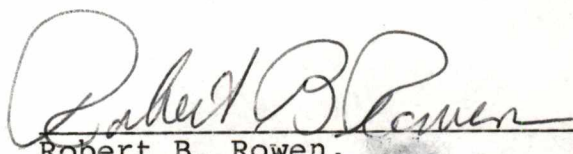
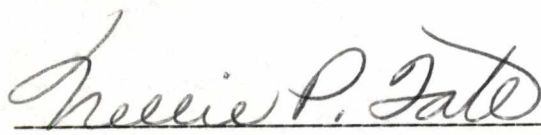
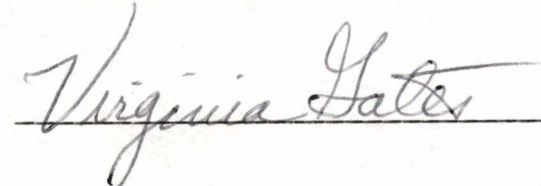


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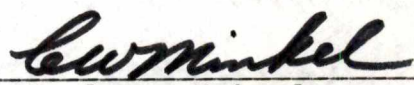
I am submitting herewith a thesis written by Sandra A. Stone entitled "A Descriptive Study of the Long Term Care Ombudsman Program in West Tennessee 1982-1983". I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science in Social Work.


Robert B. Rowen,
Major Professor

We have read this thesis
and recommend its acceptance:

Accepted for the Council:


The Graduate School

3

A DESCRIPTIVE STUDY OF THE LONG TERM CARE OMBUDSMAN
PROGRAM IN WEST TENNESSEE
1982-1983

A Thesis
Presented for
The Master of Science Degree
in Social Work
The University of Tennessee, Knoxville

Sandra A. Stone

June 1984

ACKNOWLEDGEMENTS

Shirley Lenoir, Long Term Care Ombudsman for the Northwest Tennessee Development District is to be thanked formally for her cooperation during data collection and her contributions to the design of the survey tool. I am thankful to Paul Steele, Director of the Northwest Tennessee Area Agency on Aging, Bonnie Tuck, Assistant Director of the Northwest Tennessee Area Agency on Aging, Ann Lewis, Director of the Southwest Area Agency on Aging, Gary Vanasek, Director of West Tennessee Legal Services, Inc. Pam Ford, Managing Attorney, Senior Citizens Law Project and Dana Siler, Southwest Tennessee Long Term Care Ombudsman for their cooperation and permission in obtaining access to the information needed to conduct this study. Jane Jarvis, Managing Attorney, West Tennessee Legal Services, Inc. has also been supportive during the production of this document. Laura Douglass, Legal Secretary, who typed this document, has done excellent work in the areas of typing, proofreading and moral support.

Without Jane Bridgman, State Long Term Care Ombudsman, who initiated the use of the "documentation summaries", there would have been no structure from which

to gather data. From countless conversations with Ms. Bridgman as well as with the district ombudsman across the state, many of the theories which are advanced on the following pages had their germination. To the other district ombudsman, a special thanks; to be associated with you over the years has been a personal and professional privilege. Special acknowledgement to: Pat Wingo--Upper East District, Howard Hinds--East Tennessee District, Becky Ingle--Chattanooga Based District, Mary Lee Stiles--Mid-Cumberland District, Cathy Henegor--Upper Cumberland District, Kay Sharpton-- South Central District, and Gloria Fouche'--Memphis Based District.

My thesis committee members, Dr. Robert B. Rowen, Chairman, Dr. Nellie Tate and Virginia Gates are heartily appreciated. Without their approval, this thesis effort would not have been launched. Without their assistance, it would not have been completed.

ABSTRACT

This descriptive study of two district long term care ombudsman programs in West Tennessee surveyed role choices made by the ombudsmen during case resolution in the calendar year 1982. A secondary goal of the study was to determine if in fact most complaints processed were categorized as "not against the facility," rather than reflecting activity in an advocacy role within the category of complaints "against the facility."

The case records and the documentation summaries completed at case closure by the two district ombudsman programs selected for study were used to extract demographic information, the type of complaint treated, and the role assumed by the ombudsmen. A total of 80 cases were surveyed with the greatest percentage (80%) coming from the more urban counties in the two districts. While the overwhelming number of complaints were made on behalf of those persons 60 years of age or older (almost 89%), 11% were under age 60. About 64% were females while 34% were males. Eleven percent were black. About 84% fell in the low-income category while 16% were middle to upper-level.

It was found that the majority of complaints were against the facility. Most of these complaints were about

building safety and about food in Unlicensed Residential Homes for the aged. The primary role choice made was that of broker in those situations involving building safety. This involved, most often, making referrals to the state licensure agency. The most frequent secondary role choice was the investigator role and it occurred most often during treatment of complaints about food.

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CHAPTER I

INTRODUCTION AND STATEMENT OF THE PROBLEM

Historical Background

The position of ombudsman may be traced to the Swedish parliament who created the "Justitieombudsman" in 1809. "His function of receiving complaints from citizens and protecting them against injustice" remains a standard definition of ombudsman functions in a variety of settings. (Linnane, 1977, p. 15). There are other countries in which the position of ombudsman has existed historically and continues to function. Rowat (1966), described heightened interest in the ombudsman concept here in the United States as "ombudsmania" (p. xiii). Today, one may find an ombudsman employed in banks and department stores in addition to governmental settings. The classic ombudsman's setting however, is in a governmental context. Forman (1974), describes the classic ombudsman as "a highly placed official in national, state, or local government, appointed by and responsible to the legislature" (pp. 129-130). He sees the overall purpose of ombudsmanship as improving governmental administration by resolving and investigating citizen complaints against governmental agencies. The application of the ombudsman's concept to

long term care, and to nursing home complaints, in particular, was an indirect result of the nursing home industry's expansion.

The creation of Medicare and Medicaid in 1965 changed the nursing home industry from a service provided largely by non-profit organizations to one in which private industry found a "booming" profit margin. (Administration on Aging, 1977). Because of the traditional lag between funding of programs and the development of adequate regulations, many problems arising in nursing homes were not solved by regulatory authorities. Various informal "ombudsman" programs had developed across the nation in response to continuing complaints about the quality of nursing home care. (Special Committee on Aging, 1975).

Public outcry, documented through legislative hearings during the 1970's described poor quality care within the expanding nursing home industry. Testimony given to the subcommittee on Long Term Care of the Special Committee on Aging of the United States Senate by a Task Force on nursing homes was typical of the period. The task force, organized by Ralph Nader, reported of poorly trained personnel, neglectful and abusive practices by nursing home personnel as well as improper procedures for fire safety and structural defects during testimony given in December of 1970 (Special Committee on Aging, 1971).

When President Nixon announced an "eight point nursing home initiative in 1971" for nursing home reform, the long term care ombudsman program concept was begun by these statements:

I have also directed the Department of Health, Education, and Welfare to assist the States in establishing investigative units which will respond in a responsible and constructive way to complaints made by or on behalf of individual patients. The individual who is confined to an institution and dependent upon it is often powerless to make his voice heard. This new program will help him deal with concerns such as accounting for his funds and other personal property, protecting himself against involuntary transfers from one nursing home to another or to a mental hospital, and gaining a fair hearing for reports of physical and psychological abuse (Special Committee on Aging, 1975, p. 610).

In 1972, the Department of Health, Education and Welfare invited the States and national associations of older people to submit proposals for establishing model nursing home ombudsman offices with these responsibilities:

Become informed of the conditions under which nursing home residents live;

Receive, respond to, and work to resolve complaints made by or on behalf of nursing home residents;

Take appropriate action to resolve problems in the area of long term care (Administration on Aging Report, 1981, pp. 1-2).

