

**STRENGTHENING THE OLDER AMERICANS  
ACT'S LONG-TERM CARE PROTECTION  
PROVISIONS: A CALL FOR  
FURTHER IMPROVEMENT OF  
IMPORTANT STATE OMBUDSMAN PROGRAMS**

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*The problem of nursing home abuse is pervasive throughout the country. Nationwide, nursing home residents, as well as family and friends of residents, complain regularly about inadequate care. The federal government has recognized this severe problem and has attempted to address it legislatively through the use of ombudsmen. This legislation arose from the belief that an objective third party was necessary to monitor nursing home residents' care. Theoretically, the ombudsmen receive, investigate, and try to resolve problems or complaints affecting residents in long-term care facilities. Across the country, the role of the nursing home ombudsman varies substantially and reflects the policies established by the state program. Unfortunately, due to such problems as poor staffing and limited authority and autonomy, ombudsmen are not nearly as effective as they should be.*

*In this note, Ms. Elizabeth Herrington proposes several changes to the current ombudsman program. She emphasizes that the federal government needs to establish a uniform documentation system to see the actual effects of the ombudsman program. In addition, Ms. Herrington asserts that because ombudsman program funding is from the federal government, additional statutes should be implemented to en-*

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sure residents in one state receive similar benefits as in another. She proposes that ombudsman programs should use in-house or outside legal counsel as their primary counsel for advice, representation, and consultation. Ms. Herrington also argues that by giving ombudsmen more authority and training and making other necessary improvements, the program will be an effective way to curb elder abuse in nursing homes nationwide.

## I. Introduction

Patrick Shane Williams, a young male nurse, was found in the room of a screaming, half-naked eighty-four-year-old Alzheimer's sufferer.<sup>1</sup> An investigation by the nursing home ensued when Williams could offer no plausible explanation for the resident's agitated condition.<sup>2</sup>

Confronted with incriminating evidence, Williams confessed his wrongdoing to receive a plea bargain from the state.<sup>3</sup> During his employment as a night nurse, he had raped again and again victims ranging from 61 to 102 years old.<sup>4</sup> For three years at the Meadow Manor nursing home in Taylorville, Illinois, Williams had raped several women, all of whom were confused or demented.<sup>5</sup> Although several complaints had been made about him, no one listened to the victimized women's pleas for help.<sup>6</sup> Until this final incident, Williams maintained the women were delusional and no further investigation had occurred.<sup>7</sup>

Many complaints in nursing homes do not reach the outrageous abuse level of the Williams case, nor do the majority involve sexual abuse. According to recent data, however, the problem is extensive; the state-legislated Illinois Department on Aging Elder Abuse Pro-

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1. See Jennifer Foote, *Sex Abuse Easy to Hide, Difficult to Prosecute*, PLAIN DEALER (Cleveland, Ohio), May 15, 1995, at 4E.

2. See *id.*

3. See *id.*

4. See *id.*

5. See *id.*

6. See *id.*

7. See Doug Finke, *Area Nursing Home Fined for Not Having Equipment*, THE STATE JOURNAL-REG. (Springfield, Ill.), June 28, 1995, at 11. The nursing home involved is the subject of several civil lawsuits filed by relatives of nursing home patients allegedly raped by Williams. Williams was sentenced February 22, 1995, to 10 years in prison after pleading guilty to aggravated criminal sexual abuse and attempted aggravated assault against the 84-year-old woman involved in the case. *Id.*

gram assisted nearly 5000 elder abuse victims in fiscal year 1995.<sup>8</sup> The majority of these reports involved financial exploitation, which is highly associated with emotional abuse.<sup>9</sup>

Many experts believe these complaint rates are not indicative of the truly high incidence of resident negligence and abuse.<sup>10</sup> The types of possible abuse also vary greatly among facilities. Once in the homes, many residents have no one to monitor their care closely. Choosing the wrong nursing home, therefore, may possibly consign a resident to physical and emotional hardships, including premature dependency or even premature death.<sup>11</sup> An attorney or family member may be called upon not only to counsel an elderly person on long-term needs, but also to assist that person in choosing providers.<sup>12</sup>

The federal government has recognized this severe problem and has attempted to address it legislatively.<sup>13</sup> Such growing awareness of the need for protection in nursing homes led to the belief that a neutral third party must keep an objective eye on patients' care.<sup>14</sup> As a result of these findings, the Long-Term Care Ombudsman Program was created by the federal government in the early 1970s.<sup>15</sup> In a 1975 statement, former Commissioner on Aging, Arthur S. Flemming, warned that all the new nursing home regulations would be of little help "unless our communities are organized in such a manner that

8. See 1996 ILL. DEP'T ON AGING ANN. REP. 3.

9. See *id.*

10. See MARIA R. PIPPIDIS & KAREN F. STEIN, NATIONAL AGING RESOURCE CTR. ON ELDER ABUSE, ELDER ABUSE AND NEGLECT: A SYNTHESIS OF ELDER ABUSE RESEARCH 1 (1990) [hereinafter ELDER ABUSE]; Susan J. Hemp, Note, *The Right to a Remedy: When Should an Abused Nursing Home Resident Sue?*, 2 ELDER L.J. 195, 197 (1995).

11. See *Nursing Homes. When a Loved One Needs Care. In Search of the Right Home (Nursing Homes: Part I)*, CONSUMER REP., Aug. 1995, at 518, 518 [hereinafter *Nursing Homes*].

12. See JOAN M. KRAUSKOPF ET AL., ELDERLAW: ADVOCACY FOR THE AGING § 12.58 (West 2d ed. 1993).

13. See INSTITUTE OF MED., REAL PEOPLE, REAL PROBLEMS: AN EVALUATION OF THE LONG-TERM CARE OMBUDSMAN PROGRAMS OF THE OLDER AMERICANS ACT 44 (1995).

14. See *id.* at 41.

15. See *id.* at 2. Although current ombuds practitioners are both male and female, the majority of nursing home ombuds practitioners are female. When referring to the ombuds position, however, this note will use the term "ombudsman" to encompass both females and males serving in this capacity. This is due to the fact that historically, those who served in the ombuds office were male and were titled "ombudsmen." See Shirley A. Wiegand, *A Just and Lasting Peace: Supplanting Mediation with the Ombuds Model*, 12 OHIO ST. J. ON DISP. RESOL. 95 (1996). This does not implicate that males are more frequently utilized or have been found better qualified for such work.

new laws and new regulations are utilized to deal with the individual complaints of older persons who are living in nursing homes."<sup>16</sup>

In 1993, the Institute of Medicine began an evaluation of the long-term care ombudsman programs and made various recommendations.<sup>17</sup> Many problems, however, still persist with the manner in which the program's objectives are currently implemented, and the federal government has not yet made needed changes. Although federally mandated, the funding and staffing of ombudsman program offices are regulated by the states, as are duties and powers delegated to the individual offices.<sup>18</sup> As a result, states still vary in the role and responsibilities they place upon the ombudsmen.<sup>19</sup> Many elder law advocates agree that although ombudsman programs in nursing facilities may have the potential to be a real force in modern quality assurance, their role to date has been ambiguous and interpreted differently by the majority of states.<sup>20</sup> Numerous barriers today still impede their maximum effectiveness.<sup>21</sup>

In August 1995, Consumer Reports performed an undercover investigation of fifty-three nursing homes and twenty-seven assisted living and board-and-care facilities across the country.<sup>22</sup> Among other deficiencies, the findings of this investigation showed that the quality of care at thousands of this nation's nursing homes is "poor or questionable at best" and that government agencies set up to assist the public, such as area agencies on aging and state and local departments

16. 1993 ILL. DEP'T ON AGING LONG-TERM CARE OMBUDSMAN PROGRAM ANN. REP. 1.

17. See INSTITUTE OF MED., *supra* note 13, at 2. This study was conducted by an Institute of Medicine appointed 16-member expert committee comprising individuals recognized for their long-term care expertise and other relevant backgrounds. The committee engaged in many fact-finding activities to develop its evaluation. See *id.*

18. See *id.* at 99-100. States and localities vary in the manner in which they comply with both the actual law and spirit of these programs. In Illinois, of the ombudsmen surveyed in preparation for this note, few conducted training of their visiting volunteers identically. Almost every area varied somewhat in the manner in which they carried out their programs and recruited their volunteers, although many indicated they required 14 1/2 hours of initial training for area ombudsmen.

19. See *id.* at 87.

20. See generally GEORGE D. POZGAR, LONG-TERM CARE AND THE LAW, A LEGAL GUIDE FOR HEALTH CARE PROFESSIONALS (1992).

21. See INSTITUTE OF MED., *supra* note 13, at 147.

22. See *Nursing Homes*, *supra* note 11, at 518. The article was based on a year-long investigation into the long-term care system, during which a senior editor, posing as a daughter whose mother needed care, visited the nursing homes and assisted-living facilities, requested assistance from government and other referral agencies, and analyzed thousands of inspection reports from the Health Care Financing Administration. See *id.*

of elder affairs, provide "little or no useful, concrete information about specific facilities."<sup>23</sup> Over twenty years after the inception of the long-term care ombudsman programs, a question remains as to whether the programs constitute a real solution to the nursing home dilemmas across the country and, if so, how such programs may reach their maximum effect. In regard to ombudsman programs, Flemming's warning has proven to be justified.

This note proposes that the currently operated ombudsman programs are not effective and, therefore, must be examined and altered in order to rectify the problems existing in nursing homes today. The examination involves an in-depth look at the background of the programs, the function of ombudsmen, and their roles in nursing facilities. The author reviews the program at the national level and more specifically at the Illinois state level. The author analyzes the effectiveness of the current ombudsman programs as a remedy to nursing home complaints and the barriers to the program's ultimate success. Finally, this note proposes changes in the role of the ombudsman, improvement in the structure of the program, access to legal remedies, and more funding to support the program.

## II. Background

### A. The Need for Monitoring Nursing Homes

#### 1. THE GRAYING AMERICAN POPULATION

The need for nursing home care has risen, causing a corresponding increase in the numbers of facilities established in this country.<sup>24</sup> In the United States today, 12.6% of the population is at least sixty-five

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23. *Id.* at 518-19.

24. See Gerard Mantese et al., *Issues Relating to the Care of the Elderly in Nursing Homes*, 73 MICH. B.J. 176, 176 (1994).

A nursing home is one type of institutional living arrangement in which residents—usually older persons who cannot care for themselves—pay a fee to live in a facility which provides shelter, food, medical care, and assistance in daily functions, as needed. Many different living options may meet part or all of this definition, including home health care programs, adult day care centers, elderly housing, retirement villages, nursing homes, and hospices. . . . Another term often used is long-term care, which refers to prolonged health care and domestic services provided to people who are unable to do many things for themselves.

