ABSTRACT

*Data are reported from a pilot study of the ombudsman reporting system in one southeastern state. The focus of this article is the relationship between types of complaints investigated and resolved by both paid and volunteer long-term care ombudsmen operating under various auspices. Statistically significant differences exist between the resolution of complaints by volunteer and paid ombudsmen. Data are discussed in terms of the implications of these differences for the implementation of a federal mandate to increase citizen participation in long-term care facilities.*

# Volunteer and Paid Long Term Care Ombudsmen: Differences in Complaint Resolution

**F. Ellen Netting, PhD, ACSW, Ruth Huber, PhD, and James R. Kautz III, PhD**

## INTRODUCTION

Originally conceived in the early 1970s, the Long Term Care Ombudsman Program (LTC) emerged from demonstration projects in five states. In 1975 grants were provided to most states for ombudsman program development, and by 1978 each state was required to establish and operate a statewide ombudsman program. The program's original purpose was to respond to complaints from residents, families, staff, and others involved in nursing home facilities in the United States. Over the last few years, the purpose has expanded to include the monitoring of board and care, assisted living, and even home care programs in some states.

The Long Term Care Ombudsman Program provides an opportunity to explore how a public mandate is implemented through the use of paid and volunteer ombudsmen performing under both public and private auspices. The Older Americans Act requires ombudsmen to investigate complaints in long-term care facilities, but data have not been systematically collected to document what paid and volunteer ombudsmen do in their daily work. In 1993, one article analyzed data from various secondary sources in an attempt to understand volunteer and paid staff mix. It was concluded that there was a dearth of reliable documentation (Huber, Netting and Paton, 1993).

In this paper, the authors focus on those complaints that are most difficult for Long Term Care Ombudsmen to resolve, and differences between volunteer and paid ombudsmen. Using a database from one southeastern state in which the National Ombudsman Reporting System (NORS) has been piloted, the authors discuss the implications of these data for the use of volunteers and paid staff in district ombudsman programs.

## BACKGROUND

In 1984, Monk, Kaye and Litwin published a study which became the baseline

*F. Ellen Netting, PhD,* is Professor of Social Work at Virginia Commonwealth University. Current research activities include the evaluation of the coordinated care case management project at St. Joseph's Health Care Foundation in Albuquerque, New Mexico. She serves on the research team with Huber and Kautz in the development of a reporting system for the national long-term care of Ombudsman Program. *Ruth Huber, PhD,* is Associate Professor at Kent School of Social Work, University of Louisville, Kentucky. Current research areas include the cevelopment of computer software for the national long-term care of Ombudsman Program, which is funded by the Administration on Aging, three Hospice studies, and Social Work Education. *James R. Kautz, PhD,* is Program Evaluator in the Georgia Division of Aging Services located in Atlanta, Georgia. He previously served as the State Long-term Care Ombudsman in Louisiana from 1986–1990. Recent publications include the status of the Ombudsman program, a commissioned paper for the Insitute of Medicine Report on the Long-term Care Ombudsman Program.

measure of how ombudsman program implementation progressed in the early years. On a national level, the most common complaints heard by ombudsmen (and thus the most frequently addressed issues) were defined as follows:

- Residents' rights
- Consumer education for long-term care
- Nursing home regulations/ enforcement
- Abuse of residents
- Alternatives to institutionalization

Monk and his colleagues noted that "All these with the exception of nursing home regulation enforcement, were among the issues perceived as less difficult to address."

Ombudsmen were also asked to identify the "least frequently addressed issues." These were identified in the following order:

- Relocation trauma
- Residents' participation in facility governance
- Medicaid discrimination
- Boarding home standards
- Mental health needs of long-term care residents
- The upgrading of nursing home staff

It was reported that "with the exception of mental health needs of long-term care residents, these issues [were] perceived as more difficult to address."

Two possible explanations were suggested for why certain problems were more difficult to address than others. First, it was speculated that those complaints with which one dealt most frequently were perceived to be easier to resolve as ombudsmen became more familiar with them. Second, it was suggested that ombudsmen tended to focus their energies on those areas that were most easily resolved, thus inadvertently influencing the very type of complaints identified (Monk, Kaye and Litwin, 1984).

Whatever the reasons, the fact remains that the ombudsman program is designed to deal with those issues, problems, situations, and needs that arise in long-term care facilities in this country. By design, the program is somewhat reactive in that complaints are received and investigated. On the other hand, there is opportunity for ombudsmen to circumvent potential problems as they go in and out of various long-term care facilities and become familiar with those persons who work and live there. This may be especially true when volunteer ombudsmen are assigned to specific local facilities and become a community presences there.

