Office of the State Long-Term Care Ombudsman Annual Report 2007

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SUMMARY

Each small improvement in the daily life of a person living in a long-term care facility is one small step to improving the entire long-term care system.

The *Institute of Medicine Real People Real Problems* report concludes that the ombudsman program serves a vital public purpose. Through system advocacy work and educational efforts, the long-term care ombudsman program can justly claim to have improved the system of long-term care services.

Thanks to legislative support, the Office of the State Long-Term Care Ombudsman has grown significantly in the past 8 years. From only one ombudsman in 1999, to nine at the end of 2007, Iowa is now a recognized program in the nation. The introduction of local offices and clearly defined program standards resulted in increased contact with residents and others seeking information and assistance about long-term care.

Local ombudsmen continue to do everything possible to respond to requests for assistance. As the number of calls continue to rise work must be continually reprioritized and adjusted. Local ombudsmen are dedicated to meeting the needs of those needing services in assigned districts, however without expanded resources the program will not be able to adapt and be responsive to changing needs.

The Resident Advocate Committee volunteer program has been existence for 30 years. With the increase in assisted living facilities, changes in the profiles of people living in residential care facilities and the implementation of person directed care, the knowledge base for both volunteers and paid staff needs to be increased. There are over 2400 volunteers throughout the ninety-nine counties in Iowa. This makes annual training, education and support challenging. The program will be evaluated throughout 2008 to determine how we can continue to provide the necessary training, education and support to meet the needs of people living in long-term care facilities.

Solving problems in long-term care settings at the lowest level possible is crucial to improving the quality of life and quality of care for the people who live there. Without adequate staff, wait times for investigation of cases or requests for assistance will continue to grow. When a formal complaint is submitted to the Department of Inspections and Appeals, that agency has up to 45 days to investigate. Local program standards for the ombudsman's office require that complaints are investigated within 10 business days when possible. A resident advocate volunteer is usually able to immediately begin work to resolve the concern.

It is vital that we continue to review our volunteer program to find ways to enhance the training, education and support needed to respond to the requests of people living in long-term care facilities. Without volunteers, the local long-term care ombudsmen would not be able to adequately do their job.

“What does the resident want?” is the question repeated daily, if not hourly, by representatives of this office when a call is received. The dedicated staff of this office works hard to improve the quality of life and quality of care for people living in long-term care facilities. Listening to the resident and following their lead for resolution of concerns helps us to take small steps in the direction of improving the daily life of people living in long-term care facilities.

INTRODUCTION

The Office of the State Long-Term Care Ombudsman is an effective presence in advocating for and protecting the rights of more than 48,900 people living in long-term care facilities. The program was created in the early 1970's to help identify and resolve problems on behalf of residents in order to improve the quality of life and quality of care for each individual. Nationally, fifty-two ombudsman programs currently exist that includes all fifty states, Washington DC and Puerto Rico.

The Older Americans Act mandates that each state have an Office of the Long-Term Care Ombudsman, although there is no single model of an ombudsman program. The office is housed in the state unit on aging in some states, in other states the office is housed in an independent, single-purpose agency, or in larger agencies, while others are not affiliated with state government. Local programs may be contracted out to area agencies on aging or other non-profit entities, or local ombudsmen may be state employees. Iowa continues to hire all local ombudsmen as state employees rather than contracting the program out to local or non-profit agencies. This has resulted in a cohesive, consistent and stable program.

The Ombudsman program is designed to encompass advocacy and representation of residents' rights. Long-term care ombudsmen are mandated to address and attempt to resolve the broader causes of problems for people living in long-term care facilities. System advocacy includes advocating for policy change, providing education, promoting the development of citizen organizations, resident and family councils. All of this is in addition to the daily work of investigating and working to resolve complaints to the satisfaction of the resident.

In Iowa, the office remains within the Department of Elder Affairs. Until 1999 there was only one ombudsman to do the work of the office. Effective September 2007, there is one state long-term care ombudsman, seven local ombudsmen, a program coordinator and two office staff. The title "regional ombudsman" was changed to "local ombudsman/program" to follow the national trend. Each of the seven local long-term care ombudsman are responsible for a district that includes an average of 14 counties, 119 facilities and 7,186 beds. Regional offices were closed during 2007 since the ombudsmen spend 80% of their time on the road and using modern technology, work can be completed in any setting. This change is both cost effective and time efficient. Local office program standards have been developed and this model is being used as a model by other states.