*Id.* The term "nursing home" encompasses this type of service as well and will be used throughout this note to refer generally to these various care options.

years old, and 1.3% is eighty-five and older.<sup>25</sup> According to the Population Reference Bureau, by the year 2020, the number of those at least sixty-five is expected to reach 52 million people, or 17.7% of the U.S. population.<sup>26</sup> By the year 2025, estimates predict an American population with approximately half as many teenagers as people over sixty-five.<sup>27</sup> By 2030, the number of eighty-five year olds may reach 2.2% of the population.<sup>28</sup>

In 1980 approximately 1.2 million nursing home residents lived in the United States.<sup>29</sup> In 1990, there were approximately 1.5 million people<sup>30</sup> living in thousands of nursing homes in the United States. There is a 50% likelihood that a person will, at some time, be placed in a nursing home.<sup>31</sup> Furthermore, the total number of nursing home residents is predicted to grow from an estimated 3.4 million in 1992<sup>32</sup> to 4.8 million by 2050.<sup>33</sup>

Two distinct groups of elderly residents have been recognized as needing nursing home care.<sup>34</sup> One group is made up of persons recovering in a skilled nursing facility after an illness, broken bone, or similar condition.<sup>35</sup> These people reside in the facility a relatively short time and are soon discharged, or their condition may worsen immediately and they die. The other group of residents more likely suffers from many chronic illnesses and may reside in the homes for

25. See Theresamarie Mantese & Gerard Mantese, *Nursing Homes and the Care of the Elderly*, 51 J. Mo. B. 155, 155 (1995).

26. See Bruce C. Vladek et al., *The Changing Face of Long-Term Care*, HEALTH CARE FIN. REV., Summer 1993, at 6.

27. See Gerard Mantese et al., *supra* note 24, at 176.

28. See POPULATION REFERENCE BUREAU, POPULATION REFERENCE HANDBOOK (1994).

29. See Mantese et al., *supra* note 24, at 176.

30. See CHAIRMAN OF THE SUBCOMM. ON HEALTH & LONG-TERM CARE, HOUSE SELECT COMM. ON AGING, 102D CONG., 1ST SESS., PROTECTING AMERICA'S ABUSED ELDERLY: THE NEED FOR CONGRESSIONAL ACTION 1 (Comm. Print 1991) [hereinafter PROTECTING].

31. See Mantese et al., *supra* note 24, at 176.

32. See PROTECTING, *supra* note 30, at 148.

33. See Mantese et al., *supra* note 24, at 176. Therefore, the use of nursing homes is expected to grow by 76% in the next 30 years. See *id.*; PROTECTING, *supra* note 30, at 176. Such changing character of the nursing home population and the fact there are relatively very few caregiver families that exist today has been well recognized among elder scholars. See Jan Ellen Rein, *Preserving Dignity and Self-Determination of the Elderly in the Face of Competing Interests and Grim Alternatives: A Proposal for Statutory Refocus and Reform*, 60 GEO. WASH. L. REV. 1818, 1820 (1992). Professor Rein notes that as projected, nearly one-fourth of all Americans will be age 65 or older, and one-fourth of those Americans will be placed in a nursing home at some time. *Id.*

34. See KRAUSKOPF ET AL., *supra* note 12, § 12.2.

35. See *id.*

an extended period of time, often years.<sup>36</sup> The average long-term resident stays in a facility more than two years.<sup>37</sup>

Clearly, the changing character of society requires preparation for the pressure that will be placed on our care resources. To ensure that humane care for the needs of our aging population is provided, nursing homes will need more monitoring.

## 2. ILLINOIS NURSING HOME DEMOGRAPHICS

Each state has its own system of nursing facilities available for its aging population. In 1994, more than 100,000 individuals resided in Illinois nursing homes.<sup>38</sup> Thirty-eight percent of these residents are over eighty-five years old, 29% are between the ages of seventy-five and eighty-four, and 13% are between sixty and seventy-four years of age.<sup>39</sup>

In 1994, Illinois had 1220 licensed long-term care facilities.<sup>40</sup> Of these, over two-thirds were privately owned by individuals or corporations.<sup>41</sup> The remaining one-third was owned by religious, charitable, or fraternal groups.<sup>42</sup> A small fraction of facilities was owned either by the state, federal, or local county governments.<sup>43</sup> Like many other states and their respective health departments, all of these Illinois facilities receive an annual licensure inspection by the Illinois Department of Public Health to monitor the quality of the care rendered.

## 3. THE PROBLEM OF ABUSE NATIONWIDE

The special needs of the dependent elderly in nursing facilities heightens the concern about the quality of their care. Although federal and state regulatory responses to abuse grew and ultimately

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36. *See id.*

37. *See id.*

38. *See* 1994 ILL. DEP'T OF PUB. HEALTH LONG-TERM CARE FACILITY STATEWIDE SUMMARY PROFILE (Sept. 1995). When this note was written, these were the most recent compilations of Illinois statistics available. As of December 31, 1994, there were 103,108 residents in Illinois nursing homes. *See id.*

39. *See id.*

40. *See id.* This figure grew from 1119 in 1993, exemplifying the trend Illinois is showing in nursing care growth. *See* 1993 ILL. DEP'T ON AGING LONG-TERM CARE OMBUDSMAN PROGRAM ANN. REP. 8 (1994).

41. *See* ALTERNATIVES FOR THE OLDER ADULT, INC., YOUR GUIDE TO SELECTING A NURSING HOME 4 (1995).

42. *See id.*

43. *See id.* The exact figures cited by Alternatives for the Older Adult are as follows: 67% privately owned by individuals or corporations, 28% not for profit owned by religious, charitable, or fraternal groups, 5% public operated by the state, federal, or local county governments. *See id.*

peaked in the 1970s,<sup>44</sup> the problem still runs rampant in nursing homes nationwide.<sup>45</sup> Abuse may encompass a wide range of actions by nursing home staff, but has been specifically defined by one study as "the infliction of physical pain, injury or physical coercion."<sup>46</sup>

"Elderly persons may suffer a series of losses [including] health, mobility, independence, faculties, and personal dignity."<sup>47</sup> Many nursing home residents require assisted feeding, bathing, and constant attention.<sup>48</sup> "Almost half . . . have senile dementia or chronic organic brain syndrome."<sup>49</sup> Nearly half of people over eighty-five have Alzheimer's disease.<sup>50</sup> Often residents suffer from "heart conditions, . . . visual impairments (including cataracts), urinary problems, . . . cancer or they might have had a stroke."<sup>51</sup> Residents' various health problems may require constant care such as assistance with dressing, bathing, or getting in or out of bed or a chair.<sup>52</sup>

According to the General Accounting Office (GAO), while these residents are becoming increasingly dependent, they are ironically given less care.<sup>53</sup> Nationwide, nursing home residents, as well as their family and friends, complain regularly about the inadequate care many residents receive in their nursing homes.<sup>54</sup> More than 197,820 total complaints were received in fifty states in 1993,<sup>55</sup> and nursing facility investigations have regularly found appalling conditions.<sup>56</sup> Federal review committees have recognized that high quality care still eludes many nursing homes today.<sup>57</sup>

44. See Hemp, *supra* note 10, at 197.

45. See *id.* (citing COMMITTEE ON NURSING HOME REGULATION, INSTITUTE OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES 3 (1986)).

46. See ELDER ABUSE, *supra* note 10, at 2.

47. Mantese & Mantese, *supra* note 25, at 177.

48. See *id.* "Approximately 91% of all nursing home residents require assistance with bathing, and over half have bowel or urinary incontinence." *Id.*

49. *Id.*

50. See *id.* Alzheimer's is "described as an organic mental disorder caused by a progressive degeneration of brain cells." *Id.*

51. *Id.*

52. See PROTECTING, *supra* note 30, at 2.

53. See GENERAL ACCOUNTING OFFICE, MEDICAID AND NURSING HOME CARE: COST INCREASES AND THE NEED FOR SERVICES ARE CREATING PROBLEMS FOR THE STATES AND THE ELDERLY 26-27 (1983).

54. See INSTITUTE OF MED., *supra* note 13, at 77.

55. See *id.*

56. See *Nursing Homes*, *supra* note 11; *Today* (NBC television broadcast, Aug. 23, 1995). Interviewee Trudy Lieberman of Consumer Reports stated that through a survey of fifty nursing homes in eight states around the country she found "a great deal of neglect and poor care given to the residents of nursing homes." *Id.*

57. See GENERAL ACCOUNTING OFFICE, MEDICARE AND MEDICAID: STRONGER ENFORCEMENT OF NURSING HOME REQUIREMENTS NEEDED 3 (1987) [hereinafter *MEDI-*



The House Subcommittees on Health and Long-Term Care have provided statistics regarding the abuse of institutionalized elderly.<sup>58</sup> Approximately 35% of nursing home residents may be denied necessary medical and nursing care, 20% may not be provided a safe, clean environment at the facility, and 15% may be subjected to physical or sexual abuse.<sup>59</sup> The majority of negligence claims, however, come from injuries that occur when residents fall or wander away from staff members.<sup>60</sup>

In a 1990 survey of 577 nurses and nurses' aides in long-term care facilities, four out of five respondents had seen at least one incident of psychological abuse of a resident in the preceding year, with the most prevalent form being yelling, swearing, or insulting a patient in anger.<sup>61</sup> Half of the respondents observed swearing at or insulting patients.<sup>62</sup> One-fifth of survey respondents reported physical abuse by using unnecessary physical restraints.<sup>63</sup> One in six said they saw nursing home staff push, pinch, or grab a resident in some manner.<sup>64</sup>

Surprisingly, 10% of the respondents from the nursing homes reported that they themselves had committed one or more physically abusive acts.<sup>65</sup> Almost 40% of these same respondents reported that they had committed at least one psychologically abusive act within

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CARE AND MEDICAID] (finding that approximately one-third of nursing homes failed to meet health or safety requirements in three consecutive inspections).

58. See PROTECTING, *supra* note 30, at 5-6.

59. See *id.* In this congressional survey:

9 of 10 require assistance bathing;

7 of 10 require assistance dressing;

1 of 2 require assistance going to the bathroom;

1 of 3 require assistance eating;

4 of 10 have trouble or cannot control their bowels or bladders.

*Id.* at 2.

60. See Marshall B. Kapp, *Malpractice Liability in Long-Term Care: A Changing Environment*, 24 CREIGHTON L. REV. 1235, 1242 (1991).