Eventually seven demonstration projects were begun. To insure independence and objectivity the projects were not placed in settings concerned with the regulation of nursing homes (Forman, 1974). The success of such demonstration projects led to the availability of grants

from the Administration of Aging to states to "assist in the promotion and development of ombudsman services for residents of nursing homes" (Public Law 94-135 Section 308(5), 1975). The Administration on Aging was chosen to administer long term care ombudsman services because of recommendations from the assessment of the demonstration projects indicating the state agency on aging was the best location for the program--contrasted with the non-governmental voluntary organization and the state executive office. (Administration on Aging, 1975). Although the original emphasis of the ombudsman program appeared to be at the state level, as evidenced by the creation of the "ombudsman development specialist" in the state office, later policy issuances directed the program toward the sub-state level. "The 1978 amendments to the Older Americans Act brought an end to the formerly designated ombudsman developmental specialist role and elevated the Long Term Care Ombudsman Program to a statutory level" (Wainess and Administration on Aging, 1982, p. I-8). The statute and subsequent regulations required the state agency on aging to establish an ombudsman program which would carry out the following activities:

- Investigate and resolve long term care facility residents' complaints;

- Promote the development of citizens organizations and train volunteers;

- Identify significant problems by establishing a statewide reporting system, and work to resolve

these problems by bringing them to the attention of appropriate public agencies;

Monitor the development and implementation of Federal State, and local long term care laws and policies,

Gain access to long term care facilities and to residents' records;

Protect the confidentiality of residents' records, complainants' identities, and ombudsman files (Wainess, and Administration on Aging, 1982, p. I-8).

The reauthorization of the Older Americans Act in 1981 reiterated existing ombudsman activities and broadened the definition of long term care facility to cover not only nursing homes but also "boarding homes." These board and care homes were defined as "any category of institutions, foster homes, or group living arrangements in which...a significant number of recipients of Supplemental Security Income benefits is residing or is likely to reside" (Wainess and Administration on Aging 1982, p. I-10).

Bridgman (1983) states that Tennessee began its long term care ombudsman program in 1975 in the First Tennessee Development District. Presently, nine ombudsman programs exist in Tennessee through contract with Regional Area Agencies on Aging. A state ombudsman, employed by the Tennessee Commission on Aging, is responsible for coordination of training for regional or district programs and

the development of a comprehensive complaint documentation and reporting system, among other duties.

The setting for this descriptive study is within two of Tennessee's district programs during the calendar year 1982 - 1983. The Southwest area district program encompasses the counties of Decatur, Chester, McNairy, Hardeman, Hardin, Haywood, Henderson, and Madison. Benton, Carroll, Crockett, Dyer, Gibson, Henry, Lake, Obion, Weakley are the counties serviced by the Northwest district ombudsman.

Statement of the Problem

A state-wide system for recording the results of complaint investigations has been in effect for cases closed since fiscal year 1981. The basic information gathering tool--a "complaint documentation summary"--records demographic data about the complaint and complainant. (See Appendix A, p. 51 for example). The type of complaint is coded and recorded; whether or not the complaint was resolved is also documented in the summary. The complaints are categorized into two major groups: "against the facility" or "not against the facility"; Table I p. 52 in Appendix A illustrates the categories.

A complaint which would be categorized as "against the facility" might involve a violation of resident's rights: for example, money not being returned. A complaint regarding the quality of resident care falling in

the category of "against the facility" could involve the resident being neglected or abused. Complaints that are judged to be "not against the facility" may involve a termination of a resident's Medicaid eligibility, or problems with a resident's conservator or guardian.

The state ombudsman discovered, after an initial compilation of complaint documentation summaries in 1981, the majority of complaint cases recorded by Tennessee ombudsmen was falling into the category: "not against the facility." The ombudsman program has traditionally been considered an "advocacy" program. On first impression, a preponderance of complaints being processed which are "not against the facility", could be interpreted to indicate the programs were not "doing their jobs," or at best "doing their jobs" in an altered fashion. In a search to explain such an outcome, the writer has researched selected sources, finding a variety of program styles or role choices in addition to the highly visible advocate role which could result in complaints frequently falling into the category of "not against the facility". A major assumption of the study was that there are identifiable roles assumed by an ombudsman during complaint resolution. These roles are assumed when addressing complaints falling

into either category: "against the facility," or "not against the facility."

The problem under study is to identify what roles are assumed most often by ombudsmen during the resolution of complaints and in which complaint category the role choices most frequently occur. The frequency of role choices according to the different types of complaints treated will also be identified.

Justification of the Study

Despite policy choices which move toward "de-institutionalization"; nursing homes and other long-term care facilities continue to be the only viable way to care for many chronically ill elderly. Complaints about the quality of life available in nursing homes and other long-term care facilities continue to be voiced by consumers. The classical ombudsman concept--that of negotiator of sorts not attached to any regulatory or political body--continues to offer a means for investigating complaints and assuring advocacy for many vulnerable Americans. This detachment from formal authority, and the unique body of knowledge assembled from the ombudsman's viewpoint, offers a means of enhancing as well as documenting the quality of life available for nursing home residents. There have been no signs of discontinuing the ombudsman program, therefore, justification for a descriptive study of ombudsman program would be to "a) improve its practices

and procedures, b) add or drop specific strategies and techniques, or c) accept or reject a program approach or theory" (Weiss, 1972, p. 16). In order to accomplish any of these purposes, one must find out more about the inner workings of the program. This descriptive study will do so by recording role choices as they occur within major complaint categories. No such study of role choices of the ombudsman has been conducted in Tennessee. Few descriptive studies of ombudsman programs have been published and a need exists to support or contradict present evidence.

Limitations of the Study

Only looking at the ombudsman program as it existed during 1982 - 1983 in West Tennessee may limit possibilities for generalization to other parts of the state. The Northwest and Southwest Development Districts are semi-rural; this characteristic may hamper comparisons with programs in urban areas.

The major tool used for case documentation, the documentation summary, although standardized, was not implemented statewide until 1981. The manner in which it is completed has been known to vary somewhat from program to program. Having each ombudsman survey the other's records was a needed check for objectivity. Differences in the way the documentation summary and corresponding case records were recorded could affect interpretation by the evaluator.

Valid recording of original role choices could in turn suffer. As with all ex post facto survey designs, limitations are present. There was much communication initially between the surveyors in regard to the operationalization of the roles to be surveyed. (See Appendix B, pp. 54-55 for case examples of roles). The manner in which the survey was conducted is much like a "self-report" survey. "Retrospective self-reports are not always reliable, particularly on attitudinal measures; people often distort their reports on the past, usually in the direction of congruence with present attitudes" (Weiss, 1972, p. 75).

Definitions of Terms

The following terms have been used within the study. They are operationalized as follows:

Intermediate Care Facility - A nursing home where an intermediate level of nursing care is given the individual. The I.C.F. is licensed by the state.

Skilled Nursing Facility - A nursing home where the nursing provided is intensive. One must be in need of twenty-four hour supervision by a nurse under state licensure requirements.

Residential Care Facility - Private homes which hold themselves out to provide board and personal care to one

or more unrelated individuals. These homes must be licensed by the state.

Unlicensed Boarding Home - A residential care facility which has not met licensure requirements.

Private Residence - The setting for some complaint cases the long term care ombudsman has the expertise to resolve but the complainants are not residents of long term care facilities.

Long Term Care Facilities - Encompasses Intermediate Care Facility, Skilled Nursing Facility, Residential Care Facility and Unlicensed Boarding Homes. All institutions providing living space and care to older adults possessing chronic needs for such care.

Broker - Role assumed when intervention occurs through the securing of services available from another or multiple sources.

Mediator - Role assumed by an impartial negotiator who is functionally independent, non-judgmental and nonpartisan. (Monk and Kaye, 1982).

Educator - Role assumed during the impartation of specific knowledge not generally known to an individual or group.

Organizer - Role assumed while assisting a group of concerned individuals in banding together, utilizing techniques of community organization and group empowerment.

