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## A History of the Long-Term Care Ombudsman Program in America: A Changing Aging Population

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Notes:

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Caitlin Dorris

A History of the Long-Term Care Ombudsman Program in America

A Changing Aging Population

University of Kentucky

## **Introduction**

One of the most beneficial resources in modern elder care facilities is the Long-Term Care Ombudsman. Not only do they provide a voice and advocate for the residents of care homes, but act as a confidant, or third-party supporter, to the dependent adults they work with. As the population of older adults increases and the senior care industry works tirelessly to keep up with a growing and changing population, the Long-Term Care Ombudsman continues to create balance in the quality of life for care facility residents nation-wide. As the program and position of Long-Term Care Ombudsman rapidly changes and evolves with today's society, it is critical to understand the program's history and establishment to be aware of its true purpose and impact.

## **A Change in Population**

Documented history traces the pioneering of almshouse utilization to the 10<sup>th</sup> century in England, where the first almshouse was established in city of York (The Almshouse Association, 2017). The concepts of housing the poor and contemptible members of society into a segregated habitation spread internationally, and the idea of adopting almshouses was brought to America (Wagner, 2005). In the 1620s, English settlers introduced Poor Laws to the those dwelling on the new American land. These laws consisted of a set of requirements that local authorities would use to determine whether an individual was worthy of redeeming minimal aid or residing within an almshouse, (Wagner, 2005). The concept of saving government aid funding by isolating a percentage of the poor and unable caught interest, and throughout the next 200 years, almshouses became more popular across America (Wagner, 2005).

City officials, known as Overseers of the Poor, would determine an individual's eligibility to receive government aid, and those awarded earned a place in an almshouse. Unfortunately, it was common that the Overseers were not properly educated on poverty, mental illness or aging needs, therefore appropriate provisions were not set in place (Wagner, 2005). At the time, almshouses were operated by families selected by the Overseers of the Poor (Rothman, 1971). A married male would be chosen from a pool of applicants, and he and his family would manage the almshouse as they would their own home, meaning they would reside in the facility and assign tasks and chores to those living there in order to keep the almshouse functional. (Rothman, 1971). Outside of the designated almshouse caretaker, very few staff were implemented into these poorhouses. Most of the work done, including janitorial duties, nursing care, gardening, cooking and sewing, were all completed by residents of the almshouse, as work was mandatory for all in order to earn compensation for their stay (Katz, 1986).

Despite all efforts, almshouse conditions were often ruinous due to overcrowding, which lead to issues such as insufficient amounts of food, as well as poor construction efforts as a result of developing cheap structures which caused contagious diseases to quickly spread in close quarters due to lack of space and poor ventilation (Steckel, 2002). In 1857, the almshouse Overseers of Charleston, South Carolina were shocked by the poor conditions they reviewed when writing a report on the state of the area's almshouses. They described filthy conditions of drains clogged with "offensive matter," toilets in unusable states, unclean floors, dirty bedding and, in some cases, invasions of pests and insects (Bellows, 1984). It was clear that the current methods of housing the poor, sick and elderly were not sustainable.

By the turn of the 20<sup>th</sup> century, a reform was being led to make a separation for those who were poor by misfortune and those who were poor due to mental illness or age discrepancies.

(Wagner, 2005) In 1906, The Department of Commerce and Labor and the Bureau of the Census issued and published a Special Report that assigned each state in the U.S. a set of specific instructions on the implementation of almshouses, management of those houses and regulations that would govern their daily functions (Department of Commerce and Labor, 1906). For example, the state of Kentucky was given orders to construct a poorhouse in each county and to appoint a commissioner to each that would have authority to maintain and control the establishment, provide refuge for paupers throughout the state and to direct any able-bodied resident to labor for the benefit of the house and to care for any other person kept there (Department of Commerce and Labor, 1906). This type of regulation and policy theory is what lead a proper and legitimate reform that made unprecedented changes for poorhouse residents. As a focus shifted toward separating poor house residents into appropriate facilities designated to suitable ministrations, such as accepting children into orphanages and admitting the ill into hospitals with medical care, the elderly unintentionally became the dominant population of the remaining almshouses (Binstock, 1996). However, while initiative for proper, quality care was a priority for reformers, a decrease in funding and support from municipality put a halt in progress towards appropriate care for older and/or disabled adults (Binstock, 1996).

