

# California's Elder Abuse Investigators: Ombudsmen Shackled by Conflicting Laws and Duties

*A report prepared for the California Senate  
Rules Committee at the request of the  
Subcommittee on Aging and Long-Term Care*

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## Executive Summary

As the eyes and ears of the public in California's long-term care facilities, ombudsmen provide the first line of defense against abuse and exploitation of one of the state's most vulnerable groups – elderly people who lack the capacity to continue living independently.

Yet in the past year, these 1,000 or so long-term care ombudsmen, including paid staff and volunteers in 35 local programs, have been making far fewer reports to outside agencies with the power to punish abusers or the facilities where they work. In one example, the state unit that licenses nursing homes saw a 44 percent drop in referrals from ombudsmen.

An investigation by the Senate Office of Oversight and Outcomes found that the sudden decrease exposes deep flaws in California's system for detecting and responding to elder abuse and neglect. These shortcomings prevent some abuse and neglect cases from ever coming to light.

One ostensible cause was Gov. Arnold Schwarzenegger's decision one year ago to cut all General Fund support for the ombudsman program, slashing its overall budget almost in half. The cut had a devastating effect on the program's performance not just because of its magnitude, but because California is almost alone among the states in relying on ombudsmen to investigate elder abuse and neglect.

Over three decades, the state has strayed far from the original intent of the federal program. The Older Americans Act envisioned ombudsmen as advocates for the elderly in nursing homes, listening to their concerns and working with administrators to improve living conditions. Like all the states, California established its own ombudsman program with the help of federal funding.

In the 1980s, the state made ombudsmen key players in another new initiative – requiring health care professionals and others who work in facilities to report suspected abuse and neglect. Ombudsmen became legally responsible for receiving and investigating these mandated reports. But there was a hitch: they were also bound by a requirement in the federal law to obtain consent from long-term care residents before releasing their names or forwarding their complaints to other agencies.

The conflict put ombudsmen in the difficult position of knowing about abuse or neglect, but being forced by federal law to remain silent. The state long-term care ombudsman's office found that three-quarters of residents who made abuse and neglect complaints refused to consent to release of their identities. 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.

Abuse and neglect investigations have become a major focus of California's ombudsman program. This has come at the expense of the other functions envisioned by the federal initiative, such as making regular, unannounced visits to check in on residents of the state's 1,377 nursing facilities and 7,648 residential care facilities for the elderly. When the program's budget was cut last October, local programs, with fewer staff and volunteers, curtailed these visits so they could continue to do abuse and neglect investigations. That led to the drop in ombudsman referrals to outside agencies. Ombudsmen were no longer in the facilities, gaining the trust of residents and learning of serious abuse and neglect cases.

Our investigation found that the following problems hamper the prompt and thorough reporting of elder abuse and neglect:

- California is almost alone among the states in depending on ombudsmen to investigate mandated reports. One of the three other states that make ombudsmen abuse and neglect investigators, New Jersey, takes steps to assure that they are not blocked from reporting to outside agencies. Mandated reports in New Jersey go to ombudsmen and the state agency that licenses long-term care facilities, which is not bound by the consent requirements of the federal law. Also, residents of nursing homes are asked to sign consent forms for any future investigations when they move into a long-term care facility.
- While some local programs ban volunteers from doing these complex investigations, others rely on them, raising questions about whether they are qualified or prepared to handle such high-stakes cases. Volunteers themselves report feeling overwhelmed. They also feel torn by their dual roles. They work with facilities to correct the everyday problems faced by residents. Yet they must act as adversaries of those facilities in abuse and neglect investigations.
- Until last month, the state ombudsman interpreted federal law to require consent from witnesses, including the alleged abuser, before ombudsmen could forward full reports to outside agencies. This interpretation put California at odds with other states and went beyond what the federal government itself says the law requires. It further handcuffed local programs charged with handling serious abuse and neglect complaints. 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.
- In the absence of regulations or other guidance, local ombudsman programs have widely varying understandings of the state office's requirements. Many fail to get consent at all, even from the long-term care resident. Some intentionally ignore

consent requirements when they consider the case too serious. Others, including volunteers, simply don't know the rules. The state ombudsman says the office failed to follow its own five year plan and state law requiring regulations because the department lacks a regulation writer. The office submitted regulations ten years ago, but the Office of Administrative Law found them deficient, and they were never revised.

