SCRIPPS GERONTOLOGY CENTER

MIAMI UNIVERSITY

Enhancing the Performance of Local Long-Term Care Ombudsman Programs in Ohio

CHARTBOOK

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INTRODUCTION 1

Overview of the Study

Following the completion of the *Enhancing the Effectiveness of Local Long Term Care Ombudsman Programs in New York and California* project, other states expressed an interest in replicating the project in their own states. In Ohio, under a collaborative agreement, researchers at the Scripps Gerontology Center at Miami University were the lead agency in using the structure and survey instrument created by researchers at the Institute for Health & Aging (IHA) at the University of California, San Francisco. Our goal has been two fold: 1) to replicate the New York and California projects in order to advance comparative knowledge of program performance and barriers across the nation; and 2) to identify and examine LTCOP issues of particular relevance to Ohio. Throughout this endeavor we have had superb cooperation and support from the State Ombudsman Program of Ohio, under the direction of Beverly Laubert.

The Ohio state study benefits from collaboration between Chris Wellin and Cary S. Kart, of Miami University's Scripps Gerontology Center, and Dr. Carroll Estes and colleagues at the Institute for Health & Aging (IHA) at the University of California, San Francisco. Dr. Estes is a national authority on the Ombudsman Program and a member of a task force convened by the Institute of Medicine some years ago to examine the viability and performance of the LTCOP nationally. Researchers in Ohio conducted in-person survey interviews with all of the LTCOP program directors in the state—10 persons who are responsible for 12 Program Service Areas or "PSAs." (Two respondents have responsibility for two regional programs each; inasmuch as they face different issues, and have different host agencies in each PSA, we interviewed them twice.). Thus we have a 100% response rate. The survey instrument is detailed and comprehensive in addressing organizational, programmatic, and policy issues that are germane to the ability of regional Program Directors to meet their various mandated responsibilities. The charts presented here, in which we summarize and display our findings, are comparable to those in the New York/California Comparative chartbook, and in the just published Illinois study.

INTRODUCTION 1

Overview of the Study, cont'd.

In the Ohio case study, our major goals regarding the impact of the study are to:

- identify the specific factors (activities, resources, roles and organizational characteristics) that are associated with program effectiveness in Ohio;
- develop a set of actionable recommendations specifically for the Ohio Ombudsman Program (A Blueprint for Action);
- work with local ombudsman programs and the Ohio state ombudsman director in developing steps to strengthen their programs;
- promote communication and enhance synergy between state and local ombudsman entities in Ohio; and
- disseminate findings and *best practices* to Ohio LTCOPs from other states and from Ohio to LTCOPs in other states, using the web, and appropriate state and national organizations and meetings.

INTRODUCTION 1

Overview of the Study, cont'd.

As part of a multi-state effort to improve the ability of local ombudsman programs to assist residents of LTC facilities to resolve complaints and problems regarding quality of care, the Ohio LTCOP project will both contribute to and benefit from the larger project. The comparison of issues confronting local Ohio ombudsmen programs with those confronted in similar programs across six geographically, demographically, and politically diverse states will be informative in identifying and sharing information regarding best practices, and program strengths and weaknesses. The project is committed to the application of findings through the development of a Blueprint for Improving the Local LTC Ombudsman Program, the Ombudsman Summit, and at least one key policy event in Ohio. The overall multi-state project is expected to contribute to dialogue at both the state and national levels concerning future programmatic and policy directions in time for deliberations concerning the re-authorization of the Older Americans Act and the Ombudsman Program.

Regional ombudsman programs in Ohio are housed in a variety of host agencies – Catholic Social Services (2), legal services (2), Lutheran Metropolitan Ministry (1), government ombudsman office (1), and Area Agencies on Aging (6). The impact of organizational placement on effective advocacy is not well understood. Shedding light on the nature and impact of this impact is a major goal of this study. Regional programs formed the Ohio Association of Regional Long-Term Care Ombudsmen (OARLTCO) in 1984. OARLTCO's activity has waxed and waned through the twenty years of their organization and effectiveness is dependent on the elected officers. Another factor in their degree of organization and advocacy seems to be the leadership of the State Ombudsman and existence or lack of organizational constraints at the state level. The blueprint for action informed by this project should provide guidance to the State Ombudsman with regard to working effectively with the association and how the relationship with the association does or should differ from the relationship with individual programs. Ohio has a fairly large urban area and large number of older persons with a high percentage residing in nursing homes. Adding Ohio to the Local LTCOP Project would enhance the regional variation of the project and increase knowledge on a comparative state basis within it.

INTRODUCTION 1

Project Methods

The project has two phases. Phase 1 involved collaboration between researchers from the Miami University Scripps Gerontology Center and from the Institute for Health & Aging at the University of California, San Francisco, and state and local LTC leaders to implement the research study. Phase 2 is devoted to eliciting reactions from informants, and to developing recommendations and generalized dissemination as well as targeted follow up with LTC policymakers and other critical stakeholder groups. Two meetings in Ohio will be held in order to strengthen and disseminate the study's recommendations. One, an Ombudsman Mini-Summit to occur on February the 15th of 2007 in Columbus, will bring local ombudsmen together to discuss study findings and consider how to define and implement key project recommendations. Because local Program Directors are most knowledgeable about, and directly involved in, administering the LTCOP, their perspectives will be the focus of our first meeting. In the second meeting, scheduled for March of this year, we will also share findings from ten "Key Informant" interviews, and from analysis of secondary data gleaned from ODIS, Ohio's mandated online reporting system. This March meeting will include, in addition to Program Directors, various state policymakers and other critical stakeholders who will be instrumental in developing a framework (Blueprint) for implementing policy and programmatic improvements. In both meetings we will be alert to areas of consensus, as well as expressed differences—in philosophy, perspective, or strategy—among those who have a shared stake and distinct roles in the LTCOP of Ohio.

INTRODUCTION 1

Background

Ohio's LTCOP works to improve the lives of residents of LTC facilities. Mandated under the federal Older Americans Act, Long Term Care Ombudsman Programs play an important role in the quality of care of older residents of LTC institutional settings and community living arrangements by advocating to protect the health, safety, welfare and rights of elderly and other residents. Specifically, LTCOPs address five federally mandated activities and roles including: complaint investigation; community education; resident and family education; monitoring federal, state and local law, regulations and other government policies and actions; and legislative and administrative advocacy.

INTRODUCTION 1

Focal Areas of Research Attention in the Comparative Study

It may be useful here briefly to sketch the major topical areas we addressed in the study. These are areas that have been found to affect program effectiveness in prior research: *(1) adequacy of and control over resources; (2) organizational autonomy; and (3) inter-organizational relationships and coordination.*

The first area encompasses staffing, budgetary pressures, and the stability of these crucial resources for particular local programs over time. The second topical area reflects the variation in "host agencies" among local LTCOPs. At the inception of the program nationally, it was generally believed not to be ideal for local programs to be housed in Area Agencies on Aging. There were concerns regarding potential conflicts of interest for LTCOs, inasmuch as clients would likely be participating in programs administered through the AAA. More generally, researchers have investigated whether the level of support for the mission of the LTCOP, and various kinds of technical and legal support, vary according to where (in which kind of agency) local programs are housed. Finally, as a program that spans federal agencies and mandates, state-level programs, and local relationships with social service and legal entities, LTCOPs require ongoing coordination across these boundaries and jurisdictions. Research has sought to identify the nature and quality of such coordination.

A final area of substantive interest in our study is the ability of LTCOPs (given current staffing and budgetary resources) to respond to systemic shifts in the Long-Term Care system. In Ohio, as nationally, this shift has involved greater demand for and provision of long-term care in community-based settings such as board-and-care homes (often independent and owner-occupied) and assisted living facilities. The emergence of more community-based options is widely-regarded as a positive and overdue development in the continuum of care in the U.S. However, given that community-based settings are both geographically more dispersed, and less tightly-regulated, than custodial/nursing institutions, we need to examine what new demands and pressures this set of changes may be imposing on regional LTCOPs.

INTRODUCTION 1

Program Characteristics

Program Directors in Ohio have considerable tenure and experience; nearly three-quarters reported five or more years of service in their current position (Figure 2.1). In fact, the same proportion report ten or more years of *total* experience, which reflects earlier involvement as volunteers and/or other roles (Figure 2.2). About half of Ohio's local programs are located in Area Agencies on Aging, with the remainder divided between multi-purpose non-profit agencies (2); legal services agencies (2) or stand-alone Non-profit agencies (1) [Figure 2.3]. Nearly half of local programs report having fewer than 5 volunteers, and only one quarter report having more than 10 (Figure 2.5). It will be important to assess the adequacy of volunteer staff in relation to the particular PSA's in which programs are located (which vary greatly in the size, diversity, and density of their populations). Three-quarters of respondents report needing additional funding to carry out all mandates (Figure 3.3), and the same proportion report disagreement that they have sufficient paid staff on hand (Figure 3.4). Local program directors report strong support in host agencies, with two-thirds perceiving that the LTCOP is recognized as a priority by the host agency (Figure 3.7).

Self-Rated Effectiveness

As Figure 3.1 indicates, regional program directors rate highly their perceived effectiveness in handling complaint investigation (with 83% rating this as "highly effective"), while fewer (25%) rate as "highly effective" their effectiveness in resident and community education; community education; and monitoring federal, state, and local laws and regulations. Only 8% rate their "legislative and administrative policy advocacy" as highly effective. Also, program directors rate their effectiveness in nursing homes more highly than they do in board & care/assisted living facilities; 67% and 50%, respectively, rate themselves as "very effective" in the two settings (Figure 3.2). We found substantial consensus among program directors in these self-ratings. Also, we see these data as pointing to important pressures and tensions between various roles and mandates for which program directors are responsible. However, in our upcoming meeting we will elicit reactions and interpretations to these data, from regional directors.

INTRODUCTION 1

Study Special Issue Domains

Informants rate highly their effectiveness in addressing complaints and concerns regarding Elder Abuse, with nearly 60% believing they are "very effective" in this arena; fewer (25%) rate as highly their capacity to address gross neglect, and one third (33%) rate their ability to address financial exploitation as "very effective." Above we noted the systemic shift in Ohio's long-term care system; in addition to more residents in board & care and assisted living, we see more "short-term" nursing home residents, who are receiving post-acute, rehabilitative, and convalescent care. Only 17% of respondents report feeling "very effective" in meeting the needs of such residents, and 75% perceive themselves to be "somewhat ineffective" in this regard. Clearly, the task of LTCOs, to inform residents about rights and the complaint process, and to monitor the more intensive, often technologically-elaborate treatments that occur during post-acute and rehabilitative care, is challenging. The challenge arises because of the shorter stays for such patients (who may be in residence for only a matter of weeks), and also of the need of ombudsmen to master new kinds of knowledge and information regarding post-acute and rehabilitative care. Given that local programs report difficulties in providing basic staff training and community education, the goal of finding "extra" time and resources for such supplementary training is likely to be elusive. This is precisely the kind of longer-term systemic challenge we hope to identify, and to help address, in this study.

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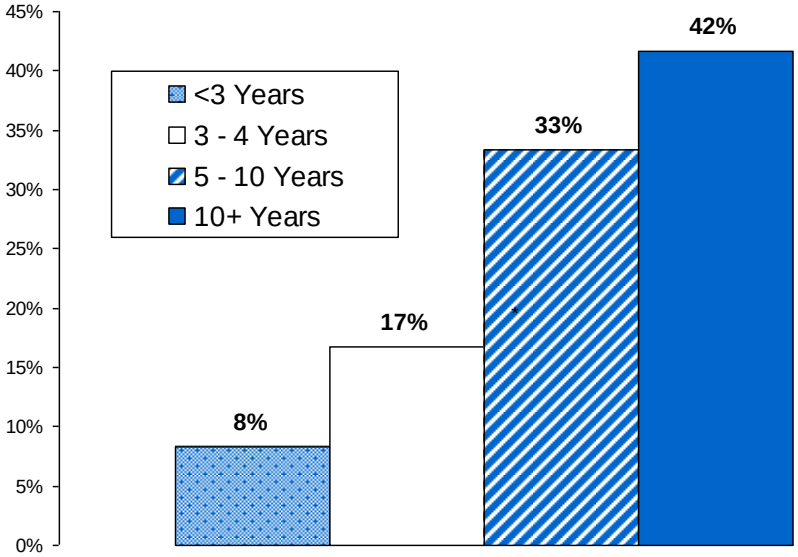
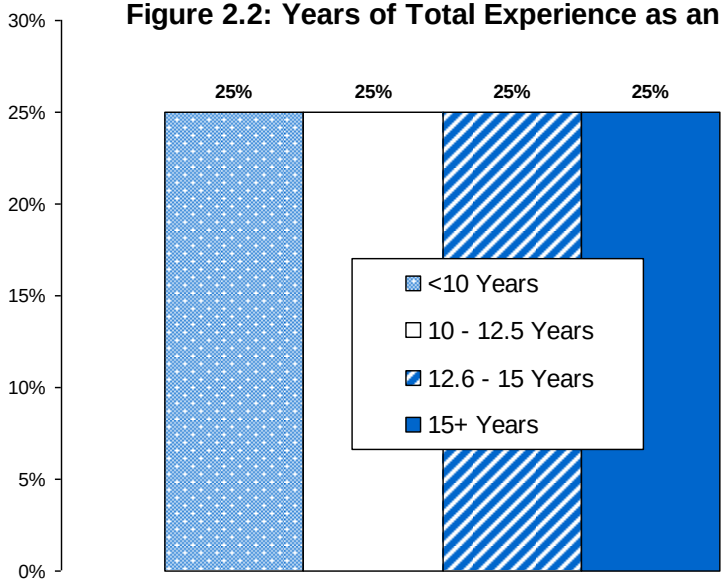
Characteristics of LTC Ombudsman Program Coordinators

Figure 2.1: Years of Experience in Current Position as an Ombudsman



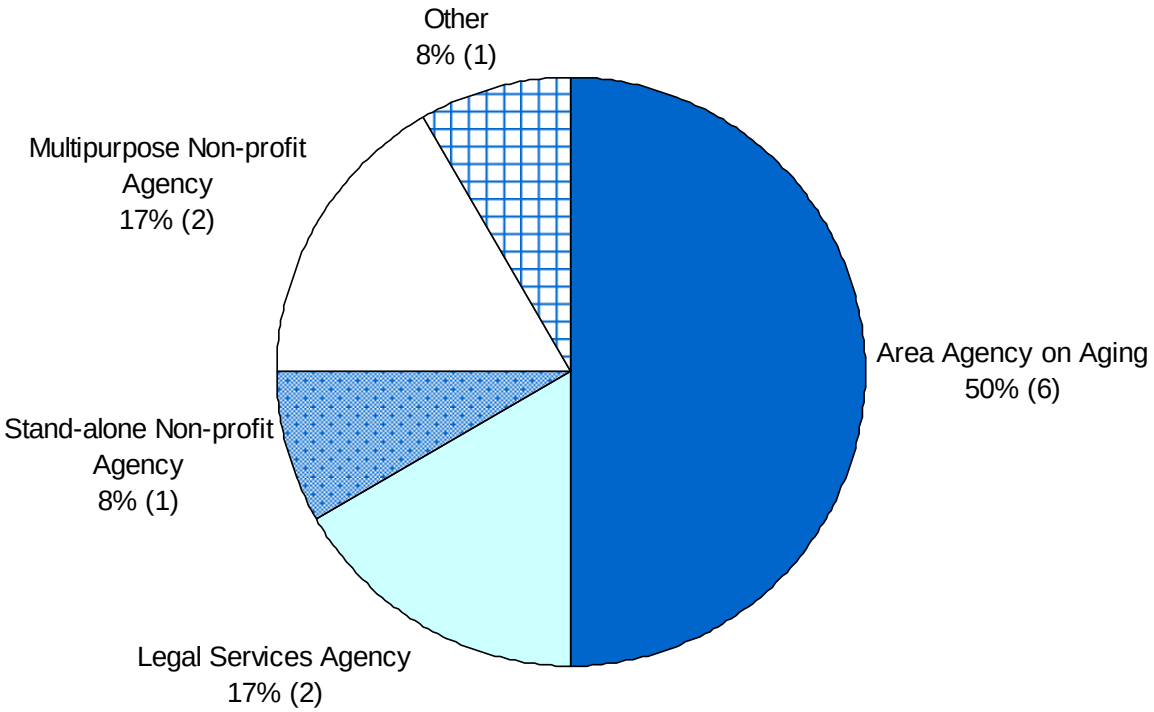
Q. How long (in years) have you been in your current position as an Ombudsman?
Respondents' duration in current position as an Ombudsman ranged from 1.0 to 19.5 years, with a mean of 9.167 years

Figure 2.2: Years of Total Experience as an Ombudsman



Q. How many years total experience do you have as an Ombudsman, including years in your current position?
Respondents have years of total experience as an Ombudsman ranging from 1.0 to 23.0 years, with a mean of 12.375 years (sd = 5.593). The median years of total experience as an Ombudsman is 12.75 years.

