Older Americans Act: Long-Term Care Ombudsman Program

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Summary

Quality of care in long-term care settings has been, and continues to be, a concern for federal policymakers. The Long-Term Care (LTC) Ombudsman Program is a consumer advocacy program that aims to improve the quality of care, as well as the quality of life, for residents in long-term care settings by investigating and resolving complaints made by, or on behalf of, such residents. 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 2010, there were 53 state LTC Ombudsman Programs operating in all 50 states, the District of Columbia, Guam, and Puerto Rico, and 578 local programs. Title VII programs received about $21.8 million in FY2011 and FY2012. Total FY2010 funding for ombudsman activities from all sources combined (federal and non-federal) was $87.7 million, the most recent year for which data on funding from all sources are available. Of that total, 58% ($50.9 million) represented funding from federal sources.

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. In FY2010, ombudsmen reported just over 16,600 nursing facilities and about 52,700 other residential long-term care facilities operating nationwide. This translated to a nationwide ratio of one paid ombudsman for every 59 facilities and one paid ombudsman for every 2,500 resident beds. With respect to staffing, the program receives significant support from volunteers. In FY2010, almost 1,200 paid staff and just over 8,800 certified volunteers investigated about 212,000 resident complaints. Issues regarding residents' care were the chief complaint in nursing homes, followed by residents' rights issues in FY2010. Among residents in other long-term care facilities, the top complaint categories in FY2010 were quality of life and residents' rights.

The OAA Amendments of 2006 (P.L. 109-365) authorized appropriations for the LTC Ombudsman Program through FY2011. Thus, the authorization of appropriations for the LTC Ombudsman program has expired. Congress has continued to appropriate funding for OAA-authorized activities for FY2012. The 112th Congress may choose to reauthorize the Act. In doing so, federal policymakers may consider amending or deleting existing authorities under the Act or establishing new authorities, including those under the LTC Ombudsman Program. In addition, Congress will likely consider annual appropriations for LTC Ombudsman Program activities, as well as appropriations for newly established authorities enacted under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) that support the program.

This report describes the LTC Ombudsman Program, including the program's legislative history, administrative function, and FY2010 funding amounts by source. It also identifies selected issues for federal policymakers, including staffing and resources, in-home care ombudsman, and specialized ombudsman training.

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Background

Quality of care in long-term care settings has been, and continues to be, a concern for federal policymakers. The Long-Term Care (LTC) Ombudsman Program is a consumer advocacy program that aims to improve the quality of care and quality of life for residents in nursing facilities and other residential care settings by responding to the needs of those facing problems in such facilities. Ombudsmen help to resolve resident's complaints about the quality of their care and protect resident rights. Resident-focused ombudsmen services complement those of federal and state staff who enforce facility-focused quality standards that are required under statute or regulation. Among their many functions, ombudsmen provide services to assist residents in protecting their health, safety, welfare, and rights such as representing residents before governmental agencies or recommending changes to current law or regulation. Ombudsmen are available to help all long-term care facility residents, not just those residents in nursing facilities certified by Medicare and Medicaid, including those residing in assisted living facilities, board and care homes, and other similar adult residential care settings.

What Is an Ombudsman?

The Old Norse term ombudsman essentially means "representative." An ombudsman is an individual who investigates and attempts to resolve complaints and problems on behalf of citizens against businesses, institutions, and officials. The modern day use of the term ombudsman began in 19th-century Sweden with the establishment of the Swedish Parliamentary Ombudsman to safeguard citizens' rights by establishing an agency independent of the executive branch.

This report describes the LTC Ombudsman Program authorized under the Older Americans Act (OAA). The OAA Amendments of 2006 (P.L. 109-365) authorized appropriations for OAA-funded activities, including the LTC Ombudsman Program, through FY2011. Thus, the authorization of appropriations for most OAA programs, including the LTC Ombudsman Program, expired at the end of FY2011. However, Congress has continued to appropriate funding for OAA-authorized activities for FY2012. The 112th Congress may choose to reauthorize the Act. In doing so, federal policymakers may consider amending or deleting existing authorities under the Act or establishing new authorities, including those under the LTC Ombudsman Program. In addition, Congress will likely consider annual appropriations for LTC Ombudsman Program activities as well as appropriations for newly established authorities enacted under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) that support the program.

