Older Americans Act: Long-Term Care Ombudsman Program

Kirsten J. Colello
Specialist in Health and Aging Policy

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Summary

The purpose of the Long-Term Care Ombudsman Program is to investigate and resolve complaints made by, or on behalf of, older persons who are residents of long-term care facilities. Established under Title VII of the Older Americans Act (OAA), the Administration on Aging (AoA) within the Department of Health and Human Services (HHS) administers the nationwide program. As of 2007, there are 53 state Long-Term Care Ombudsman Programs operating in all 50 states, the District of Columbia, Guam, and Puerto Rico, and 569 local programs. The program is funded by two separate titles of the OAA, in addition to other federal sources, state funds, and nonfederal funds. With respect to staffing, the program receives significant support from volunteers. In FY2007, over 1,300 paid staff and 12,600 volunteers investigated more than 282,000 resident complaints. Issues regarding residents' care were the chief complaint in nursing homes, followed by residents' rights issues in FY2007. Among residents in other long-term care facilities, the top complaint categories were quality of life and residents' rights.

An evaluation conducted by the Institute of Medicine (IOM) in 1995 concluded that the program is understaffed and underfunded to carry out its broad and complex responsibilities. In March 1999, HHS's OIG recommended that AoA work with states to strengthen the program by developing guidelines for a minimum level of program visibility that include criteria for the frequency and length of regular visits, as well as the ratio of ombudsman program staff to long-term care beds; further developing strategies for recruiting, training, and supervising more volunteers; and establishing ways in which ombudsman programs can enhance collaboration with the state nursing home survey and certification agencies, which are responsible for oversight of nursing home care quality. This report will be updated occasionally.

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Background

The purpose of the Long-Term Care Ombudsman Program is to respond to the needs of residents facing problems in long-term care facilities, including nursing homes, assisted living facilities, board and care homes, and other similar adult residential care settings. Ombudsmen are available to help all long-term care facility residents, not only those residents in facilities certified by Medicare and/or Medicaid. Created in 1972 as a Public Health Service (PHS) demonstration project in five states, authority for administering the ombudsman demonstration program was transferred to the Administration on Aging (AoA) within the Department of Health and Human Services (HHS) in 1974. The results of the demonstration effort led to statutory authority under the Older Americans Act (OAA)[1] in 1978 (P.L. 95-478). In 1987, the program was given a separate authorization of appropriations (P.L. 100-175) and, in 1992, the program was incorporated into a new Title VII of the Act authorizing vulnerable elder rights protection activities (P.L. 102-375). Also in 1992, a provision was added to the OAA amendments requiring AoA to establish a permanent National Ombudsman Resource Center. The most recent amendments to the OAA in 2006 (P.L. 109-365) made no major changes to the program.

There are 53 state Long-Term Care Ombudsman Programs operating in all 50 states, the District of Columbia, Guam, and Puerto Rico, and 569 local programs as of 2007.[2] The AoA's National Ombudsman Reporting System (NORS) compiles national statistics relating to ombudsman activities. This information includes number, status, and type of cases reported to state and local ombudsman programs; data on staff, volunteers, and funding; and, other ombudsman activities.

Function

The OAA requires State Units on Aging to establish an Office of the Long-Term Care Ombudsman. The functions of the state ombudsman programs are mandated by law and include

- identifying, investigating, and resolving resident complaints;
- protecting the legal rights of residents, advocating for systemic change, and providing information and consultation to residents and their families; and
- publicizing issues of importance to residents.

Complaints investigated by ombudsmen relate to actions, inactions, or decisions of long-term care providers or other agencies that adversely affect the health, safety, welfare, or rights of residents. Among its other responsibilities, the Office is to analyze and monitor federal, state, and local policies that affect residential long-term care facilities.

The federal law requires that a full-time ombudsman administer the program at the state level; local ombudsmen may be designated by the state and are considered to be representatives of the

[1] Congress in 1978 amended the OAA (P.L. 95-478) to include a requirement that each state develop a Long-Term Care Ombudsman Program in order to protect the health, safety, welfare, quality of care, and rights of the institutionalized residents in nursing facilities, board and care homes, assisted living facilities, and other similar facilities. For further information, see CRS Report RL31336, *The Older Americans Act: Programs, Funding, and 2006 Reauthorization (P.L. 109-365)*, by Carol O'Shaughnessy and Angela Napili.

[2] Guam's ombudsman program is for all elderly, not just those residing in long-term care facilities.