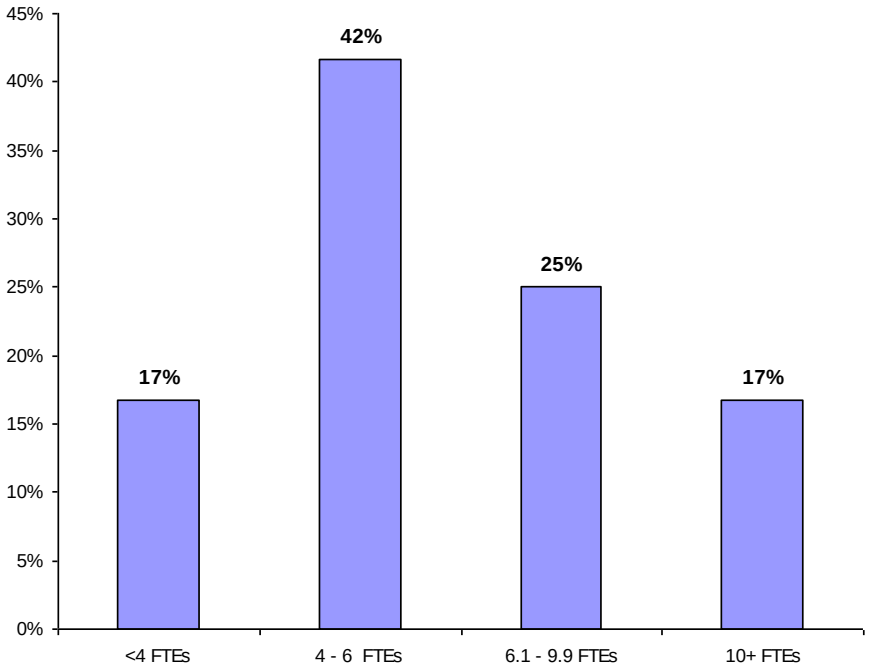
Figure 2.3: Location of Regional LTCOPs



Q. Which of the following most accurately describes the host agency of your local LTCOP? [A "host agency" is the organization in which your LTCOP is located or agency that sponsors your LTCOP.]
Six of the 12 LTCOPs (50.0%) are hosted by an Area Agency on Aging. Eleven of the 12 regional LTCOPs described their host agencies as "private non-profit" and none (0) report having had a change in the host agency in the last five years.

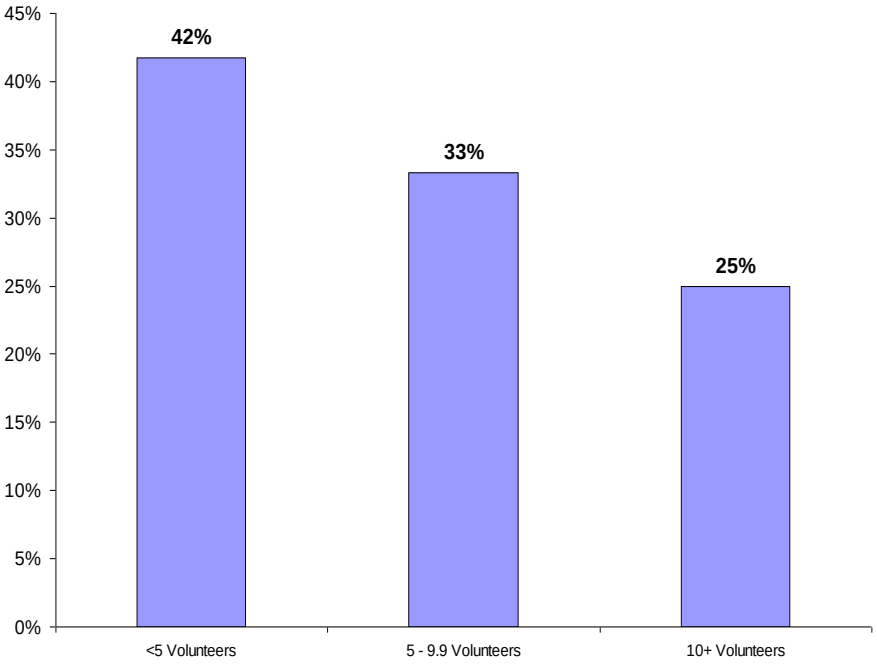
Staffing of Local Long-Term Care Ombudsman Programs

Figure 2.4: Ratio of Paid Program Staff (Full-Time Equivalents) in Regional LTCOPs



Paid program staff (FTEs) at the regional LTCOPs ranged from 2.0 to 13.0, with a mean of 6.158 FTEs (sd = 3. 144) and a median number of 5.5 FTEs.

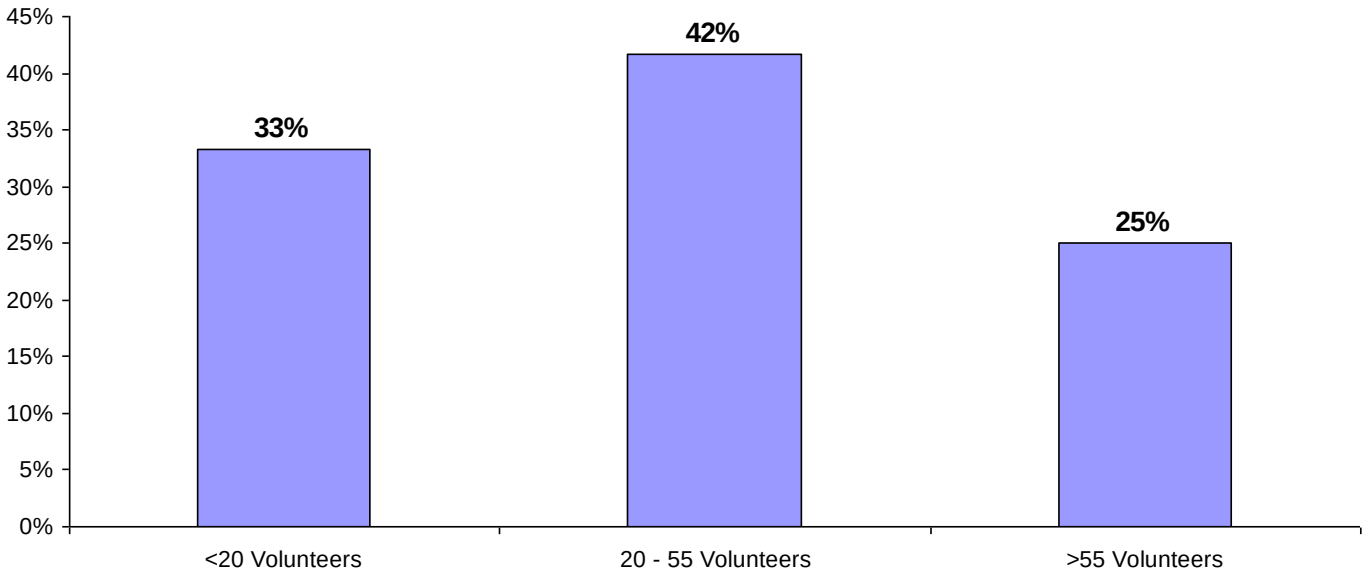
Figure 2.5: Ratio of Certified Volunteer Staff in Regional LTCOPs



The number of certified volunteer staff at the regional LTCOPs ranged from 2.0 to 13.0 with a mean of 6.42 (sd = 3.502), and a median number of certified volunteer staff of 5.0.

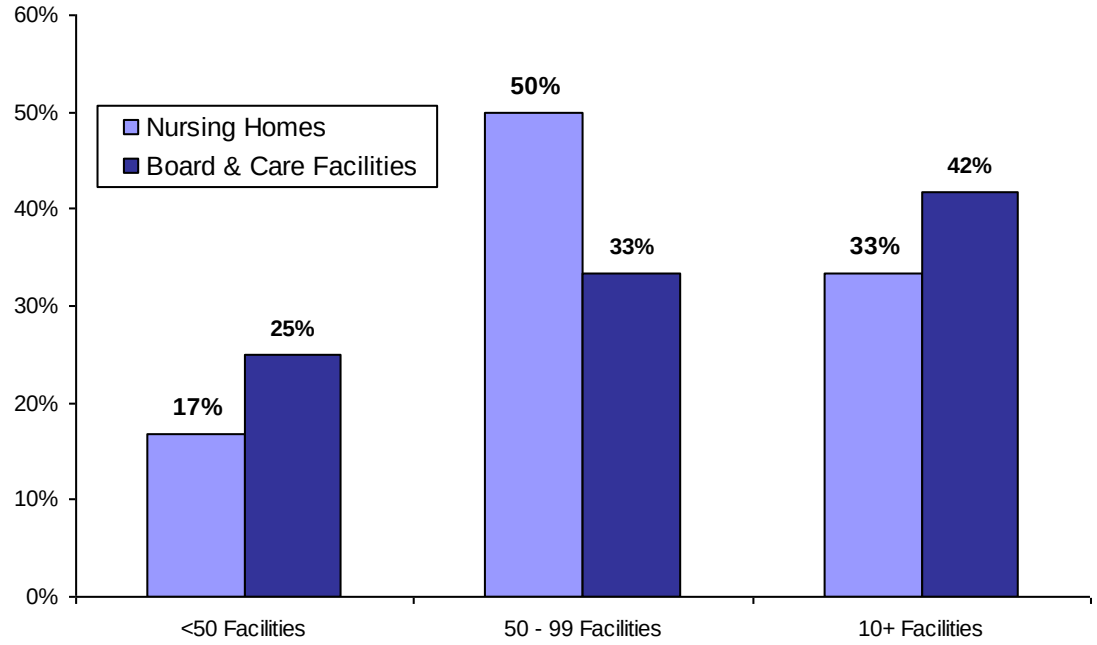
Staffing of Local Long-term Care Ombudsman Programs, cont'd

Figure 2.6: Ratio of Volunteers, 2005-2006 (Average of 2005 Designation & Service Review Summaries and 2006 Ombudsman Registry)



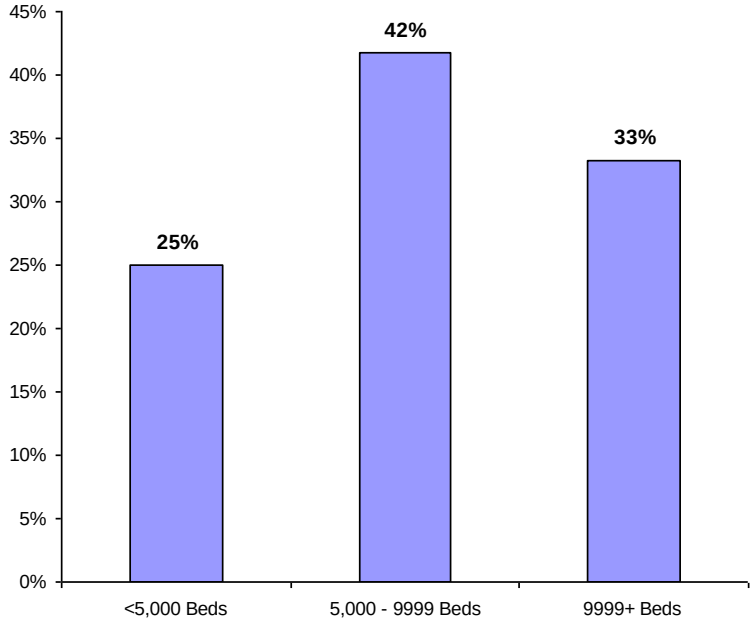
The average number of volunteers reported by the regional LTCOPs across 2005-2006 is 42.00 (sd = 26.861), with a median = 42.50 and a range from 7.00 to 93.50.

Figure 2.7: Percentage of Nursing Homes and Board & Care Facilities Served by the Regional LTCOPs



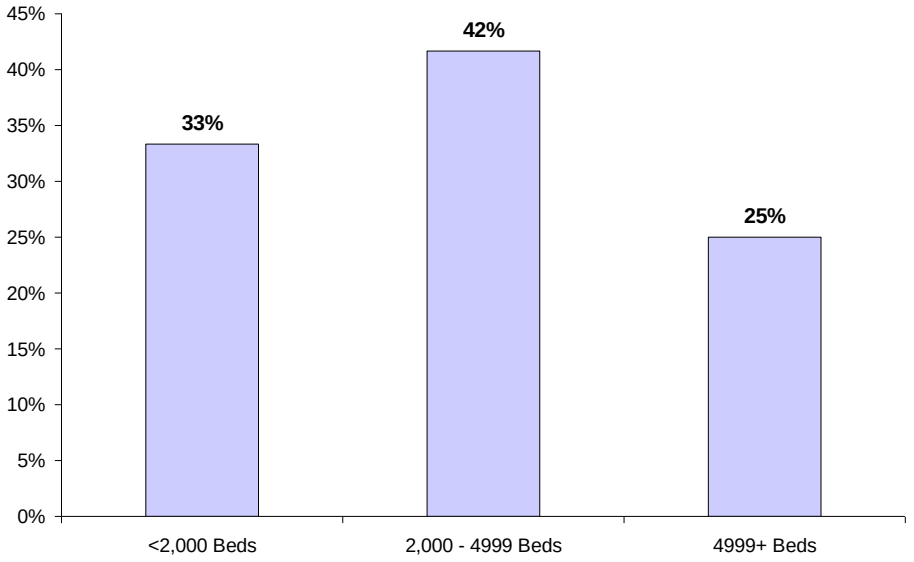
The regional LTCOPs vary widely with regard to the number of nursing homes and board & care facilities (includes assisted living and residential care facilities) they serve, although there is a strong positive correlation between the two (r = .959). On average, a regional LTCOP in Ohio serves 84 nursing homes (sd = 37.803), but this ranges from 23 to 164 nursing homes. The average LTCOP serves 100.50 board & care facilities (sd = 74.199), with a range from 12 to 282 facilities.

Figure 2.8a: Percentage of Nursing Home Beds in the Regional LTCOPs



The regional LTCOPs vary sharply with regard to the number of nursing home beds they serve. This ranges from 2,148 to 18,422 beds, with an average of 8226.75 (sd = 4560.117) and a median of 8094 nursing home beds.

