Selected LTCOP Literature

References	Overview	Program Effectiveness (EF)	Adequacy of Resources (AR)	Conflict of Interest (CI)	Organizational Relationships (OR)	Quality of Care (QC)	Elder Abuse & Neglect (EA)	Post-Acute Care (PA)	Cultural Competency (CC)	End of Life Care (EL)	Advocacy / Policy (AP)	Legal Services (LS)	Best Practices (BP)
Administration on Aging (AoA) (2002-2001). NORS, FY 2002.	The data presented and analyzed in this report are collected annually by AoA from state ombudsmen under the National Ombudsmen Reporting System (NORS).									X			
Administration on Aging (AoA) (2001-2000). Long-term care ombudsman report FY 2001.	This report provides data for fiscal year (FY) 2001 from all state ombudsman programs on the activities of those who participate in the Ombudsman Program at the state and local levels, and analyzes changes in the data since FY 1998, the date of the last report. The central observation to be made from the data presented in the report is the significant increase in program activity over a three-year period, reflecting greater use of the Ombudsman Program by residents of long-term care facilities, their relatives, and by those who operate and work in those facilities.									X			
Bishop, C.E. (1999). Where are the missing elders: the decline in nursing home use, 1985-1995.	In 1995 many more nursing home beds were filled by a group of patients who were barely in evidence in 1985: those receiving Medicare-financed postacute care. The absolute increase in the number of Medicare patients observed in nursing facility beds on the survey date was ninefold, from about 20,000 in 1985 to178,000 in 1995. Many Medicare-funded patients using nursing home care will return to the community after a relatively short postacute stay.						X						
Burger, S. G., Fraser, V., Hunt, S., Frank, B. (2002). Nursing homes: getting good care there. National Citizens' Coalition for Nursing Home Reform (NCCNHR).	Guide on how to get good care in a nursing home and become an advocate for a loved one in a long-term care facility. Examines the individual experience of entering a nursing home, focusing on the resident's struggle to retain individuality within an institutional routine. Explains federal and state laws that affirm residents' rights to make choices about their lives, to exercise control over their care and treatment, and to have information about what is happening to them. Examines the 7 most common problems experienced by residents in nursing homes (not being taken to the bathroom according to individualized needs, not getting enough fluids, not getting enough to eat, not being groomed properly, not receiving preventive skin care, not being helped with a range of motion exercises, and no encouragement to retain independence) and how to deal with them. Provides suggestions for improving a relative's quality of life in the nursing home. Contains a guide to problem solving that focuses on dealing with staff and specific concerns.					X	X				X		
Cherry, R.L. (1993). Community presence and nursing home quality of care: the ombudsman as a complementary role.	Nursing home ombudsmen represent a community presence in long-term care facilities. This study examines ombudsmen in the context of Litwak's theory of complementary roles in order to assess the theory's association with quality of care. A multivariate analysis of a random sample of 210 Missouri nursing homes revealed that the presence of an ombudsman in intermediate care facilities is significantly related to both process and outcome measures of quality of nursing care. The implication is that conceptualizations of complementary roles should include the quality assurance functions illustrated by ombudsmen.	X				X							
Eisendrath, B. (2002). Reimaging the ombudsman: an appraisal: an ombudsman program can serve as a useful alternative to the court system for nursing-home residents.	This article looks at the issues surrounding the ombudsman's role in long-term care facilities including purpose, criticisms, and local and national recommendations.. Part II examines the history and purpose of the classic ombudsman role. Part III summarizes the federal long-term care ombudsman program as authorized in the Older Americans Act, while Part IV explores criticisms of ombudsmen and ombudsman programs in general. Part V describes the Wisconsin long-term care ombudsman program and criticisms of it. Part VI concludes with a look at local and national recommendations for ombudsman programs.	X								X			X

References	Overview	EF	AR	CI	RE	QC	EA	PA	CC	EL	AP	LS	BP
Estes, C.L., Zulman, D.M., Goldberg, S.C., and Ogawa, D.D. (2004, in press). State long term care ombudsman programs: Factors Associated with Perceived Effectiveness.	This article reports findings from a nationwide study on factors associated with the perceived effectiveness of state Long Term Care Ombudsman Programs (LTCOPs). Several factors limit the perceived effectiveness of state LTCOPs, including insufficient funding and insufficient LTCOP autonomy caused by organizational placement. Despite these problem areas, state ombudsmen report that their programs meet statutorily mandated requirements with varying degrees of effectiveness. Findings show significant positive associations between program funding and paid and volunteer staff levels and between the ratio of long-term care beds per ombudsman and the percentage of nursing facilities visited. Sufficient funding is positively associated with perceived effectiveness of work with nursing facilities.	X	X	X	X	X					X		X
