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Reimaging the Ombudsman: An Appraisal

An ombudsman program can serve as a useful alternative to the court system for nursing-home residents. This article examines issues related to the ombudsman's role in long-term care facilities, including purpose, criticisms, and local and national recommendations.

By Beth Elsendrath

During the adaptation to more crowded city conditions, older, less-productive family members have lost their purpose. They are often seen as ineffective, superfluous, to be tolerated if necessary, but preferably to be disposed of in some acceptable manner. Older people have come to see themselves as being in the way and unproductive. They feel guilty and are willing to participate in their own disenfranchisement as members of the family and of society. They have been made to accept isolation, abandonment, or incarceration. In short, yesterday's elders still had enough bargaining points left to negotiate a dignified passage from this life to the realm of the dead. Today's elders do not.

October 30, 2000:

Congressional investigators said today that they had found widespread violations of federal health and safety standards at nursing homes. They found "serious deficiencies" in about seventy percent of nursing homes in Texas, and similar problems at more than half of the homes in Chicago, Los Angeles and the San Francisco Bay Area.

Introduction

Approximately one and one half million people currently reside in 17,000 nursing homes across the nation. Yet, a recent study by congressional investigators discovered "widespread violations of federal health and safety standards at nursing homes in Texas, New York, New Jersey, Illinois, and California."

Moreover, sweeping changes to the healthcare system involving the switch to managed care and consolidation of nursing homes in the last decade have disrupted the long-term care environment, with

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more shifts likely in the next ten years. One example of that future change is the alteration of nursing homes from long-term care facilities to subacute facilities with concomitant changes in cost-containment structures.

Nursing-home residents rarely bring cases to court. They may be hesitant to bring suit for fear of retaliation, they may be unable to sue due to a physical or mental disability, or they may simply lack the logistical means to leave the nursing home to hire a lawyer. An ombudsman program often serves as a useful alternative to the court system for nursing-home residents. However, at a time when nursing-home use is projected to expand by seventy-six percent in the next three decades, it is essential to examine what the ombudsman role is and whether the mandates of the Older Americans Act, which requires states to have ombudsman programs, are being fulfilled.

Clearly, ombudsmen fulfill a vital role for residents adversely affected by change, but reorganization would seem to be in order if the United States hopes to follow the statutory provisions of the Older Americans Act. The Act calls for giving responsibility to

An individual who will, on a full-time basis (i) investigate and resolve complaints made by or on behalf of older individuals who are residents of long-term care facilities relating to action, inaction, or decisions of providers, or their representatives, of long-term care services, of public agencies, or of social service agencies, which may adversely affect the health, safety, welfare, or rights of such residents.

This article looks at the issues surrounding the ombudsman’s role in long-term care facilities. Part II examines the history and purpose of the classic ombudsman role. Part III summarizes the federal long-term care ombudsman program as authorized in the Older Americans Act, while Part IV explores criticisms of ombudsmen and ombudsman programs in general. Part V describes the Wisconsin long-term care ombudsman program and criticisms of it. Part VI concludes with a look at local and national recommendations for ombudsman programs.

**History and Purpose of the Classic Ombudsman**

An ombudsman is “a third party who intervenes in addressing concerns of individuals or dependent groups in relation to powerful organizations or bureaucracies.” The function of the ombudsman dates to Egyptian times, when pharaohs used complaint agents in their courts. In 1809, Sweden’s Parliament appointed a “Justitieombudsman,” whose duty was to protect citizens’ rights during disagreements with government entities.

The role later evolved into that of an intermediary who resolves citizens’ complaints about unethical or illegal government behavior. These appointed national ombudsmen report to the head of state or to the parliament. They settle citizen grievances and serve as links to bureaucracies.

Finland adopted the office of the ombudsman in 1919, and Denmark instituted an office of ombudsman in 1955. By the 1960s, many other countries had adopted a national ombudsman model, including New Zealand, France, Hong Kong, and the United Kingdom. In the United States, the ombudsman is frequently used in long-term care settings, universities, and private corporations.

The early Scandinavian ombudsman model is often called the “classic” model. In the classic ombudsman model, the ombudsman acts as an autonomous liaison defending the interests of citizens against the rival claims of the government. Professor Paul R. Verkuil notes three key features of the classic ombudsman:

1. The Ombudsman is an independent and non-partisan officer of the legislature, usually provided for within the constitution, who supervises the administration;
2. The Ombudsman deals with specific complaints from the public against administrative injustice and maladministration;
3. The Ombudsman has the power to investigate, criticize and publicize, but not to reverse, administration action.

The classic ombudsman concentrates on seeking solutions that dispel future conflicts, rather than on implementing punitive measures. She acts as a neutral observer, neither wholly in the camp of the administration nor on the side of the private individual.