Because the complaint reporting system is pivotal to what the ombudsman does, it has been viewed with concern over the past few years (Chelminsky, 1991; Huber, Netting and Paton, 1993; Kautz, 1990, 1993; Kusserow, 1991; Netting, Paton and Huber, 1992). Recently, there has been movement from the Administration on Aging (AoA) in developing the National Ombudsman Reporting System (NORS). In the process of developing NORS, there have been many changes made in the complaint reporting form. Complaints are categorized as follows:

*Residents' Rights*

A. Abuse, Gross Neglect, Exploitation
B. Access to Information
C. Admission, Transfer, Discharge, Eviction
D. Autonomy, Choice, Exercise of Rights, Privacy
E. Financial, Property (except for Financial Exploitation)

*Resident Care*

F. Care
G. Rehabilitation or Maintenance of Function
H. Restraints—Chemical and Physical

*Quality of Life*

I. Activities and Social Services
J. Dietary
K. Environment

*Administration*

L. Policies, Procedures, Attitude, Resources

M. Staffing
N. Certification/Licensing Agency
O. State Medicaid Agency
P. System/Others

Within each category, additional breakdowns are provided. For example, under Abuse, Gross Neglect, Exploitation, six types of abuse and exploitation are listed. The new revised form contains 133 complaint subcategories which were identified with extensive input from ombudsmen around the country. Many states are already using the new forms.

A complaint is defined by AoA as "a concern brought to, or initiated by, the ombudsman for investigation and action by or on behalf of one or more residents of a long-term care facility relating to health, safety, welfare or rights of a resident. One or more complaints constitute a case" (AoA, 1994). Therefore, a complainant may bring more than one concern to the ombudsman's attention and this situation may affect one or more persons.

From a national perspective, volunteers play important roles in most states' ombudsman programs. Their numbers have increased 209% since 1982 (from 3,306 in 1982 to 10,213 in 1994, Schiman and Lordeman, 1989; AARP/LCE, 1994). Many of these volunteers are certified or otherwise authorized to conduct investigations; however, a large number serve as visitors who are not authorized to investigate complaints but who assist paid ombudsmen in maintaining a presence in the facilities, keeping residents informed of their rights and of the ombudsman's service, and identifying problem conditions.

Although the need for sufficient human resources to visit facilities and resolve complaints is a major reason for recruiting, training, and managing volunteers, 20 of the 26 states that have strong volunteer programs reported that their commitment to increased community involvement in facilities significantly influenced their decision to invest in volunteers (Schiman and Lordeman, 1989b). This philosophical reason may explain why the Office of the Inspector General and AoA found that some states with relatively smaller populations over 60 years of age have more volunteers than states with over 1.5 million in that age range (AoA/OIG, 1993).

Volunteer efforts are not without their costs. "Although three-quarters of state ombudsmen reported to the American Association of Retired Persons (AARP) that volunteer recruitment is a very (48.9%) or moderately (25.5%) important activity for their programs, fewer than one-fifth (17.8%) reported that they are very successful with their recruitment efforts" (Feder, Edwards and Kidder, 1988). States also report high turnover of volunteers, which requires an investment in training, and states vary in how they manage their volunteer programs.

## THE STUDY

There are 15 local ombudsman programs in Kentucky: nine (60%) were located in Area Agencies on Aging (AAAs[1]) at the time current data were collected, and six (40%) were either housed by nonprofit organizations or independently incorporated. In October 1992, Kentucky began piloting the computerization of the revised ombudsman reporting form, using the 133 complaint subcategories identified above.

The ombudsman program in Louisville, the largest metropolitan area in Kentucky, is located in an AAA. In 1992–94 this program served 7,696 beds (23% of the Long Term Care beds in the state) and investigated approximately 13% of the complaints in the state. The ombudsman program in Lexington, the second most populous area, is a freestanding nonprofit agency designed specifically to operate the ombudsman program. This program served 4,880 beds in nursing facilities and board and care homes (14% of the LTC beds in the state), and investigated 33% of the complaints.

This study focuses on verified complaints:[2] what types of complaints are

most difficult to resolve, who investigates those complaints, and their disposition. To verify a complaint, ombudsmen must be able to contact a source, to actually observe or at least to have the situation confirmed by a reliable party. This is often a challenge, given the diverse nature of complaints and the frailty of the target population. If the complaint is verified, the ombudsman investigates the circumstances, develops resolution strategies, and follows through to disposition of the complaint (AoA, 1994).

## RESULTS

From October 1992 to August 1994, Kentucky's ombudsmen investigated 6,271 complaints and fielded 2,123 questions from callers. Of the 6,271 complaints lodged, 4,313 (69%) were verified. Table I provides the two most frequently lodged complaints in each of the five major complaint categories, and the number and percentage that were verified.

