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

CHARTBOOK

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Background & Significance

The long term care ombudsman program (LTCOP), mandated under the federal Older Americans Act, is a crucial mechanism for maintaining oversight on the quality of care and life of residents of long term care (LTC) facilities by advocating for their health, safety, welfare, and rights. Specifically local LTC ombudsmen address mandated activities including: complaint investigation, community and resident and family education, laws and regulations monitoring, and legislative and administrative advocacy. Knowledge and understanding concerning barriers to effective program operation and successful programmatic approaches are essential to enhance the safety and well-being of persons residing in LTC facilities, to strengthen local ombudsman programs, and to develop meaningful public policy.

It is important to note that "long-term care" encompasses more than nursing homes: in fact, in Georgia the LTC facilities served by local ombudsmen include intermediate care facilities for persons with mental retardation (ICF/MRs), and various community-based models, specifically personal care homes (PCHs), and community living arrangements (CLAs). Thus the challenge of monitoring the quality and safety of long-term care is compounded by the fact that LTC residents are in these four different settings. Particularly challenging in Georgia is the population of mentally ill, and mentally retarded residents in ICF/MRs and CLAs.

This project builds on the 1995 Institute on Medicine report *Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act* and the 2001 Kaiser Family Foundation study of the *Effectiveness of State Long Term Care Ombudsman Programs*. The project *Enhancing the Effectiveness of Local Long Term Care Ombudsman Programs in Georgia* is part of a multi-state effort involving California, New York, Illinois, and Ohio to strengthen the capacity of local ombudsman programs. Following the completion of the *Enhancing the Effectiveness of Local Long-Term Care Ombudsman Programs in New York and California* project, additional state ombudsmen expressed interest in replicating the project (http://www.ltcombudsman.org/ombpublic/251_1341_12783.cfm). Under collaborative agreements, in-state researchers used the structure and survey instruments created by Institute for Health & Aging (IHA) researchers to replicate the project in Illinois and Ohio. The Georgia Department of Human Resources, Division of Aging Services (DAS) contracted with IHA researchers to replicate the project in Georgia.

Background & Significance, cont'd.

The Georgia LTCOP project both contributes to and benefits from the larger project. The comparison of issues confronting local Georgia ombudsmen programs with those confronted in similar programs across five geographically, demographically, and politically diverse states is informative in identifying and sharing information regarding program strengths and weaknesses. The overall multi-state local LTCOP project is expected to contribute to dialogue at both the state and national levels concerning future programmatic and policy directions.

In the Georgia project, the major goals were to:

- Identify and examine issues of particular relevance to Georgia local LTCOPs;
- Replicate earlier research projects in order to advance comparative knowledge of local LTCOP performance and barriers to effectiveness across the nation; and
- Disseminate findings and cultivate the development of a set of actionable recommendations with the Georgia local LTCOPs, the Office of the State Long Term Care Ombudsman ,and the Council of Community Ombudsmen.

Throughout this project we have had superb cooperation and support from the Office of the State Long Term Care Ombudsman (OSLTCO) in Georgia, under the leadership of Becky Kurtz, Esq. and Jeni Coyne, as well as the Council of Community Ombudsmen (CoCO), and their current president, Penny Medhurst.

References:

Estes, C. L., Zulman, D. M., Goldberg, S. C., & Ogawa, D. D. (2001). *Effectiveness of the state long term care ombudsman programs*: Final Report for the Henry J. Kaiser Family Foundation, Institute for Health & Aging, University of California, San Francisco.

Harris-Wehling, J., Feasley, J. C., & Estes, C. L. (1995). *Real people, real problems: An evaluation of the long term care ombudsman programs of the Older American's Act*. Washington, DC: Division of Health Care Services, Institute of Medicine

INTRODUCTION 1

Methods

The research includes primary data collection via a telephone survey instrument with local ombudsman and other informed respondents in Georgia and secondary data of local LTCOPs in Georgia from the Aging Information Management System (AIMS) and Online Survey, Certification and Reporting (OSCAR).

The telephone survey instrument for local ombudsman was refined and revised from that utilized in the four additional project states. In-depth semi-structured telephone interviews were conducted with the coordinators of each of the 15 local programs in Georgia April and May of 2007. The 60-90 minute interview consisted of open and closed-ended questions addressing the performance and activities of the program and perceptual questions (perceived effectiveness and barriers to fulfilling mandates).

In-depth, open ended, and semi-structured telephone interviews were conducted with a purposive sample of six representatives identified as Informed Respondents during the months of July and August, 2007. Interviews with informed respondents varied in length from 30 to 120 minutes.

The project utilizes a community based participatory approach involving regular input and feedback from local and state ombudsmen to obtain buy-in from the local ombudsmen themselves and assure relevance and utilization of the findings. Researchers held regular teleconference meetings with key state and local ombudsmen representatives at all stages of the project including design, data collection and analysis, interpretation of data, and determination of key issues for briefing papers. In addition the project involves disseminating findings and participating in a summit with Georgia LTC ombudsmen to develop recommendations and action steps.

INTRODUCTION 1

Analysis

We present basic descriptive statistics drawn from the local LTCOP coordinator survey (n=15) and Aging Information Management System (AIMS) data (n=12) provided by the Georgia Office of the State Long Term Care Ombudsman (OSLTCO). While there are 15 local LTCOP coordinators in Georgia, there are only 12 PSAs.

We present the quantitative information in chart form along with a description of the source of the data. Pie charts typically represent the proportion of mutually exclusive responses and bar charts represent the frequencies among units. We also provide means and standard deviations to represent average responses and average variability around those responses when the values are continuous numbers (such as ratios) or ordinal rankings (such as strength of agreement). We do not provide statistical tests for any comparisons because we are not attempting to generalize to a target population the data are based on the total population of Georgia coordinators or program data and not a sample of these units. Frequencies and descriptive statistics were run using SPSS 15.0.

We also present qualitative information primarily by citing the direct quotations of local ombudsmen and informed respondents which serve to further describe the quantitative findings.

Finally, we provide cross-state comparison data gleaned from local coordinators in California (n=35), New York (n=39/50 programs), Illinois (n=16/17 programs) and Ohio (n=12) as well as national level informed respondents (n=16) about key issues relating to the effectiveness of local LTCOPs.

PROGRAM CHARACTERISTICS 2

Overview:

This chapter presents general program characteristics describing local Long Term Care Ombudsman Programs (LTCOPs) in Georgia. Data for this chapter were drawn from the local LTCOP coordinator survey (n=15) and Aging Information Management System (AIMS) program level data (n=12) provided by the Georgia Office of the State Long Term Care Ombudsman (OSLTCO). In addition, the chapter presents cross state comparison data from surveys conducted with local LTCOP coordinators in California (n=35), New York (n=39 out of 50 total programs), Illinois (n=16/17 programs) and Ohio (n=12) over the past three years as well as program level National Ombudsman Reporting System (NORS) data provided by each OSLTCO from this same time period.

Local LTCOP coordinators in Georgia have considerable tenure and experience; with the average reporting 13.1 years in their current position [Figure 2.1]. Close to half of Georgia's local LTCOPs are located in either a multi-purpose, non-profit (40%) or free-standing non-profit agency with about one-quarter hosted by legal service agencies (27%) [Figure 2.2]. Local LTCOPs in Georgia had an average of 3.9 paid FTE staff and a range of 0-35 volunteers [Figure 2.3], with an average volunteer / unpaid staff to paid FTE staff ratio of 2.8, and certified volunteer to FTE ratio of .08. On average local LTCOPs in Georgia serve 32 nursing homes, 148 personal care homes (PCHs), 28 community living arrangements (CLAs) and 1 intermediate care facility for persons with mental retarded (ICF/MR) [Figure 2.6]. This translates into local LTCOPs serving on average 3,390 nursing home beds, 2,170 PCH beds, 126 ICF/MR beds and 94 CLA beds [Figure 2.7]. Georgia local LTCOPs served on average 48 facilities or a total of 1,427 beds per FTE staff [Figures 2.8, 2.9]. Local programs in Georgia received on average $1,161 per facility or $37.34 per bed served [Figures 2.10, 2.11]. It must be noted that wide variation characterized most of these descriptive characteristics (evidenced by large standard deviations), indicating that within state variations across programs is considerable.

PROGRAM CHARACTERISTICS 2

Mission:

Local LTCOP coordinators were asked to describe what they considered to be the mission/main goal of their program…

My program's goal is to be as much of a presence in facilities as possible so that we are readily accessible to residents as an advocate. Our goal is to help resolve resident and family complaints and to offer advice and support regarding resident rights to the facilities. We hope to know our facilities well enough that we can recognize red flags and address those.

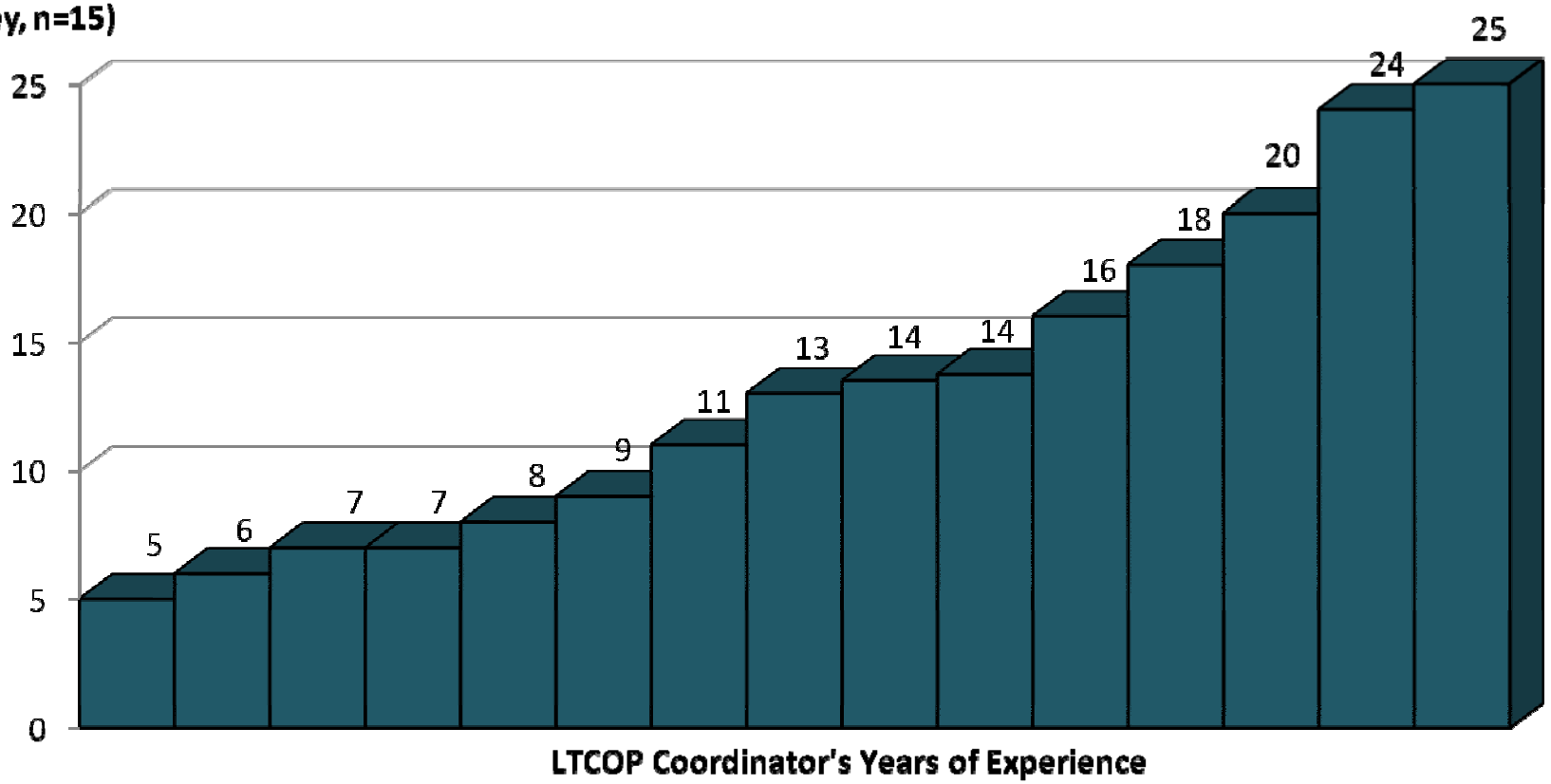
To visit the LTC facilities and residents, and advocate to resolve their problems or complaints. All the other stuff is superfluous.

To advocate and represent the interest of residents of LTC facilities. To ensure that complaints are addressed and resolved to their satisfaction. Also to identify and address issues within the facility that will help improve the quality of care for residents.

To advocate for residents of LTC facilities, respond to residents and families of residents who have complaints and concerns about the quality of care in facilities.

PROGRAM CHARACTERISTICS 2

Figure 2.1: Years of Experience in Current Position as an Ombudsman Coordinator (LTCOP coordinator survey, n=15)



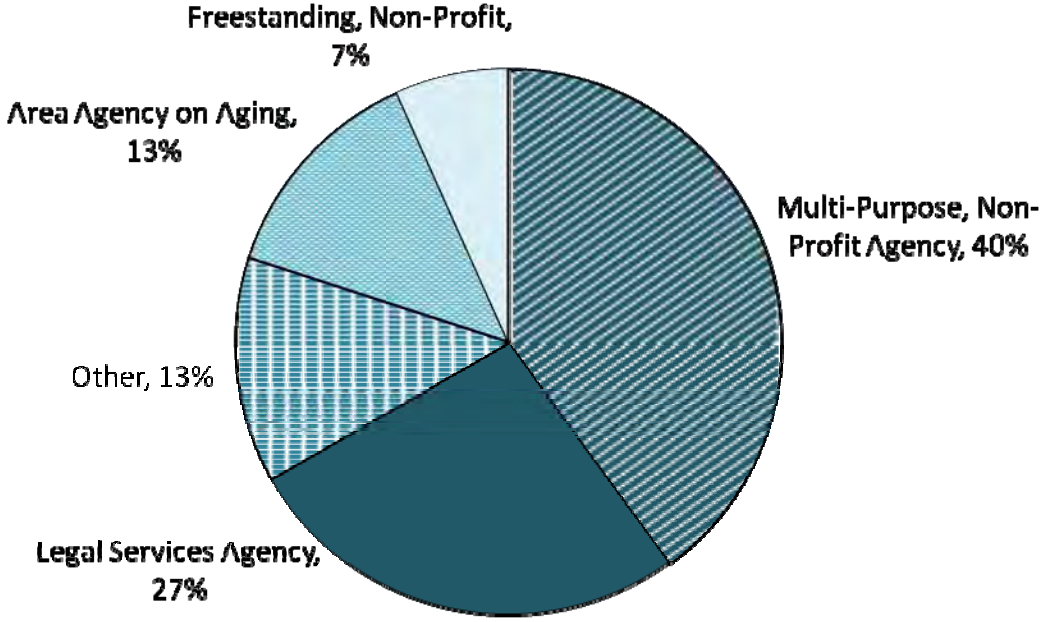
Q. How long (in years) have you been in your current position as an Ombudsman?

Local LTCOP coordinators have been in their current positions for an average of 13.1 years (range= 5- 25, sd= 6.4).

Cross-state Comparisons: The average number of years of experience coordinators reported in their current positions was approximately 6.5 in California, nearly 8 in New York, and 9.2 in Ohio. In Illinois the majority had been in their positions for 2+ years (average not available).

PROGRAM CHARACTERISTICS 2

Figure 2.2: Location / Host Agency of Local LTCOPs (LTCOP coordinator survey, n=15)



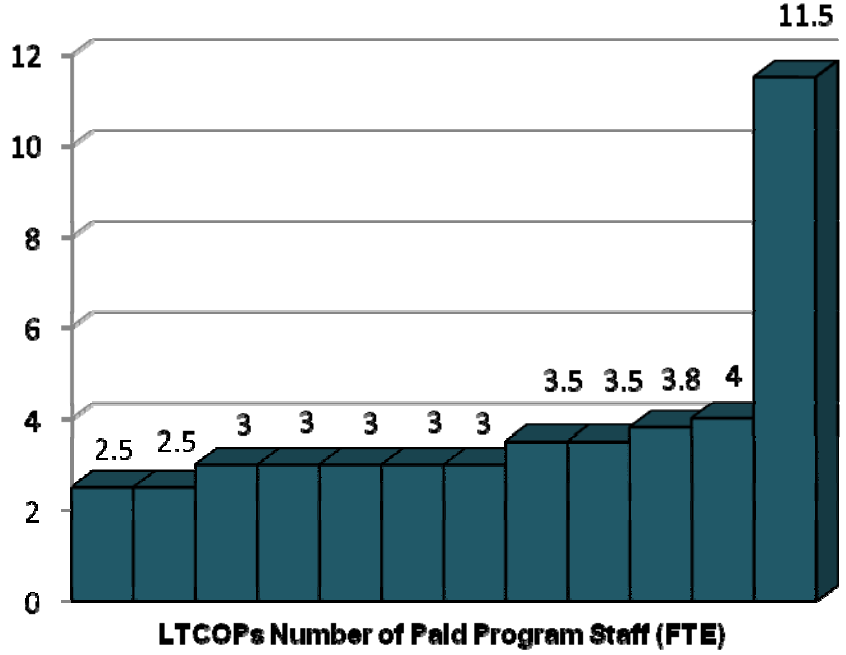
Q. Which of the following most accurately describes the host agency of your local LTCOP?

Six of the 15 local LTCOP coordinators (40%) describe their host agency as Multi-purpose, non-profit, 4 (26.7%) were hosted by a Legal Services Agency, and 1 (6.7%) is Freestanding, Non-Profit. Three coordinators (20%) report having had a change in their host agency in the last 5 years.

Comparisons: The most common host agency in California was a multi-purpose, non-profit agency (38%), followed by AAA (27%), and free-standing, non-profit (27%) then legal services agency (9%). In New York most programs were hosted within AAAs (62%), followed by 33% multi-purpose, non profits and 5% other. In Illinois, 31% were located in multi-purpose, non-profit agencies, 25% in freestanding, non-profits, 25% in AAAs, 13% in legal services agency, and 6% other. In Ohio, 50% were in AAAs, 17% in both multi-purpose, non-profits and legal services agencies, 8% freestanding, non-profits and 8% other.

PROGRAM CHARACTERISTICS 2

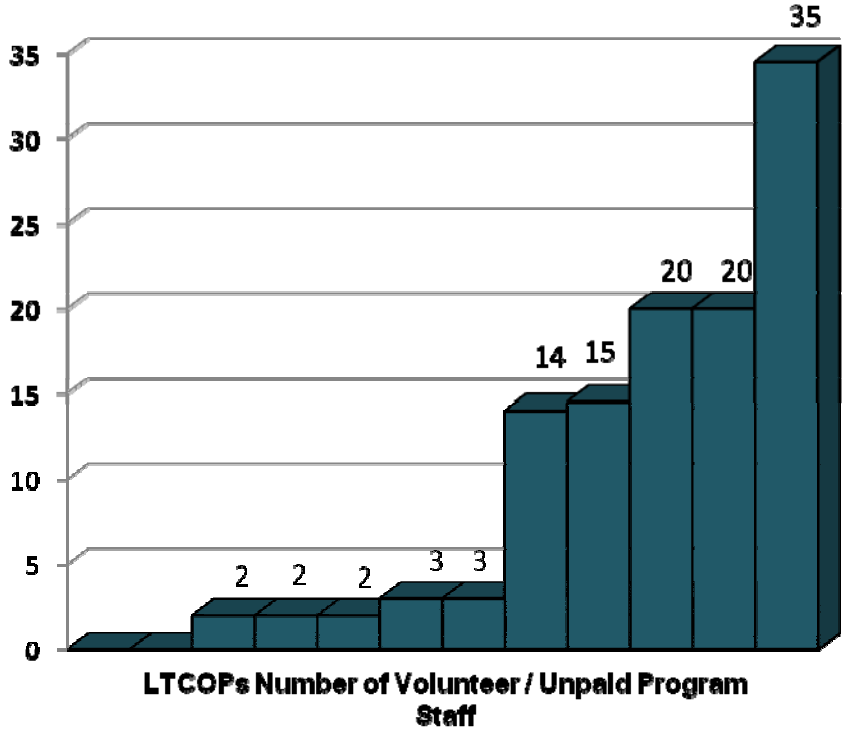
Figure 2.3: Number of Paid Program Staff (Full-Time Equivalents) in Local LTCOPs (AIMS FY2006)



Local LTCOPs have an average of 3.9 paid program staff (FTEs) (range= 2.5- 11.5, sd= 2.45) and a state-wide total of 46.3 FTEs. Because of the large outlier (11.5), the median of 3 is a more representative number of FTEs per local LTCOP.

Comparisons: The average number of FTEs per local LTCOP was approximately 3.9 in California and 0.9 in New York. In Illinois, the majority of local LTCOPs had between one and three FTEs (average not available). There were on average 6.2 FTEs in the local LTCOPs in Ohio .

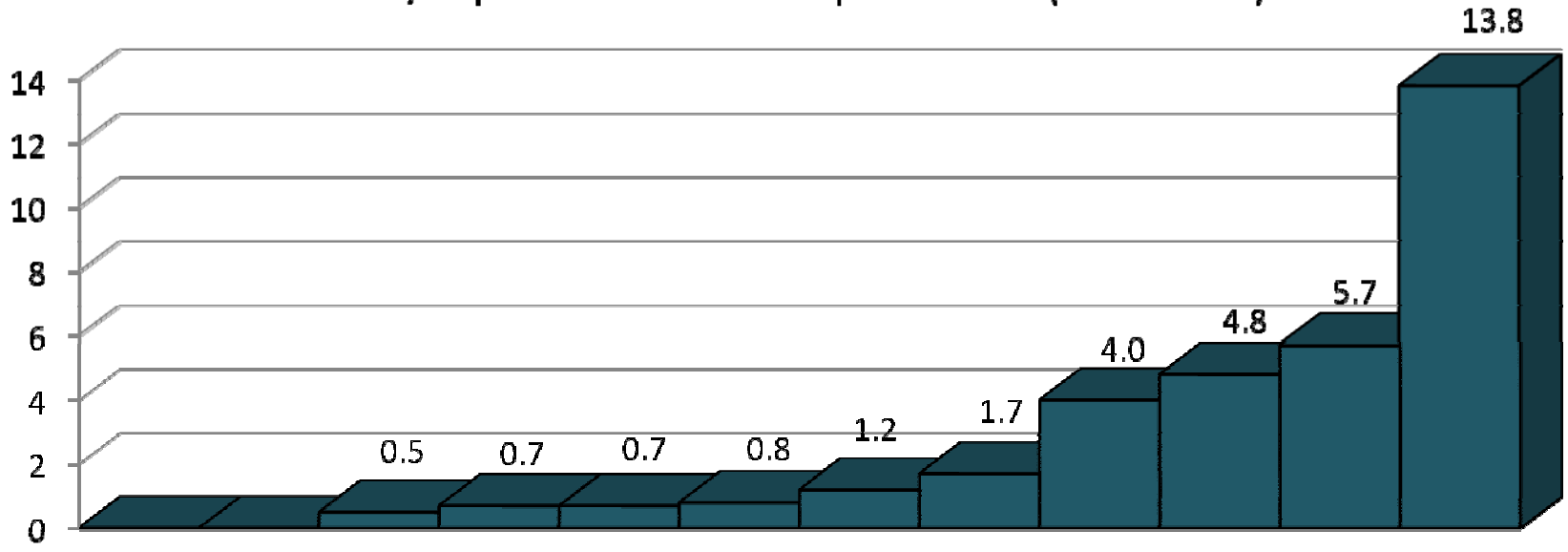
Figure 2.4: Number of Volunteer / Unpaid Staff in Local LTCOPs (AIMS FY2006)



Local LTCOPs have an average of 9.6 volunteer / unpaid program staff (range= 0- 34.5, sd = 11) and a state-wide total of 115 volunteer / unpaid staff.

Comparisons: The average number of certified volunteers per local LTCOP was more than 31 in California, more than 20 in New York, and 6.4 in Ohio. In Illinois, the majority of local LTCOPs had 30 or less volunteer / unpaid staff (average not available).

Figure 2.5: Ratio of Volunteers / Unpaid Staff to Full-Time Equivalent Staff (AIMS FY2006)

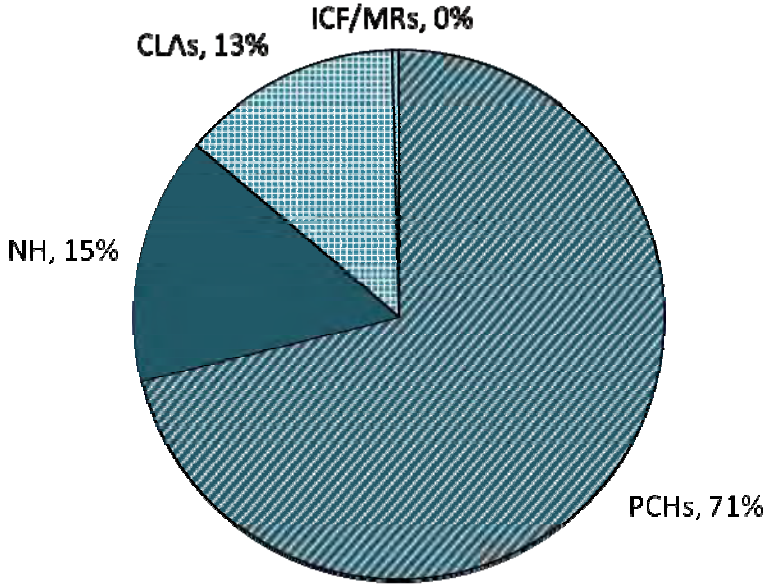


Georgia local LTCOPs were staffed by an average of 2.8 volunteers / unpaid staff per FTE (full time equivalent paid staff) (range= 0-13.8). Because of the large outlier (13.8), the median of 1.0 volunteers / unpaid staff may be a more representative number. The ratio of certified volunteers to paid FTE staff is extremely low with only 7 certified volunteers in the state and an average of .08 certified volunteers to one paid FTE staff. When asked about their ideal ratio of volunteers to staff, local LTCOP coordinators replied on average 0.7 volunteers / unpaid staff per FTE staff (n=13). All LTCOPs fall short of meeting the minimum recommended IoM standard of 1 FTE to every 20 certified volunteers.

Comparisons: On average, local LTCOPS had 9 certified volunteer ombudsman per FTE staff in California, 22 certified volunteer ombudsman per FTE staff in New York, and 6.4 certified volunteers per FTE staff in Ohio. The majority of local LTCOPs in Illinois had a ratio of 10 or less certified volunteers per FTE staff (average not available).

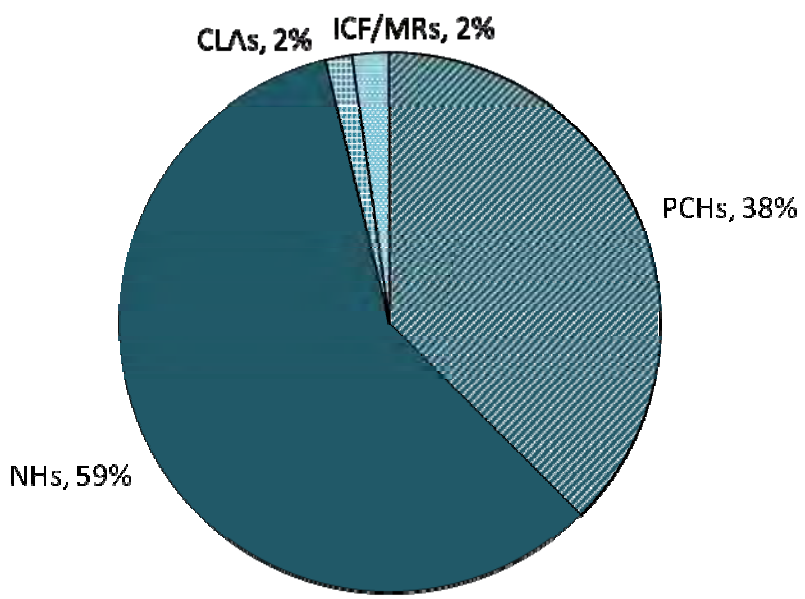
PROGRAM CHARACTERISTICS 2

Figure 2.6: Percentage of Facilities (NHs, ICF/MRs, PCHs and CLAs) Served by Local LTCOPs (AIMS 9/2006)



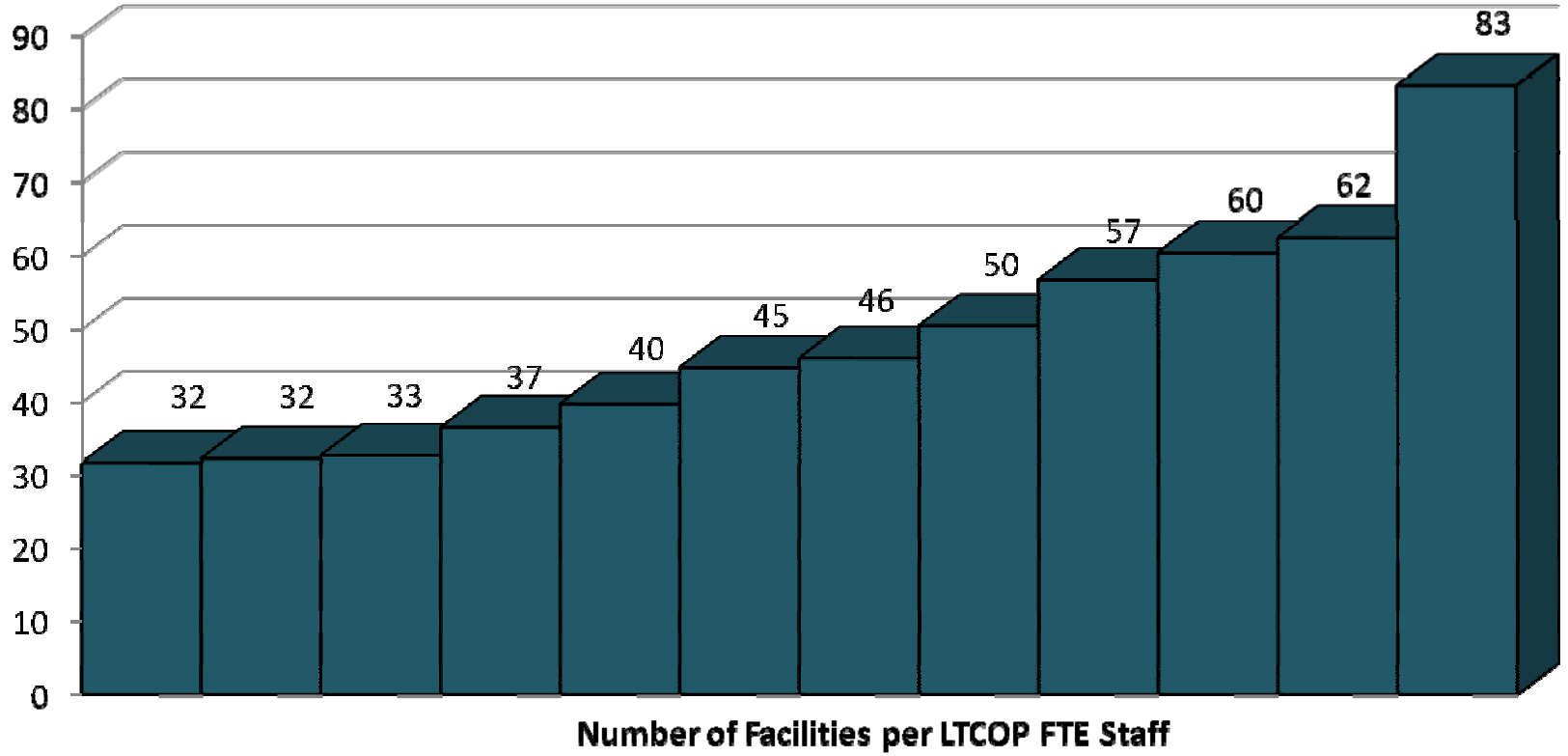
Local LTCOPs vary widely with regard to the number of NHs, ICF/MRs, PCHs and CLAs they serve. Local LTCOPS in Georgia serve a total of 2,502 facilities (379 NHs, 11 ICF/MRs, 1,777 PCHs, and 335 CLAs). On average, local LTCOPs in Georgia serve 31.6 NHs (range= 21- 79, sd= 15.9), 0.9 ICF/MRs (range= 0- 4, sd= 1.2), 148.1 PCHs (range= 57- 721, sd= 183.6), and 27.9 CLAs (range= 2- 154, sd= 40.5). Of the total facilities served, 15.1% are NHs, 0.4% are ICF/MRs, 71.0% are PCHs, and 13.4% are CLAs. If a mental health ombudsman program were funded to serve ICF/MRs and CLAs, Georgia local LTCOPs would be alleviated of 13.8% of the facilities they currently serve.