The following factors should be weighed in creation and evaluation of the ombudsman within the larger system:

The person who performs the role of ombudsman must be completely neutral, both in fact and in appearance.
The neutrality of the ombudsman should be protected by the structure of the position. The ombudsman should have access to all levels and departments, and all non-privileged, relevant records within an organization. Various means should be used to educate others about the functions and benefits of the ombudsman. Persons using the ombudsman must be assured of complete privacy and confidentiality of conversations and the ombudsman's files.

**Purposes of the Ombudsman**

The ombudsman's role has developed as agency and government ranks have grown in complexity and number. Benefits of the ombudsman system include "greater flexibility, accessibility, cost effectiveness and a better fit with preventive . . . orientations to safeguarding the interests of the individual." One early authority, Walter Gellhorn, saw the ombudsman's role as supplementary to, rather than a substitute for, existing methods of handling injustices.

When the ombudsman came to the United States, the role evolved from the classic model into a more active, localized model known as the "hybrid" ombudsman. The hybrid ombudsman has a more fluid role that moves from neutral mediator to energetic ally. Author Jeffrey Kahana theorizes that the classic ombudsman role was appropriate for consensus-based societies; in contrast, the United States is more conflict-ridden, and therefore a more zealous agent is needed.

Where the classic ombudsman concentrated on designing methods with which to avoid conflict, the hybrid ombudsman's functional vocabulary includes shuttle diplomacy and negotiation. The hybrid ombudsman can switch between "impartial umpire [and] partisan advocate." The eagerness with which the United States has adopted the hybrid model illustrates a widespread concern. Professor Shirley Weigand traces this interest to legislators' proposals to adopt the ombudsman model to assist in handling citizens' complaints. Today, the United States has more ombudsmen than any country in the world. Ombudsmen are located in 4,000 hospitals, businesses, newspapers, and private organizations.

**Rationale**

An ombudsman can use fluid and flexible methods of problem-solving that the parties might see as less intimidating than traditional judicial methods. Ombudsmen are not restricted to adjudicatory dichotomies of one party triumphing while the other party fails. The ombudsman also is economical when compared with the cost of litigation in terms of both money and time. However, she does not generally have the power to bring lawsuits.

Different parties see the ombudsman as serving their particular individual interests: The resident sees an advocate who will navigate the system, the bureaucrat sees a cost-effective way of addressing a set of problems, and the government agency sees ombudsmen as fulfilling a regulatory role.

**Long-Term Care Ombudsman Program In the United States**

The Federal Long-Term Care Ombudsman Program began in 1972 as a five-state Public Health Service demonstration project. The states, including Wisconsin, were contracted to create nursing-home ombudsman programs. The following year, the experimental programs were positioned "within the infrastructure of the 'aging network' of state and area agencies on aging." Four years later, in the Older Americans Act, Congress mandated that each state institute a Long-Term Care Ombudsman Program.

Currently, approximately 865 paid ombudsmen work in programs in fifty states, the District of Columbia, and Puerto Rico. All the programs operate differently in their funding and position in each state's organizational structure. Approximately 1,500 ombudsmen (including volunteers) operate within the long-term care environment. In 1996, nearly 180,000 complaints from 154,000 nursing home residents (and others) were managed by ombudsmen.

Funding for the ombudsman program issues comes from diverse sources, although the Older Americans Act provides the bulk of funding. Other financing comes from state and local governments, area agencies on aging, the United Way, and foundations.

The purpose of these programs is to "identify, investigate, and resolve complaints that are made by, or on behalf of, residents," "provide services to assist . . . in protecting the health, safety, welfare, and rights of the residents," "inform the residents about the means of obtaining services," and "represent the interests of the residents before governmental agencies and seek administrative, legal and other remedies." Ombudsmen programs "arose in response to the widespread perception of problems in nursing
facility quality."41 For example, a need arose to "give voice to resident grievances in a way that allow[ed] the administration to save face and [did] not result in dismissal of the resident."42 As a United States Senate committee noted,

The primary role of long-term care ombudsmen is that of consumer advocate, and they are not limited to responding to complaints about the quality of care. Problems with public entitlements, guardianships, or any number of issues that a nursing home resident may encounter are within the jurisdiction of the ombudsman.43

The long-term care ombudsman acts to resolve problems between residents and their families and nursing homes. She also advocates for residents with the state administration that oversees elderly services. Ombudsmen function as mediators, problem-solvers, and sometimes as publicists and educators. However, despite these numerous roles, there is no precise job description for the ombudsman.44

The Institute of Medicine describes examples of changes promoted by ombudsman programs (along with other groups) as follows:

[Enactment of the federal Nursing Home Reform Law of 1987 . . . ; increased personal needs allowances; protections from involuntary discharge and room transfers; reduced use of physical restraints; improved building and safety standards; increased state funding for inspection and surveying of LTC [long-term care] facilities; reduced use of psychotropic medications; better licensing oversight of healthcare professionals; increased use of advance directives; stronger LTC staff competencies and sensitivities; and empowerment of residents through stronger resident and family governance structures.45