In Kentucky, 599 complaints (10%) were investigated by volunteers, and 5,509 (90%) by paid ombudsmen. There were significant differences across local programs within the Commonwealth in the use of volunteers. Eighty-seven percent of volunteer ombudsmen in Kentucky were used by programs housed within AAAs, as compared to 13% in nonprofit agencies. Within AAAs, volunteers represented 20% of ombudsman personnel, with paid staff comprising 80%. In non-AAA programs, volunteers represented only 2% as compared to 98% paid personnel. Of the approximately 108 certified ombudsmen who investigated complaints during the period of the current database, 51 (47%) were paid and 57 (53%) were volunteers. Of those 51 who were paid, however, 35 were part-time ombudsmen in a large, independent program with 12.5 full time equivalents.

The number of days that volunteer and paid ombudsmen took to act on complaints and the number of days cases remained open were similar. Numbers of miles traveled to facilities were almost the same for volunteers (16 miles) and paid staff (17 miles).

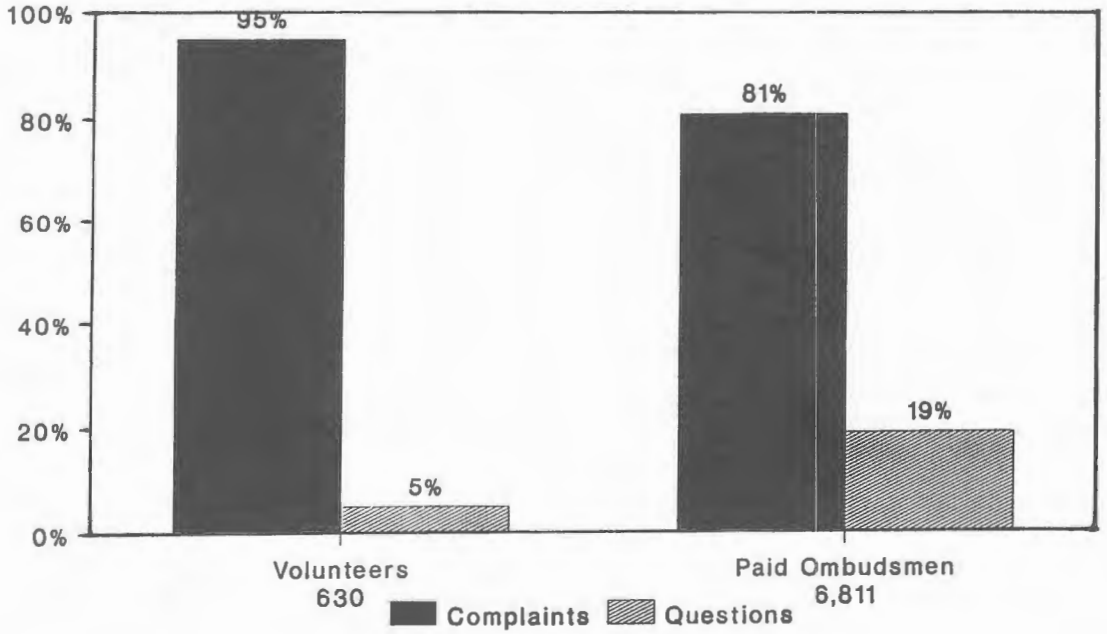
Because ombudsman programs are dependent upon volunteer as well as paid ombudsmen (see Huber, Netting and Paton, 1993 for elaboration on staff mix), complaint data were examined by

**Table I**
**Frequentcy and verification of the two most frequently lodged complaints in a sampling from the general complaint categories**

| | *Number and % of complaints lodged most frequently in each category* | | *Of complaints lodged, number and percentage verified* | |
|---|---|---|---|---|
| *Resident Rights* | | | | |
| Property lost or stolen | 197 | 10.3% | 139 | 70.6% |
| Resident's rights violated regarding discharge or eviction procedure | 167 | 8.7% | 129 | 77.2% |
| *Resident Care* | | | | |
| Poor personal hygiene | 278 | 15.5% | 189 | 68.0% |
| Call lights/requests for assistance ignored | 206 | 11.5% | 159 | 77.2% |
| *Quality of Life* | | | | |
| Poor quantity, quality of dietary and social services, variation and choice of menu; | 279 | 18.4% | 169 | 60.6% |
| Poor air temperature/quality | 122 | 8.0% | 90 | 73.8% |
| *Administrative* | | | | |
| Shortage of staff | 167 | 35.6% | 94 | 56.3% |
| Staff supervision | 61 | 13.0% | 29 | 47.5% |
| *Outside Systems* | | | | |
| Bed shortage: placement | 88 | 15.8% | 81 | 92.0% |
| Legal: guardianship, conservatorship, power of attorney, wills | 74 | 13.3% | 58 | 78.4% |

