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COMMUNITY REPRESENTATION AND EMPOWERMENT IN LONG TERM CARE SETTINGS:
THE CASE OF THE NURSING HOME PATIENT OMBUDSMAN

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Introduction

It is widely recognized that regulatory efforts outside of the nursing home have had relatively limited success in monitoring patient care complaints (New York State Moreland Act Commission, 1975; Weatherby, 1975). As a result, the public at large and an increasing number of policy analysts have aggressively called for the initiation of alternative long term care monitoring strategies (Regan, 1977; Linnane, 1977; Vladeck, 1980). One such recently developed administrative ameliorative, with direct ties to the local community, is the nursing home patient ombudsman. The ombudsman program, when serving as a complaint redress mechanism for the institutionalized aged, is believed to operate in a dynamic interaction between nursing home residents, their families and friends, facility personnel, community and government. Such programs have stressed the importance of the citizen volunteer, and the development of communication networks between residential facilities and the larger community.

Legislation supportive of this type of program remains, however, vague, allowing for considerable variation in implementation from state to state. Furthermore, there is a conspicuous absence of systematic research assessing the structure and function as well as the efficacy of the ombudsman concept in long term care. There are those who have argued for the potential effectiveness of ombudsman programs (Katz, 1973; Broderick, 1973) while others are considerably more pessimistic concerning the idea of "community as ombudsman" (Hazard, 1968; Cloward, 1967; Eckert, 1976). Regardless of the final verdict as to the efficacy of ombudsmanship in long-stay institutions, the fact that there is at present minimal legislative authority provided such programs makes it especially important to examine the ways in which nonstatutory community empowerment strategies may substitute for more aggressive long term care regulatory policy.

The research reported here represents an attempt to examine the extent and manner in which the communication gaps between institutions and the larger community may be reduced. It reports on a strategy to increase meaningful community participation in institution services through the utilization of available community resources.

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Research Design

A 1979-80 survey study examining the experience of the New York City Nursing Home Patient Ombudsman Program collected data which illuminate the extent to which the involvement of concerned community residents can serve to reduce the isolation, vulnerability and powerlessness of the frail elderly residing in nursing homes. Structured interviews were carried out in 22 skilled nursing and health-related facilities with long term care staff (N = 61), volunteer ombudsmen (N = 25), community advisory board members (N = 24) and actual residents of long stay institutions (N = 210). Secondary analysis of program records supplement these sources of data as well as semistructured interviews with various respondents situated in the study program's interorganizational support network. The study, by necessity, followed an ex post facto design, as no pretest measures had been administered at the point of program inception.

Components of Community Empowerment

The importance of community-wide involvement is explicit in program objectives identified by the New York City Nursing Home Patient Ombudsman Program. To what extent, then, has the program worked? In what ways has the program succeeded in building an interorganizational constituency which may reinforce its organizational core and participate in joint efforts at upgrading the quality of long term care? The focus here is on several dimensions of community empowerment: 1) the status of the program's advisory boards; 2) the quality of interorganizational relations and coalitions throughout the secondary support network; 3) the efficacy of program efforts; 4) the role behaviors and power resource needs of community ombudsmen; and 5) factors limiting effective community intervention.

The Program Advisory Board

A primary mechanism through which the Ombudsman Program has sought to relate the institution to the public has been the community advisory board. The indigenous community advisory board is composed of representatives of local health and social service organizations, long term care facilities, the general public and volunteer ombudsmen themselves. Data were collected on the functions advisory members perceived themselves to have performed in the past for the Ombudsman Program. Responses were differentially weighted and summed due to the ranked nature of these data. They indicated that members placed greatest weight on three indirect service functions (serving as program consultants, involvement in defining overall program objectives, and monitoring program activities) and one direct service function (negotiating access to nursing homes). These four functions were distinctly separated from the remaining five tasks or roles (providing technical assistance, performing public relations, negotiating working relationships between program and community, determining day-to-day objectives and participating in volunteer recruitment). These latter functions tended to be more closely associated with direct, day-to-day service activities from which the advisory boards obviously disassociated themselves.

Comparative analysis between "actual" committee function and "desired" committee function was considered. Advisory respondents were in substantial agreement that their primary function should be the setting of program policy and goals. Two additional functions assigned considerable importance were the monitoring/evaluation of program performance and the performance of a public relations function. Membership was in large part less enthusiastic about being "access negotiators," "educators" concerning the needs of patients and "legitimizers" of overall program effort. Comparisons between these findings and those reported earlier suggest only partial congruence between respondents' perceptions of actual and desired committee function. Thus members saw themselves as continuing to function as program policy setters and monitors of program effort. On the other hand, members did not want to serve as nursing home access negotiators to the extent that they had in the past. Moreover, they wanted to assume more of a public relations function in the future than they have had in the past.