Filinson, R. (2002). Evaluation of the impact of a volunteer Ombudsman program. [**NOTE – abstract available online "Health & Wellness Resource Center" – but not able to locate article – not able to confirm as an article (was as an '02 GSA presentation)].	The Long-Term Care Ombudsman Program safeguards the needs of long-term care residents through the vigilance of an external observer. In 1997, in Rhode Island, a volunteer component was introduced in which community members were trained as advocates for long-term care residents. This research assessed the impact of the new component on the effectiveness of the statewide ombudsman program through comparisons of complaints reported to the State Ombudsman and documented deficiencies at facilities with and without ombudsmen. Analysis revealed more complaints and more serious ones in facilities with a volunteer, but also a negative and significant correlation between the length of volunteer presence and number of deficiencies.	X									X		
Frank, B. (2000). Ombudsman Best Practices: Supporting Culture Change to Promote Individualized Care in Nursing Homes.	Paper presenting long term care ombudsman best practices in supporting culture change in nursing homes, drawing on lessons learned by State Ombudsman Programs that have engaged in such initiatives. Includes an overview of the issues, relevant practice precedents and examples of best practices.								X				X
Freeman, I. C. (2000). Uneasy allies: nursing home regulators and consumer advocates.	Examines the working relationships between nursing home regulators and consumer advocates, particularly advocates in designated ombudsman programs, comparing the diverse yet compatible roles of the two entities. It is argued that regulators and ombudsman programs need to join forces for survival, commit to education to improve the quality of care in nursing homes, and fight for residents' rights.		X		X	X					X		X
Grant, R. (2003). Translating Nursing Home Ombudsman Skills to Assisted Living: Something Old, Something New	The purpose of this paper is to strengthen ombudsman assisted living advocacy by drawing upon the effective strategies already employed by ombudsmen in the nursing home arena. The paper examines the commonalties and differences between ombudsman practice in assisted living and nursing homes and presents a range of ombudsman strategies for assisted living work. Seven important issues are examined: care or service planning, promoting residents' rights, resident autonomy/choice, transfer/discharge, staffing, resident agreements/contracts, and disclosure.	X									X		X
Grant, R. (2000) Best Practices: Confidentiality	Best Practice paper addresses key issues facing state and local ombudsmen. Includes many examples of specific state practices that uphold confidentiality. Paper addresses the importance of maintaining confidentiality, underlying principles, promoting and preserving confidentiality in 4 areas of ombudsman work, and measuring outcomes.										X		X
Hawes, C. (1999). Key piece of the integration puzzle: managing the chronic care needs of the frail elderly in residential care settings.	Suggests that residential care settings are increasingly being seen as a viable alternative to providing long term care. In recent years, such facilities have expanded the range of services they offer and residents they serve. The result has been increasing levels of functional and cognitive impairment among board and care home residents.					X							
Hosay C.K. (2003). State long-term care ombudsman knowledge of state laws concerning nursing home conscience policies.	A study of the Long-Term Care Ombudsman in each state and the District of Columbia found that fourteen of the twenty-five respondents did not know when their state laws allowed nursing homes to refuse to honor patient end-of-life wishes. The Ombudsman is supposed to be an advocate for residents of nursing homes and a source of information. State laws vary as to when a facility may refuse to honor treatment directives and what it must do if it will not honor a patient wish. Patients and their families who do not know that an end-of-life directive will not be honored until the patient is dying may turn to the ombudsman for assistance. The ombudsman must know the laws of the state to intercede for the patient and to advocate for policy changes when the need for change is suggested.	X								X	X		