### **Legislative Intervention**

It is believed that the system of nursing care implemented in America today began as early as 1871 at the first hospital in the U.S. to house and employ the poor, support orphans and provide for the insane and the sick (Nutting, 1907). However, it was not until the 1930s at the National Conference on Economic Security that the government acknowledged the inadequate boarding of an abundant population of older adults in almshouses, and determined that a new structure for housing, care and financial planning for the elderly needed to be executed

(Committee on Economic Security, 1934). Then, in 1935, the passing of the Social Security Act initiated government intervention and the nation made great strides in reform for elder care and facility standards. The law not only provided a source of income and assistance for the elderly, but created a system that would administer direct payment to facilities designated and specialized for older adult care (Social Security Administration, 1935). The laws stemmed from a post-Great Depression era of relief and recovery, pioneered by President Roosevelt's *New Deal* (Dewitt, 2010). Since the passing of the Social Security Act, professionalism, standards of care and environment, as well as patient and resident advocacy, have been on the rise in the elder care industry. In 1965, the act was amended to establish Medicare and Medicaid services which offered access to healthcare insurance to the poor and to adults over the age of 65 (Centers for Medicare and Medicaid Services, 2017).

Later that year, legislation passed The Older Americans Act (OAA) of 1965 (National Committee to Preserve Social Security and Medicare, 2016). One of Congress' focal efforts of this law was the establishment of the Administration on Aging (AOA) which would ultimately serve as a centerfold for all funding of grant programs and all other federal concerns of elderly Americans (Colello, 2016). The OAA, being one of the most monumental laws passed with concern for residential quality of life, was authorized to provide support to several programs including nutrition services, caregiver support and the Nursing Home Ombudsman Program through the Administration on Aging (Colello, 2016). This initiative toward quality and comforting care for nursing home residents triggered a spark for the Nursing Home Ombudsman Program, which has taken a lead in resident advocacy and resolution (The National Long-Term Care Ombudsman Resource Center, 2016).

### **About Long-Term Care Ombudsmen**

The term Ombudsman was originally coined by members of the Swedish government assembly, dating back to 1809, to describe an official of high esteem that would intercede as a highly-regarded voice for citizens with negotiable complaints and find ways to resolve issues and concerns of those citizens (Howard, 2010). Ombudsman positions have been adopted across America in public service fields for decades, but the 1971 proposal of a Nursing Home Ombudsman meant redefining the role and creating parameters that appropriately and effectively benefitted the residents in terms of representation and advocacy (Institute of Medicine, 1995).

The idea was proposed by Dr. Arthur S. Flemming, who served as the Commissioner on Aging to the office of President Richard Nixon (Hunt, 2008). The theory for implementation of this concept was initiated by President Nixon, who prompted a movement for nursing home care reform. His movement consisted of eight radical changes to be integrated into the long-term care discipline (Hunt, 2008). Nixon's proposal had a goal creating a quality and comfortable life to all nursing home residents (Nixon, 1971). In his speech to Congress, Nixon anticipated the training of 2,000 nursing home inspectors to enforce acceptable care and to ensure that no substandard care facilities were receiving government support and funding, and requested that the inspection program be fully funded by the federal government as well (Nixon, 1971). He also suggested a consolidation of all government entities that relate to standard enforcement and regulation, which soon took place under the Department of Health, Education and Welfare (now the Department of Health and Human Services) and was labeled the Office of Nursing Home Affairs (Hunt, 2008). However, for the purpose of this paper, a focus will rely on only one of the eight directives proposed by President Nixon - the one that established the Nursing Home Ombudsman Program.