While continuation of the community advisory board was assigned high priority by members, there was considerable evidence to suggest that its representation needed to be modified. The majority were not fully convinced that the current "mix" or representation of its members was the most appropriate to insure proper performance. They felt that membership on such a committee ought to be dominated by members who express a willingness to actively participate. Key actors included human service professionals from community agencies, nursing home staff and finally institutionalized residents and their relatives.

Interorganizational Relations and Coalitions

The quality of interactions between the Ombudsman Program and other organizational entities was measured from several perspectives: the advisory board, the volunteer ombudsmen, the secondary sponsors or program support network, and salaried program staff. When program advisors were asked to identify those organizations with which the Program had encountered major difficulties, voluntary grass roots groups were cited twice as often as the next leading organizational entity--nursing homes themselves. Far less frequently cited were the local Area Agency on Aging and the Department of Social Services. Furthermore, only 3 in 10 advisory members (29.2%) were fully convinced that the Ombudsman Program had worked closely enough with voluntary associations of friends and relations in the communities in which the participating long term care facilities are located. Of those advisory board respondents who expressed an opinion, a clear majority considered it most important that the Program's staff work closely in the future with local voluntary community advocacy and social action organizations. Significantly less importance was assigned to working more closely with other organizations such as social service agencies, labor unions and nursing home associations. Thus the value of coalition-building between groups having similar patient representation structures was emphasized.

Where dissatisfaction was voiced concerning interagency relations, both by salaried Ombudsman Program staff and network representatives, it more often than not revolved around the issue of perceived lack of reciprocity. That is, one or the other party was of the opinion that their counterpart did not always respond

with equal measures of information, expertise and effort when a particular issue was being addressed.

The lack of standardized methods of information flow may well have served to promote such perceptions. For example, the Ombudsman Program staff frequently perceived laxness on the part of certain network agencies in resolving a nursing home grievance. The network agencies, for their part, were often critical concerning the lack of information they received about ombudsmen activities.

The other organizations generally did not perceive the Ombudsman Program as duplicating their own efforts. Indeed, no one agency viewed their own efforts to be adequate nor sufficiently effective in addressing the issue of quality care in long-stay institutions. Several network respondents suggested that independent or individualistic functioning by various organizations in the field was not an appropriate strategy in light of the severity and persistence of long term care issues. Nevertheless, few individuals were able to more than verbally support the idea of increased interagency efforts, citing the scarcity of organizational resources that could be redirected toward coordination activities between programs.

The Efficacy of Program Efforts

To evaluate ombudsman performance, responses were obtained on several measures of program effectiveness from the perspective of the community service provider (volunteer ombudsmen), the service observer (long term care staff) and the potential service beneficiary (long term care residents). Providers and observers were questioned as to the degree of success the ombudsman had realized in addressing 10 program-related effectiveness issues (score metrics: 1 = not successful at all to 5 = extremely successful). Two indices measuring aspects of policy/planning and relationship/social interactive effectiveness were also employed. They were composed of a subset of items within the larger index. Finally, a composite measure of "experienced" effectiveness was developed and administered to actual users of the ombudsman service (i.e., program beneficiaries). This 5-item index allowed aged residents the opportunity to assess whether they agreed or not that the ombudsman they spoke to was sensitive, respectful, interested in their problem, competent to deal with their problem and accountable (i.e., able to keep them informed of results) (summary score metrics: 5 = strongly agree to 25 = strongly disagree). Table 1 summarizes scale item and reliability information for the four indices.

There was considerable agreement on the extent of program efficacy across provider and observer groups (see Table 2). Staff means for perceived effectiveness indicated ombudsman program effort to have been viewed as only "slightly successful." Volunteer ombudsmen were found to be in close accord with facility staff concerning perceptions of general program effectiveness ($F = 67$; $df = 3$; $p = .570$).