Figure 2.7: Percentage of Beds (NH, ICF/MR, PCH and CLA) Served by Local LTCOPs (AIMS 9/2006)



Local LTCOPS in Georgia serve a total of 69,393 beds (40,681 in NHs, 1,515 in ICF/MRs, 26,043 in PCHs, and 1,124 in CLAs). On average, Georgia local LTCOPs serve 3,390 NH beds (range= 2,042-10,569, sd= 2,327), 126 ICF/MR beds (range= 0- 553, sd= 197), 2,170 PCH beds (range= 929- 10,379, sd= 2,599), and 94 CLA beds (range= 9- 503, sd= 131). Of the total beds served, 58.6% are in NHs, 2.2% are in ICF/MRs, 37.5% are in PCHs, and 1.6% are in CLAs. If a mental health ombudsman program were funded to serve ICF/MRs and CLAs in Georgia, local LTCOPs would be alleviated of 3.8% of the beds they currently serve.

Figure 2.8: Ratio of LTC Facilities (All Facilities) to Full-Time Equivalent (FTE) Staff (AIMS FY2006)

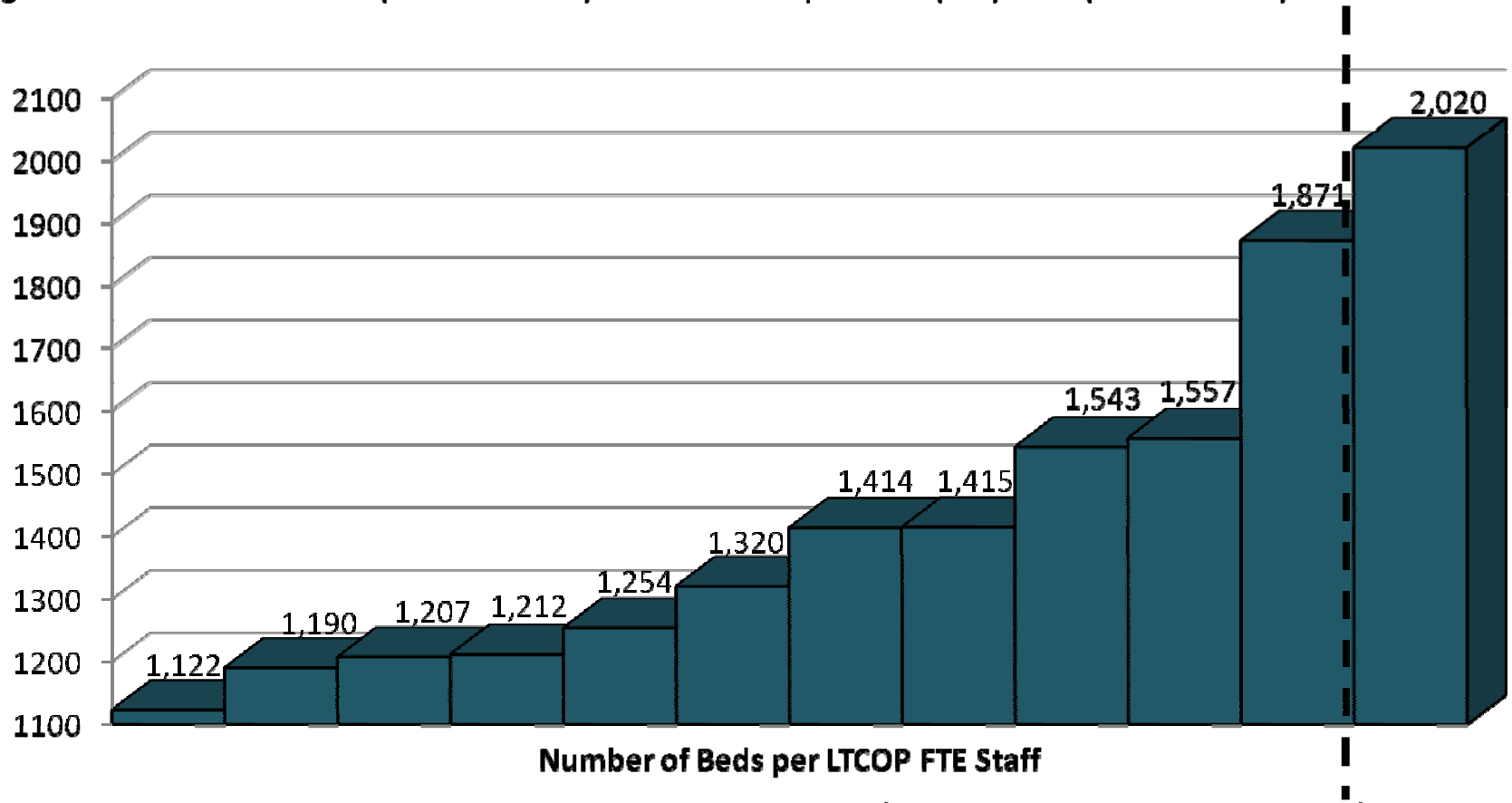


Georgia local LTCOPs served on average 48 facilities per FTE staff (range= 31.7- 83, sd= 15.5).

Comparisons: On average, local LTCOPs served 51 facilities per FTE staff in California , 30 facilities per FTE staff in New York, and 29 facilities per FTE staff in Ohio. In Illinois the majority of local LTCOPs serve 15 to 30 facilities per FTE staff (average not available).

PROGRAM CHARACTERISTICS 2

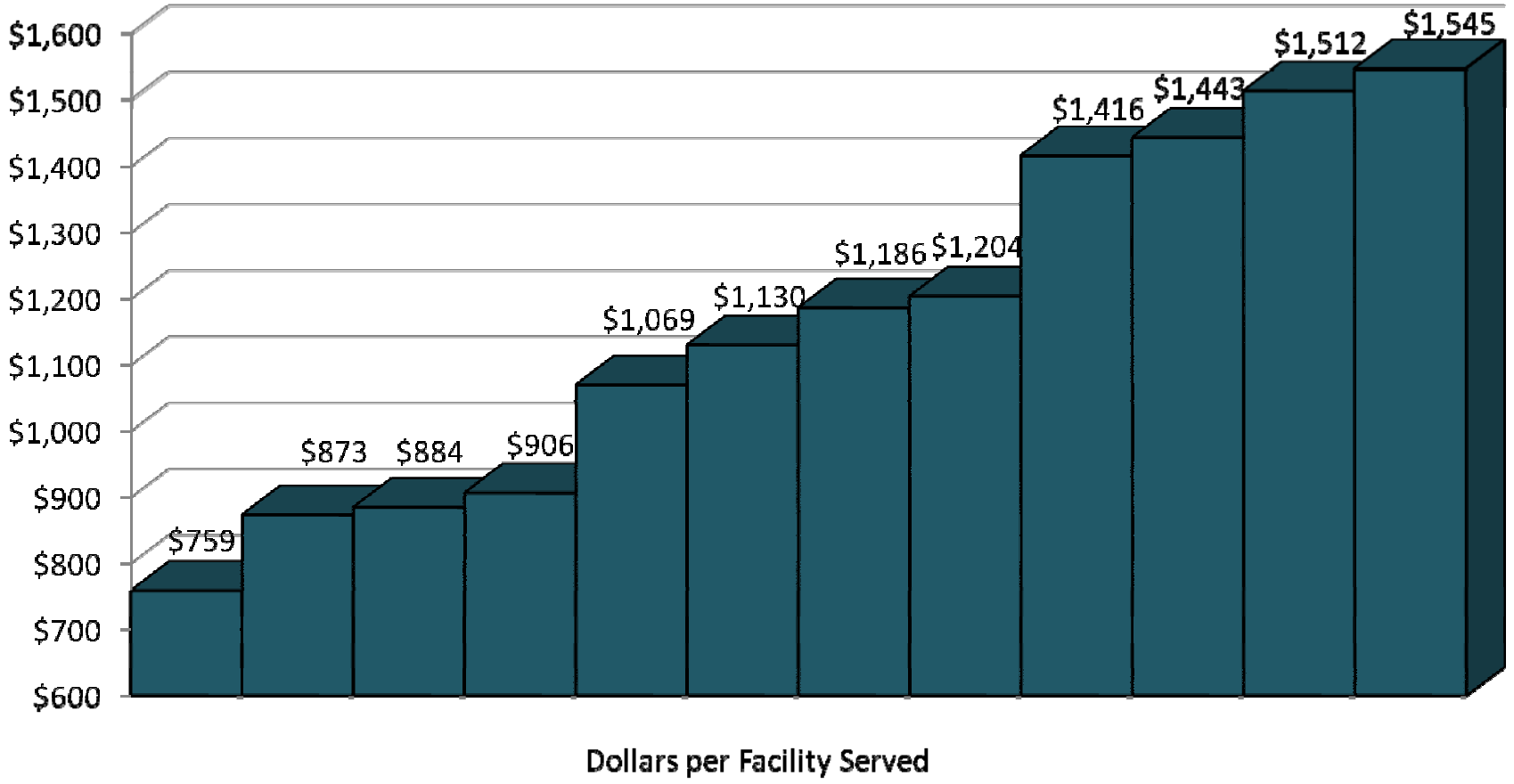
Figure 2.9: Ratio of LTC Beds (in all Facilities) to Full-Time Equivalent (FTE) Staff (AIMS FY2006)



Georgia LTCOPs served on average 1,427 beds per FTE staff (range= 1,122- 2,020, sd= 260.4). Only 1 program served over the IoM maximum recommended program standard of 2,000 beds per FTE staff.

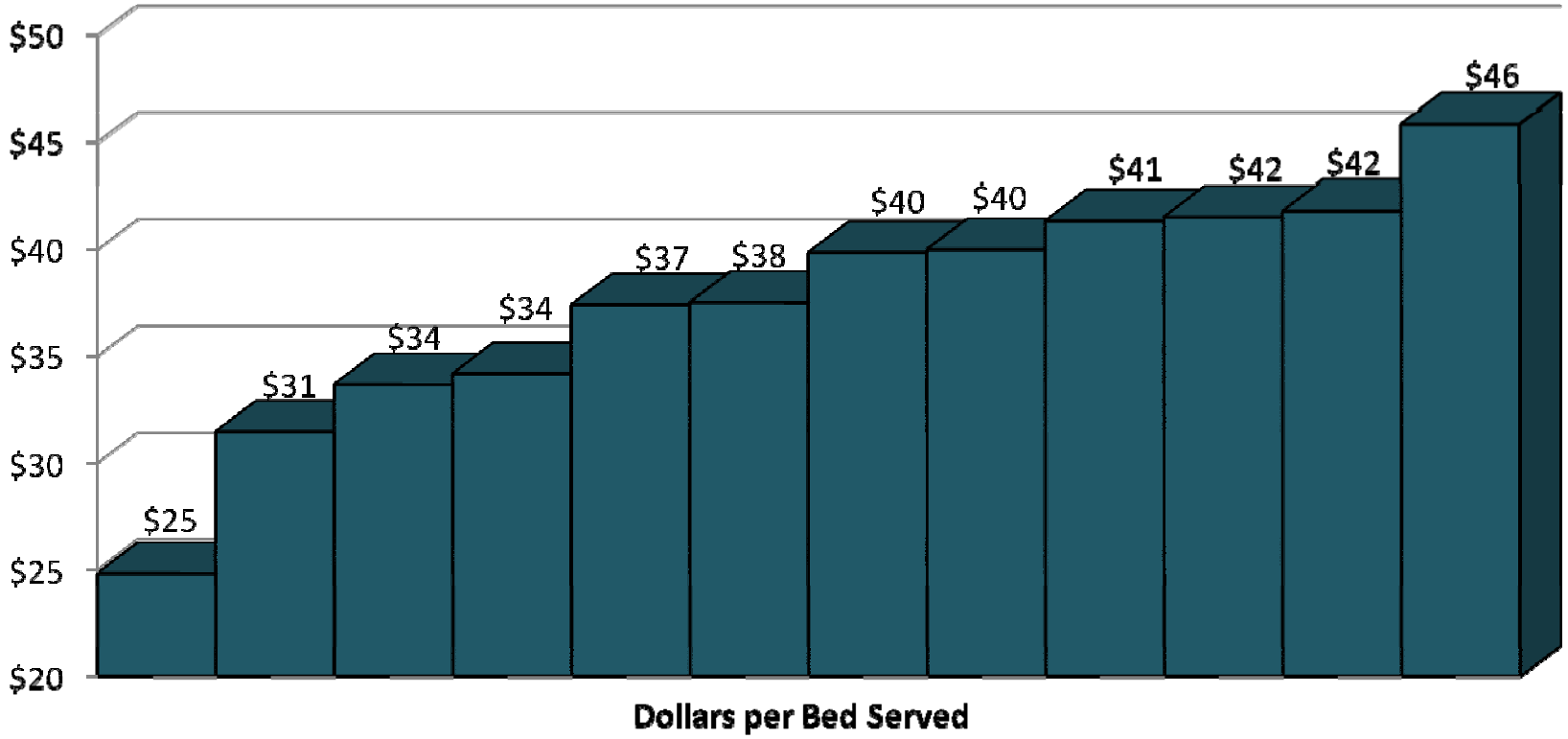
Comparisons: On average, local LTCOPs served 1,752 beds per FTE staff in California, 2,568 beds per FTE staff in New York, 2,701 LTC beds per FTE staff in Illinois, and 1,870 beds per FTE staff in Ohio.

Figure 2.10: Ratio of Local LTCOPs Total Funding per Facility Served (AIMS FY2006)



Georgia local LTCOPs received on average, $1,160.64 per facility served (range= $758.64 - $1,545.42, sd= $271.90).

Figure 2.11: Ratio of Local LTCOPs Total Funding per Bed Served (AIMS FY2006)



Georgia local LTCOPs received on average, $37.34 per bed served (range= $24.81 - $45.83, sd= $5.67).

Comparisons: On average, local LTCOPs received $49.76 per facility bed in California, $23.16 per facility bed in New York, and $35 per facility bed in Ohio. In Illinois, the majority of local LTCOPs received between $15 to $30 per facility bed (average not available).

Figure 2.12a: Most Frequently Closed Complaints by Facility / Service Category (AIMS 10/2005-9/2006)

Top Categories of Complaint

Nursing Homes

Care	1330
Environment	834
Autonomy, Choice, Preference, Exercise of Rights, Privacy	642
Dietary	381
Admission, Transfer, Discharge, Eviction	378

ICF/MRs

Autonomy, Choice, Preference, Exercise of Rights, Privacy	5
Care	5
Abuse, Gross Neglect, Exploitation	3
System/Others	3
Policies, Procedures, Attitudes, Resources	1
Staffing	1

PCHs

Care	177
Environment	159
Autonomy, Choice, Preference, Exercise of Rights, Privacy	148
Dietary	123
System/Others	110

CLAs

Abuse, Gross Neglect, Exploitation	9
Autonomy, Choice, Preference, Exercise of Rights, Privacy	5
Environment	3
Care	2
Activities and Social Services	2

Figure 2.12b: Most Frequently Closed Complaints by Facility / Service Type (AIMS 10/2005-9/2006)

Top Types of Complaint

Nursing Homes

Dignity, respect: staff attitudes	370
Discharge/eviction: planning, notice, procedure	321
Failure to respond to requests for assistance	296
Personal hygiene (includes oral hygiene)	291
Cleanliness, pests	212

PCHs

Food Service: quantity, quality, variation, choice, condiments, utensils, menu	91
Medications: administration, organization	81
Discharge/eviction: planning, notice, procedure	61
Equipment: disrepair, hazard, poor lighting, fire safety, not secure	54
Dignity, respect: staff attitudes	48

ICF/MRs

Dignity, respect: staff attitudes	4
Abuse, physical (including corporal punishment)	3
Accidents/unknown injuries, falls, improper handling	2

CLAs

Abuse, physical (including corporal punishment)	5
Abuse, verbal, psychological (including punishment, seclusion)	2
Dignity, respect: staff attitudes	2
Exercise choice and/or civil/religious rights, individual's right to smoke	2
Resident conflict, including roommates	2

PERCEIVED EFFECTIVENESS 3

Overview:

This chapter presents data related broadly to program effectiveness as perceived by local LTCOP coordinators in Georgia. Data were drawn from the surveys with coordinators of the 15 local LTCOPs in Georgia. In addition, the chapter presents selected cross state comparison data from surveys conducted with local LTCOP coordinators in California (n=35/35 programs), New York (n=39/50 programs), Illinois (n=16/17 programs) and Ohio (n=12/23 programs) over the past three years.

As Figure 3.1 indicates, coordinators rate highly the effectiveness of their LTCOPs in handling complaint investigation (with a 93% "very effective" rating), while fewer (40%) rate monitoring federal, state and local laws and regulations (40%) and legislative and administrative policy advocacy (47%) as "very effective." Coordinators report that their LTCOP is most effective in nursing home settings (93% indicating "very effective",) and personal care homes (80% "very effective"), and less so in ICF/MRs and CLAs (with 50% and 47% ratings of "very effective" respectively) [Figure 3.2]. Coordinators are somewhat divided as to whether they prefer the standards for frequency of visits to be based on the current timeframe (60% agree) or other criteria specific to the facilities operation (40% agree) [Figure 3.5]. Figure 3.6 reveals that 60% of respondents report the need for additional funding in order to carry out all mandates; 40% report that they do not have a sufficient number of paid staff and 60% do not have a sufficient number of volunteer / unpaid staff to carry out their duties [Figure 3.7]. Coordinators report that their LTCOP neglects certain activities that are central to its broad mission due to lack of resources. For example, in Figure 3.8, one-third report not being able to conduct legislative and administrative policy advocacy [Figure 3.8]. In addition, close to half (47%) reported having additional duties or state-funded mandates that add to the workload of their local LTCOP and one-third indicated that there are additional unfunded mandates that add to their workload [Figure 3.9]. The majority of coordinators report positive working relationships between their LTCOPs and other organizations, with the OSLTCO and GeorgiaCares having the highest ratings [Figure 3.12]. Coordinators highlighted the need for improved training in the areas of cultural competency, Medicare and post acute care [Figure 3.13].

PERCEIVED EFFECTIVENESS 3

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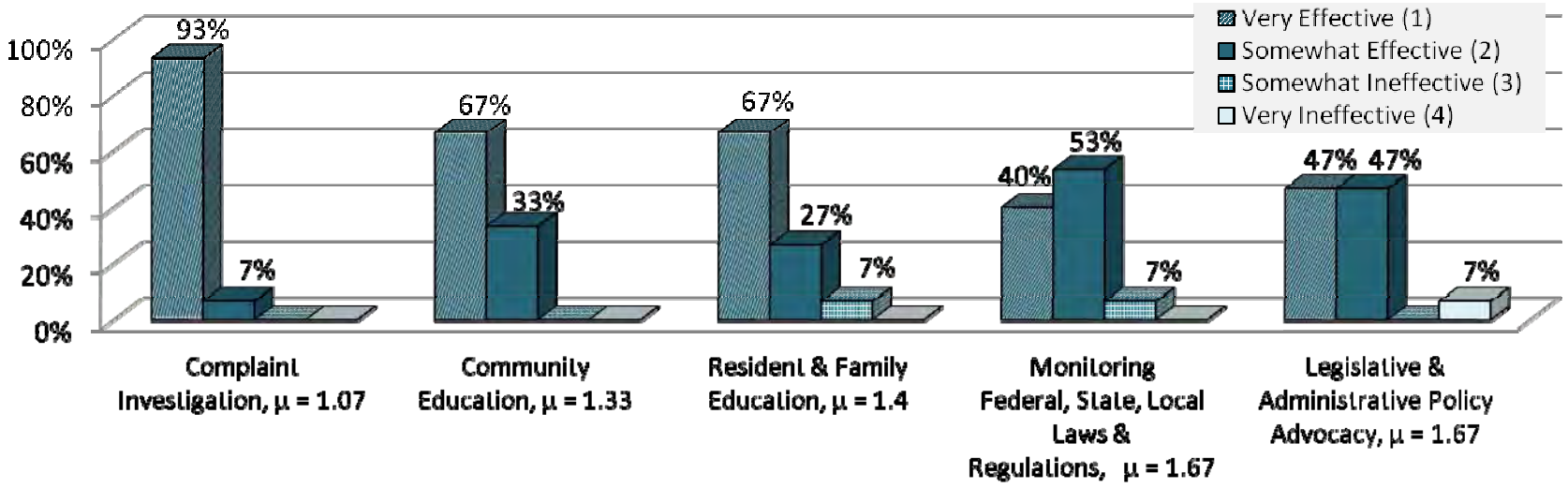
PERCEIVED EFFECTIVENESS 3

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

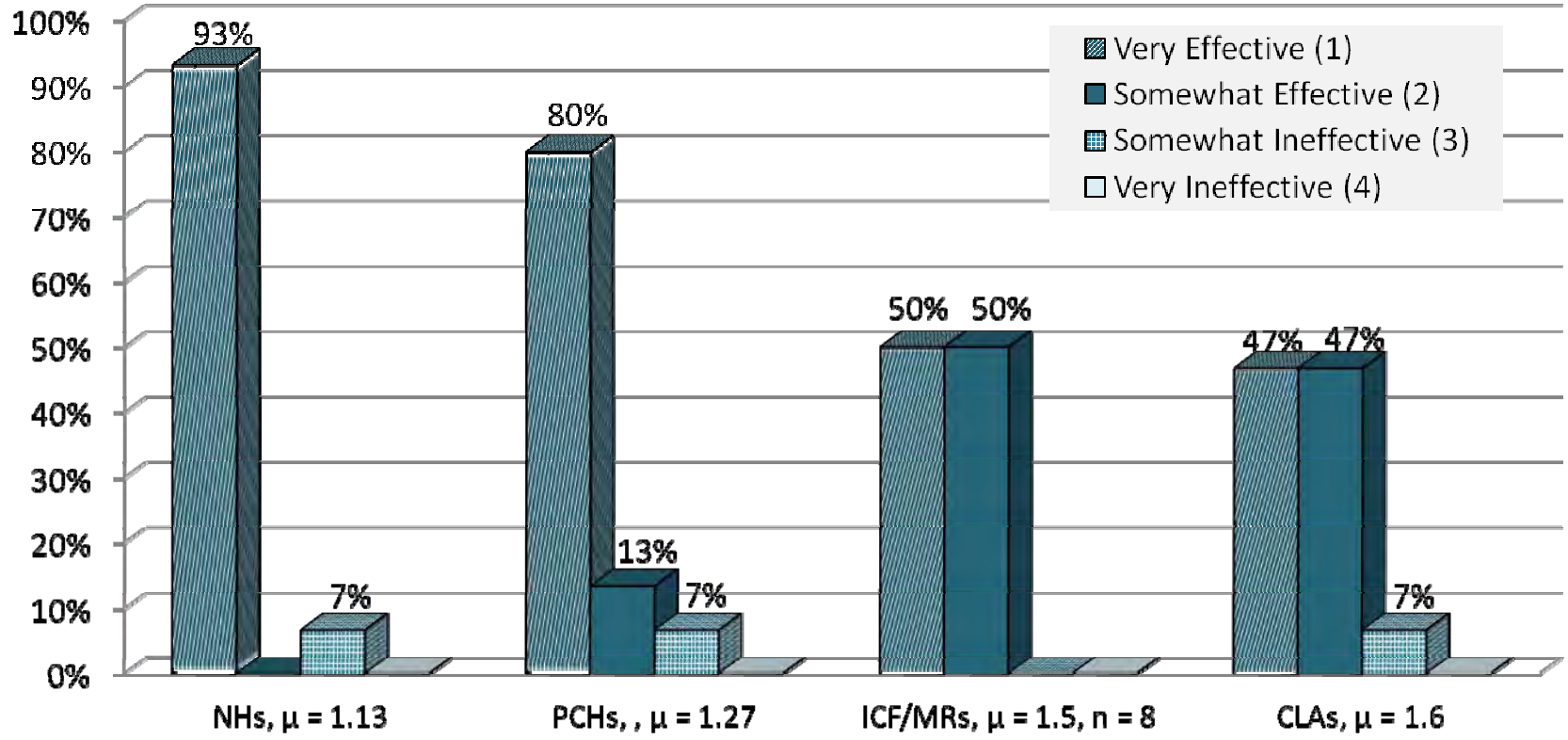


Q. How you would rate the effectiveness of your local LTCOP's performance in meeting the specific federally mandated requirements?
All coordinators rated their local LTCOP's performance in complaint investigation as effective with 93.3% rating performance as very effective. Although a majority of the coordinators similarly rated their performance in meeting the other federally mandated requirements as either somewhat or very effective, the slightly increased mean (μ) or average for the other mandates, indicates that more coordinators rated their LTCOP as only somewhat effective at meeting those mandates.

Comparisons: While all local LTCOP coordinators in California reported that their LTCOPs were either somewhat or very effective in complaint investigation, more than half (54%) reported that their LTCOPs were somewhat or very ineffective in legislative and administrative policy advocacy. Similarly, in New York all coordinators reported that their LTCOPs were either somewhat or very effective in complaint investigation, but about 37% reported their LTCOPs were somewhat or very ineffective in legislative and administrative policy advocacy. In Illinois, coordinators rated their LTCOPs as either somewhat or very effective in the areas of complaint investigation (94%) and community education (100%) and somewhat ineffective in the areas of monitoring federal, state and local laws and regulations (31%) and legislative and administrative policy advocacy (25%). In Ohio, all coordinators report their LTCOPs being somewhat or very effective in complaint investigation and somewhat or very ineffective in legislative and administrative policy advocacy (42%), monitoring federal, state, local laws and regulations (33%) and resident and family education (33%).

PERCEIVED EFFECTIVENESS 3

Figure 3.2: Self-Rated Effectiveness of Local LTCOPs in Settings Served



Q. How would you rate your local LTCOP's performance with each of the following settings?

The majority of coordinators rated their LTCOP's effectiveness in nursing homes (93.3%) and personal care homes (80%) as very effective. As shown by the increased mean (average, μ) for ICF/MRs and CLAs, slightly more coordinators rated their LTCOP as only somewhat effective in those settings.

PERCEIVED EFFECTIVENESS 3

Local LTCOP coordinators were asked to describe their ratings of their program at meeting its mandates…

I have program components that I have to meet for complaint investigation, community education and resident and family education. Those have to come first. With the time that I have left I work on the state and federal legislation and advocacy.

Complaint investigation is our highest priority and so we concentrate on that more. We have a requirement of educations we need to do per year, and we fulfill that. I would like to do more.

It relates to how much time we have. We are a small program with a very small budget… We have to prioritize. The monitoring of regulations, policy and advocacy just aren't a priority.

Local LTCOP coordinators were asked to specify how meeting mandates differs in the types of facilities served…

Due to the lack of staff personnel, it makes it extremely difficult to meet the routine visits. It tends to be the PCH visits that are more difficult to meet because there are more of them.

We cannot meet PCH and CLA mandates because of the number of facilities in our county area.

With ICF/MRs and CLAs, the population is much less able to communicate with us and there is less involvement of family. That does make it different.

Local LTCOP coordinators were asked to briefly describe any differences in effectiveness between the types of facilities visited…

The differences have to do with ICF/MRs and CLAs having the dual diagnosis of mental retardation and mental health issues. You need more time to be able to work in those environments and you need really good education on how to work in those environments and those tend to be lacking.

In nursing homes we are very effective, that is where we spend most of our time, PCHs we go into only once a quarter. MR and MH facilities we are only somewhat effective because the residents can't communicate problems and issues with you. It's observation versus communication, you can't see all problems, and they don't remember you. Turnover of ombudsman and clients is also a problem. We need a state ombudsman for MH/MR residents.

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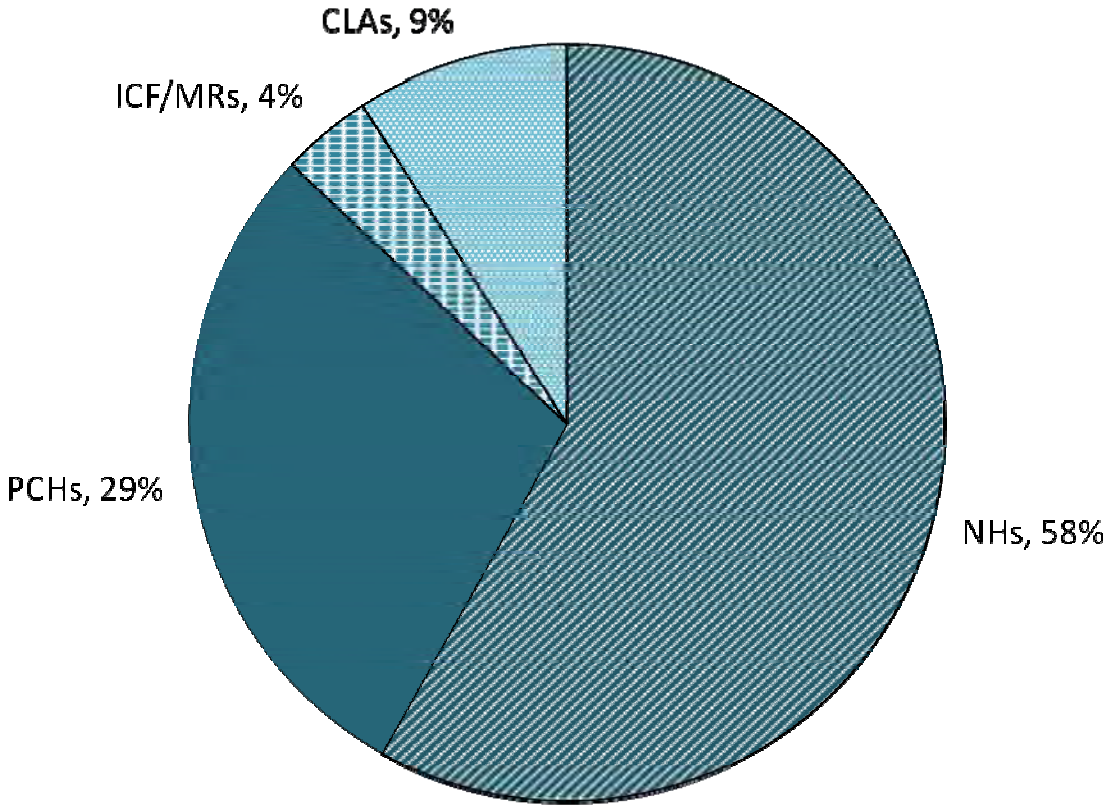
Figure 3.3: Self-Reported Percentage of Time Spent in Each of the Four Types of Settings Served



Q. What percentage of your time was devoted to each of the four types of settings?

On average, coordinators report that their LTCOP spent the most time in NHs (58.3%, range= 40- 75%), 29% of their time in PCHs (range= 20- 46%), 3.9% of their time in ICF/MRs (range= 0%- 15%), and 9.1% of their time in CLAs (range= 1- 20%).

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Figure 3.4: Self-Rated Effectiveness of the Current Timeframe for Required Visits to Facilities

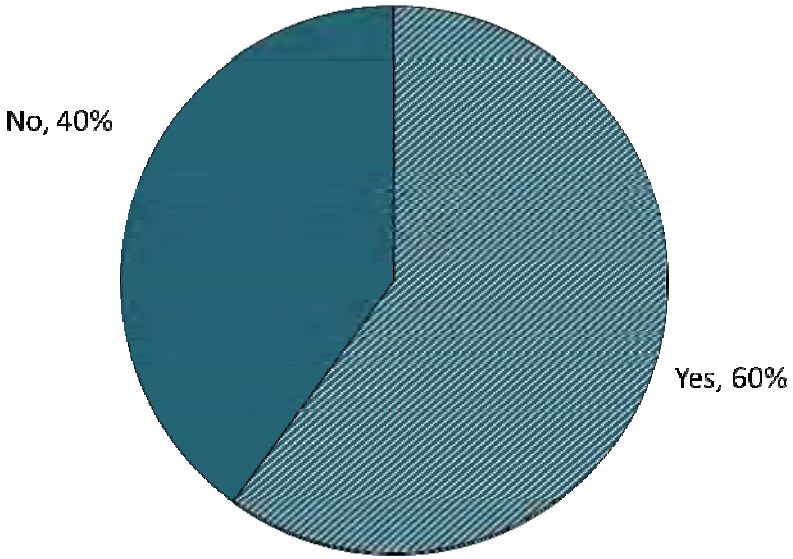
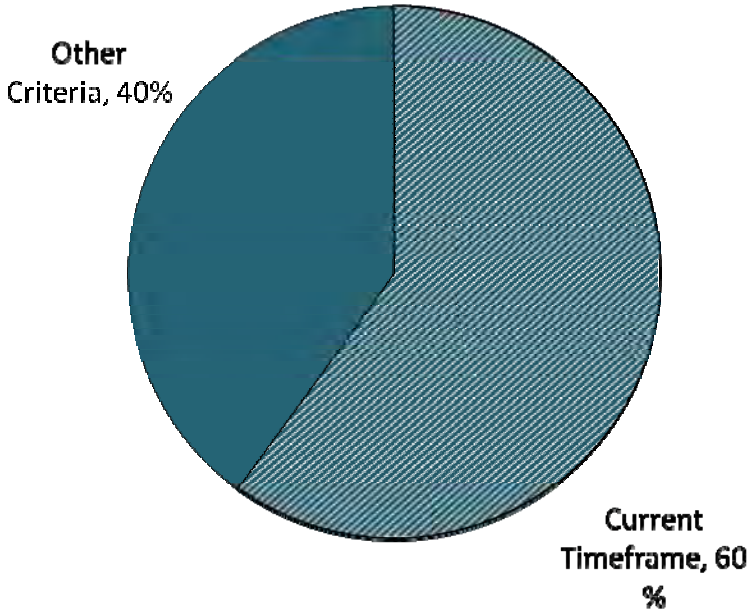


Figure 3.5: Self-Reported Preference for Required Visits to be Based on the Current Timeframe or Other Criteria Related to the Facilities Operation



Q. Does the current frequency of required visits to facilities provide residents with sufficiently "ready and timely access" to ombudsman services?