Criticism of Ombudsmen and Ombudsman Programs

Many criticisms of ombudsman programs have existed in the United States since their beginning here,46 even as the ombudsman’s unusual role has evolved to meet specific societal needs for an arbiter, advocate, and mediator.47 The Institute of Medicine reported in its 1994 study that “[o]bstacles to effective performance include inadequate funding, resulting staff shortages, low salary levels for paid staff, [and] structural conflicts of interest that limit the ability to act.”48

A common criticism of ombudsmen is that an appointed ombudsman may hesitate to criticize other areas within the agency or government structure because of concerns over job security.49 Moreover, the dual mediation and trouble-shooting functions of ombudsmen may conflict.50 A related conflict-based criticism notes the “possibility of uninformed and inconsistent decisions that are based on the ombudsman’s own professional values or personal opinions rather than on the legal and ethical standards the service provider must meet.”51

Professor John J. Regan also found the ombudsman’s shape-shifting mix of roles questionable. In his view, the advocacy role was disjunctive with the ombudsman’s neutral role, and the amorphous nature of the two identities “call[ed] into question whether the ombudsman is the appropriate person to achieve [the] goals” of advancing the interests of the elderly.52 For example, sometimes the necessity to nurture ongoing dialog with nursing facilities means that the ombudsman cannot be as direct and firm as might be the case if the relationship were transitory.

Relatedly, author Kahana sees a possibility for the filing of frivolous complaints since ombudsmen, unlike the courts, may be accessed for free.53 A lonely nursing-home resident may contact an ombudsman simply to get needed attention. In addition, those surrounding the ombudsman may see her as impotent since she lacks the power to punish.54 Others may perceive a “lack of authority, which may hinder enforcing recommendations.”55

An appointed ombudsman’s association with a governor gives visibility and political status. However, she is often seen as linked to the governor rather than as an independent entity.56 Professor Regan believed that if the office of ombudsman were appointed by a governor, true autonomy might not be realized.57

The ombudsman’s role, meanwhile, also can have a coercive element. Regan noted that in the process of manufacturing compromise, an ombudsman may simply adjust the fit, tailoring the complaining party to a dreary status quo and dissuading decision-makers from taking binding action.58 Similarly, complaints directed at the ombudsman may serve to deflect the charge from its appropriate target, thus protecting that which is complained about.59
WISCONSIN'S LONG-TERM CARE OMBUDSMAN PROGRAM: AN EXAMPLE EXAMINED

The Wisconsin long-term care ombudsman program came into being in 1978 as a component of the Office of the Lieutenant Governor. Of those early years, volunteer ombudsman coordinator Kellie Miller McLellan recounts, "We used to have the 'midnight raiders'—the ombudsman would come into the nursing home at five o'clock or even later, to see what he could see, horrible stuff. Now you can see the horrible stuff and not have to come in there at midnight."

Three years later, the Wisconsin Board on Aging and Long-Term Care was created as an umbrella organization to house the Wisconsin Ombudsman Program. Kevin Zwart is a Medigap Insurance counselor with the Medigap Helpline Program, also located within the Board on Aging and Long-Term Care. He remarks, "The movement of the ombudsman out of the Lieutenant Governor's office, and the start of the Board, that all happened because ombudsmen started getting... notoriety—so the Governor wanted to get more of the credit."

In Wisconsin, the ombudsman conforms to federal provisions in being an advocate rather than a neutral. Notwithstanding, the Wisconsin Board diverges from the conventional view of the long-term care ombudsman: While the customary view of the affiliation is that both the nursing-home resident and her or his family are clients of the ombudsman, the Wisconsin Board on Aging and Long-Term Care views solely the resident as the ombudsman's client. This position is not universally held within the Wisconsin Ombudsman Program. For example, volunteer coordinator Miller McLellan believes that while residents are the ombudsman's primary clients, the volunteers may respond to residents' families as well.

Wisconsin has fifteen full-time, paid ombudsmen; of those, five are in Milwaukee. A total of sixty-five volunteer ombudsmen are concentrated in four counties. One intake coordinator, also an ombudsman, fields questions and returns phone calls on a full-time basis. The number of clients served by the program nearly doubled to 12,000 clients between 1996 and 1999. Complaints increased by one-third over the same period, and during that period, reports of abuse and other serious incidents consistently increased.

The most recent two-year operating budget of the Wisconsin Board on Aging and Long-Term Care was approximately $2.3 million for 1997-1999. State taxes provide approximately half of the budget; nearly one-quarter comes from the federal Older Americans Act and the Healthcare Financing Administration (HCFA). The balance of the budget comes from a segregated fund in the Office of the Commissioner of Insurance and from private foundations.

In the past biennium, three ombudsman positions were created, including the full-time phone ombudsman position.