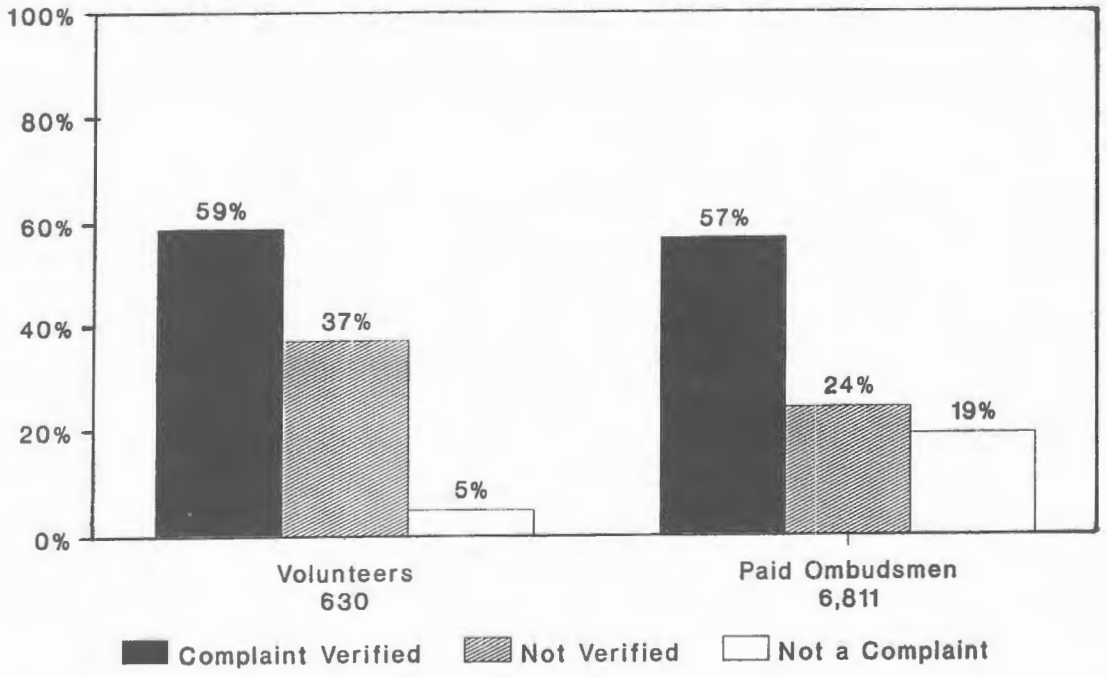
***The level of significance set for this study is p <.001.**

FIGURE 1.




Type of activity by ombudsmen's positions (n = 7,411)

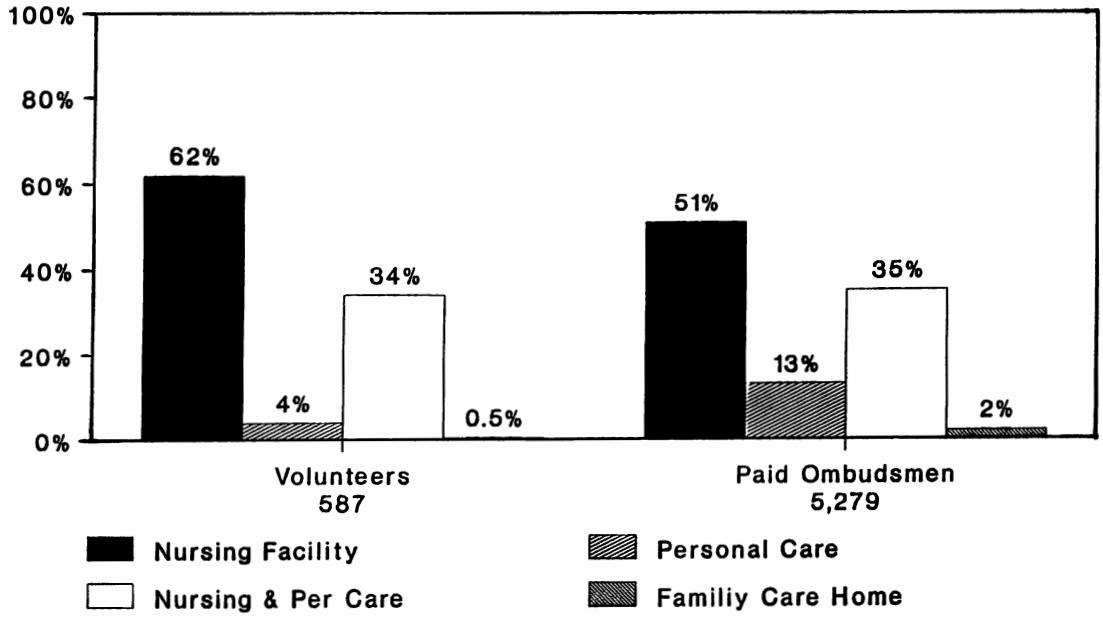
FIGURE 2.