Office. According to AoA, most state ombudsman programs are located in State Units on Aging, but programs in 15 states and the District of Columbia[3] are located in other types of organizational settings, such as non-profit organizations. Variation exists partly because the OAA gives each state discretion in determining many aspects of the ombudsman program. For example, states can decide

- where ombudsman programs may be located organizationally within the state,
- whether enabling legislation should be passed at the state level, and
- whether additional funding will be made available through state and local sources.[4]

These differences mean that the structure, operation, and effectiveness of the ombudsman programs can vary from state to state.

In addition, ombudsman programs in 12 states are authorized or mandated under state law to advocate on behalf of consumers who receive home and community-based care. According to a 2007 report of state Home Care Ombudsman programs, the majority of these states have responsibility for complaints regarding services provided under the state's Medicaid home and community-based waivers. [5] States also reported that home care ombudsman cover complaints regarding home health agency services and home care services that may be privately funded, state funded, or funded through the OAA. In general, state Home Care Ombudsman programs are supported by state general funds.

Authorization and Funding

The OAA Amendments of 2006 (P.L. 109-365) reauthorized the ombudsman program for five years through FY2011. Ombudsman services are authorized under two separate titles of the OAA:

- Title III – Grants for States and Community Programs on Aging, and
- Title VII – Vulnerable Elder Rights Protection Activities.

Title III authorizes grants to states for supportive services and senior centers that provide for a wide range of social services, including long-term care ombudsman services. Title VII has two separate authorizations for support of ombudsman activities: Chapter 2 (the long-term care ombudsman program) and Chapter 3 (the elder abuse prevention program).[6]

[3] Based on CRS discussions with Sue Wheaton, Ombudsman Program Specialist, Administration on Aging, as of November 2006, programs in Alaska, Colorado, Connecticut, District of Columbia, Kansas, Kentucky, New Hampshire, New Jersey, Maine, Oregon, Rhode Island, Virginia, Vermont, Washington, Wisconsin, and Wyoming are either free-standing programs or located in private, non-profit agencies or a larger government ombudsman program.

[4] For further information, see J. Harris-Wehling, J. Feasley, and C. Estes, eds., *Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older American Act*, Washington, DC: Institute of Medicine (IOM), 1995.

[5] M. Miller, *Home Care Ombudsman Programs Status Report: 2007*, National Association of State Units on Aging, November 2007.

[6] Under Chapter 3, states may use funds to support the Long-Term Care Ombudsman Program if they choose.

While the majority of federal funding for ombudsman activities comes from appropriations for Titles III and VII of the OAA, the program also receives substantial non-federal support. **Table 1** shows total support for ombudsman activities in FY2007. Total FY2007 funding for ombudsman activities from all sources combined (federal and non-federal) was $81.8 million. Of that total, 58.8% represented funding from federal sources, with 32.2% from Title III funds, 20.8% from Title VII funds, and 5.9% from other federal funds. In FY2007, nonfederal funding represented 41.2% of total support (32.7% state funding and 8.5% local funding).

Table 1. Long-Term Care Ombudsman Program Funding, by Source

FY2007

Total FY2007 funds (in millions)			**$81.8**	**100%**
Federal funds	**Total**		**$48.1**	**58.8%**
	Title III, OAA		$26.3	32.2%
	Title VII, OAA	Chapter 2: ombudsman program	$14.7	18.0%
		Chapter 3: elder abuse prevention	$2.3	2.8%
	Other		$4.8	5.9%
State funds			**$26.7**	**32.7%**
Local funds			**$7.0**	**8.5%**

Source: CRS analysis based on AoA, *2007 National Ombudsman Reporting System Data Tables*: Table A-9 Long-Term Care Ombudsman Program Funding.

Note: Data may not sum to totals due to rounding.

From FY2000 through FY2007, the share of federal funding for Long-Term Care Ombudsman Program activities remained relatively constant, while the proportion of state funding increased from 27.6% to 32.7% and spending at the local level decreased from 13.4% to 8.5%.

Staffing

In FY2007, there were approximately 1,311 paid staff (full-time equivalents) in state Long-Term Care Ombudsman Programs, an increase of 35% since FY2000.[7] Despite this increase, the program still relies heavily on volunteers to carry out program responsibilities. Nine out of every ten ombudsman staff serve as volunteers. In FY2007, there were over 12,600 total volunteers, 8,668 of which were certified to investigate complaints. While the number of paid ombudsman staff has increased from FY2000, the total number of volunteers decreased 7% during this same time period (from just over 13,600 in FY2000). A nationwide study conducted by the National Long Term Care Ombudsman Center found that 45 state ombudsman programs have volunteer programs and 37 state programs reported having a certification process for their volunteers as of 1999.[8]

[7] For further information, see 2007 National Ombudsman Reporting System Data Tables, at http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/2007/Index.aspx.