61. See Karl Pillemer & David W. Moore, *Abuse of Patients in Nursing Homes: Findings from a Survey of Staff*, 29 GERONTOLOGIST 314, 317 (1989). Pillemer and Moore conducted a phone survey of 577 respondents, "61% of which were nursing aides, 20% were licensed practical nurses, and 19% were registered nurses." *Id.* at 315.

62. See *id.* at 317. The majority of these had reported seeing abuse indicated that it had occurred more than once. Of the 577 respondents, "23% had witnessed other staff isolating a patient beyond what was needed to control him or her." Fifteen percent reported threats to residents, and thirteen percent reported witnessing denial of food or privileges to residents. See *id.*

63. See *id.*

64. See *id.*

65. See *id.*

the preceding year.<sup>66</sup> The study results suggest that maltreatment of elderly in nursing homes may occur as a common part of institutional life rather than merely in isolated, well-publicized incidents.

A variety of staff characteristics contribute to the level of abuse that occurs. Studies have shown that lower quality care tends to be provided by staff who are younger, less well educated, have fewer years of experience working in nursing homes, and are nursing aides rather than nurses.<sup>67</sup> None of these variables, however, relate to any particular form of abuse.<sup>68</sup>

Instead of psychological or physical abuse by a staff member, sometimes a resident's relative is the offender.<sup>69</sup> Relatives have been found stealing from the resident's bank account, as well as denying the elderly relative an opportunity to object to being placed in the home against his or her will.<sup>70</sup> Because abuse may come from the only source of human contact available to an elderly victim, the abuse is especially egregious and unfair. The elderly may be at the mercy of these people they trust and are not able to actively seek out alternate help.<sup>71</sup> There clearly needs to be a remedy available for abuses of the vulnerable elderly, a remedy within the homes themselves.

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66. See *id.* This study also asked the facility staff members what characteristics are most prevalent among the physically and psychologically abusive staff people they observed. The characteristics included: (1) reporting frequent thoughts of quitting; (2) believing that "patients are like children"; (3) reporting high burn out; (4) reporting high conflict with patients; (5) complaining of stress in their personal lives. Characteristics found not to be explanative of abusive behaviors included: size and patient cost of the facility; age, experience, and education of the staff person; and the type of staff. See *id.* at 318.

67. See T.M. Baltz & J.G. Turner, *Development and Analysis of a Nursing Home Aid Screening Device*, 17 GERONTOLOGIST 66, 67 (1977).

68. See Pillemer & Moore, *supra* note 61, at 318.

69. See ELDER ABUSE, *supra* note 10, at 15.

70. Telephone Interview with Annette Scherer, Illinois Substate Ombudsman from Peoria, Ill. (Jan. 16, 1995).

71. Note the House Subcommittee on Health and Long-Term Care determined only one out of every eight cases of elder abuse is reported. This is even much lower than the estimate that one out of every three cases of child abuse is reported. A House Subcommittee's 1990 report reflects a decrease in reporting from the 1981 House Report, which estimated that one out of every five cases of elder abuse is reported. CHAIRMAN OF HOUSE SUBCOMM. ON HEALTH AND LONG-TERM CARE OF THE SELECT COMM. ON AGING, 1ST CONG., 2D SESS., REPORT ON ELDER ABUSE: A DECADE OF SHAME AND INACTION 1-28 (Comm. Print 1990).

## B. The United States' Ombudsman Model Remedy

### 1. ORIGIN OF THE OMBUDSMAN MECHANISM

The term "ombudsman" is derived from an 1809 concept of the Swedish Parliament and originally designated a person who would listen to complaints about the government and attempt to resolve the disputes in an impartial manner.<sup>72</sup> Throughout its various public agencies and private organizations, "the United States has more ombudspersons than anywhere else in the world."<sup>73</sup> Some ombudspersons are also used for dispute resolution settings other than traditional government functions.<sup>74</sup>

Interestingly, the ombudsman dispute resolution mechanism has undergone substantial changes since implemented, and the current American ombudsman model bears little similarity to the classic Swedish model.<sup>75</sup> However, regardless of the changes to the original ombudsman model, the United States has clearly embraced the ombuds idea in the past twenty-five years, including its usage in nursing facilities.<sup>76</sup>

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72. See Wiegand, *supra* note 15, at 98. Although the ombudsman office originated in Sweden in the 18th century, "[t]he name 'ombudsman' derived from practices of medieval Germanic tribes." Under the decentralized, informal governments of these tribes, one of the punishments available for wrongdoers was to pay a fine. The lawbreaker's family was expected to pay such fine to the victim's family. A neutral third person collected the fine and delivered it to the victim's family to avoid further conflict. "Imagine a Viking with horned helmet marching up to the door of a medieval Nordic hut. The man of the house answers the call and then shouts back to his family: 'It's the man about the fine: the Ombudsman.'" *Id.* (citing Stanley V. Anderson, OMBUDSMAN PAPERS: AMERICAN EXPERIENCE AND PROPOSALS 2 (1969)). "Om" means "about"; "bud" originates from "offering" or "bribe"; one who visits regarding an offering is an ombudsman. The word has since come to mean any type of agent. *Id.*

73. *Id.* at 102 (footnote omitted). Numbers of ombudsmen throughout these organizations are difficult to estimate exactly. As of 1987, some examples of their implementation frequency included three dozen newspapers and nearly 4000 hospitals. Also, a great many businesses have client or consumer complaint offices which employ ombudsmen. Mary P. Rowe, *The Corporate Ombudsman: An Overview and Analysis*, 3 NEGOTIATION J. 127, 139 (1987).

74. See John M. Eckert et al., *Training and Orientation of Certified Ombudsperson Volunteers for Long-Term Care Facilities*, EDUC. GERONTOLOGY 743, 744 (1993). Mr. Eckert, an Illinois substate ombudsman from Evanston, Illinois, noted in his article that some of the newer roles for ombudspersons include helping mental patients, hospital psychiatric patients, and vocational rehabilitation clients. See *id.*

75. See Wiegand, *supra* note 15, at 96. According to Professor Wiegand, it is fair to say that few, if any, of the American ombuds offices exactly fit the classical model of the Swedish ombudsman. See *id.* at 103.

76. See *id.* at 103-10 for a history of the implementation of ombuds offices into federal and state governments over the past 25 years.

## 2. THE FEDERAL NURSING HOME OMBUDSMAN DEVELOPMENT

Responding to increasing concerns about the quality of nursing facilities, the care provided in them, and the government's ability to regulate these facilities, former President Richard Nixon proposed an eight-point initiative in 1971 to improve conditions in the nation's nursing facilities.<sup>77</sup> One point called for using state ombudsman investigative units to improve quality of care by focusing exclusively on the resident, in order to compensate for the limitations of regulations and other quality assurance strategies.<sup>78</sup> Then, in 1972, the Department of Health, Education, and Welfare (DHEW) gave five contracts for states to implement nursing facility ombudsman programs.<sup>79</sup> In 1973, due to a DHEW reorganization, the federal Administration on Aging (AOA) received administrative responsibility for the five experimental ombudsman programs.<sup>80</sup> Under the guidance of the AOA, the five programs were placed "within the infrastructure of the 'aging network' of state and area agencies on aging."<sup>81</sup> "This network, through the [Older Americans Act (OAA)]<sup>82</sup> . . . is authorized to foster the development . . . of supportive services for individuals 60 years of age or older."<sup>83</sup>

"The 1978 amendments to the OAA provided the ombudsman program with federal enabling legislation by requiring each state to establish an ombudsman program."<sup>84</sup> This federal "mandate instructed ombudsman programs to investigate complaints; train and supervise volunteers; monitor the development of federal, state and local laws, regulations, and policies and provide public agencies with information about problems faced by [nursing facility] . . . residents."<sup>85</sup> The federal government, however, provided limited oversight and gave the states great flexibility to administer this mandate as they de-

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77. See INSTITUTE OF MED., *supra* note 13, at 43.

78. See *id.*

79. See *id.* These demonstration programs were in Michigan, Pennsylvania, South Carolina, Wisconsin, and Idaho.

80. See *id.* Assignment of such programs "was consistent with AOA's statutory responsibilities for advocacy and coordination on behalf of the elderly at the federal level." *Id.*

81. *Id.*

82. Older Americans Act of 1965, Pub. L. No. 89-73, 79 Stat. 218 (codified as amended in scattered sections of 42 U.S.C.).

83. INSTITUTE OF MED., *supra* note 13, at 43.

84. *Id.* at 44.

85. *Id.*

sired.<sup>86</sup> Therefore, the state programs have taken on diverse roles, assumed different tasks, and developed differently.<sup>87</sup>

In 1981, the program grew when Congress added oversight of "board and care" facilities to the ombudsmen's required responsibilities.<sup>88</sup> At that time, the ombudsman program's name changed from "Nursing Home Ombudsman" to "Long-Term Care Ombudsman" but federal funding was not increased with the expansion.<sup>89</sup>

The idea of the volunteer ombudsman gained acceptance within communities nationwide. A 1986 Institute of Medicine report<sup>90</sup> documented an investigation which found resident abuses occurring nationwide, many of which violated rights of privacy, informed consent, and access to legal advocacy services. After issuance of this report, Congress passed landmark federal nursing home reform legislation in 1987.<sup>91</sup> The Omnibus Budget Reconciliation Act,<sup>92</sup> known as OBRA '87, contained two major legislative changes which attempted to unify states' compliance and their ability to reach and serve residents.<sup>93</sup> First, the Nursing Home Quality Reform Act mandated that nursing facility residents have "direct and immediate access to ombudspersons when protection and advocacy services become necessary."<sup>94</sup> Second, "the 1987 reauthorization of the OAA charged states to guarantee ombudsmen access to facilities and patient records," as well as provide more legal services for the program's use.<sup>95</sup> With this legislation, "[s]tate ombudsmen were also given the official authority to designate local programs to carry out ombudsman functions."<sup>96</sup> "Duly

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86. *See id.*

87. All 50 states currently create ombudsman programs for their nursing facilities by statute, although these programs vary greatly in many aspects. *See id.* at 45-46.

88. *See id.*

89. *See id.* at 44-45.

90. INSTITUTE OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES (1986).

91. *See* INSTITUTE OF MED., *supra* note 13, at 45.

92. 42 U.S.C. § 3058 (1994).

93. *See* INSTITUTE OF MED., *supra* note 13, at 45.

94. *Id.* Note that the Institute of Medicine, under contract with the Administration on Aging, produced a comprehensive study of nursing home regulations and policies, with recommendations for reform. *See id.* at v. Many of the Institute of Medicine study's proposals were adopted by Congress in OBRA '87, which was "widely hailed as the most significant federal legislation affecting nursing homes since the creation of the Medicare and Medicaid programs in 1965." Joel M. Hamme, *Federal Nursing Home Reform: An Overview*, in THE LONG TERM CARE HANDBOOK: LEGAL, OPERATIONAL & FINANCIAL GUIDEPOSTS 9, 9 (1991).