Advocate - Role assumed during negotiation when worker vigorously supports the view of the client or clients.

Therapeutically Supportive Role - Role assumed in negotiation, focuses on provision of emotional support and provision of concern and caring; to prevent psychological pain or discomfort during interaction with a dominant authority. (Monk and Kaye, 1982).

Investigator - Role assumed in initial verification of complaint, role used when gathering information about situation.

Coordinator - Role assumed when bringing several interested parties together and facilitating activity for the benefit of the complainant.

Verification by Strong Standard - Term used in verifying complaints by documentary evidence or first hand reports.

Verification by Weak Standard - Term used in verifying complaints only when documentary evidence or first hand reports are unavailable.

Long Term Care - Care rendered to individuals possessing chronic health problems.

An historical background of the generic ombudsman concept and an account of the long term care ombudsman's development within the auspices of the Administration on Aging has been provided. The statement of the problem for

study has included the justification for the study, limitations of the study and definitions of terms used within the study. The next chapter will present the review of the literature.

CHAPTER II

REVIEW OF THE LITERATURE

Ombudsman programs have a relatively short history in this country even though many professional groups have adopted advocacy as a major thrust of their organizations. In view of this, one can easily understand why research in this area is limited, particularly when role choices of the ombudsman are considered. Thus, while Monk and Kaye (1981; 1982) have done the most extensive work around role perceptions, much of the literature has been concerned with describing and/or evaluating ombudsmanship within a governmental context and more recently, describing or evaluating ombudsmanship in long term care. This review will examine research done in both these spheres beginning with those works around the ombudsmanship in the governmental concept.

A number of scholars have surveyed the use of ombudsman offices around the world. Weeks (1973), for example, examined various ombudsman offices around the world at the national as well as the provincial or state level. He surveyed offices in such diverse places as the Norwegian countries, the United Kingdom, some African nations and,

at the state and provincial level, some Canadian provinces as well as two states in this country. Each program was analyzed regarding to the population served, the term of office, and the level of jurisdiction among other things. He found that ombudsmen have more prosecutorial powers in some European countries than do ombudsmen in the United States.

Similarly, Gellhorn (1966) and Stacey (1978) focused on a comparison of ombudsmen in countries in Scandinavia, Canada, Western Europe, and the United States. They, too, found that in the Scandinavian countries, the ombudsman is a recognized authority, usually with a small staff, and intimately involved in all episodes of any consequence.

Examining ombudsman programs in the United States, Rowat (1968) concluded that the burgeoning interest in ombudsmanship in the United States was tantamount to "ombudsmania." This seems reasonable in view of the civil liberties guaranteed to citizens in this country. Ombudsmania notwithstanding, Stacey (1978) concluded that while the idea of ombudsman is well accepted in the United States, implementation of the concept has met some resistance due in part to America's system of checks and balances. Thus, it would appear that this system limits the

authority of the ombudsman and hence, his ability to be an advocate.

When the effectiveness of ombudsman programs is considered, Danet (1978) suggests that these programs have not been properly evaluated because of the problems inherent in evaluation research (operationalization of terms, experimental vs. quasi-experimental design, etc.) as well as the variety of settings where ombudsmen are found. Monk and Kaye (1982) state Hill, evaluating New Zealand's ombudsman found that offensive complaints were more frequent than were defensive complaints. Offensive complaints (those not against the facility) were those made when services were withheld by client-serving agencies while defensive complaints (those against the facility) involved mal-treatment by agencies. This suggests that the very nature of the complaints limits the authority and power of the ombudsman, especially when the eligibility requirements of client-serving agencies are taken into account.

In another vein, Friedman (1977), surveyed the perceptions and attitudes of the public toward the ombudsman in Britain and Alberta, Canada. He found that the more knowledge an individual had about the roles and functions of the ombudsman, the more likely the individual was to have exhibited positive attitudes toward the ombudsman.

While the classical view of the ombudsman suggests a strong role in a governmental setting, ombudsmen have been used in other areas as well. For example, Anderson (1979) discussed the application of the "ombud" concept in health services. He strongly suggested that the ombudsman functions best where he is least needed. Put another way, in the health services area, an ombudsman is truly needed; however, because of the complexity of the health services system and the power of the health professionals (especially the physician), the ombudsman in this arena has been least effective.

Specific to long term care, Linnane (1977), examined how the nursing home ombudsman differed from the classical model in resolving complaints. He found that the nursing home ombudsman needed to have a broad scope of the knowledge covering a number of laws regulating the industry. Moreover, the nursing home ombudsman lacked formal access to records which the classical ombudsman usually possesses. The inability to secure records severely limits the power of the nursing home ombudsman to carry out his job.

Most recently, Monk and Kaye (1981; 1982) and Monk, Kaye and Litwin (1982) have examined the evolution of the ombudsman concept and its application to long term care. Most of their work has involved roles and role perceptions as well as the functions of the ombudsman. In their 1981

publication, they have documented the existence of the following role descriptions.:

Making easier the conditions of residents, guiding the residents through the proper channels; serving as a middleman between nursing home and the resident; arguing the cause of the resident; serving as an impartial listener; translating the rules and regulations of nursing home residents; explaining decisions of others to residents; observing staff practices in nursing homes; occupying a watchdogging position to insure adequate nursing home conditions; and providing emotional support to residents/patients (Monk and Kaye 1982, p. 104).

From their look at the literature Monk and Kaye suggest there are three broad categories of ombudsman function. The first type would include those programs that align themselves with the classical notion of ombudsman-ship, functioning more as an impartial mediator like the Swedish ombudsman Gellhorn (1966) describes. The second grouping of ombudsman orientation is considered by Monk and Kaye to include the more partisan approach, that of the vigorous advocate as opposed to the classical more impartial orientation. The third type they term the "therapeutically supportive ombudsman" who "focuses on the provision of emotional support and the expression of friendly concern and caring" (1982 p. 196).

A continuum of sorts is suggested by the "Brookdale Study," Monk, Kaye and Litwin (1982), in which ombudsman role choices may reflect a program philosophy falling somewhere in-between the "patient rights" model and the "quality of life" model. The "patient's rights" oriented

ombudsman would be more adversarial and issue oriented, while the "quality of life" oriented ombudsman would provide emotional support and also be more likely to collaborate.

The Brookdale Study also identified several factors which may determine which direction a program will develop:

- the size of the institutionalized aged population;

- the scope and configuration of the long term care system;

- the influence of special interest groups;

- the status of alternative state regulatory and monitoring systems;

- community norms/public attitudes;

- predilections of the state's chief executive;

- history of the past abuse in long term care....
(Monk, Kaye and Litwin, 1982 p. I-18).

Monk and Kaye have done extensive work in the area of long term care. Their work has been parallel to the work of the Administration on Aging through its Nursing Home Interests Staff from which the Ombudsman Technical Assistance Manual was developed. Ten roles that nursing home ombudsmen should fulfill were identified by the Nursing Home Interests Staff. These roles were: advisor, mediator, facilitator, coordinator, broker, catalyst, patient advocate, advisor, publicist, and expert witness (Administration on Aging, 1975). The technical assistance

manual makes more explicit the role requirements and functions as well as explains the implementation of long term care ombudsman programs at the state and local levels.

While the earliest literature reviewed regarding generic ombudsman programs was evaluative as well as descriptive, the works of Monk and Kaye (1981) and Monk, Kaye and Litwin (1982) are most germane to this study. They examined roles of the ombudsman as well as enviromental factors such as the setting and the political atmosphere. They found these and other factors could or would determine not only the roles that an ombudsman would assume, but also the extent to which the ombudsman will be successful in executing his job. The next chapter will discuss the methods and procedures of the study.

CHAPTER III

METHODS AND PROCEDURES

Design for the Study

The purpose of this descriptive study of two district long term care ombudsman programs was to survey role choices made by the ombudsman during case resolution during the calendar year 1982.