[8] G. McInnes and A. Hedt, *Volunteers in the Long Term Care Ombudsman Program: Training, Certification and Liability Coverage*, Washington, DC: National Long Term Care Ombudsman Resource Center, December 1999.

The 1995 IOM evaluation along with a study done by the Office of Inspector General (OIG) in HHS (1991) acknowledged the importance of volunteers as a contributing factor to high complaint resolution rates in this program.[9] However, the IOM evaluation advised that adequate methods for recruiting, training, and supervising volunteers are essential to maximum utilization of ombudsman program volunteers. State programs have different procedures for certification of volunteers, varying from required classroom training to tests for certification. Data from AoA's NORS report that over two-thirds of volunteers (69%) were trained and certified to investigate complaints in FY2007, a 3% increase since FY2000.

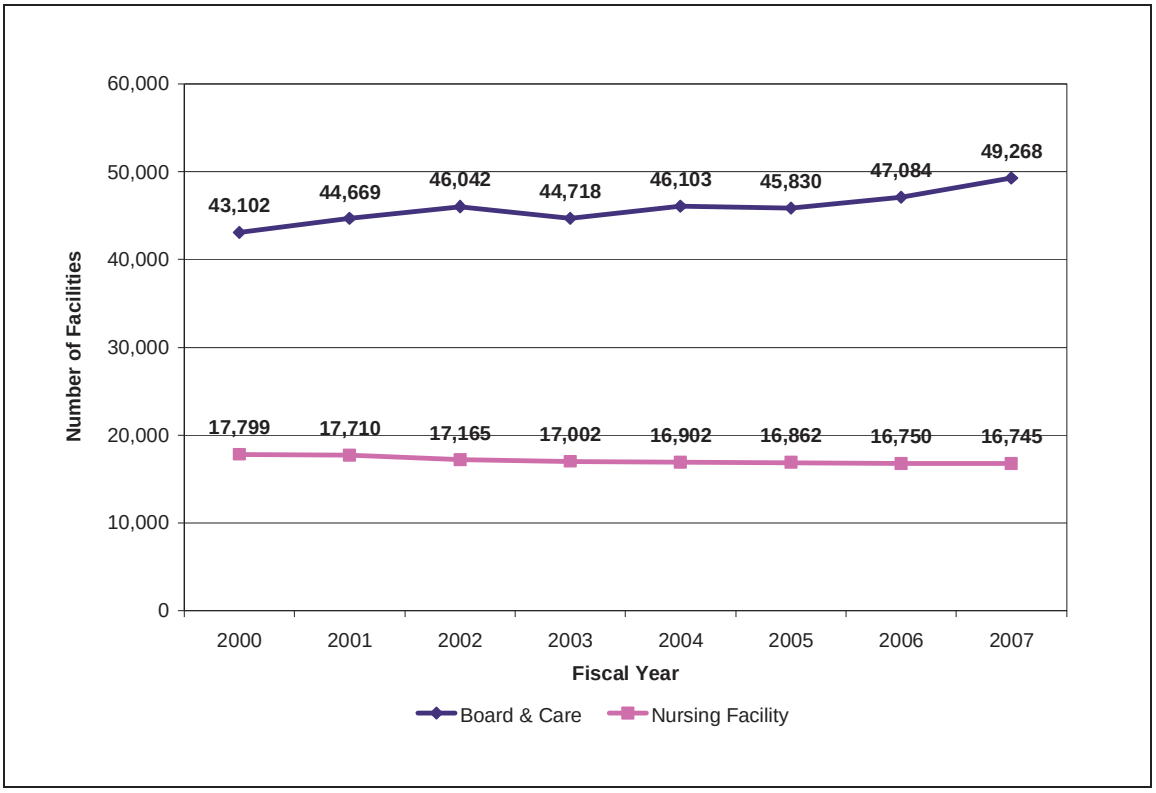
In FY2007, ombudsmen reported just over 16,700 nursing facilities and more than 49,000 other residential long-term care facilities operating nationwide.[10] Since FY2000 the total number of regulated facilities has increased by 8% from almost 61,000 to more than 66,000 in FY2007 (see **Figure 1**). This increase is due to an increase in assisted living facilities, board and care homes, and other similar facilities, which more than offset the decrease in nursing homes over the past seven years.