### **The Beginning of the Long-Term Care Ombudsman Program**

The investigative force established by President Nixon was directed to advocate on behalf of nursing home residents in order to resolve any conflicts that may arise, stating that the individuals in this new position would act as a liaison for residents within the care facility considering that “the individual who is confined to an institution and depend upon it is often powerless to make his voice heard” (Nixon, 1971). The training of the first cohort of investigators triggered the start for the demonstration project of the Nursing Home Ombudsman Service (Health Service Reports, 1974). In June of 1972, Idaho, Pennsylvania, South Carolina and Wisconsin were contracted to establish trial projects, with the requirement that it be held within any agency that did not regulate nursing home services for the sake of independence and lack of bias (Health Service Reports, 1974). The projects took off with goals of recruiting and training the first ombudsmen, developing a set of policies and procedures for the program, connecting and building functional relations with outside federal and regulatory agencies, as well as community outreach groups, advertising the available services that the new program will offer, and ultimately beginning the work of complaint inquiry and resolution (Health Service Reports, 1974). When found to be successful the following year, the Department of Health, Education and Welfare underwent a restructuring that placed the demonstration projects under the authority of the Administration on Aging (AoA), which was officially amended to Title VII of the Older Americans Act in 1978 (H.R., 1978).

President Nixon's Commissioner on Aging, Arthur Flemming had a tenacious perspective on the improvements that would be required for nursing homes and long-term care to make advancements that benefit the consumer. In May of 1975, Flemming offered a proposal to all U.S. states to submit a grant request for the establishment Area Agencies on Aging that would house services such as the nursing home ombudsman (Harris-Wehling, 1995). All states except

for Nebraska and Oklahoma applied for the grant and within the first year all states had received funding and began the hiring process for the first office ombudsman specialists (Harris-Wehling, 1995). The original demonstration projects determined that a local administration was more effective in managing a high volume of complaints rather than one overseeing authority, therefore the original ombudsman specialists were tasked with developing local entities that would branch out to handle resident complaints (Harris-Wehling, 1995).

### **Outside Forces Unite for Advocacy**

During this time of renovation for long-term nursing home care by the U.S. government, other individuals and organizations were acting to make improvements as well. Elma Holder, an advocate and lobbyist for the support of nursing home reform, was working with groups such as Ralph Nader's Retired Professional Action Group and The National Gray Panthers to organize the first resident satisfaction survey as well as help change care standards such as the use of restraints on the mentally ill (The National Consumer Voice for Quality Long-Term Care, 2015).

In 1975, using the knowledge she had gained through her previous projects, Holder founded the National Citizens' Coalition for Nursing Home Reform (NCCNHR), known today as the National Consumer Voice. The NCCNHR was designed to advocate for nursing home residents and publicize the need for better care and representation of the target population, as well as operate the National Long-Term Care Ombudsman Resource Center that provides training and support services for ombudsmen (The National Consumer Voice for Quality Long-Term Care, 2017). After evaluation of the initial Nursing Home Ombudsman demonstration projects and adjusting the previously mentioned outreach approaches, the AoA subsidized the National Paralegal Institute in 1977 to develop and administer the first training program for state

ombudsmen, in conjunction with Holder, who was hired to supervise the training sessions (The National Long-Term Care Ombudsman Resource Center).

### **The Growth of the Program**

With continuing success of the ombudsman program, a focus shifted from establishment to expansion and development. An amendment was added to the OAA in 1978, mandating that every state provide nursing home ombudsman services within every nursing care establishment. The amendment provides a thorough description of the ombudsman's responsibilities and role in the nursing home community (S. 2969, 1978). To aid in the implementation of the extension of ombudsman services, the AoA presented additional grants to each State Ombudsman Agency. The amounts varied in amount, from \$50,000 to \$135,000, depending on each state's population density of institutionalized senior citizens. The AoA awarded another grant the following year to the NCCNHR with a goal of increasing citizen involvement within long-term care communities. This grant would allow for training projects and opportunities to promote participation (National Consumer Voice, 2016).

The expansion continued when an OAA amendment in 1981 redefined the classification of long-term care facility to include board homes and group care accommodations, requiring that ombudsman services be offered in these facilities (S.1086, 1981). Consequently, the title of Nursing Home Ombudsman was changed to Long-Term Care Ombudsman to reflect these changes (The National Long-Term Care Ombudsman Resource Center, 2016). Throughout the following years, the AoA published several papers on the policies and role of the Long-Term Care Ombudsman Program and compiled them to create the first Ombudsman Technical Assistance Manual in 1984. This manual would serve as training materials for ombudsmen, with

each state customizing the text to include their own regulations and methods (Hearing before the Subcommittee on Human Services of the Select Committee on Aging, 1985).

