

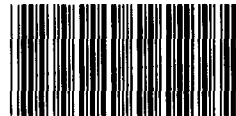
GAO

Report to the Chairman, Subcommittee on
Aging, Committee on Labor and Human
Resources, U.S. Senate

May 1992

THE OLDER AMERICANS ACT

Access to and Utilization of the Ombudsman Program



146448



**Program Evaluation and
Methodology Division**

B-242550

May 6, 1992

The Honorable Brock Adams, Chairman
Subcommittee on Aging
Committee on Labor and Human Resources
United States Senate

Dear Mr. Chairman:

This report contains testimony presented to the Subcommittee on Aging of the Senate Committee on Labor and Human Resources on June 13, 1991. We are publishing the statement as a report to make the information more widely available. In addition, with the completion of our work, we now make a recommendation to the Commissioner of the Administration on Aging (AOA) and include a matter for congressional consideration.

Our testimony responded to your request for the following information on the long-term care ombudsman program: (1) what the objective of the ombudsman program is; (2) what the impact of the program is, and what data are currently being collected to measure that impact; (3) how well the program is being utilized by residents of nursing home and board and care facilities; and (4) what difficulties, if any, ombudsmen experience in gaining access to nursing home and board and care residents.

On the basis of our analysis, we concluded that in order for the ombudsman program to achieve its objective of removing impediments to resident well-being, safety, welfare, or rights (including the right to refuse treatment), three criteria must be met: (1) resident awareness of the ombudsman program; (2) open two-way communication, with residents and ombudsmen having free access to each other; and (3) a high percentage of complaint resolutions.

We also concluded that appropriate data to measure the impact of the program were not being collected at the national level, including data on resident awareness of the program and resident access to ombudsmen. Finally, we concluded that, if the ombudsman program is to be evaluated effectively, a standard definition of what constitutes the resolution of a complaint must be developed.

The extent to which the program was being utilized by eligible residents varied across states, and categorizing programs by available characteristics (that is, numbers of nursing home beds and full-time paid ombudsmen) did not provide a sufficient explanation for that variation. In addition, not

enough data were being collected about other program characteristics to account adequately for the variation in complaint rates across states with similar resources.

We recommend that the Commissioner of AOA modify the annual data collection instrument to allow measurement of utilization rates for the ombudsman program across states. This would require collecting information on (1) the total number of complaints received by type of facility (nursing home or board and care facility) and (2) the total number of nursing home and board and care residents (or, at a minimum, beds).

The Older Americans Act mandates that ombudsmen shall have appropriate access to residents, nursing home and board and care facilities, and residents' medical and social records. Since 1987, legal barriers to access have greatly diminished in the following areas: (1) access to residents, (2) access to nursing homes, (3) access to board and care facilities, and (4) access to residents' medical and financial records. The one area that has not shown a meaningful change during this period is access to administrative records maintained by facilities. Administrative records are an important source of information during complaint investigations. These records may contain such vital information as facility incident reports and staffing patterns. However, state laws in 15 states still do not provide ombudsmen with access to administrative records. The Congress may therefore wish to consider amending the Older Americans Act so that it explicitly grants ombudsmen access to facility administrative records.

We discussed the results of our work with responsible AOA officials. These officials told us that they were in complete agreement with our conclusions and recommendation and planned to modify the ombudsman data collection instrument to ensure accurate measurement of utilization rates and the impact of the ombudsman program. As a result, we did not ask for written agency comments.

As agreed with your office, we will make copies of this report available to interested organizations, as appropriate, and to others upon request.

If you have any questions or would like additional information, please call me at (202) 275-1854 or Robert L. York, Director of Program Evaluation in Human Services Areas, at (202) 275-5885. Other major contributors to this report are listed in appendix II.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Eleanor Chelimsky". The signature is fluid and cursive, with a large initial "E" and a long, sweeping tail.

Eleanor Chelimsky
Assistant Comptroller General

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Abbreviations

AOA Administration on Aging

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It is a pleasure to be here today to discuss the preliminary results of our work on the long-term care ombudsman program. As you requested, we will present our findings on three questions: (1) What is the utilization of the ombudsman program by nursing home or board and care residents, and how does utilization vary across states? (2) What barriers, if any, prevent access by ombudsmen to residents; specifically,

- are there legislative limitations on ombudsman access to nursing home or board and care residents?
- to what extent are ombudsmen impeded when residents are unable to give legal consent to investigate complaints?
- what difficulties, if any, do ombudsmen have in gaining access to board and care residents?

(3) What impact can be expected from the program, and what impact data, including information on factors likely to affect impact, are being collected by the Administration on Aging (AOA) and the states?