95. INSTITUTE OF MED., *supra* note 13, at 45.

96. *Id.*

authorized employees and volunteers of these programs were then considered 'representatives' of the state ombudsman with all the ombudsman's rights and privileges accorded to them."<sup>97</sup>

OBRA '87 legislation also codified specific high quality standards and emphasized meeting nursing home residents' needs.<sup>98</sup> Among other remedial provisions, OBRA established resident care standards, created a federal resident's "bill of rights" to be monitored by ombudsmen and residents themselves, and required a sharp reduction in the use of restraints on residents.<sup>99</sup>

Congress then adopted regulations to enact OBRA '87 in 1991.<sup>100</sup> OAA amendments made in 1992, however, are the most recent regulations pertaining to ombudsmen duties.<sup>101</sup> They highlight the role of local ombudsman programs and the state ombudsman's role as an advocate and agent for systemwide change in the treatment of elders in nursing facilities nationwide. Importantly, the majority of nursing facilities are Medicare and Medicaid participants and therefore must comply with the Nursing Home Reform Act and with OBRA's implementing regulations in order to receive compensation for residents backed by these two federal funds.<sup>102</sup>

The ombudsman programs today operate in all fifty states, the District of Columbia, and Puerto Rico.<sup>103</sup> Some individual state statutes supplement and enhance the federal mandate of OBRA.<sup>104</sup> There are approximately 12,000 trained and state-licensed volunteers nationwide serving as long-term care ombudsmen under state run programs funded by the federal government and administered by the federal AOA.<sup>105</sup> The AOA reports that more than 218,000 complaints were

97. *Id.*

98. See Steven M. Levin et al., *Protecting the Rights of Nursing Home Residents Through Litigation*, 84 ILL. B.J. 36, 36-37 (1996).

99. See *id.*

100. See *id.* These codified standards then changed expectations from a goal of minimum maintenance of residents to the "highest practicable physical, mental, and psychosocial well-being" of individual nursing home residents. *Id.* (citing 42 C.F.R. § 483.25 of OBRA regulations).

101. See Older Americans Act Amendments of 1992, Pub. L. No. 102-375, 106 Stat. 1195.

102. See 42 U.S.C. §§ 1395(i)(3)(a)-(h), 1396(r)(a)-(h) (Supp. 1994).

103. See INSTITUTE OF MED., *supra* note 13, at 45.

104. See, e.g., CAL. WELF. & INST. CODE § 9700 (West 1995); FLA. STAT. ANN. § 415.106 (West 1997); MASS. ANN. GEN. LAWS ch. 19A, §§ 27-35 (Law. Coop. 1988).

105. See Robert W. Stock, *On Patrol to Help Those Who Cannot Help Themselves*, N.Y. TIMES, Oct. 24, 1996, at C4.

made by nursing home residents and their families to ombudsman programs in 1995, twice the figure reported in 1987.<sup>106</sup>

### III. Analysis

#### A. Implementation of Nursing Home Ombudsman Programs

##### 1. THE INTENDED ROLE OF THE NURSING HOME OMBUDSMAN

A nursing home ombudsman, in theory, trouble-shoots or mediates unresolved problems between residents or their families and a nursing facility.<sup>107</sup> Researchers have concluded, however, that there is no exact job description accurately reflecting the duties of the ombudsman in the nursing home.<sup>108</sup> According to many definitions, good ombudsmen are objective mediators and problem solvers, but their goals may vary.<sup>109</sup> The role of nursing home ombudsmen combines this neutrality with the objective of advocacy and representation of residents' interests over those of other parties involved.<sup>110</sup> Abuse of their duty of neutrality can cause them to forfeit the trust and respect of the constituencies they serve. Theoretically, the ombudsmen receive, investigate, and try to resolve problems or complaints affecting residents in long-term care facilities. Ombudsmen, however, can neither make, set, nor change laws, nor can they independently enforce particular recommendations.<sup>111</sup>

The OAA does not specifically define the ombudsmen's role within a nursing facility.<sup>112</sup> Various theories have been posited concerning the functions of the ombudsmen once they reach the homes. Interviews with ombudsmen suggest that the positions may be inherently tension filled.<sup>113</sup> For example, at times the "ombudsmen must often be highly critical of facilities and agencies under their review; on the other hand, they must be able to work cooperatively with these parties to ensure the resident is well-served."<sup>114</sup> Ombudsmen also

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106. See *id.*

107. See *id.*

108. See Wiegand, *supra* note 15, at 99.

109. See *id.*

110. See INSTITUTE OF MED., *supra* note 13, at 45.

111. See Jeffrey S. Kahana, *Reevaluating the Nursing Home Ombudsman's Role with a View Toward Expanding the Concept of Dispute Resolution*, 1994 J. DISP. RESOL. 217, 217 (1994).

112. See INSTITUTE OF MED., *supra* note 13, at 62.

113. Telephone Interview with Kathleen Allison, Illinois Substate Ombudsman from Bloomington, Ill. (Jan. 30, 1996).

114. INSTITUTE OF MED., *supra* note 13, at 45.

must interact with an extensive array of program administrators and policy makers regarding laws, regulations, and policy and program instructions.<sup>115</sup>

The OAA requires an ombudsman to identify, investigate, and resolve individual complaints relating to the residents of nursing homes.<sup>116</sup> Research reveals, however, at least three different roles which ombudsmen may play within the nursing home: friend, advocate, and mediator.<sup>117</sup>

**a. Therapeutic Role: Residents' Helpers** First, ombudsmen may play a therapeutic or developmental role in the homes.<sup>118</sup> Such a role may include education of residents and families of residents, or merely serving as a helper to the resident.<sup>119</sup> The ombudsman who falls into this category is seen as providing emotional support to individual residents, thereby facilitating residents' adjustment in the nursing home. In this role, volunteer ombudsmen are often available to facilitate discussions about the merits of different nursing homes in their area to help concerned families make informed decisions about nursing home placement for a loved one.<sup>120</sup>

**b. Advocate Role: Active Legal Service Provider** The ombudsman may act also as an active advocate on behalf of residents. Those states most closely adhering to the "legal advocate" philosophy emphasize the 1987 and 1992 amendments to the OAA which add the requirement that adequate legal counsel be available to the ombudsman program.<sup>121</sup>

115. See *id.* at 66.

116. See 42 U.S.C. § 3058(a)(3)(A) (1994).

117. See Kahana, *supra* note 111, at 228.

118. See Abraham Monk & Lenard W. Kaye, *The Ombudsman Volunteer in the Nursing Home: Differential Role Perceptions of Patient Representatives for the Institutionalized Aged*, 22 GERONTOLOGIST 194, 195 (1984).

119. Telephone Interview with Kathleen Allison, Illinois Substate Ombudsman from Bloomington, Ill. (June 27, 1997). Although residents and their families sometimes do become an ombudsman's friend, their role primarily remains more as a "helper" to residents rather than a friend. See *id.*

120. See generally *Nursing Homes*, *supra* note 11. Some ombudsmen appear more willing to implicate wrongdoing by certain nursing facilities than others. According to the report, Sister Gloria Maher, an ombudsman in New Orleans, stated, "I don't tell much about the bad [nursing homes]." *Id.* This suggests that in this role ombudsmen may sometimes not be as effective as in their other roles.

121. The states are required by the OAA amendments to provide the following:



The Vermont Long-Term Care Ombudsman Program is representative of this theory.<sup>122</sup> Their program is part of Vermont Legal Aid and has continuous direct legal support, more so than some other states.<sup>123</sup> The Florida Program also relies on a full-time in-house counsel who actually specializes in long-term care issues.<sup>124</sup> Illinois, in contrast, does not directly utilize this model and does not have continuous direct legal support for complaints.<sup>125</sup>

Although in need of legal services, most programs do not contain this component.<sup>126</sup> The legal needs of the ombudsman are usually of two types: complaint investigation coupled with daily advocacy, and program issues.<sup>127</sup> Legal issues often pervade a nursing home resident's life with respect to quality of benefits such as Medicare or Social Security.<sup>128</sup> A resident's benefits can be easily reduced by the facility administering them.

Although the state offices of the long-term care ombudsman do not seem to be litigation-prone organizations, they sometimes defend the rights of those living in a nursing home. For example, in 1994, nursing home residents assisted by the District of Columbia Office of the Long-Term Care Ombudsman filed a class action suit against the District for its failure to fully implement the Nursing Home Reform Law of 1987.<sup>129</sup> The previous year, another Washington D.C. ombudsman filed suit in order to gain the right to inspect a District

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(1)(A) *adequate legal counsel is available*, and is able, without conflict of interest, to— (i) provide advice and consultation needed to protect the health, safety, welfare, and rights of residents; and (ii) assist the Ombudsman and representative of the Office in the performance of the official duties of the Ombudsman and representatives; and (B) legal representation is provided to any representative of the Office against whom suit or other legal action is brought or threatened to be brought in connection with the performance of the official duties of the Ombudsman or such a representative; and (2) the Office pursues administrative, legal, and other appropriate remedies on behalf of resident.

42 U.S.C. § 3058g(g) (1994) (emphasis added).

122. See Lori Owen & Michael R. Schuster, *Legal Support to Long-Term Care Ombudsman Programs: Seven Years Later*, 28 CLEARINGHOUSE REV. 617, 619 (1994).

123. See *id.*

124. See *id.* at 618.

125. See *id.* at 620.

126. See *id.* at 619. Many state ombudsman programs are housed within state agencies and therefore rely on the Office of the Attorney General for both legal advice and representation rather than actually containing legal services within their program. See *id.*

127. See *id.* at 617.

128. See *id.* at 617-18.

129. See *Newman v. Kelly*, 848 F. Supp. 228, 228 (D.C. Cir. 1994).

facility's records.<sup>130</sup> In that case, both pro bono counsel and Legal Counsel for the Elderly represented the ombudsmen.<sup>131</sup>

Ombudsmen surveys indicate that three legal support possibilities are available: the state attorney general's office, ombudsman program in-house counsel and private attorneys, or legal services program.<sup>132</sup> Most state ombudsman programs depend on individual state Offices of the Attorney General for "formal advice, consultation, and legal representation."<sup>133</sup> Those states, like Illinois, have programs housed within a state agency.<sup>134</sup> Some also rely on the legal services department in their state for legal support.<sup>135</sup>

The ombudsman advocate can use information-gathering powers on behalf of the residents to help bring political or legal action.<sup>136</sup> Federal law requires state nursing home ombudsmen to keep records of abuse and other problems in nursing homes, but often the categories of abuse are not specified in detail.<sup>137</sup> Therefore, this reporting requirement tells the federal government very little about problems in the homes. Some ombudsmen, however, are employed by their respective state departments, and therefore are not permitted to lobby their legislatures for program changes as actively as they might wish.<sup>138</sup>

In January 1994, a survey was sent to state ombudsmen from the National Long-Term Care Ombudsman Resource Center.<sup>139</sup> The results showed that on average states relied mostly on informal counsel, as developed through relationships with agencies.<sup>140</sup> In response, several state ombudsmen suggested that funds should be made available to hire in-house counsel for the state program.<sup>141</sup>

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130. See Owen & Schuster, *supra* note 122, at 618 n.5 (citing *Rye v. Kelly*, No. 93-12791 (D.C. Super. Ct. filed Nov. 8, 1993)).