Goals
The Institute of Medicine report asserts that "[n]ot all residents of long-term care facilities in need of advocacy assistance have meaningful access to the services of an ombudsman." Yet one key goal of the Wisconsin Ombudsman Program is to implement site visits to all nursing homes by ombudsmen.

Bill Donaldson, the legal counsel for the Board on Aging and Long-Term Care, states, "We are concerned with monitoring rules and implementation. In Wisconsin, we take monitoring as seriously as other functions." Kevin Zwart, a Medigap Helpline counselor, agrees: "Representation in the facilities is real important. We're preventative. Volunteers are in there every week."

The high value placed on site-visit consistency by the program echoes the emphasis accorded by the Senate Committee on Aging: "A major objective of the ombudsmen is to establish a regular presence in long-term care facilities, so they can become well acquainted with the residents, the employees, and the workings of the facility. This presence is important as it helps the ombudsman establish credibility and trust."

Other Wisconsin Ombudsman Program goals include increasing access to ombudsman services, acquiring more ombudsman volunteers to make regular site visits to long-term care facilities, and improving residents' quality of life. The program issues a "self-evaluation that takes the form of a biennial report... highlight[ing] what the agency has done well and what it's done not so well at, and it makes recommendations."

Former long-term care ombudsman Jean Trimble observes that ombudsmen work best as educators. "Talking to families about residents' rights, talking to staff about bioethics, talking to media."

Current Operations
Forty nursing homes in Wisconsin (approximately ten percent of the total number of state facilities)
have filed for Chapter Eleven bankruptcy protection over the last two years. Because the Wisconsin Ombudsman Program’s aims include responding to resource cutbacks in nursing facilities, the large number of facilities undergoing Chapter Eleven reorganization receive harder scrutiny.

Still, the long-term care environment in Wisconsin is insecure. Volunteer Coordinator Kellie Miller McLellan notes, “There are heartbreaking stories about nursing homes going through bankruptcy.” She adds that aides from one insolvent nursing home worked without pay because of their commitment to the residents. Nonetheless, “[w]hen this happens, we have to find places to transfer the residents.”

Along with the flux in the long-term care environments, chronic staffing shortages in nursing facilities add to the atmosphere of instability. Short staffing signals a need for increased alertness by the visiting ombudsmen. Former long-term care ombudsman Jean Trimble calls short staffing “[t]he most frustrating chronic nursing home problem... it’s all over the place... It’s frustrating to keep raising the issue.”

Another program concern involves the ombudsman’s need to command respect while simultaneously improving relations with the facilities. Trimble believes that the ombudsman program is taken more seriously “since the Omnibus Reconciliation Budget Act of 1987... The local level also got more important—as ombudsmen got more experienced, as we’d been there longer, we got taken more seriously.”

Yet Rachel Selking, regional ombudsman for the Milwaukee area, comments, “At some facilities, it doesn’t matter what you say—they still won’t take the ombudsmen seriously. It just depends on the philosophy of the individual facility. And then, we have some facilities that call asking for advice.” The Board’s attorney, Donaldson, says that a number of nursing facilities have even attempted to challenge the ombudsmen’s right to visit. “The statutory language is, ‘Ombudsmen have a right to visit and be there without notice at any time,’” he says. “It’s very explicit.”

Thus, the ombudsman’s role necessitates diplomacy. Officials observe that many nursing homes see the ombudsmen as outsiders, rather than as the residents’ representatives. Officials also comment that some facilities view ombudsmen as overly inquisitive, attempting to require unnecessary registrations of ombudsmen as they enter the nursing home: “They feel threatened.”

Milwaukee ombudsman Selking finds that some facilities are open to criticism, but others remain intransigent. She adds, “We see things with the residents, ranging from inappropriate discharges to abuse to incontinence; people lying there without being changed for hours.” Zwart, meanwhile, notes that the regular presence of the program fosters a higher level of performance from staff and administration.

If a disagreement cannot be settled, the ombudsmen have alternatives. Donaldson asserts:

We start out with negotiation and mediation. We frame the problem so everyone is looking at it the same way. Then, if that doesn’t work out, the ombudsman refers the problem to law enforcement or the district attorney or the Bureau of Quality Assurance—to a regulatory agency. We don’t have any regulatory enforcement capability.

Former ombudsman Trimble adds:

Ombudsmen don’t have sanction power, so we were taken more seriously as we used what we did have. Nursing homes followed the ombudsman’s recommendations because they were a better alternative than having the surveyors in... It took a while for surveyors to see the utility of ombudsmen, because when we would criticize the surveyors, they’d see us as “bitches.”

Milwaukee ombudsman Selking finds that she can call on colleagues, use state codes, or threaten to refer problems to the Bureau of Quality Assurance to resolve disagreement. “Right now, we’re studying whether the Bureau is effective. We also have the federal surveyors. But they are sparse—only three for the whole region.”