By establishing the local programs, driving time is reduced and more time is spent in facilities talking with residents. Local ombudsmen are becoming more aware of issues that need to be addressed, yet as evidenced by the tables included in this report, the increase in work load has been phenomenal, and is reaching the point of being unmanageable with the current staff. While many people are still not aware this office exists, marketing proves to be a challenge due to limited staff and the inability to handle more cases in a reasonable time frame.

The State Long-Term Care Ombudsman program is responsible for over 830 long-term care facilities in the state of Iowa, including intermediate and skilled nursing facilities, residential care facilities, elder group homes, hospital based long-term care units and assisted living programs.

Julie Pollock and Carol DeBoom joined the office in December 2006 as local long-term care ombudsmen. Pam Railsback and Kim Weaver joined at the end of September 2007. While Pam and Kim are listed in this report they were hired at the end of September so statistics do not reflect their work since this office operates on a federal fiscal year.

The current ratio of local ombudsmen to residents is 1 to 7186. Iowa continues to rank almost last in the nation in the number of ombudsman to residents ratio. Priorities had to be made for the local programs. Complaint investigations and responding to requests for information and assistance are the driving force for most work days.

Iowa continues to be the only state in the nation with the Resident Advocate Committee volunteer system. Without adequate resources to support this program it merely exists and does not improve. Resources, education and training remain below the minimum standards this office believes is necessary for this important work.

Managing over 2400 volunteers is more than a full time job for one person. Orientation, training, support and technical assistance consume a significant number of hours for the paid staff. It would be impossible for this office to operate without a volunteer program. With the increase in activities for the paid staff options are being explored to update the volunteer program to meet the growing demand for ombudsman services.

OFFICE OF THE STATE LONG-TERM CARE OMBUDSMAN

DES MOINES OFFICE STAFF

JEANNE YORDI
State Long-Term Care Ombudsman

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Long-Term Care Ombudsman Program
Resident Advocate Committee Program

KATIE MULFORD
Administrative Assistant

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Secretary

LOCAL LONG-TERM CARE OMBUDSMEN

KIM COOPER
Local Long-Term Care Ombudsman
Southeast Iowa

CONNIE HADDEN
Local Long-Term Care Ombudsman
North Central Iowa

ANGIE O'BRIEN
Local Long-Term Care Ombudsman
Central Iowa

JULIE POLLOCK
Local Long-Term Care Ombudsman
Southwest Iowa

CAROL DEBOOM
Local Long-Term Care Ombudsman
Northeast Iowa

PAM RAILSBACK
Local Long-Term Care Ombudsman
East Central Iowa

KIM WEAVER
Local Long-Term Care Ombudsman
Northwest Iowa

OFFICE OF THE STATE
LONG-TERM CARE OMBUDSMAN
FACT SHEET FFY 2006

This fact sheet contains information from the Administration on Aging National Ombudsman Reporting System for Federal Fiscal Year 2006. Please note this information is not for the recently completed federal fiscal year, but is always one year behind so that statistics can be compiled on the national level.

- ✓ Iowa ranks 20/52 in the number of facilities and number of beds under the jurisdiction of the ombudsman program. This represents 1.6% of all facilities and beds in the nation.

- ✓ Iowa continues to rank almost last in the number of paid ombudsman per long-term care beds.
  - o 2006 National Ombudsman Reporting System shows one ombudsman per 9781 beds.
    - During FFY 2006 Iowa had 1 FT state ombudsman and 5 local ombudsmen.
    - It is recommended that each state have 1 ombudsman per 2,000 beds.
    - Iowa would need 25 ombudsmen to meet that mandate
    - National average is 1 ombudsman to 2,192 beds.

- ✓ Iowa ranks 49/52 in the number of paid full time ombudsmen.
  - o National average is 23 full time employees.
  - o In FFY 2006 Iowa had 5 local ombudsmen plus one State Long-Term Care Ombudsman.
  - o Iowa currently has 7 local ombudsmen.

- ✓ Only 19% of nursing facilities and 9% of residential care facilities were monitored on a routine basis. Assisted living facilities were not monitored.

- ✓ Iowa ranks 26/52 in number of community education presentations given.
- ✓ Iowa ranks 42/52 in number of DIA surveys in which an ombudsman participated.
- ✓ Iowa ranks 47/52 in number of consultations to facility staff.