131. See *id.*

132. See *id.*

133. *Id.* at 619.

134. See *id.* at 620.

135. See *id.* at 619. Note that some surveyed Illinois substate ombudsmen, including Esther Hays Wander of Carterville, Illinois, indicated that law school legal clinics such as that at Southern Illinois University were supportive of their local needs.

136. See Kahana, *supra* note 112, at 229.

137. See *id.* at 225-26.

138. Telephone Interview with Kathleen Allison, *supra* note 119.

139. See Owen & Schuster, *supra* note 122, at 616 n.7 (citing a survey sent to state ombudsmen in January 1994 by the National Long-Term Care Ombudsman Resource Center (NLTCORC)).

140. See *id.*

141. See *id.*

*c. Mediation Role: Conduit for Resident Legal Help* The ombudsman also might play a mediation role, that of a catalyst to ensure that legal service is made available to persons who would not ordinarily have access.<sup>142</sup> Although the catalyst philosophy is advocate oriented, it perceives litigation by ombudsmen as “an ineffective method of resolving residents’ complaints.”<sup>143</sup> Proponents of this advocacy concept argue that the licensing agency or legal services programs should pursue legal remedies on behalf of residents.<sup>144</sup> Catalyst theorists argue that these legal agencies should perform their legal mandates.<sup>145</sup> Instead of the ombudsmen being involved in litigation, ombudsmen act as conduits of information for legal professionals under this theory.

Catalyst theorists’ experience and knowledge lead them to believe that involvement in litigation can strain the relationship ombudsmen have with facilities and other agencies, thereby making communication, consumer advocacy, and negotiation more difficult.<sup>146</sup> Legal services attorneys, rather than the actual ombudsmen, provide the legal representation. Some ombudsmen, as in Georgia, act as the resident’s representative.<sup>147</sup> This mediator role of the nursing facility ombudsman facilitates a method of dispute resolution that may be efficient, cost effective, and permits individually tailored solutions to be developed by the ombudsman that can be matched to the particular needs of the nursing home resident.<sup>148</sup>

Regardless of which of the three ombudsman models is chosen by an individual state program, the pertinent OAA amendment requires “adequate” and “available” legal services.<sup>149</sup> These words indicate that some form of counsel must devote the time and resources to address an ombudsman’s particular needs within the state.<sup>150</sup> Research reveals, however, that ombudsman programs need more resources to retain counsel and legal services.<sup>151</sup>

Actual availability of adequate legal counsel is contingent on numerous factors. Often, too, such legal counsel must overcome con-

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142. See Monk & Kaye, *supra* note 118, at 197.

143. Owen & Schuster, *supra* note 122, at 620.

144. See *id.*

145. See *id.*

146. See *id.*

147. See *id.*

148. See Kahana, *supra* note 111, at 222.

149. See Owen & Schuster, *supra* note 122, at 620.

150. See *id.*

151. See INSTITUTE OF MED., *supra* note 13, at 150.

flicts of interests and standing issues.<sup>152</sup> If the ombudsman is not an attorney, which most are not, he or she needs the ready help of competent counsel that is sufficiently experienced in long-term care issues to zealously advocate on behalf of the programs. This requires more adequate and available funding and proper ombudsman training so they may anticipate the need for legal services.

Across the country, the role of the nursing home ombudsman varies substantially and reflects the policies established by the state program. Variability in organizational placement, program operation, funding, and utilization of human resources has given rise to at least fifty-two distinctive approaches to implementing the program.<sup>153</sup> Often the functions vary for an individual ombudsman as circumstances may dictate. When able to switch roles easily, the ombudsmen may be particularly well-suited to handle a wide range of disputes and may have greater ease in processing options they choose to pursue on residents' behalf.<sup>154</sup> Conflicts of interests to which ombudsmen respond may vary according to the types of disputes, the individuals or groups involved, the state requirements of a particular ombudsman program, and the experience of the particular ombudsman.<sup>155</sup>

To fulfill their responsibilities, ombudsmen also must have thorough and up-to-date knowledge concerning various topics for the roles they perform. The ombudsmen must at least vaguely know the laws and regulations governing nursing facilities before they can make an assessment of whether a violation needing intervention has occurred. The AOA, since 1988, has supported a resource center that provides information for the ombudsman program.<sup>156</sup>

The 1992 congressional amendments mandated that the AOA establish procedures for the training of ombudsmen, both paid and volunteer.<sup>157</sup> The AOA, however, has failed to do so.<sup>158</sup> Therefore, the states have made up their own guidelines for training new ombudsmen.<sup>159</sup> Depending on the particular state, different roles are

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152. See Owen & Schuster, *supra* note 123, at 620.

153. See INSTITUTE OF MED., *supra* note 13, at 45.

154. See Kahana, *supra* note 111, at 229.

155. See *id.*

156. See INSTITUTE OF MED., *supra* note 13, at 71. The center is sponsored jointly by the National Citizen's Coalition for Nursing Home Reform and the National Association of State Units on Aging. See *id.* at 88.

157. See *id.*

158. See *id.*

159. See *id.* at 90.

more encouraged than others.<sup>160</sup> Where there are fewer visits per home due to fewer ombudsmen in a certain area, the ombudsmen likely focus more on advocacy rather than adopting a more therapeutic role. The Illinois program has developed its own specific arrangement.

## 2. THE DESIGN OF THE ILLINOIS LONG-TERM CARE OMBUDSMAN PROGRAM

Pursuant to statute, the Illinois Nursing Home Ombudsman Program<sup>161</sup> was established through the federal Older Americans Act in 1971. The state promulgates administrative rules establishing responsibilities of the Illinois ombudsmen.<sup>162</sup> In Illinois, the therapeutic or catalyst view of the ombudsman's role appears to be the current view of the program.<sup>163</sup>

The Illinois Long-Term Care Ombudsman Program is organized in a pyramid structure.<sup>164</sup> This structure determines the level of influence the ombudsmen have—the most influential at the top of the triangle being the two paid state ombudsmen with offices at the Illinois Department on Aging in Springfield.<sup>165</sup> Illinois is divided into thirteen planning and service areas (PSAs) based on census data of persons over the age of sixty.<sup>166</sup> The two state ombudsmen oversee the operation of the ombudsman programs and assist residents and families in over 1000 nursing homes within Illinois counties.<sup>167</sup>

Seventeen substate ombudsmen operate under the guidance of the two state ombudsmen. The number of substate ombudsmen per PSA varies depending upon the number of licensed beds for the eld-

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160. See Kahana, *supra* note 111, at 232.

161. 20 ILL. COMP. STAT. 105/4.04 (West 1996).

162. Telephone Interview with Neyna Johnson, Co-Director of Illinois State Ombudsman Program (Oct. 31, 1995).

163. See *id.*

164. See *id.*

165. See *id.* The two state ombudsmen directors, Neyna Johnson and Beverly Rowley, oversee the 18 substate ombudsmen that are dispersed throughout the state, each covering a number of counties. 1993 ILL. DEP'T ON AGING LONG-TERM CARE OMBUDSMAN PROGRAM ANN. REP. 20. Illinois is divided into 13 planning and service areas (PSAs). See *id.* at 19. In these areas, the substate ombudsmen oversee and train volunteer ombudsmen that visit the homes. The number of visits per nursing home depends greatly on the number of volunteers the program attracts and can afford to train. See Telephone Interview with Kathleen Allison, *supra* note 119.

166. See Eckert et al., *supra* note 74, at 745.

167. See 1993 ILL. DEP'T ON AGING LONG-TERM CARE OMBUDSMAN PROGRAM ANN. REP. 8 tbl.1.

erly and the needs of each area.<sup>168</sup> Finally, at the base of this organizational structure are the volunteer ombudsmen who visit the homes on a regular basis and are the "eyes and ears" of the program. Ombudsmen visitors have an ongoing presence but do not have investigative power.<sup>169</sup> The substate ombudsmen recruit and oversee volunteer ombudsmen though the number of volunteers per PSA varies greatly.<sup>170</sup> Although volunteer ombudsmen appear to have little authority, they serve to gain the trust of residents through their repeated appearances at the homes.<sup>171</sup>

Pursuant to Illinois law, the Department of Aging rules dictate the responsibility of ombudsmen to investigate and resolve complaints "made by or on behalf of residents of long term [sic] care facilities relating to actions, inaction or decisions of providers, or their representatives, of long term [sic] care facilities, of public agencies, or of social services agencies, which may adversely affect the health, safety, welfare, or rights of such residents."<sup>172</sup> When the need arises, the representatives are to report complaints to the relevant regulatory state agency. In the last four years, Illinois ombudsmen have fielded a 53% increase in abuse and neglect complaints.<sup>173</sup> The 1996 Illinois Department on Aging Annual Report states that between October 1994 and September 1995, the Illinois Ombudsman Program responded to 4124 complaints made by or on behalf of licensed long-term care facility residents.<sup>174</sup>

According to a 1993 report on Illinois' program, the reported number of days between the beginning of an investigation of a nursing facility complaint and the resolution may vary, taking as little as one day to complete or lasting as long as 474 days.<sup>175</sup> An average resolution time is sixty days.<sup>176</sup> Of that total time, ombudsmen may spend from fifteen minutes to seventy hours investigating and resolving the complaint, with the average being five hours.<sup>177</sup>

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168. See Telephone Interview with Kathleen Allison, *supra* note 119.

169. See Telephone Interview with Neyna Johnson, Director of Illinois State Ombudsman Program (Mar. 7, 1996).

170. See *id.*

171. See *id.*

172. 20 ILL. COMP. STAT. 105/4.04 (3)(c) (West 1996).

173. See Levin et al., *supra* note 98, at 38 (citing ILL. DEP'T ON AGING, REPORT OF THE ILLINOIS LONG-TERM CARE OMBUDSMAN PROGRAM (unpublished excerpt)).