Furthermore, the great changes to the healthcare system occasioned by the healthcare industry’s switch to managed care have altered the Wisconsin long-term care environment. As the Institute of Medicine has noted, “The increasing growth and dominance of managed-care organizations raise complex issues for Long-Term care.” For example, Medigap Insurance counselor Kevin Zwart says that the last decade brought a consolidation trend to the nursing-home industry that has the potential to erode the quality of healthcare.
Milwaukee ombudsman Selking adds that the recent orientation of the long-term care industry toward increasingly larger corporations has brought a corresponding impersonal element. She contends that some nursing homes funnel their resources into marketing rather than address staffing problems: "Some of these places have beautiful facilities, but the part that's beautiful, the residents never get to see."

**Volunteer Ombudsman Program**

Nationwide, volunteer ombudsman number approximately 7,000. Institute of Medicine officials assert that a positive correlation exists between the use of ombudsman volunteers and the "number of complaints made and resolved." Wisconsin Board on Aging and Long-Term Care legal counsel Donaldson says that some states have a predominantly volunteer ombudsman base, whereas Wisconsin emphasizes professional ombudsmen since they can be trained more intensively.

Since a key goal of the six-year-old program is to improve the regularity of nursing-home visits, volunteers make trips at least weekly to thirty-five facilities.

Trimble, the former Long-Term care ombudsman, remarks that volunteers are time-intensive and require much effort to train, but that they are good for handling day-to-day aspects of the residents' lives, such as quality of meals and regular access to fluids. As Volunteer Ombudsman Director Miller McLellan observes, "The regular ombudsman investigates the tough stuff."

In their one-on-one relations with nursing home residents, volunteers are constrained by layers of regulation. As a staff member comments, liability problems prevent the volunteers from working in a hands-on manner.

Volunteers may also be constrained by forces inside the ombudsman program itself. Trimble contends that "there's also a fear of regional ombudsmen that if volunteers get stronger, they'd get rid of the regional ombudsmen—and that would be terrible."

**Criticisms of Wisconsin's Ombudsman Program**

In Wisconsin, some officials believe that more funding would help in raising the quality of the ombudsman program. Similarly, the Institute of Medicine concluded that "resources are not adequate for each state LTC (long-term care) ombudsman program to perform at a level that ensures compliance with even the basic, decade-old mandates of the OAA (Older Americans Act) ombudsman program."

Mitch Hagopian, an attorney with the Coalition of Wisconsin Aging Groups, says:

We run into people who contact benefit specialists because the ombudsman program has declined to serve them for some reason. The ombudsman program sometimes has taken the side of the facility or their performance for the resident is lackluster. [For example, in one case,] the daughter [of a resident complained so much that she] wore out the facility, and the ombudsman got tired of her too, so we got the case. There was a personal conflict between the ombudsman and the resident.

Former ombudsman Trimble believes that Wisconsin is out of compliance with federal regulations in at least two ways. First, federal regulations state that long-term care ombudsmen must have no conflicts of interest. But as the Institute of Medicine notes, the "politically charged environment" in which ombudsmen operate means that "most state and local ombudsman programs are subject to one or more . . . conflicts of interest . . . All conflicts of interest work to the disadvantage of the vulnerable client."

Trimble argues that for the Director of the Board on Aging and Long-Term Care to double as head ombudsman, as the Wisconsin statute mandates, is a conflict of interest. The ombudsman cannot easily make recommendations and criticisms of the Board if he is simultaneously the head of the Board, she believes.

Furthermore, the federal regulation stipulates that "the Ombudsman shall serve on full-time basis . . ." If the ombudsman has another job description—as director of the Board overseeing not only the Ombudsman Program and the Medigap Helpline Program, but also lobbying at the Capitol as Director of the Board on Aging and Long-Term Care—he is not full time and thus does not conform to the federal statute.

The current Wisconsin statute stipulates that the same person must hold both positions. This was not always the case; in contrast, the 1987-1988 statute makes no such stipulation that the same person holds both positions.
In Trimble's view, the second way in which Wisconsin is federally noncompliant is that the legal counsel to the Board on Aging cannot bring suits to the Court of Appeals as he is supposed to. She asserts that when nursing homes involuntarily discharge a resident over that resident's objections, the discharge goes to a "fair hearing" handled by non-attorneys, and then to appellate court. She was told that the legal counsel to the Board was unable to bring cases to appellate court. Along the same lines, it is alleged that the original legal counsel subpoenaed the governor and was fired; after that, the Board reduced the power of the legal counsel. Trimble asserts, "The ombudsman doesn't take the place of the legal advocate."