- Laws passed by the Legislature in recent years to promote the reporting of elder abuse, including a 2008 measure requiring ombudsmen to send abuse complaints to district attorneys, have run smack into these federal confidentiality requirements. The state office told local programs they still had to get consent, and as a result very few reports are being forwarded.
- National studies of the ombudsman program have long advocated making the state ombudsman an independent office. In some states, they are outside of state government. Local coordinators in California say that having a political appointee running the state office makes it hard for the program to speak out on issues concerning long-term care residents, one of the original intents of the federal ombudsman program. California's state ombudsman, in an interview for this report, said he supported steps that would give him more flexibility and independence.

## Background

California's long-term care ombudsman program has its roots in a push by the federal government in the 1970s to improve conditions for residents of nursing homes and other long-term care facilities. These facilities proliferated after the passage of Medicare and Medicaid in 1965. Tales of shoddy care and conditions were getting the attention of Congress and the public.

In 1978, amendments to the federal Older Americans Act required states to start ombudsman programs that could investigate and resolve complaints at nursing homes and, in a more general sense, advocate for residents by commenting on laws and policies and identifying widespread problems. With a combination of paid staff and volunteers, the program was supposed to work with facilities to address residents' complaints – not enough recreational activities, say, or lukewarm food.

In 1981, the Older Americans Act was amended again to include long-term care facilities other than nursing homes, such as small board-and-care homes. Changes in 1987 required states to toughen their laws to protect ombudsmen in the performance of their duties.

These 1987 amendments also strengthened provisions on nursing home resident confidentiality that would later be at the heart of conflicts with California state laws. In resolving complaints, ombudsmen were not to disclose the identities of residents without first getting consent. The idea was that ombudsmen would not be able to gain the trust of residents and their families unless they honored their wishes on whether to go public.

### **California's program**

California started its ombudsman program in 1979, and put the state office within the Department of Aging. The state ombudsman is appointed by the department director on the advice of the governor. The current ombudsman, Joseph Rodrigues, was appointed in August, 2002. He is responsible for monitoring 35 local programs, in which paid

staff develops and oversees a network of volunteers. These local programs are either run directly by local Area Agencies on Aging, which coordinate the distribution of federal, state, and local funds for services for the elderly, or private organizations that contract with them.

Over the years, the Legislature passed laws to protect ombudsmen in the performance of their duties, and eventually, to add to their responsibilities. In the 1980s, for instance, the ombudsman program took on a key role in the state's mandated reporting law, which requires health care professionals and others who work at long-term care facilities to report abuse and neglect.

That change would have dramatic consequences for California's ombudsman program. It put ombudsmen in the difficult position of having knowledge of abuse and neglect of vulnerable long-term care residents, while being constrained by the requirement in the federal Older Americans Act to get consent of residents before revealing their identities. Despite subsequent changes in the law, that tension remains. Many local coordinators told this office that they have been forced to drop serious abuse cases because they were unable to get consent from victims.

The program relies on a combination of state and federal funds. In 2008, Gov. Schwarzenegger vetoed \$3.8 million of the program's budget – slicing the total government funding almost in half. That put immense pressure on many local programs to focus on abuse and neglect cases at the expense of the many other duties that are part of the program's original mission.

In August, 2009, Gov. Schwarzenegger signed AB 392 to restore \$1.6 million of the program's budget for one year, bringing the total with federal and special funds to \$5.7 million – still almost 27 percent below the total 2007-08 budget.