Background

Before presenting our results, it is important to discuss their context. In 1989, 29.6 million Americans, about 12 percent of the total U.S. population, were 65 years of age or older, and almost 3 million of those individuals were 85 years or older. Moreover, since the incidence and prevalence of chronic conditions increase with age, many of these elderly persons suffer from such chronic conditions as arthritis, hypertension, and heart disease.¹ In fact, according to some estimates, 19.5 percent of the elderly population have at least one functional limitation. And while most elderly people with functional limitations are able to live independently in the community, some require institutional assistance, such as nursing homes or board and care facilities.

The number of Americans living in nursing homes was estimated in 1990 to be about 1.5 million, the majority of whom were elderly. In addition, according to one source, approximately 563,000 individuals resided in licensed board and care facilities; how many of these individuals were elderly, however, is unknown. Finally, there are no reliable estimates of the number of individuals currently residing in unlicensed board and care facilities.

¹C.A. Schoenborn and M. Marano, Current Estimates From The National Health Interview Survey: United States, 1987 (Washington, D.C.: U.S. Government Printing Office, 1988).

Persons needing a nursing home or board and care facility often suffer from a large array of physical, emotional, and functional disabilities. A significant proportion of all residents of these facilities are mentally impaired. Some residents who reside in nursing homes lack close family members to act as their advocates. Even when they have family, there are limited opportunities to transfer to another home when they are dissatisfied with the care they receive, due to factors such as high occupancy rates and shortages of personal finances. As a result, residents are dependent on nursing home staff for their well-being. Accordingly, regulation is important in protecting vulnerable consumers of nursing home services.

In the last 15 years, several nursing home studies have identified both grossly inadequate care and abuse of residents. The incidence of abuse and neglect in nursing home or board and care facilities is difficult to quantify. Whatever their incidence, however, recent state studies of nursing homes, as well as the testimony of experts, together suggest that problems such as neglect and abuse can lead to premature death, permanent injury, increased disability, and unnecessary fear and suffering on the part of residents. When the nursing home is viewed as a permanent and final living situation, these problems become even more unacceptable.

The ombudsman program responded to a growing public awareness of such problems and the need for stronger consumer-protection activities in nursing homes to reinforce government regulations. It was during the late 1960's and early 1970's that stories of nursing home abuse and fraud began to appear in the press. In 1971, President Nixon established an "8-point nursing home initiative" to address these issues and improve the quality of care in nursing homes. Under this initiative, the Department of Health, Education, and Welfare was directed to assist states in establishing investigative units, which were directed to respond to the grievances of nursing home residents. In 1972 and 1973, seven ombudsman demonstration projects were initiated. The success of these early demonstration projects in resolving complaints led to the development of a national ombudsman program in 1975, with the Administration on Aging (AOA) as the federal agency responsible for the implementation of the program. At that time, every state was given the opportunity to voluntarily establish an ombudsman program.

In 1978, title III of the Older Americans Act was amended, mandating that all states establish an ombudsman program to protect the health, safety, welfare, or rights of residents in nursing homes. Ombudsmen investigate

and resolve complaints made by or on behalf of residents, monitor laws concerning facility-based elderly, and provide information on long-term care options. Over the years, a number of statutory actions have been taken to strengthen the role of the ombudsman. In 1981, the act was broadened to include the category of board and care facilities.

AOA, through its 10 regional offices, oversees and distributes funds authorized for state ombudsman programs. In addition, AOA provides technical support and guidance to state and local ombudsmen, collects data on their activities from each state, and presents a yearly summary report to the Congress. The report for fiscal year 1989 included national data on the total number of complaints; total number of persons presenting complaints; how complaints were investigated (by ombudsman staff only, other agencies only, or ombudsman staff and other agencies); complaint disposition (resolved, not acted upon, or still active at end of year); who the complaint was filed against (nursing homes, board and care facilities, regulatory agencies, or others); complaint categories (for example, resident care, resident rights, or medications); and sources of funding (for example, title III, state funds, or other nonfederal funds).

Utilization of the Ombudsman Program by Nursing Home or Board and Care Residents

To answer the first question on how residents utilize the program across states, we chose "complaints" as a measure of program use and examined data on the number of nursing home complaints received in each state during a particular year. We also calculated complaint rates by dividing the total number of complaints received by ombudsmen by the total number of nursing home beds in each state for a given year.

We computed complaint rates as a proxy measure for utilization because the act states that the resolution of complaints will be used to attain the program's objectives, and because information was not available on other forms of use, such as the number of residents to whom ombudsmen gave information about the program. It should be emphasized that complaint rates are not indicative of the real incidence of negligence and abuse in such facilities and that these rates are neither a good measure of the underlying need for ombudsman services nor do they identify all those residents who, for a variety of reasons, do not receive ombudsman services. What they do show is some residents' perceptions of problems in nursing home facilities, as well as their access to, and use of, ombudsman services.