[9] For further information, see Office of Inspector General (OIG) Report OEI-02-90-02120, *Successful Ombudsman Programs*; OEI-02-90-02121, *Ombudsman Output Measures*; and, OEI-02-90-02122, *Effective Ombudsman Programs: Six Case Studies;* J. Harris-Wehling, J. Feasley, and C. Estes, eds., Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older American Act, Washington, DC: Institute of Medicine (IOM), 1995.

[10] Other residential long-term care facilities include board and care homes and similar facilities, such as residential care facilities, adult congregate living facilities, assisted living facilities, foster care homes, and other adult care homes similar to a nursing facility or board and care home that provides room, board, and personal care services to a primarily older residential population.

Figure 1. Number of Long-Term Care Facilities, by Facility Type

FY2000 to FY2007



Source: CRS analysis based on AoA, *2007 National Ombudsman Reporting System Data Tables*: Table A-6-A Long-Term Care Ombudsman Program Funding.

Note: The number of nursing facilities and board and care homes and similar facilities includes those regulated (licensed or registered) in the state. Under the OAA, the ombudsman program covers all such facilities, whether regulated or unregulated by the state; however, according to the OMB instructions for completing the Long Term Care Ombudsman Program Reporting Form for NORS, it would not be possible for the program to provide the total number of unregulated facilities and beds. Therefore, the actual number of these facilities may be higher. The number of nursing homes may be slightly higher than estimates by the Centers for Medicare and Medicaid Services (CMS), which include only nursing homes certified to participate in Medicare and/or Medicaid.

Workload

Due to the requirement that ombudsmen investigate and resolve complaints of all residents in residential long-term care facilities, the workload of staff and volunteers is substantial, as shown by the reported ratio of staff to facilities and beds. The nationwide ratio of paid ombudsman to facilities was one ombudsman to every 50 facilities in FY2007, a smaller ratio than reported in FY2000 (one ombudsman to every 62 facilities). Nationwide, there were a reported 2.8 million facility beds under the program's jurisdiction (just over 1.7 million nursing home beds and about 1.1 million beds in other long-term care facilities) in FY2007. The nationwide ratio of full-time paid ombudsman to facility beds was about one ombudsman per 2,200 beds, a smaller ratio than reported in FY2000 (one ombudsman per 2,800 beds). However, it is important to note that these ratios are nationwide, and each state has a unique ratio of paid ombudsman staff per facility bed.[11]

[11] For further information, see *2006 National Ombudsman Reporting System Data Tables*, at http://www.aoa.gov/prof/ (continued...)

The 1995 IOM study recommended a standard staffing ratio of one paid full-time equivalent staff per 2,000 long-term care facility beds.

Despite the high number of facilities to be covered by each ombudsman, ombudsman staff and volunteers visited 83% of nursing homes on a regular basis (defined as at least quarterly) in FY2007. These visits were not in response to a complaint. The percentage of nursing homes visited regularly by ombudsman staff was greater than visits by staff to other residential long-term care facilities. The proportion of regular visits to assisted living and other long-term care facilities was 47% in FY2007.

Training

State ombudsman programs are responsible for training new and existing staff. The OAA contains only basic requirements for training and stipulates that the AoA is to develop model standards for training long-term care ombudsman, both paid and unpaid volunteers. Furthermore, the law stipulates that the State Long Term Care Ombudsman is responsible for establishing procedures for training representatives of the local ombudsman program based on the AoA standards and that training is to be developed in consultation with representatives of citizen groups, long-term care providers, and ombudsmen. In the absence of specific federal training requirements and/or required training materials, many states have developed their own standards. Several states provide the training directly through an individual who is responsible for conducting all of the training while some states require local ombudsman programs to conduct training. State long-term care ombudsman programs have received assistance in developing training programs from the National Long Term Care Ombudsman Resource Center, operated by the National Citizen's Coalition for Nursing Home Reform.[12]

Program Data and Resident Complaints

In FY2007, AoA data show that ombudsmen opened just over 186,000 new cases of resident complaints and closed more than 184,000 cases in all types of facilities.[13] Between FY2000 and FY2007, the total number of cases closed increased by more than one-third (34%).