60% of coordinators believe the current frequency of required visits to facilities are sufficient (monthly to NHs, quarterly to PCHs and ICF/MRs, and bi-annually to CLAs).

Q. Would you prefer the minimum standards for frequency of visits to facilities to be based on the current time frame or on other criteria related to the facility's operations?

60% of coordinators believe the minimum standards for frequency of visits should be based on the current timeframe.

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Local LTCOP coordinators were asked to briefly describe why they feel the timeframe for required visits to facilities is effective or ineffective…

With nursing homes and PCHs, we're good, we're in there, the residents know us, the contact information is up and we go out more frequently as needed. For ICF/MRs and CLAs, frankly, I don't feel like we should be serving those. There is the mental health ombudsman issue in Georgia. Probably because our program is really overloaded with those, we really feel like it is imperative that we get that mental health ombudsman position funded, and that person serves that population instead of our program. We need to go back to our original mandate of serving our original target population, which are the elderly and disabled.

I believe it does, we visit CLAs quarterly also rather than twice a year. I think it is very beneficial to visit quarterly because of the population you are serving, we go more frequently if we can…. The more frequently you visit, the more familiar the residents are to you, and about your services. They know who you are and what you do.

It goes back to not having enough time to conduct more thorough visits. The resident and family members are being disserviced by not being able to spend the time you need in a facility. I think it would be better to go in once every two months or once a quarter to be able to spend more sufficient time.

I don't have enough staff to be able to meet those requirements.

Local LTCOP coordinators were asked to briefly describe what specific criteria they would use to determine which facilities to visit more or less frequently…

In nursing homes sometimes, there are some you would rarely get a complaint from, and you might only visit those once a quarter. Then the ones you are having problems with, need to be visited more often. When you have good staff interaction and good rapport with residents, you can go less often.

The frequency of complaints, and determining whether there is other agency involvement and oversight, and then allow the state office to formulate a policy on frequency of visits based on those two criteria. The frequency of complaints that are already logged in AIMS and whether or not other agencies do regular monitoring visits in facilities. Some of those facilities have monthly social worker visits, supervisors and managers. When there is more oversight we are thinking that our visits don't need to be as frequent because there is outside intervention.

We have a practice where we identify our problem facilities, we visit them more, it doesn't take a mandate. I don't see a need to change it. You need to leave as much judgment to local LTCOPs as possible. With requirements, it would be across the board. I believe with more flexibility comes better effectiveness. You only have a certain amount of time and can only make a certain amount of visits. Having more mandates across the board will leave less time to focus on the bad ones.

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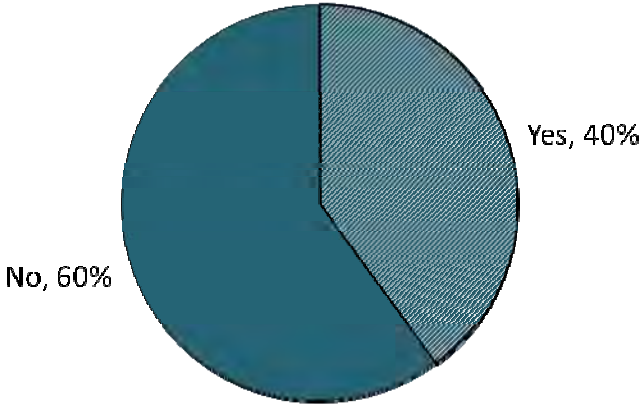
Figure 3.6: Extent to Which Local LTCOP Coordinators Perceived Their Program to Have a Sufficient Amount of Funding to Carry Out Program Mandates

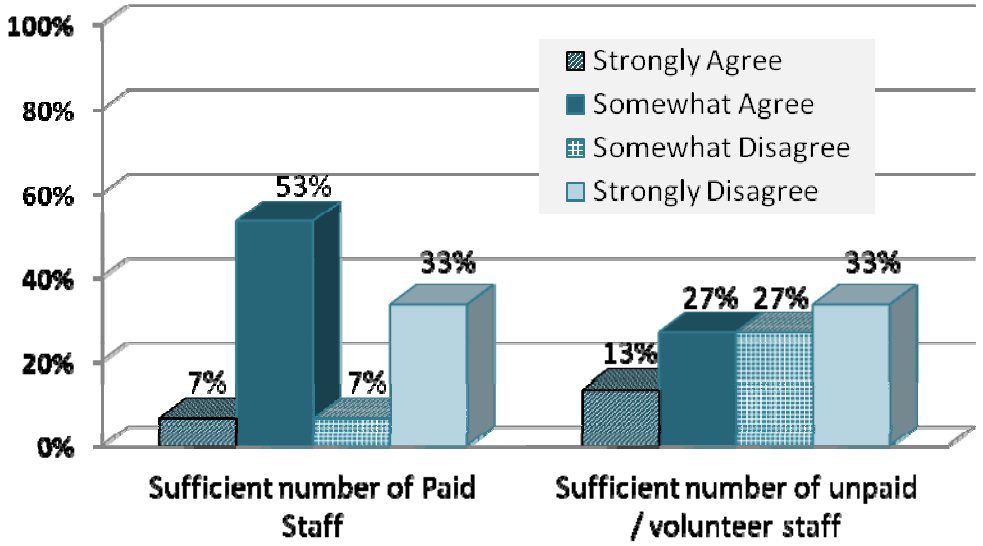


Q. Does you local LTCOP have a sufficient amount of funding to carry out all of its state and federal mandates?

Only 40% of coordinators report that their LTCOP has sufficient funding to carry out program mandates. When asked how much additional funding was needed, coordinators reported an average of $108,278 with a range of responses from $5,000 to $720,000. These responses represented a 27% increase in funding on average, ranging from a 10% to a 62% increase.

Comparisons: A lower percentage of local LTCOP coordinators reported that their current budget was adequate to carry out all mandates in California (20%), New York (30%), Illinois (7%), and Ohio (25%).

Figure 3.7: Extent to Which local LTCOP Coordinators Perceived Their Program to Have Sufficient Numbers of Paid Staff and Volunteer Staff



Q. Does your LTCOP have a sufficient number of paid or unpaid / volunteer staff to carry out its duties?

About half of the coordinators report that they either somewhat or strongly disagree that their LTCOP has a sufficient number of paid staff (40%) and a sufficient number of unpaid / volunteer staff (60%).

Comparisons: Local LTCOP coordinators in California (80%), New York (50%), Illinois (88%), and Ohio (75%) either somewhat or strongly disagreed that their programs have a sufficient number of paid staff. Coordinators in California (50%), New York (62%), Illinois (57%), and Ohio (58%) either somewhat or strongly disagreed that their programs have a sufficient number of volunteer / unpaid staff.

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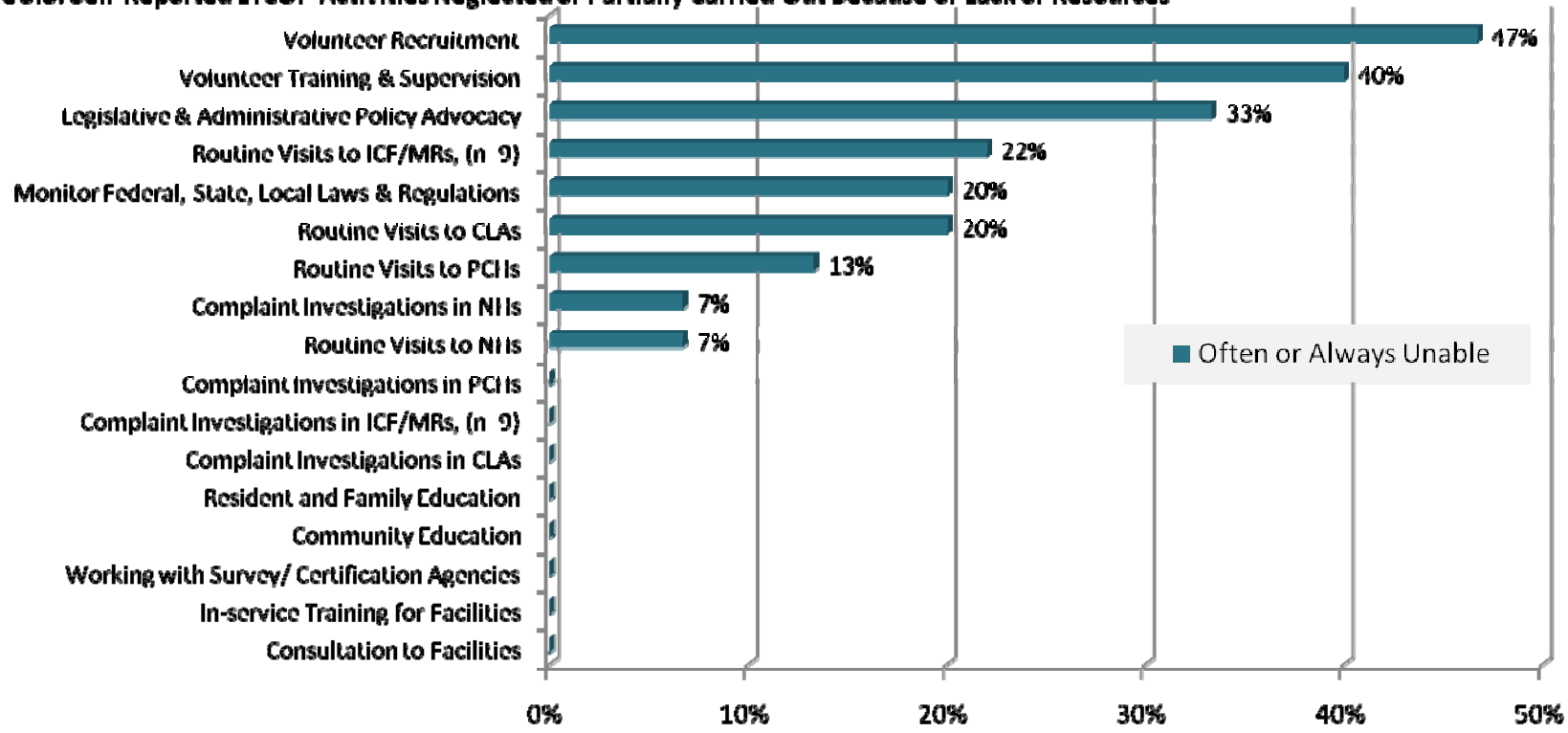
Figure 3.8: Self-Reported LTCOP Activities Neglected or Partially Carried Out Because of Lack of Resources



Q. What activities, if any, has your local LTCOP been unable to adequately perform because of lack of resources or funds?

Less than 50% of coordinators reported that their LTCOP is either often or always unable to perform the program activities listed. Volunteer recruitment (16.7%), volunteer training and supervision (40%), and legislative and administrative policy advocacy (33.3%) were most likely to be reported by coordinators as activities their LTCOP was often or always unable to perform because of a lack of resources or funds.

Comparisons: The activities most likely to be neglected by California local LTCOPs due to a lack of resources or funds, were legislative and administrative policy advocacy (72%) and monitoring laws and regulations (56%). In New York they were community education, (44%) and resident, family education (43%), and legislative and administrative policy advocacy (42%). In Illinois they were programs reported often or always being unable to carry out legislative and administrative policy advocacy (63%), monitoring laws and regulations (50%) and community and resident and family education (44% each). In Ohio, the largest percentage by far (92%) neglected legislative and administrative policy advocacy.

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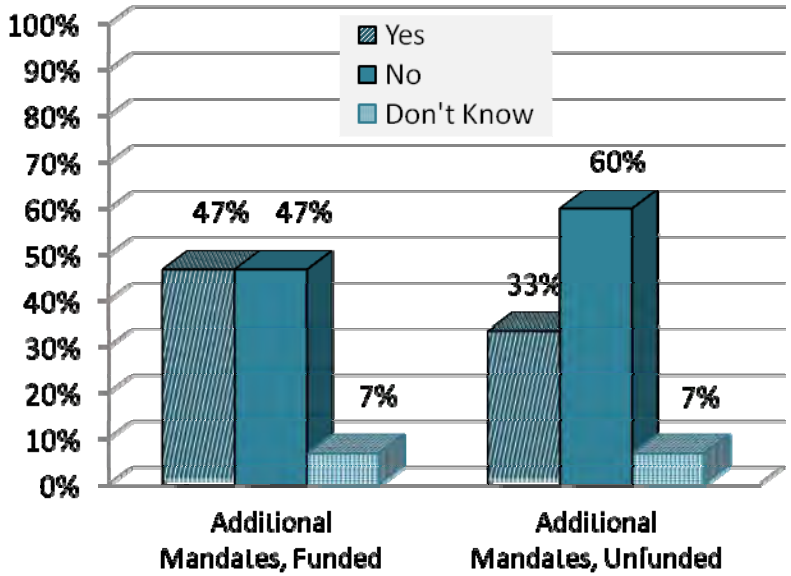
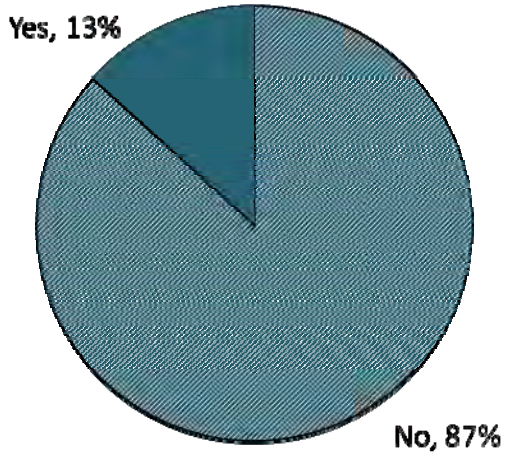
Figure 3.9: Extent to Which Local LTCOP Coordinators Perceived Additional Duties or Mandates (funded or unfunded) that Added to the Workload of the Program



Q. Are there any additional duties or mandates, funded or unfunded, that add to the workload of your local LTCOP?
Almost half (46.7%) of the coordinators reported that their LTCOP has funded additional duties or state mandates. A third of the coordinators (33.3%) report having unfunded duties or mandates that add to the workload of their program.

Figure 3.10: Extent to Which Local LTCOP Coordinators Perceived any State Laws, Regulations, or Agency Agreements that Conflict with the Ability of the Program to Carry-Out its Federal and State Mandates



Q. Do you have any State laws, regulations, or agency agreements that conflict with the ability of your local LTCOP to carry-out its Federal and State mandates?
The majority of coordinators (86.7%) report no conflicts in their LTCOPs with carrying out their federal and state mandates.

Comparisons: More than half (59%) of local LTCOP coordinators in California, 16% in New York, 13% in Illinois and one-third (33%) in Ohio reported that there were state laws, and/or regulations that conflicted with the ability of their program to perform federally mandated duties.

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Local LTCOP coordinators were asked to describe their LTCOP's additional duties or mandates…

I just think the state office wants us to do so many things to bring attention to the ombudsman program for funding issues and sometimes it take us away from protecting resident's rights and investigating complaints. We spent so much time with Katrina victims, weekly reports, etc. and I know it is important but is it the ombudsman's job? What is the ombudsman's job and what is the facility's job? The Miller Trust issue, the government decided to raise the Medicaid eligibility and the nursing homes weren't going to get paid if they didn't do the Miller Trust, so I feel like the facility should have been doing that work. We had to send reports to the governor every week on how we were progressing getting each one of those people taken care of. The sex offenders, we had to find out who we had in nursing homes that were sex offenders. We get off on these tangents that take up so much of our time, and we lose focus on what we're supposed to be doing. It seems like anytime something comes up the ombudsman program volunteers to do it and we're stretched too thin as it is.

The elder abuse program, we are funded very little. We chose to do training, elder abuse training, report to DFCS, ORS, etc. We have brochures and information we distribute all over. A lot of times we can't fix the problem because it is in the community, but we refer community problems to the agency they need to call.

The elder abuse funds that we receive. They have reporting requirements that take a lot of time, and they have time consuming tasks like evaluations for every in-service you give. In nursing homes you have 30 minutes to give an in-service, and you have to take 10 minutes of that to have them fill out the evaluations. This can be very frustrating.

When the state survey agency, ORS cannot respond to complaints they call on us to respond to complaints. We are expected to work with them and that is a funded part of our job but that is supposed to be one of their duties, not ours. Sometimes with the ELAP provider, we have a lot of administrative work that we do for them. That varies throughout Georgia, and some of the attorneys prefer to do all of their work. They know we can do it.

With each component, we have a quota, required numbers we have to meet. For example, routine visits to NHs, PCHs, and CLAs. The same for resident and family council meetings, we have required numbers. Community education, we have required numbers. It really makes it difficult, having all of these numbers. You're really more focused on the numbers rather than doing the job.

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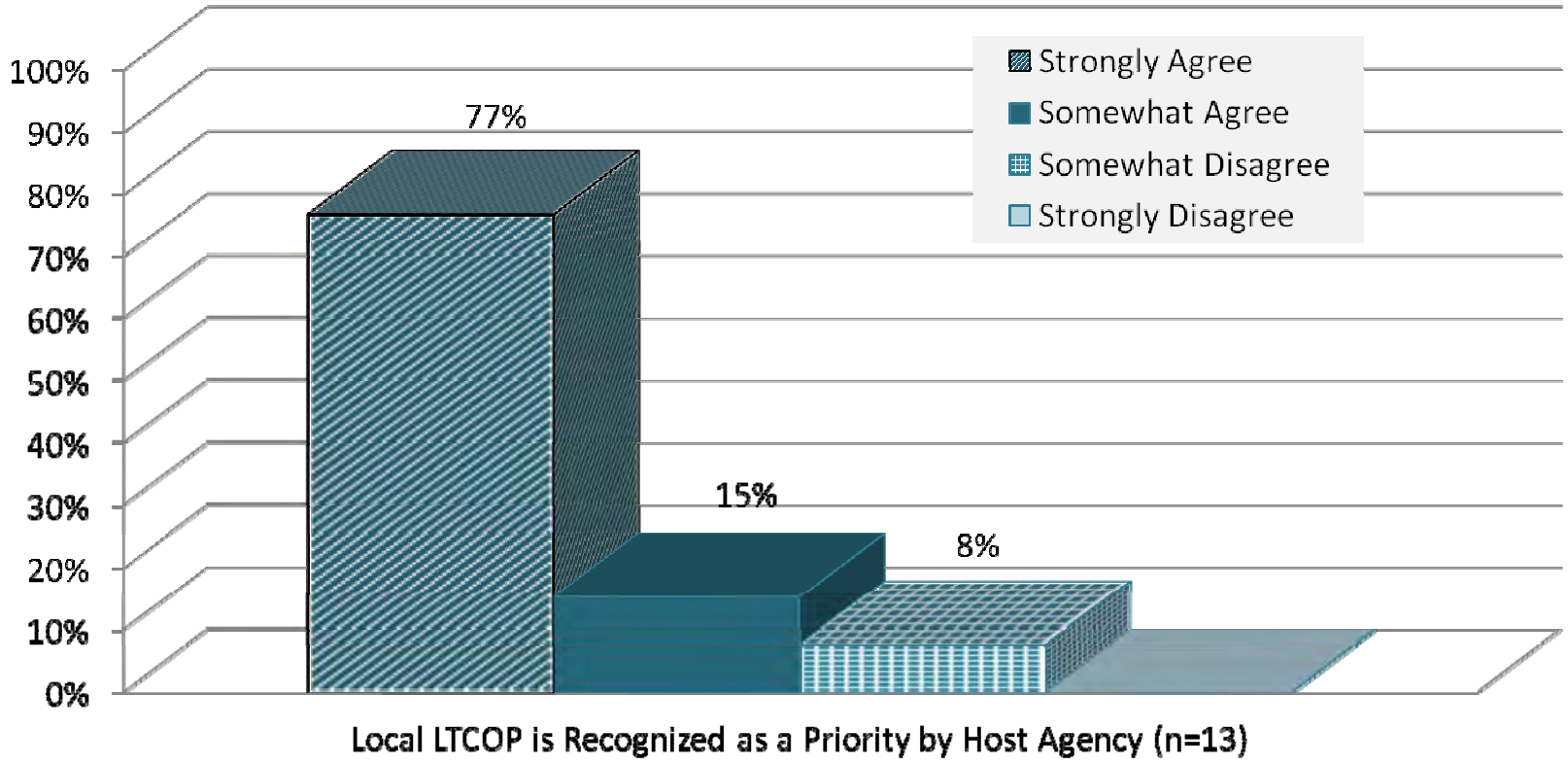
Figure 3.11: Extent to which Local LTCOP Coordinators Perceive That Their Local Program is Recognized as a Priority by their Host Agency



Q. To what extent do you agree with the statement, your local LTCOP is recognized as a priority by your host agency?

The majority of coordinators (76.9%) strongly agree that their local LTCOP is recognized as a priority by their host agency.

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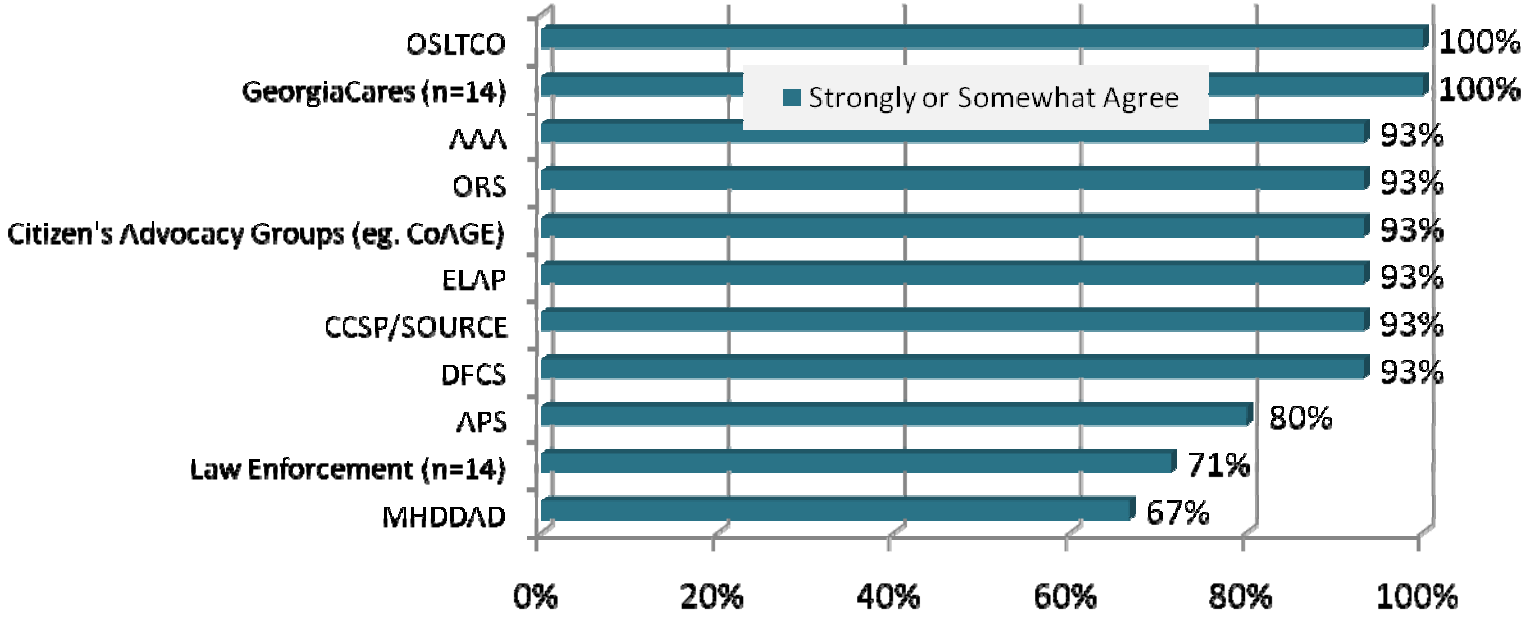
Figure 3.12: Extent to Which Local LTCOP Coordinators Perceive a Positive Relationship with Other Organizations/ Agencies



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

The majority of coordinators either somewhat or strongly agree that their LTCOP has a positive working relationships with other organizations and agencies. Relationships with MHDDAD (66.7%), law enforcement (71.4%), and APS (80%) had the least positive ratings among coordinators. All coordinators reported their LTCOP as having a positive working relationship the OSLTCO and GeorgiaCares.

Comparisons: About one-third (35%) of California local LTCOP coordinators either somewhat or strongly disagreed that they had a positive working relationship with local law enforcement agencies, as did 16% of coordinators in New York regarding their working relationship with licensing and regulatory agencies, and 60% in Ohio regarding their working relationships with citizen advocacy groups. (No data available for Illinois).

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Local LTCOP coordinators were asked to describe their programs working relationship with other organizations / agencies…

OSLTCO:

We have a great state office. Easily accessible, very knowledgeable, they will answer every question you have, great resource, very helpful. Been through several state offices and this one is the best.

The state office is helpful at times with consultation. Basically the only time we interact is when the state needs something from the local program. The state does not respond very well or on a timely basis. The state expects more from us than we are able to give. No program is able to meet all of the goals. We don't have the time or staff to do all the extra stuff, data and so forth….I think we are going to have problems if the expectations and stress is not reduced. I worry about staff well-being.

AAA:

They are very supportive to the ombudsman program, and provide most of everything that I need. But they don't provide enough funding. They do keep me involved in other community events, senior expos, things like that help with community education. They do provide assistance with my planning workshops and trainings.

Our AAA is located far away and they have a lot of staff turnover. When we get a new program manager out of their office they don't understand our role and we have to re-explain what it is. They are intrusive and want to come watch an in-service. We already have all of that oversight from the state office and it is kind of a bother. There is so much about what we do that we can't share with them, like if they receive a complaint and give it to us, but we don't respond. There is not a lot we can tell them because of patient confidentiality. We can't share things with them. Then again they did help us with gas, increasing the reimbursement. They are removed from us. I wish we had a straight line from us to the state office.

ORS:

We work well with them and provide valuable information to them and they respond very quickly and very timely.

I write out my complaints instead of verbally giving them to the complaint intake worker over the phone because she doesn't write down everything verbatim. It's kind of like that game where you tell one person something, they tell someone else and by the time it get around it ends up nothing like the complaint itself. They only get a fraction of what I say.

Local LTCOP coordinators were asked to describe their programs working relationship with other organizations / agencies (cont'd)…

ORS doesn't always substantiate and cite complaints that we refer to them. They make it where they have to see something themselves in order to cite an issue. There is a problem with them enforcing the facilities.

APS:

We work closely together on elder rights issues and extremely closely on licensed personal care home complaints and issues. We are well familiar with one another and help one another every way we can.

They used to be housed with DFCS, and you could call them directly and get help quicker. Now, since they are in the DAS, and we thought it would help. To me, you can't call the APS worker anymore, you have to call the complaint number. I would say 50% of the time, they have gone home. I have to keep calling or figure out how to take care of the complaint myself. In my facility, we have the area APS worker, but now they say you have to call the state office. We don't have time to keep calling. The LTCOP especially should be able to work directly with APS without having to go through the complaint line. We were put in the pot like everybody else, and we're not like everybody else.

APS workers serve on our committee which gives us a chance to explore and exchange work and ideas together on issues to resolve those issues. They have their own office, they have satellite offices and one of them is located here in town, two of them serve on our committee.

Law Enforcement:

We provide the elder abuse awareness training for all law enforcement. We are in partnership with them in our area. We are a team and we come together through our SALT council to discuss abuse and neglect.

We set up multi-disciplinary task forces, it is hard to get them involved and to come to meetings.

We cover many counties, all of those counties have a sheriffs department. In those counties there are many small cities with police departments and they are just not familiar with the ombudsman program until we have direct contact with them. They don't really understand the ombudsman program. Some of our bigger counties are like that… we come in contact with them for case work or SALT councils and community educations, but none of them really know what the ombudsman program is. This is part of our FY 2008 goals, to identify all of the players and take them a packet of information.

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Local LTCOP coordinators were asked to describe their programs working relationship with other organizations / agencies (cont'd)…

CCSP/SOURCE:

CCSP program serves on LTCOP committee, where again we can dialogue on the different issues and responsibility. We have been meeting 3 times a year and more often by phone and through email when needed.

They've had a lot of staff turnover, so it has been hard to develop those relationships. Understanding each others' programs and that you need to work together. Sometimes I am concerned about the job they are doing with their clients. I wouldn't say we have a great working relationship, but it's there, its good enough.

MHDDAD:

They're system is so messed up, they don't even know who's in charge. It is so hard to navigate that system, it's a nightmare. When you finally do get the person you need to work with… we work together to get things taken care of. But they're just a mess. It is extremely difficult, anytime I have those issues come up. It is a constant battle trying to find out who does what. They funded a MH LTCO program, which we were so excited about, because we would have one person to contact instead of this situation, but GA won't fund it. So that's a mess. They created the position, but they won't fund it.

DFCS:

I deal mostly with the eligibility people and they are very cooperative. They answer my questions.

I don't think our contact with them is that regular because it doesn't need to be. We really just contact them if we have a resident with a complaint that involves them.

Citizen's Advocacy Groups, CoAGE:

We really stay up on all of the legislation they are sponsoring, and support that legislation with advocacy through legislators, family councils, nursing homes. Co-Age has also picked up several ombudsman recommended legislations.

We participate in most of their activities and some of their priorities have been directly related to omb work. They have been successful legislatively for our residents and for the ombudsman program. They were most helpful in getting the PNA increased in GA, and a couple of years ago in restoring some funding that was cut from the ombudsman program.

We just don't have that much interaction with them. That goes back to prioritizing and what we have time to do and that just wouldn't be a priority.

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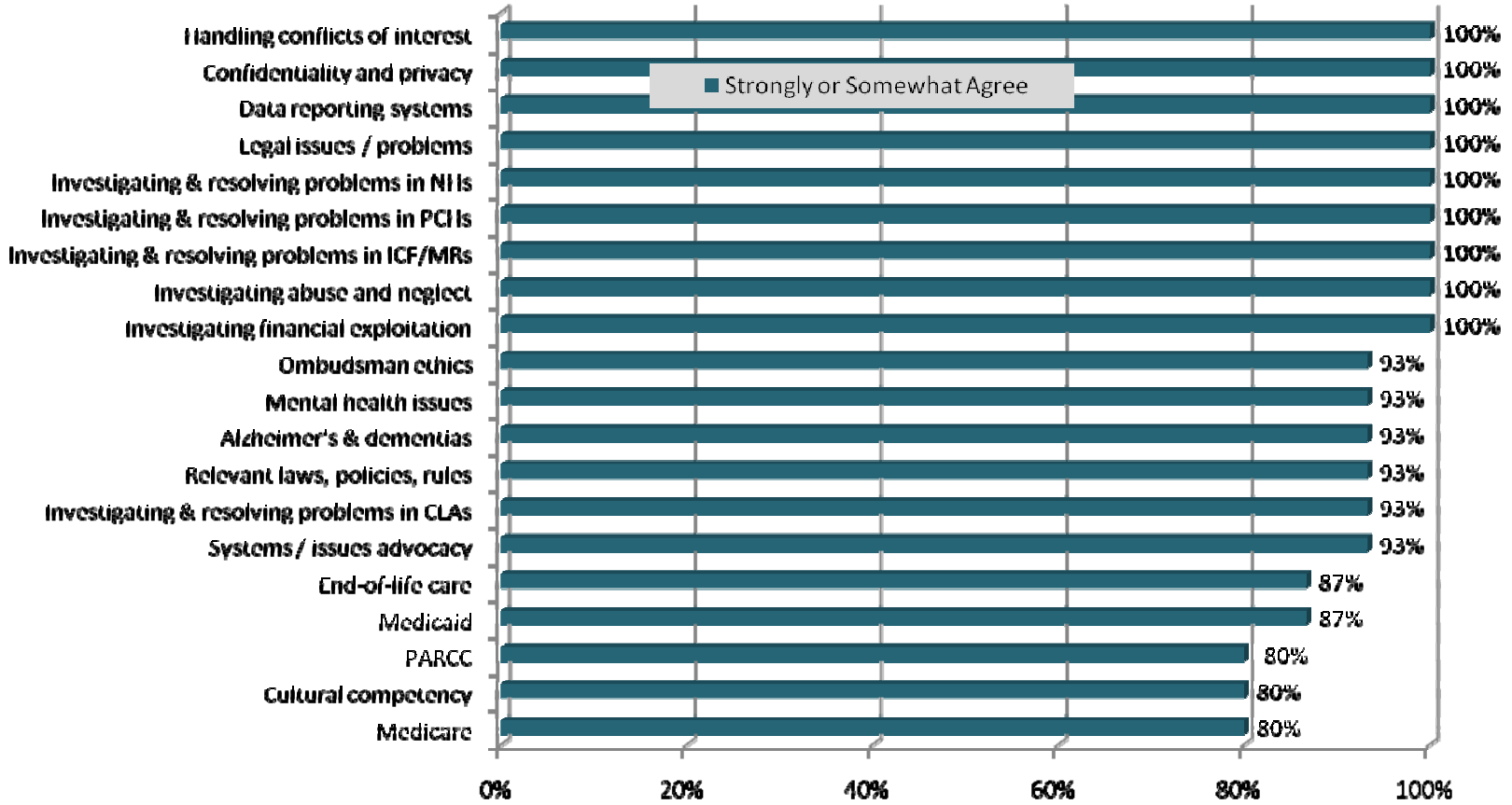
Figure 3.13: Self-Reported Percentage of Satisfactory Ratings for Training Provided in Specific Content Areas for local LTCOP Staff Members



Q. For each of the following, tell us to what extent you agree with the statement, my local LTCOP is adequately trained (through initial certification training, ongoing training, and/or communication from the state office) in this area?