Such a claim is consistent with the finding of the Institute of Medicine that "[e]xcept in a very few states, State Units on Aging have not fulfilled their responsibility to ensure adequate and independent legal counsel is available to the ombudsman programs for the purpose of providing advice and counsel related to Long-Term care residents." Mitch Hagopian, attorney for the Coalition of Wisconsin Aging Groups, believes that the legal counsel should advocate for residents. Hagopian says:

[T]he ombudsmen are hired as social workers, not attorneys. . . . The first thing the [first] counsel did after being named legal counsel, was sue the governor and depose him. So a nonconfrontational guy was hired and they changed the law, and the legal counsel was named legal counsel for the agency, not the residents. This legal counsel is a real nice guy; he spends a lot of time keeping up with the business at the Capitol, he knows the status of every bill, but his job shouldn't be advocate for the agency but advocate for the residents. . . . It's important that their [ombudsman program's] legal counsel be evaluated and expanded. If they wanted to make the ombudsman program something that would actually deal with residents' rights, they need to strengthen the legal counsel. . . . Nursing homes assume there's no one to represent those that they kick out. I have yet to see someone get evicted once a lawyer is involved. It cost the facility $40,000 to get legal representation in [one] proceeding, that really makes them think about doing that sort of thing again. . . . When the social workers [who are ombudsmen] are finished negotiating and schmoozing, it's a paper tiger.

Former ombudsman Trimble further alleges that the first director of the State Ombudsman program was terminated from the program because of activism and advocacy. She adds, "The problem with the Board is that everyone is tied in some way to the governor."

Program Needs
The Wisconsin Board on Aging and Long-Term Care plans to enlarge operations by hiring two more volunteer ombudsman coordinators for the Milwaukee and Fox River Valley areas. The Board is also slated to increase the pay of regional ombudsmen. Currently, two of the state's fourteen regional ombudsman positions are vacant, and regional ombudsmen and staff attribute the vacancies to comparatively low pay in relation to the challenges of the job.

The ombudsman program currently has one full-time supervisor whose duty it is to consult on cases, plan staff training, and monitor quality. The Board intends to double the supervisors on staff, to two full-time supervisors.

In addition, the ombudsman program plans to continue a practice of closely observing facilities that have undergone problems, to make a priority of assuring a smooth transition to residents and their families when a facility must close.

According to the Wisconsin Board on Aging and Long-Term Care,

More than ten percent of the nursing home beds in Wisconsin have been affected by bankruptcy of their corporate owners. . . . Ombudsmen are made aware of situations where facilities are known to be experiencing financial difficulties and they . . . pay . . . attention to care and treatment factors that may signal . . . deterioration in a provider's ability to care for the residents . . . monitor[ing] for signs of inconsistent care, inadequate staffing, supplies, or other indications of financial instability.

The major system-wide problem that ex-ombudsman Trimble sees is a lack of ombudsmen to oversee nursing homes, home healthcare and other programs. This view is shared by the volunteer ombudsman coordinator.

Recommendations
The Wisconsin Board on Aging and Long-Term Care must lobby for greater federal oversight of the ombudsman system, both locally and nationally.
Stronger federal oversight would in turn strengthen Wisconsin standards, allowing the Wisconsin program to more easily negotiate to improve nursing facility standards, increase local funding and achieve its other goals.

On the local level, biweekly visits to all nursing homes are necessary to assure quality and accountability. As the volunteer ombudsman coordinator noted, the program is still in the process of developing a schedule of regular visits.\(^{131}\)

In addition, the Wisconsin ombudsman program would benefit from autonomy from the Board on Aging and Long-Term Care. The separation of the program would help ombudsmen's ability to make policy recommendations and engage in lobbying efforts. Neighboring states share the problem of lack of autonomy: "Substate ombudsmen Robyn O'Neill of Suburban Cook County and Margaret Niederer of Springfield both observed... that the dependent status of the [Illinois] program impedes its ultimate effectiveness for change."\(^{132}\)

Furthermore, state ombudsman program officials must improve the ratio of long-term care ombudsmen to nursing home beds. The 1994 Institute of Medicine study recommends a ratio of one ombudsman to 2,000 beds.\(^{133}\) Currently in Wisconsin, the program has a ratio of approximately one ombudsman to 6,500 beds.\(^{134}\)

Moreover, the Wisconsin legal counsel should have the opportunity to represent residents in the appeals process. As the Institute of Medicine recommendations make clear, an "adequate legal counsel [as] an integral part of the ombudsman program" encompasses two functions: First, the legal counsel must "represent the program itself;" second, he or she must "provide advice and counsel in matters related to long-term facility residents."\(^{135}\) Currently, the Wisconsin Board on Aging and Long-Term Care legal counsel is active only in the second category; thus, the Wisconsin ombudsman program is inadequate as regards Institute of Medicine recommendations.