Since 2000, resident care issues have been the primary complaint category in nursing homes. Poor quality of care in nursing homes has been attributed to insufficient numbers of staff to care for residents. However, the relationship between staffing and quality of care is complex and

(...continued)

aoaprog/elder_rights/LTCombudsman/National_and_State_Data/2006nors/2006tables.xls, visited April 11, 2008.

[12] For further information on training materials to assist states, see the National Ombudsman Resource Center website at http://www.ltcombudsman.org/.

[13] According to the NORS Reporting Requirements Form (OMB No. 0985-0005), a complaint is a concern brought to, or initiated by, the ombudsman for investigation and action by or on behalf of one or more residents of a long-term care facility relating to health, safety, welfare, or rights of a resident. Each inquiry involving one or more complaints constitutes an "opened" case, which then requires ombudsman investigation, strategy to resolve, and follow-up. A case is reported "closed" when none of the complaints within the case require any further action on the part of the ombudsman and every complaint has been assigned the appropriate disposition code.

includes a range of staffing-related issues such as wages and benefits, education, training, experience, and staff turnover.[14]

The top five resident complaints in nursing homes for FY2007 are

(1) unheeded requests for assistance;

(2) problems with discharge planning or eviction notification and procedures;

(3) lack of dignity or respect for residents by staff;

(4) lack of quantity, quality, variety, and choice in food; and

(5) improper handling of residents that resulted in unexplained accidents or injury.

These top five complaints have remained among the top 10 resident complaints in nursing homes since FY2000.

Similarly, the top five resident complaints in other long-term care facilities have remained the same since FY2000 and are

(1) lack of quantity, quality, variety, and choice in food,

(2) problems with medication administration or organization,

(3) inadequate discharge or eviction notice or procedure,

(4) poor equipment or building conditions, and

(5) lack of dignity or respect for residents by staff.

In FY2007, the top five resident complaints in nursing homes and other long-term care facilities accounted for one-fifth of all complaints for each facility type.

Program Evaluation

The most recent national evaluation of the ombudsman program, conducted in 1995 by the IOM, concluded that the program plays an important role in improving long-term care services, but is understaffed and underfunded to carry out its broad and complex responsibilities.[15] In March 1999, HHS's OIG recommended that AoA work with states to strengthen the program by: developing guidelines for a minimum level of program visibility that include criteria for the frequency and length of regular visits, as well as the ratio of ombudsman program staff to long-term care beds; further developing strategies for recruiting, training, and supervising more volunteers; and establishing ways in which ombudsman programs can enhance collaboration with the state nursing home survey and certification agencies, which are responsible for oversight of nursing home care quality.[16]

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[14] J. Schnelle et al., *Relationship of Nursing Home Staffing to Quality of Care.* Health Services Research, 39(2): 225-250, April 2004; R. Kane. *Commentary: Nursing Home Staffing—More Is Necessary but Not Necessarily Sufficient*, 39(2): 251-256, April 2004.

[15] J. Harris-Wehling, J. Feasley, and C. Estes, eds., *Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older American Act*, Washington, DC: Institute of Medicine (IOM), 1995.

[16] OIG Report OEI-02-98-00351, *Long-Term Care Ombudsman Program: Overall Capacity.*

A 2000 study of state ombudsman programs reaffirmed the importance of several factors identified in the IOM evaluation as key to program effectiveness including sufficient funding, staff, and volunteers; autonomy of ombudsman program in organizational placement within the state; a supportive political or social environment; and strong interorganizational relationships.[17] A study of local ombudsman programs conducted in two states, California and New York, in 2004, found wide variation both across and within each state's program in terms of program location (area agency on aging versus nonprofit organization) and the number of paid staff versus volunteers. Despite reporting that their program budgets were inadequate to support their mandated requirements, program coordinators in both states perceived their programs as effective, more so in the nursing home setting than in board and care facilities. Program coordinators in both states similarly identified staffing, resident care, and residents' rights as the most pressing issues.[18]

Author Contact Information

Kirsten J. Colello
Specialist in Health and Aging Policy
kcolello@crs.loc.gov, 7-7839

[17] C. Estes, et al. *State Long Term Care Ombudsman Programs: Factors Associated with Perceived Effectiveness,* The Gerontologist, vol. 44(1), pp.104-115, 2004.

[18] C. Estes, *Enhancing the Performance of Local Long Term Care Ombudsman in New York Sate and California: Chartbook*, University of California, San Francisco, 2006.