All coordinators had favorable ratings of their local LTCOP's training; reporting they either somewhat or strongly agree that their LTCOP is adequately trained in 9 specific content areas. The areas that received the lowest percentage of satisfactory ratings include, Medicare (80%), cultural competency **(80%), PARCC (80%), Medicaid (86.7%),** and end-of-life care **(86.7%).**

Comparisons: Coordinators gave the lowest percentage of satisfactory ratings to training on data reporting systems, issues advocacy, PARCC, and mental health issues (all 71%) in California; PARCC (58%), and cultural competency (65%) in New York; investigating financial exploitation (56%), and mental health issues (63%) in Illinois; and issues advocacy (42%), and mental health issues (58%) in Ohio.

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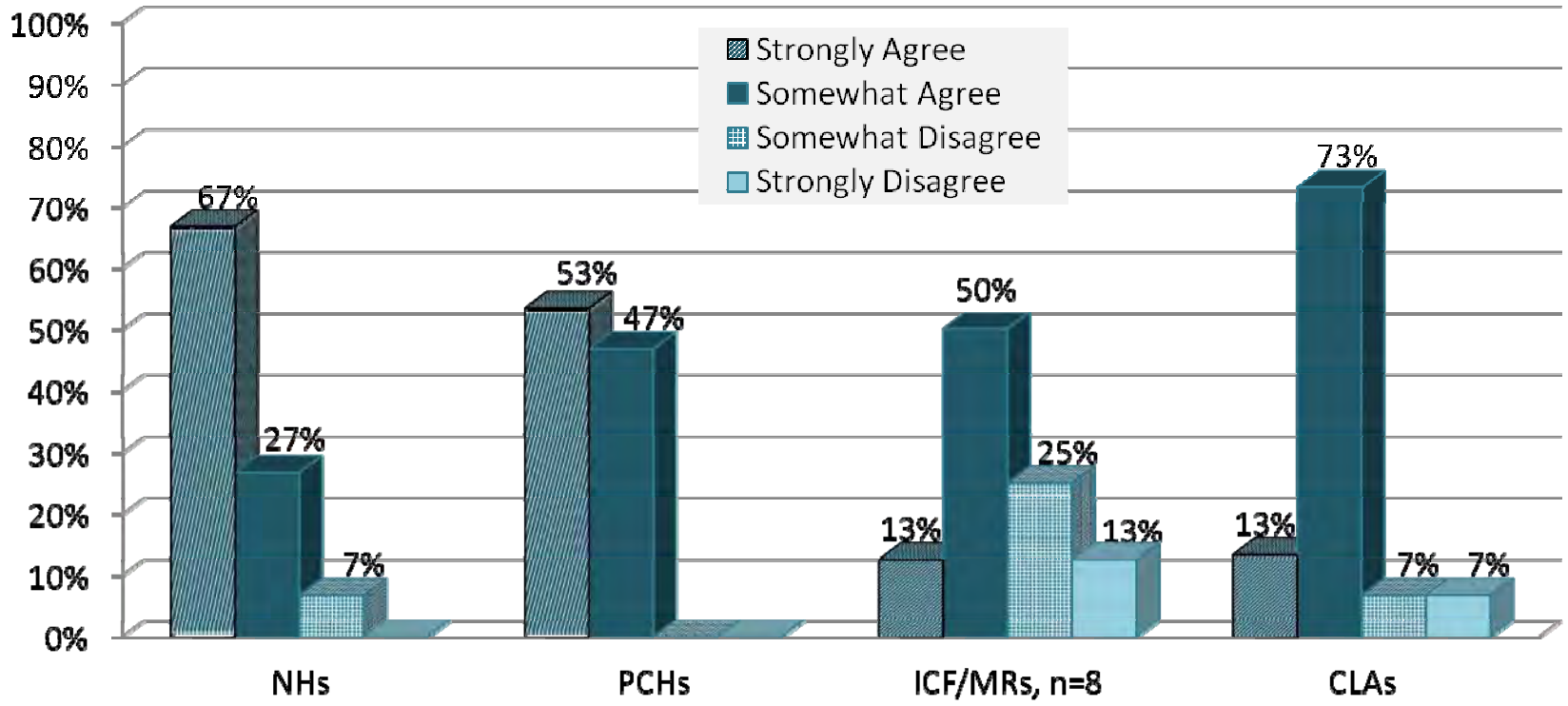
Figure 3.14: Extent to which local LTCOP coordinators agree that the program is well-known by facility residents



Q. To what extent do you agree that your local LTCOP is well known by _____ (facility type) residents?

Ombudsmen on average reported being better known by residents of nursing homes (93.4% somewhat or strongly agree) and personal care homes (100%) than residents of ICF/MRs (62.5%, n=8) and community living arrangements (86.6%).

SPECIAL ISSUE DOMAINS 4

Overview:

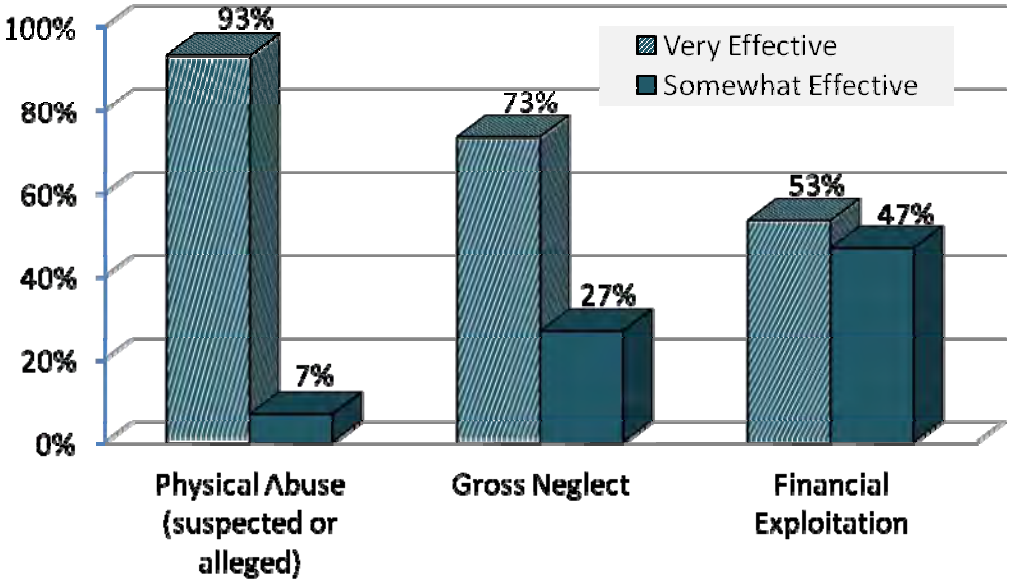
This chapter presents data related to specific topic areas in which local LTCOPs in Georgia are engaged. Specifically we focus on the topics of elder abuse, legal services, autonomy, cultural competency, end-of-life care, systems / issues advocacy, post-acute care, as well as AIMS. Data for this chapter were drawn from the surveys with coordinators of the 15 local LTCOPs in Georgia. In addition, the chapter presents selected cross state comparison data from surveys conducted with local LTCOP coordinators in California (n=35), New York (n=39/50 programs), Illinois (n=16/17 programs) and Ohio (n=12) over the past three years.

Ombudsman rate highly the effectiveness of their LTCOP in addressing complaints and concerns regarding elder physical abuse, with 93% reporting that they are "very effective" in this arena; fewer rated as highly the effectiveness of their LTCOP in addressing gross neglect and financial exploitation [Figure 4.1]. Almost half (40%) of the coordinators reported that there are unmet legal service needs for program-related matters and resident quality of care and rights related issues [Figure 4.6]. All coordinators reported that their host agency allows for sufficient autonomy [Figure 4.8]. Furthermore, 80% did not perceive constraints on the autonomy of their LTCOP due to the placement of the OSLTCO. All coordinators reported that their LTCOP was effective in dealing with issues related to cultural competence with 40% reporting that their LTCOP was "very effective' [Figure 4.10]. Similar ratings were reported for addressing complaints and concerns related to end-of-life care and conducting issues and conducting systems/issues advocacy with 47% indicating "very effective" for each of these domains [Figures 4.13, 4.16]. In addition, close to half (40%) reported using the data from AIMS to guide their LTCOPs' issues advocacy efforts.

SPECIAL ISSUE DOMAINS 4

List of Figures

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

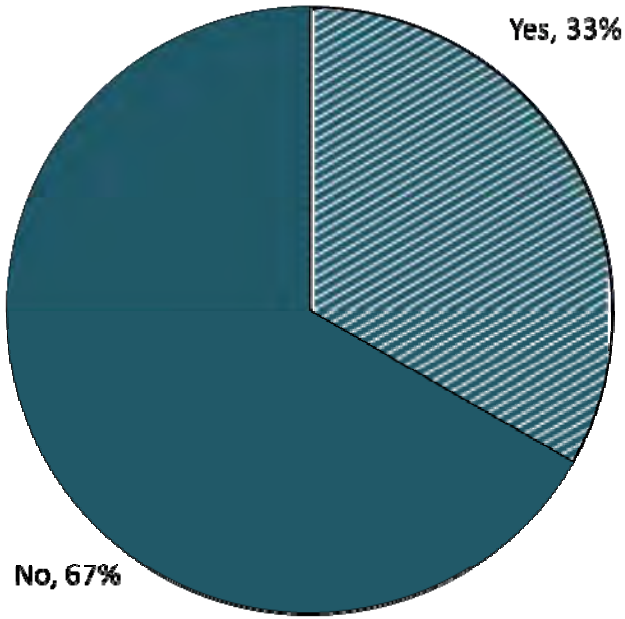


Q. How would you rate the effectiveness of your local LTCOP in addressing complaints and concerns related to Physical Abuse, Gross Neglect, and Financial Exploitation?

All coordinators report that their programs were effective in addressing complaints and concerns related to elder abuse. Coordinators rated program efforts in handling complaints and concerns related to physical abuse (93.3%), gross neglect (73.3%), and financial exploitation (53.3%) as very effective.

Comparisons: California, New York, Illinois, and Ohio local LTCOP coordinators rated the performance of their programs as either somewhat or very effective in addressing complaints and concerns related to physical abuse (100%, 100%, 100%, and 92% respectively), gross neglect (94%, 94%, 88%, and 93%), and financial exploitation (91%, 91%, 75%, and 75%).

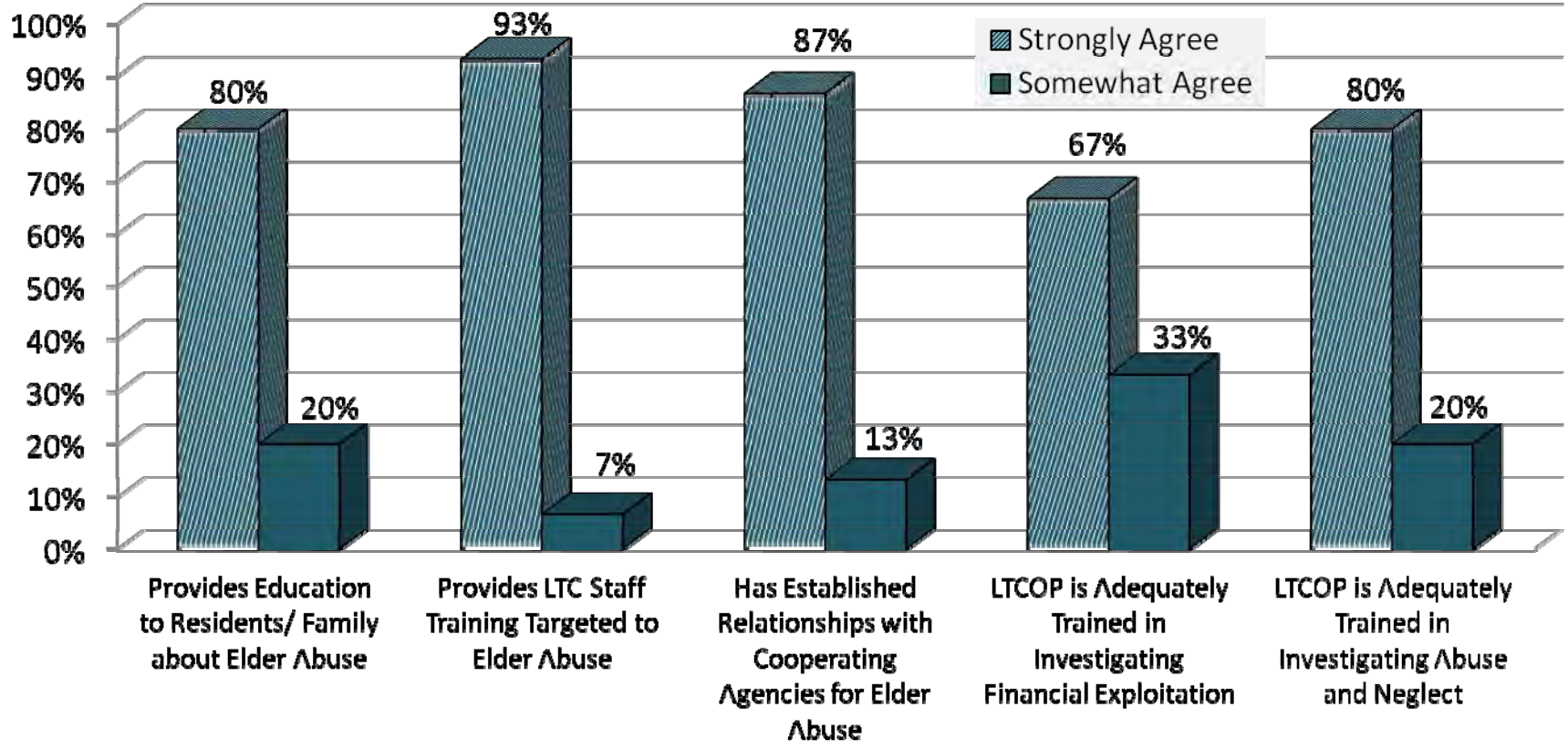
Figure 4.2: Self-Reported Differences in Addressing or Advocating for Issues Related to Elder Abuse in the Different Settings Served



Q. Are there unique differences in addressing and/or advocating for issues related to elder abuse across the settings served by your local LTCOP?

Serving four different types of facilities, one-third (33.3%) of the coordinators reported that addressing and/or advocating for issues related to elder abuse can be different across the types of facilities and residents they serve.

Figure 4.3: Extent to Which Characteristics / Activities Apply to Local 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, coordinators strongly agree that their LTCOP provides education to residents and families about elder abuse (80%), provides LTC facility staff training on elder abuse (93.3%), has established cooperative relationships with other agencies related to elder abuse (86.7%), and is adequately trained in investigating abuse and neglect (80%). Only two-thirds (66.7%) of coordinators agree that their program receives adequate training in investigating financial exploitation.

SPECIAL ISSUE DOMAINS 4 ELDER ABUSE

Local LTCOP coordinators were asked to describe their LTCOPs' biggest challenges or obstacles in addressing and / or advocating for issues related to physical abuse, gross neglect, and financial exploitation…

In long term care facilities, it is hard unless you have a witness. Most residents are afraid to complain, and be identified. With gross neglect, it is something where you have to keep going back, or move the person out. With financial exploitation, it is difficult, sometimes you don't have all the facts. Nursing homes wait until the family owes $30k before they do anything and they want to discharge the resident. It is hard to convince them not to take it out on the resident.

Fighting unlicensed personal care homes, boarding houses, they have no rules and regulations guiding them. They don't have any background checks. There are no steps in place, no rules, regulations or laws in place to protect the residents in these facilities.

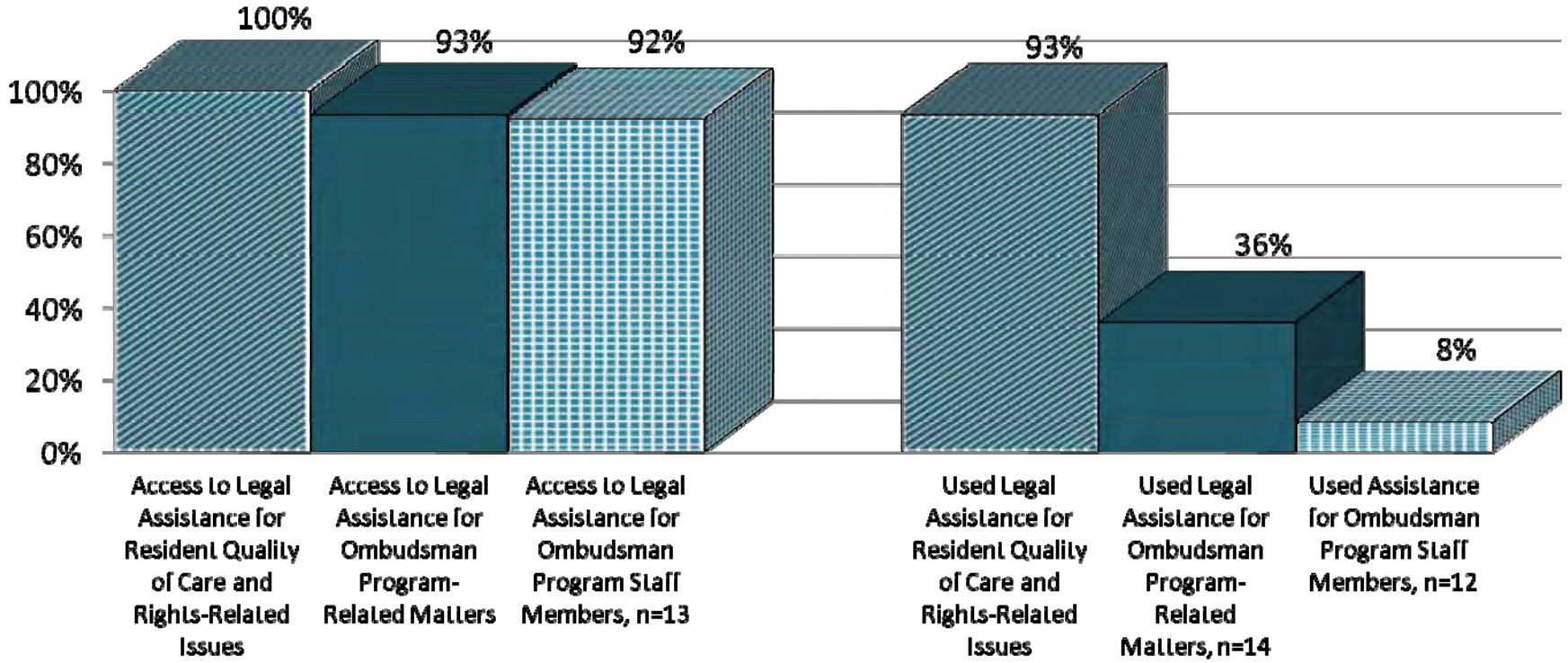
Other agencies response or lack thereof. Sometimes it just means they don't know what they're doing, it's not necessarily negative. Particularly when it comes to law enforcement, they want to do it right, but they just don't know what to do.

Trying to keep in contact with other agencies, keep a list of agencies and build relationships with those agencies. Refer to them if we need to.

Adult Protective Services has such a long range of time before they have to respond. A lot of times when we call APS with an emergency, they are just slow to respond. They have up to 2 - 3 weeks. Like when the resident leaves against medical advice and we know they are going to an unsafe environment, they have up to 3 weeks to respond.

The Office of Regulatory Services does not always validate complaints, they don't always provide the enforcement needed in the nursing homes and personal care homes in particular.

Figure 4.4: Self-Report of Local LTCOP's Access to and Utilization of Legal Services and Support Over the Past Year

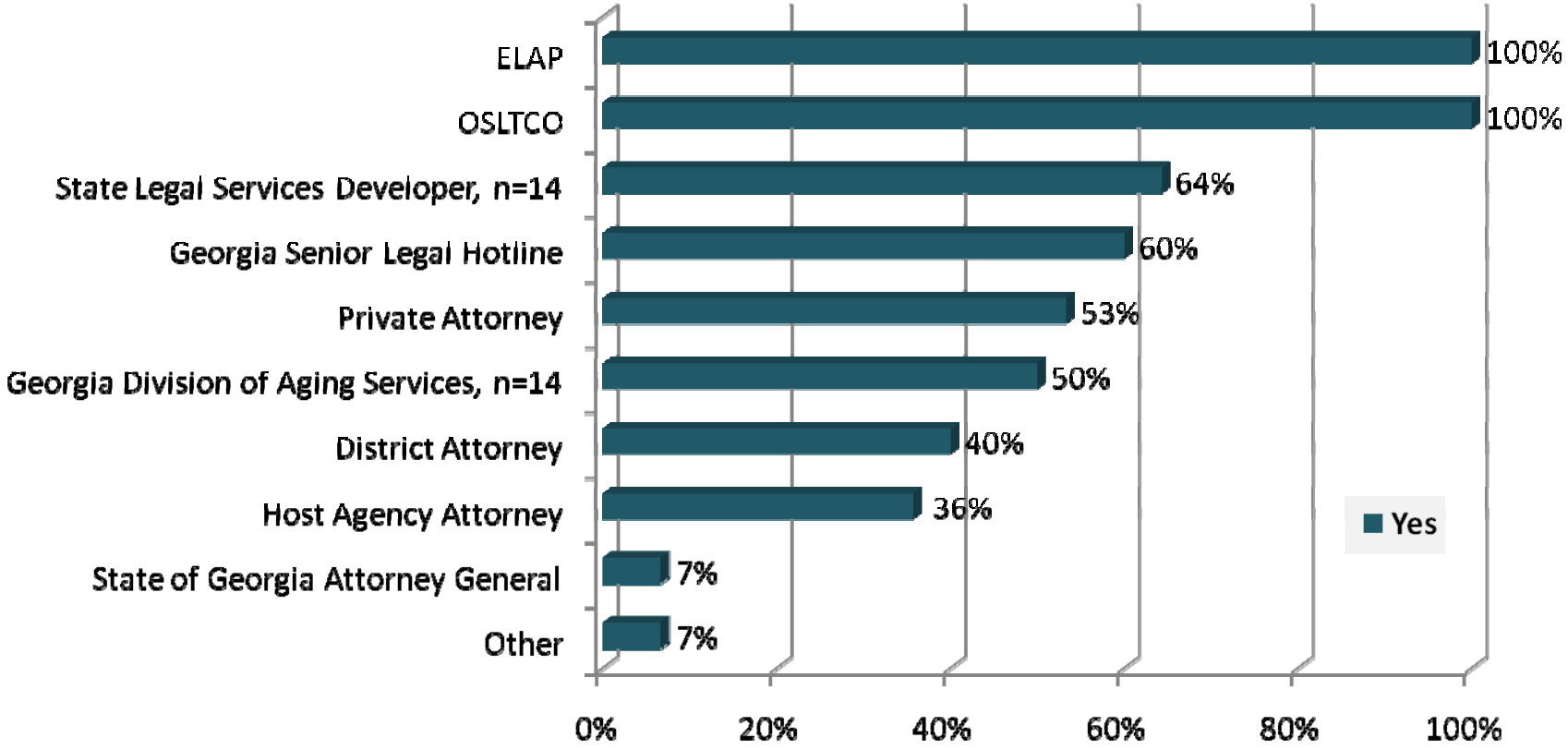


Q. Does your LTCOP have access to legal assistance for _____? Has your LTCOP used legal assistance for _____ in the past year?

Over 90% of coordinators report that their LTCOP has access to legal services for resident quality of care and rights related issues (100%), ombudsman program related matters (93.3%), and ombudsman program staff members (93.3%). Use of legal services (for those that had access to them) for program matters (35.7%) and program staff (8.3%) were much less than for resident quality of care and rights related issues (93.3%).

Comparisons: The majority of coordinators in California, New York, and Ohio had access to legal assistance for resident quality of care and rights related issues (88%, 95%, and 75% respectively), and have used legal assistance for resident quality of care and rights related issues (77%, 60%, and 75%). Less coordinators in California, New York and Ohio reported having access to legal assistance for ombudsman program related matters (71%, 85%, and 83%), and have used legal assistance for such related matters (47%, 33%, and 67%). (No data available on access to and use of legal services for ombudsman program staff members, no data for Illinois).

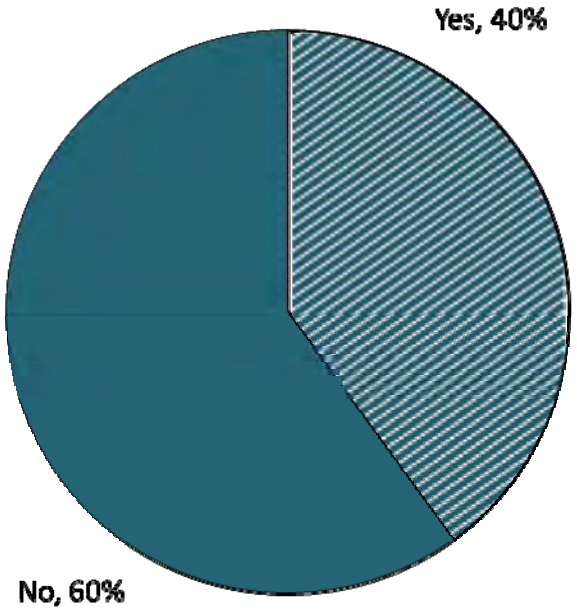
Figure 4.5: Self-Report of Local LTCOPs Use of Legal Services Providers



Q. Please indicate whether your local LTCOP received any legal counsel or assistance from the following sources?

All coordinators report that their LTCOP received legal counsel or assistance from ELAP and the Office of the State LTC Ombudsman. The State of Georgia Attorney General (for criminal cases) was used the least (6.7%) and one coordinator (6.7%) reported receiving other legal counsel and assistance from the Office of the Inspector General and the Social Security Administration.

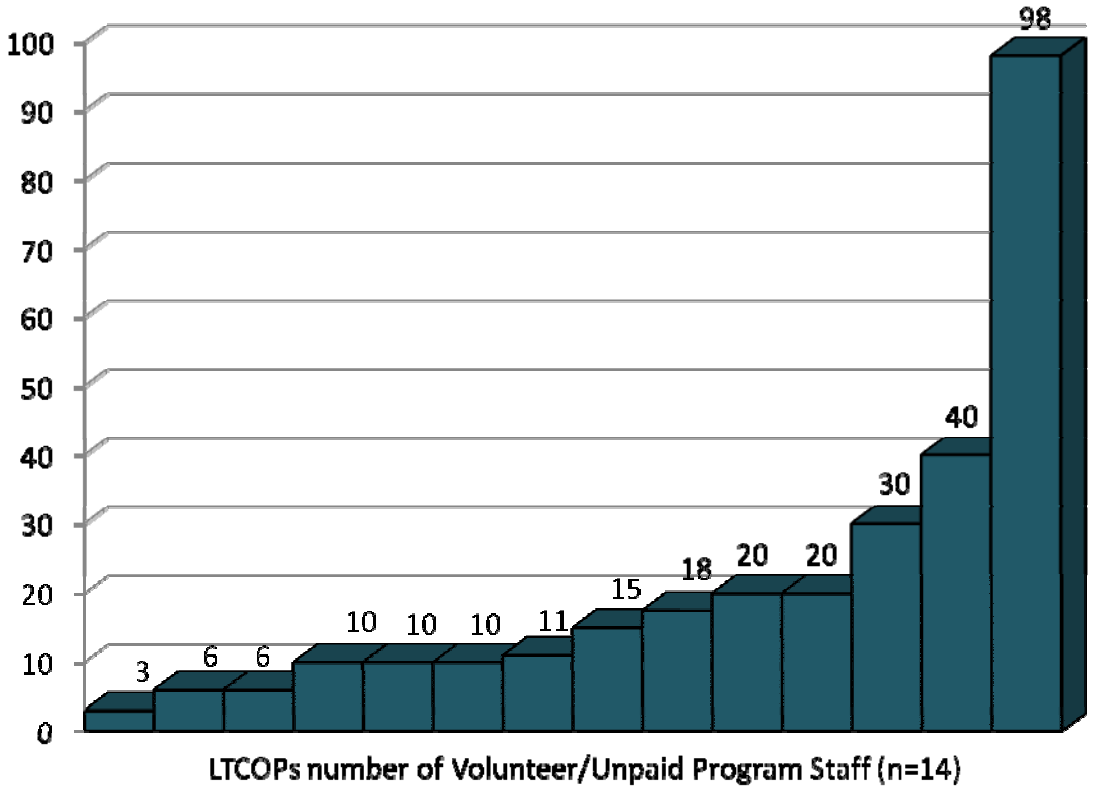
Figure 4.6: Self-Report of Unmet Resident and Local LTCOP Legal Service Needs



Q. Are there program or resident legal assistance and service needs that are left unmet?

Almost half (40%) of coordinators report that there are program or resident legal service needs that are left unmet.

Figure 4.7: Self-Reported Number of Local LTCOPs' Requests for Legal Assistance Over the Past Year



Q. In the last year, approximately how many times did your local LTCOP request legal assistance?

The average number of reported requests for legal assistance by local LTCOPs is 21.1. The range of request for legal assistance is 3 to 98. Because of the large outlier (98) the median (13) may be a more representative number.

Local LTCOP coordinators were asked to describe their program's working relationship with ELAP…

They've been helpful in providing legal representation in discharge appeal cases, and also in helping residents set up Miller Trusts in order to obtain Medicaid eligibility.

Every time we have something they work closely with us, very effective, great advocates. I don't think it is the same across the board. They present information at workshops.

We have a sorry ELAP program. They don't take cases, they're slow, they did help with Miller Trusts. They did a good job helping people establish Miller Trusts. All other interactions were poor.

Local LTCOP coordinators were asked to describe what program or resident legal assistance and service needs are left unmet…

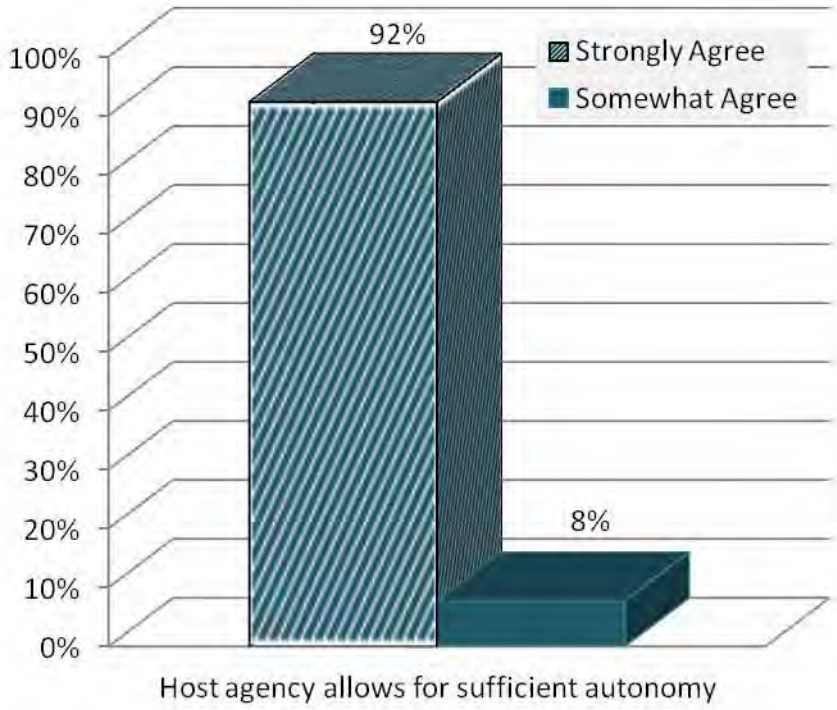
Residents need help with criminal matters, ID theft and other criminal issues, financial abuse. There are just not enough pro bono attorneys or individuals that can help them with those issues. We have a few, but they need much more help in that area.