The year of 1987 was a monumental time for reform in the care of older Americans and the Long-Term Care Ombudsman Program. The Older Americans Act was amended again with some of the most significant advances in providing information for ombudsman to work with for complaint resolution. Firstly, the amendment required each state to establish an Office of State Long-Term Care Ombudsmen, through which all subcategories of district and local ombudsmen would operate through. This helped contribute to the more efficient organization of the program that is still used today. Secondly, the amendment provided ombudsman with the right to have access to all resident records including all medical and social records upon permission given by the resident. This allowed the ombudsman to have a better understanding of resident situations and purpose for care methods when dealing with a complaint. Lastly, one of the major components of the 1987 amendment was the prohibition of any interference with the work of a Long-Term Care Ombudsman in any long-term care facility (H.R. 1451, 1987).

In addition to the OAA amendment that contributed to the success of the agency, the Omnibus Budget Reconciliation Act of 1987, commonly known as OBRA, was one of the most significant laws influencing the reorganization of long-term care. Being the first major revision of federal standards since President Nixon and Congress passed the OAA law in 1965, OBRA had a major impact on the quality of care and the environment of long-term care facilities entirely. The bill for this law was prompted by a report in 1986 from the Institute of Medicine, who was requested by Congress to form a committee that would study the outcomes of government regulation in nursing homes and compile a list of suggested improvements and changes (Committee on Nursing Home Regulation, 1986). Congress had an increasing interest in

the quality of care provided in government funded facilities, as there was a common unanimity from the public and advocacy agencies, such as the ombudsman agency, that conditions of the majority of accommodations were still substandard (Committee on Nursing Home Regulation, 1986).

After publication and submission to Congress, the suggestions from the Committee were considered to develop a new law that would require all long-term care facilities to be improved by establishing new standards for Medicare funded facilities (H.R. 3545, 1097). These new standards established by OBRA included several resident rights, such as the right to organize a resident or family council, the right to bank personal funds with the facility, the right to return to the facility after any overnight stay outside of the home (including hospitalization) and the right to be free from all restraints (physical and chemical) (H.R. 3545, 1987). Along with these resident rights is a mandatory emphasis on quality of life as well as quality of care for the residents, and the statement that activities of daily living should remain constant for a resident and should only decrease with natural diminishing health (H.R. 3545, 1987).

### **Technical Support**

With the increasing population of elderly citizens and need for ombudsmen in long-term care facilities, the AoA developed and funded a program that would act as a technical assistance and training resource for ombudsmen (AoA, 2009). The new National Long-Term Care Ombudsman Resource Center would be operated by the National Consumer Voice within the National Association of State Units on Aging so that specific state methods and information were easily accessible within the department (AoA, 2009). This organization would offer ombudsman an array of services such as publicizing the work of the ombudsmen, developing trainings and finding helpful information for ombudsmen as well as facilitating communication between the

ombudsman program and other agencies (National Consumer Voice, 2016). Today, the Resource Center has advanced to more intensive research in aiding ombudsmen by sending out annual surveys to draw information directly from the ombudsmen about their concerns and questions that the Resource Center can potentially resolve (National Consumer Voice, 2016)

### **Revising the Establishment**

As with any new program, the Long-Term Care Ombudsman Program had missing pieces in procedure and protocol that took time to discover. In 1992, amendments to the Older Americans Act created solutions to these issues that had been encountered over the years. These modifications, listed in the House of Representatives bill 2780, included the establishment of a National Office on Long-Term Care Ombudsman Programs by the AoA that would be headed by a new position of Associate Commissioner on Aging. This individual would serve as a direct advocate for ombudsman clients nationally and would use resident feedback to better the program (H.R., 1992). Along with this bill was listed requirements for a study on the overall impact of having a State Long-Term Care Ombudsman Program, offering immediate access to resident records for ombudsmen, extending ombudsmen authority to representing residents in legal matters that deal with their rights, and requiring that ombudsmen make their services known and available to all residents at their designated facilities, including rehabilitation and respite care residents (H.R., 1992).