This report briefly describes the program's legislative history, administrative function, and funding. Next, it presents program data for FY2010, the most recent year for which data are available. The report then provides findings from an Institute of Medicine (IOM) evaluation and other studies. Finally, it identifies further issues for Congress to consider.

Legislative History

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 1973. 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 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. Finally, the ACA includes two elder justice-related activities in a new Section 2043 of the Social Security Act that would directly assist state LTC Ombudsman Programs. The first aims to improve the capacity of ombudsman programs, while the second addresses ombudsman training with respect to elder abuse. Both authorize appropriations to fund these initiatives through FY2014.[2] For FY2011 and FY2012, no funding was provided for these newly authorized programs.

Administrative Function

There are 53 state LTC Ombudsman Programs operating in all 50 states, the District of Columbia, Guam, and Puerto Rico, and 578 local programs as of 2010. 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.

The OAA requires State Units on Aging (SUAs) to establish an Office of the State 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 Office. According to AoA, most state ombudsman programs (36 states and Puerto Rico) are located within SUAs. Another five ombudsman programs are located in another government agency, outside the SUA. Nine states, the District of Columbia, and Guam have ombudsman programs that are located outside of state government in other organizations, such as a legal

[1] In 1978 Congress amended the OAA (P.L. 95-478) to include a requirement that each state develop a LTC Ombudsman Program in order to protect the health, safety, welfare, quality of care, and rights of institutionalized residents in nursing facilities, board and care homes, assisted living facilities, and other similar facilities.

[2] Section 6703 of PPACA adds a new subtitle B, Elder Justice, under Title XX of the Social Security Act. For further information on these elder justice provisions, see CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in PPACA: Summary and Timeline*, coordinated by C. Stephen Redhead and Erin D. Williams.

services agency or protection and advocacy agency.[3] 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.

Other Resident Advocacy Activities

In addition to resolving resident complaints in long-term care facilities, ombudsmen provide a variety of other educational and advocacy activities to benefit long-term care residents, including participation in a number of federal initiatives. These activities range from involvement with quality improvement initiatives to informing nursing home residents and family members about various long-term care options, including home and community-based care. For example, the Centers for Medicare and Medicaid Services (CMS) encourages ombudsmen to communicate and work collaboratively with Quality Improvement Organizations (QIOs).[5] Ombudsmen may assist QIOs in identifying and working with facilities on quality assessment and improvement efforts or assist residents and family members with the use of quality measures in nursing home selection.[6]

Ombudsmen may also assist residents transitioning from nursing homes to private homes or other residential care facilities. In doing so, ombudsmen may refer residents and family members to community resources or monitor the discharge planning process. Some ombudsman programs are actively involved in federal nursing home transition initiatives such as the CMS Money Follows the Person Rebalancing Demonstration program. Ombudsman programs may participate in state level coalitions and advisory committees that oversee these initiatives.[7] According to information solicited from state ombudsmen by the National Association of State Units on Aging and

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[3] National Association of State Units on Aging, *Long-Term Care Ombudsman Program: Structure, Responsibilities, Quality and Funding*, September 2003.

[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] Sections 1152-1154 of the Social Security Act require the Secretary of HHS to establish Quality Improvement Organizations (QIOs). According to CMS, QIOs are private, mostly not-for-profit organizations staffed by doctors and other health care professionals who are trained to review medical care, help beneficiaries with complaints about the quality of care, and implement quality improvements. CMS contracts with one organization in each state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands to serve as the QIO contractor. For more information on QIOs see http://www.cms.gov/qualityimprovementorgs/.

[6] Centers for Medicare and Medicaid Services, *Nursing Home Quality Initiative: Relationship of Quality Improvement Organizations and State Offices of the Long-Term Care Ombudsman*, https://www.cms.gov/NursingHomeQualityInits/downloads/NHQIombudqio472a200512.pdf.

[7] For more information on CMS' Money Follows the Person Rebalancing Demonstration see http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html.

