Subcommittee Testimony to the Senate on Aging and Long Term Care
***CA Elder Abuse Investigators: Ombudsman Shackled By Conflicting Laws and Duties***
**California Elder Justice Work Group (CEJW)**

The California Elder Justice Work Group (CEJW) is grateful to Senator Alquist for requesting this study and congratulates the Senate Office of Oversight and Outcomes for its incisive report. We appreciate this opportunity to comment.

CEJW was launched in October 2009 to protect the rights, independence, security, and well being of vulnerable elders in California by improving the response of the legal, long-term care, and protective service systems. It is administered by the Center of Excellence in Elder Abuse and Neglect at the University of California, Irvine, and supported by a grant from the Archstone Foundation. CEJW got started in 2008 when a small group of service providers participating in the Archstone Foundation's Elder Abuse and Neglect Initiative began meeting to explore how common challenges and needs could be addressed through information sharing, problem solving, and collective advocacy. A description of CEJW is attached.

Ensuring the safety, security, and rights of elderly Californians who live in long term care facilities poses formidable challenges. Long Term Care Ombudsmen play a pivotal role in meeting those challenges and we're here today to support our Ombudsmen colleagues and to offer recommendations for strengthening the state's response.

The Senate Office of Oversight and Outcome's report raises troubling questions about California's response to allegations of abuse in facilities. Although some of these concerns have been recognized for many years, the recent devastating cuts to the Ombudsman program have clearly exacerbated the situation. Members of the CEJW recognize that some of the issues raised by the report, including the question of what agency or entity should have responsibility for investigating abuse in facilities are highly controversial. Rather than offering specific recommendations, we would like to recommend some basic principles that we hope will serve as a template for evaluating the various proposals that are put forth. In addition, we would like to point out some additional concerns that were not raised in the report that we believe warrant consideration. And finally, we would like to offer our assistance in exploring and implementing strategies for strengthening California's response both within and outside of long-term care (LTC) facilities.

Guiding Principles

1. **The Long Term Care Ombudsman Program plays a critical role in advocating on behalf of long-term care facility residents. This advocacy role must be preserved and strengthened.**
   Under their federal mandate, Long Term Care Ombudsmen maintain a visible presence in facilities, make unannounced visits, provide confidential counsel, mediate disputes, witness the signing of advance directives for health care, help relocate victims when facilities are forced to close, and perform many other critical roles. Further, their familiarity with facilities' day-to-day operations, acceptable standards

of practice, regulatory schema, gives them unparalleled insights and expertise in identifying abuse and neglect. These important duties should not be compromised by competing demands or conflicting goals.

2. **Criminal conduct in long-term care facilities must not be tolerated**.
Failure to aggressively respond to criminal or other unlawful conduct in facilities interferes with society's responsibility to hold perpetrators accountable and jeopardizes the safety of all residents. Barriers to investigation must therefore be removed. Alleged perpetrators should not have a voice in determining whether investigations proceed. Further, the responsibility for deciding whether to pursue criminal action against offenders should not rest with victims. Doing so undermines basic precepts of our justice system and further creates incentives for criminals to manipulate, threaten, retaliate against, or silence victims.

   We are fortunate that the California Attorney General's Office of MediCal Fraud and Abuse has done groundbreaking work in investigating and prosecuting abuse and neglect in long-term care facilities. However the unit lacks the resources needed to meet the demand and respond to complaints at the local level. The capacity to respond to crimes and other unlawful activities at the local levels needs to be expanded.

3. **Role conflicts must be addressed.**
As the Office of Oversight and Outcomes report suggests, Ombudsmen's role as advocates may be in conflict with their state mandated duties to serve as objective finders of fact under the state's mandatory reporting laws in some situations (e.g. when residents are not willing to report crimes committed against them). These conflicts must be resolved. If that cannot be accomplished by clarifying Ombudsmen's duties under state and federal mandates (see #4), these mandates need to be revisited. A successful resolution must provide for both: bringing offenders to justice and advocating for patients' rights and safety.

4. **The Ombudsman federal mandate needs to be reviewed.**
Although Ombudsmen in California face special challenges pursuant to their dual mandates, we believe that federal policy with respect to Ombudsmen may also warrant consideration in light of current trends and developments, which include:
   - Increased numbers of "unbefriended" or "unrepresented" elders in long-term care facilities (residents who lack decision-making capacity and surrogates). Specificially, federal lawmakers need to provide clearer guidance to Ombudsmen in how advocacy for these individuals will be carried out. Among the issues that need to be addressed or reassessed are prohibitions against serving as surrogates in critical situations and how to evaluate decision making capacity and consent with respect to the specific circumstances Ombudsmen are likely to encounter.
   - As more cases of abuse in long-term care facilities come to the attention of the civil and criminal justice officials, the role of Ombudsmen in relation to local, state, and federal law enforcement entities needs to be reconsidered to ensure

that the Ombudsmen role as advocates complement, rather that interfere with, law enforcement.