Description of the Sample

Cases recorded by two ombudsman programs in West Tennessee have been used for study. One program covers Benton, Carroll, Crockett, Dyer, Gibson, Henry, Lake, Obion and Weakley counties in Northwest Tennessee; Decatur, Chester, McNairy, Hardeman, Hardin, Haywood, Henderson and Madison counties constitute the geographic area covered by the Southwest Tennessee program. Cases opened between the time period of January 1, 1982 through December 31, 1982 were selected. Only those cases for which a documentation summary was completed have been included in the evaluation. Documentation summaries were not completed for information and referral cases. Approximately 40 case records for each program, constituted the basis for the collection of data in this study.

Procedures and Analysis

Case records and documentation summaries for the designated time period (January 1, 1982 through January 1, 1983) were examined: the Northwest ombudsman examined the records of the Southwest ombudsman and vice versa. The survey tool included the documentation summary format plus a check list for primary and secondary roles. (See Appendix B, p. 56). The surveyors reviewed the role choices and case examples of each role choice. It was decided to add two additional roles to the checklist, the roles of investigator and coordinator.

In addition to recording role choices the tool recorded: 1) demographic data - age, sex, race of complainant, 2) whether the complaint was "against the facility" or "not against the facility", 3) whether the complaint was resolved or not resolved, plus what type of complaint had been treated, among other items.

Data collection was done by recording types of complaints, types of facilities, and the primary and secondary role choices made by the ombudsman. Data was gathered from documentation summaries completed for each case. This format is similar to the one used by the state and national ombudsmen in preparing their annual reports. (See Appendix B, pp. 57-62 for computer coding sheet). Crosstabulation of the role choices according to type of complaint was obtained. Other variables such as area and

race were also crosstabulated. S.P.S.S., Statistical Package for the Social Sciences, was used within this study.

No identifying information such as name of complainant or facility was recorded; this restriction both protected the rights of "subjects" of the study and observed the restrictions set by the Older Americans Act for maintaining confidentiality of the complainant's identity.

The design for the study, a description of the sample plus an account of the procedures and methods of analysis has been explained within this chapter. The next chapter will present the findings.

CHAPTER IV

FINDINGS

The findings were organized in a manner that answered the following questions. 1) Who were the complainants? 2) What were the types and sources of complaints? 3) In what kinds of facilities did these complaints emerge? 4) What were the primary role choices made by the ombudsman? and 5) What were the secondary role choices made by the ombudsman?

The greatest percentage (80%) came from the more urban counties. Table II, Appendix C. p. 64 illustrates this point. Almost 89% of the complainants in the surveyed cases were over 60, while about 11% were under age 60. About 64% were females and 34% were males. Only 11% of the complainants were black. About 84% fell in the low-income category while 16% had middle to upper-level incomes.

Table III, Appendix C, p. 65 demonstrates that the greatest number of cases fell in the category of "against the facility." Types of complaints processed during the survey period are reflected in this table. Complaints involving building safety were most often received. Fifteen cases involved building safety while twelve involved understaffing; The percentages were 26.7 and 21.4,

respectively. Placement problems encompassed another 7.5% of the responses.

Looking at the findings in the area of source of referrals, the category of friend and relative showed the highest frequency with 27 cases being referred from this source. The ombudsman was the second highest source of referral with a frequency of 13. Residents as a source of referral had a frequency of 8. Table IV, Appendix C, p. 66 shows the findings. It is interesting to note 10% of referrals were found to be coming from facility employees.

The type of facility in which most cases occurred was the Intermediate Care Facility--or nursing home, with a frequency of 33 or 41%. The categories of Residential Homes for the Aged and Unlicensed Boarding Homes when combined, yielded a frequency of 32 (or 40%). A Residential Home for the Aged is a boarding home licensed by the Tennessee Department of Health and Environment. An Unlicensed Boarding Home constitutes a Residential Home for the Aged that has not been licensed by the department. The Private Residence was the setting for sixteen percent of the complaint cases surveyed. Table V Appendix C, p. 67 presents these findings.

Other noteworthy findings involved the length of time cases were held open, verification of the complaint, the extent of resolution of the complaint, the satisfaction of

the ombudsman and the client with the service rendered, and the frequency with which confidentiality was requested by complainants.

Around 40% of the cases surveyed were held open between two weeks and one month. Twenty-four percent of the cases were processed within one to two months and another 16% were closed within two weeks or less. Table VI Appendix C, p. 68 illustrates these findings. Sixty-five cases or approximately 81% were found to be verified by a strong standard. Verification by a strong standard is present when documentary evidence is available. During the treatment of 9 cases, the ombudsman was unable to prove or disprove the complaint. Four cases were verified by a weak standard, that is, no documentary evidence was present to back up the complaint.

Sixty-four percent of the cases surveyed were recorded as resolved by the case-handlers. Another 23% were recorded as partially resolved. Only eight cases were considered not to be resolved. Table VII, Appendix C, p. 69 displays the data in a table format. According to the surveyed records, complainants reported satisfaction with the handling of their problem in 59 of 80 cases. The ombudsman reported satisfaction with the outcome of the case in 56 of the surveyed cases.

One of the mainstays of the long term care ombudsman program is the client's right to confidentiality. The

ombudsman shall not reveal the identity of the complainant to anyone unless permission is given by the complainant. Anonymity was requested in 69 cases, or 87% of the clients served in the sample. In only ten or 13% of the cases, the complainant did not request anonymity, allegedly because of fearfulness.

The most important findings of the study involve the primary and secondary role choices of the ombudsman. These findings were crosstabulated with the types of complaints according to each role choice. Also crosstabulated with role choices were the types of facilities the complaints occurred in plus the race of complainants.

The broker role was recorded in 21% of the cases surveyed as the primary role choice of the case handler. Fifteen percent of the cases surveyed reflect the primary assumption of the organizer role; the role of investigator was the primary role assumed in 10% of the cases. Around 13% of the cases surveyed showed the usage of the advocate role, as a primary approach in treatment. Secondary role choices were cited falling in the categories of the advocate role eighteen times; the investigator role 15 times, and the broker role 12 times, respectively. It was impossible to determine a secondary role orientation in 18 of the cases surveyed. Table VIII, Appendix C, p. 70 illustrates these role choice frequencies in a Table Format.

Looking at the findings of role choice frequency according to the type of complaint, Tables IX and X Appendix C, pp. 71-72 illustrate the use of the most frequently chosen roles as a primary or secondary choice according to the type of complaint. The type of facility in which each role choice most frequently appeared is illustrated by Table XI, Appendix C, p. 73.

The broker role was used as a primary role most often in complaints against the facility, specifically it was used 10 times in the category of complaints regarding building safety. In complaints against the facility, the broker role was chosen as a primary mode of intervention in six cases distributed rather evenly among the types of complaints "not against the facility" that were recorded. As a secondary role, broker was recorded as a role choice in eight cases designated as being "against the facility."

The most frequent type of complaint category citing "broker" secondarily was that of residents rights - use of possessions restricted. The Unlicensed Boarding Home was noted as the type of facility in which the choice of broker as a primary role was recorded most often with a frequency at 12; Residential Homes for the Aged was the setting for five of the same role choices. Cases occurred most often in an Intermediate Care Facility--that showed

broker as a secondary role choice. The Licensed Residential Home was the setting for four complaints utilizing broker as a secondary role.

Since the broker role choice has been recorded so often, it is interesting to note the objects of referral and consultation for the ombudsman. The ombudsman consulted with the state licensure agency in 49% of the cases. Referral was made to the state licensure agency in 18% of the cases. Referrals were made to other entities such as family, guardians, county judges, etc. in 57% of cases. Tables XII and XIII pp. 74-75 show the findings.

The organizer was the second ranking primary role choice with a frequency of 12, followed by the advocate role and investigator role with 11 and 10 cases, respectively. The organizer was chosen only as a primary role in the Southwest Area within an Intermediate Care Facility setting. It was cited only in reference to the complaint--"against the facility"--of understaffing. It was not used in a case involving a black complainant.