Disabilities (NASUAD), the ombudsman's knowledge of community resources is important in assuring that referrals to the appropriate services are made. [8] In some states, ombudsmen have received training about such initiatives in order to better assist residents with transitions.

In addition, ombudsman programs in at least 12 states are authorized or mandated under state law to advocate on behalf of consumers who receive in-home long-term 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.[9] States also reported that in-home care ombudsmen 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 funds.

Authorization and Funding

The OAA Amendments of 2006 (P.L. 109-365) authorized appropriations for the LTC ombudsman program through FY2011. Thus, the authorization of appropriations for the program has expired. However, Congress has continued to appropriate funding for ombudsman program activities for FY2012. Ombudsman activities 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 ombudsman activities.[10] Title VII authorizes grants to states for Chapter 2 (the LTC Ombudsman Program) and Chapter 3 (the Elder Abuse Prevention Program). Under Chapter 3, some states choose to perform elder abuse prevention activities through the LTC Ombudsman Program.

Title VII programs received about $21.8 million in each of FY2011 and FY2012.[11] 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 FY2010, the most recent year for which data on funding from all sources are available. Total FY2010 funding for ombudsman activities from all sources combined (federal and non-federal) was $87.7 million. Of that total, 58.0% represented funding from federal sources, with 30.0% from Title III funds, 21.3% from Title VII funds, and 6.7% from

[8] National Association of State Units on Aging, *Strategy Brief: Ombudsman Program Involvement in Nursing Home Transition Activities*, December 2004.

[9] M. Miller, *Home Care Ombudsman Programs Status Report: 2007, National Association of State Units on Aging*, November 2007. According to the AoA, in FY2010, Delaware initiated development of an in-home care ombudsman program. Georgia also initiated a pilot program for in-home care in 3 of its 12 areas limited to the Money Follows the Person Demonstration program.

[10] For more information on how funding under Title VII is allocated to states, see CRS Report RS22549, *Older Americans Act: Funding Formulas*, by Kirsten J. Colello; State allocation tables are at AOA, Funding Allocations to States and Tribal Organizations, http://www.aoa.gov/AoARoot/AoA_Programs/OAA/Aging_Network/State_Allocations/index.aspx.

[11] HHS, AOA, *Fiscal Year 2013 Justification of Estimates for Appropriations Committees*, p. 22.

other federal funds. In FY2010, nonfederal funding represented 42.0% of total support (34.3% state funding and 7.7% local funding).

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

FY2010

Total FY2010 funds (in millions)			**$87.7**	**100%**
Federal funds	**Total**		**$50.9**	**58.0%**
	Title III, OAA		$26.3	30.0%
	Title VII, OAA	Chapter 2: ombudsman program	$16.4	18.7%
		Chapter 3: elder abuse prevention	$2.3	2.6%
	Other		$5.8	6.7%
State funds			**$30.1**	**34.3%**
Local funds			**$6.7**	**7.7%**

Source: CRS analysis based on AoA, *2010 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 FY2010, the share of federal funding for LTC Ombudsman Program activities overall has remained relatively constant (59.1% vs. 58.0%, respectively), while the proportion of state funding increased from 27.6% to 34.3% and spending at the local level declined from 13.4% to 7.7%. Compared to the previous fiscal year, the share of federal funding decreased from 60.3% to 58.0% from FY2009 to FY2010, with an increase in the proportion of program funding from state governments (32.0% vs. 34.3%, respectively) and the same proportion of funding from local governments (7.7%).

Staffing

In FY2010, there were 1,167 paid staff (full-time equivalents) in state LTC Ombudsman Programs, an increase of 20% since FY2000.[12] 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 FY2010, there were about 11,400 total volunteers, just over 8,800 of which were certified to investigate complaints. While the number of paid ombudsman staff has increased from FY2000, the total number of volunteers decreased almost 17% during this same time period (from just over 13,600 in FY2000). In FY2010, 48 state ombudsman programs reported at least one certified volunteer and one state (MD) reported volunteers, none of which were certified. Four states (IA, NV, SD, WY) reported no volunteer activity during this period.

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.[13] However, the IOM evaluation advised that adequate

[12] For further information, see the AoA's AGing Integrated Database (AGID) which includes data for the National Ombudsman Reporting System (NORS), at http://www.agidnet.org/.