Status of activities by ombudsmen's positions (n = 7,411)

whether ombudsmen were paid or volunteer. Volunteers indicated that the complaints they investigated affected a significantly higher number of residents than complaints addressed by paid ombudsmen ($p < .001$). An average of 85 residents were affected by each complaint investigated by volunteers, compared with 27 for

**FIGURE 3.**




**Kind of facility complaints were lodged against, by ombudsmen's positions (n = 5,866)**

paid ombudsmen. This may relate to the fact that volunteers monitor facilities with an average of 140 beds, compared with 117 beds for paid ombudsmen.

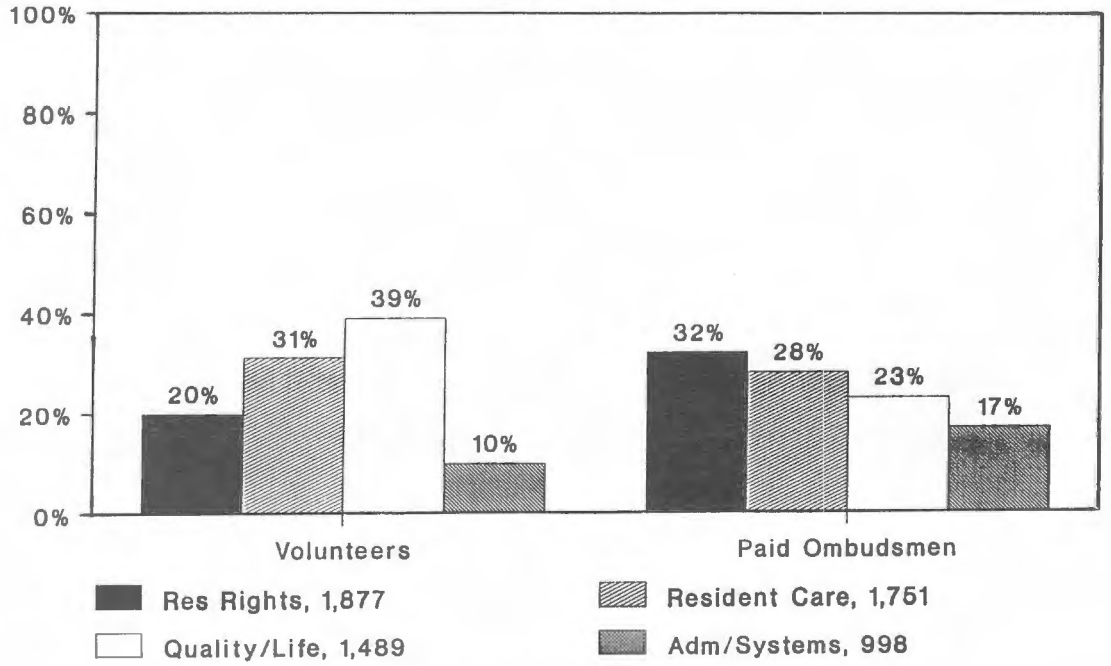
Figure 1 shows that 95% of volunteers' work pertains to actual complaints lodged, compared with 81% of the work of paid ombudsmen. Nineteen percent of paid ombudsmen's "complaint" activities were devoted to fielding questions from the public, compared with only 5% of volunteer activity. This 19% should be kept in mind as the differences between volunteer and paid ombudsmen are examined.

Figure 2 further breaks down the percentages of complaints that are verified/not verified by volunteer and paid ombudsmen. The percentages of complaints verified are quite similar: 59% of the complaints investigated by volunteers are verified, compared with 57% of those investigated by paid ombudsmen (Figure 2). The major difference is that 19% of paid ombudsmen's activities are devoted to answering questions, as previously discussed for Figure 1.

The practice of assigning volunteers to specific facilities, usually larger ones, is seen in Figure 3. Sixty-two percent of the complaints investigated by volunteer ombudsmen were lodged against nursing facilities (first bar in each group, Figure 3), compared with 51% of the complaints investigated by paid ombudsmen. Paid ombudsmen appear to be more active with complaints lodged against facilities that provide personal care (13% of paid ombudsmen, compared with 4% of volunteer ombudsmen). This difference will be mentioned again in the following discussion of the relationship between ombudsmen's positions (volunteer/paid) and general types of complaints investigated.

The differences in types of complaints investigated by volunteer and paid ombudsmen indicate that these two types of ombudsmen may approach their roles from different perspectives. Overall, only 16% of the complaints are lodged by the ombudsmen themselves. The largest single group of complainants includes family members and friends of residents (39%), followed by complaints lodged by residents themselves (27%). Facility staff and administrators lodge another 10% and the remaining 8% are lodged by guardians, staff members of medical and social service agencies, and other

FIGURE 4.




**Complaint type by ombudsmen's positions (6,115 complaints)**

unknown/anonymous reporters. However, of the complaints investigated by volunteers, 34% are discovered and lodged by the ombudsmen themselves. Of the complaints investigated by paid ombudsmen, only 14% are lodged by the ombudsmen themselves.