The advocate role was cited nine times as a primary orientation involving complaints "against the facility"; it was cited two times each as a secondary role in complaints "against the facility" as well as two times each in both primary and secondary choice categories for complaints "not against the facility." Table XIV, Appendix C, p. 76 illustrates the appearance of the advocate role.

The complaint type-food--preferences not considered showed the advocate role being used primarily in 5 cases. Two cases showed the same orientation. One case was cited in the following complaints using the advocate role primarily: residents rights--civil liberties restricted, building heating, Medicaid and needs less restrictive placement. The role was cited being used as a secondary choice in one case within the following complaint areas: resident care--M.D. not called, resident care--other, Medicaid, and family problems. The advocate role was used five times as a primary role in the Northwest Area and two times as a primary role in the Southwest Area. In a secondary role the Southwest Ombudsman operated as an advocate four times. The Intermediate Care Facility and Unlicensed Boarding Home were the locations for the primary use of the advocate role in five cases each. The Intermediate Care Facility was the site of the advocate role's use secondarily in six cases, the Residential Home was the setting in four cases.

The role of investigator was found to have been utilized most often in complaints against facilities; it was used as a secondary role choice for complaints of understaffing in 10 cases. The role of investigator was used as a primary role 10 times, 2 times in the complaint type of residents rights--civil liberties restricted.

Unlicensed boarding homes housed the investigator role as

a secondary approach in eleven cases. Cited in fifteen cases as a secondary role choice, the investigator role was chosen in 22% of the cases surveyed, second only to the educator role which was chosen as a secondary orientation in 18% of the cases.

The mediator and educator roles were used only three times as primary roles. As a secondary role the mediator was cited in two cases. Two of the three cases using mediator as a primary role involved black clients; all three cases were within Intermediate Care Facilities and the complaints involved resident care. Of the 18 secondary role choices of educator, ten cases involved the complaint of understaffing; five cases involved complaints in the area of food--preferences not considered. The Intermediate Care Facility was the setting for eleven of the educator role choices; the Residential Home setting was cited for five educator role choices.

The therapeutically supportive role was recorded only once as a primary role choice. It surfaced five times as a secondary orientation. This role was not used at all in complaints "against the facility." Three of the five secondary role uses occurred in cases involving black clients.

The only role not utilized as a primary role was that of coordinator. It was not chosen at all as a mode of intervention in the Southwest Area. Two of the four role

applications in the Northwest Area occurred within residential homes. It was also not used for any cases involving black complainants.

Frequencies from demographic data about the complainants, the types and sources of complaints, the types of facilities involved in complaints, the primary and secondary role choices selected as well as other factors have been presented. The following chapter discusses implications of the findings.

CHAPTER V

IMPLICATIONS

The statements made by Friedman (1977) and others regarding the ombudsman concept being best known by individuals who are better educated and of higher socio-economic levels is borne out by the findings, in that the largest number of cases came from counties possessing a comparatively urban center. This conclusion would be true if we assume as Friedman did, that the forementioned individuals make up more of the urban population than the rural population within our survey. Although the majority of clients surveyed were judged to be low-income, the low-income population of the urban areas may still be better informed about services. This same principle, attributed to Hill by Danet, (1978) has been interpreted to indicate those who need the ombudsman most have less access to him. This premise may also explain why complaints came more frequently from white individuals than from black individuals. There has been much speculation in the community that black individuals are kept at home with relatives rather than being institutionalized. If this speculation is true, it could also account for the small number of black complainants touched by the programs in the study.

One measure of efficiency for the ombudsman was cited by Friedman (1977), by Dante (1978), and by Danet of Hill, as being the length of time cases were held open during processing. The cases studied were processed within two weeks to one month for 41% of the problems received. Twenty-four percent were processed between one month to two months: the caseload of the ombudsman seems to rise and wane in two month intervals. Complaints appear to be processed in an acceptable time frame.

It is interesting to note that 87% of clients served requested confidentiality during the treatment of their problem. Although this policy of respecting confidentiality is a mainstay of the program, many Tennessee Long Term Care Ombudsmen contend it can limit the ability of the ombudsman during investigation. Often the ombudsman may be unable to investigate a complaint properly without advertently exposing the identity of the complainant. Despite this possible limitation 61% of the cases handled were reported to be resolved. Twenty-two percent were recorded as partially resolved, while eight cases were not resolved. The ombudsman was recorded as satisfied by the outcome in 56 of the surveyed cases. Client satisfaction was noted in 59 cases.

Since 65% of the cases were judged as verified complaints, one can conclude the ombudsman program is serving

a useful purpose. One may also conclude there is a legitimate amount of waste in the system that is being remedied by the existence of such complaint resolution mechanisms.

Because the ombudsman relies heavily on the cooperation of other entities, it is interesting to note that the state licensure agency emerged as the primary source of referral and consultation. This finding supports a contention that many of the problems involve a violation of regulations, which are evidently being resolved to the satisfaction of clients and ombudsmen.

It is noteworthy to observe that while most complaints came from the Intermediate Care Facility, the broker role was used more often than not in treating complaints. One might expect the advocacy role to be used most often if the majority of complaints was lodged regarding problems in nursing homes due to the program's roots in nursing home reform movement of the 1970's. Considering that the broker role was used most often in Unlicensed Boarding Homes, one may conclude that the worker's approach toward the unlicensed operator was gentle in referring the matter, rather than taking a stance "against the facility."

Although a secondary purpose for this study was to learn if the majority of complaints occurred within the category "not against the facility," the findings showed the majority of cases fell within the category of "against the

facility." In these cases, the primary roles chosen most often were the broker and organizer roles. The type of complaint for which the primary role of broker most frequently appeared was "building safety." This could have easily been considered a complaint area in which the advocate role should have been used. One might expect a vigorous stance against a facility in violation of regulations involving "safety." Technically, the broker role was the most appropriate orientation as complaints about building safety involve regulatory issues and should be referred to the state licensure agency.

The use of the organizer role by the studied programs falls under a similar premise. "Understaffing," is a complaint area which should be referred to the state licensure agency. The secondary role choice was that of advocate for this group of complaints. Although referral was made to the state licensure authorities, primary emphasis went into organizing a group of concerned citizens who in turn advocated for the residents of the nursing home by taking an assertive stance against the facility.

The advocate role choice was utilized nine times as a primary role choice involving complaints against the facility. Most of the cases involving the advocate role were within the complaint category--"food--preferences not considered." These findings are similar to findings about

other programs of this type. In fact a national summary of programs throughout this nation found that dietary complaints were recorded most frequently. (Administration on Aging, 1981). The role of advocate is alleged to be taken often by nursing home ombudsman programs in other states.

The role of investigator was used most frequently during treatment of complaints against facilities. The very nature of the job mandates that one investigate every complaint received. In this study, the investigator role was cited when all of the ombudsman's energies were directed toward investigation. The role was cited when the worker cannot assume a role beyond investigator initially.

Although the ombudsman's scope of formal authority is limited the frequent use of the educator role as a secondary role choice suggested that the ombudsmen are becoming change agents within the system. The ombudsman may be attempting to amplify the effects of their intervention rather than confining them to the individual complainant's situation.

Since there were so few black complainants in the survey, it is interesting to note the role of mediator was assumed most often as a primary role in treating these complaints. These cases, occurring within Intermediate Care Facilities, involved resident care. One can only assume why the mediator role was chosen. It could have

been because the complainant had already assumed the stance of an advocate toward the facility leaving mediation between competing interests the only possible stance.