- ✓ Iowa ranks 44/52 in number of consultations to individuals.
- ✓ Iowa is tied for last with no help given to resident or family councils.

- ✓ Iowa ranks 42/52 in number of new cases opened.
- ✓ Iowa ranks 35/52 in number of new complaints.

- ✓ Local ombudsmen resolved 83.9% of the cases investigated, compared to the national average of 57.45%.

- ✓ Iowa is one of only 8 states that do not use certified volunteer ombudsmen.

Source: 2006 National Ombudsman Reporting System (NORS), Administration on Aging

OLDER AMERICANS ACT

Duties of all long-term care ombudsmen are mandated by the Older Americans Act. Duties of the State Long-Term Care Ombudsman include the following tasks, by doing them either personally or designating the work to the local program. A description of the work follows each task.

A. Identify, investigate, and resolve complaints that

- **are made by or on behalf of residents and**
  - **relate to action, inaction, or decisions that may adversely affect the health, safety,**
  - **welfare, or rights of the residents (including the welfare and rights of the residents with respect to the appointment and activities of guardians and representative payees), or**
    - **providers, or representatives of providers, of long-term care services;**
    - **public agencies; or**
    - **health and social service agencies;**

This task has been delegated to the local programs and the ombudsmen continue to be driven by complaints. The ombudsmen are skilled at identifying the root cause of problems presented and working with the resident and facility to find resolution. Residents report that complaints are resolved to their satisfaction 83.6% of the time, well above the national average of 59.19%.

B. Provide services to assist the residents in protecting the health, safety, welfare and rights of the residents;

Local ombudsmen spend as much time as possible in facilities. However with an average of 119 facilities per ombudsman it is virtually impossible to spend the necessary time in any one facility. Services are provided at the very basic level which means an ombudsman investigates complaints but is not able to spend routine time in each facility to establish a solid presence.

C. Inform the residents about means of obtaining services provided by providers or agencies described above;

Each ombudsman is familiar with resources in her district. This is especially important as involuntary discharges continue at an alarming rate. Local ombudsmen provide resource information for people when their condition has improved and they are able to move out of a facility and resume life in the community or when they are forced to move because of an involuntary discharge. Working with each facility to ensure a safe transition is essential to assure success for an individual.

D. Ensure that the residents have regular and timely access to the services provided through the Office and that the residents and complainants receive timely responses from representatives of the Office to complaints;

Local ombudsmen make every attempt to investigate cases within ten business days of receipt of the complaint. Processes are continually reviewed and monitored to assist local ombudsmen in providing timely access to services.

E. Represent the interests of the residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;

This task falls primarily to the State Ombudsman but local ombudsmen are also skilled at representing the interests of residents on committees and task forces. It is imperative that any work undertaken by any group or organization to improve the quality of life or quality of care for people living in long-term care facilities puts the resident at the center of the initiative and translates all suggestions for change to the bedside of the people who will receive the service.

F. Provide administrative and technical assistance to regional long-term care ombudsmen;

Both the Program Coordinator and State Ombudsmen are available to assist local ombudsmen sort through the details of challenging cases, to provide resources and information and to offer support and encouragement as they deal with the many tasks associated with this position.

G. Analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions,

- **a. that pertain to the health, safety, welfare, and rights of the residents, and with respect to the adequacy of long term care facilities and services in the State;**
- **b. recommend any changes in such laws, regulations, policies, and actions as the Office determines to be appropriate; and**
- **c. facilitate public comment on the laws, regulations, policies, and actions;**

This task also diverts to the State Ombudsman. *The Institute of Medicine Report* reminds us that advocating for system change can create a politically charged environment since in many states, including Iowa, the state ombudsman is a state employee. By federal statute the ombudsman is required to speak out against government laws, regulations, policy and actions when the circumstances justify such action. While conflicts could potentially occur, Iowa is fortunate to have a state unit on aging that is supportive of the state ombudsman role and ensures that autonomy is allowed and that it does not work to the disadvantage of the vulnerable people served.

H. Provide for training representatives of the Office

a. promote the development of citizen organizations, the participate in the program; and

b. provide technical support for the development of resident and family councils to protect the well-being and rights of residents; and

A limited amount of this work can be accomplished because of the tremendous volume of calls received for assistance. Resource information will be developed in 2008 to help people who wish to develop a resident or family council and local ombudsmen will be able to provide information and limited technical assistance for groups who wish to establish a facility program.