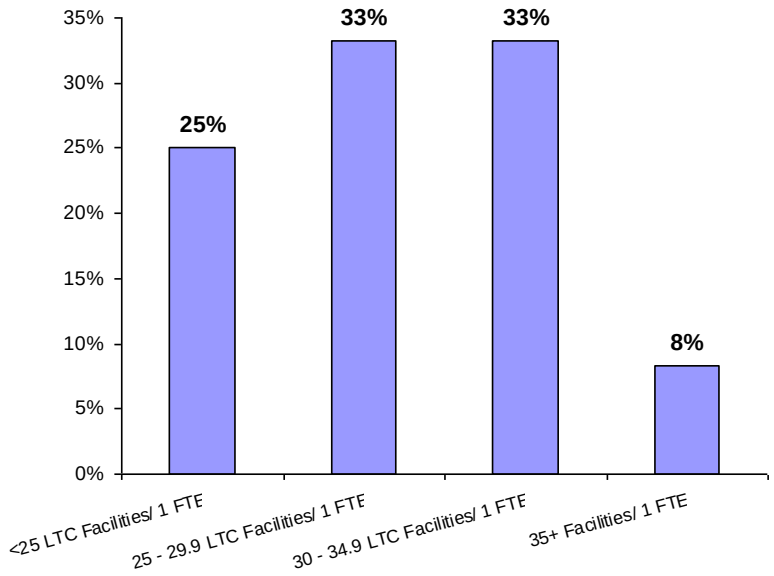
Figure 2.8b: Percentage of Board & Care Beds in the Regional LTCOPs



The average number of board & care beds in a regional LTCOP in Ohio is 3621.83 (sd = 2474.487), with a median of 3050. The regional LTCOPs vary sharply, however, with a low of 512 and a high of 9079 board & care beds.

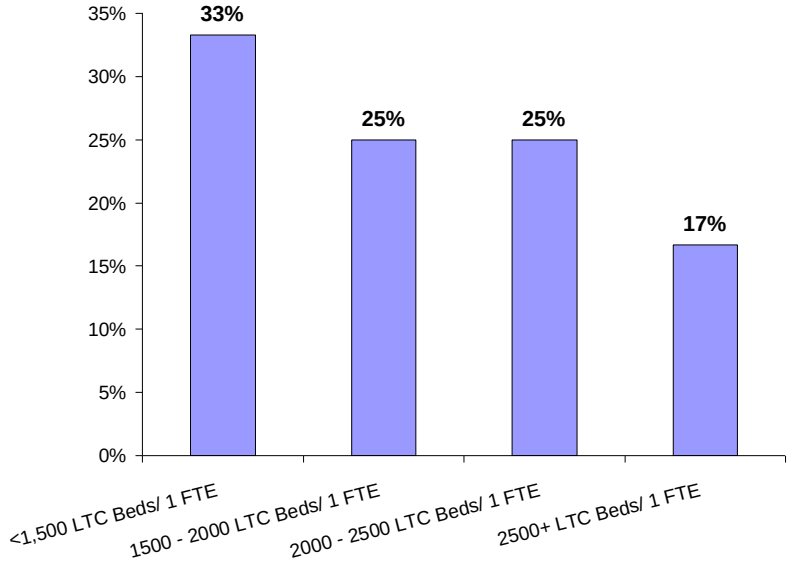
Ratio of LTC Beds to Full-Time Equivalent Staff

Figure 2.9: Ratio of LTC Facilities (Nursing Home + Board & Care Facilities) to Full-Time Equivalent Staff



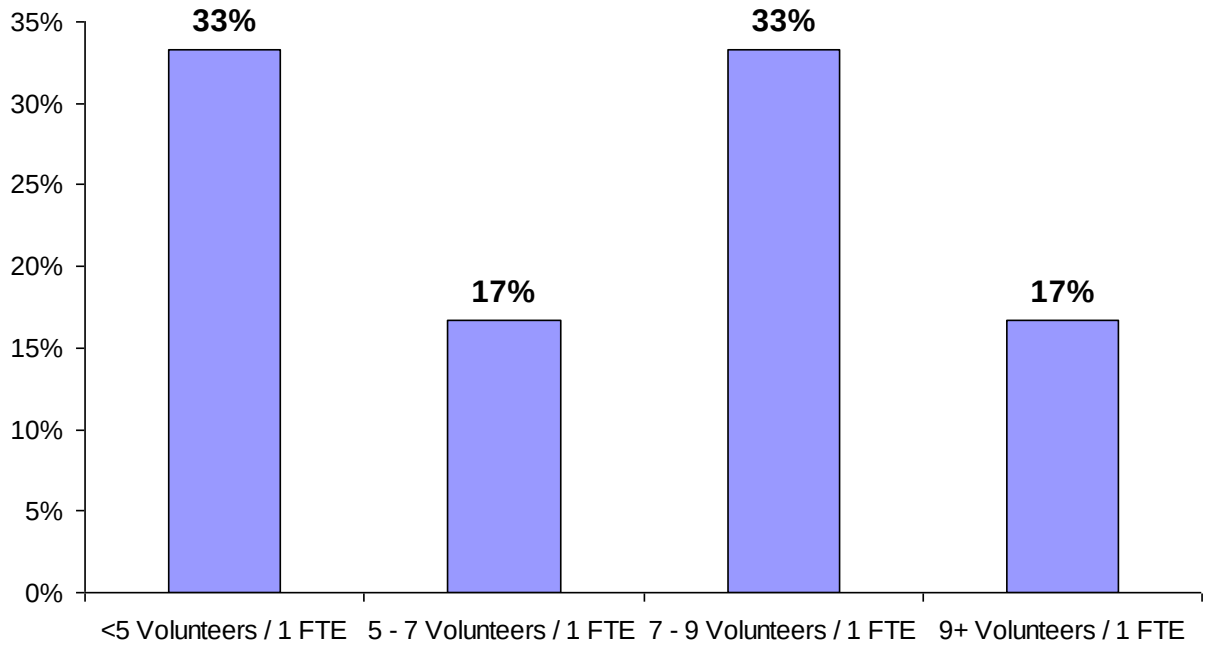
As we have already noted, the regional LTCOPs vary widely in paid staff as well as the number of long-term care facilities (nursing homes + board & care facilities) which they serve. On average, a regional LTCOP in Ohio has one staff FTE for each 28.845 facilities it serves (sd = 6.289), with a range in values from a low of 17.50 to a high of 41.00 facilities for each FTE.

Figure 2.10: Ratio of LTC Beds (Nursing Home + Board & Care Facilities) to Full-Time Equivalent Staff



The regional LTCOPS also vary widely in the ratio of staff FTEs to long-term care beds, with a range of one staff FTE for 1330 beds on the low end and 2627.75 beds on the high end. On average, the LTCOPs in Ohio show a ratio of 1 FTE per 1869.916 beds (sd = 449.870) and a median of 1 FTE per 1718.779 beds.

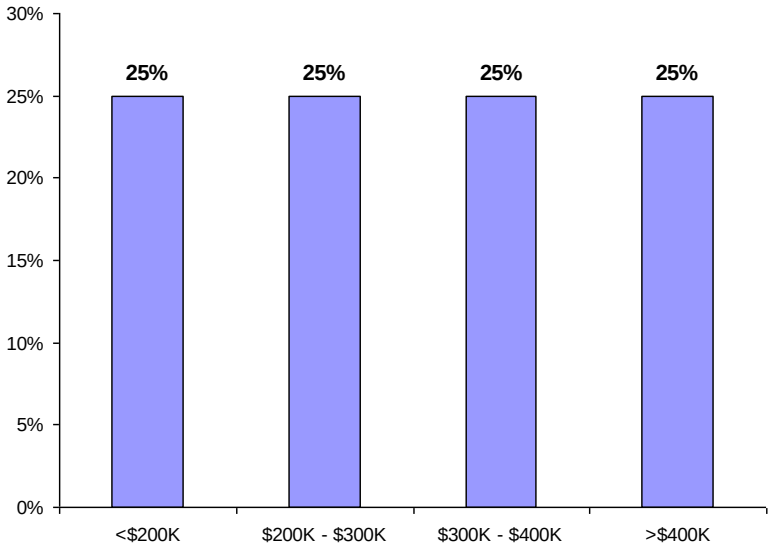
Figure 2.11: Ratio of Volunteers (2005-2006) to Full-Time Equivalent Staff



As we have already seen in Figure 2.5, the regional LTCOPs in Ohio vary in their numbers of certified volunteer staff. They vary as well in terms of the ratio of volunteers to FTE staff with a range from 2.06 volunteers/FTE to 10.17/FTE (mean = 6.415, sd = 2.542).

Budget Dollars

Figure 2.12a: Budget Dollars from Federal and State Sources, FY2005

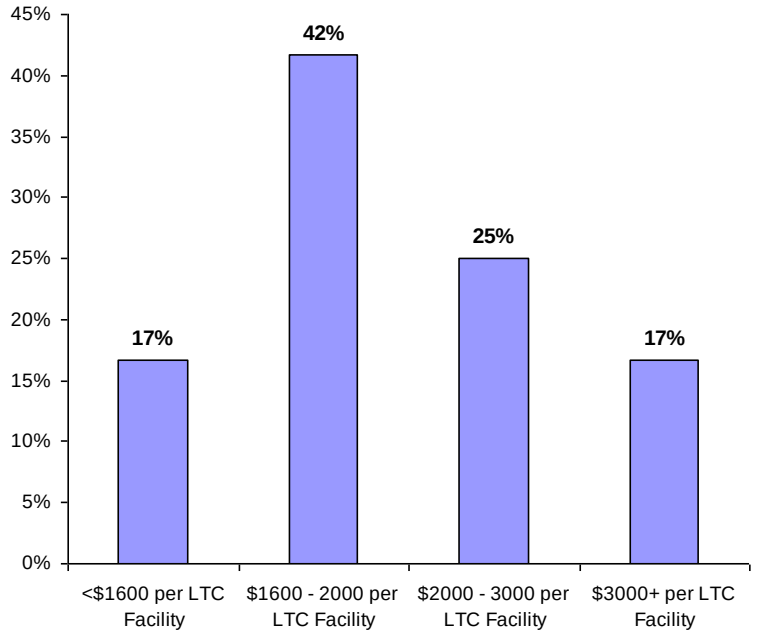


Regional LTCOPs in Ohio differ in size and geographic location. As a result, the budget dollars they receive from federal and state sources varies widely. Although the average budget amount from these sources is $346,302 for FY2005 (sd = $218,796), the median amount is $295,018 and the range is from $122,952 to $903,004.

Figure 2.12b: Total Budget Dollars from Federal, State and Local Sources, FY2005

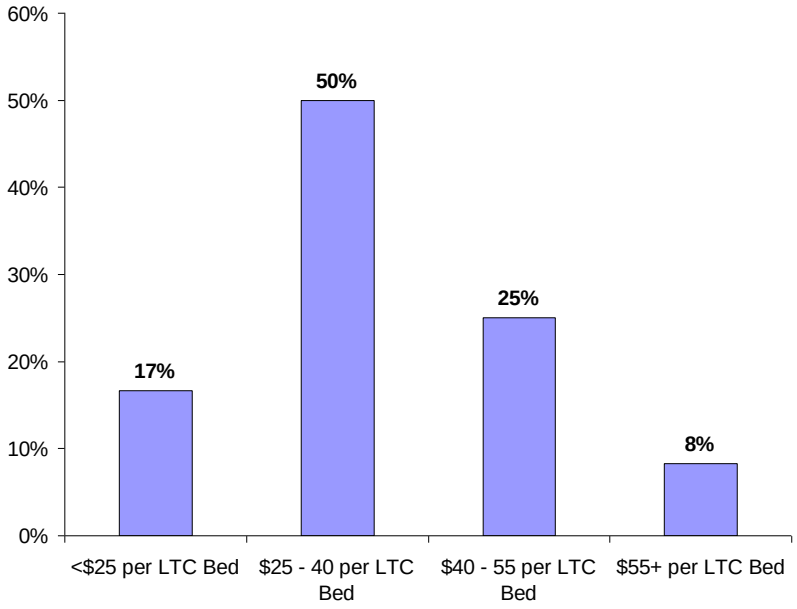
For the regional LTCOPs in Ohio, budgets are very much a function of the federal and state support they receive. Five of the 12 LTCOPs report no local contribution to their budgets. The average total budget dollars available to the LTCOPs is $386,571 (sd = 283,033), with a median of $328,024 and a range from $122,952 to $937,514.

Figure 2.13: Ratio of Regional LTCOP Budget Dollars for Each LTC Facility



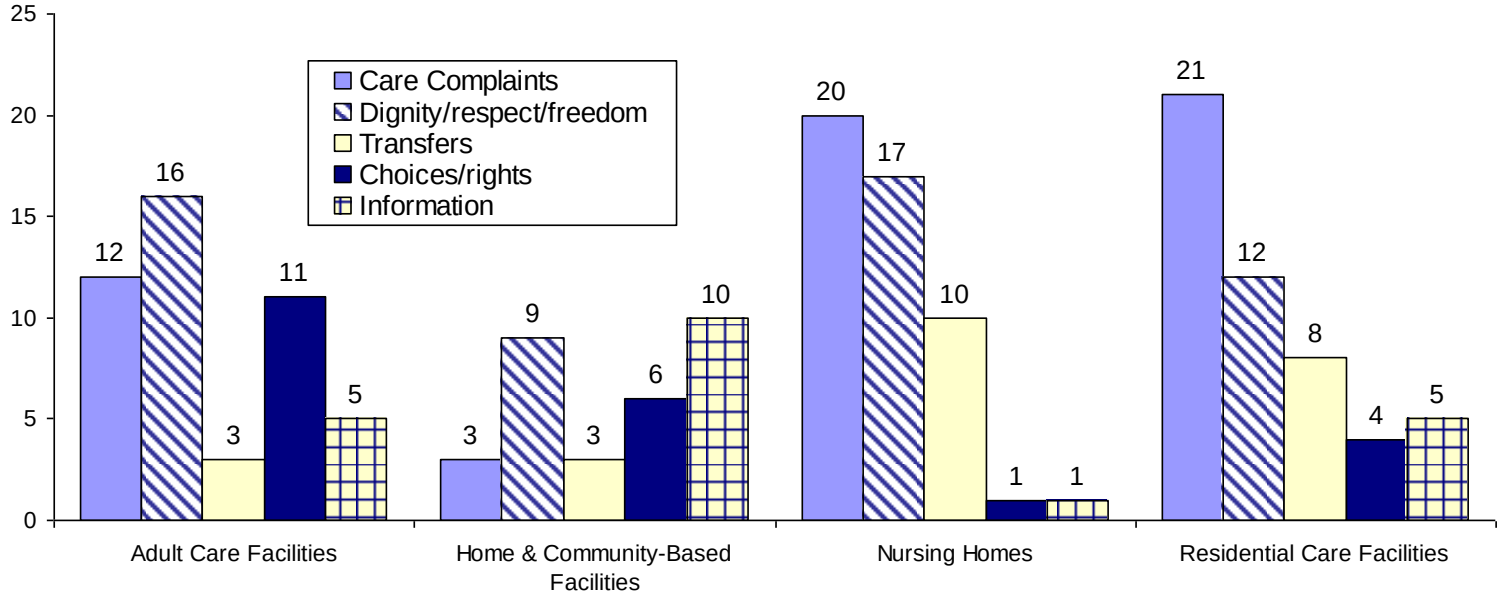
The regional LTCOPs in Ohio differ in the average total dollars in their budget for each LTC facility they serve. Across the regional LTCOPs, the mean total budget dollars is $2242/LTC facility (sd = $768) with a range of $1520 to $3765/LTC facility.