Theories advanced in the literature have been linked with the findings to form implications regarding the socioeconomic level of complainants, measures of efficiency for the ombudsman, and appearance of particular role choices. Implications have been suggested by the writer involving treatment of confidential complaints, and sources of referral and consultation for the ombudsman. Possible reasons behind the selection of particular primary and secondary roles during the treatment of specific complaints have been presented. Implications concerning the frequency of the role choice according to the type of facility and race of the complainant have been explored. The final chapter will summarize the study and discuss conclusions made and recommendations for further study.

CHAPTER VI

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

FOR FURTHER STUDY

Historical background information traced the generic ombudsman concept from Sweden's citizens protector in the early 1800's to "ombudsmania" in the United States during the 1960's. The application of the ombudsman concept to nursing home complaints was found to have been indirectly caused by the creation of Medicare and Medicaid in the mid 1960's which changed the nursing home industry from a small largely non-profit business to a booming industry by the early 1970's. The development of the long term care ombudsman program as a remedy for nursing home residents' complaints under the auspices of the Administration on Aging was traced to the present day.

The problem for study was explained as an attempt to determine what role choices were occurring for the two district ombudsman during case resolution in the calendar year 1982. A secondary goal for the study was to determine if in fact most complaints processed were categorized as "not against the facility," rather than reflecting activity in an advocacy role within the other major category of complaints "against the facility."

Sources concerned with surveying generic ombudsman programs world wide were cited, as were sources studying the ombudsman concept within the United States. The most relevant material to the study was produced by researchers concerned specifically with the long term care ombudsman program. Literature produced by the Administration on Aging and the Brookdale Institute on Aging was helpful in outlining specific role choices to be pursued by obmuds-men.

Procedures used in conducting the study were explained. The case records and the documentation summaries completed at the case closure by the two programs selected for study were used to extract demographic information, the type of complaint treated, and the role assumed by the ombudsmen.

A total of 80 cases were surveyed with the greatest percentage (80%) coming from the more urban counties in the two districts. While the overwhelming number of complaints were made on behalf of those persons 60 years of age or older (almost 89%), about 11% were under age 60. About 64% were females while 34% were males. Only 11% were black. About 84% fell in the low income category while 16% had middle to upper level incomes.

It was found that the majority of complaints was against the facility. These complaints were about building safety and about food in Unlicensed Residential Homes

for the Aged. The primary role choice made was that of broker in those situations involving building safety. This involved, most often, making referrals to the state licensure agency. The most frequent secondary role choice was the investigator role and it occurred most often during treatment of complaints about food.

A large percentage of complaints were received from white individuals living in urban areas. Contentions in the literature reviewed that ombudsman programs are generally more accessible to those better informed individuals of higher socioeconomic levels were judged to be supported by the findings. Evaluative studies of ombudsman programs indicated the length of time a case remained open was a measure of the program's efficiency. Cases were found to be closed in a timely fashion by the surveyed programs.

Contrary to earlier findings, most of the cases in this study were found to be in the category against the facility. The most frequent role choice found for these complaints was that of broker, rather than advocate. This was a surprise given expectations that an advocate's stance might be taken during treatment of complaints against the facility. The most frequent type of complaint for the use of the broker role was building safety. The type of facility in which most of these role choices occurred was the Unlicensed Boarding Home. It was concluded that the choice of the broker role was appropriate

in these cases involving building safety within Unlicensed Boarding Homes for the most frequent source of referral was to the state licensure agency responsible for bringing these homes to standards.

The most frequently appearing secondary role choice was that of the investigator. Appearing most often in Licensed Boarding Homes and in regard to complaints about food the role of investigator was recorded by the researchers when most of the energies of the ombudsman was taken up by attempts to verify the complaint.

The overall picture of the ombudsman programs surveyed is positive. A majority of cases were reported verified and resolved. Both clients and ombudsman ranked high in satisfaction with outcomes. The lack of a majority of complaint cases being treated with an advocate role choice is not necessarily a negative finding. Monk and others (1982), claim several factors influence the direction in which an ombudsman program may evolve. Political considerations may move the surveyed programs away from a patients' rights focus. The degree of organization possessed by the nursing home industry's lobby in Tennessee and the political clout brought to bear by them against the ombudsman program is intense. Worth mentioning as well is the fact that comprehensive access rules allowing the ombudsman access to facilities and their records were not officially approved until May of 1983, a few months

after the survey period ended. Although the access rules are sanctioned by the rulemaking authority of the Tennessee Commission on Aging, the lay public and the nursing home (and other facility) personnel may not regard the rules as having the force of law. Some states actually have "access to facility laws" for patient's rights advocates. It is the opinion of the researcher that the program personnel have found creative ways of "doing their jobs" without adopting the vigorous and politically sensitive advocate's stance in many instances. This was evidenced by the appearance of the broker, educator and organizer roles, the high rate of case resolution and the frequency of satisfaction reported by the clients served.

The Northwest and Southwest Tennessee Ombudsman Programs appear to be fulfilling the obligations charged them by the Older Americans Act. More emphasis needs to be given their exposure to rural and minority populations. Further study utilizing a measure of role choice could easily be accomplished by including a selection of primary and secondary role orientation on the documentation summary. The documentation summary could be structured differently in order to yield more definitive information linking role choice to complaint and facility type. Although the majority of complaints fell into the category, "against the facility" for the period surveyed, a

documentation of the role choices pursued by the ombudsman could help explain the type of activity the workers are engaged in despite the category of the complaint. It is possible in the future, for example, that the advocate role could be assumed most frequently during the treatment of complaints when a majority of the complaints is categorized as "against the facility."

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APPENDIXES

APPENDIX A

Documentation Summary and Table I

COMPLAINT DOCUMENTATION SUMMARY

RESIDENT AND FACILITY

- | | |
|---------------------------------------|--|
| 1. ID # _____ | County/
2. Town _____ |
| 3. Area _____ | 4. Excluded _____ |
| 5. Date Opened _____ | 6. Date Closed _____ |
| 7. Facility Type _____ | 8. Resident Age _____ |
| 9. Complainant _____
code | 10. Anonymity Requested:
yes _____ no _____ |
| 11. Source of payment for care _____ | |
| 12. Sex _____ | 13. Race _____ |
| 14. Low income:
yes _____ no _____ | |
-

COMPLAINT

15. Type of complaint(s) _____
16. Verification _____
17. Scope _____
-

OUTCOME

18. Client satisfied? _____
19. Ombudsman satisfied? _____
20. Resolution _____
21. Consulted with: _____
22. Referred to: _____
-

Comments

TABLE I

COMPLAINTS AGAINST AND NOT AGAINST FACILITY

Complaint Area	Types of Complaints
Against the Facility	
Resident Care	Bedsore, Physical abuse, verbal abuse, doctor not called, lack of medical equipment,
Physician Services	Inaccessible, unresponsive, does not take medicaid,
Medications	Not given according to orders, shortage, etc.
Financial	Deposits, other money not returned,
Food Nutrition	Not assisted in eating, insufficient amount, etc.
Administrative	Understaffing, Improper placement, etc.
Resident Rights	Use of possessions restricted, etc.
Building, Sanitation	Safety factors
Not Against Facility	
	Medicaid Re-classification, etc.

APPENDIX B

Examples of Roles, Role Checklist,
and Coding Sheet for Computer

EXAMPLES OF ROLES

1. BROKER - Complaint of unsupervised mentally ill residents in nursing home - Ombudsman assists facility in obtaining counseling services from the local mental health center.
2. MEDIATOR - Complaint between roommates in a nursing home - ombudsman assists both residents in working out difficulties. Complaint re: quality of care reveals communication problems between facility staff and family. Ombudsman calls a conference during which mutual difficulties are aired.
3. EDUCATOR - Complaint involving violation of resident's rights - Ombudsman conducts inservice facility re: resident's rights.
4. ORGANIZER - Several complaints received: understaffing - ombudsman calls a meeting of the complainants to draft a bill of concerns.
5. ADVOCATE - Complaint re: lost possessions - Ombudsman requests facility produce possessions or provide acceptable compensation - A P.A.E. (pre-admission evaluation) denied - Ombudsman requests appeal, during hearing presents factors giving need for I.C.F. level care.