To estimate complaint rates across states, we intended to use national information on the number of nursing home complaints and the total number of elderly persons residing in nursing homes for each state. However, when we examined AOA's data base, we found that, while it included the number of complaints, it did not contain the total number of elderly nursing homes residents, nor did it distinguish complaints according to type of facility. In fact, we did not find any data base that included information on the number of elderly residents in these facilities. However, because the mean occupancy for nursing homes is 92 percent of the total number of available beds, we concluded that the number of beds could serve as a proxy measure for the number of residents in such facilities. We did locate a data source that provided information on both the number of nursing home complaints received and the total number of nursing home beds in each state.² We therefore computed complaint rates using the number of complaints received for each 1,000 nursing home beds. It is important to note that no data base included information on the total number of elderly residents in board and care facilities; therefore, no complaint rates for board and care facilities could be calculated.

Findings

First, we examined the differences among states in program participation, as measured by complaint rates. The total number of nursing home complaints reported in the 1988 National Center for State Long-Term Care Ombudsman Resources study was 102,231. The number of nursing home complaints by state varied widely, ranging from 0 in Puerto Rico to 28,578 in California. The mean number of complaints per state was 1,966; however, this figure is influenced greatly by a few large states. A better indication of the true level across states is the median number of complaints, which was 906.

The number of complaints in any given state should somehow be related to the number of elderly residents in nursing homes—the more such persons there are, the more complaints one would expect, all other factors being equal. To provide a useful comparison between states, we needed to take account of this fact. Therefore, we divided the number of complaints by the

²These data were calculated as part of a 1988 survey of state ombudsmen conducted by the National Center for State Long-Term Care Ombudsman Resources. We updated those data to include information missing in the original study. This yielded data on all 50 states, the District of Columbia, and Puerto Rico. See National Center for State Long-Term Care Ombudsman Resources, A Study of the Involvement of State Long-Term Care Ombudsman Programs in Board and Care Issues (Washington, D.C.: National Association of State Units on Aging, December 1989).

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number of nursing home beds in each state, and then multiplied by 1,000. This resulted in an estimate of the number of complaints per 1,000 nursing home beds in each state—in effect, treating all states as if they had the same eligible population.

If the ombudsman program worked precisely the same way in every state, we would expect little or no difference in complaint rates across states. However, we found a wide variation in those rates, ranging from 0 complaints for each 1,000 beds in Puerto Rico to 431 for each 1,000 beds in the District of Columbia. This variation suggests that ombudsman programs may operate quite differently across states. One obvious difference is the variation in the number of ombudsmen states employ. Other factors being equal, states with more ombudsmen may be expected to contact more nursing home residents, and at least potentially to receive more complaints. To examine this possibility, we grouped states with similar numbers of full-time paid ombudsmen. To the extent that differences between states in the number of full-time paid ombudsmen account for differences in complaint rates, we would expect that the variation within each group should be less than the variation between groups.

However, we did not find this to be the case. In figure I.1 on pages 12 and 13, we show the complaint rate for each state as a vertical bar. The states have been grouped by the number of ombudsmen they employed. It is obvious that the variation within each group is much greater than that between the groups. For example, even though Arizona and New Mexico each employed 2 full-time paid ombudsmen, the former reported 15 complaints per 1,000 beds and the latter 108, more than 7 times as many. Similarly, Vermont's complaint rate of 69 per 1,000 beds was more than 3 times Virginia's rate of 22, even though both of these states employed 6 full-time paid ombudsmen.