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Hosay C.K. (2002). Compliance with patients' end-of-life wishes by nursing homes in New York City with conscience policies.	Nursing patients have a constitutional right to refuse treatment. The Patient Self-Determination Act confirmed that right. State laws address the obligations of health care providers and facilities to honor that right. The New York State law is more specific than those of many other states. It allows exemptions for "reasons of conscience" and imposes a number of requirements on nursing homes claiming such an exemption, including the transfer of a patient to a home that will honor an end-of-life wish. This study, conducted by FRIA, investigated the refusal of some nursing homes in New York City to carry out patients' end-of-life wishes because of conscience-based objections. The study also investigated the willingness of homes which did not have such policies to accept patients transferring from a home with a policy so that the patient's end-of-life wishes would be honored. Implications for administrators, policy makers, and regulators are discussed.	X								X	X	X	X
Huber, R., Borders, K.W., Badrak, K., Netting, F.E., and Nelson, H.W. (2001). National standards for the long-term care ombudsman program and a tool to assess compliance: The Huber Badrak Borders scales.	Authors propose national standards previously recommended for the Long-Term Care Ombudsman Program by an Institute of Medicine program evaluation committee, and introduce a tool to measure the compliance of local ombudsman programs to those standards: the Huber Badrak Borders Scales. The best practices for ombudsman programs detailed in the committee's report were adapted to 43 Likert-type scales that were then averaged into 10 infrastructure component scales: (a) program structure, (b) qualifications of local ombudsmen, (c) legal authority, (d) financial resources, (e) management information systems, (f) legal resources, (g) human resources, (h) resident advocacy services, (i) systemic advocacy, and (j) educational services. The means of 9 of these 10 scales were higher in 1999 than in 1996, suggesting that local ombudsman programs were more in compliance with the proposed standards in 1999 than three years earlier.	X		X									X
Huber, R., Netting, F. & Kautz, J. (1996). Differences in types of complaints and how they were resolved by local long-term care ombudsmen operating in/not in Area Agencies on Aging.	Examines the differences between types of complaints and how they are resolved in the context of whether local ombudsman programs are housed in Area Agencies on Aging (AAAs). The results show differences in terms of program support. Housing of ombudsman programs in AAAs is being opposed due to conflicts of interest. Housing ombudsman programs in non-AAAs does not result in autonomy or in resolving conflicts of interest	X		X	X						X		X
Hunt, S. (2002). Ombudsman Best Practices: Using Systems Advocacy to Improve Life for Residents.	The paper is designed to provide support, guidance and ideas for state and local long term care ombudsmen to use in pursuing changes in systems to improve quality of life for residents. Includes "Tips for Sanity and Success" and "Real World Examples."					X					X		X
Hunt, S. (2001). Joining Forces For Residents: Citizen Advocates And Long Term Care Ombudsmen.	The purpose of this paper is to assist citizen advocates and long term care ombudsmen in working together on behalf of residents. A session at the 2000 Annual Meeting of the National Citizens' Coalition for Nursing Home Reform focused on ways citizen advocacy groups (CAGs) and Long Term Care Ombudsman Programs (LTCOPs) have worked together to achieve a common goal.				X						X		X
Hunt, S. (2000). Best Practices: Training programs for long term ombudsmen.	This paper is a resource to states in re-assessing or revising their training programs for new ombudsmen. It identifies: key components in LTCOP training programs, various approaches used among the states, and salient questions ombudsman programs need to consider in designing or reassessing their training.	X	X								X		X
Institute of Medicine (IoM), Harris-Wehling, J., Feasley, J.C., and Estes, C.L. (1995). Real people real problems: an evaluation of the long term care ombudsman programs of the Older Americans Act.	This report from the Institute of Medicine (IOM) addresses important aspects of the LTC ombudsman program--specifically the LTC ombudsmen's ability to deal with problems that affect the care provided to and the quality of life achieved by elderly residents of LTC facilities. The committee's report examines four key issues: 1) the extent of compliance with the program's federal mandates, including conflict of interest issues; 2) the availability of, unmet need for, and effectiveness of the ombudsman program for residents of LTC facilities; 3) the adequacy of federal and other resources available to operate the programs; and 4) the need for and feasibility of providing ombudsman services to older individuals who are not residing in LTC facilities.	X	X	X		X					X		X