In recent months, the federal Administration on Aging has been conducting hearings to accept testimony on the reauthorization of the Older American's Act, the act that defines LTC federal mandate. It is our understanding that ombudsman programs around the country will use this opportunity to alert the Administration on Aging of the challenges that state and local ombudsman programs face.

5. **Agencies/entities designated to report need adequate resources and training. Inadequate or incomplete investigations, or investigations by entities that are not properly trained may further endanger residents.**
Abuse investigations in long-term care facilities pose unique challenges. They may require such highly specialized skills and expertise as evaluating the testimony of residents or witnesses with diminished capacity, evaluating individual patients' medical status and records, collecting and evaluating aggregate data on facilities' performance and rates of accidents, injuries, deaths, and pressure ulcers; to auditing financial records to establish patterns of fraud.

We would like to point out some resources that members of our network, including Archstone Foundation supported projects, can offer for the committee's review. These resources can contribute to understanding of abuse in long-term care facilities, facilitate investigations, and provide guidance in training frontline responders.

- Solano County's Financial Abuse Specialist Team, which is operated through the Area Agency on Aging Serving Napa and Solano Counties has explored obstacles and challenges that law enforcement officers face in investigating crimes against older adults.
- Forensic Centers in Orange County, Los Angeles, San Diego, and San Francisco have developed expertise in working with justice system professionals to build criminal and civil cases.
- The Center of Excellence at the University of California, Irvine recently completed a study of the rates of pressure ulcers in long-term care facilities that can potentially be used in evaluating reports. They further conducted a study aimed at establishing the emotional memory of persons with memory deficits, which suggests how courts can evaluate testimony.
- Death review teams, which monitor deaths in long-term care facilities and the community, have suggested promising practices and recommendations for improving care in facilities and developed expertise in substantiating abuse.
- Educational institutions, including state universities and community colleges have developed state of the art professional education programs for Adult Protective Services (APS) and other frontline professionals. These institutions have done pioneering work customizing training for specific groups of mandated abuse reporters, developed dynamic partnerships with professional association, and pioneered the use of adult education and online technology.

6. **All stakeholders' voices must be heard.**
   Multiple agencies have a role to play in the reporting process. Discussion about changes in the reporting system requires input from a wide group of stakeholders including the law enforcement community, Adult Protective Services, and others.

7. **All agencies/entities in the abuse reporting and investigation process need clear policy and guidance to carry out mandates.**
   Ombudsmen, APS, and others charged with investigating and responding to elder abuse reports must have clear and consistent policies and procedures and guidance to help them interpret and carry out their mandates. They must further have prompt access to legal experts to clarify and interpret their roles as well as guidance support.

**Other Issues Related to the Ombudsman Role in Reporting and Reporting in General**

CEJW's has identified additional issues related to California's elder and dependent adult abuse reporting system. These concerns pertain to the investigation of reports of abuse within long-term care facilities and in community settings. We believe that these hearings and the report provide an unprecedented opportunity to address these issues in a comprehensive way. We urge the committee to explore these issues and to continue to solicit feedback from other stakeholders.

**Issues Related to Abuse Reporting in Long-Term Care Facilities**

- A lack of clarity exists with respect to what entity is charged with investigating allegations of financial abuse in long term care facilities when family members or professionals from outside the facility, ask residents whose decision-making capacity is questionable to sign wills, powers of attorney, or other documents.
- In addition to the conflicts addressed in the Senate Office of Oversight and Outcomes report, Ombudsmen in California face other conflicts in carrying out their state and federal responsibilities. For example, under California Health and Safety Code §1418 Ombudsmen may serve on Interdisciplinary Team Reviews (ITRs) to make health/medical decisions for "unbefriended elders" in LTC facilities (other ITR members include representatives from the facilities). However, according to the OAA, Ombudsman cannot serve as surrogates. The question of who can and should make decisions for unbefriended elders in California's LTC facilities may therefore warrant further discussion. An expanded role for Ombudsmen as objective, "disinterested" surrogates for residents who lack family, friends, and formal representatives may also warrant consideration.

**General Issues Related to the Mandatory Reporting of Elder Abuse in California**

- Statutory definitions in the reporting codes have been interpreted differently across the state leading to disparities in how reports are evaluated and responded to. Examples include definitions of "dependent adult" and "abandonment." These disparities are currently being explored by the Protective Services Operations Committee (PSOC) of the County Welfare Directors Association in collaboration

with the Center of Excellence at the University of California, Irvine.

- Disparities also exist in how APS unit define eligibility for services. These disparities are described in a report conducted by Workgroup Steering Committee member Lori Delagrammatikas.
- Mandated reporters are dissatisfied with the feedback they receive about what happens after they've made reports. The lack of clarity about the type of information that can be shared interferes with safety planning for victims.
- Some groups, including clergy and law enforcement, are not reporting.
- There is almost no enforcement of reporting laws.
- The list of persons/professions covered under the state's reporting law needs may need to be expanded. Groups that have been recommended for inclusion include notaries, federal employees (including postal workers, personnel from federal law enforcement and regulatory agencies, providers of federally subsidized housing, notaries, etc.