacity to make specific informed decisions.
  - Springing powers of attorney are durable powers of attorney which do not become effective until some specified future event occurs. One such “trigger” might be the individual becoming incapacitated to make decisions, as certified by two physicians,
The role of legal representatives is recognized in federal law in the Social Security Act and the Nursing Home Reform Act of 1987 (OBRA), as well as in the Older Americans Act.

- The Social Security Act defines the circumstances under which a representative payee may be appointed to handle financial decisions for a beneficiary, which include when convincing evidence is presented indicating that the beneficiary is mentally or physically unable to manage her benefit check. Beneficiaries with a primary diagnosis of alcohol or drug addiction are required to have a representative payee.

- Residents’ rights regulations implementing OBRA in long term care facilities recognize the role of “legal surrogates” or “legal representatives” in exercising the rights of residents unable to act on their own behalf.

**SOURCES OF INFORMATION**

It is not necessary for Ombudsmen to be experts on guardianship or laws which govern the appointment of legal representatives. However, since Ombudsmen often handle complaints on behalf of residents who have guardians or other legal representatives, it is important for Ombudsmen to have a broad understanding of how legal representatives are appointed, and know where to go for more information as the need arises. Because the appointment of legal representatives is primarily governed by state law, it is important for Ombudsmen to get information from attorneys with expertise in this arena. In order to learn how surrogate decision-making works in New York State. Specifically, Ombudsmen are advised to:

- Consult program policies on handling complaints and accessing records when guardians and other legal representatives are involved.

- Get information on guardianship and other legal representative arrangements from the courts and other attorneys with expertise, including: legal service providers funded under the Older
Americans Act and the Legal Service Corporation; the protection and advocacy agency; State Bar Sections or Committees such as probate and estate committees; and private attorneys who specialize in elder law.

- Develop a relationship with agencies and programs involved in guardianship and legal representative services, including attorneys and service providers, in order to: educate stakeholders on the Ombudsman’s approach to advocacy; create a process for making referrals when residents need legal advice and/or representation; and develop resources for training Ombudsman staff and volunteers on legal representative issues.

**STAFF TRAINING**

Ombudsman Programs should consider including in their training curricula for new staff and volunteers basic information on the state’s laws regarding guardianship and legal, representative arrangements. If staff education is already being provided on ethical issues which Ombudsmen face, it would be appropriate to include in that training a discussion of complaint handling and consent issues which may arise when the resident has a legal representative. Ideally, legal services providers, State Bar Associations, providers of guardianship services, Adult Protective Services Programs, state guardianship associations, and other experts should be invited to assist the Ombudsman Program develop the training.
Record Access

Ombudsmen are provided legal rights to have access to medical and other records where necessary to protect the health, safety and rights of residents of long term care facilities. Records access is only to be used for the purpose of resolving complaints and should be used only when clearly necessary to achieve resolution of an issue. All other methods for complaint resolution must be attempted before record access is used.

Once determination has been made to access a resident’s records, the Ombudsman should follow accepted procedures for seeking records access, including but not limited to obtaining written authorization from the resident or legal representative, advising them of the reason for the record review and assuring them that the information will be held in confidence by the Ombudsman and used only for the specific purpose listed on the consent form used. A Records Access Authorization Form is located in the Appendix.

In order to qualify for record access rights, a Long Term Care Ombudsman must be additionally designated as a records access Ombudsman. This designation is awarded upon completion of the record access training program. The training program is designed to impress upon the participant the value, purpose and confidentiality of medical and personal records; familiarize the participant with the operation of longterm care facilities; and deal with the medical and psychosocial needs of residents in such facilities.
Code of Ethics

Regardless of an Ombudsman’s level(s) of advocacy effort, or the complexity of the issue/problem addressed, there is a basic set of principles which guide an Ombudsman’s decisions. The National Association of State Long Term Ombudsman Programs developed the following Code of Ethics for Ombudsmen.

- The Ombudsman provides services with the respect for human dignity and the individuality of the client unrestricted by considerations of age, social or economic status, personal characteristics or lifestyle choices.
- The Ombudsman respects and promotes the client’s right to self-determination.
- The Ombudsman makes every reasonable effort to ascertain and act in accordance with the client’s wishes.
- The Ombudsman acts to protect vulnerable individuals from abuse and neglect.
- The Ombudsman safeguards the client’s right to privacy by protecting confidential information.
- The Ombudsman remains knowledgeable in areas relevant to the long term system, especially regulatory and legislative information, and long term care service options.
- The Ombudsman acts in accordance with the standards and practices of the Long Term Care Ombudsman Program, and with respect for the policies of the sponsoring (contract) organization.
- The Ombudsman will provide professional advocacy services unrestricted by his/her personal belief or opinion.
- The Ombudsman participates in efforts to promote a quality long term care system.
• The Ombudsman participates in efforts to maintain and promote the integrity of the Long Term Care Ombudsman Program.

• The Ombudsman supports a strict conflict of interest standard which prohibits any financial interest in the delivery or provision of nursing home board and care services, or other long term care services which are within their scope of involvement.

• The Ombudsman shall conduct him/herself in a manner which will strengthen the statewide and national Ombudsman network.
2. Adapted from training materials from the State of Montana
4. Adapted from training materials from the State of Ohio
5. Davis, W.E., Ibid.
6. Adapted from State of Ohio training materials.
8. Ibid
10. AOA-PI-75-30
11. AOA-TAM-76-24
12. Ibid
13. AOA-PI-78-12