Among patients who had presented grievances to a volunteer ombudsman, 43.5 percent believed that the problems were solved, 39.1 percent believed they were not and 14.4 percent were not sure. When patients were asked to assess their personal experiences with the ombudsman (using the 5-item experienced effectiveness scale), they reported a relatively high level of satisfaction (mean = 10.18; s.d. = 3.29). Analysis of individual scale items indicates that volunteers were more likely to

Table 1
 Scale Item Information and Reliability Analysis
 for Summary and Individual Effectiveness Indices

Effectiveness Index	Number of Index Items	Identity of Index Items	Alpha Coefficient
Experienced Effectiveness Index	5	EE1-EE5*	.91
Perceived Effectiveness Index	10	PE1-PE10**	.88
Policy/Planning Effectiveness Index	2	PE3	.41
Relationship/Social Interactive Effectiveness Index	1	PE5	--

* EE1 = Sensitivity to concerns
 EE2 = Respectfulness
 EE3 = Interest in problem
 EE4 = Competency dealing with problems
 EE5 = Accountability/Informing of Results.

** PE1 = Assist in protecting rights
 PE2 = Establish a speedy complaint resolution mechanism
 PE3 = Propose changes in policy/regulations
 PE4 = Increase communication between staff/residents
 PE5 = Establish better community/nursing home relations
 PE6 = Improve day-to-day life of residents
 PE7 = Provide information for legislators
 PE8 = Prevent recurrence of deficiencies
 PE9 = Alert staff to patient needs
 PE10 = Support changes in policies/regulations

Table 2
Descriptive Statistics for Summary and Individual
Effectiveness Indices by Respondent Group

Respondent Group	Effectiveness Index			
	Experienced Effectiveness (a)	Perceived Effectiveness (b)	Policy/Planning Effectiveness (c)	Relationship/Social Interactive Effectiveness (c)
Volunteer Ombudsmen	Mean	23.77	1.62	1.42
	S.D.	5.93	.65	.83
Nursing Home Administrators	Mean	24.62	1.83	2.31
	S.D.	9.07	.83	1.25
Directors of Nursing	Mean	22.33	2.10	1.70
	S.D.	10.21	.96	.95
Directors of Social Services	Mean	19.50	1.44	1.71
	S.D.	8.31	.56	.91
Residents/Patients	Mean			
	S.D.	10.18		
F Value Probability				
		.67	1.10	2.38
		.570	.360	.079

(a) Scale Range: 5-25; where a lower score indicates greater effectiveness
 (b) Scale Range: 10-50; where a higher score indicates greater effectiveness
 (c) Scale Range: 1-5; where a higher score indicates greater effectiveness

be seen as sensitive (mean = 1.83; s.d. = .58), respectful (mean = 1.56; s.d. = .59) and interested (mean = 1.65; s.d. = .65) than competent (mean = 2.56; s.d. = .90) or accountable (mean = 2.59; s.d. = 1.14).

As noted above, the perceived effectiveness scale included two separate dimensions of program success. The "policy/planning" effectiveness dimension tapped the degree to which ombudsmen initiated change more likely to have collective or systemic rather than individual consequences for long term institutional care. A "relationship/social interactive" effectiveness dimension reflected interpersonal or socializing consequences of ombudsman activity.

The perceptions of external agents (volunteer ombudsmen) approached significant divergence from those of long term care staff for only one dimension--relationship/social interactive ($F = 2.38$; $df = 3$; $p = .079$). Interestingly, each long term care staff category believed that the ombudsman program has been measurably more effective along this dimension (i.e., establishing better community/nursing home relations) than the volunteers themselves. Correlated t-tests performed on the pair of validated effectiveness dimensions did not reveal significantly different levels of goal attainment accorded by either the external agents or long term care staff.

It is worthy of note that 3 of the original 10 effectiveness items with strong but less than significant tendencies (as judged by an expert panel) toward inclusion in a hypothesized "organizational/programmatic dimension," were accorded considerably higher levels of attainment than the validated dimensions discussed above. This was the case for both external agents and long term care staff. These program effectiveness issues--1) alerting staff to patient needs; 2) assisting in the protection of residents' rights; and 3) establishing a speedy complaint resolution mechanism--achieved relatively high group means by all respondents. These data indicate that the ombudsman program was considerably more successful in establishing specific operating procedures and processes in the facilities than in bringing about systemic change in long term care, or improved social relationships between individuals and groups in long term care.