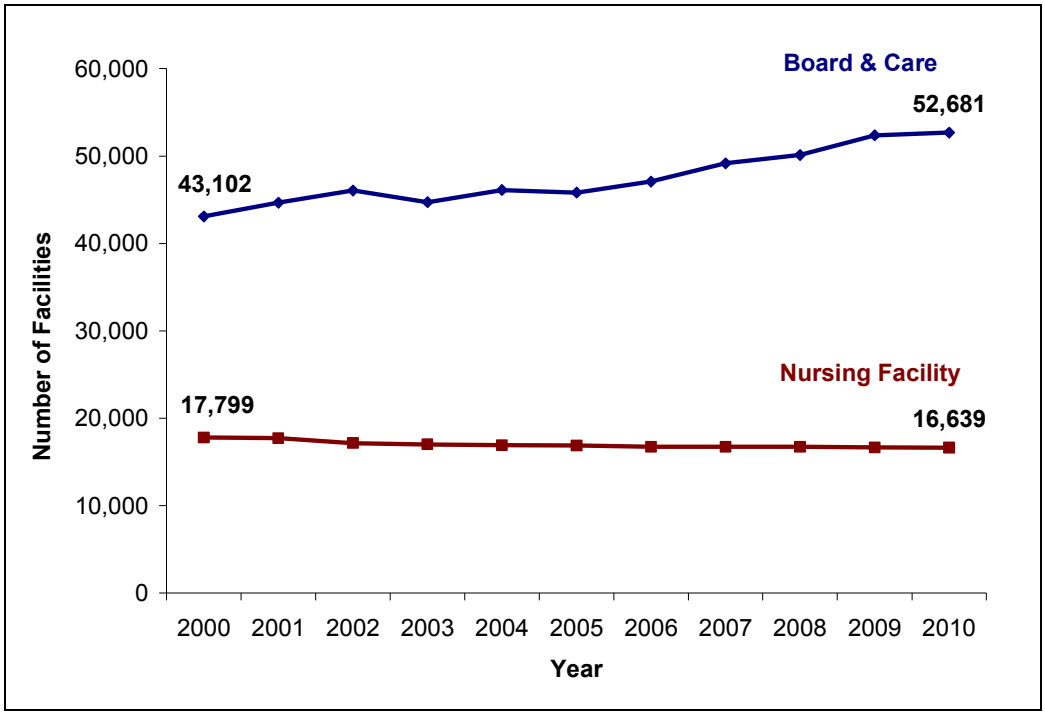
[13] For further information, see Office of Inspector General (OIG) Report OEI-02-90-02120, *Successful Ombudsman* (continued...)

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 about 8 out of 10 volunteers (78%) were trained and certified to investigate complaints in FY2010, representing an increase in the proportion of certified volunteers from 62% in 2000.

In FY2010, ombudsmen reported over 16,600 nursing facilities and almost 52,700 other residential long-term care facilities operating nationwide.[14] Since FY2000 the total number of regulated facilities has increased 14% from 61,000 to more than 69,000 in FY2010 (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 decade.

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

FY2000 to FY2010



Source: CRS analysis based on AoA, *2010 National Ombudsman Reporting System Data Tables*: Table A-6-A Long-Term Care Ombudsman Program Funding.

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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.

[14] 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.

Notes: 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 59 facilities in FY2010, a somewhat smaller ratio than reported in FY2000 (one ombudsman to every 62 facilities). Nationwide, there were a reported 2.95 million facility beds under the program's jurisdiction (almost 1.74 million nursing home beds and just over 1.21 million beds in other long-term care facilities) in FY2010. The nationwide ratio of full-time paid ombudsman to facility beds was about one ombudsman per 2,500 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.[15] 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 74% of nursing homes on a regular basis (defined as at least quarterly) in FY2010. 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 39% in FY2010.

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 LTC 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 Consumer Voice for Quality Long-Term Care.[16]

[15] For further information, see *2010 National Ombudsman Reporting System Data Tables*, at http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/2010/Index.aspx.

[16] The National Consumer Voice for Quality Long-Term Care is formerly known as the National Citizen's Coalition for (continued...)

