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Senate Office of Oversight and Outcomes Exposes Urgent Flaws in State Program to Detect and Respond to Elder Abuse and Neglect

(SACRAMENTO)- The Senate Office of Oversight and Outcomes today released a report that shows that California's ombudsmen, who act as watchdogs against abuse and exploitation of the elderly in long-term care facilities, cannot effectively do their job because of conflicting demands of federal and state laws, a slashed budget and a poorly-run state program. The report offers several recommendations to the Legislature.

The report, "California's Elder Abuse Investigators: Ombudsmen Shackled by Conflicting Laws and Duties," can be found online here (link).

Senate President pro Tem Darrell Steinberg (D-Sacramento) created The Senate Office of Oversight and Outcomes last year as an independent investigative unit to assess implementation of important laws by the executive branch.

The new elder abuse report is the first analysis of the highly unusual use of ombudsmen as the key investigators of physical and financial abuse of the elderly in California long-term residential facilities. The report documents a sudden drop in reports filed in the past year by staff and volunteers in 35 local ombudsman programs to outside agencies with the power to punish abusers or the facilities where they work. It highlights many shortcomings that prevent even serious abuse and neglect cases from ever coming to light. In one example, the state unit that licenses nursing homes saw a 44 percent drop in referrals from ombudsmen.

"The last thing we should do is handcuff those who we entrust to watch over the care and safety of our elderly loved ones with conflicting and ill-conceived mandates, confusing protocol, and inadequate regulations," Steinberg said. "The Senate will take a close look at the thoughtful recommendations provided in this report and respond appropriately."

The state requires ombudsmen under its mandated reporter law to receive and investigate reports of abuse and neglect from health care professionals. However, the federal Older Americans Act requires ombudsmen to obtain consent from long-term care residents before releasing their names or forwarding their complaints to other agencies. The state ombudsman's office found that three-quarters of victims in abuse and neglect

cases refused to consent to the release of their identities. Ombudsmen point out that getting consent from a resident can be challenging. Despite the urgent need for corrective action or prosecution, many residents worry about retaliation or being evicted from the facility. This conflict puts ombudsmen in the difficult position of knowing about abuse or neglect, but being forced by federal law to remain silent.

California is one of only four states that put ombudsmen in this bind. The rest rely instead on Adult Protective Services, state agencies that license long-term care facilities, or others not constrained by the consent requirement in the Older Americans Act.

Furthermore, until this month, the state's ombudsman interpreted federal law to require consent from witnesses, including the alleged abuser, before local programs could forward full reports to outside agencies. The report notes, "The state still has not revised its erroneous view that witnesses have the right to block the forwarding of full reports, but as a result of this investigation, that interpretation is under review."

The report points out that Governor Schwarzenegger's cut in October of 2008 of all General Fund support had a devastating effect on the program's performance. The cut slashed its overall budget almost in half, leading ombudsmen to commit almost all their resources to investigations at the expense of other essential duties, such as making regular, unannounced visits to check in on the residents of the state's 1,377 nursing facilities and 7,648 other residential care facilities for the elderly.

The investigation found other problems that hamper the prompt and thorough reporting of elder abuse and neglect, including:

- Reliance on volunteers who may not be qualified or prepared to handle cases
- Absence of regulations or other guidance that would allow local programs to understand consent requirements
- The state ombudsman's position as a political appointee, which some local coordinators say makes it hard for the program to speak out on issues concerning long-term care residents

The report suggests that the Legislature consider several measures, including:

- Revise the state's mandated reporter law to make it consistent with federal law
- Transfer the responsibility of receiving mandated reports and investigating abuse to another entity not bound by the federal Older Americans Act, while also requiring that the ombudsman program be informed of mandated reports
- Require mandated reporters to go to ombudsmen and local law enforcement or some other agency, instead of being able to choose between the two
- Prohibit volunteers from conducting investigations or require them to have more training
- Require regulations and other policy directives to clarify the state's legal interpretation of consent laws
- Provide the program the necessary resources to perform investigations as well as its many other duties
- Require the state ombudsman's office to develop a protocol for reporting elder abuse even without resident consent if the situation poses an imminent threat to long-term care residents.

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