I. Carry out such other activities as the Commissioner determines to be appropriate.

Since the mandates of the Older Americans Act cannot be met with the minimal staff in this office, there is very little time for other activities.

Table 1

PROGRAM ACTIVITIES

CATEGORY	% CHANGE FROM 2006	FFY 07	FFY 06	FFY 05
Training for Ombudsmen/Volunteers	+171%	149	55	37
Technical Assistance for Ombudsmen/Volunteers	+274%	2668	713	76
Training for Facility Staff	+3%	29	28	32
Consultations to Facilities/Providers	+113%	770	362	957
Consultations to Individuals	+53%	1385	908	1837
Resident Visitation-Non Complaint Related	+189%	422	146	258
Resident visitation-Complaint Related	-.07%	567	571	512
Participation in Facility Surveys	+1512%	1016	63	91
Work with Resident Councils	+300%	3	0	1
Work with Family Councils	+100%	2	1	1
Community Education	+188%	26	9	17
Media Interviews	11	9	21	6
Monitoring Laws		4%	4%	4%

PROGRAM ACTIVITIES OVERVIEW

Table 1 shows the program activity categories that must be reported to the Administration on Aging each year.

This office had a significant increase in complaints for federal fiscal year 2007. While the actual number of cases declined slightly for the second year in a row, most of the other program activities increased. A study of the work completed by the local long-term care ombudsmen indicates that local ombudsmen are becoming respected experts within the assigned districts and are providing education and assistance before a problem rises to the level of a case.

The changes in program activities for FFY 2007 are significant and reflect the success of local programming.

Training for Ombudsmen/volunteers
Over 50 training sessions were held in different parts of the state during 2007. Person directed care information was presented by the local ombudsmen for the volunteers. This allowed the volunteers an opportunity to meet the local ombudsman, learn more about the ombudsman program and receive requested information about person directed care. While attendance has increased significantly, it is virtually impossible to schedule one training date in a community and expect everyone to attend. This resulted in multiple requests for a local ombudsman to attend a committee meeting for training. Individual committee training is not always possible due to the large number of facilities for which a local ombudsman is responsible.

Orientation for all new volunteers is now mandatory. Orientation is conducted twice each month via teleconference. This number has been added to the volunteer training category.

Technical assistance for ombudsmen/volunteers
This area has never been efficiently tracked prior to this year, so the 274% increase in calls is simply a reflection of additional documentation on the part of this office. During FFY 2005 and 2006 this program was contracted to an outside provider and calls were not documented. FFY 2007 will be considered the base year with which to measure future years.

Technical assistance for FFY 2007 also included a personal telephone call to each committee chair to review committee membership, ensure the volunteers know how to reach the local ombudsman and identify any needed resources or information. The transition for this program to be managed in the Des Moines office also resulted in increased calls from the volunteers for clarification.

Training for facility staff
Each intermediate care facility and skilled nursing facility is required to educate staff about resident rights once each year. While the ombudsmen are the experts in this

area, time does not allow for local ombudsmen to do this training at each facility. Each local ombudsman attempts to conduct approximately four inservices for long-term care facility staff each year. More may be scheduled as time allows in each district.

Consultations to facilities/providers
This increase of 113% is a direct outcome of each ombudsman being assigned a smaller district. This office has worked hard to become a trusted source of information and education. With local ombudsmen now in place, facility staff feel more comfortable calling for assistance and information. This office remains committed to working with any provider who is striving to improve the quality of life and quality of care for the people who live in the facility.

The increase in consultations to facilities is an indicator of why the number of cases has declined. When an administrator encounters a problem and needs information or suggestions, he or she typically calls this office for assistance. When a resident can get resolution to concerns within the facility, it is better for all.

Consultations to individuals
1,385 phone calls were received requesting information and assistance, which represents a 53% increase over FFY 2006.

As with other program activities, the establishment of local programs and the increased presence of the ombudsmen in communities have created an increase in calls. Instead of calling a toll free number and talking with an unidentified stranger, Iowans now call to speak with a local person they have met.