Congress also passed bill 2967 the same year (H.R. 2967,1992). This amendment provided an outline for funding requirements for the new National Long-Term Care Ombudsman Resource Center, and adds the new Title VII: Vulnerable Elder Right Protection Activities that allows for appropriate designation of entities within advocacy agencies, such as the ombudsman program, as well as grant funding (H.R. 2968, 1992). Following the efforts of improving the

allocations of program services, the AoA funded a three-year grant to the National Association of State Units on Aging through the NCCNHR to operate all State Long-Term Care Ombudsman Programs. Today, the organizations work through the National Long-Term Care Ombudsman Resource Center to provide support and training services to ombudsmen nationwide (Estes, 2001).

In 1995, following a study conducted by the AoA, an assessment of the State Ombudsman Programs was published due to a push from local ombudsmen for policymakers to reevaluate of the program after the implementation of several new policies. The AoA recruited the Institute of Medicine to study the effectiveness of the services offered by the ombudsman program, as had been done in previously in 1986 to observe immediate improvements needed in nursing care facilities. The committee to perform the study was composed of professionals from various fields - from elder care advocates, to hospital directors, to experts in funding analysis and institution advancement. The committee's goal was to observe the inner workings of the Long-Term Care Ombudsman Program, as well as its complaint resolution outcomes and client satisfaction, in order to develop a list of recommendations for improvement. The study was performed by methods of physical site visits for discussion with state and local ombudsmen, contacting directors of State Units on Aging, public hearings, meetings with long-term care physicians and two "open-mic" opportunities at national professional conferences that allowed committee members to gather information from direct contacts of ombudsman services on the efficiency of the program.

Ultimately, the committee concluded that the Long-Term Care Ombudsman has a vital role in the care of older adults, but despite previous efforts, the program still had much to improve. Some recommendations made in the final report from the committee included

extending ombudsman services to younger individuals in long-term care, such as the mentally and/or physically debilitated residents, as well as including those admitted to facilities for respite care, and developing and implementing the use of a data system that would uniformly collect information and updates on resident cases. One of the main discussion points for the committee was the expansion of the program outside of strictly skilled nursing care homes, as there were many pros and cons on the topic.

Those in favor of expanding the program to populations outside of skilled nursing facilities into other adult care homes and the community reiterated the statement that the fundamental principle of the Long-Term Care Ombudsman Program is to advocate for and enforce the rights of older adults who require the help of the long-term care industry. Because of this, supporters of expansion defended their argument with claims that some older adults desire to remain at home for as long as possible and the complexity and confusion that comes with consuming in an evolving industry make this difficult. A lay out for a different model of operation was proposed that focused on the same concept with individual casework and a central advocacy and educational theme, but introduced new subsectors for advocacy with home and community based clients. This model promoted would prompt ombudsmen to promote and support consumer rights on information, participation and control in care decisions, general civil and protection rights in home based care, remedial rights of protection when filing complains, as well as the right to quality comparable to in-facility care. The committee also claimed the defense that a growing older population pressures the industry and its leaders to make progress and create a more function system. On the other hand, committee members who were against expansion of the program were concerned with the digression of focus on care for skilled nursing facility residents, and clearly stated that the expansion should not take place at the expense of

those currently being served. They also had apprehension that offering services to new populations may interfere with the work of other organizations and may introduce conflicts that would not be worth the efforts (Harris-Wehling, 1995).

Once the Institute of Medicine published the conclusions and suggestions made by the committee, the agency began implementing some of the institute's recommendations. Early in 1995, the OAA was amended to require each state to establish a form of state-wide reporting system to document and account for each resident as well as their complaint cases (H.R. 2560, 1996). Within the year, the AoA and the National Association for State Long-Term Care Ombudsman worked in conjunction to develop and introduced the National Ombudsman Reporting System, known as NORS. The software program would systematically file data collected on all residents and complaints, which were all categorized by code for further analysis when compiled. This information was used to help improve quality assurance within the ombudsman program on topics such as resource allocation, training purposes, and state-to-state complaint comparisons. (Hunt, 2005). In the first year after NORS launched, 25 states were reporting through the system and by 1996, all states were utilizing the software (Office of Inspector General, 1999). Today, there is still a uniformity in the use of NORS across the nation with even more data being collected.