Role Behaviors of Community Ombudsmen

Ombudsman role perception scales were constructed especially for this study, determined to be statistically reliable and validated by an expert panel composed of university professors throughout New York State with acknowledged expertise in the field of social welfare. It was found that both external agents (volunteer ombudsmen and advisors) and facility representatives (administrators, nurses and social workers) accorded highest accuracy to the therapeutic support dimension of ombudsmanship (e.g., providing emotional support, easing conditions) and lowest accuracy to volunteers functioning as advocates or adversaries (e.g., arguing the cause of the patient, acting as a watchdog or reformer of nursing home conditions). The mediator role (e.g., serving as a middleman, an explainer of decisions), most closely associated with the classical definition of the ombudsman, was seen as a moderately accurate description for the volunteer's efforts. Data further indicated that persons directly associated with the program had a more clear and definitive sense of what the ombudsman role was all about. Long term care staff, on the other hand, had a more diffused or

blurred notion of what the ombudsmen were actually doing in their facilities. This conclusion was based on the emergence of significantly less accurate scores assigned to each of the 3 potential program functions by facility respondents.

It is noteworthy that facility personnel all but ruled out the need for advocative ombudsman stances when they were asked to indicate their views of desired ombudsman behavior, suggesting relative congruence between their perceptions of actual and desired role performance. They also assigned almost equal significance to mediative and therapeutic functions, perceiving them to be more critical modes of potential ombudsman intervention. On the other hand, ombudsmen and their community advisors did not rule out the need for aggressive approaches to the provision of service. Ideally, then, they included selective use of classical, nonpartisan approaches and authoritative stances depending on the particular needs of the aged resident.

Needed Program Powers

Survey respondents were asked whether the Ombudsman Program needed additional power or authority to function effectively. In order to measure this variable, a composite measure of "needed" program power was developed. This five item index, which was determined to be internally consistent ($\alpha = .86$), contained 4 specific measures of needed power (i.e., the importance of having the authority: a) to change nursing home decisions; b) to enforce nursing home decisions; c) to mandate access to nursing homes; and d) to mandate access to patient records). The fifth scale item considered the importance of gaining more legislative/legal authority.

Statistical analysis of these data provided further evidence of significantly divergent role perceptions subscribed to by external agents as compared to long term care staff. Ombudsmen expressed the greatest need for additional program powers. Their views were quite similar to those of their advisory board members who indicated only a slightly reduced need for more program powers. In sharp contrast with these views, the 3 categories of long term care staff were in close agreement as to the limited importance of giving the ombudsman program more authority. The minimal concern voiced by long term care staff for program power acquisition is consistent with their disregard for a potential ombudsman advocate role. It is noteworthy that when long term care staff were disaggregated by institutional auspice, proprietary staff indicated that significantly less program power was needed than staff working in voluntary facilities.

An interesting relationship emerged as well between power acquisition and the three potential ombudsman program roles for both the external agents and long term care staff. A positive correlation was found to exist between perceived need for power acquisition and importance assigned to the advocate role. This correlation reached a level of significance in the case of the external agents ($p < .05$) and approached significance in the case of long term care staff ($p = .06$). For long term care staff the need for program power tended to be negatively correlated with the mediator role and the therapeutic role though these findings were not statistically significant. A negative correlation between power acquisition and both the mediator and the therapeutic support roles did not appear to any degree in the case of the volunteer ombudsmen. It would seem

that the volunteers did not rule out the need for additional power merely because they subscribed to less political, nonpartisan ombudsman roles. Indeed, acquiring more power may have been considered beneficial in their efforts at performing a range of interventive tasks.

Factors Impinging On Effective Intervention

Volunteers and advisory board members were asked to assess the importance of a series of factors in making the job of the ombudsman more difficult. External agents agreed on the top limiting factors--resistance by nursing home administrators and resistance by other nursing home staff. At that point advisory board members assign only slightly less importance to 3 "program specific" issues-- a) inadequate program funding; b) incomplete training of volunteers; and c) inadequacies in program administration/supervision. In the opinion of the ombudsmen these 3 issues were viewed as considerably less important. The lack of legal authority, the voluntary nature of the ombudsman role and the status of the user population, while still considered to be mildly important factors, tend to be given lesser weight by both groups.

An additional perspective on factors effecting program performance was gained by identifying those nursing home problems most resistant to resolution. Over 90 percent of ombudsmen interviewed were convinced that certain patient complaints were more apt to be resistant to amelioration. It was found that ombudsmen believed issues of food and nutrition to be the number one ranking problem. Indeed, this problem category was separated out from other problems in terms of resistance to resolution. Issues of health care and problematic interpersonal relations between residents and staff were also frequently cited as well as issues of patients' rights and administrative difficulty. It is worthy of note that while all long term care staff had views of problems similar to those of the ombudsmen, directors of social services tended to be in closest accord with the volunteers.