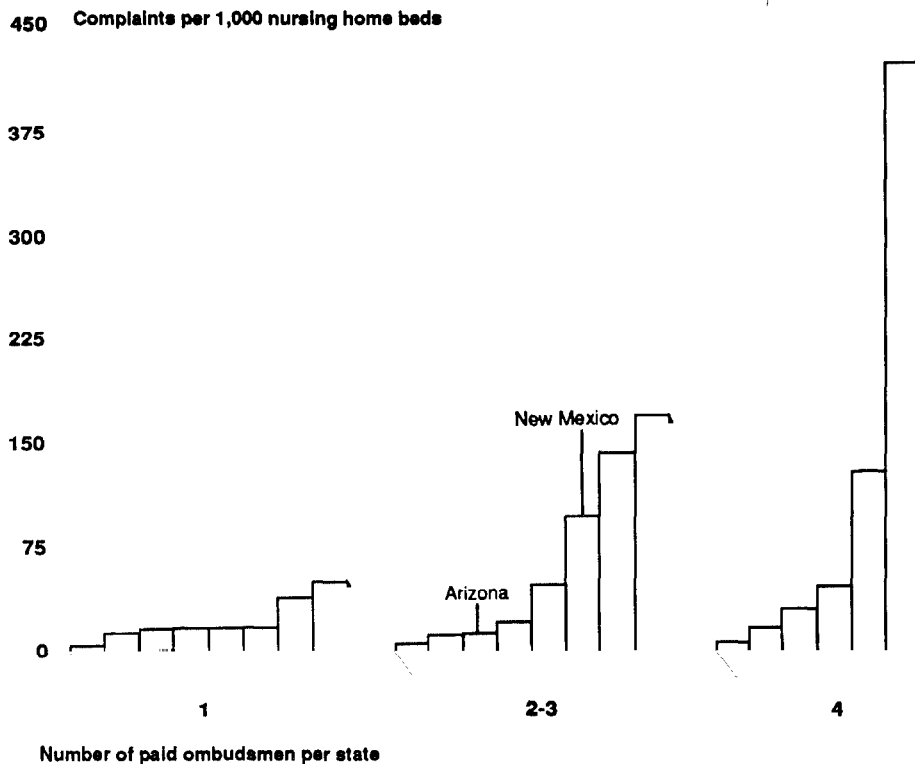
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The persistence of wide variations between states in numbers of complaints, even when size of nursing home populations and number of ombudsmen were taken into account, indicated that other factors may be at work. We have identified several such factors. First, many states supplemented their staff of full-time paid ombudsmen with part-time and volunteer ombudsmen. We were not able to take these two groups into account because meaningful data were lacking across the states. Second, states appeared to vary in the number of residents living in board and care facilities and in the emphasis their ombudsmen placed on reaching those populations. However, AOA does not collect information on the number of board and care facility residents, nor were we able to determine the extent to which individual states sought out those residents under the ombudsman program. Third, the states also appeared to use varying definitions in determining what constituted a complaint, so that comparisons may be somewhat misleading. Finally, it may be that some programs were particularly aggressive in seeking out nursing home problems and identifying residents with complaints; for example, this appeared to be the case with the District of Columbia program.

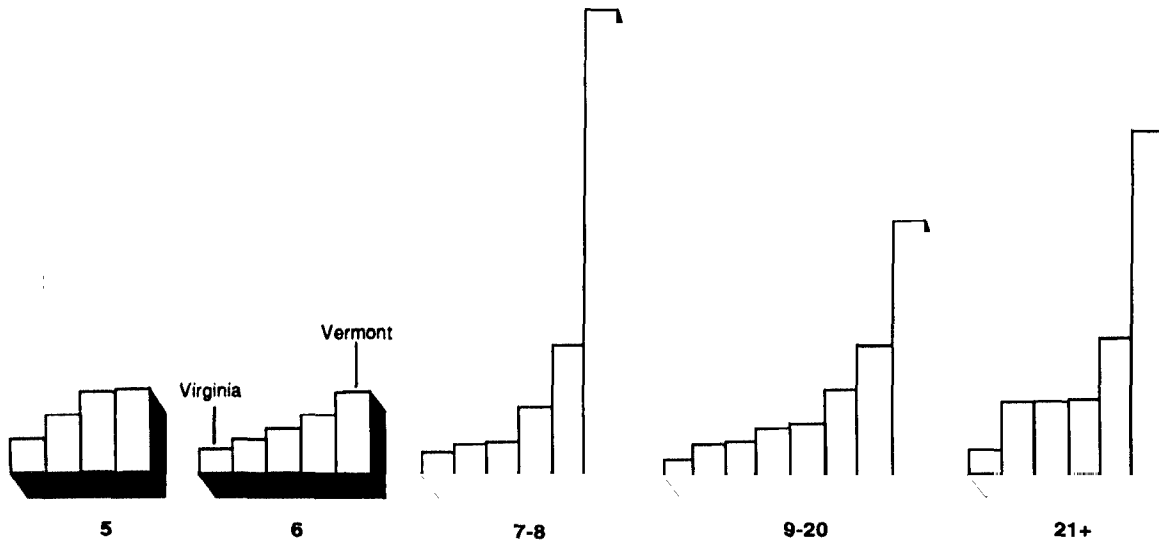
In summary, we found that the number of complaints varied widely across states. Taking into account the differing numbers of nursing home beds and full-time paid ombudsmen across states did not fully explain this variation. Currently, AOA does not collect the information necessary to gauge the level of utilization of the ombudsman program, including the total number of complaints by the type of facility and the number of nursing home and board and care residents in each state.

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Figure I.1: Nursing Home Complaints per State^a



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^aPuerto Rico not shown (0 complaints).

Source: National Association of State Units on Aging and AOA.