Guardianship, representation for residents. Like if someone tries to get guardianship over a resident the residents need representation. ELAP cannot do that in Georgia. If a resident is in need of a guardian, there are none.

They only have certain hours during the day that they take calls (ELAP). Inconvenient intake, funding so short, they take a minimum number of cases, they turn down a lot. They represent 60+, but young people are in nursing homes now. ELAP should serve everyone in nursing homes, even if they are under 60. If people are in nursing homes, they should qualify to use ELAP.

SPECIAL ISSUE DOMAINS 4 AUTONOMY

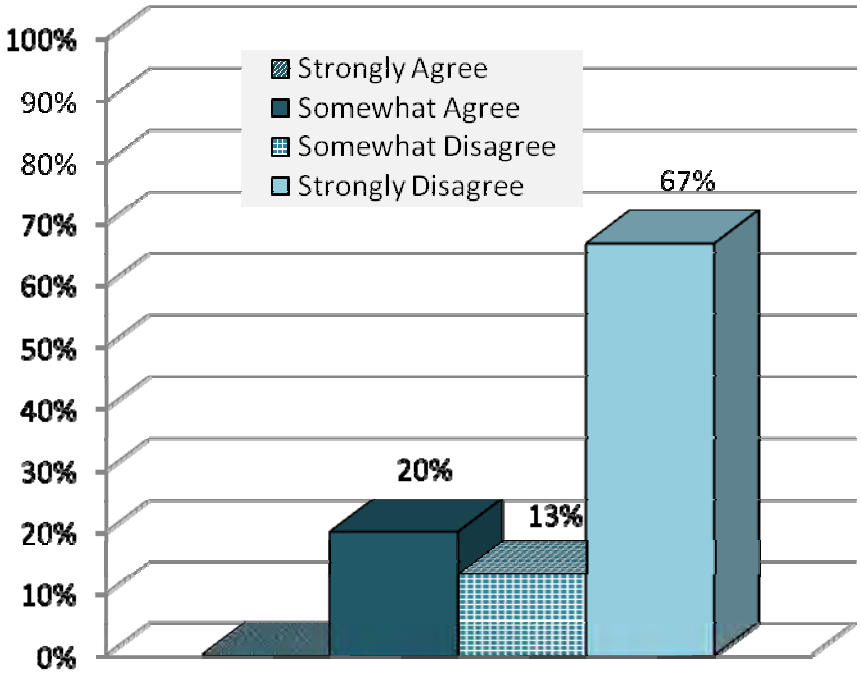
Figure 4.8: Extent to Which Local LTCOP Coordinators Perceived that their Host Agency Allows for Sufficient Autonomy



Q. To what extent do you agree with the following statement, your local LTCOP's host agency (or organizational placement) allows for sufficient autonomy to carry out the programs' duties and activities?

Most ombudsmen coordinators (92.3%, n=13) strongly agree that their host agency allows for sufficient autonomy.

Figure 4.9: Extent to Which Local LTCOP Coordinators Perceived Constraints on Autonomy due to the Placement of the OSLTCO



Q. To what extent do you agree with the following statement, your local LTCOP encounters constraints on autonomy due to the organizational placement of the OSLTCO?

Most ombudsmen coordinators disagreed (80%) that the placement of the OSLTCO resulted in constraints on their LTCOP's autonomy.

SPECIAL ISSUE DOMAINS 4 AUTONOMY

Local LTCOP coordinators were asked to describe how their program's host agency affects program autonomy…

Our limitations are those limitations faced by the legal services corporation on lobbying and legislative advocacy, however, the state ombudsman is a registered lobbyist in Georgia, other than that there are few limitations.

The agency doesn't micromanage this program, it provides support and guidance when needed. They encourage program advocacy and legislative advocacy on issues regarding residents and encourage and support extra-curricular activities for residents.

Local LTCOP coordinators were asked to describe how the placement of the Office of the State LTC Ombudsman affects program autonomy…

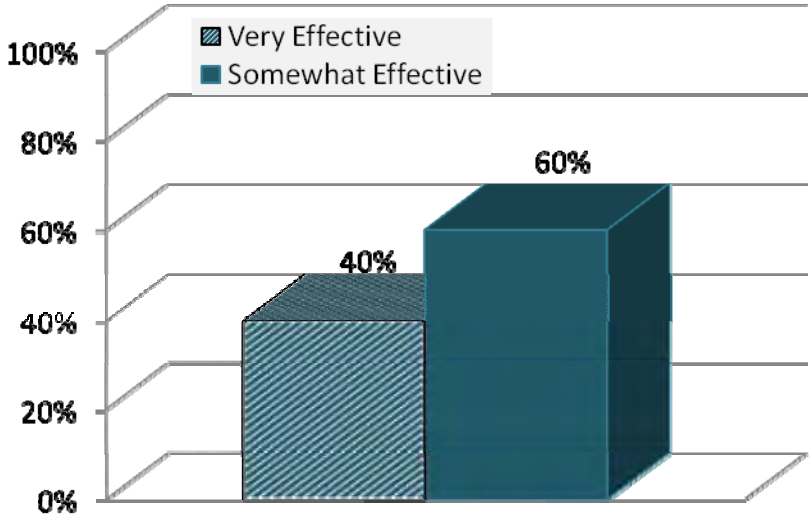
Our state office is housed with ORS and all the other aging programs and sometimes it poses a conflict.

If the state office were under a non-profit status, there could be fundraising for statewide programs. Grants could actually contract directly with the state ombudsman. There wouldn't be any conflicts of interest with agencies that now provide services.… Well right now, ORS for PCHs and NHs are housed in the same division as the state office, but I think they are moving. Being where Becky is, is a constraint on one hand, but because of the support we get from the director, Maria Greene, it can be an asset.

We've never been asked to do anything that violates the role of the ombudsman. The only people who have access to any of our materials is the state ombudsman and we have a good working relationship with that office. I am very comfortable with how things are here.

Being housed in the state HR aging division places political constraints on the state ombudsman, we have had formal meetings in the past to discuss this issue but most of the participants of those meetings are state employees and I don't feel that they see that conflict. We were outnumbered.

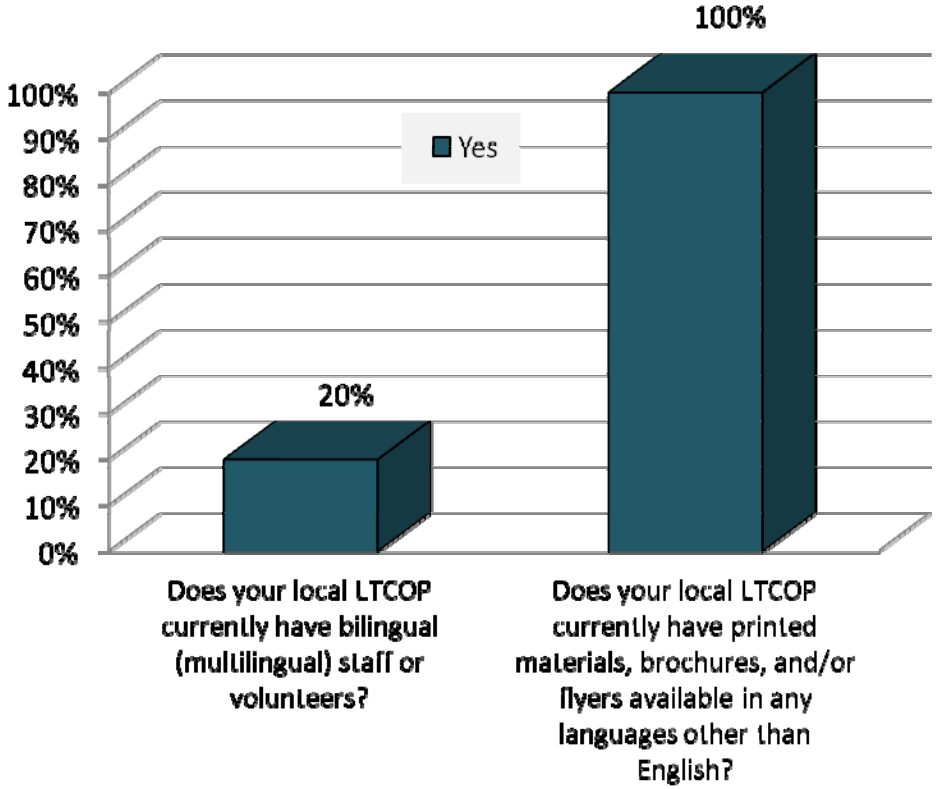
Figure 4.10: Self-Rated Effectiveness of local LTCOPs in Addressing Complaints and Concerns Related to Cultural Competence



Q. How would you rate your local LTCOP in addressing complaints and concerns related to resident's diversity?
All coordinators report that their LTCOP was effective in dealing with issues related to diversity, with 40% reporting that their program was very effective.

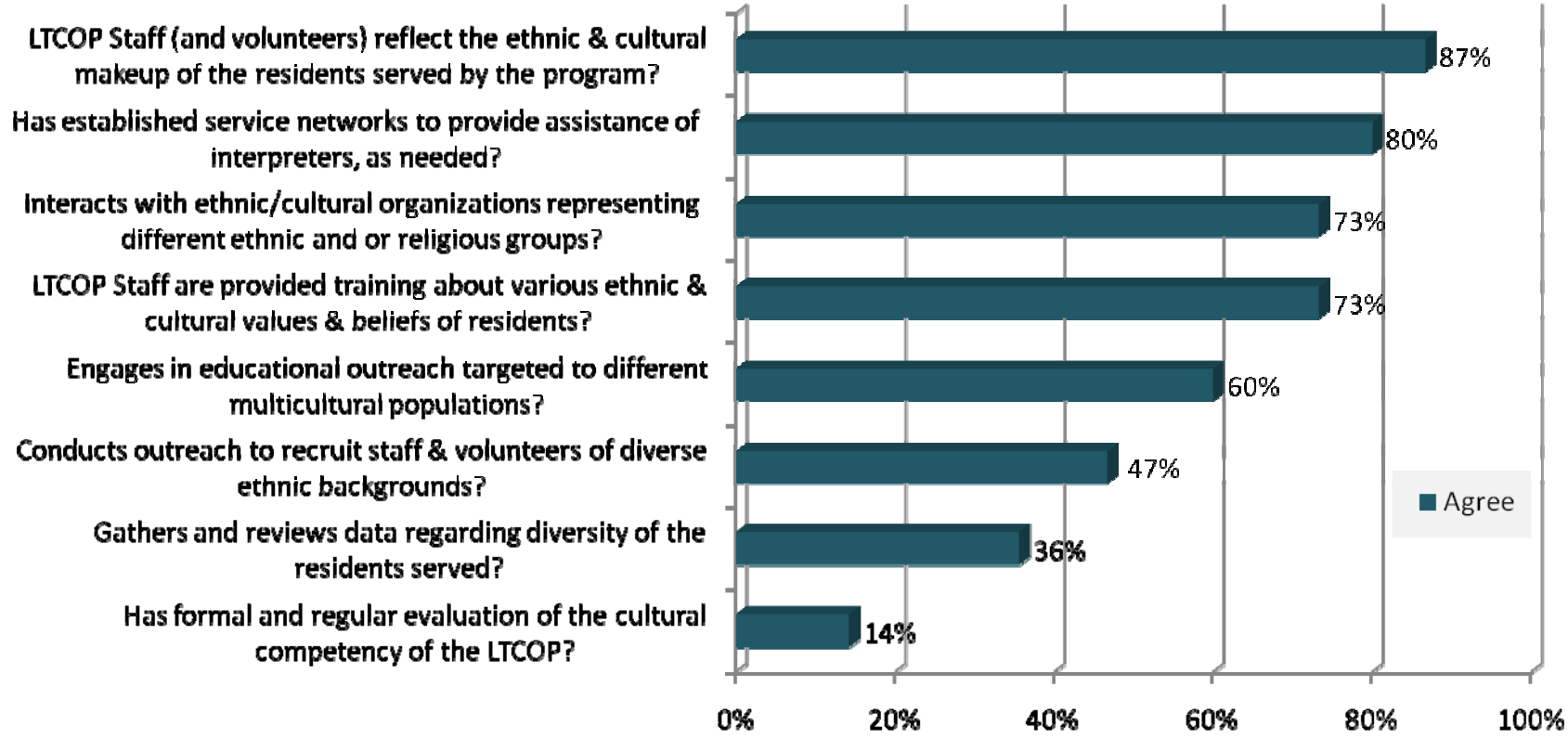
Comparisons: More than four-fifths (82%) of California coordinators rated the performance of their LTCOP in addressing complaints and concerns related to cultural competence as at least somewhat effective. The same was true for nearly three-quarters (73%) of New York coordinators and 90% of Ohio coordinators. (No data available for Illinois).

Figure 4.11: Self-Report of Local LTCOPs Availability of Bilingual Staff / Volunteers and Information in Other Languages



Q. Does your local LTCOP currently have bilingual (multilingual) staff or volunteers? Does your local LTCOP currently have printed materials, brochures, and/or flyers available in any language other than English?
Only 20% of LTCOPs have bilingual staff or volunteers. However, all LTCOPs offer informational materials in languages other than English.

Figure 4.12: Extent to Which Characteristics/Activities Applied to local LTCOPs in Addressing Issues Related to Cultural Competency



Q. For each of the following, indicate to what extent you agree that the item applies to your local LTCOP?

The majority of coordinators report that their LTCOP staff reflected the ethnic and cultural makeup of the residents served (86.7%), that they had established networks to provide the service of interpreters when needed (80%), that they interact with ethnic / cultural organizations (73.3%),and that their staff are provided training about various ethnic and cultural values and beliefs of residents (73.3%). Few coordinators reported having formal and regular evaluations of the cultural competency of their LTCOP (14.3%).

SPECIAL ISSUE DOMAINS 4 CULTURAL COMPETENCY

Local LTCOP coordinators were asked to describe their program's biggest challenges or obstacles in addressing complaints and concerns related to issues of resident's diversity…

Community prejudices, all folks in nursing homes are white, and they don't like black folks, and you have to deal with that, and visa versa. Religion, especially. A lot of older folks have a problem with people who are gay, there are prejudices in long term care…. One woman with cerebral palsy who goes to our luncheon said "It is nice to go someplace out to eat where people don't stare at you." Mostly, I think it is community prejudices in and outside of the facility.

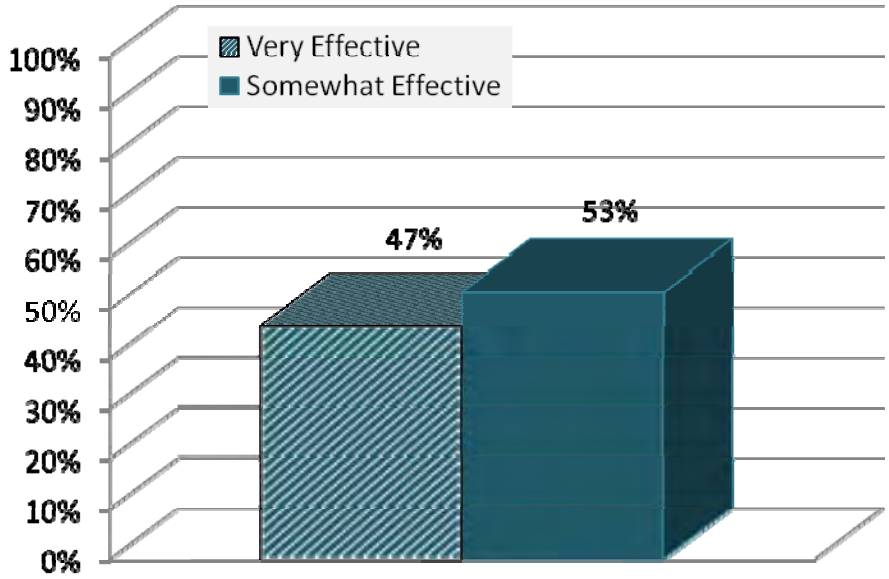
The biggest challenge that we have is that we rarely have any complaints. I don't think that I have ever worked a complaint related to religion, SES, never had one about sexual orientation. Literacy, we are equipped, we know how to deal with them. There's no discrimination. There are no obstacles related to anyone with physical or mental abilities. We don't have any.

Freedom of sexual expression. We're living in the bible belt and we have dealt with this issue on several occasions and it is often difficult to get family and staff to believe that the resident has the right to chose who they want to be with. We use a training movie, The Freedom of Sexual Expression. Good for family, staff and residents.

Being in the deep south and having to work with facility staff prejudices and resident prejudices…. We have a lot of training on diversity. Even staff coming in, I have a staff person that I hired… and when she got here she had to deal with some of the religious issues, and racial issues. She was like a fish out of water with some of that. In the nursing homes it is really interesting because you've got your older residents here that are white that grew up in a different time. Then you have African American staff many who are young and they are not going to have any of that, and it is very difficult to deal with.

The mental ability, is one of the biggest challenges. With the residents who lack mental capacity, it is very difficult to communicate with them. We need more training on how to handle those residents and deal with sometimes very aggressive behavior…. A lot of staff are young, and may not be familiar with the aging process, they need more training. I think we are seeing a little bit of issues with sexual orientation, same sex issues, and making sure the residents' rights being protected.

Figure 4.13: Self-Rated Effectiveness of local LTCOPs in Addressing Complaints and Concerns Related to End-of-Life Care



Q. How would you rate your local LTCOP in addressing complaints and concerns related to end-of-life care issues?
All coordinators report that their LTCOP was effective in dealing with issues related to end-of-life care, 46.7% report that they were very effective.

Comparisons: The majority of California, New York, and Ohio local LTCOP coordinators rated the performance of their program in addressing complaints and concerns related to end-of-life care favorably (94%, 91%, and 100% respectively). (No data available for Illinois).

Local LTCOP coordinators were asked to describe their programs' biggest challenges or obstacles in addressing complaints and concerns related to end-of-life care…

Pain management, medical choices, and problems with hospice.

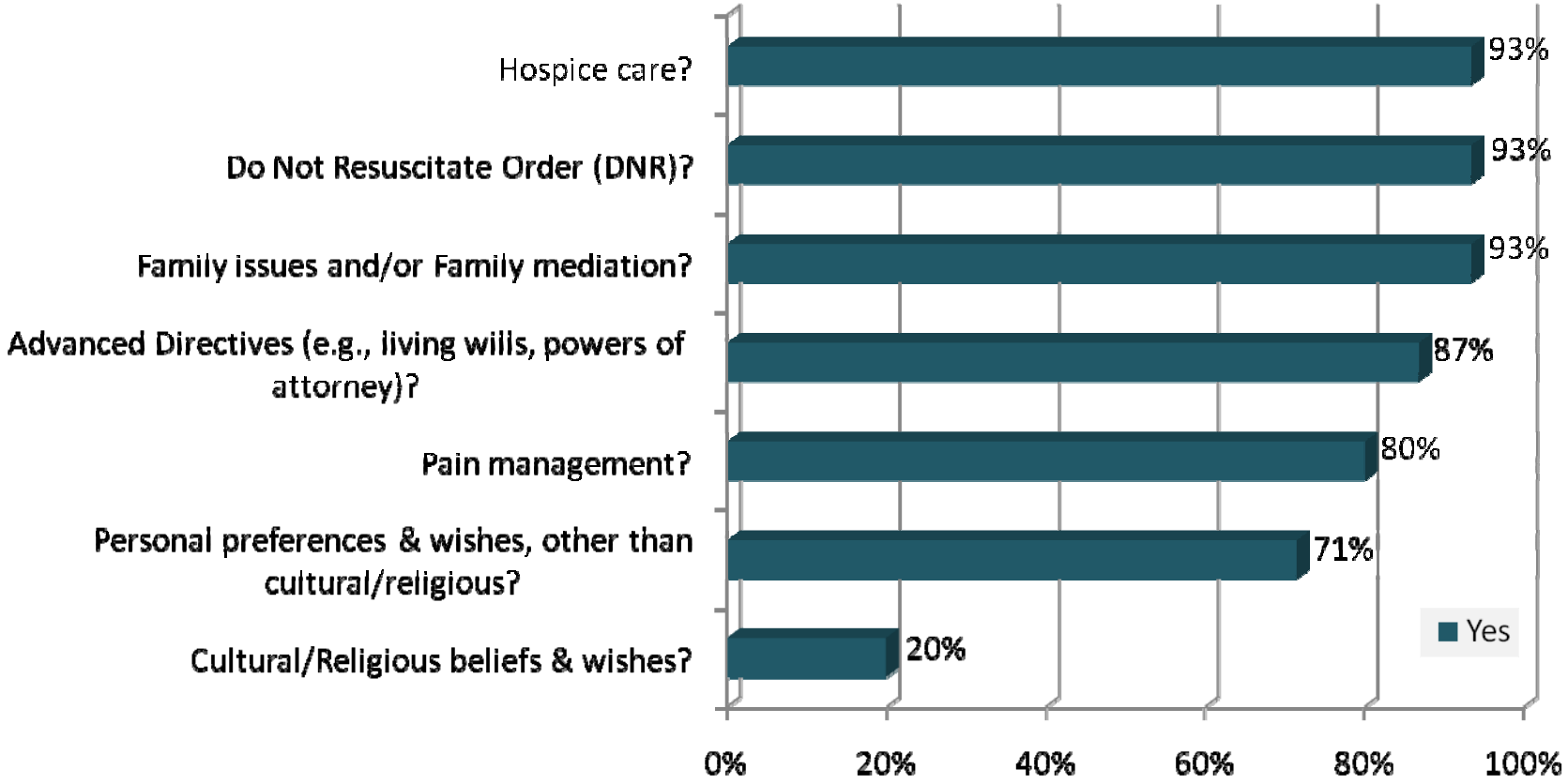
The issues are family conflict vs. resident wishes, appropriate documentation in the resident's file regarding the resident's wishes.

Doctors do not pay attention to advanced directives of the resident. If the family is there, they listen to what the family wants instead of looking in the chart for the resident's advanced directives.

Residents not being consulted, need more attention to advanced directives upon admission, family wishes vs. resident wishes.

The resident wanting a certain hospice service and the facility saying no, this is the provider we use.

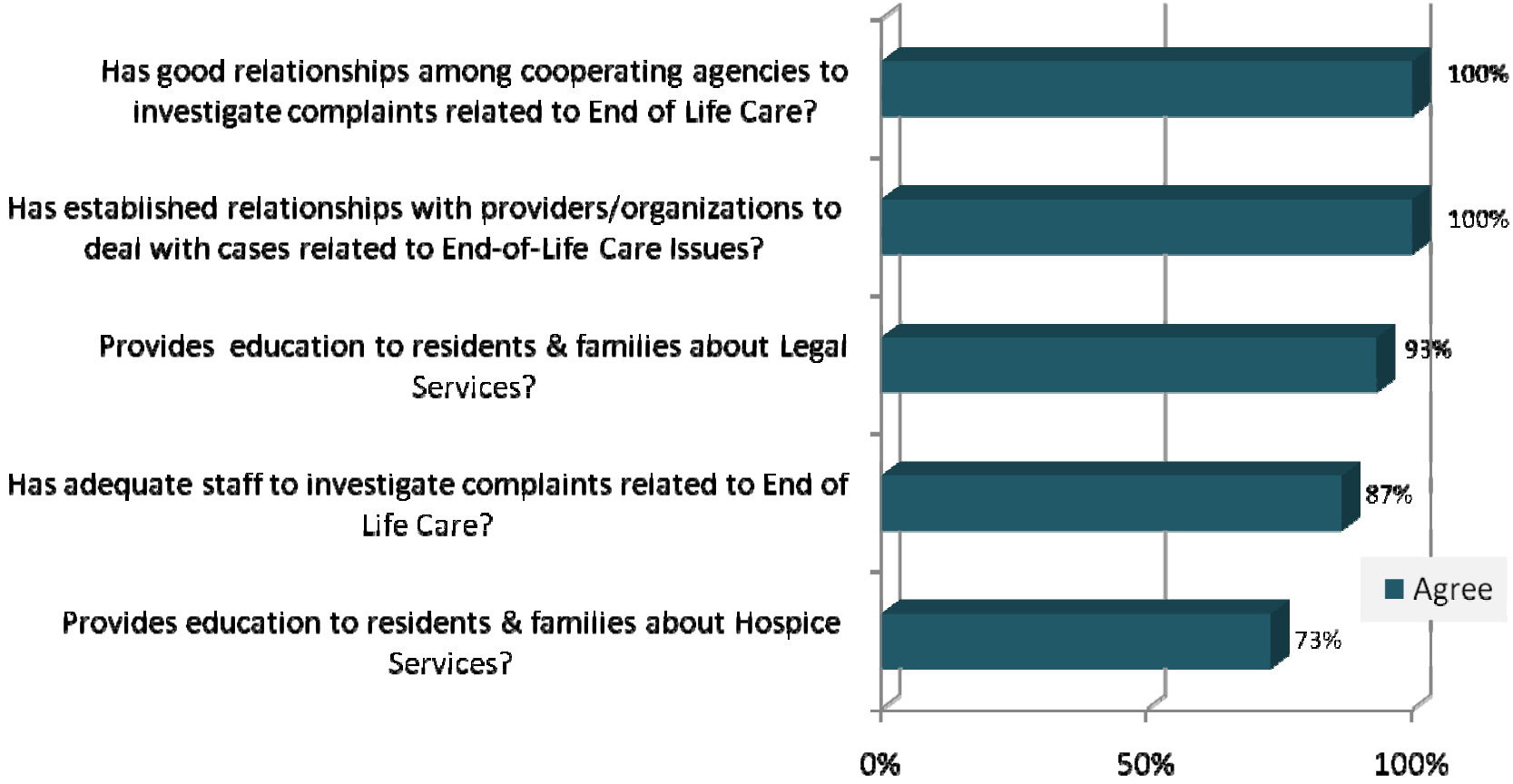
Figure 4.14: Self-Report of Local LTCOP's Involvement in Issues Related to End-of-Life Care Over the Past Year



Q. Over the past year, have cases related to end-of-life care services for residents involved any of the following issues?

Hospice Care (93.3%), DNRs, (93.3%) and family issues and / or mediation (93.3%) represent the top issues LTCOPs were involved in related to end of life care. Cultural / religious beliefs and wishes had the lowest rating of LTCOP involvement by coordinators (20%).

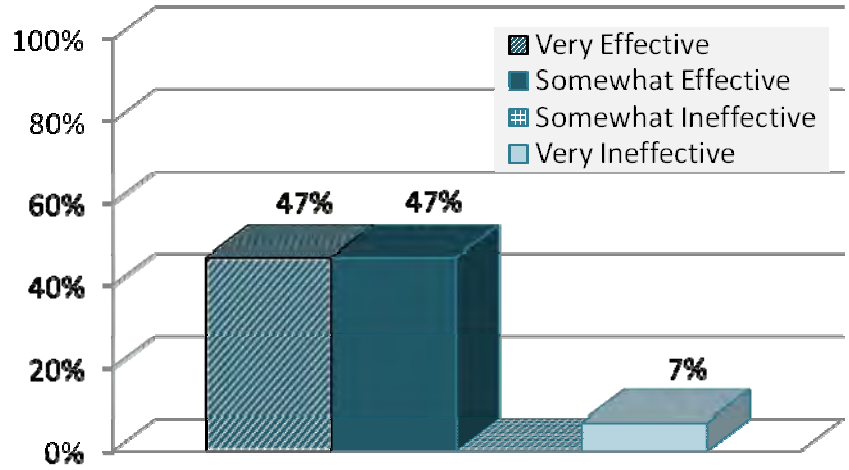
Figure 4.15: Extent to Which Characteristics / Activities Applied to Local LTCOPs in Addressing Issues Related to End-of-Life Care



Q. For each of the following indicate to what extent you agree that the item applies to your local LTCOP?

All coordinators agree that their LTCOPs have good working relationships among cooperating agencies investigating complaints related to end-of-life care, and have established relationships with providers / organizations to deal with cases related to end-of-life care issues. To a lesser extent, coordinators reported that their LTCOP provides education to residents and families about hospice services (73.3%).

Figure 4.16: Self-Rated Effectiveness of Local LTCOPs in Conducting Legislative & Administrative Policy Advocacy (Issues Advocacy)



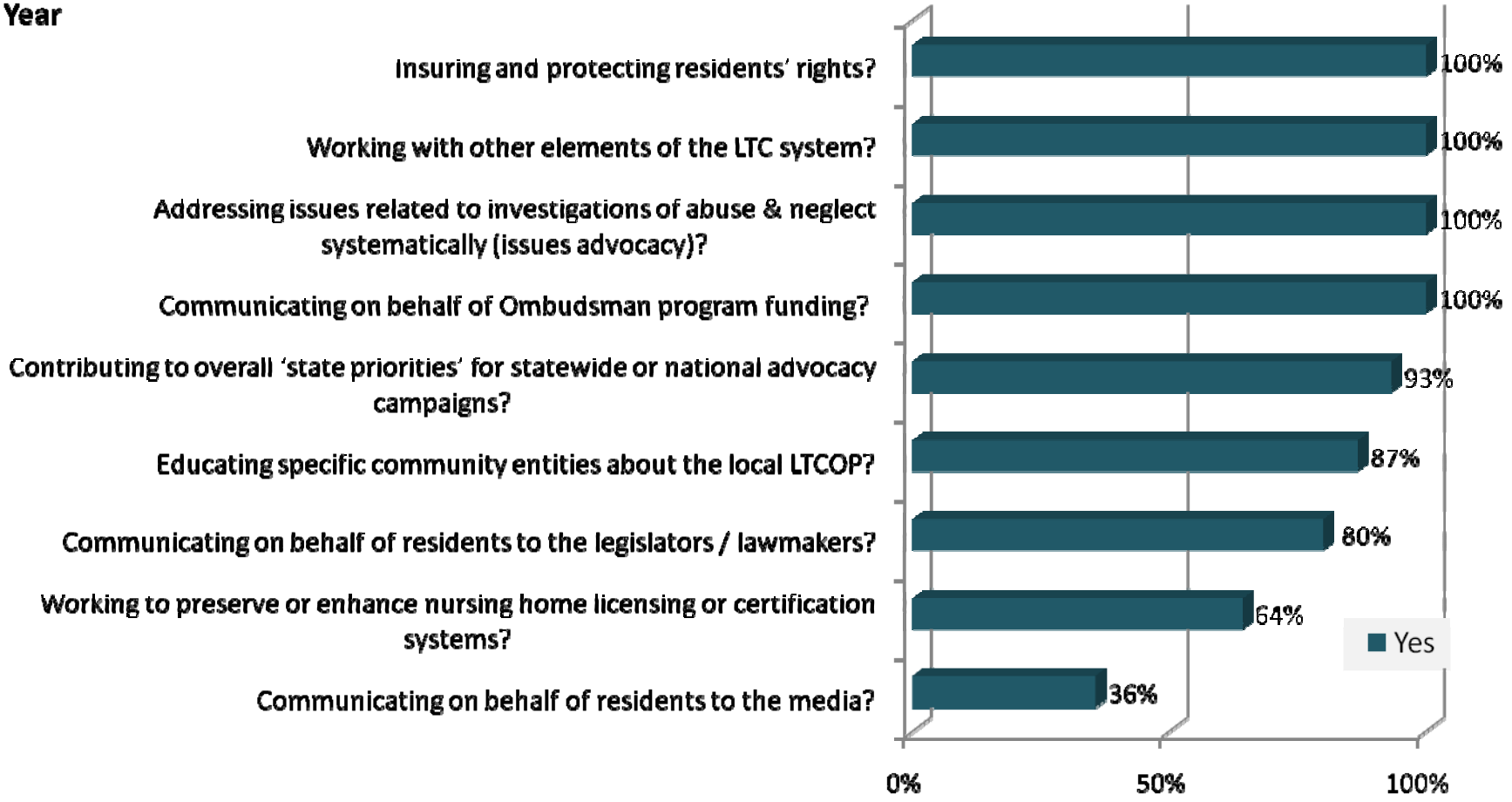
Q. How would you rate your local LTCOP in conducting Legislative & Administrative Policy Advocacy (Issues Advocacy)?
Most coordinators reported that their LTCOP was either somewhat or very effective in conducting issues advocacy. One respondent (6.7%) rated their program as very ineffective in conducting issues advocacy.

The majority of coordinators in California (54%) and Illinois (75%) reported that their program was either somewhat or very ineffective in conducting issues advocacy; while over half of the coordinators in New York (63%) and Ohio (58%) rated their programs as either somewhat or very effective.