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Keith, P.M. (2003). Doing good for the aged: volunteers in an ombudsman program.	Book that examines the effects of participation on resident-advocate committees in nursing homes in Iowa. A total of 778 committee members responded to a mail survey. Analysis focused on pathways to volunteering, social-psychological outcomes of volunteering, role orientations, support from others, and efficacy.	X	X										X
Lewin Group, Inc. (2002). Indicators of cultural competence in health care delivery organizations: An organizational cultural competence assessment profile.	The Assessment Profile is an analytic or organizing framework and set of specific indicators to be used as a tool for examining, demonstrating, and documenting cultural competence in organizations involved in the direct delivery of health care and services. At a general level, the Profile can help organizations frame and organize their perspectives and activities related to the assessment of cultural competence. More specifically, it can be used in routine performance monitoring, regular quality review and improvement activities, assessment of voluntary compliance with cultural competence standards or guidelines, and periodic evaluative studies.								X				X
MacInnes, G. & Hedt, A. (1999). Long term care ombudsman programs: Training, certification and insurance coverage.	This study is an initial examination of the varied state ombudsman programs, their use of volunteers and the training provided. A simple survey was distributed to all state ombudsmen in the summer of 1999.	X	X										
MacInnes, G. & Hedt, A. (1999). Long term care ombudsman salary analysis.	The study found that yearly full-time salary ranges for local ombudsmen varied from $12,480 - $24,960 (Montana) to $34,278 - $61,540 (Maryland). Local salary levels are very different both between and within states. Twenty-two states reported the low end of their salary scale for local ombudsmen to be $20,000 a year or less for a full-time employee. Twelve states reported the upper end of their salary scale for local ombudsmen to be $40,000 or more annually.		X										
National Association of State Long Term Care Ombudsman Programs (NASOP) (1996). Licensing and certification for nursing facilities and the long term care ombudsman program.	Paper describes the mission and functions of the Long Term Care Ombudsman Programs and the Licensing and Certification Agencies in order to promote a discussion which will result in better understanding, working relationships and coordination between these entities.	X			X						X		X
National Association of State Long Term Care Ombudsman Programs (NASOP) (1994). Adult protective services and the LTC ombudsman program.	Paper describes the mission and functions of the Long Term Care Ombudsman Programs and Adult Protective Services in order to promote a discussion which will result in better understanding, working relationships and coordination between these entities.	X			X						X		X
National Association of State Ombudsman Programs (NASOP) Retreat (2003). The LTCOP: rethinking and retooling for the future: NASOP Retreat: Proceedings and Recommendations.	This publication provides the proceedings, recommendations, and background materials from the 2002 retreat of the National Association of State Long-Term Care Ombudsman Programs (NASOP) made possible with the help of the Helen Bader Foundation.	X	X	X		X					X		X
National Association of State Units on Aging (NASUA) (2002). Long-Term Care Ombudsman Program: A Summary of State Enabling Statutes.	Compares state statutes concerning the authority of the Long-Term Care Ombudsman Program to access residents and facilities and resolve complaints.										X		
National Association of State Units on Aging (NASUA) (2000). Ombudsman program outcomes: consensus document adopted by ombudsman outcomes work group.	This document represents a first step in the process of developing and testing outcomes for the Ombudsman Program. It was developed by an Outcomes Work Group of State Ombudsmen and State Aging staff and builds on the work that already has been done to set program standards and identify quality measures for the program. It defines "outcomes," presents a mission statement for the Ombudsman Program, and identifies a set of "beginning principles" to guide the development of outcomes.	X											X

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National Association of State Units on Aging (NASUA) (2000). Tried and true methods for reaching under-served populations.	Includes suggestions or methods for outreach developed from Ombudsmen and other elder rights program managers' experience. Organized under the Four P's -- people, places, props and pathways-- the recommendations highlight many of the critical actions that the Ombudsman leadership should consider as efforts to ensure more cultural awareness, diversity and minority outreach are initiated.	X							X		X		X