Barriers That Prevent Access by Ombudsmen to Residents

You also asked us to identify what barriers, if any, prevent access by ombudsmen to residents. We studied this question by examining (1) legislative limitations on ombudsman access to residents, (2) limitations on ombudsmen that exist when residents are unable to give legal consent to complaint investigations, and (3) difficulties ombudsmen have, if any, in gaining access to board and care residents. To accomplish this, we interviewed 37 state ombudsmen concerning their state laws and how they provide services to residents who are unable to consent to a complaint investigation. We also interviewed a group of 16 state and local ombudsmen and reviewed literature on the difficulties ombudsmen may experience in gaining access to board and care residents.

Legislative Limitations on Ombudsman Access to Nursing Home or Board and Care Residents

The act mandates that ombudsmen shall have appropriate access to residents, nursing home and board and care facilities, and resident medical and social records. The right to review a resident's medical records is also guaranteed in the Omnibus Budget Reconciliation Act of 1987. With appropriate access, ombudsmen could reach all eligible residents in such facilities. Providing a statutory basis in state law for such access is an important (but not sufficient) assurance that all residents will have the opportunity to contact, or be contacted by, an ombudsman.

A 1987 study by the American Association of Retired Persons asked 48 state ombudsmen if their state laws gave ombudsmen access to residents, facilities, and/or records.³ We resurveyed state ombudsmen in the 37 states that indicated in 1987 that their state laws did not provide ombudsmen with access to either residents, facilities, or records. As shown in table I.1, since the 1987 reauthorization of the Older Americans Act, legal barriers to access, as reported by our respondents, have greatly diminished in the following categories: (1) access to residents, (2) access to nursing homes, (3) access to board and care facilities, and (4) access to residents' medical and financial records. The one area that has not shown a change during this period is access to administrative records maintained by facilities. Administrative records are an important source of information for ombudsmen during complaint investigations. However, the act currently does not explicitly require that facilities make administrative records available to ombudsmen.

³American Association of Retired Persons, Long-Term Care Ombudsman Program: Report on a Survey of State and Local Programs (Washington, D.C.: American Association of Retired Persons, 1990).

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**Table I.1: Legislative Limitations on
Ombudsman Access**

Area of access	Number of states not providing for access in their laws	
	1987^a	1991^b
Residents	5	0
Nursing home facilities	7	2
Board and care facilities	9	3
Resident medical records	11	1
Resident financial records	11	2
Facility administrative records	16	15

^aAmerican Association of Retired Persons 1987 survey of 48 state ombudsman programs (excludes four nonreporting states)

^bOur resurvey of the original 37 state ombudsman programs reporting barriers to access in the American Association of Retired Persons survey

**To What Extent Are
Ombudsmen Impeded When
Residents Are Unable to Give
Legal Consent to Investigate
Complaints?**

According to the annual survey of nursing homes conducted by the Health Care Finance Administration, up to 59 percent of residents in nursing homes have cognitive impairments. It is unknown what proportion of these residents have guardians to act for them to ensure quality of care. Again, we asked the 37 state ombudsmen whether they faced a serious barrier when a resident was incapable of consenting to a complaint investigation and did not have a guardian who could address such a problem. Ten of these state ombudsmen reported that this situation was a potential barrier, while three ombudsmen stated that it was a serious existing barrier.

We also asked the 37 state ombudsmen how they dealt with residents who were incapable of consenting to an investigation and had no guardian to act on their behalf. We found that states varied in their attempts to alleviate this problem. According to our respondents, eight states provided ombudsmen the necessary legal authority to fully investigate a complaint on behalf of a resident regardless of that resident's ability to consent legally. Six states offered their ombudsmen the assistance of an agency with investigative authority, such as a state licensing agency, when a resident could not give legal consent. Conversely, at least one state required that the ombudsman cancel the investigation in cases where a resident was unable to provide written approval for a review of the records. In states that do not provide assurances of access when a resident cannot legally consent to an investigation, the ability of the ombudsman program to provide services to residents (who could be in serious need of such services) is constrained.

**Difficulties Ombudsmen
Experience in Gaining Access
to Board and Care Residents**

We interviewed 8 state and 8 local ombudsmen concerning difficulties they may have experienced in gaining access to board and care residents. Three ombudsmen told us that they could not make regular visits to board and care facilities due to limited financial resources. Three ombudsmen also indicated that they could not access all eligible board and care residents because they lacked sufficient information on the location of licensed and unlicensed board and care facilities in their area. One reason for the inability to access all board and care residents was the variation in terminology used to identify board and care homes. For example, a 1988 study identified 225 different titles used to describe board and care facilities.⁴ The same study also found that differences in titles can also represent differences in the services provided and persons served by those facilities. Without a uniform definition of what constitutes a board and care facility and an accurate estimate of the percentage of total residents served, it is difficult to determine how well ombudsmen are serving residents in these facilities, and it is impossible to compare findings across states about their services.