Resident visitation-*non*-complaint related
Non-complaint related visits have almost tripled in the past year. Again, the local presence and reduced driving time allowed ombudsmen to spend more time in facilities. These are unduplicated visits, but it remains impossible to monitor each long-term care facility on at least a quarterly basis as is recommended by the Administration on Aging.

Resident visitation-complaint related
With the decrease in cases it is reasonable that the number of complaint related visits decreased. Local ombudsmen are encouraged to investigate complaints in person to make certain they understand all of the facts and information. However, with the continued high volume of involuntary discharges and the inclusion of legal assistance in those cases, many do not require an ombudsman to visit the facility.

Participation in facility surveys
Federal rules require that surveyors from the Iowa Department of Inspections and Appeals-Health Facilities Division (DIA) call the Office of the State Long-Term Care Ombudsman upon entrance into a facility for an annual survey or a complaint investigation. In past years, these calls were accepted by a receptionist at the Department of Elder Affairs.

DIA and the Office of the State Long-Term Care Ombudsman have changed the protocol during annual surveys and complaint investigations so when a surveyor enters a facility the call is placed directly to the local ombudsman. This allows for the sharing of information and keeps the local ombudsman informed of the compliance status of each facility. This has resulted in increased communication between the surveyors and the local ombudsmen and keeps both groups better informed.

Work with resident councils and family councils
Work with these groups continues to remain at the bottom of the priority list as local ombudsmen simply do not have time to establish councils in each facility. Resources are being developed to provide information to interested parties throughout the state via meetings, brochures and other printed materials.

Community education
As with other program activities, community education must remain a low priority so that the focus can continue to be the people currently living in long-term care facilities. Plans to increase community education and awareness are in the development stages for FFY 2008 despite the limited staff time and resources available.

TABLE 2

CASES AND COMPLAINTS

	FFY07	FFY06	FFY05
Number of New Cases Opened	698	749	787
Number of New Complaints	1687	1310	1246
Abuse, Gross Neglect, Exploitation	15	9	26
Access to Information	51	28	16
Admission, Transfer, Discharge, Eviction	224	202	178
Autonomy, Choice, Exercise of Rights, Privacy	327	228	230
Financial, Property Lost, Missing or Stolen	72	75	73
Care	353	301	245
Rehabilitation of Maintenance of Function	34	18	28
Restraints-Chemical or Physical	8	1	3
Activities and Social Services	55	52	38
Dietary	108	81	10
Environment	137	86	103
Policies, Procedures, Attitudes, Resources	34	32	45
Staffing	123	115	91
Certification/Licensing Agency	10	12	11
State Medicaid Agency	6	5	6
System/Others	105	62	47
Other than ICF/RCF/ALP	25	3	4
TOTALS	1687	1310	1246

CASES AND COMPLAINTS OVERVIEW

The complaint categories and codes listed in table 2 are determined by the Administration on Aging. 133 complaint codes are divided into the 16 categories listed in both Tables 2 and 3. Each case may have multiple complaints, but each problem, or complaint, will have only one code.

For the second year in a row, the number of cases reported to this office has slightly declined. According to the instructions for completing the National Ombudsman Report System (NORS) a case is defined as "each inquiry brought to, or initiated by, the ombudsman on behalf of a resident or group of residents involving one or more complaints which requires opening a case and includes ombudsman investigation, strategy to resolve and follow-up. Calls reporting incidents or seeking advice but not requiring ombudsman involvement are counted as consultations."

There are two reasons the number of cases appears to have declined. First, additional education has been provided to local ombudsmen to clarify the definition required to open a case, therefore data more accurately reflects the work being done by the members of this unit.

Second, the ombudsmen have begun to establish a local presence in communities and are called before a concern rises to the level of a full-fledged case.

Empowerment of residents is a priority and providing information and resources so a person is able to work through the system by him/herself is crucial to the promotion of resident rights.

The number one complaint received falls under the category of care and is consistent with past years, that long-term care facility staff fails to respond to requests for assistance. This includes: call lights not being answered or call lights being turned off by a staff member without the request being fulfilled.

Other complaints include: reports of medication errors, falls or accidents due to inappropriate transfers, staff not paying attention to changing symptoms and residents not being assisted to the bathroom within a reasonable time.

Complaints regarding long-term care facility staff attitudes continue to rise. Residents frequently complain about not being treated with dignity and respect, staff not listening to or responding to preferences, or staff simply telling the resident what to do and when to do it with little or no choice offered. This coincides with an increase in complaints about resident rights and the ability to make personal life choices.