National Long Term Care Ombudsman Resource Center (NLTCORC) (2003). Nursing Home Quality Initiative: Evaluation of the Relationship between Long-term Care Ombudsman Program (LTCOPs) and Quality Improvement Organizations (QIOs).	Report prepared by Donna Lind Infeld, PhD, as part of the Center for Medicare and Medicaid Services' (CMS) Nursing Home Quality Initiative (NHQI), a fundamental role of the LTCOP is to educate and advise consumers on how to use the quality measures as one tool in making decisions about nursing home placement and quality of care issues. Ombudsmen from the six pilot states summarized their experience with the NHQI. They generally indicated the new information provides another piece of the puzzle about quality of care in nursing homes. The quality measures are seen as a tool to empower consumers to make better decisions regarding nursing home care.					X					X		X
National Long Term Care Ombudsman Resource Center (NLTCORC) (2001). Medicare Prospective Payment in SNFs and its impact on nursing home residents: questions for ombudsmen considering the care of Medicare patients in nursing homes	By most accounts, people who require rehabilitation services experience fewer delays finding SNF care because they are reimbursed under the highest RUG-III categories. Although PPS was supposed to curb abusive uses of therapy to enhance reimbursement, it gives nursing homes incentives to provide medically questionable therapies to obtain higher payments.							X					
Netting, E.F., Huber, R., Borders, K., Kautz, J.R. & Nelson, H.W. (2000). Volunteer and paid ombudsmen investigating complaints in six states: a natural triaging.	The Long Term Care Ombudsman Program provides an opportunity to explore how a public mandate is implemented through the use of paid and volunteer ombudsmen who investigate complaints in long-term care facilities. In this article, the authors report partial findings from a growing data base across six states, focusing on what is known about the use of volunteers and paid staff complaint investigation. Findings reveal differences in the types of complaints received, the sources of complaints, and the percentage of complex (difficult) complaints investigated by volunteers and paid staff. These differences result in a natural triaging that occurs among volunteers and paid staff, so that complaints viewed as difficult to verify and resolve are automatically given to paid staff.	X									X		
Office of Inspector General (OIG) (2003). State ombudsman data: nursing home complaints.	This report is based on an analysis of NORS data from 1996 - 2000, interviews with 46 state and local ombudsmen in 9 states, and a more in-depth analysis of the data in those states - CA, CT, AL, MD, MO, SC, TX, SD, NY. The summary of the findings states, "Nationally, the number of nursing home complaints increased, but the types of complaints have not changed significantly. However, the data are not comprehensive. NORS data should not be used to compare States with respect to the volume and types of complaints, because local ombudsmen do not report all nursing home complaints in NORS, and they do not always use the same categories to classify complaints." AoA has made a commitment to address data inconsistencies and this is one of the Center's priorities.	X									X		X
Office of Inspector General (OIG) (1999). Quality of care in nursing homes: An overview. Office of Inspector General – U.S. Department of Health and Human Services.	An analysis of currently available program data reveals that problems with quality of care continue to exist in nursing homes. First, according to survey and certification data, 13 of 25 "quality of care" deficiencies have increased in recent years. They include a lack of supervision to prevent accidents, improper care for pressure sores, and lack of proper care for activities of daily living. At the same time, ombudsman complaints have been steadily increasing since 1989 and complaints about resident care, such as pressure sores and hygiene, have been particularly prevalent. Approximately one percent or more of nursing home residents have had an experience serious enough to register an abuse complaint. Lastly, survey and certification data, as well as discussions with survey and certification staff and ombudsmen, reveal that some nursing homes are chronically substandard.	X				X	X				X		

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Payne, B. & Berg, B. (2003). Perceptions about the criminalization of elder abuse among police chiefs and ombudsmen.	The 1990s witnessed the criminalization of elder abuse. This criminalization included the creation of mandatory-reporting legislation, increased penalties for elder abusers, and modifications in criminal procedures for older victims. Little attention has been given to those officials actually involved in deciding how elder abuse cases should be handled. This research considers the sanctions recommended by police chiefs and ombudsmen for six different types of offenses against seniors. Attention is also directed toward potential differences between the groups' attitudes about elder abuse. Results indicate that ombudsmen see nursing home offenses as more severe than street offenses or white-collar offenses. Police chiefs see street offenses as the most severe offense type. Implications are provided.				X		X				X	X	X