*Many local coordinators told this office that they have been forced to drop serious abuse cases because they were unable to get consent from victims.*



## State Ombudsman Program By the Numbers

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Ombudsman complaints that involve abuse, gross neglect or exploitation:

**13 percent**  
In California

**5 percent**  
In the rest of the US

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Percent of ombudsman completed cases from facility staff and other professionals:

**40**  
In California

**19**  
In the rest of the US

Number of abuse and neglect complaints per volunteer:

**8.2**  
In California

**1.4**  
In the rest of the US

Number of abuse and neglect complaints per paid staff:

**38**  
In California

**12**  
In the rest of the US

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Total state and federal budget for California ombudsmen:

2007–08: **\$7.9 million**

2008–09: **\$4.0 million**

2009–10: **\$5.7 million**

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Drop in ombudsman reports after 2008 budget cut:

To state licenser of nursing homes:  
**41 percent**

To licenser of board-and-care homes:  
**44 percent**

To Attorney General's Office:  
**29 percent**

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Number of California facilities monitored by ombudsmen

In 2003-04: **7,872**

In 2007-08: **9,025**

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Number of certified ombudsman volunteers

In 1998-99: **1,336**

In 2008-09: **858**

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Percent of ombudsman cases that state and federal governments say  
require resident consent to release full reports to outside agencies:

**100**

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Percent of residents who do give consent

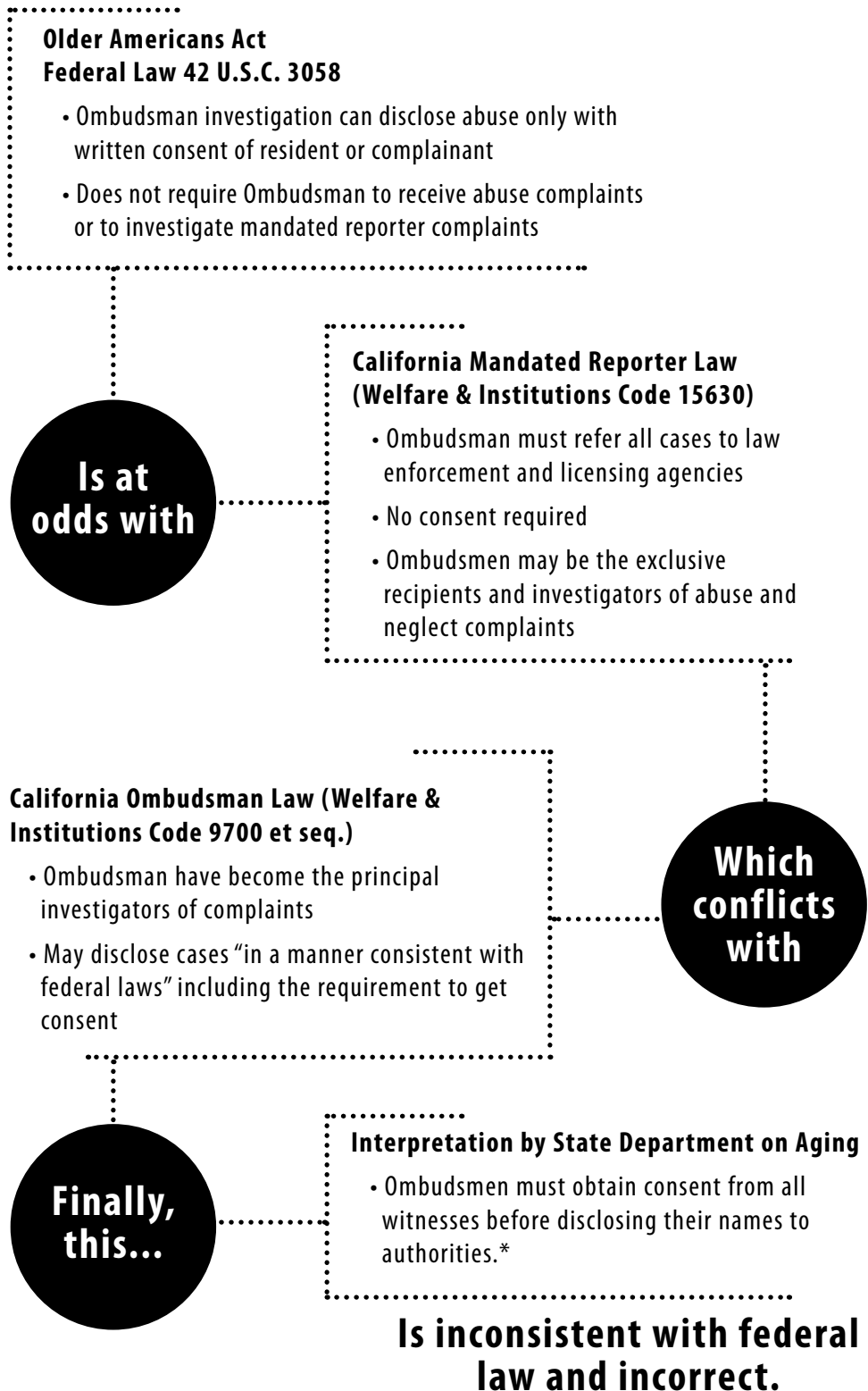
**25**

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Number of local programs for which state analysts found that  
ombudsmen did not follow proper procedure for getting consent:

**10 of 23**

## Conflicting Ombudsman Laws



\* Until this month, Ombudsman withheld the names of the accused unless accused gave consent.

## **Tales from a ride-along: Ombudsmen walk a fine line between conflicting demands of federal and state laws**

Geneva Carroll, a certified ombudsman for eight-and-a-half years, allowed a representative of the Senate Office of Oversight and Outcomes to accompany her as she made unannounced visits to a board-and-care facility and a nursing home in east Sacramento. The ride-along provided a glimpse of the challenges and delicate situations faced each day by ombudsmen across the state.

Carroll was a regional manager in the local ombudsman programs in Placer County and Sacramento County, before being laid off in October 2008 in response to Gov. Schwarzenegger's \$3.8 million budget cut. Since then, she has maintained her connection to the program as a volunteer in Placer County.

The board-and-care facility, for about 10 residents, was in a bungalow in a residential neighborhood. Carroll's knock was answered by the owner, whom Carroll had met on previous visits. Carroll told the owner she was there to check in with residents. She walked into the living room, where two women were watching television, and noticed a sign announcing that TV hours were between 7 a.m. and 10 p.m. Carroll talked to the women about how they felt about the rule and what happened if they wanted to watch TV during off hours.

As the owner followed closely, Carroll walked into the kitchen and opened the refrigerator to make sure there was enough food. In the pantry, she found something she had warned the owner about before: a container of sugar stored next to detergents and other chemicals. Carroll feared that residents could mistake the two. The owner promised to fix it, and pointed out a spot on the counter where she could put the sugar. Carroll suggested briskly that the owner do it right away, which the owner did. Carroll has no direct regulatory power to order changes, and so must rely on cajoling and insistence.

*Ombudsmen say it's common to be followed  
and sometimes harassed by owners as they talk  
to residents or conduct investigations.*

As the owner walked with us down the hallway, Carroll told her, "You don't have to follow us around. I know you have a lot to do." Ombudsmen say it's common to be followed and sometimes harassed by owners as they talk to residents or conduct investigations.

Carroll checked the fire extinguishers. Experience has taught her to do so. She used to visit a board-and-care in Citrus Heights that burned down in 2006, killing three residents. On this visit, Carroll and the owner disagreed about whether the extinguishers were due for inspection. The owner finally agreed to make a call, and reported later that Carroll was right and that the inspectors would be out in a few days.

On the back porch, one woman told Carroll, "They don't treat us so well" and added that the residents get into fights. Carroll asked if it ever escalated to physical violence. The resident said no, and we moved on.

At the nursing home, a staff member and several residents gathered around a table in the activity room to discuss the morning newspaper. Carroll checked the activity schedule. She said she's seen schedules that look full, but when the time comes, the activities don't happen.

Carroll noted some discarded tissues on the floor of one residents' room and something that might have been feces on the floor of the shower, which she reported to the staff. On her way out, she chatted amicably with the top staff members, who were in a meeting.

Ombudsmen walk a fine line, she said. They must be assertive enough to stand up for the rights and desires of residents, even if that means pestering management. But they also have to know the limits of their authority.

Ombudsmen are not permitted to help out with residents by pushing a wheelchair or getting a glass of water, because they may not know the medical conditions of residents and are not supposed to act like facility staff. First and foremost, ombudsmen must respect the wishes of the elderly residents, she said. Carroll is always careful to knock on the door frame before entering a room, and never sits on a residents' bed unless invited to.