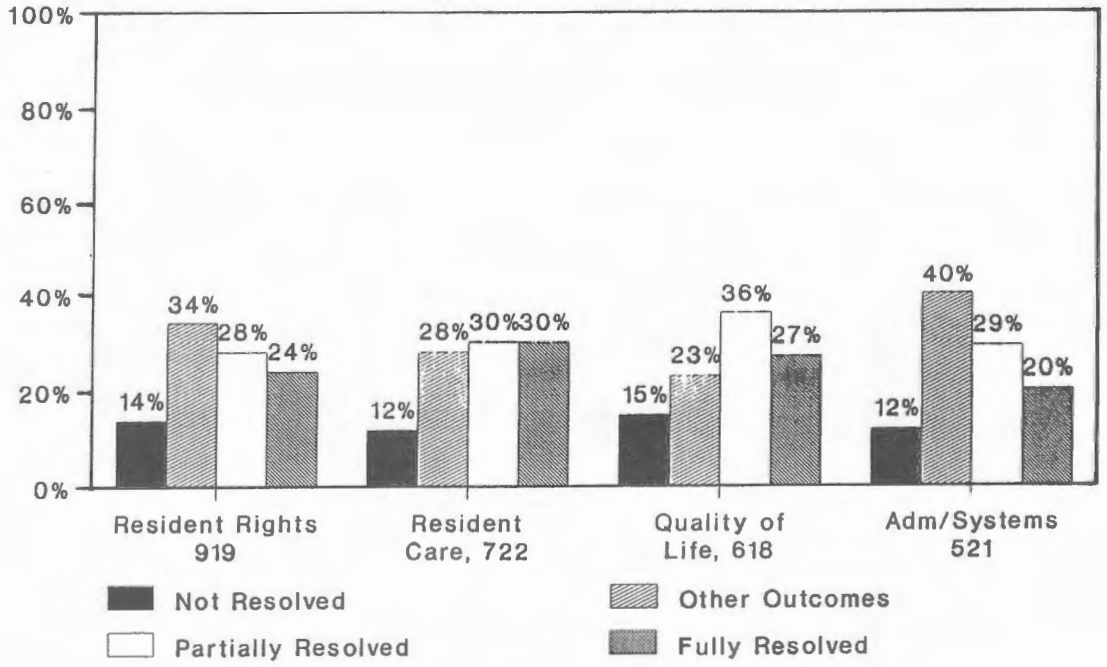
Figure 4 reveals that 20% of the complaints investigated by volunteers pertain to Resident Rights, compared with 32% of those investigated by paid ombudsmen (first bar in each group in Figure 4). Also, the third bar in each group shows that 39% of the complaints investigated by volunteers pertains to Quality of Life issues, compared with 23% of the complaints investigated by paid ombudsmen. Recall the previous finding that 34% of the volunteers' complaints are lodged by themselves, compared with only 14% of the complaints investigated by paid ombudsmen. Also remember that volunteers are more often assigned to larger facilities as a community presence for observation and monitoring. It follows, therefore, that they may have more opportunities to see the types of complaints that fall under Quality of Life (i.e., food and air quality— see Table I).

Paid ombudsmen, on the other hand, may have more training in the more complicated Resident Rights issues, and be more involved with Administrative and Larger System issues. The last bar in each group in Figure 4 shows that only 10% of the complaints investigated by volunteers pertain to these larger arenas, compared with 17% of the complaints that are investigated by paid ombudsmen. The routine presence of volunteer ombudsmen in the larger facilities may produce two very different results: (1) a decrease in the number of more serious complaints, i.e., abuse and gross neglect; but (2) the reporting of more complaints pertaining to Quality of Life issues.

After complaints are investigated, verified, and intervention has been implemented, ombudsmen choose disposition codes from the following:

1 Regulatory or legislative action is needed.
2 Not resolved.
3 Withdrawn by resident or complainant.
4 Referred, no final report received.
5 Referred, other agency failed to act.

FIGURE 5.