Peduzzi, J.J., Watzlaf, V.J., Rohrer, W.M., Rubinstein, E.N. (1997). A survey of nursing home administrators' and ombudsmen's perceptions of elderly abuse in Pennsylvania.	The topic of elder abuse has been a source of growing concern and research over the past decade. Nationally, it is believed that about four percent of elders are abused, even though every state currently has laws protecting abuse of elders. To the authors' knowledge, little or no published research has been done to assess the perceptions of nursing home administrators (NHAs) and ombudsmen with respect to elder abuse. This study explored Pennsylvania NHAs' and ombudsmen's knowledge of detecting, reporting, and managing elder abuse cases. Also, data were collected regarding the perceptions of Pennsylvania NHAs and ombudsmen about the knowledge of their nursing facility personnel in the areas of detection, legislation, and regulation of elder abuse.				X		X				X	X	X
U.S. Department of Health and Human Services (HHS), Office of Disability, Aging and Long-Term Care Policy (DALTCP) and Project Hope. (1997) Trends in Special Care: The 1995 National Nursing Home Census of Sub-Acute Units: Executive Summary.	The objectives of this study were to establish a reliable baseline estimate of the number and distribution of sub-acute care units in licensed nursing homes; to estimate the bed capacity of these units in 1995; and to sketch the characteristics of the nursing homes where these units were located. This effort was part of a larger study on the development of specialty care programming in nursing homes. If trends continue in the direction indicted by the 95/96 TSC Census, nursing homes will become more specialized in the future. It appears that the sub-acute market is particularly strong in the South, in major urban areas, and within nursing homes that have a larger than average bed capacity. These markets, combined with the large numbers of facilities planning to expand existing or develop new units, point to sub-acute care as a growing industry.							X					
Whitford, A.B. & Yates, J. (2002). Volunteerism and social capital in policy implementation: evidence from the Long-Term Care Ombudsman Program.	Authors assess the link between a program's volunteer support and state social capital in the case of the joint implementation of the federal Long-Term Care (LTC) Ombudsman Program by state and federal authorities. Authors find that volunteerism is vital to the efficacy of the program's monitoring and investigative function, and that volunteerism in this program is tied to broader level conditions of a state's social capital. Authors discuss the implications of our findings for volunteer-based programs devolved to the states.	X	X				X				X		X
Wildfire, J., Hawes, C., Mor, V., Lux, L., and Brown, F. (1998). The effect of regulation on the quality of care in board and care homes.	Assessed the effect of state regulation on the quality of care in board and care homes. Interviews were conducted with 1,138 staff members, 512 operators, and 3,257 residents in 386 licensed and 126 unlicensed board and care homes in ten states: five with extensive regulatory systems (CA, FL, NJ, OK, and OR) and five with limited regulatory systems (AK, GA, KY, IL, and TX). Most homes (56 percent) housed a predominantly older population, with 64 percent of residents aged 75 or older; however, a substantial minority of homes (21 percent) primarily served people with mental, emotional, or nervous conditions. States with extensive regulatory systems had significantly fewer unlicensed facilities. Extensive regulatory systems were associated with better quality of care; they were more likely to have operators trained in care of older and disabled adults, and staff were more knowledgeable about the long term care ombudsmen programs and more willing to refer residents and families to them.					X							X
Yip, J. Y., K. H. Wilber, et al. (2002). The impact of the 1997 Balanced Budget Amendment's prospective payment system on patient case mix and rehabilitation utilization in skilled nursing.	Study examines the impact of the post-acute prospective payment system (PPS) on Medicare-funded rehabilitation services in skilled nursing facilities (SNFs) and whether such impact varies under different payment mechanisms. Authors interviewed 214 Medicare beneficiaries admitted to three SNFs in southern California for rehabilitation, and compared patients' admission characteristics and therapy utilization among those receiving post-acute rehabilitation before and after the implementation of PPS. Patients admitted after PPS implementation were more likely to have orthopedic problems or stroke and poorer self reported physical health. They had significantly shorter lengths of stay in rehabilitation and received significantly less therapy, although those in managed care had less reduction in treatment after SNF-PPS implementation than those in fee-for-service. After SNF-PPS implementation, rehabilitation treatment levels in the study sites were reduced.				X		X						