174. See 1996 ILL. DEP'T ON AGING ANN. REP. 4-5.

175. See 1993 ILL. DEP'T ON AGING LONG-TERM CARE OMBUDSMAN PROGRAM ANN. REP. 15.

176. See *id.*

177. See *id.*

No set ratio exists between the number of ombudsmen and the number of homes per PSA.<sup>178</sup> According to Illinois Substate Ombudsman Nancy Whitty, the ratios vary depending on how many volunteers the area can afford to train.<sup>179</sup> In the area she covers, for example, 6251 residents are served by fifteen volunteers.<sup>180</sup> Each volunteer in her area spends approximately twenty-five hours per month visiting.<sup>181</sup> Volunteer presence can thus be calculated as roughly one hour per month in each home. According to a 1995 Illinois Long-Term Care Ombudsman Output Measures Report, some PSAs do not have any volunteers at all.<sup>182</sup> In those PSAs that do utilize volunteers, funding must be available to recruit, train, and supervise both volunteer and paid ombudsmen to enable them to fit a specific role for their individual programs.<sup>183</sup>

## B. Training for Ombudsman Programs

Because ombudsmen, especially the volunteers, often are exposed to such a large number of possible abuses and situations needing their assistance, they require some training before monitoring the facilities.<sup>184</sup> First, volunteers must be recruited to spend their unpaid time working in the program.<sup>185</sup> Newspapers often run advertisements requesting interested persons to call and receive information concerning the ombudsman program.<sup>186</sup> No specific qualifications, educational levels, or past experience requirements are federally mandated for the volunteer positions.<sup>187</sup>

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178. See *id.* at 7-9.

179. See Telephone Interview with Nancy Whitty, Illinois Substate Ombudsman from Rock Island, Ill. (Jan. 30, 1996).

180. See *id.*

181. See *id.*

182. See OFFICE OF THE STATE LONG-TERM CARE OMBUDSMAN, LONG-TERM CARE OMBUDSMAN PROGRAM OUTPUT MEASURES: MANAGEMENT ADVISORY REPORT FFY 1995 [hereinafter OUTPUT MEASURES].

183. See, e.g., Bonnie Greenberg, *Volunteer Ombudsmen Needed at Nursing Homes: Residents' Rights Week Underscores Need for Advocates*, PEORIA J. STAR, Sept. 28, 1995, at 3.

184. See *id.*

185. See *Ombudsmen Being Sought for Elderly in Cattaraugus*, BUFFALO NEWS, June 5, 1995, available in 1995 WL 5480128.

186. See *id.*; see also *Ombudsman Serves as Advocate for County's Elderly*, INTELLIGENCER J. (Lancaster, Pa.), Sept. 15, 1995, at D1.

187. Cf. INSTITUTE OF MED., *supra* note 13, at 16 (Only the use of "well-trained" individuals is mentioned).

The training requirements now vary from state to state, both in length of time and the goals of preparation.<sup>188</sup> In Illinois, most employees of the ombudsman program are required to take approximately ten hours of basic training, while all but the ombudsmen visitors are required to attend an extra four hours of case investigation training.<sup>189</sup> Some states require longer training. New York requires thirty-six hours,<sup>190</sup> and Kentucky requires twenty-four hours of training, including negotiation and problem-solving skills.<sup>191</sup>

Under OAA provisions, ombudsmen are required to ensure that the residents have regular and timely access to the ombudsman services and that residents receive timely responses to complaints.<sup>192</sup> Therefore, services provided by the ombudsmen should presumably be able to meet the needs of the residents. States, however, have no guidance from either Congress or the AOA as to how to interpret these rather vague requirements.<sup>193</sup> For example, the federal mandate does not specify whether it includes weekly visit requirements, state-wide complaint hot lines, or bilingual ombudsmen in areas having a large non-English-speaking resident population.<sup>194</sup>

Further, the activities which are mandated by federal law such as "program emphasis, training and qualifications of volunteers, scope of and procedures for complaint resolution and education" are phrased broadly to enable states to fashion their own programs.<sup>195</sup> Among all the states, the result is a wide variation in ombudsman

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188. See INSTITUTE OF MED., *supra* note 13, at 71-73.

189. See ILLINOIS DEP'T ON AGING, ILLINOIS DEPARTMENT ON AGING AND THE SUB-STATE OMBUDSMAN PROGRAM IN YOUR AREA LONG-TERM CARE OMBUDSMAN PROGRAM (1993) (pamphlet sent to interested people). Note, however, that in responding to a survey sent to substate ombudsmen in anticipation of this note, some indicated that their volunteer training varied somewhat from the 14 1/2 hour training requirement. Some ombudsmen, as in PSA 05, indicated that their volunteers received additional hours of in-service training after receiving the 14 1/2 hours pre-service training.

190. See *Ombudsmen Being Sought for Elderly in Cattaraugus*, *supra* note 185.

191. See Al Allen, *Nursing Home Ombudsmen Are Needed to Monitor Care*, THE COURIER J. (Louisville, Ky.), June 25, 1995, at 4H.

192. See INSTITUTE OF MED., *supra* note 13, at 80.

193. See *id.* at 53.

194. See *id.*

195. *Hearings Before the Subcomm. on Human Resources of the House Comm. on Educ. & Labor*, 98th Cong. 148 (1984) (prepared statement of the Association of Schools of Public Health).



training and roles in the process of redressing nursing home residents' complaints.<sup>196</sup>

### C. Funding of Ombudsman Programs

An estimated 865 paid staff nationwide are currently part of the ombudsman program.<sup>197</sup> The state and substate ombudsmen constitute the majority of the staff.<sup>198</sup> In 1982, the number of volunteers in the ombudsman programs was approximately 3306.<sup>199</sup> Since then, this number has more than doubled nationwide.<sup>200</sup>

Funding to pay salaries and volunteer training is gathered from multiple sources at the federal, state, and local levels. Most federal funding comes from the Titles III and VII of the OAA.<sup>201</sup> In 1993, federal dollars accounted for approximately 61% of the total program funding of nearly \$38 million.<sup>202</sup> States are required to match at least 15% of their Title III funds, but are not required to match any Title VII funds.<sup>203</sup>

Federal funds are not distributed equally among the states.<sup>204</sup> The federal government allocates money according to the number of elderly people estimated to reside in each state.<sup>205</sup> State laws then allocate money based on numerous factors such as the number of lower-income elderly in local areas and areas with overall greater social or economic need for the funding.<sup>206</sup>

Although not required, states will often provide some of their own funding to buoy the Title III money.<sup>207</sup> In 1993, the states' overall contribution to the program reached 21% of its total funding.<sup>208</sup> Five states, including Illinois, provided no state funds for the program. Illinois operates only through federal grants given to the Illinois Department on Aging through the AOA.<sup>209</sup>

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196. See *id.* at 124-25 (statement of Mary Jane Lyman, Executive Director, Waxter Center for Senior Citizens, accompanied by Joyce Leanse, Associate Director, National Council on the Aging).

197. See INSTITUTE OF MED., *supra* note 13, at 53.

198. See *id.* at 46.

199. See *id.* at 57.

200. See *id.*

201. See *id.* at 189.

202. See *id.* at 58.

203. See *id.*

204. See INSTITUTE OF MED., *supra* note 13, at 190-91.

205. See *id.* at 192.

206. See *id.* at 58.

207. See *id.* at 192.

208. See *id.* at 190-91.

209. See Telephone Interview with Kathleen Allison, *supra* note 119.

Other sources of funding for the programs are local governments, the United Way, and various other charitable groups.<sup>210</sup> Funding, however, remains a large problem for state programs and many ombudsmen see it as a primary impediment to complete effectiveness of the program today.<sup>211</sup>

#### **D. Overall Effectiveness of the Ombudsman Program**

Through numerous studies, actual effectiveness of the ombudsman program has long been debated.<sup>212</sup> The federal program is currently designed, in theory, to actively protect vulnerable elderly.<sup>213</sup> This is largely due to the stricter federal provisions implemented in 1987,<sup>214</sup> but the effectiveness is still questioned by some legal scholars.<sup>215</sup>

In the summer of 1995, Consumer Reports magazine released its report rebutting the industry claim that nursing home conditions have improved since the federal rules were passed in 1987.<sup>216</sup> In that report, ombudsmen were not portrayed as dynamic problem solvers and therapeutic, but instead merely contacts in areas concerning the quality of nursing care.<sup>217</sup> The article also reported that ombudsmen often hesitate to state anything negative about nursing facilities and may often even be misleading to consumers searching for a quality nursing home.<sup>218</sup>

In 1994, an in-depth analysis of two empirical studies assessing effectiveness of ombudsman programs was conducted.<sup>219</sup> One of the studies used in the analysis was performed from 1979-80 and was based on reports of resolved grievances from the perspectives of nurs-

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210. *See id.*

211. *See* INSTITUTE OF MED., *supra* note 13, at 150.

212. *See* Kahana, *supra* note 111, at 229.

213. *See* INSTITUTE OF MED., *supra* note 13, at 53.

214. *See id.* at 45.

215. *See* Kahana, *supra* note 111, at 223.

216. *See* *Nursing Homes*, *supra* note 11, at 518.

217. *See id.*

218. *See id.* The article reported that sometimes using ombudsmen as a guide to quality homes can be misleading. As an example the author wrote that an ombudsman in Maryland had given him misleading information. The ombudsman supposedly reported that a facility gets "good surveys" and they (the ombudsmen) "don't get complaints from there." When checking this report, there were 12 substantiated complaints over the past three years and a state inspection report with 25 pages of deficiency citations.

219. *See* Kahana, *supra* note 111, at 230.

ing home residents, staff, and the ombudsmen.<sup>220</sup> The other study, completed in 1991, reviewed the quality of care in homes implementing the ombudsman programs.<sup>221</sup>

The 1979-80 study was divided on the success of ombudsmen in resolving disputes.<sup>222</sup> Among the residents polled for the study, 43.5% reported satisfactory resolution, 39.1% reported lack of resolution, and 17.4% were unsure of how they felt.<sup>223</sup> Residents were most satisfied with the supportive or therapeutic aspect of the ombudsmen presence in the homes rather than any type of dispute resolution.<sup>224</sup> These statistical results show that the ombudsmen's roles in the nursing facilities may be associated more with comfort and friendship to residents rather than actual effectiveness in changing practices by nursing homes.