Finally, Wisconsin should alter its ombudsman program philosophy to embrace the traditional conception of seeing the nursing home resident's family members, in addition to the resident, as clients of the state ombudsman program. Often the resident is unable or unwilling to make complaints, therefore it seems unreasonable not to allow family members to utilize the ombudsman. In neighboring Illinois in fiscal year 1992, family members made twenty-eight percent of the complaints, while residents themselves were responsible for only twenty-one percent of the complaints, meaning that family members were more likely than residents to contact the ombudsman.\(^{136}\)

**Conclusion**

Because the lack of national standards for an ombudsman program has made it difficult to obtain detailed information on state programs, there is inconsistency between the states. Currently, different states have different levels of staff and volunteers, and standards for state ombudsman programs are minimal, both "among and within states."\(^{137}\)

The Institute of Medicine recommends that the United States Department of Human Services direct all state offices for the Long-Term Care Ombudsmen to offer more detailed information in their annual reports, including:

- The level of awareness of residents, their agents, and other parties regarding the ombudsman program, and the availability of ombudsmen to individual residents;
- The extent to which the complaints and concerns of residents have been satisfactorily resolved;
- The extent to which ombudsmen have provided input into activities designed to improve the overall system of care and services for long-term care residents; and
- The extent to which ombudsmen have improved the overall system of care and services for long-term care residents.\(^{138}\)

The new administration must commit to funding the recommendations outlined in the Institute of Medicine's 1994 study, "Real People Real Problems." The most important of these include:

- [T]hat the Assistant Secretary for Aging explicitly operationalize the federal government's responsibility for oversight of the long-term care ombudsman program. This should include (at a minimum) the following elements of program oversight: (1) active monitoring of programs by regional offices or the central office of the Administration on Aging; (2) effective technical assistance to the state programs; and (3)
standards and procedures for training representatives of the Office of the State Long-Term Care Ombudsman;

- [T]hat the Assistant Secretary for Aging develop plans of action and cooperative agreements with the Legal Services Corporation, the National Association of Protection and Advocacy Systems, the National Association of Medicaid Fraud Control Units, and the Office of the Inspector General of the Department of Health and Human Services to foster and encourage a variety of legal assistance resources for residents of long-term care facilities.\textsuperscript{139}

Equally important, the Administration on Aging must commit to the creation and dissemination of national guidelines for adequate funding of ombudsman programs.

The agency must also require individual states to report effective and ineffective problem-solving strategies, which would then be aggregated as a shared resource for use by states. Such a resource would allow states to avoid inefficiencies caused by experimenting with methodologies rejected by other states.

In conclusion, the time is ripe for a follow-up examination by the Institute of Medicine, revisiting the issues outlined in the 1994 study excerpted above. In addition to retracing its investigation of successes and failures, the institute should study alterations wrought by the burgeoning problem of nursing facility bankruptcy, as well as changes resulting from the growing influx of health-maintenance organizations (HMOs) in the long-term care environment. The study should also detail any of the individual states’ structural conflicts in the placement of their ombudsman programs—e.g., conflicts of interest from a program’s location within umbrella structures.

Endnotes


3. Id.

4. Id.


6. Id.


13. Weigand, \textit{supra} note 11, at 98.

14. Id. at 100.

15. Id. at 100-101.

16. Id. at 102.


22. Id. at 222.

23. Weigand, supra note 11, at 105.

24. Kahana, supra note 10, at 223.

25. Id.

26. Id. at 222.

27. Id. at 221.

28. Weigand, supra note 11, at 103.

29. Herrington, supra note 8, at 357 n. 73.


31. Id. at 222.

32. Id. at 218. But see infra note 94 and accompanying text (impact of ombudsman referrals to criminal or civil enforcement). Access by state ombudsmen to legal counsel and representation on behalf of residents is a recurring, partisan dispute in various states.

33. Id.

34. The four other demonstration programs were located in Michigan, Pennsylvania, South Carolina, and Idaho.


37. Kahana, supra note 10, at 223.


40. 42 U.S.C. § 3058g.

41. INSTITUTE OF MEDICINE, supra note 5, at 1.

42. Kahana, supra note 10, at 231.

43. SENATE COMMITTEE ON AGING, DEVELOPMENTS IN AGING 264 (1989), quoted in Lawrence A. Frolik & Alison McChrystal Barnes, ELDERLAW 381 (2nd ed. 1999).

44. Herrington, supra note 8, at 335.

45. Institute of Medicine, supra note 5, at 8.

46. See generally Regan, supra note 7, at 735 (noting that a nursing home owner’s responses to the ombudsman’s interventions will be individual facility “policy changes,” rather than “system-wide” modifications).

47. INSTITUTE OF MEDICINE, supra note 5, at 6.

48. Id. at 9.

49. Weigand, supra note 11, at 120.

50. Regan, supra note 7, at 703.


52. Regan, supra note 7, at 703.

53. Kahana, supra note 10, at 229.

54. Id.
55. *Id.* at 233.

56. Regan, *supra* note 7, at 702.

57. *Id.*

58. *Id.*


61. Interview with Kellie Miller McLellan, Volunteer Ombudsman Coordinator, Wisconsin Board of Aging and Long-Term Care, Milwaukee, WI. (Nov. 14, 2000).