For the first time since information has been collected on complainant sources, 43% of the complaints received came from a resident or a group of residents. 30% of the complainants were a relative or friend of the resident, and only 8% were initiated by the

local ombudsmen. Other complainants included medical personnel, non-relative guardian or conservators and representatives from social service agencies or programs.

A priority for local long-term care ombudsman is to begin building a working relationship with each facility of the 119 facilities in the assigned district. Even though this has been done on a very limited basis, this office has been able to successfully resolve over 80% of complaints. This is far above the national average of 57%, which is a tribute to the dedication and perseverance of the staff.

Assisted Living facilities continue to open throughout the state. Assisted living across the nation is not clearly defined and varies from program to program. Tenants often feel misled and deceived with admission contracts, services promised and level of care offered. Many times, advertised costs and services are not the reality once a tenant moves in. In some cases, assisted living facilities have, in reality, become unlicensed nursing homes with people needing continual assistance with several activities of daily living.

Cases related to assisted living programs tend to be very complicated and time consuming. These cases usually require consultations with other agencies and professionals and many times are not able to be resolved because there are no standard tenant rights, admission contracts, services or level of care standards. Lack of staff training, lack of required credentials for directors, very limited staff and arbitrary increases in monthly costs create challenges for tenants for which there is little help. While tenant-landlord rules apply, the process to fight evictions and involuntary discharges can be costly and time consuming. If the tenant believed, on admission, that assistance could increase as the physical condition declined, the tenant may be surprised when told he or she must move. When faced with an eviction or involuntary discharge a tenant does not have more than a few days or weeks to resolve the differences or is forced to move and tenant-landlord law proceedings usually do not work that quickly.

Affordable assisted living communities continue to frustrate this office. Services, such as meals, may be decreased, with no alteration in the fee required. Some offer no choice in providers or services, and simple tasks such as opening or closing curtains, assistance with jewelry, dressing or other “unplanned events” increase service costs and make the affordable program no longer affordable for many older Iowans.

For the second year in a row, involuntary discharges continue to take a great deal of time for the regional and state long-term care ombudsman. Over 140 notices were received during FFY 2007.

Iowa Administrative Code 481-58.40 states that an involuntary discharge may be appropriate for two reasons.

a. *“Medical reasons” for transfer or discharge are based on the resident’s needs and are determined and documented in the resident’s record by the attending*

physician. Transfer or discharge may be required to provide a different level of care. In the case of transfer or discharge for the reason that the resident's condition has improved such that the resident no longer needs the level of care being provided by the facility, the determination that such medical reason exists is the exclusive province of the professional standards review organization or utilization review process in effect for residents whose care is paid in full or in part by Title XIX. (II)

b. *"Welfare" of a resident or that of other residents refers to their social, emotional, or physical well–being. A resident might be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well–being of other residents or staff (e.g., the resident's behavior is incompatible with the resident's needs and rights). Evidence that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall be in writing and shall include specific information to support this determination.*

When a resident is being discharged due to non-payment of a bill this office strongly recommends legal assistance. If a responsible party is not paying the bills, this office encourages the facility to work through Adult Protective Services, Medicaid Fraud if appropriate, or to pursue legal remedies against the responsible party of the person who is not paying instead of discharging the resident.

This office strongly believes that whenever possible a person should be given the opportunity to live in the least restrictive environment. However, once the involuntary discharge process has started, options must be identified very quickly and people are sometimes forced to move into an alternative location against their will. Some people must move back into the community when services are a primary concern but not available, when the person is not able or willing to live alone, or when no family support is available.

Residents who receive an involuntary discharge notice due to behaviors are also encouraged to obtain legal assistance. Many times a resident is accepted into a facility without a thorough examination of past history and current needs. When this resident then fails to conform to facility routines or procedures, an involuntary discharge notice is issued. Reviewing records and talking with the resident and their family members sometimes leads to the conclusion that staff is simply not trained well enough to promote an atmosphere for success for some residents.

Involuntary discharges and eviction notices for people living in assisted living make advocacy efforts very challenging. If the assisted living program issues the notice, the appeal is heard by the director of the program-the very person who issued the notice. If the tenant wishes to pursue the legal remedies, legal assistance is recommended for this court process.