Program Data and Resident Complaints

As advocates for residents' rights in long-term care facilities, ombudsmen work to resolve resident complaints. In FY2010, AoA data show that ombudsmen opened just over 143,000 new cases of resident complaints and closed over 139,000 cases in all types of facilities.[17] Compared to the previous year, overall the number of complaints decreased by 9%, from 233,000 to just under 212,000. Since 2005, the number of resident complaints has decreased by about one-third (30%), from a high of 307,000 complaints.

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 includes a range of staffing-related issues such as wages and benefits, education, training, experience, and staff turnover.[18]

The top five resident complaint categories in nursing homes for FY2010 were

(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) problems with organization or administration of medications; and

(5) resident conflict, including roommate conflict.

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

Similarly, the top five resident complaint categories in other long-term care facilities for FY2010 have remained the same since FY2000 and were

(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

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

[17] According to the National Ombudsman Reporting System (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, a strategy for resolution, 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.

[18] 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.

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

In FY2010, the top five resident complaints in nursing homes and other long-term care facilities accounted for over 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.[19] 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.[20]

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.[21] 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.[22]

Issues for Congress

As the nation prepares for the growing older population and potential increase in demand for long-term services and supports among the frail elderly, assuring quality of care in long-term care facilities will likely remain a key issue for federal policymakers. In particular, the increasing number of residential care facilities has placed pressure on state LTC Ombudsman Programs to monitor quality of care in these settings. Ombudsmen indicated that regular visitation to these

[19] 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.

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

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

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

facilities was often limited and in some cases nonexistent.[23] Residents in assisted living facilities are often less frail than nursing home residents; however, some receive services paid for by Medicaid home and community-based waivers and must meet state-defined level-of-care criteria for nursing home eligibility. Policymakers may choose to address greater ombudsman program oversight of residential care facilities through additional staffing and resources for ombudsman programs and specialized training regarding the needs of these residents.

The growth in home and community-based services and increase in demand for such services has also drawn attention to potential problems with quality of care in home-based settings. Stakeholders have identified a perceived need for an in-home care ombudsman program to address quality of care issues among these long-term care recipients.[24] Policymakers may choose to consider extending ombudsman activities to older persons receiving long-term care in their own home. These activities are not among those financed by the Older Americans Act. However, without additional staff or resources to expand ombudsman activities to home settings, federal expansion of the program may overwhelm an already strained system. Moreover, the number of additional staff and amount of resources needed to provide adequate ombudsman services to home care recipients is not known.

In addition, state compliance with LTC Ombudsman Program activities has received federal attention. According to the Office of Management and Budget (OMB), AOA intends to promulgate regulations with respect to implementing the LTC Ombudsman Program in 2012.[25] This regulatory action is in response to state inquiries and an AOA compliance review in the state of Florida that, according to AOA, have "highlighted the difficulty of determining state compliance in carrying out the program functions."[26] Since placement of the LTC Ombudsman Program under Title VII of the Act in 1992, no regulations regarding the program's implementation have occurred to date. Some stakeholders have suggested that the absence of regulatory guidance has resulted in significant state variation in program interpretation and implementation.

Lastly, the expanding role of ombudsmen in quality improvement efforts as well as assisting in transitions from nursing homes emphasize the need for a well trained and informed ombudsman staff. However, most ombudsmen are volunteers and ombudsman training procedures and standards vary by state. In order for the LTC Ombudsman Program to serve as a valued resource for outreach and referral to community services, they must be educated and informed about the financing and delivery of long-term care services. Ombudsmen must also have well developed communication and critical thinking skills in order to help resolve resident complaints. Policymakers may consider establishing federal training requirements or providing technical assistance for training, such as national or regional training institutes.

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[23] Carol V. O'Shaughnessy, *The Role of the Ombudsman in Assuring Quality of Residents of Long-Term Care Facilities: Straining to Make Ends Meet,* National Health Policy Forum, Background Paper No. 71, December 2, 2009.

[24] National Association of State Units on Aging, *Charting the Long-Term Care Ombudsman Program's Role in a Modernized Long-Term Care System,* January, 2008.

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