Figure 2.14: Ratio of Regional LTCOP Budget Dollars per LTC Bed



Also as a function of budget dollars, the regional LTCOPs show wide variation in budget dollars/LTC bed they serve. With a range from $22/LTC bed to $63/LTC bed, the mean is $35/LTC bed (sd = $13).

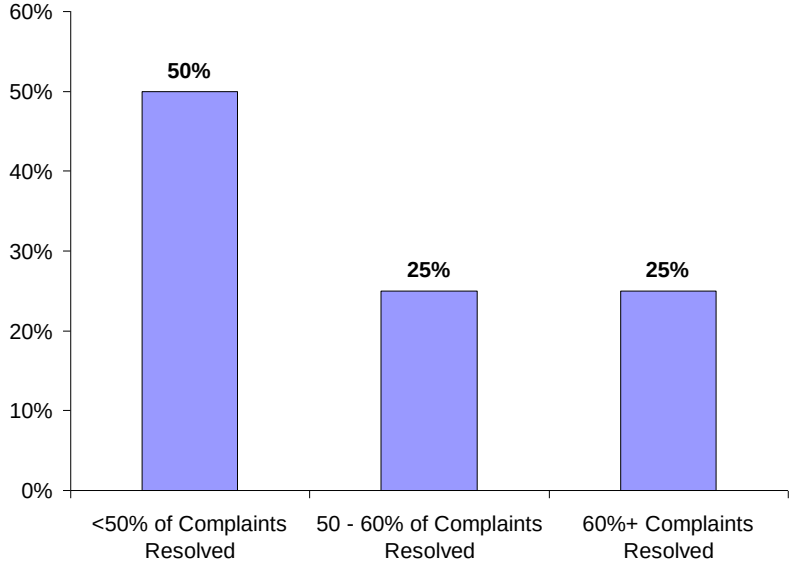
Figure 2.15: The Top Five Most Frequently Closed Complaints by Facility Type, 2005



This data provided by the State Office of the Ohio Ombudsman is based on listings of the five most frequent “closed complaints” in each regional LTCOP. The category labels are intended to represent groups of complaints around a common theme. In Ohio’s adult care facilities, home & community-based facilities, nursing homes and residential care facilities, in 2005, the five most commonly closed complaints include “care complaints,” complaints about “dignity, respect and freedom,” and complaints about “transfers,” "choices/rights," and "information."

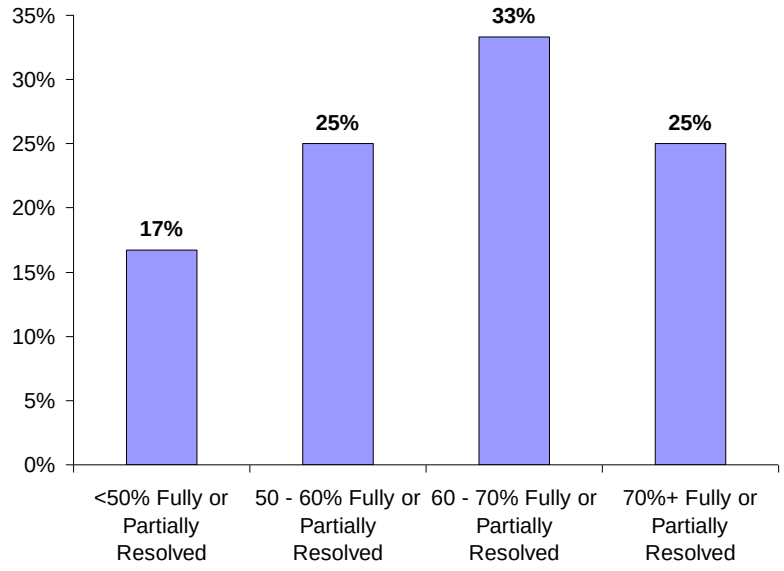
Resolution of Complaints

Figure 2.16: Percentage of Complaints Resolved for Regional LTCOPs



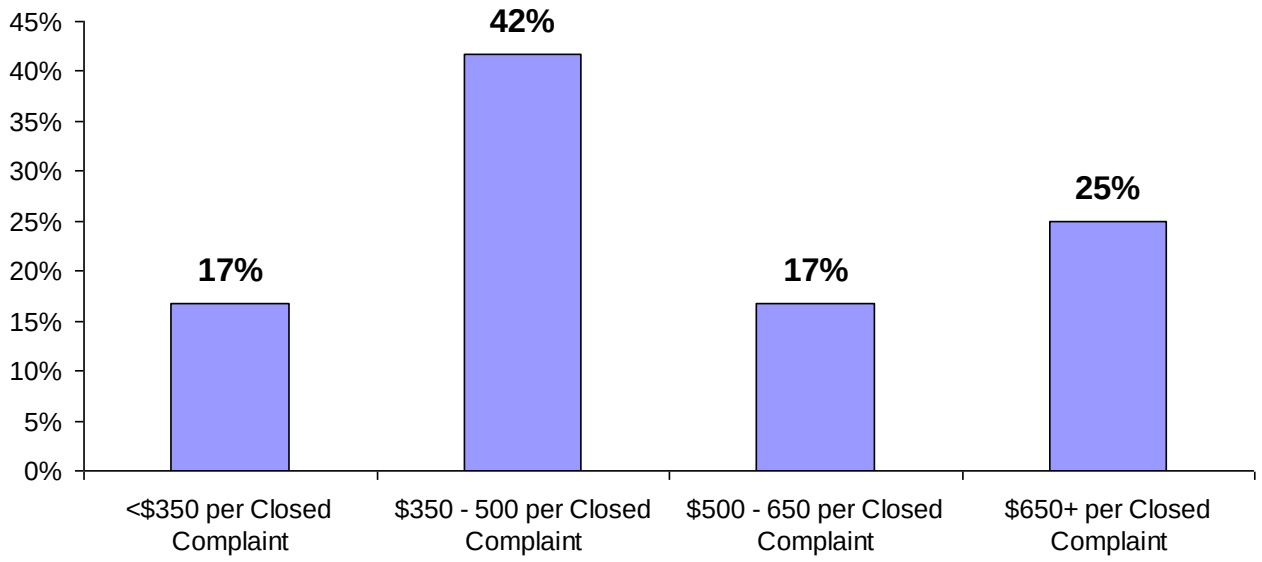
Across the regional LTCOPs, the average percentage of complaints resolved is 52.933 (sd = 9.286), with a median percentage of 51.55 and a range varying from 40.6% to 65.8%.

Figure 2.17: Percentage of Complaints Fully or Partially Resolved for the Regional LTCOPs



As Figure 2.17 above shows, on average, a majority of complaints received by the regional LTCOPs are completely resolved. However, for a variety of reasons, some complaints are only partially resolved. The average percentage of complaints either partially or completely resolved ranges from 44.4% to 72.1%, with a mean of 60.717 (sd = 9.424).

Figure 2.18: Ratio of Regional LTCOP Budget Dollars per Closed Complaint



Dollars expended in FY2005 to close complaints varied widely among the regional LTCOPs with costs ranging from $266 to $884 per closed complaint. The average cost per closed complaint was $531 (sd = $177) with median expenditure at $475.

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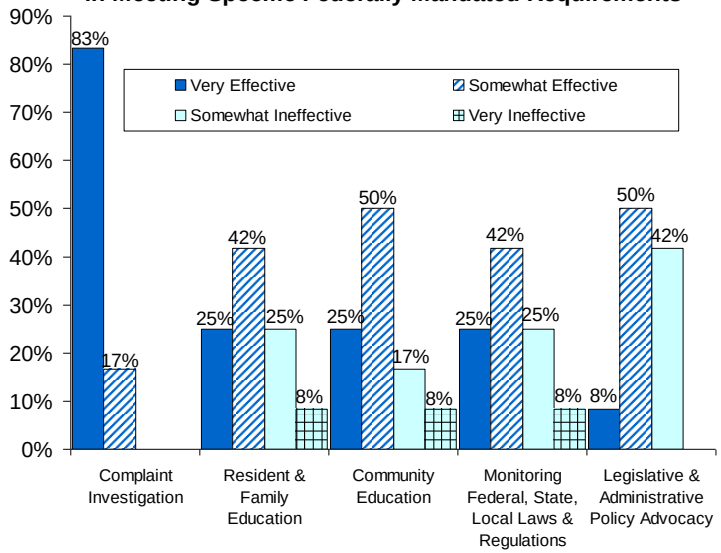
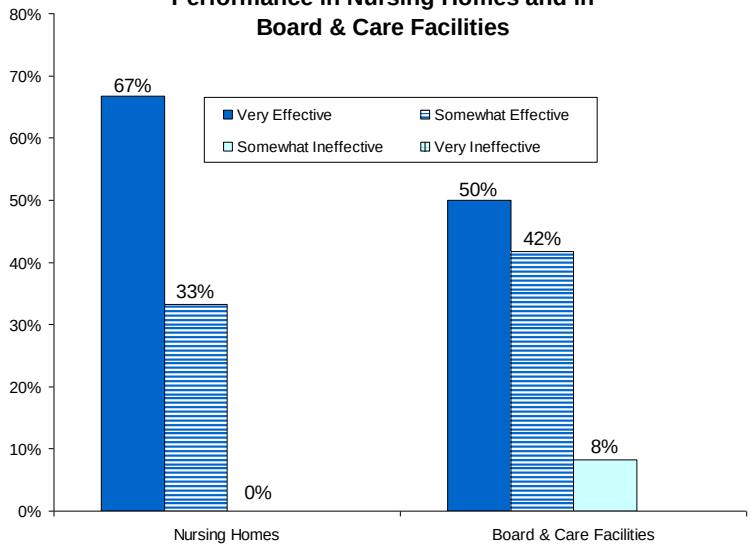
Self-Rate Effectiveness

Figure 3.1: Self-Rated Effectiveness of Regional LTCOPs in Meeting Specific Federally Mandated Requirements



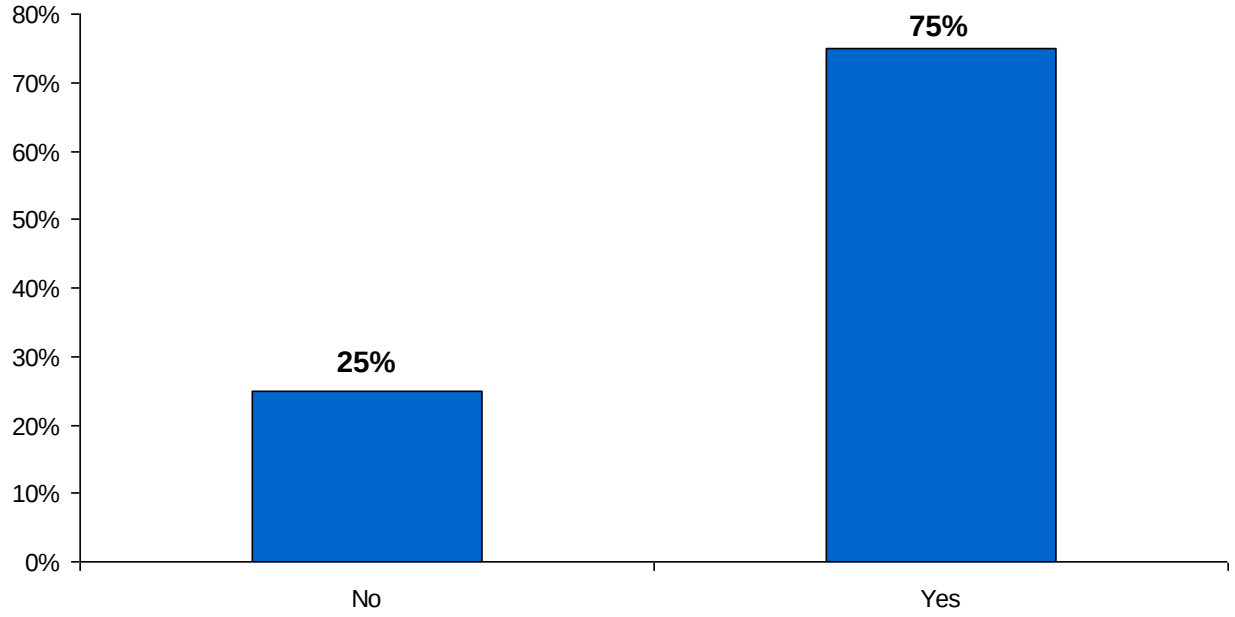
Q. How would you rate the effectiveness of your local LTCOP's performance in meeting the specific federally mandated requirements?
Ombudsmen rated their LTCOP's performance in complaint investigation as effective with 83.3% (N = 10/12) rating performance as "very effective." Although a majority of the ombudsmen similarly rated the performance of the other federally mandated requirements as very and/or somewhat effective, in each case at least 25% of the ombudsmen rated these requirements as "somewhat" and/or "very ineffective." Most noteworthy among these, in assessing "legislative and administrative policy advocacy," 41.7% of the ombudsmen rated performance as "somewhat ineffective."

Figure 3.2: Self-Rated Effectiveness of Regional LTCOP Performance in Nursing Homes and in Board & Care Facilities



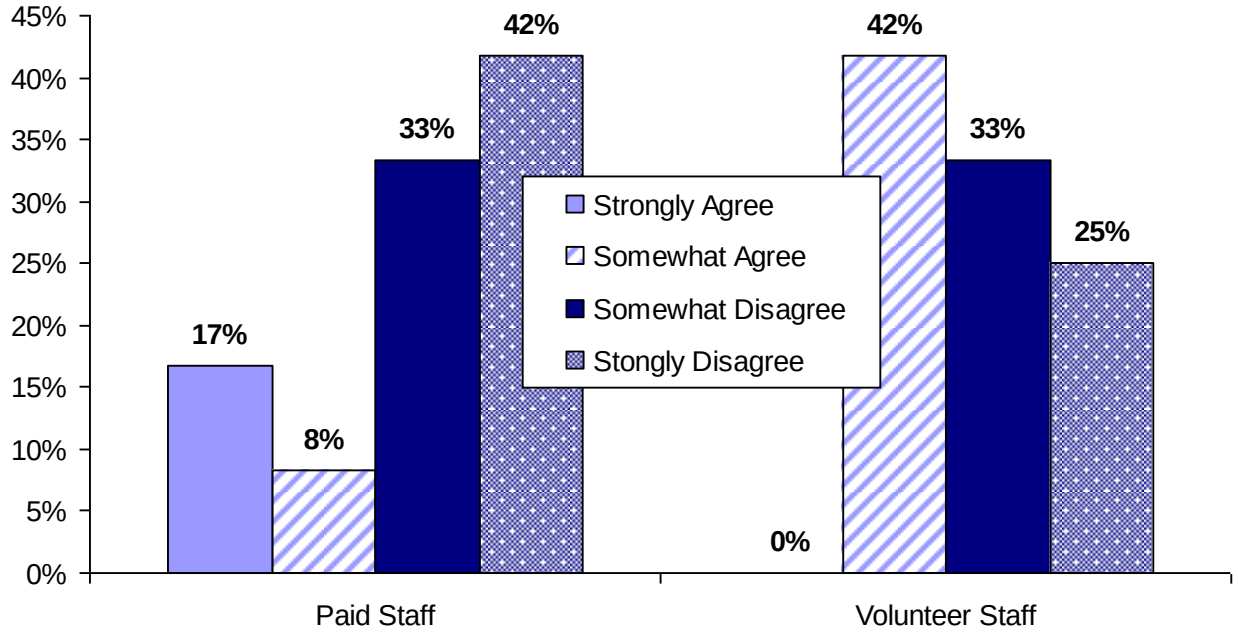
Q. Overall, how would you rate your local LTCOP's performance with each of the following settings?
Ombudsmen rated their program's overall performance as more effective in nursing homes than in the array of settings encompassed by the board and care facilities label; 66.7% vs. 50.0% rated LTCOP performance as "very effective" in the respective settings. One ombudsman even assessed program performance in board and care facilities as "somewhat ineffective."