If the Department of Inspections and Appeals (DIA) issues the notice, either the assisted living program or the tenant can request a review. However, when the regulatory agency issues an involuntary discharge notice to a tenant based on level of care or behaviors, a program may be unwilling to argue on behalf of the tenant at the risk of creating a challenge with DIA.

In facilities licensed under Iowa Code 135c (such as intermediate care facilities), the Department of Inspections and Appeals simply cites the facility for inappropriate level of care. It is then up to the facility to decide how to proceed. In assisted living, DIA makes the decision for the facility by deciding who must move.

RESIDENT ADVOCATE COMMITTEES

Information about Resident Advocate Committees is included in this report. It is not included in the annual report submitted to the Administration on Aging (AoA) because AoA has determined that these volunteers do not have sufficient training or education to be considered certified volunteer ombudsmen.

According to the *Institute of Medicine Report* evaluation of the long-term care ombudsman program, there is a direct connection between the effectiveness of volunteer programs and the number of adequately paid staff. Effectiveness is achieved through adequate resources and paid staff is the most crucial of all resources. This evaluation identifies that the establishment of a standard staff-to-volunteer ratio is needed to protect and manage volunteers and to provide quality services to people who live in long-term care facilities. The report suggests a minimum standard for this staff-to-volunteer ration of 1:40. It strongly encourages state long-term care ombudsman programs that involve volunteers to maintain paid staff-volunteer ratios at the more robust level of 1:20.

Iowa currently has 2467 volunteer working in approximately 600 facilities in ninety-nine counties. It is impossible to provide more than the very simple, basis orientation or the needed education, technical assistance, support or recognition events that are needed to support a volunteer program of this magnitude.

The program coordinator spends approximately 50% of her time coordinating this program. With seven local long-term care ombudsmen, the ratio is one paid staff member to each 348 volunteers. Each of the local ombudsmen provides technical assistance, support and encouragement to the volunteers in their assigned service area. The ratio of one paid staff for each 119 individual committees is simply not manageable. Since volunteers in Iowa work in committees it would make sense to translate the recommendation into one paid staff for each twenty to forty committees. We are far from reaching that goal.

Early in 2006 the database was updated to reflect many changes that happened in past years. This resulted in an unusually high number of resignations, but many were simply not recorded from previous years.

Orientation is offered via teleconference twice per month, and on an individual committee basis as needed. Due to limited paid staff available to conduct individual one to one training, all volunteers are strongly encouraged to take advantage of the teleconference. Volunteers are not allowed to begin work until orientation has been completed.

The 2007 Annual Resident Advocate Volunteer Committee training was conducted by the local ombudsmen. This proved to be an excellent opportunity for the volunteers to meet the staff and get acquainted. This has resulted in a tremendous increase of calls

to this office from the volunteers. Over 2600 calls were received from the volunteers in the past year.

Volunteers reported 1932 complaints with 69% being resolved at the local level. A comparison of complaints investigated by the volunteers and paid staff show striking differences. While the word “complaint” is used in this section of the report it must be noted that volunteers are encouraged to look at quality of life issues. Any assistance given to a resident by staff in the facility that may improve daily life is be recorded and submitted to this office.

During FFY2007 improved technology allowed us to begin keeping other statistics that have not been available in the past.

- The average age of volunteers is 67.
- The longest active volunteer has been a part of this program for 30 years.
- 16 active volunteers have served 25 years or more.
- 71 active volunteers have served 15 years or more.
- 740 active volunteers have served 10 years or more.
- 948 volunteers attended training in 2007, which is an increase of 35%.
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- 259 new applications were received and 237 have attended orientation at the time of this report.
- 616 resignations were received but this large number is due to the fact that it had been 2 years since we did a thorough review of active volunteers. Many people resigned in past years but did not report that information to this office.

The Resident Advocate Committee resolution rate of complaints is, and will continue to be, a part of the Medicaid Accountability Measures. Facilities may be rewarded when at least 60% of concerns that the committee brings to their attention are resolved. This program encourages the administrative staff at each facility to listen to resident concerns, frustrations, suggestions or complaints and do what is possible to make a change. As the long-term care industry continues to move toward person directed care, listening to residents is vital in changing daily life to meet individual needs.