62. Telephone Interview with Bill Donaldson, Legal Counsel, Wisconsin Board of Aging and Long-Term Care (Oct. 25, 2000).

63. Interview with Kevin Zwart, Medigap Insurance Counselor, Wisconsin Board of Aging and Long-Term Care, Milwaukee, WI. (Nov. 14, 2000).

64. Telephone Interview with Bill Donaldson, (Nov. 1, 2000); 42 U.S.C.A. § 3058g: “The Ombudsman shall . . . identify, investigate and resolve complaints that are made by, or on behalf of, residents . . .”


66. Telephone Interview with Kellie Miller McLellan (Nov. 7, 2000).


69. *Id.* The Institute of Medicine observes that it is a common practice in some states for a phone ombudsman to “investigate complaints through phone inquiries only.” In contrast, the Wisconsin Intake Coordinator hears concerns, makes follow-up queries, and saves time by briefing the regional ombudsmen.


70. *Id.* at 8.

71. *Id.* at 9.

72. *Id.* at 4.

73. *Id.* at 6.

74. INSTITUTE OF MEDICINE, *supra* note 5, at 3.

75. Telephone Interview with Bill Donaldson, *supra* note 62.

76. *Id.*

77. Interview with Kevin Zwart, *supra* note 63.

78. SENATE COMMITTEE ON AGING, Developments in Aging 264 (1989), quoted in Lawrence A. Frolik & Alison McChrystal Barnes, ELDERLAW 381 (2nd ed. 1999).


80. Interview with Rachel Selking, Milwaukee Regional Long-Term Care Ombudsman, Milwaukee, WI. (Nov. 14, 2000).


82. Interview with Jean Trimble, Legal Assistant, Nelson, Irvings, and Waeffler S.C. (Oct. 6, 2000).


84. *Id.* at 2.


86. Interview with Jean Trimble, *supra* note 82.

87. *Id.*

88. Interview with Rachel Selking, *supra* note 80.

89. Telephone Interview with Bill Donaldson, *supra* note 64.

90. *Id.*

91. Interview with Rachel Selking, *supra* note 80.

92. *Id.*

93. Interview with Kevin Zwart, *supra* note 63.

94. Telephone Interview with Bill Donaldson, *supra* note 64.

95. Interview with Jean Trimble, *supra* note 82.
96. Interview with Rachel Selking, supra note 80.

97. INSTITUTE OF MEDICINE, supra note 39, at 2.

98. Interview with Kevin Zwart, supra note 63.

99. Interview with Rachel Selking, supra note 80.

100. Id.

101. INSTITUTE OF MEDICINE, supra note 5, at 2.

102. Id. at 12.

103. Telephone Interview with Bill Donaldson, supra note 62.


105. Interview with Jean Trimble, supra note 82.

106. Interview with Kellie Miller McLellan, supra note 61.

107. Interview with Jean Trimble, supra note 82.

108. Interview with Kevin Zwart, supra note 63.


110. Telephone Interview with Mitch Hagopian, Attorney, Coalition of Wisconsin Aging Groups (Nov. 20, 2000).

111. Interview with Jean Trimble, supra note 82.

112. 42 U.S.C. § 3058g (g)(2): “The state agency shall ensure that the Office pursues administrative, legal, and other appropriate remedies on behalf of residents.”

113. INSTITUTE OF MEDICINE, supra note 5, at 6.

114. Compare Wis. Stat. § 16.009 (b)(2) (n)(4)(a) (2000): “The board shall operate the office in order to carry out the requirements of the long-term care ombudsman program under 42 U.S.C. 3027(A)(12)(a) and 42 U.S.C. 3058f to 3058h. The executive director of the board shall serve as ombudsman under the office” with 42 U.S.C. 3058g(B)(3): “The Ombudsman shall serve on a full-time basis . . . .”

115. 42 U.S.C. § 3058g (B)(3).


117. See e.g., WIS. STAT. § 16.009 (2)(a) (1987): “The board on aging and long-term care shall appoint an executive director and staff within the classified service.”

118. Interview with Jean Trimble, supra note 82.

119. Id.

120. Id.

121. Id.

122. INSTITUTE OF MEDICINE, supra note 39, at 4.

123. Telephone Interview with Mitch Hagopian, supra note 110.


125. Id. at 26.

126. Id.

127. Id. at 4.


129. Interview with Jean Trimble, supra note 82.

130. Interview with Kellie Miller McLellan, supra note 61.

131. Id.

132. Herrington, supra note 8, at 357 n. 268.

133. Institute of Medicine, supra note 5, at 13.

134. Telephone Interview with Bill Donaldson, supra note 64.

135. INSTITUTE OF MEDICINE, supra note 5, at 5.

136. Herrington, supra note 8, at 357 n. 263.

137. INSTITUTE OF MEDICINE, supra note 5, at 4.

138. Id. at 11.

139. Id. at 5.