6. THERAPEUTICALLY SUPPORTIVE - Complaint received re: violation of resident's rights, complainant refuses to allow ombudsman to intervene for fear of indirect disclosure of identity. An ombudsman keeps in contact with complainant, listening to accounts of interactions between the complainant and facility staff, giving support, encouragement and advice. Complainant may take the lead in negotiations and confer with the ombudsman for counsel and advice.
7. INVESTIGATOR - Complaint received re: poor conditions in boarding home, ombudsman goes out to verify reports.
8. COORDINATOR - Complaint received of resident being discharged from nursing home for non-payment of bill. Ombudsman calls nursing home administrator and Medicaid worker relaying information back and forth in order to assure resident stays in home.

ROLE CHECK LIST

NW _____

Primary Role

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

SW _____

Secondary Role

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

CODING SHEET FOR COMPUTER

<u>Column(s)</u>	<u>Label</u>	<u>Variable Description and Codes</u>
1 - 4	I.D. NO.	Client Identification No.
5	AREA	0 - SW 1 - NW
6 - 7	COUNTY	01 - Decatur 02 - Chester 03 - McNairy 04 - Hardeman 05 - Hardin 06 - Haywood 07 - Henderson 08 - Madison 99 - Missing Value 09 - Benton 10 - Carroll 11 - Crockett 12 - Dyer 13 - Gibson 14 - Henry 15 - Lake 16 - Obion 17 - Weakley 99 - Missing Value
8 - 13	OP DAT	Date Case Opened
14 - 19	CL DAT	Date Case Closed
20 - 21	DURA	Duration Case Opened 01 - 2 weeks or less 02 - 2 weeks - 1 month 03 - 1 month - 2 months 04 - 2 months - 3 months 05 - 3 months - 6 months 06 - 6 months - 9 months 07 - 9 months - 12 months 08 - 12 months - 15 months 09 - 15 months - 18 months 10 - 18 months - 21 months

<u>Column(s)</u>	<u>Label</u>	<u>Variable Description and Codes</u>
		11 - Over 24 months 99
22	FAC	Facility Type 1 - SNF 2 - ICF 3 - Home for the Aged 4 - Private Residence 5 - Res. Home for Aged 6 - MHD Supp. Living Fac. 7 - Unlicensed Boarding Home 8 - Other 9 - Missing Value
23	AGE	Resident Age 1 - Under 60 2 - 60 or Over 9 - Missing Value
24 - 25	COMPL	Source of Complaint 01 - Resident 02 - Friend/Relative 03 - Ombudsman 04 - Facility Administrator 05 - Facility Staff 06 - Outside Prof. 07 - AAA 08 - Community Group 09 - Other 99 - Missing Value
26	ANONY	Anonymity Requested Yes - 0 No - 1 Missing Value - 9
27 - 28	PAYMENT	Source of Payment 01 - Medicaid 02 - Medicare 03 - Private 04 - Other Combinations 99 - Missing Value 12 - Medicaid-Medicare

<u>Column(s)</u>	<u>Label</u>	<u>Variable Description and Codes</u>
		01 - Medicaid Only
		02 - Medicare Only
		03 - Medicare-Medicaid
		04 - Medicare Private Source
		05 - Medicaid Private Source
		06 - Medicare-Medicaid Private
		07 - Self or Family Only
		08 - Private Insurance Only
		09 - Self Family and Insurance
		10 - V.A. Benefits
		11 - Other
		99 - Missing Value
29	SEX	Sex
		1 - Female
		2 - Male
		9 - Missing Values
30	RACE	Race
		1 - Black
		2 - White
		3 - Asian
		4 - Native American
		5 - Hispanic
		6 - Other
		9 - Missing Value
31	INCOME	Low/Income
		1 - Yes
		0 - No
		9 - Missing Value
32 - 33	DES COMP	
34 - 37	TYPE C	Type of Complaint
		A - 11
		B - 01
		C - 02
		D - 03
		E - 04
		F - 05
		G - 06

<u>Column(s)</u>	<u>Label</u>	<u>Variable Description and Codes</u>
		H - 06 I - 07 J - 08 I&R - 10 MV - 99
38	VERI	Verification 1 - Verified by Strong Standard 2 - Weak Standard 3 - Cannot Prove or Disprove 4 - Invalid by Strong Standard 9 - Missing Value
39	SCOPE	Scope 1 - Isolated Incident 2 - Recurrent of Widespread Problem 9 - Missing Value 1 - Black 2 - White 3 - Asian 4 - Native American 5 - Hispanic 6 - Other 9 - Missing Value
40	CL SAT	Client Satisfied 1 - Yes 2 - No 3 - Not Applicable 9 - Missing Value
41	OMB SAT	Ombudsman Satisfied 1 - Yes 2 - No 3 - Not Applicable 9 - Missing Value
42	RESOLVE	Resolution 1 - Resolved 2 - Partially Resolved 3 - Not Resolved 4 - Not Applicable

<u>Column(s)</u>	<u>Label</u>	<u>Variable Description and Codes</u>
		5 - Resident Deceased Prior
		9 - Missing Value
43 - 44	CONSULT	Consulted With
		01 - State Survey Agency
		02 - State Licensure Agency
		03 - Legal Services
		04 - DHS Medicaid
		05 - DPH Medicaid
		06 - Federal
		07 - Medicare
		08 - Protective Services
		09 - Other
		99 - Missing Value
45 - 46	REFER	Referred To
		01 - State Survey Agency
		02 - State Licensure Agency
		03 - Legal Services
		04 - DHS Medicaid
		05 - DPH Medicaid
		06 - EDS Federal
		07 - Medicare
		08 - Protective Services
		09 - Other
		99 - Missing Value
47 - 48	PRIMA	Primary Role
		01 - Broker
		02 - Mediator
		03 - Educator
		04 - Organizer
		05 - Advocate
		06 - Therapeutically Supportive
		17 - Investigator
		27 - Coordinator
		07 - Other
		99 - Not Determined

<u>Column(s)</u>	<u>Label</u>	<u>Variable Description and Codes</u>
49 - 50	SECOND	Secondary Role 01 - Broker 02 - Mediator 03 - Educator 04 - Organizer 05 - Advocate 06 - Therapeutically Supportive 17 - Investigator 27 - Coordinator 07 - Other 99 - Not Determined
51	AGAINST	Against or Not Against Facility 0 - Not Against 1 - Against

APPENDIX C

Tables II - XIV

TABLE II

NUMBER OF COMPLAINT CASES REPORTED BY COUNTY

County	County Seat	No. Cases
Madison (a)	Jackson	17
Dyer (a)	Dyersburg	15
Henry (a)	Paris	11
Weakley (a)	Martin	11
Haywood (a)	Brownsville	10
		<u>64</u>
Decatur (b)	Parsons	1
Chester	Henderson	1
McNairy	Selmer	2
Hardeman	Bolivar	2
Hardin	Savannah	0
Henderson	Lexington	1
Carroll (a)	Huntingdon	2
Gibson (b)	Trenton	3
Lake (b)	Tiptonville	2
Obion (a)	Union City	2
Benton	Camden	0
Crockett (b)	Alamo	0
		<u>16</u>

N = 80

(a) Counties with an urban population over 7,000 according to 1970 Decennial Census (Postma, 1980)

(b) Counties with no urban population according to 1970 Decennial Census (Postma, 1980)