Local LTCOP coordinators were asked what type(s) of issues advocacy work their program has been involved with over the past year…

- Ombudsman funding
- Personal needs allowance
- Staffing ratios
- Elder Justice Act
- Criminal neglect laws
- Facility discharge notifications
- Mental Health Ombudsman
- Beacon Rights Program
- Katrina Victims
- Miller Trusts
- Triads with law enforcement
- Estate Recovery
- Nutrition in nursing homes
- Abuse reporting
- Medicaid coverage of electric wheelchairs in nursing homes
- Elder rights councils
- Medicare Part D
- Medicaid Regulations
- Personal care home regulations
- Medicaid funding for personal care homes
- Mental health and mental illness issues
- CNA labor issues
- Use of restraints

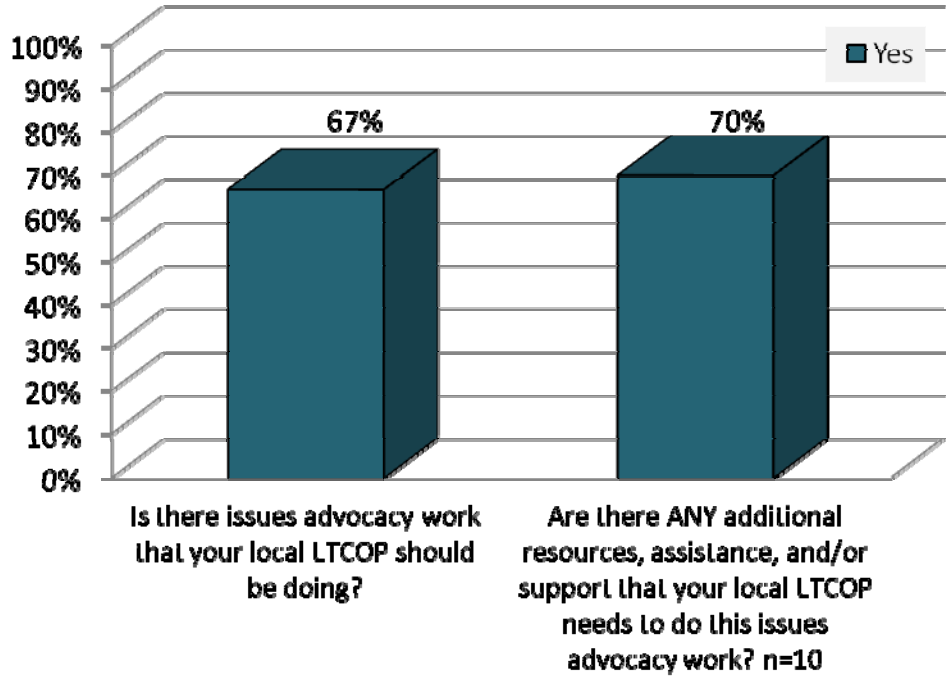
Figure 4.17: Self-Report of Local LTCOP's Involvement in Activities Related to Issues Advocacy Over the Past Year



Q. Please indcate whether your local LTCOP engages in any of the following types of issues advocacy?

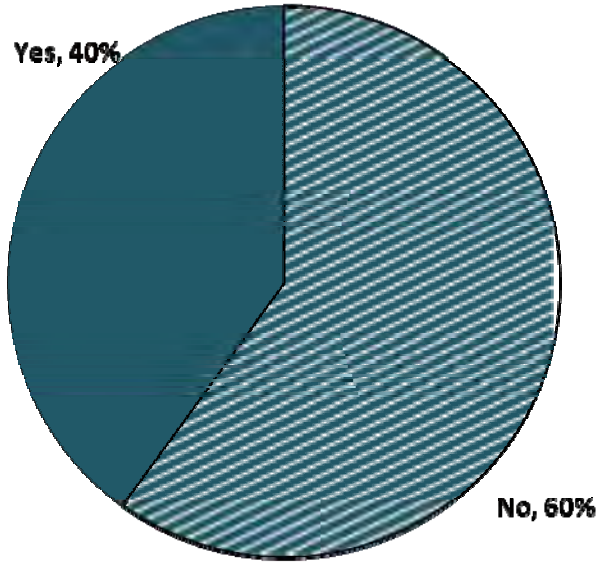
All coordinators report being involved in insuring and protecting residents' rights, working with other elements of the LTC system, addressing issues related to investigation of abuse and neglect, and communicating on behalf of LTCOP funding. Approximately one-third (35.7%) of coordinators report their LTCOP being involved in communicating on behalf of residents to the media.

Figure 4.18: Self-Report of Local LTCOP's Needed Issues Advocacy Work and Necessary Resources



Q. Is there issues advocacy work that your local LTCOP should be doing? Are there any additional resource, assistance, or support that your local LTCOP needs to do this additional issues advocacy work?
Two thirds (66.7%) of coordinators agreed that there was issues advocacy work that their program should be doing. Of those that said yes (n=10), 70% reported needing additional resources, assistance and/ or support to conduct this issues advocacy work.

Figure 4.19: Self-Report of Local LTCOP's Obstacles or Resistance to Conducting Issues Advocacy



Q. Has your local LTCOP encountered any obstacles or resistance to conducting issues advocacy?
Only 40% of coordinators report encountering obstacles or resistance to conducting issues advocacy.

SPECIAL ISSUE DOMAINS 4 SYSTEMS/ISSUES ADVOCACY

Local LTCOP coordinators were asked what resources or assistance/support were crucial in their LTCOP's ability to conduct issues advocacy efforts…

Working with CoAge and the Georgia Council on Aging. Support of the state ombudsman, and host agency, and CoCO's leadership in selecting issues, and the work they did with residents, families and legislators.

Our state office is tremendous. They keep us informed on all of the issues and on the progress of each one as the legislative session is in progress. The council on aging and NCCNHR also provides us with a lot of information. We have a network of people who keep us apprised of what is going on and we work very hard to call our legislators to tell them to support certain issues that are affecting the lives of our residents.

Local LTCOP coordinators were asked, what obstacles or resistance their LTCOP encountered in conducting issues advocacy…

Funding. We have so much to do, when you do work on an issue, you are rushing, you know it is important, but you have to go out and investigate complaints and make visits.

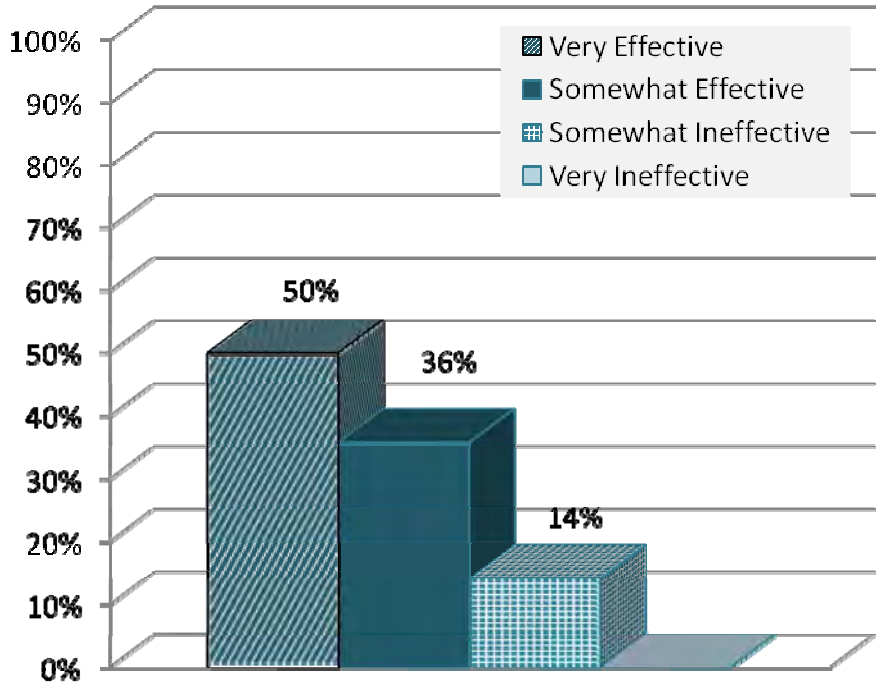
That comes from legal services. You can't lobby, you can't talk to the media without approval. In some ways it doesn't make sense.

Local LTCOP coordinators were asked what issues advocacy work should their LTCOP be doing? Are there any additional resources or assistance / support that they need to do this issues advocacy work…

When things come up with the legislators, we as ombudsmen should be in there to beat the drum for our residents. There needs to be autonomy from legal services agencies…. The state ombudsman does support us, I am not sure she can do any more. What possibly could they do at the state level. Support, I feel that our program is a good program and should be in a legal services setting…. If legal services were more loosy-goosy, the program would be able to advocate.

Bringing together a human services team in our area, including law enforcement, banks, attorneys, prosecutors for crimes committed against elders. Where we can talk about abuse and financial exploitation…. We need AAA and APS on the team, they could help us with the elder rights coordinator. Maybe get the team off the ground as far as contacts in the different agencies we want involved. The elder rights coordinator could help us pull it together.

Figure 4.20: Self-Rated Effectiveness of Local LTCOPs in Addressing Resident Needs Related to "Short-Term," Post-Acute, Rehabilitative, and Convalescent Care (PARCC) Services



Q. How would you rate the effectiveness of your local LTCOP in addressing PARCC resident needs?

Half of the coordinator's reported that their LTCOP was very effective in addressing resident needs related to "short-term," post-acute, rehabilitative, and convalescent care services (PARCC).

Local LTCOP coordinators were asked to describe any particular challenges or problems that their LTCOP has encountered in working with PARCC residents related to their needs…

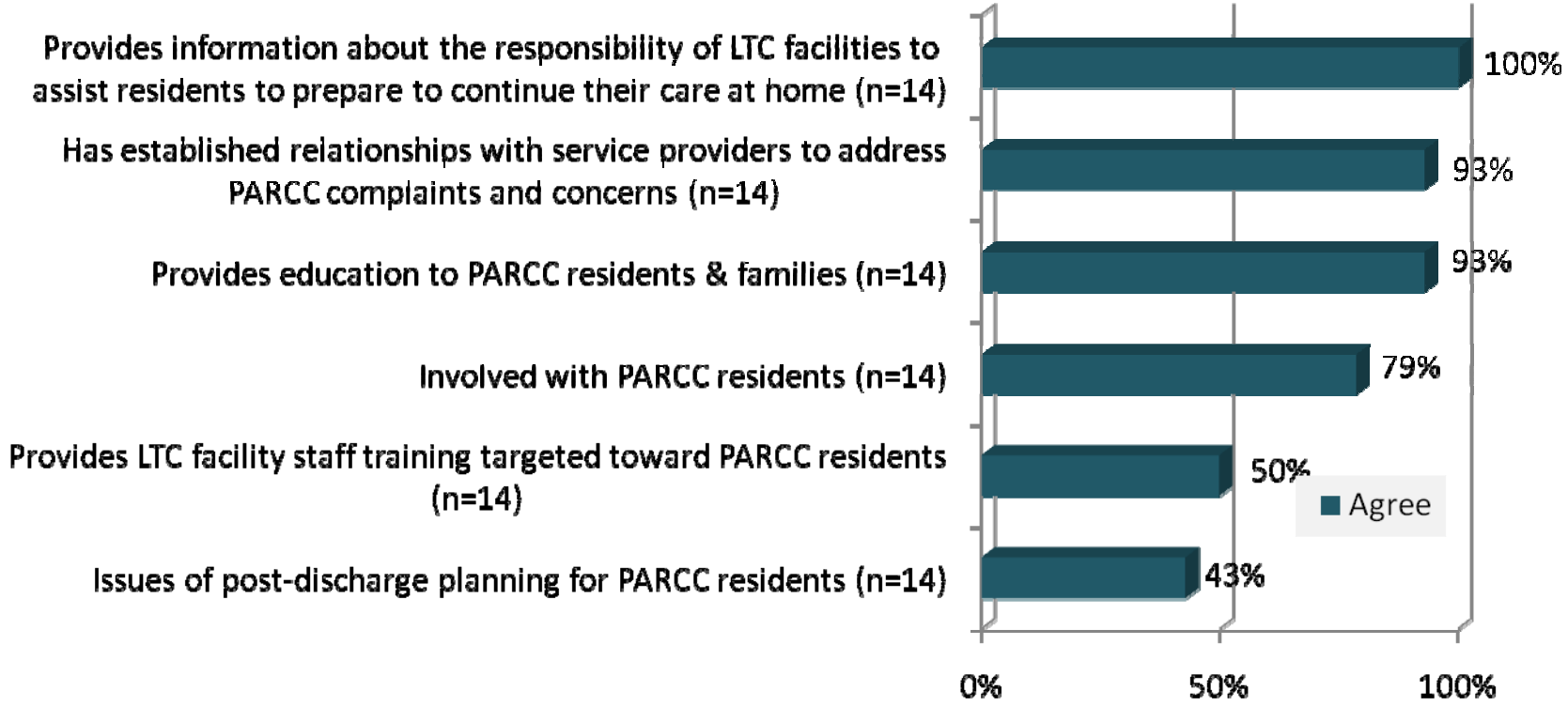
The issues that come up are therapy issues, discharge records and medication issues, and problems with home health.

What we have found is that before, when they are coming out of the hospital and going into PARCC, they are not often given the information that it is short term stay and you can stay longer if you needed to. It's an education piece.

Residents who exhaust coverage for Medicare rehabilitation are converted to Medicaid. They are afraid of estate recovery and Medicaid related issues. They are returned to the facility due to decline and lack of services at home. Also issues with those people who are short term and are converted to long term.

We don't have time to see everyone when visiting. We don't always know who is in rehab, and most time is spent resolving complaints. Sometimes the problems are that they are not getting therapy, we advocated that no matter how old you are, you deserve therapy.

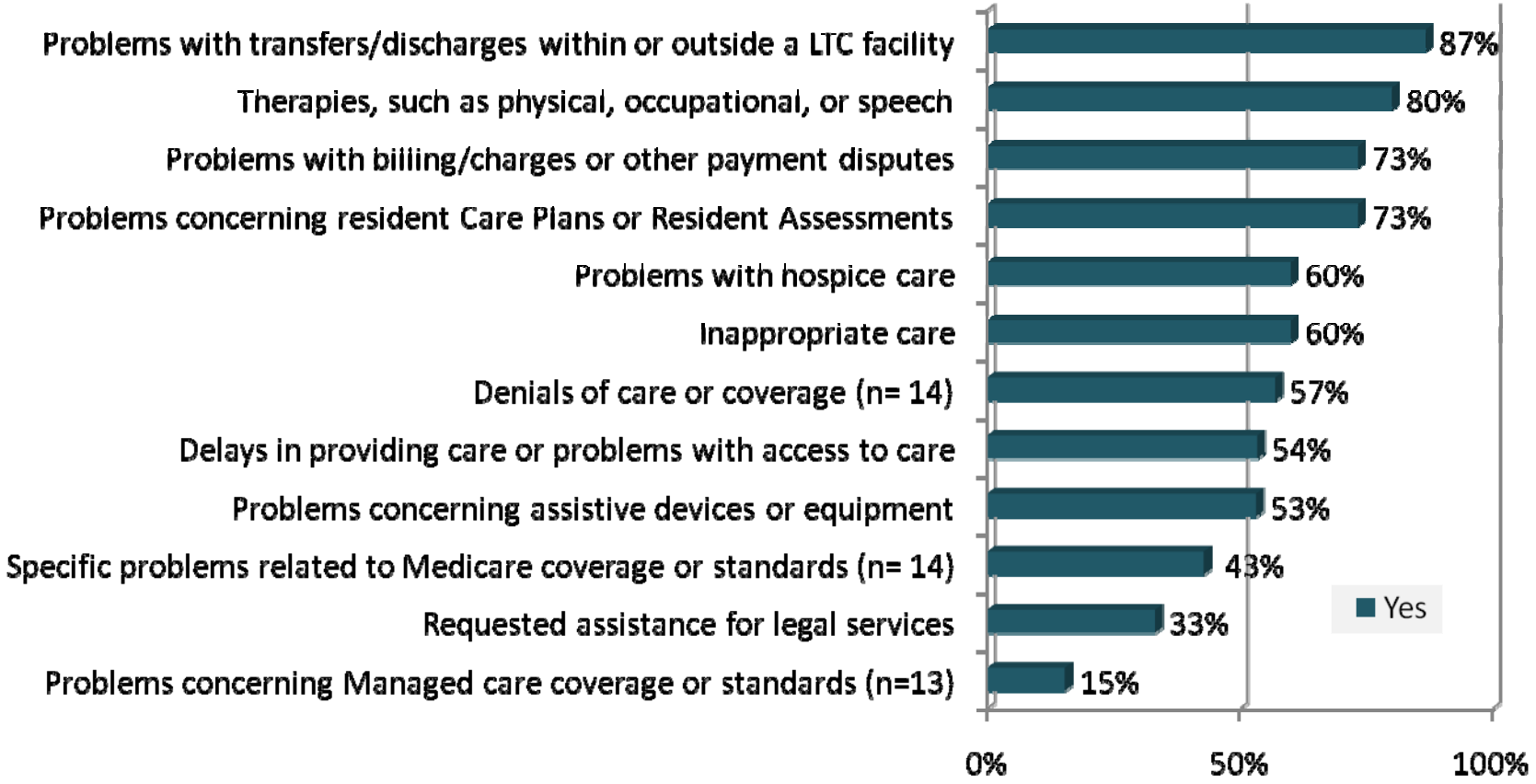
Figure 4.21: Extent to Which Characteristics/Activities of Local LTCOPs Apply to Post-Acute, Rehabilitative, and Convalescent Care (PARCC) Services



Q. To what extent do you agree that your local LTCOP is involved in the following activities related to PARCC residents and their needs?

All coordinators report being involved in providing information about the responsibility of LTC facilities to assist residents to prepare to continue their care at home (100%, n=14). To a lesser extent, coordinators report their LTCOP being involved in issues of post-discharge planning for PARCC residents (42.9%) and provides LTC facility staff training targeted toward PARCC residents (50%). 79% of local LTCOPs report being regularly involved with PARCC residents.

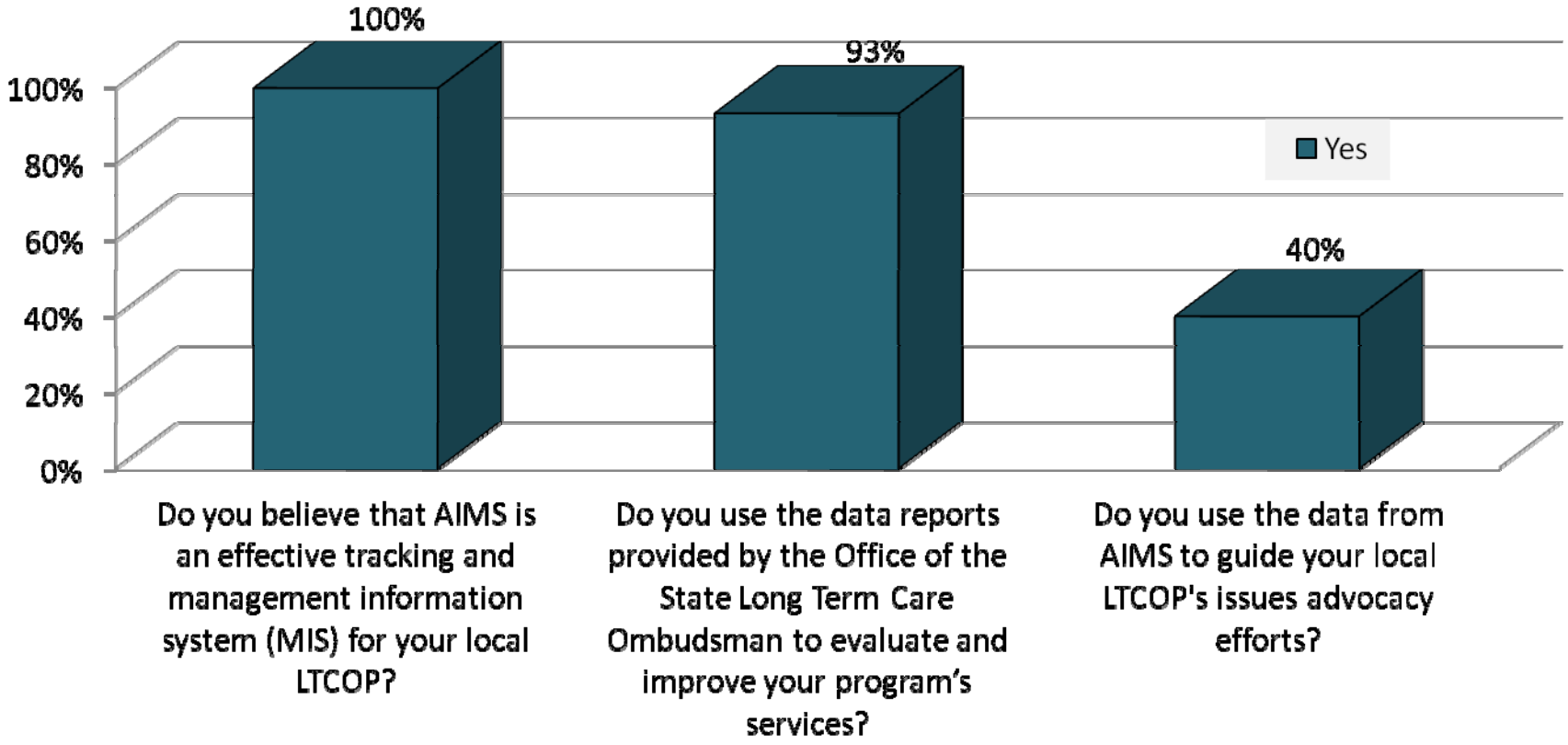
Figure 4.22: Self-Report of Local LTCOP Involvement in Issues Related to Post-Acute, Rehabilitative, and Convalescent Care (PARCC) Services in the Past Year



Q. Over the past year, have issues related to PARCC service for residents addressed by your local LTCOP involved _____?

Most coordinators reported experiencing problems with transfers / discharges within or outside of a LTC facility (86.7%) and therapies, such as physical, occupational, or speech (80%)

Figure 4.23: Self-Report of Local LTCOP's Use of AIMS Data



Q. Do you believe that AIMS is an effective tracking and management information system (MIS) for your local LTCOP? Do you use data reports provided by the OSLTCO to evaluate and improve your program's services? Do you use the data from AIMS to guide your local LTCOP's issues advocacy efforts?

All of the coordinators support the AIMS system as an effective MIS system. 93.3 % of the coordinators report using the state AIMS reports, and 40% report using AIMS data to guide their issues advocacy efforts.

Local LTCOP coordinators were asked if they believe that AIMS is or is not an effective tracking and management information system (MIS) for their LTCOP…

It enables coordinators to note, track, check progress. Which components have been completed and what we need to do.

It has been helpful in tracking our routine visits when I do monitoring of our program, to track the number of visits to facilities, facilities we've seen, types of complaints, community education, in-service, advocacy, and we can track the numbers on all of those to see if we've met our program components or not.

I hate to say this, it seems like we get monitored quite a lot. I think the AIMS tracking is good, but I think there is an overemphasis on monitoring how our program is doing.

The one we get from the state office, it shows a comparison of our program with the other programs in the state. We can see how we rate and compare to other programs.

As much as I hate data, it is effective because it gives us the numbers we need to use to advocate with the legislature, complaints, resolutions, etc. It keeps some of the people who weren't doing what they were supposed to do on track.

Local LTCOP coordinators were asked to describe how they use the data from AIMS to guide their issues advocacy efforts…

It helps with systems advocacy. It also helps when I am giving presentations on elder abuse, I can bring up the number of complaints I have had, the categories of abuse. It is very helpful. I use them too when I am doing reports for the surveyors when they are going into facilities, I give them the kind of complaints I have been having.

We use the numbers. In AIMS it doesn't really address the types of advocacy issues. If you were looking for an advocacy issue, you could look at the number of abuse cases, types of complaints that you get and see what issues stand out, to advocate for if you have a high number of abuse or financial exploitation, then it could help you in that way.

INFORMED RESPONDENTS 5

Overview:

This chapter presents information from the informed respondent survey. In-depth open-ended and semi-structured telephone interviews were conducted with a purposive sample of six key informants in Georgia. Protocols for the informed respondent interviews were similar to those of the LTCOP coordinator survey.

Informed respondents include representatives from ombudsman programs/associations, state units on aging, area agencies on aging, legal services organizations and researchers/other experts [Figure 5.1]. All informed respondents rated Georgia local LTCOP's performance in complaint investigation and community education as "very effective" [Figure 5.3]. The majority rated the LTCOP as most effective in nursing home settings and least effective in CLAs [Figure 5.4]. While half perceived the number of paid staff in local programs to be adequate the large majority (84%) report that the number of volunteers is inadequate and that paid coordinators do not receive salaries commensurate with their duties (75%) [Figure 5.5]. Most (83%) of informed respondents rated the frequency of visits required of Georgia local LTCOPs as adequate in nursing homes and personal care homes [Figure 5.6]. Informed respondents also commented on the special issue domains including elder abuse, legal services and support, autonomy, cultural competency, end-of-life care, systems / issues advocacy, post-acute, rehabilitative and convalescent care (PARCC) and AIMS. Finally informed respondents had favorable ratings of the training provided to Georgia's local LTCOPs with the exception of areas involving investigating and resolving problems in ICF/MRs and CLAs [Figure 5.8].

INFORMED RESPONDENTS 5

List of Figures:

INFORMED RESPONDENTS 5

Mission:

Informed respondents were asked to describe what they considered to be the mission / main goal of the local LTCOP…

Visit long term care residents, help resolve problems they have, ensure good care and preservation of quality of life of residents.

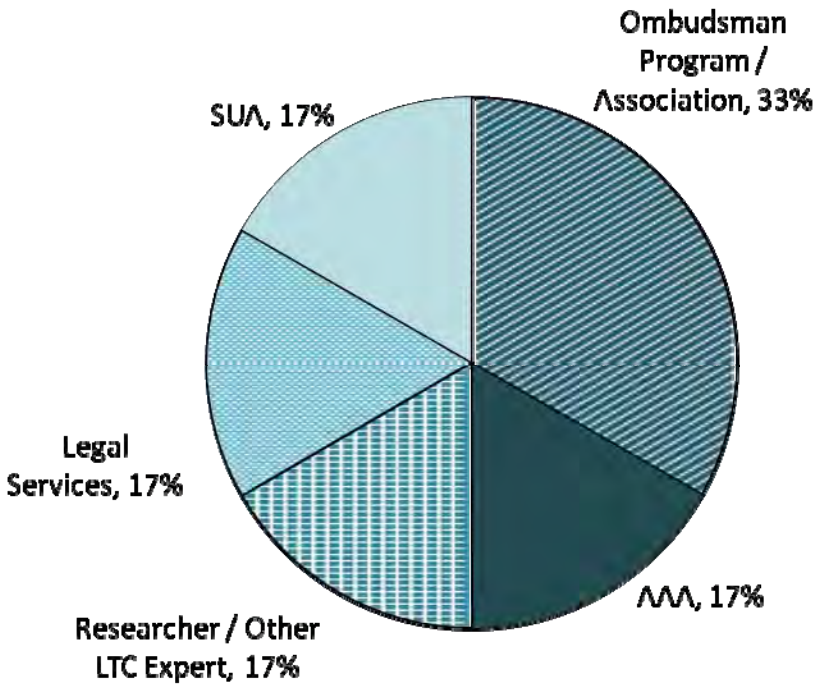
To be advocates for long term care residents in Georgia long term care facilities. To do complaint investigations and advocacy which goes beyond just legal issues…. To serve as information to family members and other advocates for long term care residents. To answer questions from the public and refer clients to legal services or to private attorneys if that is appropriate. They are part of a network of advocates for seniors and LTC residents.

They are the patient's representative. They visit nursing homes monthly, personal care homes quarterly, take complaints from clients, and help resolve issues.

They are advocates for persons in nursing homes and personal care homes, and community living arrangements.

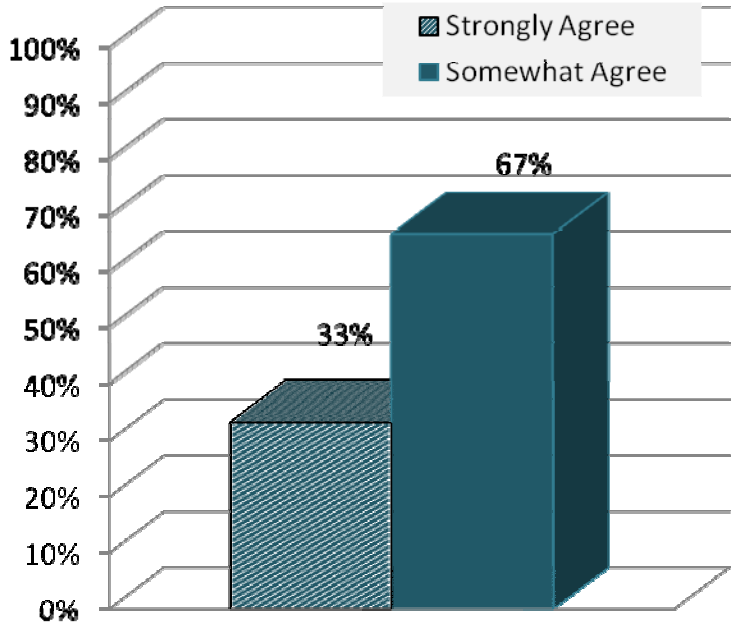
INFORMED RESPONDENTS 5

Figure 5.1: Informed Respondent Category



Respondents were selected both on their familiarity with the Georgia local LTCOPs, as well as their expertise in a particular area. Two of the informed respondents were from the Ombudsman Program / Association (33.3%). One of the informed respondents was a Researcher / Other LTC Expert, and the remaining respondents were representatives of Legal Services, the State Unit on Aging, and Area Agencies on Aging (16.7% each)

Figure 5.2: Extent to which Informed Respondents Perceived Themselves to be Knowledgeable about the Local LTCOPs in Georgia

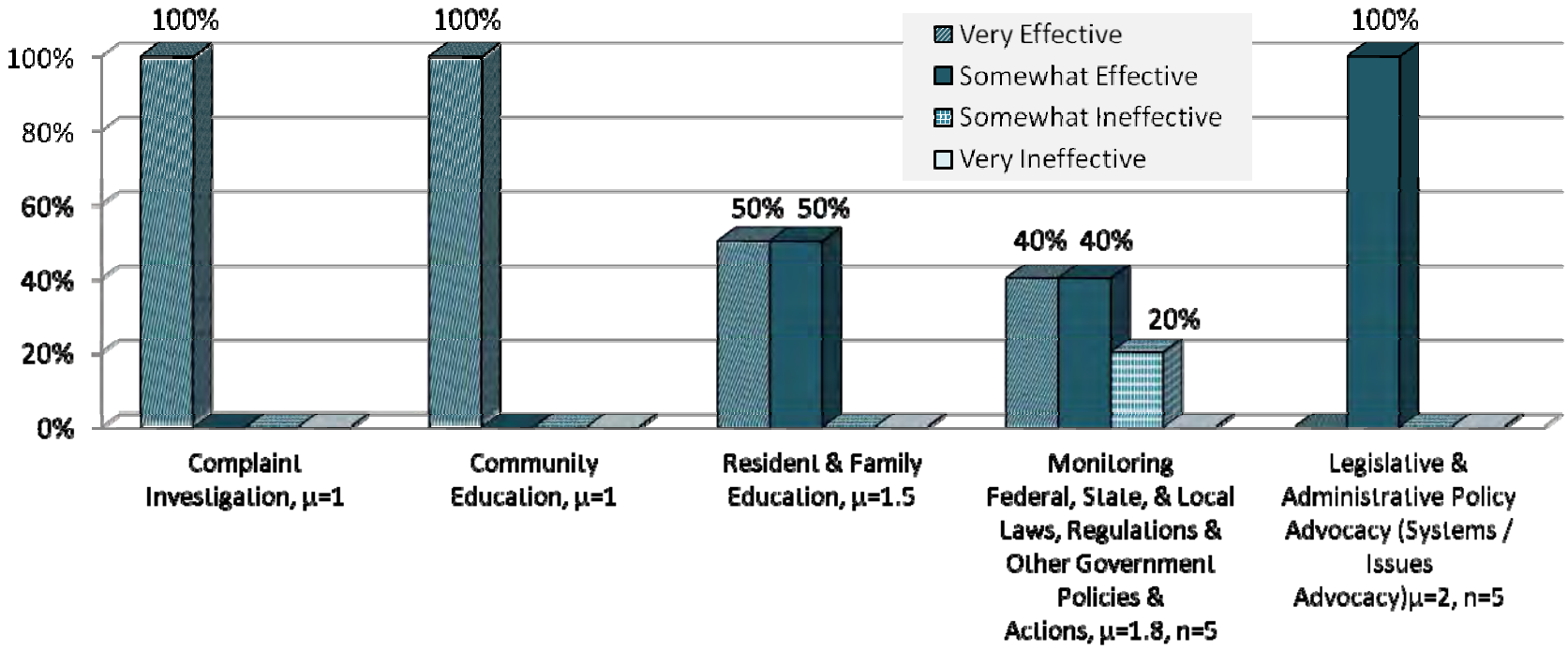


Q. To what extent do you agree with the following statement, In general, I am knowledgeable about Local LTCOPs in Georgia?