### **There is Always Room for Improvement**

Over the course of the next 10 years, the elder care industry stabilized with the efforts that had been made in improving care in skilled nursing facilities. However, in 2006, a new idea was introduced with the movement for "aging in place". The reauthorization of the OAA in 2006 made advancements in the role of the AoA by placing the responsibility of providing long-term services and support to seniors in home and community based care programs and required the

AoA to develop new demonstration projects that would assist with aging in place, including programs and organizations naturally occurring retirement communities. Programs such as mental health screenings and the provision of treatment services were encouraged (National Health Policy Forum, 2012).

While the plan for aging in place has been proposed, as of 2013, Congress had still not made a motion toward granting federally funded ombudsman services to private homes (Kurtz, 2013). However, twelve states across the nation managed to fund in-home long-term care ombudsman services through state or other funding. Five of the states allow, but do not require, ombudsmen to provided services in private homes, and their participation with in-home services is determined by priority to skilled nursing facility residents. Funding for the programs is provided by waivers, state designated funds, home health agencies and private pay. (National Association of State Units on Aging, 2007). The idea of aging in place and in-home ombudsman services is still a relatively new concept and will take legislative and funding adjustments before full adoption can take place. However, Congress' lack of momentum with granting federal funds for the project puts a halt on all progress.

### **Progressive Changes**

Under President Obama's administration in May of 2010, the Affordable Care Act was passed – a law that would drastically alter access to health insurance, decrease the cost of prescription drugs and insurance premiums, reduce Medicare spending, and increase available preventative care for seniors (National Committee to Preserve Social Security and Medicare). One of the more audacious components of this law affecting senior care and the ombudsman agency was the establishment of programs to test new ways of care delivery for maximum efficiency. Section 3026 of the Affordable Care Act outlines a Community-Based Care

Transitions Program (CCTP) that provides care continuum and transitional services to high-risk Medicare beneficiaries to improve the quality of care when moving into or returning to a community based care facility after hospitalization to prevent readmission, saving the individual from financial, mental and physical stress as well as reducing Medicare costs. According to the Centers for Medicare and Medicaid Services, nearly 2.6 million senior citizens are readmitted to the hospital within 30-days of discharge, annually – costing Medicare over \$26 billion every year (2016). The program demonstration was launched in 2012 and was set to continue for 5 years, with 2-year contracts that were available for annual renewal (Office of the Legislative Counsel, 2010). The first annual evaluation report was submitted to the Centers for Medicare and Medicaid Services by Econometrica, an international organization that specializes in the analysis of economics, statistics and mathematics. According to the first evaluation report, by June of 2013, 101 community-based organizations had submitted agreement contracts to initiate CCTPs. However, around 25% of the organizations ended their agreement after the first 2-year contract was complete. After year one, information was collected from 48 of the remaining 72 sites on 30-day readmissions to hospitals, emergency departments, as well as hospital visits by the qualifying residents, and the analysis showed that the CCTP program had only influenced reduction in the rates of hospital readmissions for high-risk Medicare beneficiaries in about 8% of the organizations surveyed (Econometrica, 2014).

Having this program in place meant that Long-Term Care Ombudsmen had to coordinate with authorities from other home and community-based services, state and local Transition Coordinators, Transition Councils and Money Follows the Person Program Directors. Ultimately, this resulted in surplus expenditures of ombudsmen services as well as additional duties to the job. In a survey of 54 Local Long-Term Care Ombudsmen from 16 different states,

conducted by The National Consumer Voice for Quality Long-Term Care, 12% reported a lack of communication between the agencies coordinating the transition and the staff at the receiving nursing facility; 33% claimed that the residents were not involved enough in the planning process and it ultimately created stress, fear and anxiety for the resident, which often was an issue needing resolved by an ombudsman; and 55% reported that proper and appropriate services, supplies and support were not always available to consumers, making the program void in these circumstances (The National Consumer Voice for Quality Long-Term Care, 2015).