TABLE III

FREQUENCY AND PERCENTAGE OF TYPE OF COMPLAINTS AGAINST
FACILITY AND NOT AGAINST FACILITY

Type of Complaint	Frequency	Percentage
Against the Facility		
Financial - Deposits not returned	3	5.35
Financial - Other	1	1.79
Food - Not assisted in eating	1	1.79
Food - Preferences not considered	5	8.93
Food - Insufficient amount	2	3.58
Food - Other	1	1.79
Administrative - Understaffing	12	21.43
Administrative - Placement	6	10.72
Residents Rights - Restricted	1	1.79
Residents Rights - Possessions	1	1.79
Building - Safety	15	26.78
Building - Heating	1	1.78
Resident Care - Bedsores	1	1.78
Resident Care - Physical abuse	1	1.78
Resident Care - Verbal abuse	1	1.78
Resident Care - M.D. not called	1	1.78
Resident Care - Lack of Medical Equipment	1	1.78
Resident Care - Other	2	3.58
	N = 56	100
Not Against the Facility		
Medicaid	5	20.84
Other Benefits	1	4.18
Guardian	1	4.18
Needs Less Restrictive Placement	1	4.18
Needs More Restrictive Placement	2	8.24
Personal Property	1	4.18
Community Alternatives	3	12.48
Family Problems	3	12.48
Placement Problems	6	24.98
Other	1	4.18
	N = 24	100

TABLE IV

FREQUENCY AND PERCENTAGE OF SOURCES OF REFERRAL

Source	Frequency	Percentages
Resident	8	10.50
Friend and Relative	27	35.00
Ombudsman	13	17.00
Other	8	10.00
Ombudsman and Community Group	6	8.00
Facility Administrator and/or Staff	8	10.50
Outside Professional	4	5.40
Ombudsman and Outside Professional	2	2.60
Resident/Friend or Relative	<u>1</u>	<u>1.30</u>
	N = 77	100

TABLE V

FREQUENCY AND PERCENTAGE OF COMPLAINTS
BY TYPE OF FACILITY

Facility Type	Frequency	Percentage
Intermediate Care Facility	33	41.77
Private Residence	13	16.46
Residential Home for Aged	16	20.25
Unlicensed Boarding Home	16	20.25
Other	<u>1</u>	<u>1.27</u>
	N = 79	100

TABLE VI

LENGTH OF TIME CASES WERE KEPT OPEN

Duration	No. of Cases
2 weeks or less	13
2 weeks to 1 month	32
1 month to 2 months	19
2 months to 3 months	5
3 months to 6 months	7
6 months to 24 months	0
12 months to 15 months	2
16 months to 12 months	0
Over 24 months	1
Missing Value	1
	N = 79

TABLE VII

FREQUENCY AND PERCENTAGE OF CASES RESOLVED

Category Label	Frequency	Percentage
Resolved	49	64.48
Partially Resolved	18	23.69
Not Resolved	8	10.52
Not Applicable	<u>1</u>	<u>1.31</u>
	N = 76	100

TABLE VIII

FREQUENCY OF PRIMARY AND SECONDARY ROLE CHOICES APPEARING
WITHIN COMPLAINTS AGAINST AND NOT AGAINST FACILITY

Roles	Number of Cases Using Primary	Number of Cases Using Secondary
Against		
Broker	15	8
Mediator	2	1
Educator	2	16
Organizer	12	0
Advocate	9	2
Therapeutically Supportive Role	0	4
Coordinator	0	4
Investigator	7	12
Not Against		
Broker	6	4
Mediator	1	1
Educator	1	2
Advocate	2	2
Therapeutically Supportive Role	1	1
Investigator	3	1
Other	<u>1</u>	<u>0</u>
	62	58

TABLE IX

MOST FREQUENTLY APPEARING PRIMARY ROLE CHOICES ACCORDING
TO THE TYPE AND CATEGORY OF COMPLAINT

Type of Complaint	Broker	Advocate	Organizer
Financial (a)		2	
Food (a)	1	5	
Administrative (a)			12
Residents Rights (a)	2	2	
Building (a)	10		
Resident Care (a)	3		
Medicaid (b)	1	1	
Other Benefits (b)			
Guardian (b)	1		
Placement (b)	2	1	
Personal Property (b)	1		
Community Alternatives(b)			
Family Problems (b)			
Other	1		

(a) Designates category of cases against the facility.

(b) Designates category of cases not against the facility.

TABLE X

MOST FREQUENTLY APPEARING SECONDARY ROLE CHOICES ACCORDING
TO THE TYPE AND CATEGORY OF COMPLAINT

Type of Complaint	Broker	Advocate	Investigator
Financial (a)	3		
Food (a)		10	5
Administrative (a)	1	1	10
Residents Rights (a)	3		1
Building (a)			
Resident Care (a)	1	1	
Medicaid (b)	2		
Other Benefits (b)			
Guardian (b)			
Placement (b)	1	2	1
Personal Property (b)			
Community Alternatives(b)		1	1
Family Problems (b)	1		
Other			

(a) Designates category of cases against the facility.

(b) Designates category of cases not against the facility.

TABLE XI

ROLE CHOICES AS THEY APPEARED MOST FREQUENTLY
IN TYPES OF FACILITIES

	ICF		RCF		Unlicensed Boarding Home		Private Home		Other	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
Broker	2	6	5	4	12	0	2	2	1	0
Mediator	3	1	0	0	0	0	2	0	0	0
Educator	3	11	5	0	0	0	2	1	0	1
Organizer	12	0	0	0	0	0	0	0	0	0
Advocate	5	0	0	0	5	2	1	0	0	0
Therapeu- tically Supportive	0	3	1	0	0	1	0	0	0	0
Coordinator	0	0	0	2	0	2	0	0	0	0
Investigator	4	2	3	1	2	11	1	0	0	0

(a) Designates the primary role

(b) Designates the secondary role

TABLE XII

FREQUENCY AND PERCENTAGE OF AGENCIES
OMBUDSMAN REFERRED TO

Category Label	Frequency	Percentage
State Licensure Agency	12	18.75
Legal Services	4	6.25
DHS Medicaid	2	3.12
Medicare	2	3.12
Other	37	57.81
Protective Services	6	9.38
DPH Medicaid	1	1.57
	N = 64	100

TABLE XIII

FREQUENCY AND PERCENTAGE AGENCIES
OMBUDSMAN CONSULTED WITH

Category Label	Frequency	Percentage
State Survey Agency	36	49.31
Legal Services	6	8.22
DHS Medicaid	6	8.22
Medicare	1	1.37
Other	24	32.88
	N = 73	100

TABLE XIV

FREQUENCY OF THE APPEARANCE OF THE ADVOCATE ROLE IN TYPES
OF COMPLAINTS AGAINST AND NOT AGAINST FACILITY

Type of Complaint	Number of Cases Using Primary	Number of Cases Using Secondary
Against		
Financial - Deposits not returned	2	
Food - Preferences not considered	5	
Residents Rights - Civil Liberties Restricted	1	
Building - Heating	1	
Resident Care - M.D. not called		1
Resident Care - Other		1
Not Against		
Medicaid	1	1
Needs More Restrictive Placement	1	
Placement Problems		1
Total	11	4

VITA

Sandra Ann Stone was born at Parks Air Force Base near Oakland, California on February 6, 1956. She attended elementary school in Lexington, Tennessee and graduated from Lexington High School in May of 1974. The following September, she entered Lambuth College, Jackson, Tennessee, and graduated in December of 1977 with a bachelor's degree in Social Work. In January of 1978, she began her practice as a social worker at the Jackson Mental Health Center. In January of 1980, she began work as long term care ombudsman with a legal services program funded by Title III of the Older Americans Act; In October of 1980, this program was absorbed by West Tennessee Legal Services, Inc. In addition to serving as long term care ombudsman, she has also received training to function as a paralegal while employed by West Tennessee Legal Services, Inc. Since June 1983, she has held the position of Coordinator/Case Manager of an In-Home Care Planning unit within the same agency. In March of 1983, she entered the Graduate School of The University of Tennessee, Knoxville, (Memphis Branch) and began study toward the degree Master of Science in Social Work. This degree was awarded in June, 1984.