In contrast to the 1979 study, the 1991 study focused more on quality of care in nursing homes where ombudsmen were present as opposed to those where ombudsmen were not present.<sup>225</sup> This statewide survey of Missouri nursing homes demonstrated that quality of care is generally better in facilities with ombudsman programs in place.<sup>226</sup>

The Institute of Medicine, a private nonprofit think tank that works under congressional charter, also conducted an extensive 1994 study on the effectiveness of ombudsmen.<sup>227</sup> Instead of a single-state analysis, as had been conducted in the 1979 and 1991 studies, the Institute sought to evaluate ombudsman programs nationwide.<sup>228</sup> The study claimed that accurately evaluating the effectiveness of programs was quite difficult because of a significant lack of uniform data across the states.<sup>229</sup>

The study extensively evaluated the programs on their ability to make communities and residents aware of their existence, their skill

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220. See *id.*; Abraham Monk & Lenard W. Kaye, *Assessing the Efficacy of Ombudsman Services for the Aged in Long-Term Care Institutions*, 5 EVALUATION & PROGRAM PLAN. 363, 364 (1982).

221. See Ralph L. Cherry, *Agents of Nursing Home Quality of Care: Ombudsmen and Staff Ratios Revisited*, 31 GERONTOLOGIST 302, 303-08 (1991); Kahana, *supra* note 111, at 230.

222. See Monk & Kaye, *supra* note 220, at 369.

223. See *id.* at 366.

224. See *id.* at 366-67.

225. See Cherry, *supra* note 221, at 302.

226. See *id.* at 303, 308.

227. INSTITUTE OF MED., *supra* note 13, at 129.

228. See *id.* at 129, 140.

229. See *id.* at 129-30.

for investigating and resolving complaints, their ability to convince nursing home providers of the program's usefulness, and their managerial skills concerning volunteer resources.<sup>230</sup> Using these four criteria, the Institute's findings showed that the programs attained several goals in selected areas and in selected locations.<sup>231</sup>

The study, however, also concluded the programs exhibit a great lack of uniformity across various states.<sup>232</sup> The study further explained that the federal government needs to implement an objective method of compliance review to help justify the massive funding needed for the programs.<sup>233</sup> Finally, the study suggested there was mismanagement of volunteer services.<sup>234</sup> The study concluded that the findings failed to provide unequivocal evidence of overall program effectiveness but recommended that programs continue to be implemented by federal provisions.<sup>235</sup>

## **E. Further Barriers to Maximum Effectiveness of Nursing Home Ombudsmen**

### **1. THE NATIONAL LEVEL**

Although on the whole, studies do indicate ombudsman programs can make a difference in residents' lives, the 1994 Institute of Medicine study suggested that nationwide, ombudsman programs continue to suffer from problems such as poor staffing, poor use of volunteers, and limited authority, accountability, and autonomy.<sup>236</sup> Currently states are not required to meet minimum staff, volunteer, or other standards, and the federal government has not monitored state efforts.<sup>237</sup> States and localities vary on the extent to which they comply with the law and spirit of operating statewide ombudsman programs.<sup>238</sup> In short, there are numerous barriers that block the ultimate success of the state ombudsman programs.

The lack of necessary funding is probably the greatest of these barriers.<sup>239</sup> Lack of funding results in lack of control at the local

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230. *See id.*

231. *See id.* at 130.

232. *See id.*

233. *See id.* at 155.

234. *See id.* at 146, 148.

235. *See id.* at 152-53.

236. *See id.* at 154.

237. *See id.*

238. *See id.* at 5.

239. *See id.* at 150.

levels.<sup>240</sup> Without any control over the income to the program or the program's budget, the local ombudsmen struggle to plan programs to train staff and volunteers.<sup>241</sup> Some surveyed Illinois substate ombudsmen also complained of insufficient legal services to pursue complaints.<sup>242</sup> This may be due in part to funding deficiencies.

Second, the manner of staffing the program with volunteers impedes the program's progress.<sup>243</sup> Often due to minimal funding, the program lacks volunteers that are skilled and well trained for their roles.<sup>244</sup> Many areas are in need of bilingual ombudsmen, as well as staff with health care backgrounds or experience in nursing.<sup>245</sup> Often programs find it difficult to maintain volunteer involvement over significant periods of time, making funding for training sometimes wasteful.<sup>246</sup>

Finally, the lack of uniformity among state programs in their expectations of ombudsmen, and the lack of a federal system for monitoring progress, greatly impedes the effectiveness of the ombudsmen and their ability to improve services.<sup>247</sup> For example, many local ombudsmen are uncertain of their relationship with other local programs that deal with aspects of nursing home care.<sup>248</sup> No uniform structural support or legislation has ever determined what the relationship should be between various programs within the facilities.<sup>249</sup> Furthermore, there are no sanctions available to impose if another state program refuses to work with the ombudsman program.<sup>250</sup>

Additionally, because of the various ways states have chosen to comply with the federal mandate in establishing ombudsman programs,<sup>251</sup> it is difficult to discover whether progress is being made throughout the programs at the same rate.<sup>252</sup> This means some local programs are more successful, and residents enjoy greater protection merely because the state either receives more funding, is better organ-

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240. *See id.*

241. *See id.*

242. *See id.*

243. *See id.*

244. *See id.*

245. *See id.*

246. *See id.*

247. *See id.*

248. *See id.*

249. *See id.*

250. *See id.*

251. *See id.* at 129-31.

252. *See id.* at 129.

ized, or both.<sup>253</sup> Hard federal data concerning the success of the program is essentially absent because of the lack of a national standard.<sup>254</sup>

Concurrent with the identification of barriers to the success of the ombudsman program is the necessary task of considering the ombudsman's role in the nursing home once the current barriers are overcome. The federal government needs to establish a stronger national standard with more funding and more assured legal assistance.

## 2. SPECIFIC ILLINOIS BARRIERS

In Illinois, there has not been a uniform assessment of the program as a whole. Although the Office of the State Long-Term Care Ombudsman now tallies annual output measures, there are limitations on the fourteen criteria areas measured in the state program.<sup>255</sup> The most recent Output Report conceded in its findings that it is nearly impossible to collect information to measure all ombudsman activities, although the report has been expanded to collect additional types of data in the past few years.<sup>256</sup>

In some areas of the state, it does appear too few ombudsmen are involved in the program for it to reach its maximum effectiveness.<sup>257</sup> Ideally, one volunteer should be assigned to a nursing home and visit it once a week so residents can depend on their habitual presence. Of the ten substate ombudsmen responding to a survey, most also agreed that the program needs more volunteer visitors in the nursing facilities.<sup>258</sup> Often the number of nursing homes exceeds the number of visitors so greatly that the homes are visited only once a month in certain districts and only once a year in others.<sup>259</sup> Volunteer efforts are not without their costs, however, and this poses substantial problems for some states like Illinois.

If the Illinois program is to be more successful, residents need the constant attention of ombudsmen in order to build their trust in

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253. *See id.*

254. *See id.*

255. *See* OUTPUT MEASURES, *supra* note 182.

256. *See id.*

257. *See id.*

258. This survey was sent to the 17 substate ombudsman to aid in preparation for this note [hereinafter *Survey*]. It confirmed the research indicating that the programs have divergent organization schemes and number of volunteers even within the state of Illinois.

259. Telephone Interview with Kathleen Allison, *supra* note 119. For receipt of federal dollars, the mandate requires that homes be visited once yearly. Ms. Allison commented that although she desires to have the homes visited weekly in her area, often resources only allow visitors once every three months.

the ombudsmen and overcome their fear of being asked to leave the nursing home or their fear of retaliation by caregivers.<sup>260</sup> According to the Illinois Department on Aging, many others besides residents utilize ombudsmen services to register and resolve complaints they have concerning resident care.<sup>261</sup> Pursuant to the 1995 Output Measures for Long Term Care Ombudsman Report, the ratio of investigating ombudsmen per number of beds in each PSA varied drastically, from one ombudsman per 1112 beds to one ombudsman per 8800 beds.<sup>262</sup>

Of the complaints received in Illinois in 1993 from residents or their family members, the most frequently reported were those concerning resident care.<sup>263</sup> In acting on these complaints, the Illinois ombudsmen may either empower a resident to act on the complaint or serve as an advocate on his or her behalf.<sup>264</sup> Illinois substate ombudsmen cite barriers to resolving complaints in the state of Illinois when they are pursuing action on complaints.<sup>265</sup> Lack of available funding to enable ombudsmen to investigate claims is a primary problem, but lack of legal services is equally problematic.<sup>266</sup>

Finally, responding to a recent survey sent to Illinois substate ombudsmen, the Illinois ombudsmen indicated that the program suffers a disability by being under the control of the Illinois Department on Aging.<sup>267</sup> Some ombudsmen indicated that state ombudsmen are usually restricted from taking a stand on legislative and policy issues or lobbying for more funding because of their status as state employees.<sup>268</sup> If the ombudsman program were changed to become an independent agency under Illinois law, as are the programs in Oregon and Michigan,<sup>269</sup> some substate ombudsmen believe they would be able to participate in active legislative advocacy more easily.<sup>270</sup> These

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260. See Greenberg, *supra* note 183, at 2.

261. See ILL. DEP'T ON AGING, *supra* note 8, at 10-11.

262. OUTPUT MEASURES, *supra* note 182.

263. See 1996 ILL. DEP'T ON AGING ANN. REP. 10-11. In fiscal year 1992, many of the complaints were received from residents' family members (28%), while 18% were made by nursing home staff, 21% were made by residents themselves, but only 15% were witnessed and reported by ombudsmen. See *id.*

264. See *id.* at 13.

265. See Survey, *supra* note 258.

266. See INSTITUTE OF MED., *supra* note 13, at 94; Survey, *supra* note 258.

267. See Survey, *supra* note 258.

268. See *id.* Substate ombudsmen Robyn O'Neill of Suburban Cook County and Margaret Niederer of Springfield both observed in their survey responses that the dependent status of the program impedes its ultimate effectiveness for change.

269. See OR. REV. STAT. § 441.100 (1996); Mantese et al., *supra* note 24, at 179.

270. Telephone Interview with Kathleen Allison, *supra* note 113.

frequently cited barriers reflect only three of the numerous problems impeding the ultimate effectiveness of many other states' ombudsman programs.