In summary, state-level legal-access barriers have reportedly diminished in all areas except that of facility administrative records. Although administrative records are not explicitly covered under the Older Americans Act, they represent an important source of information for ombudsmen conducting complaint investigations. Additionally, ombudsmen may be limited in their ability to investigate complaints on behalf of residents who are not able to consent to an investigation and who do not have a guardian to act on their behalf. From our research, we found that states varied in the authority they provided ombudsmen when a resident was unable to consent to an investigation. In addition, a lack of information on the number and location of board and care facilities, both licensed and unlicensed, and a lack of uniformity in defining such facilities, may limit the ability of ombudsmen to gain access to board and care residents.

⁴See Select Committee on Aging, House of Representatives, Board And Care Homes In America: A National Tragedy (Washington, D.C.: U.S. Government Printing Office, March 1989).

Impact of the Ombudsman Program

You also asked us to determine (1) what impact can be expected from the ombudsman program, (2) what factors are likely to affect impact, and (3) the extent to which AOA and state data bases can be used to measure impact.

An impact evaluation provides an assessment of the degree to which a program causes changes in the desired direction for the population under study. For the ombudsman program, an impact evaluation could determine the extent to which residents are aware and have access to the program, ombudsmen have access to residents, and the program is resolving the complaints it receives. We did not find a systematic evaluation of the ombudsman program at the national level conducted within the past 10 years. We interviewed AOA officials, who told us that the agency has not conducted an impact evaluation of the ombudsman program, nor has it defined what should constitute the impact of the program.

To answer your question, then, Mr. Chairman, it was necessary for us to determine what impact it was reasonable to expect from the program and what factors could affect that outcome. To do this, we first identified the program's impact (or outcomes) as stated in the act. Next, we identified factors included in the act that were likely to affect program outcome. In addition, we interviewed 8 state and 8 local-level ombudsmen, as well as representatives of organizations involved in long-term care, in order to identify additional factors not mentioned in the act that in their view could affect impact. We also examined AOA's annual data collection instrument in order to determine the extent to which the data could be used to evaluate the impact of the ombudsman program. Finally, we reviewed the data collection instruments of 26 states for relevant impact information.

What Impact Can Be Expected From the Ombudsman Program?

The act cites the removal of impediments to resident health, safety, welfare, or rights as the major objective of the ombudsman program. The act further provides that this objective be attained through the receipt and resolution of complaints. Resolution has been defined by some states as the correction of a problem to the satisfaction of the resident. Working from the act and state interpretations of it, then, we defined the percentage of complaints resolved as an important measure of the program's success in removing impediments to resident health, safety, welfare, or rights.

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**What Factors Are Likely to
Affect Impact and What Data
Are Currently Being
Collected on Them?**

Table I.2 lists program factors mentioned in the Older Americans Act. These factors include (1) ombudsman staff training, (2) development of citizen organizations, (3) ombudsman involvement in regulatory and policy recommendations, (4) ombudsman provision of information to public agencies and others, (5) coordination with the advocacy system for the developmentally disabled and mentally ill, and (6) resident access to ombudsmen. We developed sample measures that might be used to measure these factors and determined whether AOA or states are currently collecting information on those factors. As table I.2 shows, data collected by AOA do not address these factors, although many state data bases do.

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Table I.2: Factors Affecting Program Impact as Identified in the Older Americans Act and Data Currently Collected on Them

Program factor	Possible measure	Can AOA data measure this factor?	States with data that might measure this factor^a
Trained ombudsman staff	Number of hours of training that paid or volunteer ombudsmen receive in complaint resolution and advocacy	No	CA,GA,LA,MI,ND,OK WA,WV
Promoting the development of citizen organizations in the ombudsman program	Number of hours ombudsmen spend promoting the development of citizen groups in the ombudsman program	No	CA,GA,ID,IN,LA,ND NM,VT,WA,WV
Involvement in regulatory and policy recommendations	Number of issues on which ombudsmen provide information and recommendations concerning state-level policies and procedures on long-term care options	No	GA,ND,NM
	Percentage of state/local nonlegislative policy committees on aging that include an ombudsman representative	No	None
Provision of information to public agencies, legislatures, and others concerning issues faced by residents of long-term care facilities	Number of separate communications to public agencies, legislatures, and others	No	GA
Coordination with the advocacy system for developmentally disabled and mentally ill residents	Percentage of complaints concerning mentally ill or developmentally disabled residents that are appropriately referred to other agencies for resolution	No	None
Ensuring resident access to ombudsmen	Average number of noncomplaint contacts made by ombudsmen during visits to facilities	No	AR,CA,GA,ID LA,MA,MI,MN ND,NM,NY,OK OR,TX,WA,WV
	Percentage of facilities with readily available information on the ombudsman program	No	None
	Percentage of residents who know how to gain access to the ombudsman program	No	None