All informed respondents report being knowledgeable about local LTCOPs in Georgia (33.3%, Strongly Agree).

INFORMED RESPONDENTS 5

Figure 5.3: Effectiveness Ratings of the Local LTCOP in Meeting the Federally Mandates Requirements



Q. How would you rate the performance of Georgia Local LTCOPs in Meeting the following federally mandated requirements?

All informed respondents rated Georgia local LTCOP's performance in complaint investigation and community education as very effective. The slightly increased mean (μ) or average for the other mandates, indicates that more informed respondents rated Georgia local LTCOPs as less effective in meeting those mandates.

INFORMED RESPONDENTS 5

Informed respondents were asked how they would rate the performance of Georgia local LTCOPs in meeting federally mandated requirements…

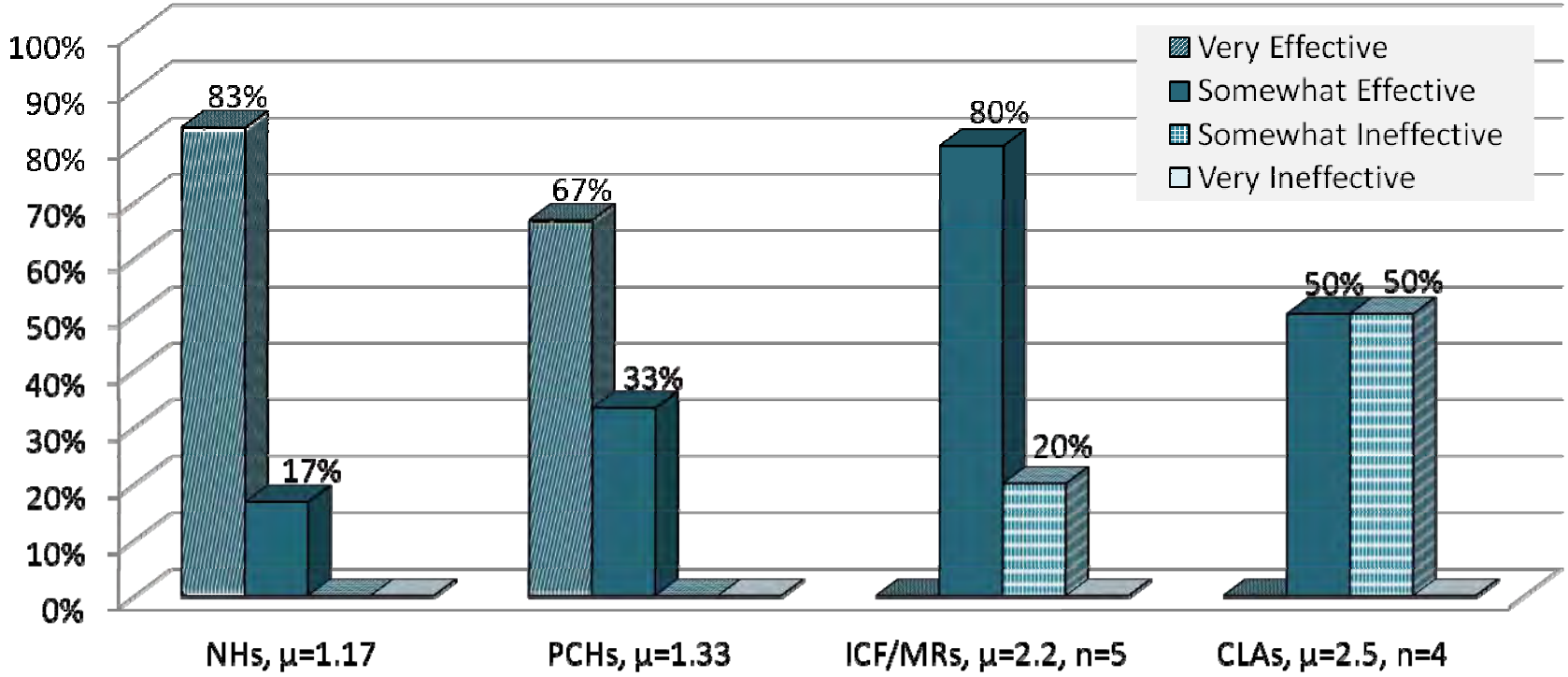
I think that there is inconsistency across the local programs in these areas…. There are two hurdles related to monitoring and advocacy. One being that some of our programs are housed with agencies that contract with the legal services corporation and the federal regulations of the legal services corporation limit some of the advocacy strategies that are permitted. The second issue is that some host agencies have policies that limit advocacy work, or advocacy strategies. Especially related to direct contact with legislators, grassroots lobbying meaning spreading the word about the issue and asking them to support it. Their ability to be effective in resident and family education is dependent on the ability of families to be involved or the fact that families are involved. It seems we have a low number in Georgia of family councils that are active and resident councils that are meaningful in problem solving as a result. I feel like our work with resident and family councils, if those existed and were strong across the state, they could be more effective.

I think with the family meetings and trainings in the homes, they are not as effective because it is not easy to get family members to come and they do not get much support from administrators in nursing homes. They are effective, but not outstanding across the board on monitoring laws and regulations. I don't think that they have enough time to do the advocacy. The state office does some, but not as effective as someone that does that full time.

I believe that LTCOPs know what their core services are, they have less time, energy and interest in monitoring policy and legislation. It varies on who their employer is with conducting policy advocacy. A majority of them are restricted by their employer.

INFORMED RESPONDENTS 5

Figure 5.4: Effectiveness of Local LTCOPs in Setting Served



Q. How would you rate your local LTCOP's performance with each of the following settings?

The majority of informed respondents rated local LTCOP's effectiveness in nursing homes (83.3%), and personal care homes (66.7%) as very effective. As shown by the increased mean (average, μ) for ICF/MRs and CLAs, slightly more informed respondents rated the local LTCOPs as only somewhat effective or somewhat ineffective in those settings.

INFORMED RESPONDENTS 5

Informed respondents were asked how they would rate the performance of Georgia local LTCOPs in each of the settings served…

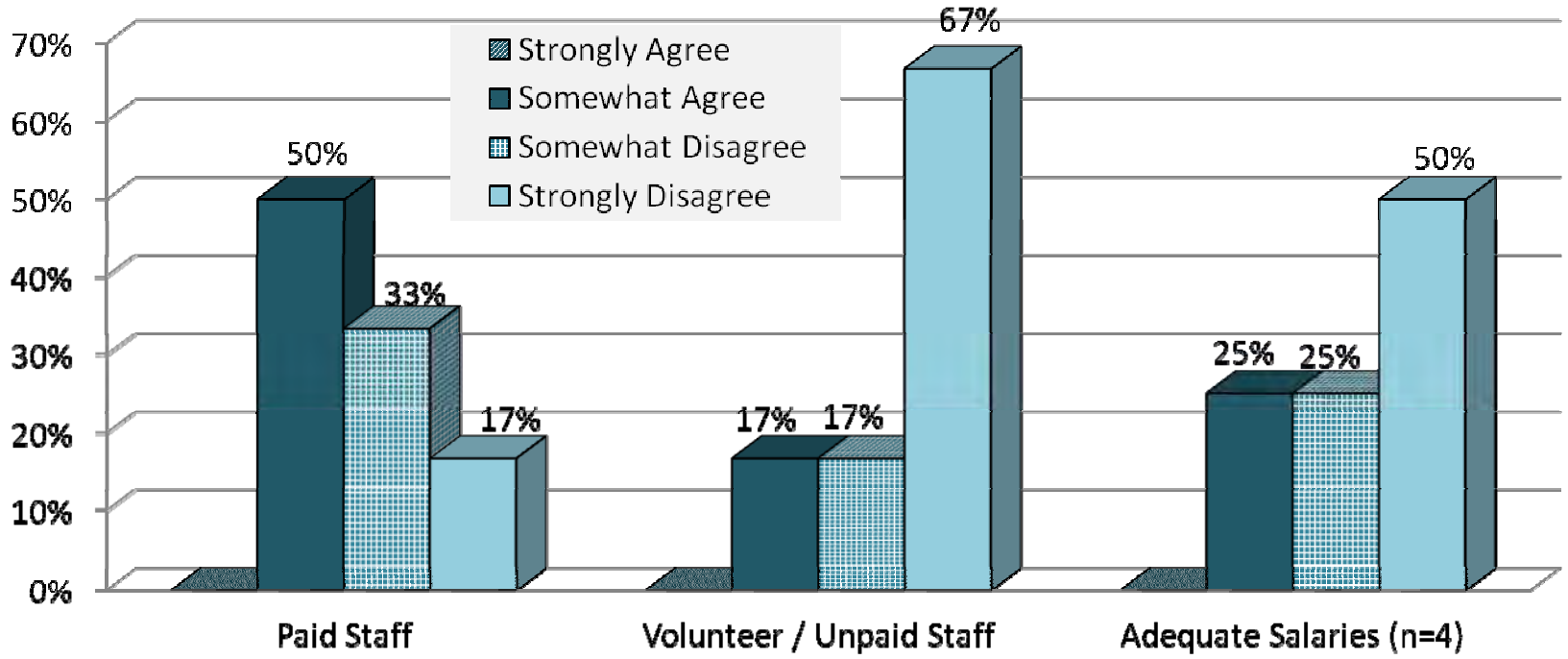
NHs and PCHs are older adult facilities and most ombudsmen are more familiar with that than ICF/MR, mental health residents. Most of those are run by agencies and it can be hard to get the agencies to interact with some people. Most ombudsmen in Georgia are not really trained to work with residents with mental retardation in Georgia.

The populations in ICF/MRs and CLAs tend to be residents who have very low functioning and very limited ability to communicate. The population is difficult to advocate for in the sense of them being able to tell the LTCOP what their issues are. An additional challenge in the ICF/MR setting is a safety issue. Ombudsmen often don't feel safe with the residents there. With CLAs, two additional challenges, some of the CLAs are not regulated by ORS, the state owned and run are not licensed and regulated by ORS. Local LTCOPs have had a very hard time learning about where they are and their current status of being open or closed. They are doing a very poor job of giving up information when the LTCOP requests it, as far as where they are and if they are open. The local LTCOPs have that all worked out with ORS, it is very easy for them to get information from ORS for all types of facilities, they can't get information on the state run facilities on a regular basis. The other issue in CLAs is frequently the residents attend day treatment programs and are gone during the regular business hours when the ombudsmen visit. Finding them and being able to work with the resident is often a challenge because they are not present in the facility during regular business hours.

With PCHs, some local LTCOPs have more PCHs, licensed and unlicensed, than they have ombudsmen to adequately cover them. A lot of the programs don't meet the required visits…. ICF/MRs and CLAs, they do fewer routine visits in those facilities…. They are cautious, unsure or untrained on how to work with people with mental health issues or mental retardation.

INFORMED RESPONDENTS 5

Figure 5.5: Extent to Which Informed Respondents Perceived that Georgia Local LTCOPs have Adequate Resources

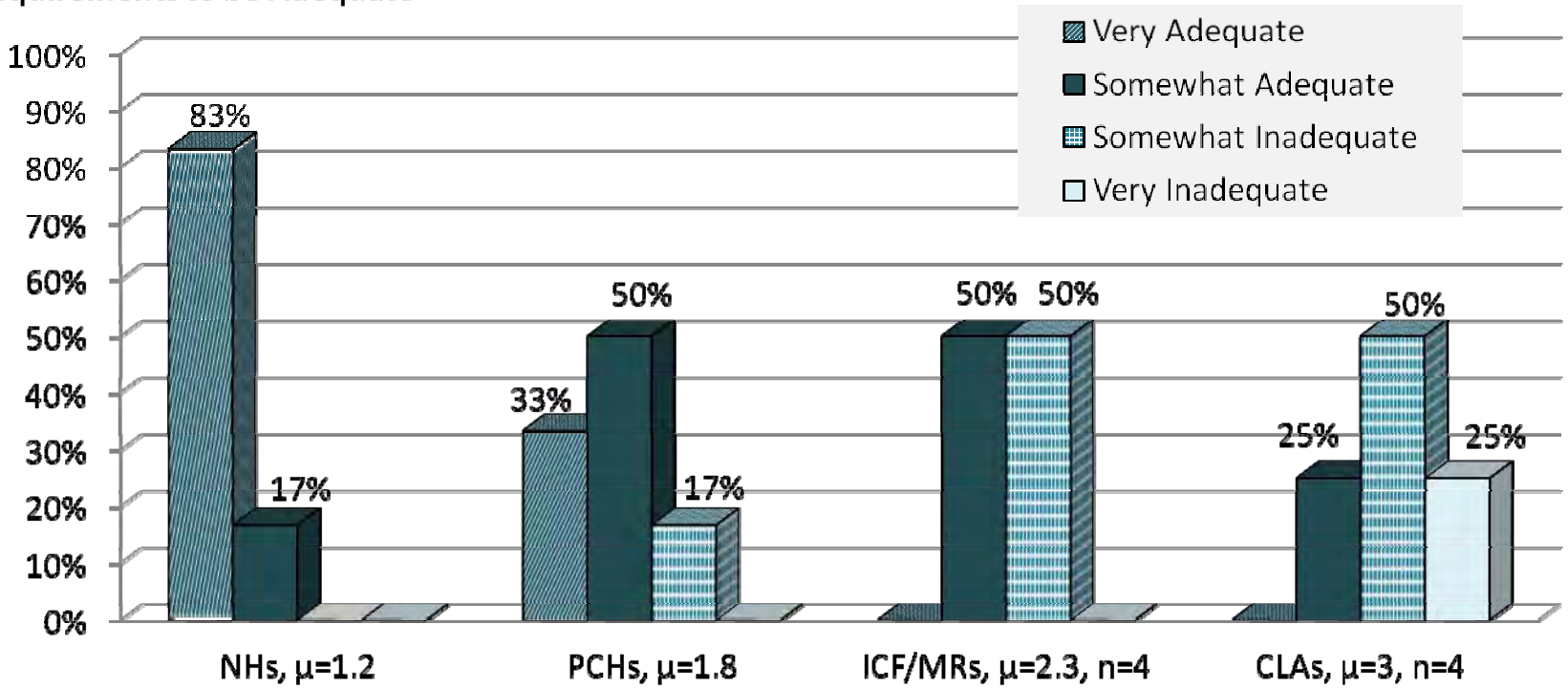


Q. To what extent do you agree with the statement, local LTCOPs in Georgia have a sufficient number of paid staff to carry-out their duties? Volunteer / unpaid staff? Adequate salaries for coordinators?

One-half of informed respondents perceived the number of paid staff in local LTCOPs to be adequate. A majority of informed respondents either somewhat or strongly disagree that Georgia local LTCOPs have an adequate number of volunteers / unpaid staff (83.4%) and that coordinators receive salaries commensurate with their duties (75%).

INFORMED RESPONDENTS 5

Figure 5.6: Extent to Which Informed Respondents Perceived the Georgia Local LTCOP Visitation Requirements to be Adequate

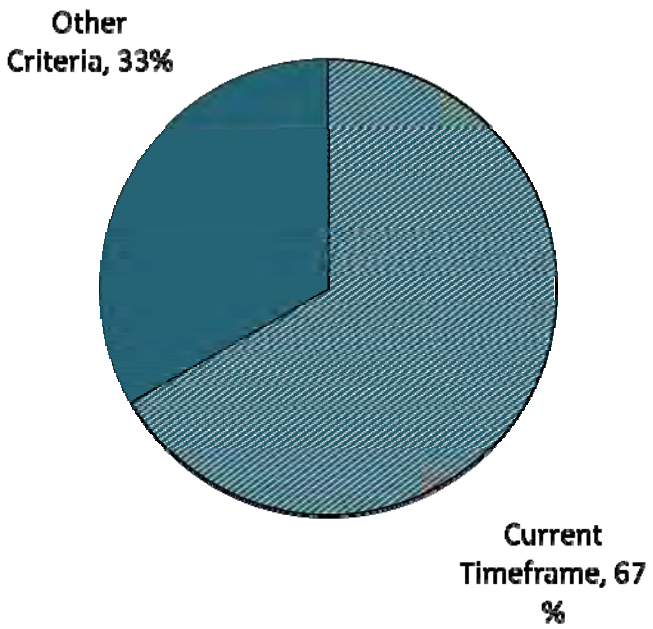


Q. Do you believe that the minimum routine visits required by the Georgia Office of the State LTCOP are adequate?

A majority of informed respondents rated the frequency of visits required of Georgia local LTCOPs as either somewhat or very adequate in nursing homes (100%), and personal care homes (83.3%). In comparison, key informants rated as either somewhat or very inadequate the visitation requirements in ICF/MRs (50%), and community living arrangements (25%).

INFORMED RESPONDENTS 5

Figure 5.7: Informed Respondents Reported Preference that Georgia Local LTCOP Visitation Requirements be Based on the Current Timeframe or Other Criteria Related to the Facilities Operation



Q. Do you believe the minimum standards for frequency of visits to facilities should be based on the current time frame or on other criteria related to the facility's operations?

67% of informed respondents believe the minimum standards for frequency of visits should be based on the current timeframe.

Informed respondents were asked to describe why they preferred that the minimum number of routine visits be based on the current timeframe or on other criteria…

There should be some minimum number of visits for all facilities, less stringent routine visit requirements plus using the common sense knowhow of the LTCOP. Look at which facilities have a poorer track record.

Criteria could come from ORS, or Medicaid with licensure, or Medicaid services.

I think that because you have some good places and some bad places, the LTCOPs around the state should be able to be involved in the routine visit planning more. They should be able to say with some authority that this facility could do with more than once a quarter. Some nursing homes could be every other month, or once a quarter. Some PCHs you may need to be there every month or every other month.

INFORMED RESPONDENTS 5

Special Issue Domains

Elder Abuse

Informed respondents were asked what they considered to be two key issues regarding investigations of suspected or alleged physical abuse, gross neglect, and financial exploitation…

The most commonly reported issues were:

•Lack of communication with other involved entities, including law enforcement, licensing and certification, legal services and facilities.

•Proving that abuse has occurred.

The challenge of getting law enforcement involved and getting prosecutions to happen. Also, the frustration level that ombudsmen have with ORS around this. There is a sense that they're not timely enough or thorough enough and the ombudsmen get frustrated about that.

Being able to prove that there has been abuse, that can be very difficult. Unless you've got a paper trail if it is financial, or the bruises can undeniably be linked to somebody.

They get very little support from the DA offices in Georgia to prosecute. Even when we they do uncover evidence of abuse, it is very difficult to get them to prosecute.

Legal Services and Support

Informed respondents were asked what they considered to be two key issues regarding legal services and support for local LTCOPs…

The most commonly reported issues were:

• Discharges from facilities

• Guardianship

Issues related to discharges from facilities…. Usually legal services is pretty helpful on those. Usually it is about the facility saying they haven't made the payment or not being able to meet their needs. It might be an excuse for saying, you're trouble and we want to get rid of you. They file the appeals and represent the clients which is great support, and I have learned from other states that they don't have that.

We have a real problem in the state, they need decision makers and don't have anybody. Our guardian of last resort, is only to serve people in the community. There is no one in the facility and that is a huge gap.

INFORMED RESPONDENTS 5

Special Issue Domains

Autonomy

Informed respondents were asked whether they perceived Local LTCOPs in Georgia to have the program autonomy to carry out their federally mandated responsibilities…

Varies by local programs, the ones housed in legal services have some restrictions because they get federal money. Some of the other programs have restrictions, probably related to conflict over funding sources and so on.

The program as a whole would have more autonomy if they weren't in the DAS. Being within an agency provides the benefits of the resources of a larger organization. They outweigh the costs of the limited restrictions that they experience. There are other states where there is a lot more control over program autonomy than in Georgia.

Cultural Competency

Informed respondents were asked what they considered to be two key issues regarding cultural competency...

The most commonly reported issues were:

•Racism between resident, ombudsman and facility staff.

•Language Barriers

•Mental ability of residents in ICF/MRs and CLAs

Racial issues are still huge in many parts of Georgia and there are times when a white ombudsman serving an African American residents and visa versa can create barriers to our ability to serve the resident and communicate effectively with staff.

Mental ability. How to deal with people with mental impairments of some sort.

INFORMED RESPONDENTS 5

Special Issue Domains

End-of-Life Care

Informed respondents were asked what they considered to be two key issues regarding end-of-life care…

The most commonly reported issues were:

•Advanced directives, resident wishes

•Hospice care

•Pain management

Getting facilities to honor residents' advanced directives, or power of attorney, or health care power of attorney, getting the facility and hospitals to honor it.

The right to remain in a facility at the end of life, and receive hospice services. The LTCOP is involved in trying to sort out what the residents wishes are and their rights to stay or leave and how they want to deal with end of life. The education of residents, staff, and others about hospice. Both community education and advocacy on their important roles. I think training for the LTCOP about end of life and their involvement in training residents, providing information and possibly making referrals to legal providers if necessary.

Systems / Issues Advocacy

Informed respondents were asked what they considered to be two key issues relating to issues systems /advocacy…

The most commonly reported issues were:

•Olmstead Act
•Staffing ratios
•MH/MR Ombudsman
•Lack of autonomy to engage in Systems / Issues advocacy.

The legislation approved for the mental health ombudsman, but they didn't give us any money. You have a more competent ombudsman, that can address issues with the MH/MR community.

Staffing is a big issue. The NCCNHR set some standards for ratios, hours that each resident gets from a staff person and that is just about the only thing that they haven't been able to succeed with to get that regulation.

I think to the extent that they can be used to advocate for alternative community based funding, alternatives to LTC placement or resources related to the community based vs. institutional placements.

INFORMED RESPONDENTS 5

Special Issue Domains

PARCC

Informed respondents were asked what they considered to be two key issues regarding serving residents in the area of post-acute, rehabilitative and convalescent care (PARCC)…

The most commonly reported issues were:

•Transfer and discharge issues, including denials of coverage.

•Knowledge of LTCOP

Financial issues, things they deal with are what's being covered, who's covering it and helping people sort that out. Discharge, what happens after 30 days, where do they go from there both in terms of financing and care?

They are present for such a short time they often don't learn about our services before they're gone.

AIMS

Informed respondents were asked in what ways have local LTCOPs in Georgia utilized technology and data management (AIMS) to improve program effectiveness…

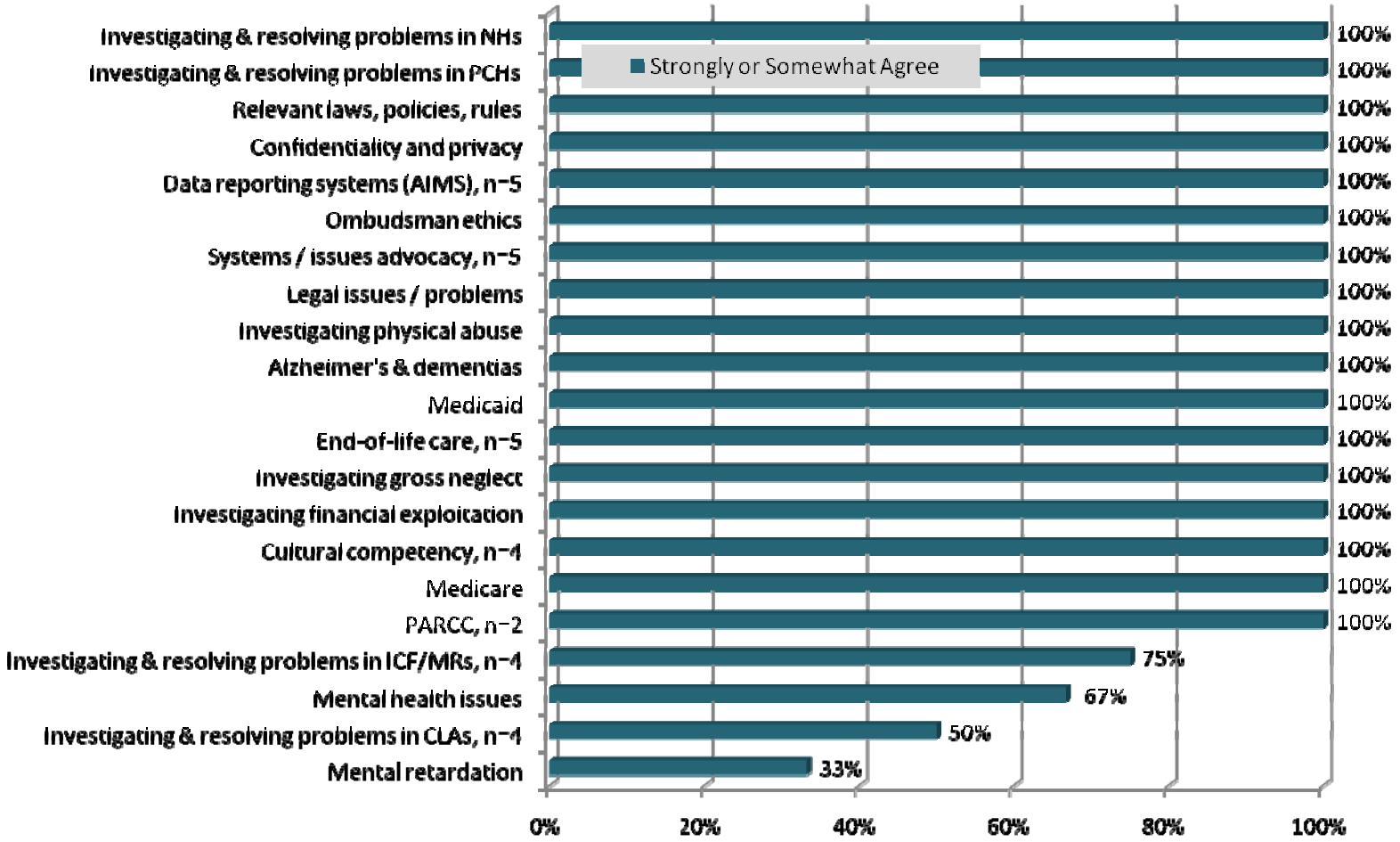
They need more help training new people or going over the training for AIMS. Most ombudsmen would like to have someone in the office to do data entry to free them up…. They know that to better the program they need statistics.

They use it to track what they do, keep up with the type and number of complaints they handle and all other aspects of program work. Tracking and reporting to the state office so that they can plan what they need to do better.

They've used it a lot. They are increasingly using it and understanding how to use it as a tool.

INFORMED RESPONDENTS 5

Figure 5.8: Percentage of Satisfactory Ratings for Training Provided in Specific Content Areas for local LTCOPs



Q. To what extent do you agree that Local LTCOPs in Georgia are adequately trained in these areas.

Informed respondents had favorable ratings of the training of Georgia local LTCOP's in most areas. The areas that received the lowest percentage of satisfactory ratings include, mental retardation (33.3%), investigating and resolving complaints in CLAs (50%), and mental health (66.7%), and investigating and resolving complaints in ICF/MRs (75%).

RECOMMENDATIONS 6

Overview:

The *Pathways to Effectiveness: Georgia Local Long Term Care Ombudsman Summit* was held on November 7-8, 2007 in Peachtree City, Georgia. Focusing on critical topic areas related to the performance of local long term care ombudsman programs (LTCOPs), the meeting was highlighted by in-depth discussions and ratification of key recommendations aimed at enhancing the local ombudsman program performance. The summit was a 1½ day convening, sponsored by the Institute for Health and Aging at the University of California, San Francisco, in conjunction with the Georgia Office of the State LTC Ombudsman (OSLTCO) Annual Conference. The summit produced a comprehensive set of recommendations and priorities to enhance the performance of local LTCOPs in Georgia.

The summit was organized around three topic areas - Elder Abuse and Inter-Organizational Relationships, Use of Volunteers, and Program Standards - based largely on survey input from local ombudsmen, and discussions with Council of Community Ombudsman (CoCO) representatives and the OSLTCO.

The format of the summit activities involved an introductory session followed by a series of topic area sessions intended to promote group discussion of major issues and propose recommendations to enhance the performance of local LTCOPs in these areas. Topic area sessions were followed by workgroup meetings charged with the responsibility of synthesizing and summarizing information into a single set of recommendations related to the topic area. The culmination of the summit was the plenary session involving brief presentations of recommendations drafted by each workgroup. Four recommendations were selected via vote as the key priorities in the closing session. Following this vote, attendees identified specific action steps to guide implementation of each recommendation.

The four recommendations selected as the key priorities are presented herein along with the action steps discussed by local ombudsmen participants.

RECOMMENDATIONS 6

1. Re-examine Requirement for LTC ombudsmen to visit CLAs *(36 votes)*. **Consider**

a) Role of LTCO
b) Appropriateness for LTCO
c) Skills
d) Potential outcome for resident
e) Resource allocation
f) Other agency roles already serving population

Stakeholders:	Strategies:	Leadership:
• CLA residents and families • Residents in other facilities • CLA providers • Community service boards • Regional boards • Law enforcement • MH & DD advocates • State and local ombudsmen • MHDDAD	• OSLTCO to get feedback from local LTCOPs • Workgroup of related agencies/stakeholders • Evaluate effectiveness of local LTCOP in CLAs • Use other states as examples • Survey CLA providers • Regional feedback from CLA residents, providers, families • Revisit entry into CLAs	• Atlanta program • Penny Medhurst • Kathy Jones • Angela Chavous • OSLTCO

Timeframe: 6 months to gather information and develop a position statement

RECOMMENDATIONS 6

2. Change Required Visit Standards *(35 votes)*

a) Once every 6 months for MR

b) Flexibility with PCH based on resident population and facility history or track record

c) Consider nursing home standards, based on few complaints, problems

Stakeholders:	Strategies:	Leadership:
• Residents • Families • Facilities • State and local ombudsmen • ORS • Subcontractors • CCSP/Source • MHDDAD	•Look at results/data from before standards •Use chartbook data •Get resident council feedback •Compare to other state strategies and effectiveness (chartbooks for CA and NY LTCOP projects) •Conversation about quality of visits vs. quantity •Trade-offs, consequences •Increased funding for visits •Other criteria to determine standards	•OSLTCO •Susan Ragan •Mary Woody-Montford •Frances Guice •Rosa Malone •Robin Miller •Atlanta program (to be determined)

Timeframe: January 2008

RECOMMENDATIONS 6

3. Issues Advocacy on Elder Abuse and Inter-organizational Relationships *(34 votes)*

a) Advocate for resources for a mental health ombudsman
b) Define and strengthen rules and regs in PCHs, CLAs and ICF/MRs
c) Accountability of facilities (sanctions, penalties)
d) Change in ORS requirements to validate complaints
e) Increased training of facility administration and staff on MH/DD
f) Advocate with other stakeholders and agencies

Stakeholders:	Strategies:	Leadership:
•MH, DD, AD residents • Residents in other facilities (seniors) •Governor's Taskforce •State and local ombudsmen •MH Association (Ellyn Jeager) •Department of HR and DCH •Facilities, state hospitals •Law enforcement, Emergency response •ADRC	•Investigate Governor's Taskforce, volunteer, follow progress, be involved •Push as Co-Age advocacy issue •Legislative investigations and advocacy (History) •NAMI collaboration •Grassroots efforts (op-eds, letter writing, etc) •CoCO multidisciplinary meeting •Media outreach at the local level •Information to local LTCOPs about taskforce •Outreach to AAAs •Post information on website about progress	•Jeff Taylor •Diane Brookings •Phyllis Sadler •Marcia Bond •Nancy Hill •OSLTCO

Timeframe: Start November 2007

RECOMMENDATIONS 6

4. Strengthen Volunteer Component *(30 votes)*

a) On the state level, fund volunteer coordinator to recruit, train, do background checks

b) On the local/regional level fund volunteer coordinator to recruit, train and retain

   i. Maximize individual skills of volunteers

   ii. Recognize different levels of experience

   iii. Develop new programs

   iv. Strengthen existing programs.