Figure 3.3: Does the Regional LTCOP Need Additional Funding to Carry Out All Mandates?



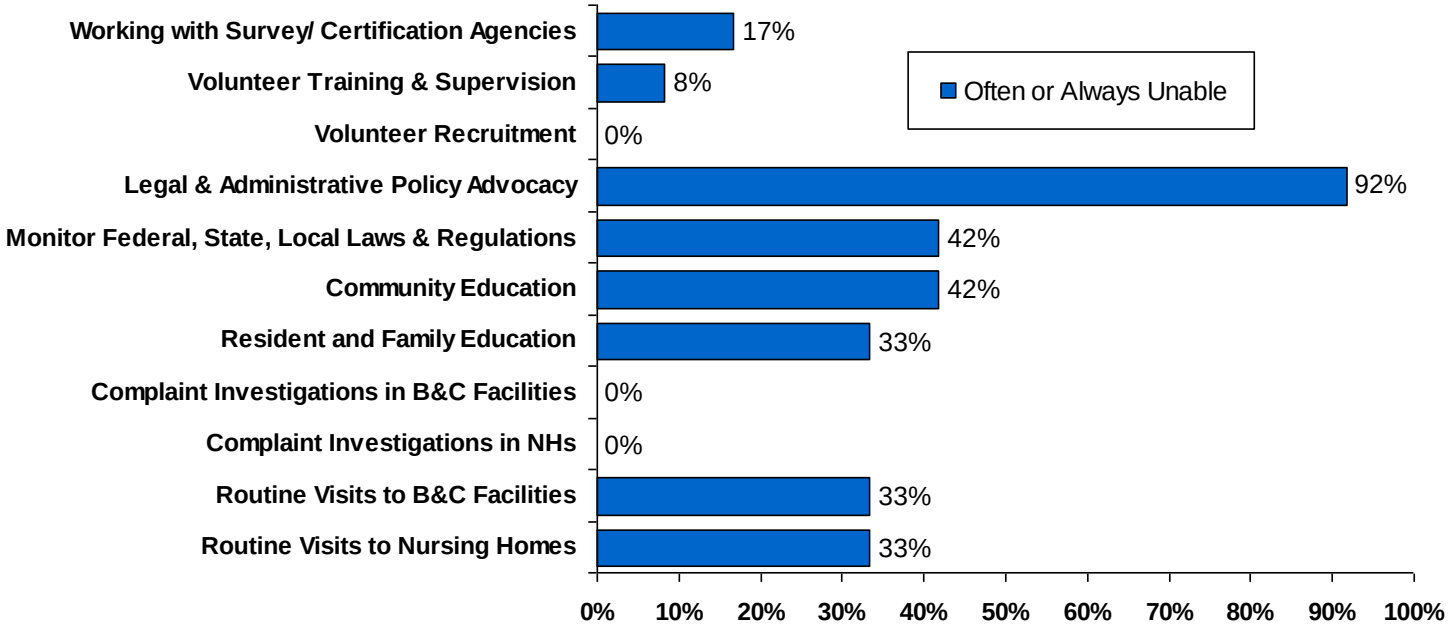
Q. Does you local LTCOP have a sufficient amount of funding to carry out all of its State and Federal mandates?
Most of the ombudsmen (75%) reported needing additional funding to carry out their program mandates.

Figure 3.4: Extent to Which Regional LTCOP Coordinators Perceived Their Program to Have Sufficient Numbers of Paid Staff and Volunteer Staff



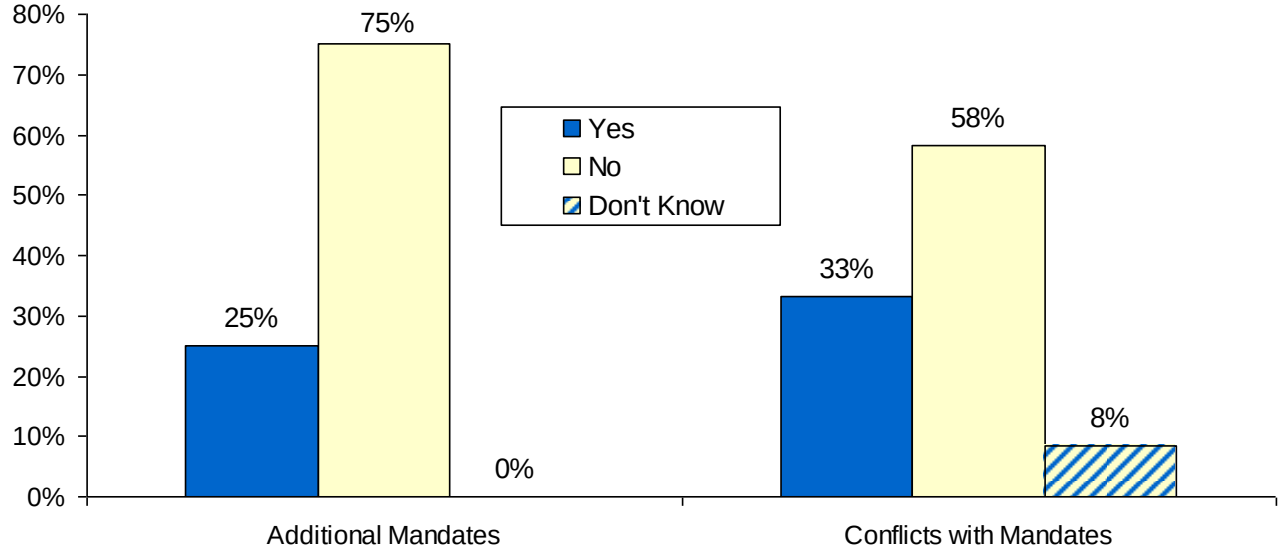
Q. To what extent do you agree with the statement, your local LTCOP has a sufficient number of paid and volunteer/unpaic
A majority of ombudsmen perceived that their programs have insufficient paid staff (75% disagreed either "somewhat" or "s
statement above) and volunteer/unpaid staff (58% disagreed).

Figure 3.5: Self-Reported LTCOP Activities Neglected or Partially Carried Out Because of Lack of Resources



Q. What activities, if any, has your local LTCOP been unable to adequately perform because of lack of resources or funds?
Noteworthy is that 92% (N = 11/12) of the ombudsmen report that legal and administrative policy advocacy is often or always unable to be carried out as a result of a lack of resources; 42% of the ombudsmen (N = 5/12) report similarly about often or unable being able to do community education and monitor federal, state and local laws and regulations.

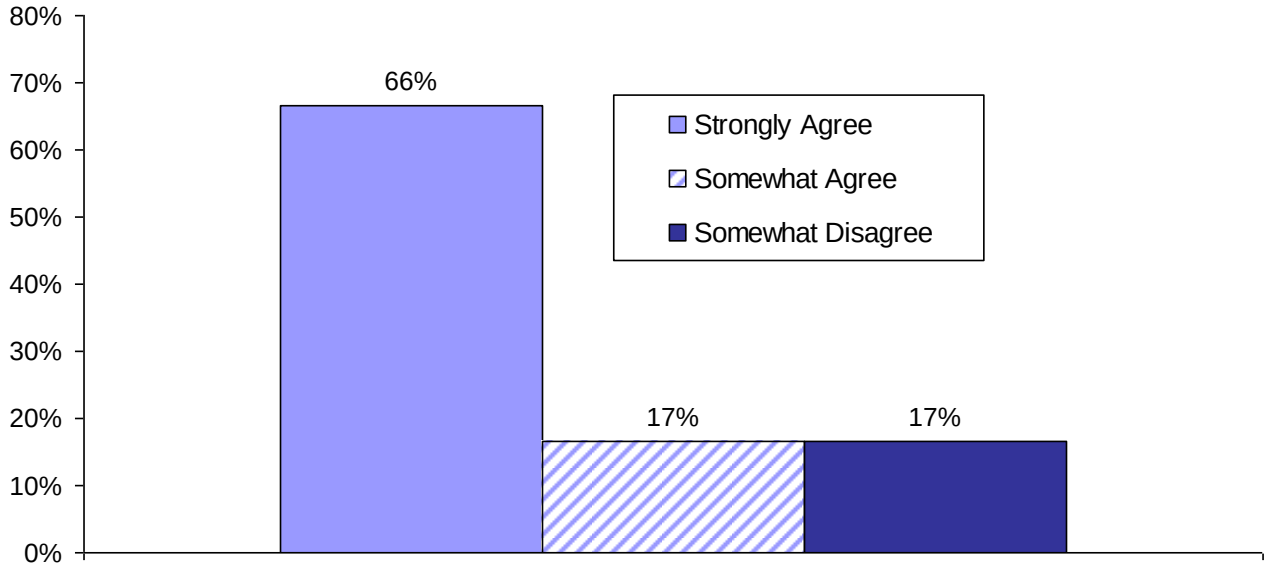
Figure 3.6: Extent to Which Regional LTCOP Coordinators Perceived Additional Mandates or Conflicts with Mandates that Added to the Workload of the Program



Q. Are there any additional state mandates, either funded or unfunded, that add to the workload of your local LTCOP? Do you have any state laws, regulations, or agency agreements that conflict with the ability of your local LTCOP to carry out its federal or state mandates?

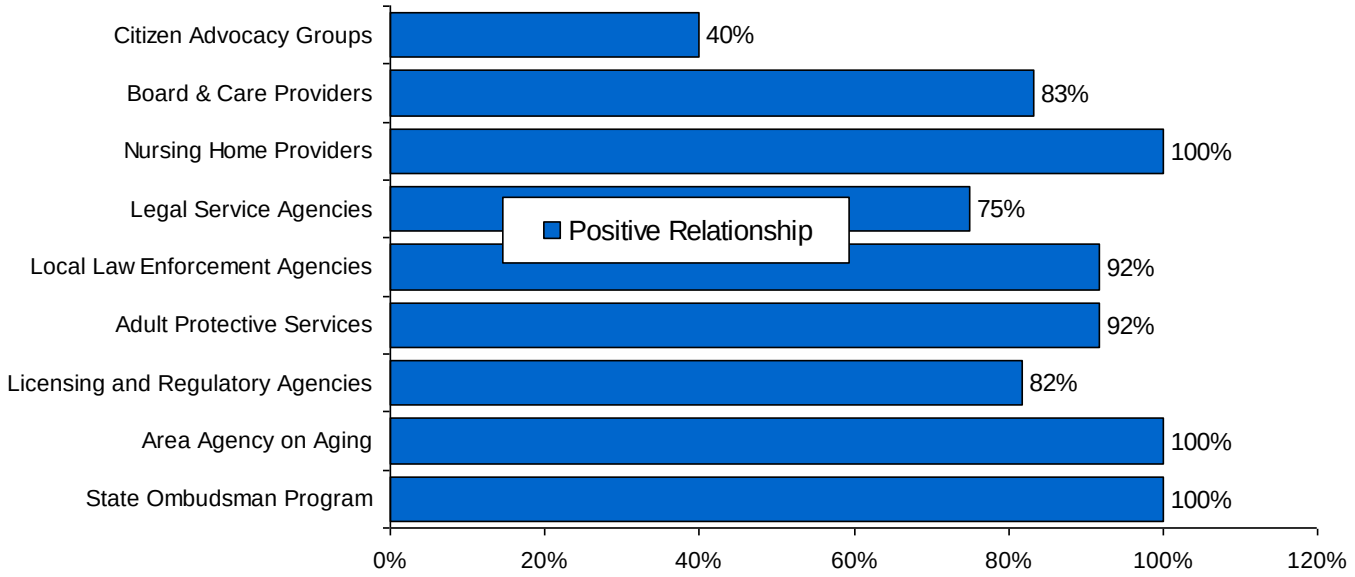
Three-of-four (75%) ombudsmen identify additional mandates that add to program workload, whereas 58% (N = 7/12) identify conflicts with mandates that increase program workload.

Figure 3.7: Extent to which Regional LTCOP Coordinators Perceive That Their Regional Program is Recognized as a Priority by the Host Agency



Q. To what extent do you agree with the statement, your local LTCOP is recognized as a priority by your host agency?
Most program coordinators (N = 10/12) perceive that their host agency recognizes the regional LTCOP as a priority.

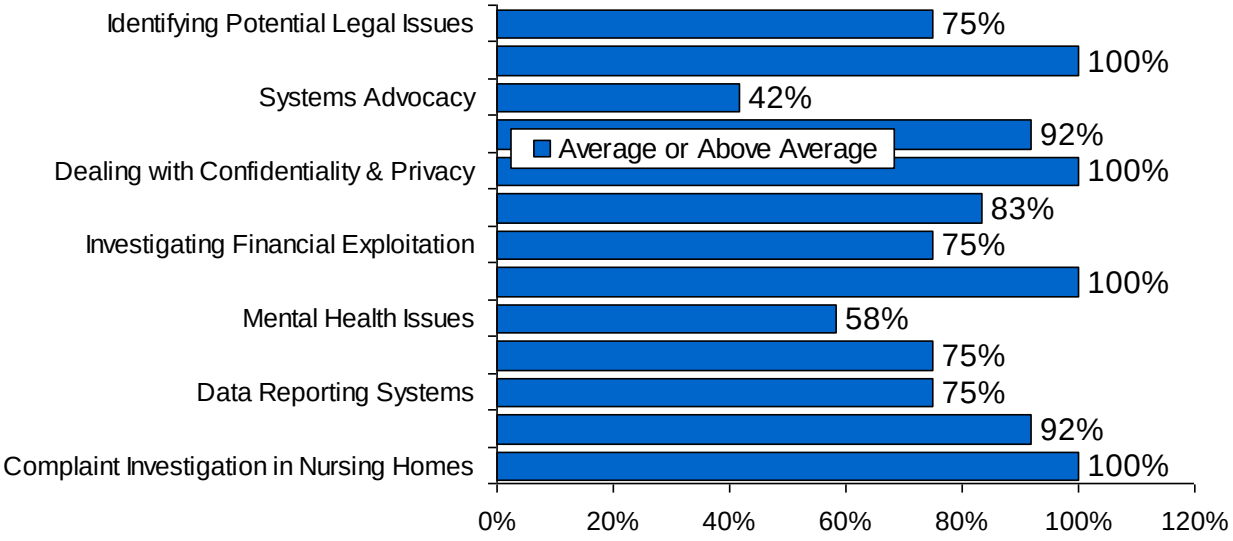
Figure 3.8: Extent to Which LTCOP Coordinators Perceive a Positive Relationship with Other Organizations/ Agencies



Q. To what extent do you agree with the following statement, Overall your LTCOP has a good working relationship with your …?

With one exception, program coordinators perceive that the LTCOP has a positive working relationship with other organizations and agencies. This seems especially the case for nursing home providers, area agencies on aging and the state ombudsman office, where 100% of program coordinators perceive a positive working relationship. Only 40% of LTCOP coordinators perceive a positive working relationship with citizen advocacy groups in their region, with a number of coordinators being unable to identify any such agencies.