**Abuse complaints complicate the ombudsman's role**

This office's examination of the ombudsman's role in long-term care facilities found that it becomes more complicated when they get reports of abuse or neglect. By California law, workers in long-term care facilities who become aware of abuse and neglect must report it to an ombudsman or local law enforcement, which are responsible for investigating it. The state Department of Aging says it has no data on what percentage of the reports go to ombudsmen, but those in the field believe it is a majority.

Of the 53,219 statewide complaints to ombudsmen last year, 7,053 involved abuse or neglect. Even though that represents only 13 percent of the total, ombudsmen say that those cases can eat up much of their time and energy. Abuse and neglect can take many forms: physical assault, sexual abuse, threats and harassment, financial exploitation, failure to attend to physical or mental health needs or personal hygiene. Neglect can often be as damaging as abuse – residents have died of infections from bedsores.

Ombudsmen may forward the standard complaint forms they get from mandated reporters to one or more of several outside agencies. These include local law enforcement, district attorneys, the units within the Department of Public Health and the Department of Social Services that license long-term care facilities and the Bureau of Medi-Cal Fraud and Elder Abuse in the California Attorney General's Office.

After doing an investigation, ombudsmen can also generate their own reports to these same agencies. But in both cases, federal law requires them to first obtain consent from the resident. The referral of a report does not end the ombudsman's role. Police may investigate a sexual assault case, but the ombudsman could still work with the facility to make sure the victim's call light is within reach or that staff regularly checks on her at night.

On the way out of the nursing home, Carroll pointed out one of the posters that by law must be displayed to tell residents about the ombudsman program. She noted that, after the drastic budget cut last year, ombudsmen started getting fewer complaints. Mandated reporters aren't making the reports as often, she said, because they know the ombudsmen don't visit as frequently. Also, with ombudsmen unable to do as much training, she said, the mandated reporters may be in the dark about their obligations to report.

## **Ombudsmen's role in California's mandated reporter law created conflicts with other state and federal statutes**

California's mandated reporter law was created and amended repeatedly in the 1980s. In the end, the law gave ombudsmen the primary responsibility for receiving and investigating abuse and neglect reports. It also made ombudsmen mandated reporters themselves. A review of the legislative record suggests that the Legislature and administration never truly considered the consequences of assigning this serious responsibility to the ombudsman program. Officials seemed most concerned about possible liability if reports from mandated reporters were not investigated, and eventually handed that responsibility to ombudsmen. That important step was taken in 1986, one year before Congress amended the Older Americans Act to bolster confidentiality provisions that conflicted with the new role taken on by California ombudsmen.

The end result of this legislation is a section of the Welfare and Institutions Code (15630 et seq.) that is fundamentally at odds with federal law and another section of state law that created the state ombudsman program and defines its responsibilities (Welfare and Institutions Code 9700 et seq.) The mandated reporter section of the law requires local ombudsmen to promptly turn over the complaints they get to law enforcement and licensing agencies. It allows for no exception when residents fail to give consent. By contrast, the section of the law setting up the ombudsman program mimics federal law in requiring ombudsmen to first obtain resident consent. The contradictions leave ombudsmen uncertain of their duties, and can create a Catch-22 in which the law requires them to remain silent about serious cases of neglect and abuse.

The idea of mandated reporting – requiring caregivers and others who deal with vulnerable populations to report abuse or neglect - took hold in the early 1980s. At first, there were two separate sections on mandated reporting in the California Welfare and

Institutions Code. One dealt with the elderly, the other with dependent adults under the age of 65, such as people with developmental disabilities.

The law failed to specify which of several agencies named as possible recipients of mandated reports was responsible for investigating them. Counties said they were worried that they might be held liable for failing to do it themselves.

In 1986, the Legislature brought together the two separate sections of the code. And it addressed the counties' concerns by handing ombudsmen the responsibility of receiving and investigating mandated reports. The new law also designated ombudsmen as mandated reporters themselves.

### **Later attempts to deal with perceived holes in the law**

In 2008, the Legislature considered a bill on abuse of the elderly and people with disabilities that required mandated reporters to go to ombudsmen and local police, instead of allowing them to choose between the two. Ombudsmen would have been required to tell mandated reporters that they were also required to go to police, and to provide them the phone number. It was opposed by the nursing home industry and died in committee.