Volunteer Ombudsman Commitment

The volunteer community ombudsman's commitment to the program could be expected to influence program performance. Advisory board members were asked to indicate what, in fact, were the three major strengths and weaknesses in using volunteers to perform the ombudsman function. Data revealed advisory board members were convinced that the volunteers' enthusiasm and motivation represented the primary benefit in utilizing their services. The second highest valued strength was the volunteers' objectivity and independence. Less often voiced benefits included the cost efficiency of volunteers and the diversity of their backgrounds and past experiences. The two most often mentioned and highly ranked shortcomings in using volunteers were: a) the resulting variability in their time commitment to the job and b) the frequent inadequacy in the level of technical skills or expertise they brought to the position. Lack of enthusiasm found among a select few volunteers was assigned lesser weight as were some volunteers' poor record-keeping practices.

Volunteer ombudsmen's perceptions reinforce the above findings. They overwhelmingly pointed out that the most encouraging aspect of giving service had been the opportunity to display in concrete terms their altruistic impulses. A lesser number cited their sense of accomplishment as influencing their decision to remain with the program. Most prominent among the discouraging aspects of service that were cited was the feeling that their efforts lacked impact/effect and the perceived insensitivity and lack of concern among long term care staff. Other disheartening aspects included the poor conditions in which the institutionalized aged lived and the amount of paperwork the volunteers were required to complete. The above data suggest that community volunteers experienced conflict between their powerful benevolent impulses and the rewards derived from a sense of accomplishment on the one hand, with a more frequent sense of relative impotency when working within what appears to them as the insensitive and rigid world of institutional life on the other.

Summary and Recommendations

Both the patient representative and the advisory board represent primary mechanisms through which the Ombudsman Program has sought to increase community consciousness of issues in long term institutional care. The development and maintenance of interorganizational coalitions are, however, largely the result of the efforts of the advisory bodies and the aggressiveness of the Ombudsman Program's salaried professional staff. Volunteers have had, as a matter of policy, minimal exposure to groups both inside and outside their assigned facility.

The quality of relations with the larger support network can best be described as unceremoniously collaborative. Casual, unofficial communications take place most commonly when issues of mutual concern are identified by one party or the other. The lack of as yet substantially formalized organizational interactions may give rise on occasion to perceptions of imbalanced or unilateral resource exchanges. Even so, there is little evidence to suggest that the Ombudsman Program is seen to be unnecessarily duplicating the efforts of previously established organizations. All members of the Ombudsman Program support network sympathize with the idea of coordinated interagency activities but at the same time cite pervasive shortages of human resources as being a hindrance to such initiatives.

Nursing home ombudsmen subscribe to a somewhat different stance than that which is implicit in the 1978 Amendments to the Older Americans Act. The absence of as yet substantial program authority may have promoted the ombudsman's acquisition of a therapeutically supportive, community counselor orientation. This does not, however, rule out the need for more confrontational stances, depending on the severity of the nursing home grievance under consideration.

Based on the disparity between the views of external agents and facility representatives concerning the need for additional program power as well as the less than optimal levels of program efficacy, several policy and program recommendations are offered. They are believed to have relevance beyond the specific program in question to citizen representation efforts generally.

- 1) Legislation should give greater recognition to the broad range of role

behaviors that are actually practiced in the delivery of nursing home patient representation services including the therapeutic, mediative and advocate approaches. Statutory guides to program development need to better merge ombudsman theory and practice. The prescriptions derived from the literature on classical ombudsman behavior are not fully applicable in the context of institutional life.

2) Volunteer community ombudsman programs can most profitably exhibit a generalist orientation with focused expertise/specialization in selected problem situations. Such programs need to capitalize on the humanitarian perspective of the volunteer yet maintain the capacity to sequentially order role behaviors depending on the point at which the ombudsman is at in the grievance resolution process.

3) There is a need for a long term care quality assurance group. This coordinating body would be composed of representatives from both public and voluntary organizations in the continuum of institutional care redress mechanisms. These individuals would meet regularly, share information, identify issues for joint action and plan appropriate inter-agency action steps.

4) Attention should be given by long term care ombudsman and other patient representative programs to potential overlap with the responsibilities of long term care facility staff. Dysfunctional and potentially duplicative efforts by ombudsmen and social service staff in institutions should be carefully monitored.

5) Finally, balanced representation should be assured on ombudsman program advisory boards. Membership must consist of active, contributing individuals committed to the ombudsman idea. Adequate representation by long term care administrators and other facility personnel, community agency professionals, the interested but unaffiliated general public, residents and their families need to be considered as well.

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