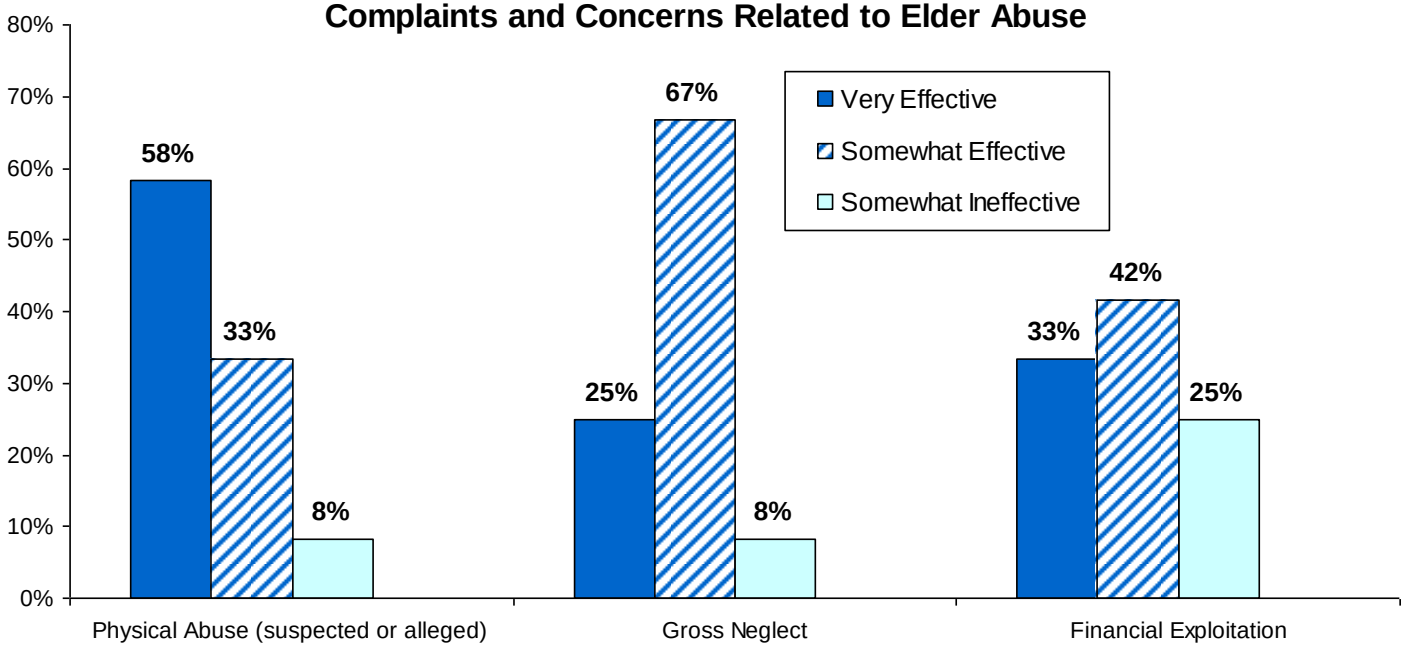
Figure 3.9: Percentage of Satisfactory Ratings of Training Provided in Specific Content Areas for Regional LTCOP Staff Members



Q. For each of the following, tell us how you would rate specific content areas of the training provided to staff (paid & unpaid staff) of your LTCOP?
For most specific content areas, program coordinators rate training provided to paid and unpaid staff as average or above. Complaint investigation in nursing homes, investigating abuse and neglect, dealing with confidentiality and privacy, and addressing laws, policies and rules receive the highest (100%) ratings. Two areas which receive the lowest percentage of satisfactory ratings include system advocacy (42%) and mental health issues (58%).

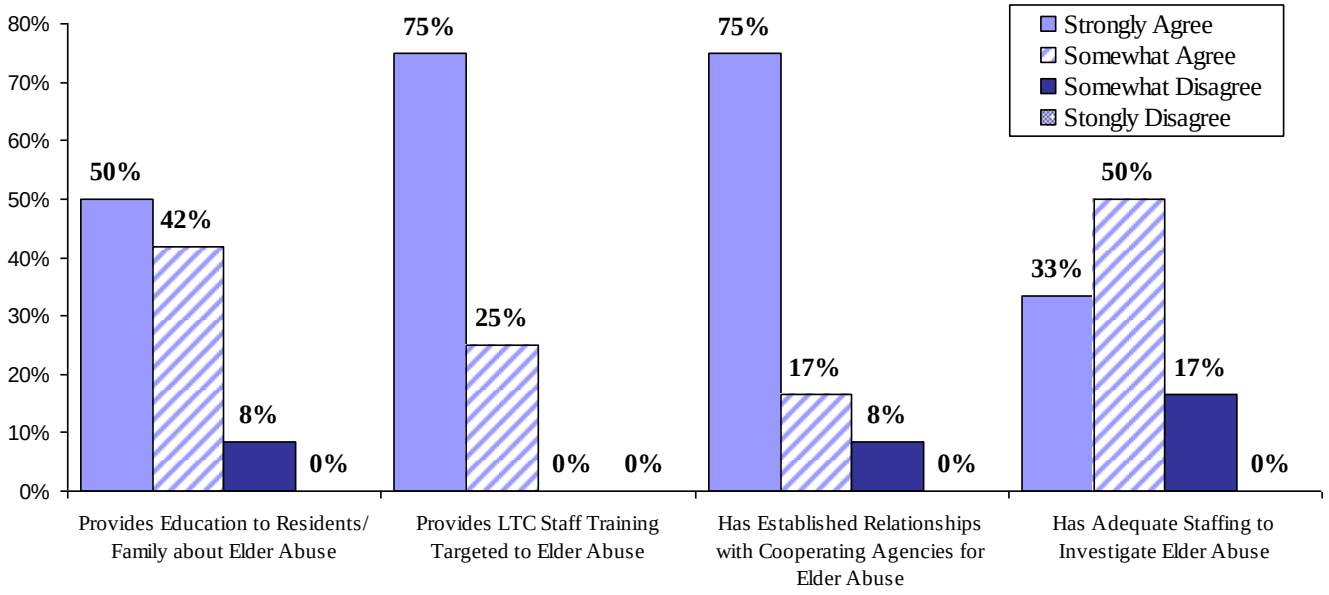
List of Tables

Figure 4.1: Self-Rated Effectiveness of Regional LTCOPs in Addressing Complaints and Concerns Related to Elder Abuse



Q. How would you rate the effectiveness of your local LTCOP in addressing complaints and concerns related to …?
In general, program coordinators rate program efforts in handling complaints and concerns related to physical abuse (91%), gross neglect (92%), and financial exploitation (75%) as either very or somewhat effective; 25% (N = 3/12) rate their handling of financial exploitation as somewhat ineffective.

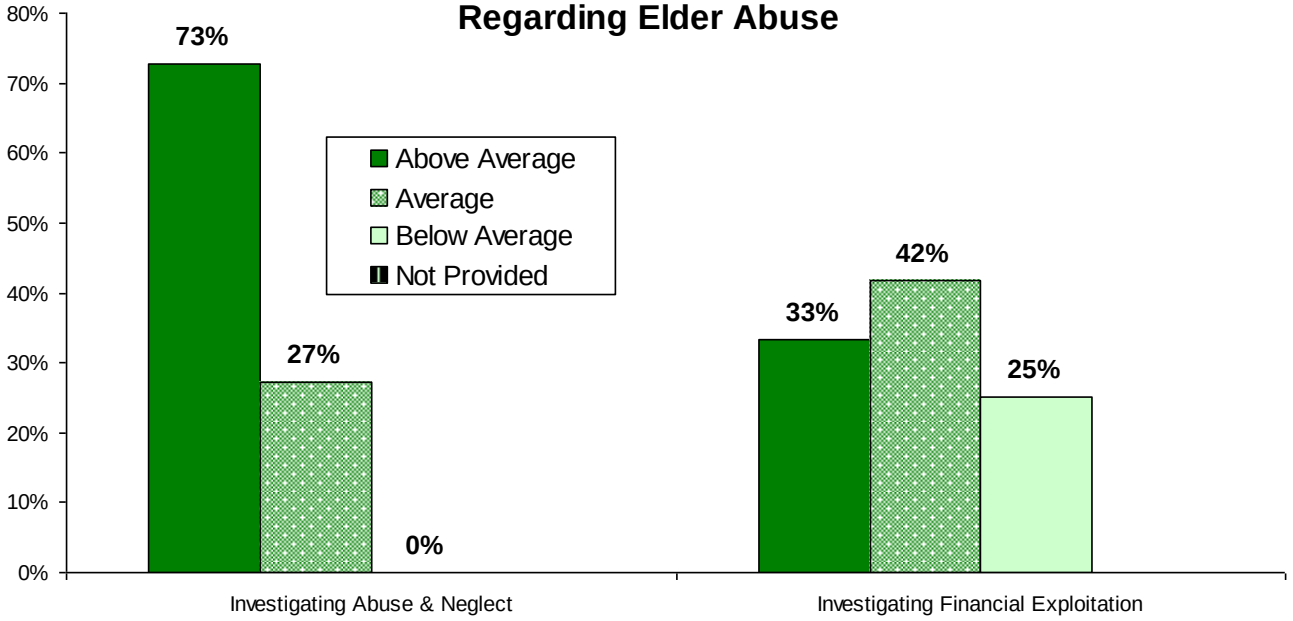
Figure 4.2: Extent to Which Characteristics/ Activities Apply to Regional LTCOPs in Issues Related to Elder Abuse



Q. for each of the following indicate whether you 'strongly agree,' 'somewhat agree,' 'somewhat disagree,' or 'strongly disagree' that the item applies to your LTCOP.

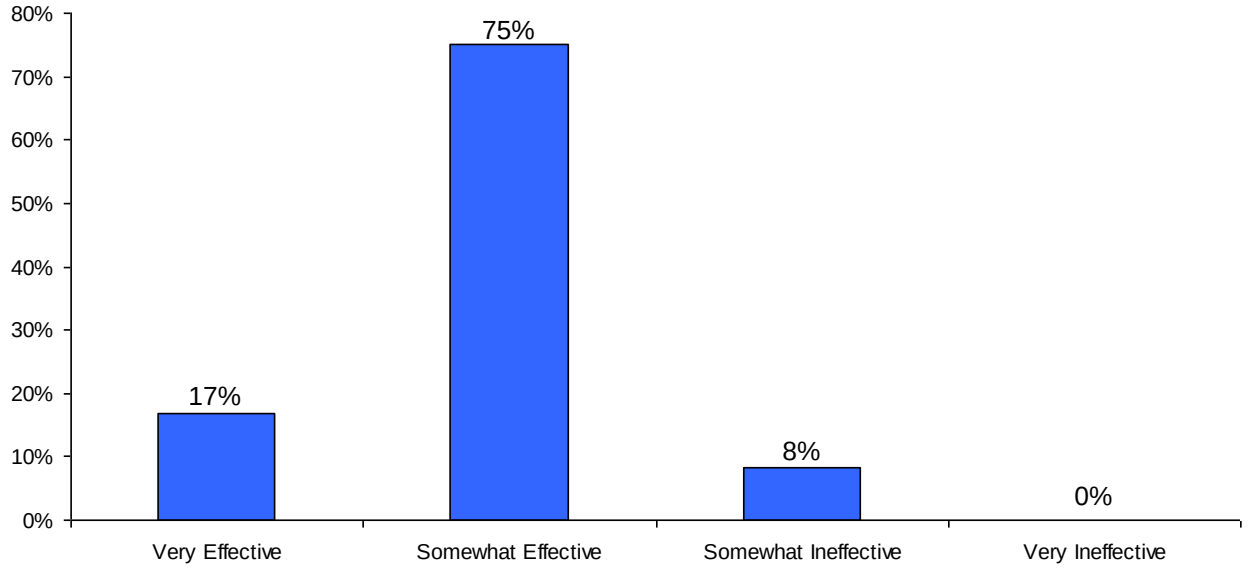
Generally, program coordinators agree (strongly or somewhat) that the LTCOP provides specific education to residents and families about abuse, neglect and financial exploitation (92%), provides LTC facility staff training in these areas (100%), has established cooperative relationships with other agencies to help investigate complaints (92%), and has adequate staffing to investigate (83%).

Figure 4.3: Ratings for Training of Program Staff of Regional LTCOPs Regarding Elder Abuse



Q. For each of the following, tell us how you would rate specific content areas of the training provided to the staff (paid & unpaid) of your LTCOP?
Program coordinators are more than twice as likely to rate training for staff regarding investigating physical abuse and gross neglect as above average (73%, N = 8/11) as they were to rate training for investigating financial exploitation in the same manner (33%, N = 4/12); 25% rate training for investigating financial exploitation as below average.

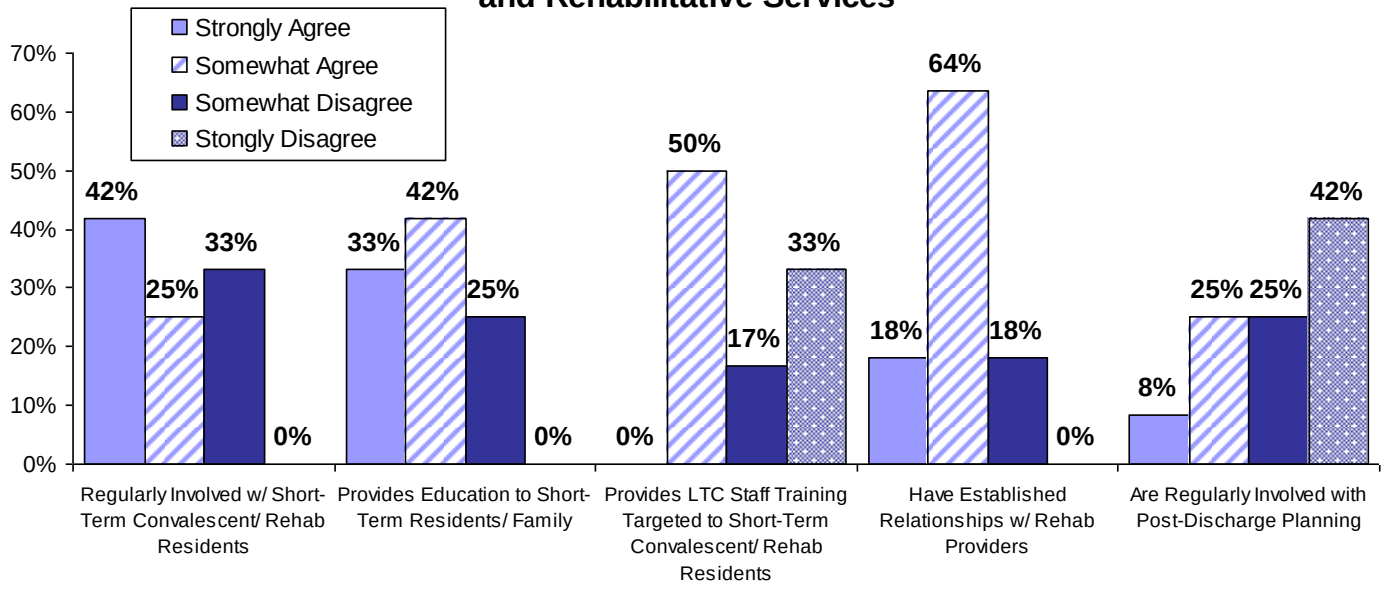
Figure 4.4: Self-Rated Effectiveness of Regional LTCOPs in Addressing Resident Needs Related to "Short-Term," Post-Acute, Convalescent and Rehabilitative Services



Q. How would you rate the effectiveness of your local LTCOP in addressing resident needs related to 'short-term' post-acute, convalescent, or rehabilitative services? (A "short-term" resident includes one whose stay in a LTC facility is expected to last less than 100 days or within Medicare coverage.)