Representatives of the California Association of Health Facilities, in an interview with this office, said one problem with having mandated reports go to two different outside agencies is that it could lead to double or triple counting. That could happen if all those who get mandated reports forward them to the Department of Public Health, which enters them in a database. These artificially inflated figures could be used in support of bills adding to mandates for long-term care facilities or in enforcement actions, they said.

This office asked the Department of Public Health to address these concerns. While it's true that the same incident may be reported more than once, the department's field offices consolidate reports into one case, said Scott Vivona, chief of field operations in the department's Licensing & Certification division. The raw data might reflect

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double-counting, he said. But the federal government strictly limits the state's ability to share this data on the level of individual facilities. Vivona said that the data most widely disseminated to the public has been corrected for overcounting.

Also in 2008, the Legislature approved AB 2100, which required ombudsmen to report cases of abuse and neglect to local district attorneys. The bill was meant to encourage local prosecutors to pursue elder abuse cases that may have previously escaped their attention. The law went into effect in 2009. But like many other California laws meant to address elder abuse, it conflicted with the consent requirements of the Older Americans Act. The state ombudsman's office, in keeping with its other interpretations of federal law, informed local programs that they would first have to obtain consent from residents. The end result is that very few reports have been finding their way to prosecutors.

Interviews with local programs suggest that some district attorneys are unaware of the new law or would rather cases come through law enforcement. And local ombudsmen are making few referrals because of the difficulty of getting resident consent.

Mary McClure, local ombudsman coordinator for Riverside County, said she has forwarded two abuse cases to the district attorney's office, including one that she considered "quite blatant." The district attorney mailed both of them back, she said, writing that if the cases didn't come through law enforcement, he didn't want them.

Tippy Irwin, executive director of Ombudsman Services of San Mateo County, said she tried unsuccessfully to talk to her district attorney before AB 2100 went into effect. She said she forwarded the standard mandated reporter forms to the district attorney just after the law was passed, until her staff pointed out she needed to get consent. After that, she said, she stopped forwarding any, sensing little interest from the DA.

Elaine Tipton, the supervising deputy DA in San Mateo, said she has been talking to Irwin about resuming the reports when the ombudsman gets consent. But Tipton said the most effective way to make cases is for the ombudsman to go first to police or Adult Protective Services.

Others say the consent barrier has prevented them from forwarding many reports at all. Molly Davies, program manager of the Los Angeles ombudsman program, said that when her staff gets a report from a law enforcement agency, they ask them to go directly to the district attorney if consent is likely to be a barrier.

The California District Attorney's Association said it does not have data on the number of reports made to prosecutors under the terms of the new law. But anecdotal evidence suggests it is very few. Like much else about the ombudsman program, officials have a hard time balancing the resident consent requirement with state laws meant to promote the reporting and prosecution of elder abuse.

## **California is one of the few states that relies on ombudsmen to investigate abuse and neglect**

To qualify for federal funds, states must meet certain requirements of the Older Americans Act. Ombudsmen must resolve complaints and try to improve living conditions in long-term care facilities. They must refer cases to law enforcement or the agencies that license facilities. But the federal law does not require ombudsmen to receive reports of abuse and neglect from workers who are mandated by law to file such reports, as is done in California. Nor does it require ombudsmen to investigate such cases.

In fact, most states do not ask or expect ombudsmen to play this role, giving it instead to Adult Protective Services or other entities not bound by the confidentiality provisions of the Older Americans Act. This difference can be seen in statistics kept by the federal Administration on Aging. In the rest of the U.S., 5 percent of ombudsman cases in 2007 involved abuse, gross neglect or exploitation. In California, it was 13 percent – almost three times the rate.

Outside of California, 19 percent of cases were originated by parties other than residents, relatives, friends, guardians or the ombudsmen themselves. In California, it was more than double – 40 percent – reflecting the large number of cases that come to ombudsmen from mandated reporters.

Local coordinators in California and national experts on the ombudsman program, including the Administration on Aging, say that combining the two roles poses serious problems that may prevent some cases of abuse or neglect from being thoroughly investigated and referred to the proper authorities.

“This is not the intent of the ombudsman’s role,” said Sue Wheaton, ombudsman specialist at the Administration on Aging.