Overall, the program put a strain on Local Long-Term Care Ombudsmen and diverted attention, time and resources away from the primary population of nursing home and long-term care facility residents. Funding for the Community-based Care Transitions Program will end this year (2017) and the program will cease. However, new organizations such as Partnership for Patients and Hospital Improvement Innovation Networks are seeking measures for the same improvement in rate of readmission and ease of transition for seniors after hospitalization and visits, but with more coordination and better planning (Centers for Medicare and Medicaid Services).

Another initiative executed by the Affordable Care Act was the Community Living Assistance Services and Support (CLASS) Act. The goal of this act was to provide financial security for individuals requiring long-term care services and support, as well as those who require care but wish to remain in home or community based settings (Colello, 2013). However, the program was deemed unemployable due to a lack of funding and unreliable organization, and was repealed when President Obama signed legislation for the American Taxpayer Relief Act. The CLASS act was then replaced with the Commission on Long-Term Care, a 15-member committee instructed to develop the most efficient system possible for providing long-term care

and subsequent financing to elderly, cognitively impaired and disabled individuals in need of services and support (H.R. 8, 2012). The commission spent nearly 100 days performing public hearings, meeting with executive officials in long-term care, surveying the general public and discussing amongst committee members about the assigned issue. After 3 months, the Commission published a final report containing recommendations and ideas on how to provide substantial benefits and support in the long-term care and submitted it to Congress (Commission on Long-Term Care, 2013).

### **Past Due Reauthorization**

The most recent, major piece of legislation affecting the Long-Term Care Ombudsman Program was the reauthorization and amending of the OAA in 2015. The law was due for reauthorization in 2011, but was unprioritized by Congress (U.S. Senate Committee on Health, Education, Labor and Pensions, 2015). However, when the act passed through the House of Representatives and the Senate in 2015, reauthorization cleared with a unanimous vote, and continued on to be signed by the President, and was republished as public law in April of 2016 (S. 192, 2016). This motion reinsured the funding and procedures of nearly all support services available for older adults in America. The amendments made to the law alongside the reauthorization impacted the Long-Term Care Ombudsman Program as well. One of the changes included a new responsibility of State Long-Term Care Ombudsman Offices to compose a report on the best and most efficient methods used by ombudsmen to approach cases of elder abuse and neglect in care facilities. The goal was to create a consisted tactic to be used nationally for ombudsman convince and program efficacy. Another amendment to the law also states that ombudsmen and office representatives will now be labelled as a “health oversight agency” and will be held accountable by the Health Insurance Portability and Accountability act of 1996

(HIPPA), in order to protect the privacy and information of nursing care facility residents (S.192, 2016).

### **The Long-Term Care Ombudsman Program Today**

All the senior advocacy and care laws created in America from the early 20<sup>th</sup> century until now have all played a delicate role in the development, implementation, protection and progression of the Long-Term Care Ombudsman Program. An upstanding voice for a growing and vulnerable population is vital to a properly functioning society. Today, the Long-Term Care Ombudsman Program has advanced from being non-existent in any facility, to handling complaints within skilled nursing facilities from older adults, to now serving the public with a network of protection agencies and ensuring the highest quality of life to any individual residing in a long-term care setting (Hunt, 2008). An example of the impact provided by the program is recorded by the 2016 Annual Report from the Kentucky Elder Abuse Council, Long-Term Care Ombudsmen, stating that in the state of Kentucky, ombudsmen made 13,505 site visits to skilled nursing facilities for care monitoring and promoting awareness of the organization, participated in 1,045 family and resident councils, was a source of information on nursing care planning and resident rights 10,726 times, provided 181 training sessions to ombudsman and staff, and intervened to resolve 7,424 complaints in the course of the past year (Kentucky Elder Abuse Committee, 2016). However, only 72% of residents surveyed claimed that their complaints were resolved to satisfaction, a statistic that could be drastically improved with enhanced communication and cooperation between ombudsmen and other agencies and care facilities, higher quality training for ombudsmen and a more focused method of complaint resolution (Kentucky Elder Abuse Committee, 2016). The Long-Term Care Ombudsman Program has

come a long way over the past century, but it still has plenty of improving left to do for an ever-changing, ever-growing population of older adults in America.

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