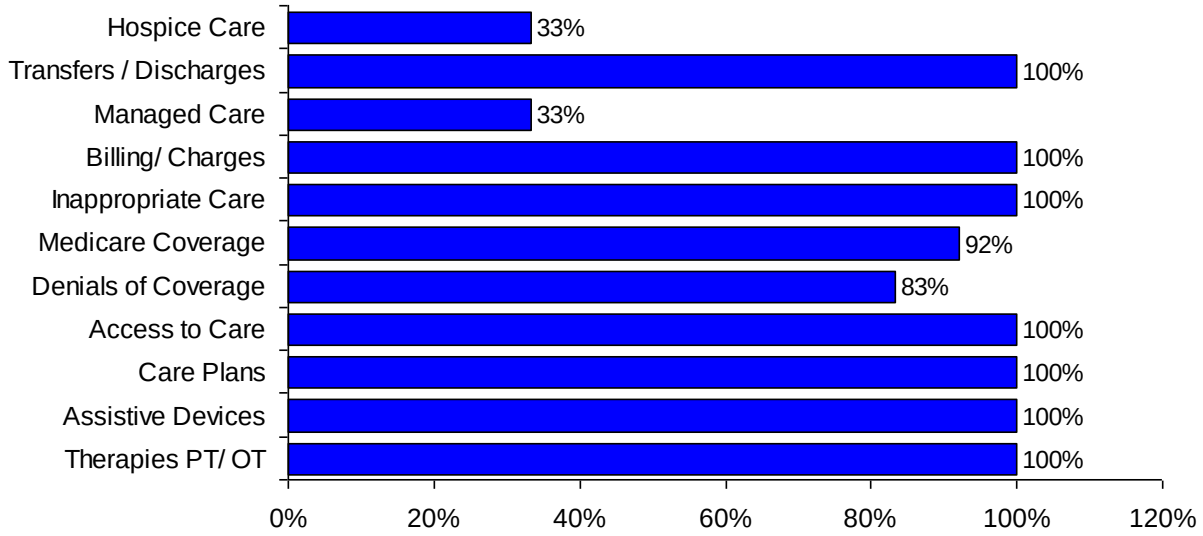
Three-of-four (75%) coordinators rate the program's addressing short-term resident needs as somewhat effective.

Figure 4.5: Extent to Which Characteristics/ Activities of Regional LTCOPs Apply to Post-Acute, Convalescent and Rehabilitative Services



Although LTCOP coordinators generally have established relationships with rehabilitation service providers (82%), and most programs are regularly involved with short-term convalescent or rehab residents (67%) and/or provide education to these residents and their families (75%), 50% do not provide targeted staff training aimed toward these residents and 67% are not regularly involved in post-discharge planning.

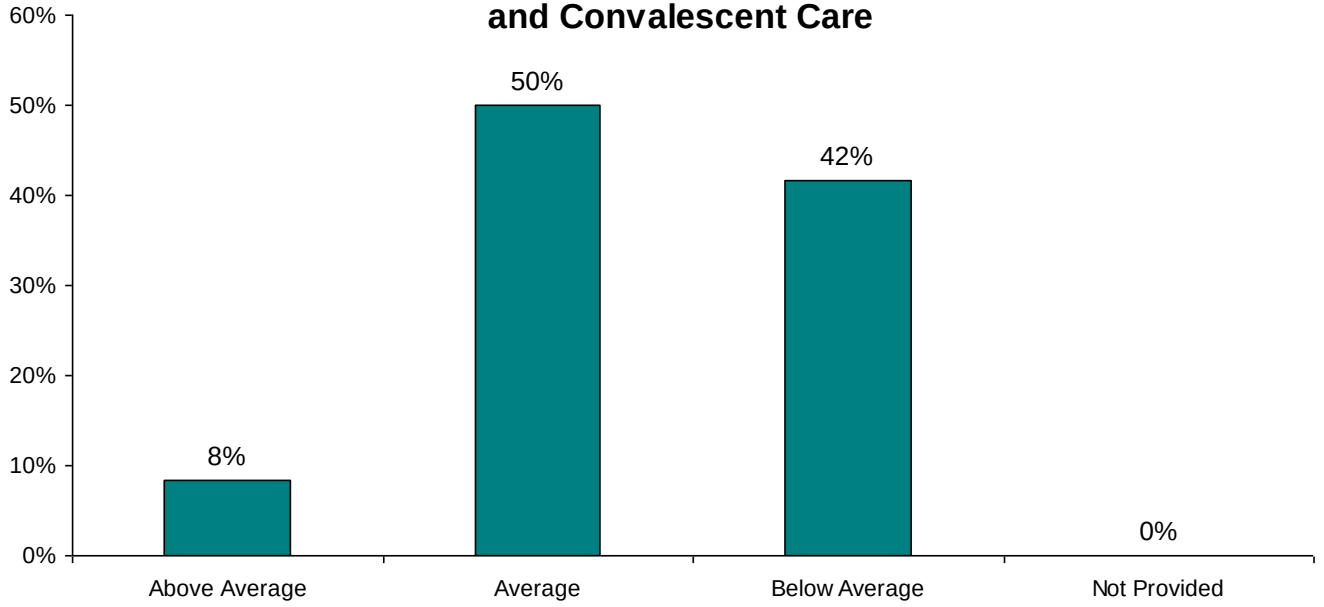
Figure 4.6: Regional LTCOP Involvement in Issues Related to Post-Acute, Convalescent and Rehabilitative Services in the Past Year (percent who responded "yes")



Q. Over the past year, have issues related to post-acute, convalescent, or rehabilitative service for residents addressed by your local LTCOP involved any of the following general issues?

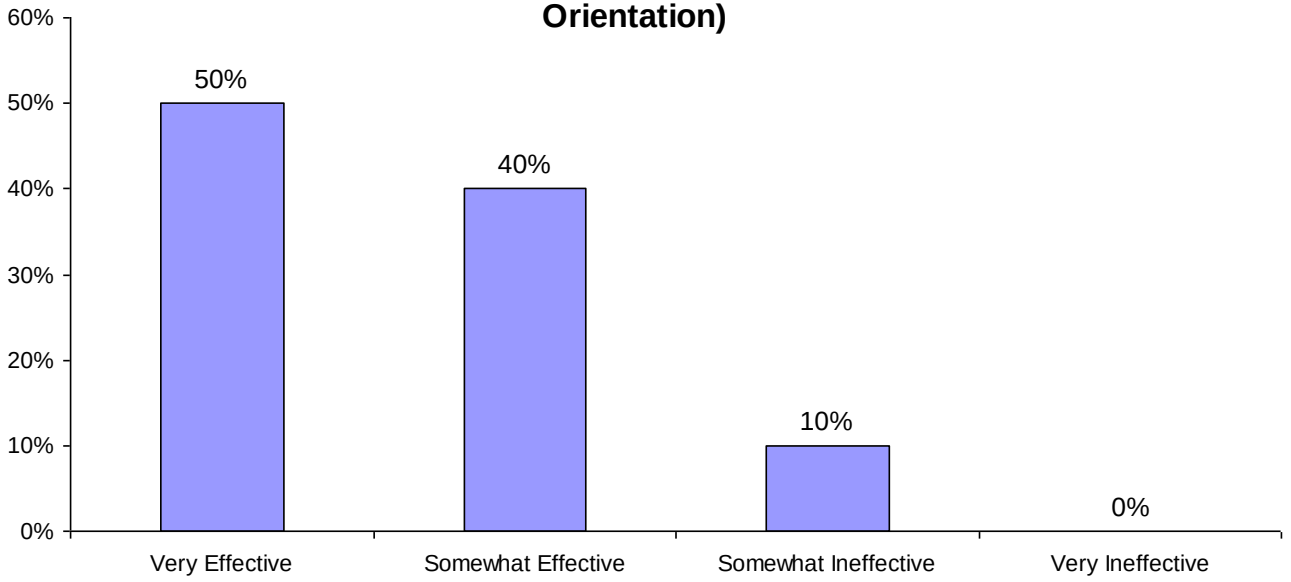
Regional LTCOPs are generally involved in a host of issues regarding post-acute, convalescent and/or rehab services for residents of various facilities They appear least involved in managed care (33%) and/or hospice care (33%) for post-acute residents.

Figure 4.7: Ratings of Training of Program Staff of Regional LTCOPs Related to Post-Acute, Rehabilitative and Convalescent Care



Q. For each of the following, tell us how you would rate specific content areas of the training provided to the staff (paid & unpaid) of your LTCOP?
Although 58% of coordinators rate training of program staff for addressing issues of post-acute and rehabilitative services as average or above average, 42% evaluate training in this content area as below average.

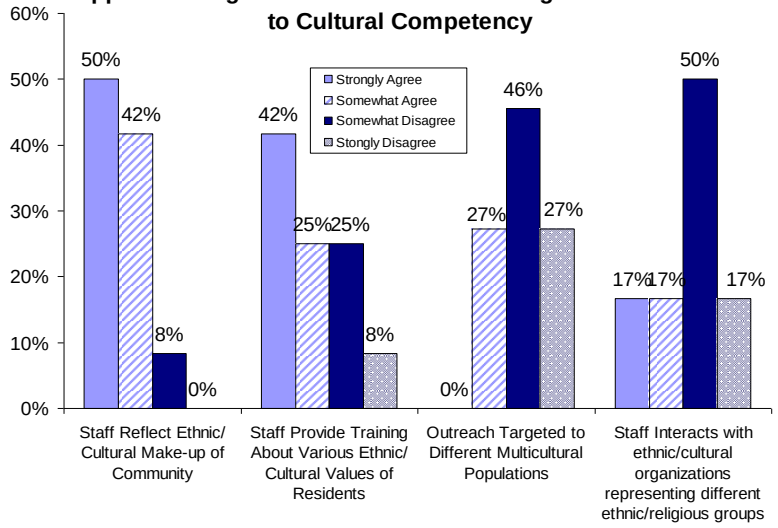
Figure 4.8: Self-Rated Effectiveness of Regional LTCOPs in Addressing Complaints and Concerns Related to Cultural Competence (Dealing with Resident's Ethnic, Cultural, Religious, Socioeconomic, and/or Sexual Orientation)



Q. How would you rate the effectiveness of your local LTCOP in addressing complaints and concerns related to resident's ethnic, cultural, religious, socioeconomic, and/or sexual orientation factors?

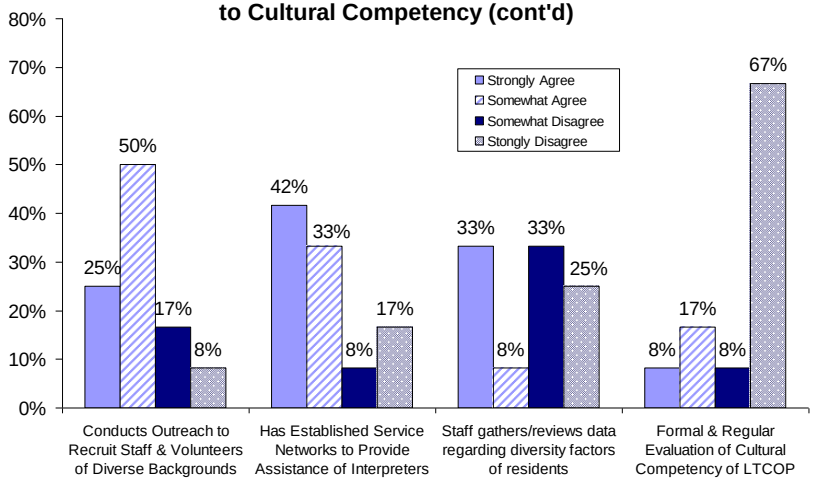
Whereas 90% (N = 9/10) of program coordinators rated their regional LTCOP's cultural competence as somewhat or very effective, one coordinator (10%) rated the LTCOPs efforts at cultural competence as somewhat ineffective.

Figure 4.9a: Extent to Which Characteristics/Activities Applied to Regional LTCOPs in Addressing Issues Related to Cultural Competency



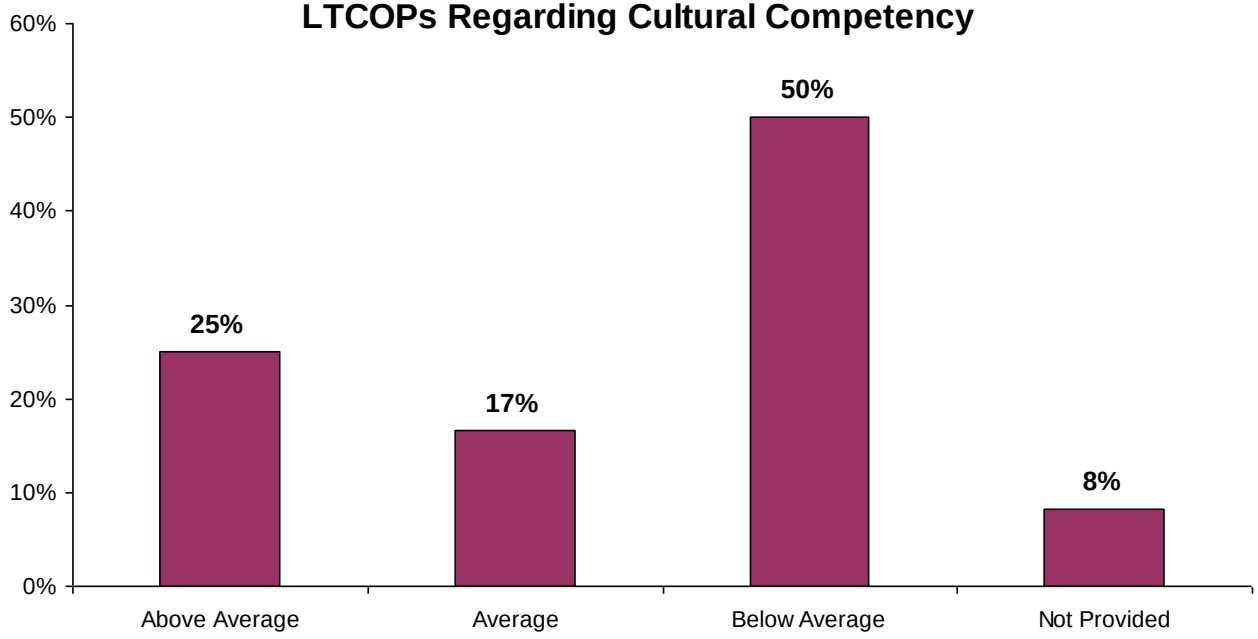
Q. For each of the following indicate whether you agree or disagree that the item applies to your local LTCOP. Ombudsmen vary in assessments of the LTCOP on issues of cultural competency. For example, whereas 92% (N = 11/12) agree that program staff reflect the ethnic and cultural make-up of the community and 67% (N = 8/12) agree that staff are provided some training about resident ethnic/cultural diversity, 73% (N = 8/11) suggest that the local LTCOP does not engage in educational outreach to different multicultural populations and 67% (N = 8/12) indicate that the program does not interact with organizations representing different multicultural and religious groups.