#### IV. Recommendations/Direction for the Program

In a 1992 GAO report, both the ombudsmen and the experts responding to report surveys stated that increasing residents' access to ombudsmen through regular facility visitations must occur if the program is to more fully develop.<sup>271</sup> The 1994 Institute of Medicine's evaluation clearly found that major improvements need to be made to the already-existing program.<sup>272</sup> Since that study, however, there has been no direct action taken to improve and better coordinate efforts of state ombudsman programs. The ombudsman program does have significant opponents, especially facility operators who do not like interference with the manner in which their nursing facilities are managed.<sup>273</sup> Also the Republican-led Congress may possibly continue to tout antiregulatory measures and attempt to loosen its reins on the long-term care industry.<sup>274</sup>

Patients' rights groups believe this is a dangerous time for the roughly two million Americans in nursing homes and other long-term care institutions.<sup>275</sup> Proponents of the ombudsmen think that the effect of the current program, even if fulfilling the helper function, is making a difference for the elderly residents.<sup>276</sup> Two basic choices are available: (1) cut the program back and save taxpayers' dollars from being allocated to a program only successful in theory; or (2) reform the program as it exists. Clearly, as the 1994 Institute of Medicine study opined, the latter is the wise option.<sup>277</sup> Because of the great degree of harm that may befall residents if the "watchful eyes" of ombudsmen are not present, solutions to fix the problems in the ombudsman program are necessary to give the program the teeth it currently lacks.

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271. See GENERAL ACCOUNTING OFFICE, THE OLDER AMERICANS ACT ACCESS TO AND UTILIZATION OF THE OMBUDSMAN PROGRAM 19-20 (1992).

272. See INSTITUTE OF MED., *supra* note 13, at 161.

273. See Cherry, *supra* note 221, at 308.

274. See Elizabeth Mehren & Robert A. Rosenblatt, *Budget Ax Puts Seniors on Edge*, DETROIT NEWS, Aug. 27, 1995, at B1.

275. See *id.*

276. See Kahana, *supra* note 111, at 230.

277. See INSTITUTE OF MED., *supra* note 13, at 153-61.



### A. Establish a Uniform, Reliable Documentation System

Before significant changes may be made to remove barriers to the program's success as suggested by the Institute of Medicine,<sup>278</sup> the federal government needs to establish a uniform documentation system to see the actual effects of the ombudsman program. An accurate study of the program's effects is difficult because the ombudsman programs are set up differently in many of the states, and collection of data in a meaningful pre- and post-program implementation comparison study is nearly impossible.

Many ombudsmen cringe over paperwork, but documentation is critical to see forward progress in the programs. Activities are currently underway by the AOA to implement a revised reporting system for complaints.<sup>279</sup> Without hard data showing the progress the program is making, the argument to maintain the program as it exists is weak.

Reliable documentation has an additional benefit. Legal practitioners may be asked to assist older persons or their families in the tough decision whether the elderly person should enter a nursing home and which is the correct one.<sup>280</sup> The search for a facility should begin well before a client's need arises to ensure the likelihood an appropriate facility will be available. Long-term care ombudsmen may assist practitioners in these decisions, and elder law practitioners should be familiar with the way their local programs operate. Additionally, state survey reports should be available from their area long-term care ombudsmen, the state health departments, and the nursing homes themselves.<sup>281</sup> Indeed, ombudsmen can be an invaluable asset in many respects to nursing home care.

### B. Federally Defined Requirements for Local Programs

Currently, every state is free to set up its ombudsman program according to its own guidelines.<sup>282</sup> Because individual states have varied numbers of volunteers at their nursing facilities and various methods of training their staff, different types of services to residents

278. *See id.*

279. *See id.* at 151. This revised system is entitled the National Ombudsman Reporting System. *See id.*

280. *See* KRAUSKOPF ET AL., *supra* note 12, at 449.

281. Written resources also may be available to aid elder law attorneys in the search for an appropriate client home. *See, e.g.,* U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. HCFA-02174, GUIDE TO CHOOSING A NURSING HOME (1991).

282. *See* INSTITUTE OF MED., *supra* note 13, at 45.

are rendered.<sup>283</sup> OBRA is a federal statute, and federal dollars support the programs. Although some states enhance this funding with state funds, a few do not.<sup>284</sup> Because the program money is from the federal government, additional statutes should be implemented to ensure residents in one state receive similar benefits as in another.

Currently, clarity is lacking in how the program should be administered and in meaningful compliance review from the AOA.<sup>285</sup> According to the Institute of Medicine, "at a minimum, the AOA ought to provide a checklist for the performance standards or indicators of good practice against which each state may be assessed."<sup>286</sup>

The AOA also should develop and distribute a policy statement detailing sanctions the AOA is authorized to use to enforce state compliance with statutory mandates of the long-term care ombudsman program. The statement should describe the sanctions and explain exactly which conditions require or justify invocation of sanctions.

The states need guidance if the ombudsman program is to become a cohesive, nationwide success. The Institute of Medicine suggested two key features and functions that are relevant to whether a state ombudsman program operates as a cohesive unit: methods by which local host agencies and individual ombudsmen are designated, trained, assisted, and monitored; and methods by which the state unit on aging carries out its responsibilities to the ombudsman program.<sup>287</sup>

Currently the AOA is not actively involved with the control over state programs.<sup>288</sup> Instead, the AOA should work to obtain a more interactive stance in order to ensure greater success and compliance with the mandates of OAA. The AOA has provided no guidance on the infrastructure of the state programs, nor active monitoring of the states' allocation of federally provided funds.<sup>289</sup>

Also, state programs like that of Illinois may benefit from independence from the Illinois Department on Aging. This greater freedom to lobby for changes before the state legislature would enable the ombudsmen to more actively advocate for the rights of the individu-

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283. See *id.* at 44.

284. See *id.* at 190.

285. See *id.* at 90.

286. *Id.* at 89 (citation omitted).

287. See *id.*

288. See *id.* at 88. "During the last half of the 1980s, AOA provided little oversight and technical assistance to the states on the implementation of the ombudsman program, and most of the effort took the form of monitoring by regional offices." *Id.*

289. See *id.*

als they serve in their respective areas. Among these lobbied-for changes would most likely be additional funding for their programs.

### C. Ensure Adequate Legal Service

Not all states view the role of the ombudsman similarly within the context of the legal system. Very few state ombudsmen view legal remedies, especially litigation, as the basis of their advocacy efforts or program needs. Nevertheless, the ombudsmen need adequate legal services, which they often do not have. A 1994 National Ombudsman Resource Center survey indicated that less than half of the twenty-seven state ombudsmen responding to the survey thought their legal support was "very good" or "excellent."<sup>290</sup> One-third responded that legal service was so inadequate that it did not meet their needs.<sup>291</sup>

Congress has implemented statutes requiring that state agencies ensure that adequate legal services be available.<sup>292</sup> Ombudsman programs should use as their primary counsel for advice, consultation, and representation in-house or outside legal counsel who are experienced in dealing with long-term care, health care decision making, and other related substantive legal issues. In many jurisdictions, such legal counsel can be obtained through a legal services program, a public interest organization such as a protection and advocacy agency, or a private law firm specializing in elder law. The most important criteria for the legal counsel should be its availability on a regular or daily basis and its ability to handle a wide range of long-term care and issues related to the nursing home context. Furthermore, to enhance the ombudsman program's legal strength, states should pass laws permitting both residents and the Office of the Long-Term Care Ombudsman a more easily accessible private right of action to enforce long-term care and license laws.

If legal services and uniformity across programs are enhanced, the merits of the program will be more readily apparent both to the public and to legislators. Current ombudsmen complain of lack of flexibility and control due to funding constraints. The only way to ensure the program will not be cut from the federal budget is to enhance the program as it already exists, both through stricter federal statutes and more provisions for legal support. Only then may the program be recognized as a dynamic solution to the current abuses

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290. See *id.* at 94.

291. See *id.*

292. See *id.* at 93.

and potential atrocities in nursing homes and a remedy worth expanding to include more staff and volunteers to reach more residents and community members. Until unification among the state programs and hard data proving the dramatic difference it makes for residents is collected, funding cannot be expected to grow. And without adequate funding, the program will only remain a worthy cause without actual documented positive results.

## V. Conclusion

The ombudsman programs may be in jeopardy. In 1995, congressional Republicans sought to cut, among other nursing facility restrictions, federal funding for the ombudsman programs.<sup>293</sup> Republican proposals would have shifted responsibility for quality nursing homes to the states, letting states, rather than the federal government, set and enforce standards.<sup>294</sup> If the Republicans had succeeded, states also would decide whether or not to keep nursing home ombudsmen. The possibility existed, under the Republican proposal, that nursing facilities would be without their watchdog ombudsmen. Fortunately, the Republican proposal has not, to date, been successful.

More recently, the Department of Health and Human Services (HHS), the department that regulates nursing homes caring for patients under Medicare and Medicaid,<sup>295</sup> has proposed cutting back on inspections of nursing homes due to its statistics showing that more than two-thirds of nursing homes are not complying with current federal standards.<sup>296</sup> The HHS's rationale in cutting back such inspections is that this would allow inspectors to concentrate on homes with more serious problems.<sup>297</sup> Such proposed changes would allow the scope of facility reviews to be greatly narrowed and would "reduce the number of residents who must be interviewed."<sup>298</sup> The changes

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293. See Mehren & Rosenblatt, *supra* note 274, at B1; *Less Nursing-Home Oversight*, DES MOINES REG., Oct. 18, 1995, at 10.

294. See *Less Nursing-Home Oversight*, *supra* note 293.

295. The Medicare and Medicaid Programs authorized by titles XXIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395, 1396 (Supp. 1994), are administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS). See MEDICARE AND MEDICAID, *supra* note 57, at 8. The vast majority of nursing facilities now participate in these two programs. See *id.* at 10.

296. See *Government Seeks to Limit Scope of Inspections at Nursing Homes*, ST. LOUIS POST-DISPATCH, Dec. 17, 1996, at 14A.

297. See *id.*

298. *Id.*

would also reduce the number of medical records and other such documentation examined at each facility.<sup>299</sup> Some nursing facility resident advocates see this proposal as authorizing, in effect, "drive-by surveys" of homes.<sup>300</sup>

The current status of the program should not continue. The ombudsman must possess more power and convince nursing home operators that negligent conduct will no longer be tolerated. More training of many additional ombudsmen, improved and uniform structure of the programs through regulations at the federal level, and more legal capabilities are requisite starting points. Studies have shown that nursing home residents need protection from abuse and neglect. Every facility should have protective ombudsmen visiting regularly to reduce the current abuses and avoid the potential atrocities in nursing homes.

Keeping in mind the at-risk, vulnerable status of the elderly in facilities today and the fact that numbers will continue to grow in the next three decades, the correct decision is to continue the ombudsman programs and make the necessary improvements.

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299. *See id.*

300. *See id.* (quoting Ellen Reap of Delaware, president of the national organization of state officials who inspect hospitals and nursing homes). Mark Miller, a nursing home ombudsman in Virginia, called the proposed changes to nursing facility surveying "most definitely" contrary to the interests of nursing home residents. *See* Robert Pear, *Nursing Home Checkups May Be Cut*, PORTLAND OREGONIAN, Dec. 17, 1996, at A7.