Stakeholders:	Strategies:	Leadership:
•Residents •Families •State and local ombudsmen (including volunteers) •Subcontractors •AAAs	•Proposal •Feedback from local LTCOPs •Regional/volunteer coordinator, knowledge of local needs and better accessibility •Local (decentralized) certification (clarify how to decentralize) •Look to other states for examples, look at other agencies' strategies	•Renee Sanders •Rachel Hilliard •Vicky Seitman •Anne Hanson (NEGA AAA staff) •Angela Chavous •OSLTCO

Timeframe: 6- 8 months, give progress report at Spring Summit

APPENDIX 7

OSCAR Data

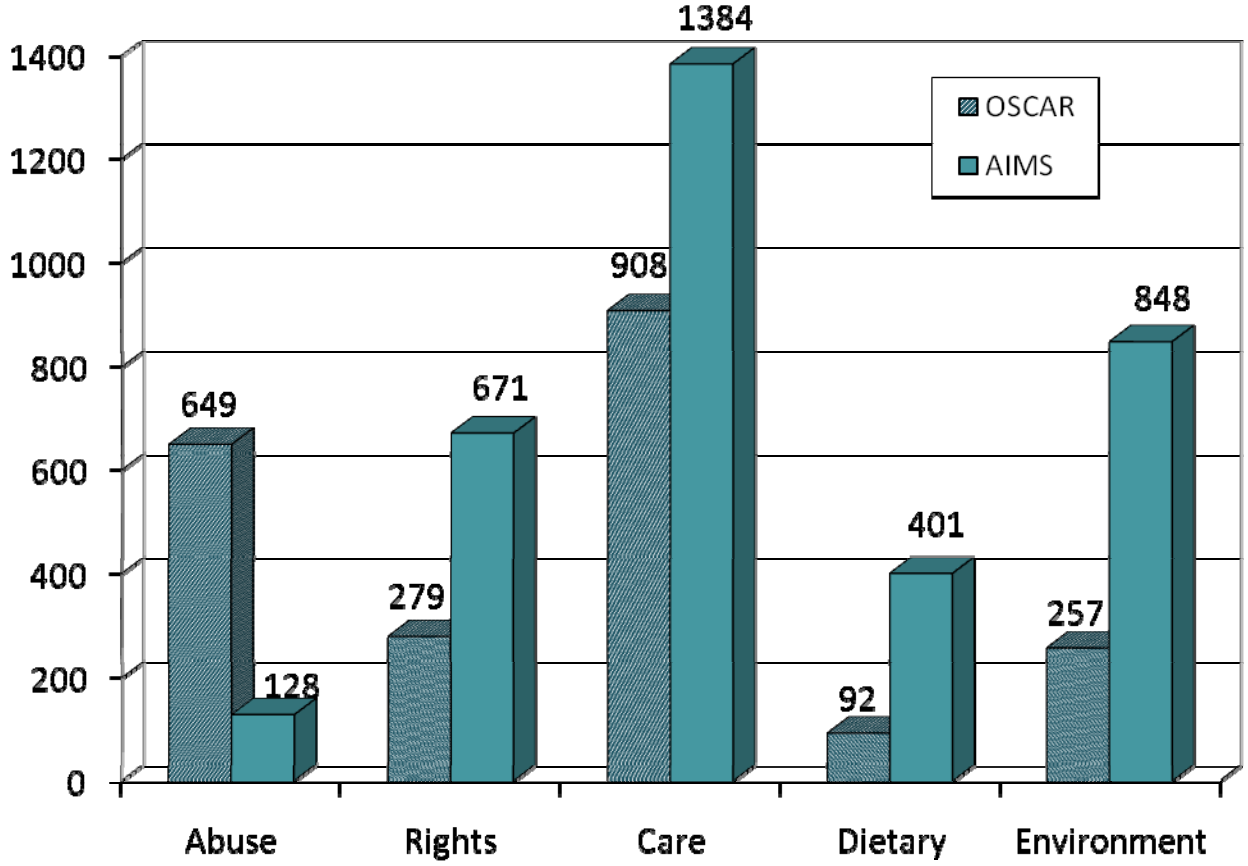
The Online Survey, Certification and Reporting system (OSCAR) is a uniform database maintained by the Centers for Medicare and Medicaid Services (CMS) which contains data from inspection surveys of skilled nursing facilities. These inspections are conducted by each state's licensing department for the purpose of certifying participation in the Medicare and Medicaid programs. They occur at least every 15 months or when a complaint is being investigated. This chartbook uses OSCAR complaint data received during the AIMS data collection period, October 2005 through September 2006. These are specific complaints made to the state licensing agency by residents, family members, employees, members of the community or the ombudsmen themselves.

We display the OSCAR complaint data alongside data from the AIMS. While it is not possible to draw a direct parallel between these two data sources, it is useful to view them together as they represent different angles of vision on the same issues surrounding the quality of life of residents of nursing homes.

There are multiple reasons why AIMS and OSCAR data cannot be directly compared. To begin, the data in each system is gathered in different ways. AIMS data are based on resident or family member complaints to long term care ombudsmen while OSCAR data are based on formal complaints filed with the licensing agency. Residents of LTC facilities, and to some extent their families, are more likely to have access to ombudsmen than licensing agencies. Furthermore, the informal and formal power differentials between residents and staff, as well as the resident's potential fear of reprisal, are likely to influence the avenue through which complaints are lodged.

APPENDIX 7

We present the complaints in each of the five most common complaint categories in AIMS or OSCAR: 1) care, 2) environment, 3) rights, 4) dietary, and 5) abuse. It is important to note that these AIMS and OSCAR categories are similar but not identical to each other. The OSCAR data include separate categories for Care, Environment, Rights, and Dietary complaints but the Abuse and Neglect complaints are combined to facilitate comparison with the AIMS Abuse/Neglect category.



APPENDIX 7

Overall, there is about 1.5 times as many AIMS complaints as OSCAR complaints recorded (3,432 vs. 2,185) for the time period October 2005 through September 2006. The exception to this pattern is for abuse/neglect complaints in which the ratio is reversed: there is about five times the number of OSCAR complaints of abuse / neglect as AIMS complaints. Since Georgia local ombudsmen refer residents to address allegations of abuse, we would expect that more abuse complaints would be recorded in OSCAR than AIMS. The Office of Regulatory Services is the agency charged with receiving and investigating reports from mandated reporters under Georgia's Long-Term Care Abuse Reporting Act.

Since representing the rights of residents is a key element of the mandate for the local LTCOP, it is not surprising that resident rights complaints would be more frequently reported in AIMS than OSCAR.

One potential reason for care complaints to be more frequently reported in AIMS than OSCAR is that residents (and their families) may be expected to feel more comfortable approaching an individual ombudsman confidentially during a facility visit than a formal official from the licensing agency for these types of complaints. In part, this might be motivated by residents' fear of retaliation and/or the recognition of the position of lesser power in which residents find themselves in relation to facility staff. Additionally, residents might have greater access to ombudsmen than licensing officials due to the frequency with which each visits facilities.

Inter-Organizational Relationships:
LTCOPs & Elder Abuse *Pathways to Effectiveness*

November 2007 **Georgia Local Long Term Care Ombudsman Summit**

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Introduction & Overview

This briefing paper provides selected information related to the topic of elder abuse, including: research findings drawn from Georgia local Long Term Care Ombudsman Program (LTCOP) coordinators and other informed respondents, "major issues and concerns" for local LTCOPs, discussion questions, and relevant on-line resources.

The data speak to the importance of collaboration between local LTCOPs and Adult Protective Services (APS), law enforcement, the Office of Regulatory Services (ORS) and legal services agencies (ELAP and Atlanta Legal Aid).

The paper presents issues related to elder abuse and inter-organizational relationships to help facilitate discussion for local LTCOP's about pathways to effectiveness in order to better serve the needs of residents in LTC facilities.

[Our biggest challenge with addressing elder abuse is] "Trying to keep in contact with other agencies, keep a list of agencies and build relationships with those agencies."
Georgia Local LTCOP Coordinator

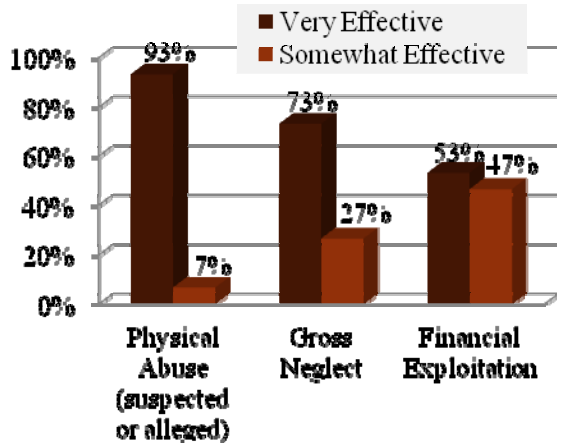
Discussion of Research Findings

Quantitative Findings

In general, Georgia's local LTCOP coordinators report that their programs are effective in addressing complaints and concerns related to elder abuse, including: physical abuse, gross neglect, and financial exploitation. Coordinators rated their programs as most effective in handling complaints and concerns related to physical abuse (93.3%, very effective), followed by gross neglect (73.3%), and financial exploitation (53.3%) [Figure 1].

Figures 2-4 display dimensions significantly correlated with self-reported effectiveness in handling complaints and concerns related to elder abuse. The associations presented in the figures are positive, that is, "better" training is associated with "higher" effectiveness. It is important to note the reported relationships are correlational, it is not possible to determine whether one factor is

Figure 1: Self-Rated Effectiveness of Local LTCOPs in Addressing Complaints and Concerns Related to Elder Abuse



"In long term care facilities, it is hard unless you have a witness. Most residents are afraid to complain, and be identified. With gross neglect, it is something where you have to keep going back, or move the person out. With financial exploitation, it is difficult, sometimes you don't have all the facts. Nursing homes wait until the family owes $30k before they do anything and they want to discharge the resident. It is hard to convince them not to take it out on the resident."
Georgia Local LTCOP Coordinator

Acknowledgements

This project was funded by the Georgia Department of Human Resources (DHR) Division of Aging Services (DAS).

We would like to thank the Georgia Council of Community Ombudsmen (CoCO), the Georgia Office of the State Long-Term Care Ombudsman, and project consultant for all of their contributions to the research project including the summit and briefing papers.

Finally, we wish to thank the Georgia local LTC ombudmen coordinators and the informed respondents who shared their experiences and knowledge throughout this project.

'causing' another. Two factors are uniformly associated with self-rated effectiveness across all types of elder abuse: 1) education about elder abuse for residents and families, facility staff, community entities, and communities; and 2) LTCOP training on investigating and resolving complaints related to abuse and neglect, and financial exploitation. Coordinator's reported effectiveness in addressing gross neglect is statistically related to the length of time in coordinator position, and having established relationships with elder abuse agencies. The higher a coordinator rates their LTCOP's effectiveness in addressing financial exploitation, the more likely they are to report having established relationships with elder abuse agencies; receiving legal assistance from a private attorney (non-ELAP), having more than 4 FTE paid staff, and being able to (a) perform routine visits to nursing homes; (b) monitor federal, state, and local laws, regulations, government policies and actions; (c) perform legislative and administrative policy advocacy; (d) perform volunteer recruitment; and (e) perform volunteer training and supervision. The more likely a coordinator is to report that their LTCOP is affected by high staff turnover (paid or volunteer/unpaid staff), the lower they rate their LTCOP's effectiveness in addressing financial exploitation. The higher a coordinator's budget, the more likely they are to report that their LTCOP is very effective in addressing financial exploitation.

"We provide the elder abuse awareness training for all law enforcement. We are in partnership with them in our area. We are a team and we come together through our SALT council to discuss abuse and neglect."
Georgia Local LTCOP Coordinator

Figure 2: Factors Related to Perceived Effectiveness in Addressing Physical Abuse

Figure 3: Factors Related to Perceived Effectiveness in Addressing Gross Neglect

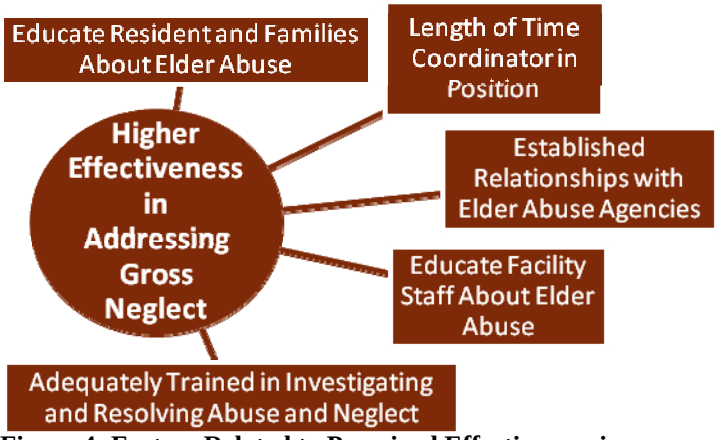


Figure 4: Factors Related to Perceived Effectiveness in Addressing Financial Exploitation

Tables 2-4: All associations are based on Spearman Rank Order Correlations > .40, and with a significance of p < .1

The majority of ombudsman coordinators report that they either "somewhat agree" or "strongly agree" that they have positive working relationships with ORS (93.3%) and ELAP (93.3%) [Figure 5]. Relationships with APS (80%), and law enforcement (71.4%, n=14), had the lowest ratings among LTCOP coordinators.

Qualitative Findings

Coordinator's perceptions of their working relationships with ORS, ELAP, APS, and law enforcement varied.

ORS:

"We work well with them and provide valuable information to them and they respond very quickly and very timely."

"ORS doesn't always substantiate and cite complaints that we refer to them. They make it where they have to see something themselves in order to cite an issue. There is a problem with them enforcing the facilities."

ELAP:

"Part of it has to do with the fact that I have been here for 13 and a half years, and I do know all of the attorneys, We do get together, we used to do a quarterly meeting, just to sit down and talk about things. We don't get to do it that much anymore because of the workload that they carry… We do the referrals to them and they come back to the ombudsman program if they need more information. We have a really good working relationship with them and I think that has to do with that the managing attorney and supervising attorney have a high regard for the ombudsman program. We do good in our area, you probably won't hear that from all the other areas."

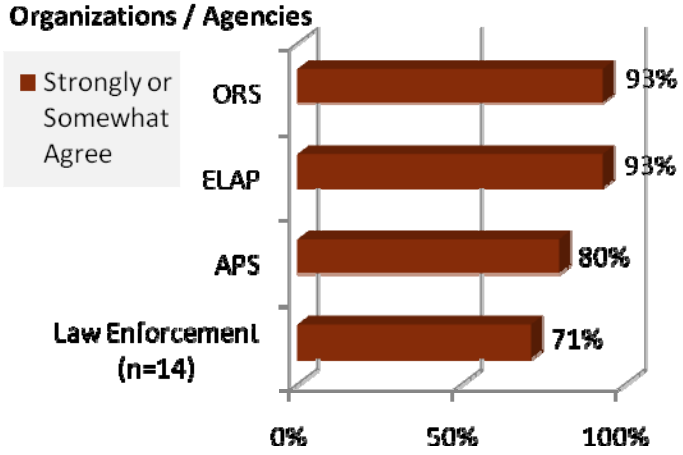
"They don't take cases, they're slow…. They did a good job helping people establish Miller Trusts. All other interactions were poor."

APS:

"They used to be housed with DFCS, and you could call them directly and get help quicker. Now, since they are in the DAS… we thought it would help. To me, you can't call the APS worker anymore. You have to call the complaint number. I would say 50% of the time, they have gone home. I have to keep calling or figure out how to take care of the complaint myself… We don't have time to keep calling. The LTCOP especially should be able to work directly with APS without having to go through the complaint line. We were put in the pot like everybody else, and we're not like everybody else."

"APS workers serve on our committee which gives us a chance to explore and exchange work and ideas together on issues to resolve those issues. They have their own office, they have satellite offices and one of them is located here in town, two of them serve on our committee."

Figure 5: Extent to Which local LTCOP Coordinators Perceive a Positive Relationship with Other Organizations / Agencies



[Our biggest challenge with addressing elder abuse is] "Other agencies response or lack thereof. Sometimes it just means they don't know what they're doing, it's not necessarily negative. Particularly when it comes to law enforcement, they want to do it right, but they just don't know what to do."

Georgia Local LTCOP Coordinator

Law Enforcement:

"We provide the elder abuse awareness training for all law enforcement. We are in partnership with them in our area. We are a team and we come together through our SALT council to discuss abuse and neglect."

"We set up multi-disciplinary task forces, it is hard to get them involved and to come to meetings."

"We cover many counties, all of those counties have a sheriff's department. In those counties there are many small cities with police departments and they are just not familiar with the ombudsman program until we have direct contact with them. They don't really understand the ombudsman program. Some of our bigger counties are like that… we come in contact with them for case work or SALT councils and community educations, but none of them really know what the ombudsman program is. This is part of our FY 2008 goals, to identify all of the players and take them a packet of information."

"The challenge of getting law enforcement involved and getting prosecutions to happen. Also, the frustration level that ombudsmen have with ORS around this. There is a sense that they're not timely enough or thorough enough and the ombudsmen get frustrated about that."

Georgia Informed Respondent

Major Issues & Concerns

A number of significant issues and concerns were raised relating to local LTCOP effectiveness in the area of elder abuse and inter-organizational relationships, some of which include:

- Shortage of Resources in all agencies - overextended and underfunded
- Education of Law Enforcement – Recognizing elder abuse, taking responsibility for residents in facilities, investigating and prosecuting
- Responsiveness of ORS – Timeliness, thoroughness, validating LTCOPs abuse referrals
- APS – Availability, responsiveness
- Legal Service – Uneven ELAP and Atlanta Legal Aid resources for LTCOPs throughout the state
- Unregulated and unlicensed personal care homes
- Different regulating agencies in ICF/MRs and CLAs require expanded relationships and LTCOP knowledge of other systems

Informed Respondents

Informed respondents were asked to identify two issues Georgia LTCOPs encounter in addressing elder abuse. We list some of their responses below:

- All agencies are overextended and underfunded
- Lack of communication with other involved entities, including law enforcement, licensing and certification, legal services and facilities
- Proving that abuse has occurred
- Discharges from facilities
- Guardianship issues, availability of guardians

Discussion Questions

- What does effectiveness in meeting the Elder Abuse mandates look like for local LTCOPs?
- What specific short- and/or long- term goals can be identified to enhance the effectiveness of local LTCOPs in the area of elder abuse? Identify specific steps you would implement to monitor progress toward achieving these goals. Are any of these goals low cost to local LTCOPs? What goals (and/or steps) are achievable at the local program level (i.e.: without OSLTCO direction or assistance)?
- What specific resources are necessary to enhance the effectiveness (for example, specific computer software, training, materials) of local LTCOPs in the area of elder abuse?
- What types of assistance from and/or coordination with other organizations or agencies is necessary to achieve these goals?
- How can local LTCOPs help enhance their working relationships with other organizations or agencies in order to encourage more effective elder abuse prevention, identification, investigation, and prosecution?
- What is needed of other organizations or agencies to enhance the local LTCOPs effectiveness in serving residents? How can local LTCOPs help other organizations or agencies better serve residents?

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Atlanta Legal Aid
http://www.atlantalegalaid.org/elderabuse.htm

National Citizen's Coalition for Nursing Home Reform
http://www.nccnhr.org/public/50_156_450.cfm

Use of Volunteers

Pathways to Effectiveness

November 2007

Georgia Local Long Term Care Ombudsman Summit

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Introduction & Overview

This briefing paper provides information on the use of volunteers and the ability of Georgia's local long term care ombudsman programs (LTCOPs) to fulfill their mandates. The paper presents findings from the IHA/UCSF project *Enhancing the Performance of Local LTC Ombudsman Programs in Georgia* which are designed to stimulate discussion about issues of the use and roles of volunteers as well as volunteer recruitment and retention. Also, the paper is intended to aid discussion in developing best practices and models to improve the effectiveness of local LTCOPs regarding the use of volunteers. Because the use of volunteers is closely linked to adequate resources, it is also important to examine program resources and whether the use of volunteers is the best expenditure of those resources.

According to the 2006 OSLTCO annual report *Ombudsman Long Term Care Residents' Advocate*, in FY 2006 Georgia local programs had 115 volunteers including seven (7) certified volunteers (who, like staff, may investigate and work to resolve complaints on behalf of residents), 41 volunteer visitors (who visit residents in coordination with the local program but are not authorized to handle complaints) and 67 volunteers who perform other services/functions to benefit the program. A recent consultation report *Increasing Ombudsman Accessibility to LTC Residents* (Adams, Burden, Dow, Harris, Klein, and Miller, 2007) conducted by a team of graduate students at the University of Georgia for the OSLTCO details that the 48 certified and volunteer visitors are located in 50% of the local programs. Atlanta's LTCOP, the only local program in the state with a paid volunteer coordinator, has 12 volunteer visitors and 6 of the 7 certified volunteers in the state. One key recommended intervention in the consultation report that motivates this summit is:

> To hold "a meeting at the annual conference as an open forum for program coordinators to discuss how they are using volunteers within their program. This will help other program coordinators be aware of the possibilities and foster creativity. Finally, the OSLTCO should clarify their commitment to volunteers within the ombudsman

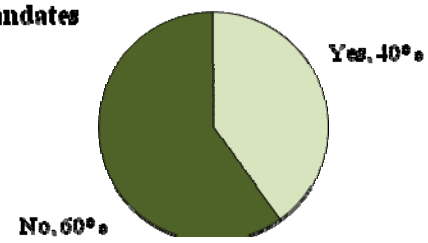
Discussion of Research Findings

The IHA/UCSF research project includes primary data collection via a telephone survey of 15 local ombudsmen coordinators and six informed respondents in Georgia as well as secondary data from AIMS and OSCAR.

Quantitative Data

The majority (60%) of Georgia's local LTCOP coordinators report that their

Figure 1: Percent of Local LTCOP Coordinators Reporting Sufficient Funding to Carry Out Program Mandates



Acknowledgements

This project was funded by the Georgia Department of Human Resources (DHR) Division of Aging Services (DAS).

We would like to thank the Georgia Council of Community Ombudsmen (CoCO), the Georgia Office of the State Long-Term Care Ombudsman, and our project consultant for all of their contributions to the research project including the summit and briefing papers.

Finally, we wish to thank the Georgia local LTC ombudsman coordinators and the informed respondents who shared their experiences and knowledge throughout this project.

programs lack a sufficient amount funding to carry out their mandates [Figure 1]. Many coordinators report that their programs are unable to conduct volunteer recruitment (47%) and volunteer training and supervision (40%) due to lack of resources [Figure 2]. Informed respondents report that the two key factors negatively influencing the performance of local LTCOPs in Georgia are (1) inadequate resources (funding and staffing) and (2) "a culture that is not supportive of volunteers."

> ***"We have historically focused on having professionally trained staff to run our programs. We have put a lot of time into training and having hired staff in our program. The flip side of that that is negative is that as a result, we have done a poor job of creating a culture that supports volunteers, and that volunteer piece of it has limited our availability to residents. We haven't developed a strong volunteer component."***
>
> **Georgia Informed Respondent**
>
> ***"We have not been proactive about recruiting and training volunteers."***
>
> **Georgia Informed Respondent**

While 60% of coordinators report that their program has a sufficient number of paid staff, only 40% report the same for unpaid/volunteer staff [Figure 3]. One-half of the informed respondents perceive the number of paid staff in Georgia's local LTCOPs to be adequate, while 83% report that the number of unpaid/volunteer staff is inadequate [Figure 4]. According to AIMS FY 2006 data, Georgia's local LTCOPs are staffed by an average of 2.8 volunteer staff per FTE paid staff [Figure 5].

Qualitative Data

Program coordinators were asked to describe the place they believe that volunteers have in their local LTCOP. Coordinators spoke about the various roles of volunteers who are not certified in their programs including friendly visiting (making routine visits), community education, outreach, and office activities. Coordinators have conflicting views about whether their program would benefit from having certified volunteers to investigate complaints versus the additional resources to hire additional paid staff to do this work. Some voice their objection to using volunteers.

> *"I feel that if you had paid workers who were certified, then you may not need as many volunteers. If you had more certified volunteers, you won't need more workers."*

Figure 2: Self-Reported LTCOP Activities Neglected or Partially Carried Out Because of Lack of Resources

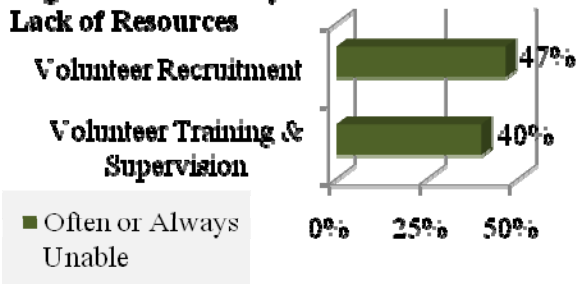


Figure 3: Percent of Local LTCOP Coordinators Reporting Sufficient Numbers of Paid Staff and Volunteer Staff

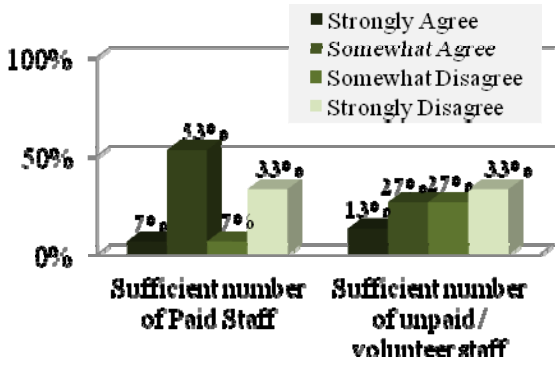


Figure 4: Percent of Informed Respondents Reporting Georgia Local LTCOPS Have Sufficient Resources

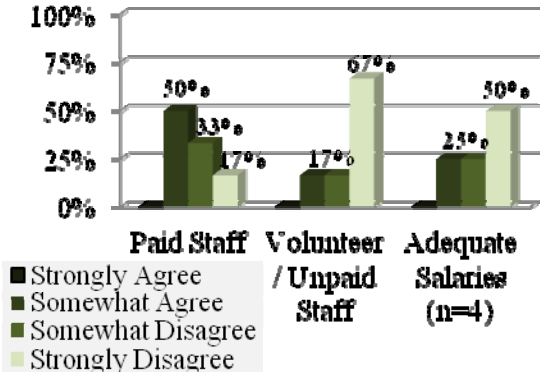
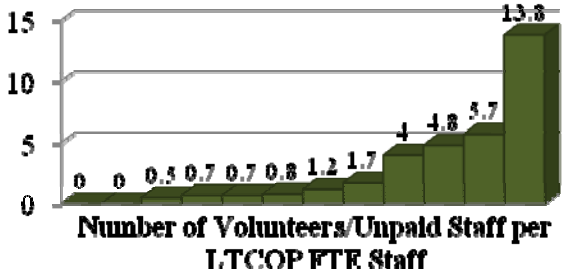


Figure 5: Ratio of Volunteers / Unpaid Staff to Full-Time Equivalent Staff (AIMS FY2006)



"Their role is limited unless there are/ we need paid staff to support them. What we have found is that volunteers as a rule require a little more time to train, recruit, and get out than they produce for the program."

"The one thing this program needs is additional funding, the majority of us believe that dealing with volunteers is not the answer to all problems."

"My truest feelings, I really don't feel that volunteers have a place."

Some coordinators highlighted the importance volunteer visitors could and do have for their programs:

"They would be an extra set of eyes and ears in facilities. They would help us because a lot of residents don't have any visitors."

"My volunteer visitor goes into nursing homes every week, visits for three hours at a time, gets to know all the residents really well, and is invaluable to me as far as what is going on in that facility. If there is a red flag, she sees it. She sees things I wouldn't because I am in there only once a month."

"They're very helpful in making routine visits and providing a presence in the facilities. They free up the paid staff to handle complaints..."

Coordinators were asked to talk about any successful practices their local LTCOP uses to improve volunteer recruitment and/or retention.

Successful practices for recruitment include:

- Advertising on a local cable TV channel
- Word of mouth (volunteers recruiting each other)
- Working closely with colleges (community service placements and internships)
- Looking for people who know something about nursing homes

Successful practices for retention include:

- Close/regular contact/good communication with volunteers (via calls/emails, lunches)
- Staff accompanying volunteers on visits; giving them a lot of autonomy in visits
- Praise and emphasizing recognition (via yearly ceremony, luncheons)
- Offering ongoing training

Coordinators were asked to comment on any barriers or difficulties their local LTCOP encountered in recruiting and/or retaining volunteers.

Barriers or difficulties in recruitment include:

- Lack of/limited resources (staff time, no volunteer coordinator)
- No benefits to offer (reimbursement for time, mileage)
- Retired professionals don't want to spend their time going into nursing homes
- Many potential volunteers are looking for paid work

"We are required to take them through an interview process, just like when you are hiring somebody. Training is very involved even for a volunteer visitor. To try to get someone certified, most people are not looking for this much of a commitment. It is hard to find someone who wants to put that much time and energy into it. There is always a fear that you are going to get a loose cannon and have to deal with that."
Georgia Local LTCOP Coordinator

Barriers or difficulties in retention include:

- Professionalism of volunteers (not usually reliable/consistent, not easily regulated, not dedicated, lose interest)
- No mileage reimbursement; large distances to travel in some areas
- Students graduate and move on; move out of the area; routine turnover

"We just have too much to do, there's no time to recruit or to train them. It's a Catch-22, well if you had volunteers you wouldn't have much to do because they could do some of it."
Georgia Local LTCOP Coordinator

"It would be nice to have a volunteer sometimes, but it would have to be a good one for me because if they're not doing things right it just creates more work for me. If I have to do it anyways it's not worth it."
Georgia Local LTCOP Coordinator

Coordinators were asked to describe any additional resources or assistance/support that their local LTCOP needs in order to improve recruiting and/or retaining volunteers. Many spoke of needing additional funding to support one FTE or at least a part-time employee who would be strictly dedicated to recruiting, training, supervising, and retaining volunteers. Coordinators also mentioned the need for mileage reimbursement for volunteer travel as well as the important role of the state office in supporting volunteers.

"I think it would be great if the state were to have a volunteer coordinator that could do recruitment for all of our programs."

"We have a good volunteer manual from the state that was developed. It carries you through recruitment and training and so many things and they can even be certified at the state level and go through the certification training with the state staff. There are adequate resources to do that."

"We feel that the state ombudsman should be doing more PR work, they ought to be doing more hands on training for new ombudsman. They should be advocating for a higher standard mileage reimbursement for staff and volunteers. The state ombudsman program should be aware that worker's compensation insurance may not cover ombudsmen."
Georgia Local LTCOP Coordinators

Discussion Questions

What does effectiveness look like for local LTCOPs in terms of the use of volunteers?

What specific short-term/long-term goals can be identified to enhance the effectiveness of local LTCOPs in the use of volunteers? Identify specific steps you would implement to monitor progress toward achieving such goals? Are any short-term/long-term goals low cost to local LTCOPs? What goals (and/or steps) are achievable at the local program level (i.e. without OSLTCO direction or assistance)?

Related Literature

Volunteers have long been central to local LTCOPs and the work they do in LTC facilities. The use of volunteers in local LTCOPs is both a blessing and a challenge. A primary concern regarding the use of volunteers in the local LTCOP is the lack of resources which results in insufficient training, inadequate supervision, and generally poor support (Harris-Wehling, Feasley & Estes, 1995). Not only do inadequate resources challenge the volunteer ombudsman's ability to perform their duties, but its effects lead to poor volunteer retention. The adequacy of resources compounds problems with the local LTCOPs effectiveness through the lack of experienced volunteers (Nelson, Netting, Huber, & Borders, 2004). In a NASOP study presented at the Bader conference in 2003 this complex issue was discussed:

"Turnover among ombudsmen, including volunteers, can be exacerbated by inadequate selection procedures and insufficient training, supervision and support. The consequence of insufficient training and high turnover rates is that LTCOP effectiveness can be compromised, resulting in lost opportunities for advocacy, unsolved or inadequately solved problems, unmet needs, and dissatisfied clients" (National Association of State Ombudsman Programs, 2003).

Several areas of research have contributed to an understanding of the role of volunteers in the local LTCOP. Through research findings one can see that the use of volunteers raises several challenges in the local LTCOP.

It has been suggested that volunteers may be confused about their roles and responsibilities, raising concerns about ombudsman retention, advocacy and complaint investigation (Nelson, Pratt, Carpenter, & Walter, 1995). The lack of consensus between the ombudsman and the facility on the role of the volunteer ombudsman may encourages misunderstandings and conflict (Persson, 2004) and may strain the relationship between the ombudsman and the resident that relies on them to play the role of an advocate. The natural role ambiguity of the ombudsman volunteer is exacerbated by the lack of training and supervision.

Additionally, it has been suggested that volunteers are under-trained for the role of advocate and complaint investigator, and may be forced into 'triaging' situations and passing complaints off to a more experienced paid ombudsman (Netting, Huber, Borders, Kautz, & Nelson, 2000). Although this 'triaging' can be confusing for residents and facilities, it could be a potential solution to the increasing role confusion, inexperience, and unwillingness to handle complaints among volunteers. Projected complaint increases in the local LTCOP due to licensing and regulatory cutbacks may strain this 'triaging' of complaints.

The local LTCOP will likely see an increase in workload with more complex complaints, as well as an expanded role in investigating and resolving those complaints. This shift in responsibility without an increase in funding will strain the local LTCOPs reliance on volunteers (Persson, 2004). Further techniques for handling complaints, training, and supervising volunteers are needed to accommodate the continuing budgetary and resource constraints on the local LTCOP.

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