**Complaint type by disposition (n = 2,780 verified complaints)**

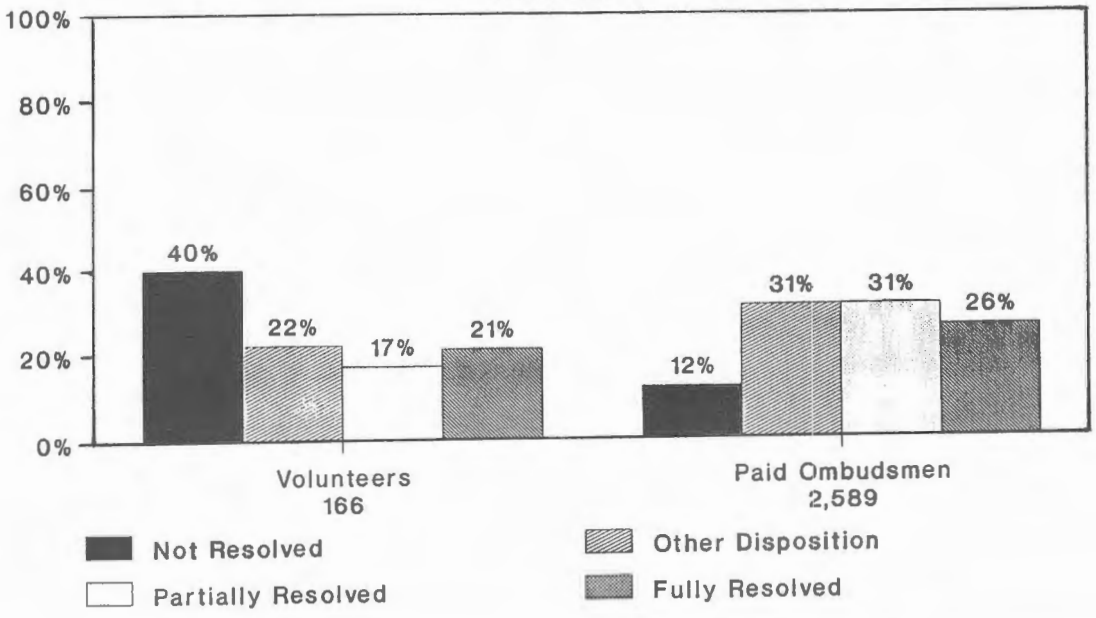
6 No action was needed/appropriate.
7 Partially resolved.
8 Fully resolved.

Overall, 56% of verified complaints are either partially or fully resolved.[3] Ombudsmen see themselves as advocates for elders who are sometimes unable to defend or advocate for themselves. Most ombudsmen, both volunteer and paid, take this role very seriously and tend to apply stringent criteria to the notion of a complaint being resolved. Some are hesitant to code a complaint as resolved even though the resident or complainant may deem it so, if they, the ombudsmen themselves, see more that could be done to improve the quality of that resident's life. Due to this critical litmus test, most ombudsmen are extremely conservative in calling a complaint fully resolved. They also must accept that some complaints just cannot *be* resolved, and some of the most rigorous ombudsmen keep their complaints open longer in their efforts to effect the best possible solution to the problem.

Across the four broad types of verified complaints, from 12% to 15% simply are not resolved (the first bar in each group in Figure 5). Not surprisingly, the most frequently reported complaints listed in Table I also appear at the top of the list of complaints that were not resolved, with the exception of Staff Supervision under Administrative, and Legal Issues under Outside Systems. Instead, appearing in the top ten complaints that were not resolved are (1) Other Abuse, Neglect and Exploitation (under Resident Rights), and (2) Care Plan/Resident Assessment issues (under Resident Care).

Quality of Life complaints are more often partially (36%) and fully resolved (27%). Even quality of life complaints are more closely associated with volunteer ombudsmen than paid; in Figure 6, 40% of the complaints investigated by volunteer ombudsmen are not resolved, compared with only 12% of those investigated by paid ombudsmen. Also in Figure 5, 40% of the complaints pertaining to Administrative and Systems issues were coded with dispositions other than Not Resolved, or Partially or Fully Resolved. These other dispositions include the need for regulatory, legal, and legislative action. While such a disposition does not

FIGURE 6.




**Disposition of verified complaints by ombudsmen's positions (n = 2,755)**

preclude the ombudsman from attempting to resolve issues through those avenues, those contacts may be more often available to paid ombudsmen than volunteers. This can also be seen in Figure 6, in the 31% of paid ombudsmen's complaints that are coded as other dispositions, compared with only 17% of the complaints investigated by volunteers.

## DISCUSSION AND IMPLICATIONS

The results of this study indicate that overall complaints involving Resident Rights, Resident Care, and Quality of Life are more often fully resolved than those complaints about Administrative or Systemic issues (Figure 5). These data are consistent with what Monk, Litwin and Kaye (1984) indicated a decade ago when ombudsmen reported that resident rights, consumer education, abuse of residents, and alternatives to institutionalization were easier to resolve than nursing home regulations/enforcement. There appears to be a difference between resolving those complaints that are more client-centered or more resident-specific, than addressing those complaints that raise administrative or larger systems concerns.

Administrative/systemic complaints would most likely be referred to other agencies such as Adult Protective Services or Legal Services. Because these complaints may take longer to investigate, particularly if legislative change or lengthy investigation is required, there is a much greater possibility that the complainants and/or the originating ombudsman will never see full resolution of their particular cases. However, these are the longer-term systemic changes that need to be well documented so that they become institutionalized into the facility or the larger system as patterns are observed and changes are made. In fact, it may be the larger system complaints that give ombudsmen clues to what strategies require collaboration with other agencies and coalitions that seek to reform the long-term care system statewide or nationally. Although these complaints are not as easy to resolve in traditional ways, it is important that they be analyzed because they may impact larger numbers of people.