TABLE 3

RESIDENT ADVOCATE COMMITTEE COMPLAINTS

COMPLAINT CATEGORY	FFY 07	FFY 06	FFY 05	FFY 04
Abuse, Gross Neglect, Exploitation	11	5	8	1
Access to Information	14	19	48	6
Admission, Transfer, Discharge, Eviction	31	37	23	7
Autonomy, Choice, Exercise of Rights, Privacy	191	156	87	161
Financial, Property	65	64	97	67
Care	449	360	461	362
Rehabilitation or Maintenance of Function	67	96	37	42
Restraints-Chemical or Physical	3	4	3	2
Activities and Social Services	184	175	148	212
Dietary	317	285	305	291
Environment	482	331	410	409
Policies, Procedures, Attitudes, Resources	8	6	12	5
Staffing	98	113	106	61
Certification/Licensing Agency	7	7	7	1
State Medicaid Agency		4	0	0
System/Others	5	6	0	11
Other than ICF/RCF				0
TOTALS				
	1932	1668	1752	1638

TABLE 4

COMPLAINT COMPARISON
RESIDENT ADVOCATE COMMITTEES
LONG-TERM CARE OMBUDSMAN

	RAC FFY 2007	**Ombudsmen FFY 2007**
Abuse, Gross Neglect, Exploitation	11	15
Access to Information	14	51
Admission, Transfer, Discharge, Eviction	31	224
Autonomy, Choice, Exercise of Rights, Privacy	191	307
Financial, Property Lost, Missing or Stolen	65	72
Care	449	331
Rehabilitation or Maintenance of Function	67	34
Restraints-Chemical or Physical	3	8
Activities and Social Services	184	55
Dietary	317	98
Environment	482	127
Policies, Procedures, Attitudes, Resources	8	34
Staffing	98	103
Certification/Licensing Agency	7	10
State Medicaid Agency		6
System/Others	5	105
Other than ICF/RCF		6
TOTALS	1932	1687

RESIDENT ADVOCATE COMPLAINTS AND LTC OMBUDSMAN COMPLAINTS OVERVIEW

A comparison of the top complaints from both the Local Long-Term Care Ombudsmen and the Resident Advocate Committee Volunteers follows a predictable pattern.

Volunteers in Iowa, as in other states, tend to focus on surface-level complaints, which include events that may be observed (food, activities) or that are reported to the individual volunteer when visiting with a resident. Local ombudsman usually work on complaints that must be investigated such as medication concerns, care plans, not following physician orders or condition changes that are not recognized. Both groups also advocate for resident rights on a regular basis.

It would be expected that volunteers are not involved in admission, transfer and eviction proceedings. Those complaints usually require a review of the resident record and thorough investigation to try to find a workable solution.

Resident Advocate Committee members and local ombudsmen report high numbers of complaints regarding autonomy, choice, exercise of rights, and privacy. The majority of these complaints fall into the categories of dignity, respect, staff attitudes and exercise preference/choice. Federal resident rights for people living in intermediate care and skilled nursing facilities allow for individual choice and autonomy. When facility practices override personal preferences, a volunteer or ombudsman can get involved to assist in finding a workable solution.

The category of care includes failure to respond to requests for assistance, medication administration/organization, personal hygiene, toileting and symptoms unattended, including pain. Both local ombudsmen and volunteers report that failure to respond to resident's requests for assistance rank high on the list of complaints. Failure to respond to requests for assistance can lead to a host of complications, including fear, anger and/or anxiety, perceived incontinence, pressure ulcers, increased falls or lack of personal hygiene. Both volunteers and ombudsmen are trained to look beyond the call light response time to determine the where the problem lies and to offer ideas to the facility.

The Resident Advocate Committee volunteers also report many environmental concerns since they are in the facility frequently. Air temperature, cleanliness, housekeeping and equipment in poor repair equal about 75% of the environmental concerns.

Staffing problems are frequently reported by the volunteers. Critical areas of concern include not enough staff, not enough supervision to ensure quality care, poorly trained leaders or staff which does not have enough education and experience to properly perform needed tasks or an administrator who does not take a daily interest in the daily operations of the facility. Work being done on the national level to support increased

leadership training for management staff and increased direct care worker staffing requirements are supported by this office.

For more information about the Office of the Long-Term Care Ombudsman Program including the Resident Advocate Committee Volunteer Program, please see our website at http://www.iowa.gov/elderaffairs/advocacy/ombudsman.html