Figure 4.9b: Extent to Which Characteristics/Activities Applied to Regional LTCOPs in Addressing Issues Related to Cultural Competency (cont'd)



Q. For each of the following indicate whether you agree or disagree that the item applies to your local LTCOP. Most ombudsmen agree (75%, N = 9/12) that the local LTCOP does outreach to recruit staff from diverse ethnic backgrounds and the local LTCOP has established service networks to provide the assistance of interpreters, as needed. On the other hand, 58% (N = 7/12) indicate that the local LTCOP does not gather or review data on the diversity factors among residents served and 75% indicate that the local LTCOP does not do regular and/or formal evaluation of its own cultural competency.

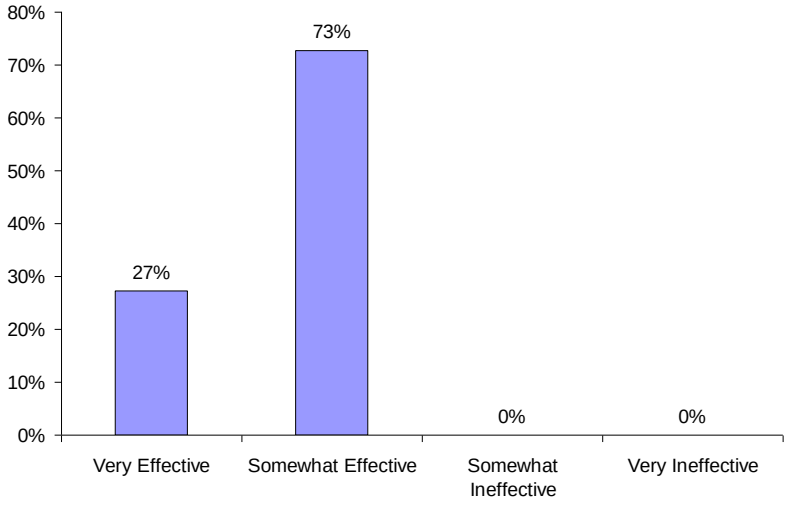
Figure 4.10: Ratings for Training of Program Staff of Regional LTCOPs Regarding Cultural Competency



Q. For each of the following, tell us how you would rate specific content areas of the training provided to the staff (paid & unpaid) of your LTCOP? Most ombudsmen (58%, N = 7/12) are dissatisfied with the training of program staff regarding cultural competency and rate this training as below average or not provided at all.

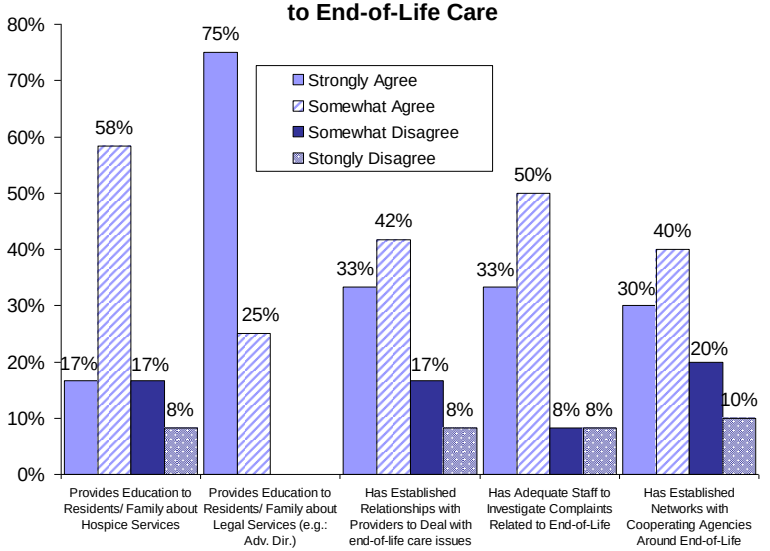
End-of-Life Care

Figure 4.11: Self-Rated Effectiveness of Regional LTCOPs in Addressing Complaints and Concerns Related to End-of-Life Care



Q. How would you rate the effectiveness of your local LTCOP in addressing complaints and concerns related to end-of-life care issues?
In general, ombudsmen rate the regional LTCOPs are being very (27%) or somewhat effective (73%) in addressing issues that arise related to end-of-life care.

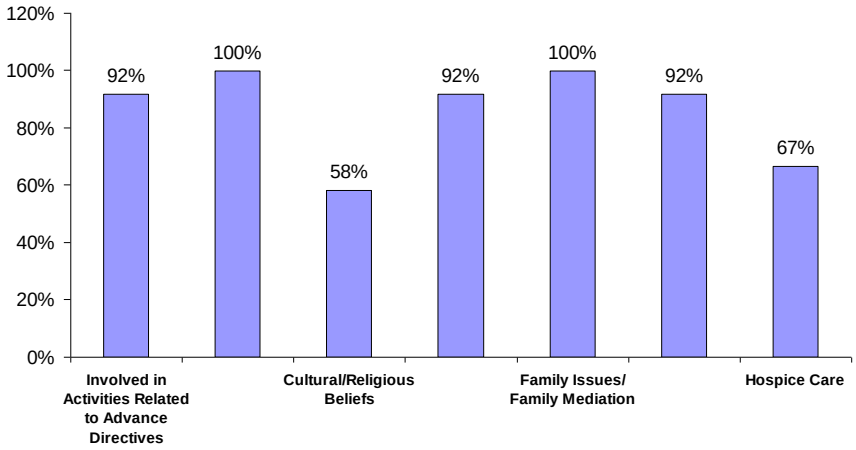
Figure 4.12: Extent to Which Characteristics/Activities Applied to Regional LTCOPs in Addressing Issues Related to End-of-Life Care



Q. For each of the following indicate whether you agree or disagree that the item applies to your local LTCOP.
A majority of the ombudsmen generally agree (strongly or somewhat) that the regional LTCOPs engage in positive activities related to end-of-life care; 75% agree that they provide education about hospice services, 100% provide education about legal services, 75% have positive relationships with providers, 83% have adequate staff to investigate complaints related to end-of-life issues, and 70% have established relationships with cooperating agencies.

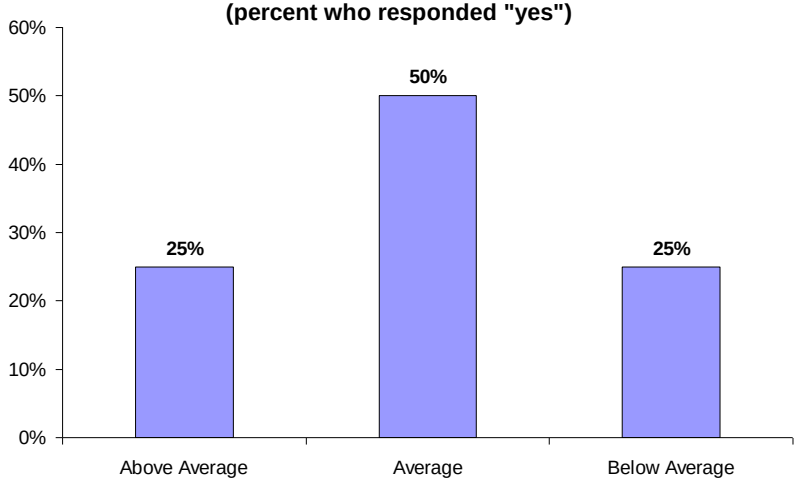
End-of-Life Care, cont'd

Figure 4.13: Regional LTCOPs Involvement in Issues Related to End-of-Life Care Over the Past Year (percent who responded "yes")



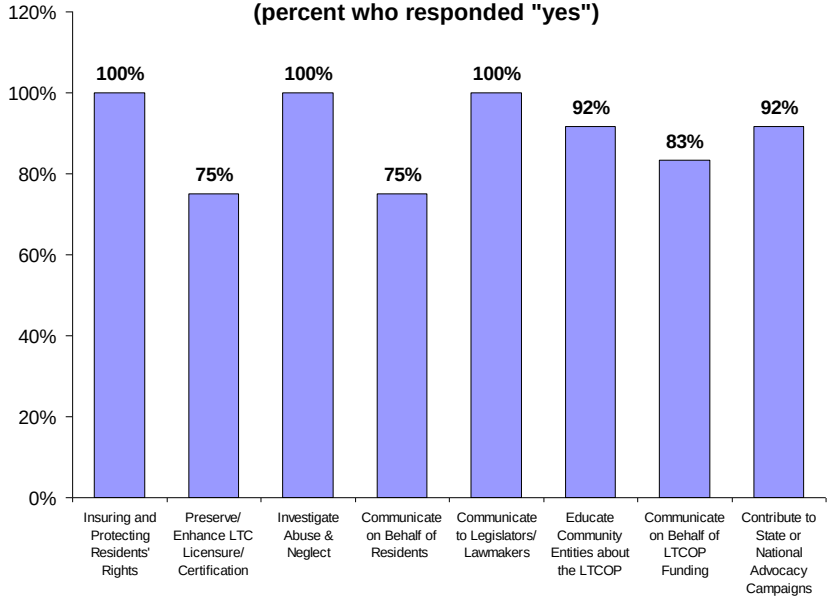
Q. Over the past year, have cases related to end-of-life care service for residents involved any of the following issues?
Generally, the regional LTCOPs (> 90%) are involved in a wide array of issues related to end-of-life care. These include advance directives, legal orders, family issues and mediation, and pain management. "Only" 58% of the ombudsmen report that the regional LTCOP was involved in cultural/religious beliefs and wishes related to end-of-life in the past year; 67% reported dealing with hospice care issues in the past year.

Figure 4.14: Ratings of Training of Program Staff of Regional LTCOPs in Areas Related to End-of-Life Care (percent who responded "yes")



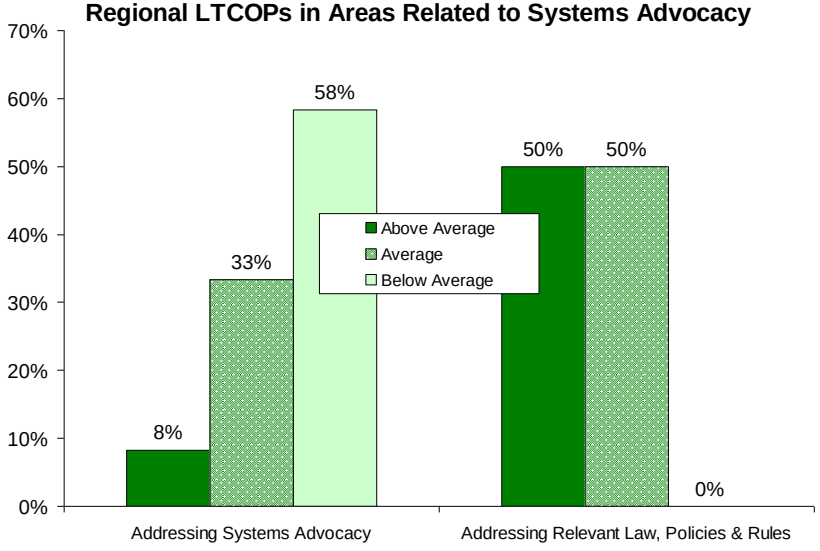
Q. For each of the following, tell us how you would rate specific content areas of the training provided to the staff (paid & unpaid) of your LTCOP?
Although 25% (N = 3/12) of the ombudsmen rate their staff training for dealing with end-of-life issues as "above average," an equal proportion rate this training as "below average."

Figure 4.15: Regional LTCOPs Involvement in Issues Related to Systems Advocacy Over the Past Year (percent who responded "yes")



Q. Please tell us if your local LTCOP engages in any of the following types of systems advocacy.
The majority of ombudsmen (>75%) report that the regional LTCOP engages in a host of systems advocacy activities including insuring and protecting residents' rights (100%), addressing issues related to investigations of abuse and neglect (100%), and communicating on behalf of residents to legislators and lawmakers, among others (100%).

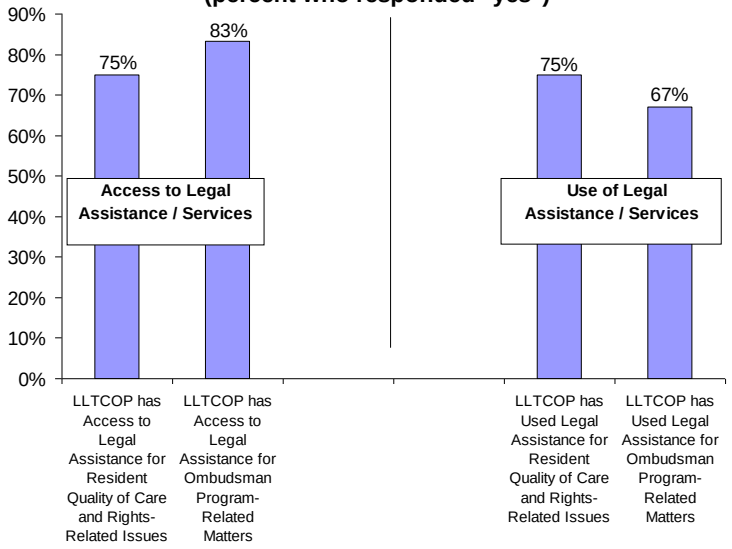
Figure 4.16: Ratings of Training of Program Staff or Regional LTCOPs in Areas Related to Systems Advocacy



Q. For each of the following, tell us how you would rate specific content areas of the training provided to the staff (paid & unpaid) of your LTCOP?
Whereas 100% of the ombudsmen rated staff training addressing relevant laws, policies and rules as average or above average, 58% rated program staff training on issues of systems advocacy as below average.

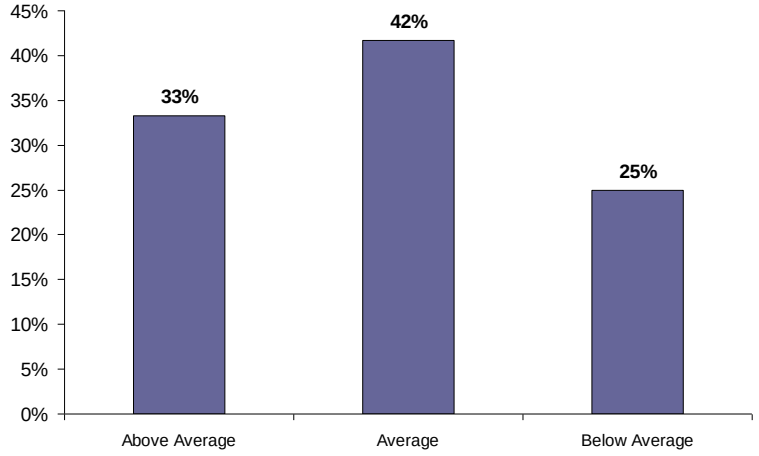
Legal Support & Services

Figure 4.17: Regional LTCOPs Access and Utilization of Legal Services and Support Over the Past Year (percent who responded "yes")



Q. Does your local LTCOP have access to legal assistance for Resident Quality of Care and Rights (or Ombudsman Program) related matters? Has your local LTCOP used legal assistance for Resident Quality of Care and Rights (or Ombudsman Program) related issues in the past year?
Whereas 75% of ombudsmen reported that the local LTCOP had access to legal services and used these legal services for resident quality of care and rights matters, 83% reported that the local LTCOP had access to legal services for Ombudsman Program matters and only 67% actually used these legal services.

Figure 4.18: Ratings of Training of Program Staff of Regional LTCOPs in Areas Related to Identification of Potential Legal Issues



Q. For each of the following, tell us how you would rate specific content areas of the training provided to the staff (paid & unpaid) of your LTCOP?
Three-of-four ombudsmen (75%) rate training for program staff on potential legal issues as average or above average, whereas 25% rate such staff training as below average.