^aBased on our review of 26 state data collection instruments

The issue of residents' access to ombudsmen was highlighted for inclusion in an impact evaluation by almost two thirds of the respondents in our interviews. As noted previously, information is lacking nationally about the total number of (1) elderly residents, (2) facilities, and (3) complaints made to ombudsmen. Both ombudsmen and experts stated that increasing residents' access to ombudsmen through regular facility visitation could broaden the range of residents from whom programs receive complaints. Respondents reported that the more often ombudsmen visit a facility, the

more opportunity residents have to gain access to the ombudsman program, and consequently the more knowledge will be acquired about the real universe of problems in that facility. Regular visitation may also enable ombudsmen to reach residents at higher risk (for example, residents with cognitive deficiencies or physical disabilities). In addition, individuals who do not have an informal social network, such as a family member or friend, to notify an ombudsman on their behalf may benefit from ombudsman services as a result of contacts made during these regular visits. One factor not included in the Older Americans Act but identified by some ombudsmen and experts as important to include in an impact evaluation was the education of facility personnel regarding resident-care issues.

**The Extent to Which AOA
and State Data Bases Can Be
Used to Measure Program
Impact**

First, as already shown in table I.2, we found that AOA does not collect information on the impact variables stated in the Older Americans Act or on those suggested by the respondents to our interviews. These included (1) ombudsman training, (2) promotion of citizen organizations, (3) ombudsman involvement in regulatory and policy recommendations, (4) provision of information to agencies and others about the program, (5) coordination with agencies for the developmentally disabled and retarded, (6) resident's access to ombudsmen, and (7) educating facility personnel concerning resident care. In a nonrandom sample of 26 state ombudsman programs, we found that some states are currently collecting data on many of the factors discussed in table I.2. However, certain factors, such as coordination with the advocacy system for developmentally disabled and mentally ill residents, were not reported on any of the data collection instruments of those states that we surveyed, and thus may represent previously unmeasured program characteristics.

Currently, the data that are being collected nationally by AOA are insufficient to evaluate the impact of the ombudsman program (as defined in the Older Americans Act) appropriately. Although AOA collects information on the outcome of the program (such as complaints resolved, still active, or not acted upon), this information is not sufficiently specific, and not enough additional information is being collected, to evaluate the impact of the ombudsman program adequately. As indicated, some states are collecting information to measure program impact and thus may be able to evaluate the impact of their own programs.

Second, the data collected by AOA—on the number and types of complaints received by each state, as well as on the status of complaints—present a number of problems that largely stem from the data collection instrument.

For example, the definitions used for some variables in the data collection were ambiguous. No clear definition of unresolved complaints was given; yet without this information, the percentage or number of complaints resolved is not an accurate measure of the program's impact. Nor did AOA's data require states to provide the information necessary to determine whether a complaint involved a resident from a nursing home or from a board and care facility. (Identifying where a complainant resides is essential in determining whether the rate of resident complaints is the same for nursing home and board and care facilities.) In addition, using AOA's data, we were unable to link specific complaint characteristics—such as complaint category (for example, resident care, resident rights, or medications)—to the resolution status of a complaint (that is, resolved, not acted upon, or still active). Finally, complaint resolution must be linked to those program factors that affect outcome for an impact evaluation to be of use in program planning.

In summary, we did not find a recent evaluation of the impact of the national ombudsman program, and AOA does not collect the information necessary to complete such an evaluation. We also found weaknesses in AOA's data collection instrument, especially that it does not provide a clear definition of unresolved complaints. Without information on how many complaints remain unresolved, the percentage or number of complaints resolved is not a meaningful measure of program impact. Furthermore, we found that some states may be collecting useful information for an evaluation study, including information on some of the factors we suggested be included in an impact evaluation. However, we did not review state data to assess the feasibility of conducting such an evaluation.

Conclusions

We believe that, at a minimum, there is a need to modify AOA's annual data collection instrument to correct its defects and to allow measurement of utilization rates of the ombudsman program. The latter would involve collecting information on (1) the total number of complaints received, by type of facility (nursing home or board and care facility), and (2) the total number of nursing home and board and care residents (or, at a minimum, beds). To appropriately evaluate the ombudsman program, a standard definition of what constitutes the resolution of a complaint should be developed. In addition, we conclude that sufficient data to measure the impact of the program are not being collected at the national level.

