The California Elder Justice Work Group (CEJW) [1] Position on
CA Elder Abuse Investigators: Ombudsman Shackled By Conflicting Laws and Duties.
February 19, 2010

Executive Summary

The Report ***CA Elder Abuse Investigators: Ombudsman Shackled By Conflicting Laws and Duties*** was written by the California Senate Office of Oversight and Outcomes at the request of the California Senate Rules Committee. The report raises troubling questions about California's response to allegations of abuse in long term care (LTC) facilities. Rather than endorsing specific recommendations contained in the report, CEJW proposes the following guiding principles to serve as a template for evaluating various proposals for reform.

Guiding Principles

1. The Long Term Care Ombudsman Program plays a critical role in advocating on behalf of LTC facility residents. This advocacy role must be preserved and strengthened to ensure a voice for our communities' most vulnerable members.
2. Criminal conduct in long-term care facilities must not be tolerated.
3. Advocates are needed to defend patients' rights and safety, ***and*** objective finders of fact are needed to bring offenders to justice. If a single service provider cannot serve in both capacities, the roles must be assumed by separate entities. Public policy must acknowledge and address potential role conflicts among those charged with ensuring residents' rights and safety.
4. The Ombudsman's federal mandate needs to be reviewed in light of current trends and developments, which include increased numbers of "unrepresented" elders in LTC facilities (residents who lack decision-making capacity and surrogates) and heightened attention to crimes in facilities and the involvement by law enforcement.
5. Agencies/entities designated to respond to reports of abuse in LTC facilities need adequate resources and training. Inadequate or incomplete investigations, or investigations by entities that are not properly trained may further endanger residents.
6. Changes in California's reporting system requires input from all stakeholders, including law enforcement, APS, regulatory agencies, and advocates for the elderly and persons with disabilities.
7. All agencies/entities in the abuse reporting and investigation process need clear policy and guidance to carry out their mandates.

Other Issues Related to California's Reporting and Response System

[1] 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. A description of CEJW is attached.

CEJW has identified the following additional concerns 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.

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 LTC 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.
- Under California Health and Safety Code §1418 Ombudsmen may serve on Interdisciplinary Team Reviews (ITRs), which are authorized to make health/medical decisions for "unbefriended elders" in LTC facilities (other ITR members include personnel from the facilities). The Older American's Act, however, prohibits Ombudsmen from serving as surrogates. Hence "unbefriended" elders in need of treatment may lack objective and "disinterested" surrogates.

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.
- Disparities also exist in how APS units define eligibility for services.
- 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 need to be expanded. Groups that warrant consideration include postal workers, personnel from federal law enforcement and regulatory agencies, providers of federally subsidized housing, notaries, etc.

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The Report ***CA Elder Abuse Investigators: Ombudsman Shackled By Conflicting Laws and Duties*** was written by the California Senate Office of Oversight and Outcomes at the request of the California Senate Rules Committee. The report raises troubling questions about California's response to allegations of abuse in long term care (LTC) 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 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

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basic precepts of our justice system and further creates incentives for criminals to manipulate, threaten, retaliate against, or silence victims.

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). Specifically, 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; and auditing financial records to establish patterns of fraud.

6. **All stakeholders' voices must be heard.**
   Multiple agencies have a role to play in the reporting process. Discussions about changes in the reporting system must include 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, 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 relevant laws their roles in enforcement.

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

CEJW 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 occurring both within long-term care facilities and in community settings. We believe that the publication of the California Senate Office of Oversight and Outcomes report provides an unprecedented opportunity to address these issues in a comprehensive way.

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 role conflicts addressed in the Senate Office of Oversight and Outcomes report, Ombudsmen in California face additional conflicts in carrying out their state and federal responsibilities. For example, under California Health and Safety Code §1418, Ombudsmen may participate in 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 Older Americans Act, Ombudsman cannot serve as surrogates. The question of who can and should make decisions for unbefriended elders in California's LTC facilities therefore warrants further discussion. An expanded role for Ombudsmen as objective, "disinterested" surrogates for residents who lack family, friends, and formal representatives may warrant consideration.

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

- Statutory definitions contained in California's abuse reporting codes have been interpreted differently across the state leading to wide 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 units define eligibility for services. These disparities are described in a report prepared 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 need to be expanded. Groups that warrant consideration include postal workers, personnel from federal law enforcement and regulatory agencies, providers of federally subsidized housing, notaries, etc.