The use of volunteers and paid staff has been discussed at length elsewhere (Schiman and Lordeman, 1989a), but it is important to point out that the findings in this paper are consistent with those re-

ported from secondary data sources (Huber, Netting and Paton, 1993). In studies conducted prior to the implementation of the database in Kentucky it was found that programs with fewer volunteers appeared to resolve a higher proportion of complaints (Huber, Netting and Patron, 1993). In this study, volunteers were less likely to fully resolve complaints than paid ombudsmen. Rather than assume that this means volunteers are less effective, it raises important questions about understanding how individual programs involve volunteers. The tasks assigned to volunteers in ombudsman programs vary greatly. Schiman and Lordeman (1989b) point out that only one-third of ombudsman programs allow volunteers to handle actual complaint investigation and resolution. It is paid staff who actually carry out these functions. Also, volunteers may be less likely to complete the paperwork, making it more difficult to know when complaints are actually resolved.

The data tell a story about the roles that volunteer and paid ombudsmen play in one state. Volunteers tend to be more tied to specific facilities which are larger than the average seen by paid ombudsmen. This probably occurs because paid ombudsmen monitor smaller personal care or board and care homes that bring the average facility size down. Volunteers tend to identify quality of life issues and assume these complaints are affecting other residents. Given the nature of Quality of Life complaints (e.g., activities and social services, dietary and environment), this is not surprising since these types of complaints go beyond individual resident needs. For example, nursing home residents are often concerned about the quality of the food and this type of complaint would be coded as Quality of Life. Food may be a concern for almost every resident there. Volunteers seem to have a more focused role in ombudsman programs in that they are typically assigned to specific facilities, investigate complaints that are more facility or resident centered, and often receive complaints directly from residents or through their own observations and interactions. Paid ombudsmen, on the other hand, appear to be more involved in larger systems issues, work with other agencies more often in complaint investigations, and receive more complaints from families and others.

Of particular interest is the fact that volunteers are used almost exclusively by those programs housed in AAAs which are public agencies in the state of Kentucky. Contrary to the nostalgic notion that the voluntary nonprofit sector uses more volunteers, this statewide program uses the majority of its volunteers in public agency positions. One could argue that AAAs are not "typical" public bureaucracies and that the aging network has been socialized to the use of volunteers from its inception. Limited funding and a community organization focus may have made AAAs more like nonprofits than typical public organizations. Regardless, it is interesting that the bulk of the volunteer ombudsmen in one state is based in the public rather than the private sector.

Given the use of volunteers in ombudsman programs throughout the United States, these Kentucky data reported in this paper reinforce the benefits of a complaint-specific database that allows state ombudsmen to more closely examine complaints that are not resolved as well as particular situations that result in "other outcomes." It is now possible to know how different types of complaints/cases are handled. State and local ombudsmen can then confer with the ombudsman (paid or volunteer) who has worked on a particular case. Rather than wondering why 607 complaints were not resolved, those complaints can be identified and staff conferencing can occur. If patterns are observed, appropriate continuing education on how to handle those types of complaints can be provided. For example, those unresolved complaints handled by volunteers can be reviewed to see why they were not resolved. If issues are identified specific to these complaints, change strategies can be mounted. For example, if

a state ombudsman observes that half of all unresolved cases involve only three facilities, the ombudsman may want to conduct a personal investigation.

## CONCLUSION

This paper provides a glimpse of what is happening in one state that is systematically developing a database for the National Long Term Care Ombudsman Program. There are implications for staff and volunteer development and training as this process occurs. By having these data at the fingertips of state and local ombudsmen, it is possible to monitor specific complaints and cases, to identify patterns, and to literally target unique situations that need concentrated attention. State and district ombudsmen (both paid and volunteer) have the opportunity to respond to trends, to structure their development and training sessions, to educate the public, and even to alter their activities as they gain clearer pictures of what is happening throughout their districts and the state.

## NOTE

We support efforts toward gender-neutral language in the social sciences and prefer to use the term *ombudsperson* instead of *ombudsman*. We have learned, however, that program officials have decided to keep the original term as it came from Sweden. Our goal is to strengthen the program—not to offend ombudsmen, so we acquiesce to their preference of terms.


## ACKNOWLEDGMENTS

We want to thank the many state and local ombudsmen who have shared their experiences with us. We are particularly grateful to Gary Hammonds, Kentucky State Long Term Care Ombudsman, and the dedicated ombudsmen throughout the Commonwealth of Kentucky.


## FOOTNOTES

[1]AAAs are the district or sub-state planning and coordination units within each state. They typically contract with local providers for direct delivery of home- and community-based services.

[2]AoA defines a verified complaint as one that is determined after investigative work (interviews, record inspection, observations, etc.) that the circumstances described in the complaint are substantiated or generally accurate.

[3]AoA defines a resolved complaint/problem as one that was addressed to the satisfaction of the resident or complainant.

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