Although complaints from residents of board and care facilities account for nearly 1 out of every 5 complaints received by the ombudsman program,

**Appendix I
Statement of Eleanor Chelimsky, Assistant
Comptroller General, Before the
Subcommittee on Aging of the Senate
Committee on Labor and Human Resources,
June 13, 1991**

not enough is known concerning how well the program is serving residents of board and care facilities. Accordingly, we believe a need exists to define, for the use of state ombudsman programs, exactly what constitutes a board and care facility. Additionally, we believe a need exists to determine how resources in the program can best be spent to meet the needs of both nursing home and board and care residents.

Finally, based on our work to date, we can conclude that ombudsmen need administrative data to complete complaint investigations. Therefore, the Congress may wish to consider amending the Older Americans Act to grant ombudsmen explicit access to facility administrative records.

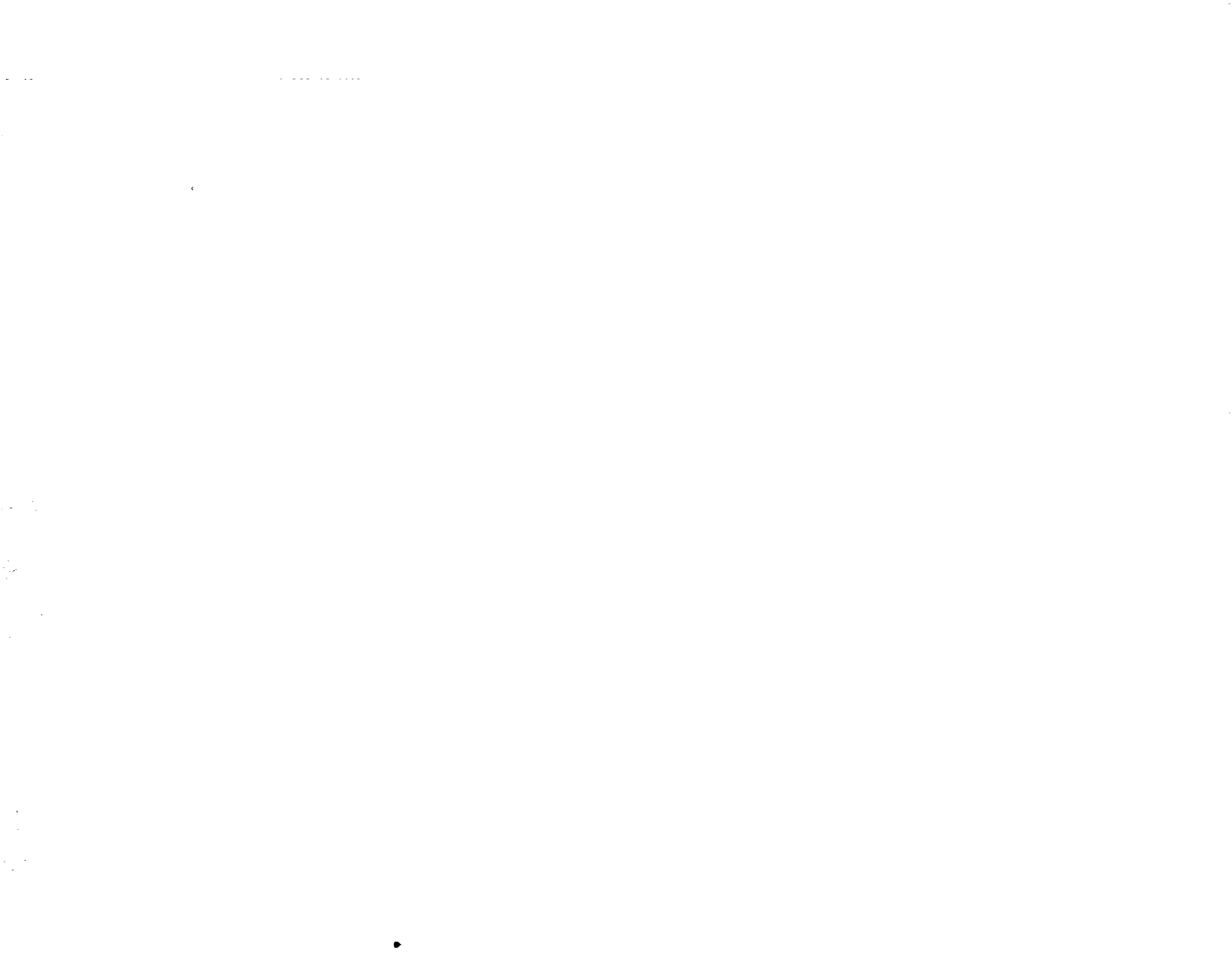
Mr. Chairman, we intend to issue our report on this important topic within a few months. At that time, we will advise you of the agency's position on our findings and conclusions and, if necessary, propose legislation to assure that needed actions are taken.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions you may have.

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