Even California’s state ombudsman, Joseph Rodrigues, thinks his program’s resources are being eaten up by the need to investigate mandated reports.

“The California ombudsman program needs to return to its core advocacy function that exists in the Older Americans Act,” Rodrigues said.

### **New Jersey’s experience**

The only other states that require ombudsmen to investigate abuse and neglect are Alaska, South Carolina, New Jersey, and South Dakota, according to Lori Smetanka, director of the National Long-term Care Ombudsman Resource Center.

New Jersey, the most populous of these states, has a program that differs in several significant respects from California’s. One is the technical expertise of its investigators.

*Nevada found that when the ombudsman's office was investigating abuse and neglect, it had little time to do anything else.*

Abuse and neglect investigations in California are conducted by local program staff and volunteers with 36 hours classroom training and 10 hours in the field on abuse and other topics. New Jersey runs all of its investigations out of the state office. Its investigators include five registered nurses, five former law enforcement officers, and a forensic accounting expert with 20 years of experience in the financial industry.

“They do have extensive backgrounds,” said Debra Branch, New Jersey’s Ombudsman for the Institutionalized Elderly.

Another difference is that New Jersey regulations require long-term care facilities to ask residents, upon being admitted, to sign a consent form giving the ombudsman’s office permission to investigate future abuse complaints, or naming a person who can give consent. Most incoming residents sign the form, Branch said. California, by contrast, only seeks consent after an abuse allegation has been made.

California law requires reports of abuse to be sent to ombudsmen or police. In practice, this means that many mandated reports are sent only to ombudsmen. New Jersey requires reports to go to both the ombudsman and the Department of Health and Senior Services, the office that licenses long-term care facilities. As a result, every mandated report goes to an entity not bound by the confidentiality requirements in the Older Americans Act and empowered to take regulatory action.

### **Nevada rejected the California model**

Until 2008, Nevada, like California, gave ombudsmen the responsibility of investigating abuse and neglect. But the state revamped its program to move the investigative function to the state’s Elder Protective Services.

“We don’t have anything to do with that at all,” said Teresa Stricker, the state’s long-term care ombudsman.

Nevada’s experience may be instructive to California policymakers. The state found the two ombudsman roles – advocate for residents and abuse investigator – to be incompatible. Under the old system, Stricker said, an ombudsman might be working together with a facility administrator to resolve residents’ complaints about lost laundry. The next day, that same administrator might be the target of an abuse allegation.

“The administrator is now my suspect. My conversation with her is definitely going to be a different tone, a different everything,” Stricker said.

Nevada found that when the ombudsman’s office was investigating abuse and neglect, it had little time to do anything else. One of the key components of the program, as envisioned by Congress, was to have ombudsmen make regular unannounced visits to facilities. That enabled ombudsmen to get to know the residents and assess what was going on at a facility. Stricker said that, having shed its investigative responsibility, Nevada’s program can visit nursing homes every week, instead of every three months. The program also is able to visit smaller residential facilities that might not have gotten any visits before.

Ombudsmen have time to help organize family councils at facilities and a number of other activities – “all those things we should have been doing but couldn’t because we were elder abuse investigators.”

Statistics gathered by the Administration on Aging show that, while California is close to the national average for the number of long-term care beds per volunteer, those volunteers are handling complicated abuse and neglect cases far more frequently. California’s program investigates 8.2 such cases per volunteer, compared to 1.4 in the rest of the United States. The same imbalance occurs among paid staff: 38 abuse and neglect cases per worker, compared to 12 in the rest of the US.

Brooke Hollister, a researcher at the University of California, San Francisco, has done in-depth studies of ombudsman programs in Illinois, Ohio, New York and Georgia – none of which act as investigators in mandated reporter abuse cases.

*Tippy Irwin, executive director of Ombudsman Services of San Mateo County, said it would be impossible for her paid staff of six to investigate the 2,000 complaints it gets each year. “We could no more do that than fly to the moon,” she said.*

Compared to California, she said, “They just don’t have that same conflict dealing with residents. They can go into a residents’ room and say, ‘I’m your advocate’ and not waver on that.”

Smetanka, of the National Long-term Care Ombudsman Resource Center, said that the experience of the states has shown “it’s really not ideal for the ombudsman to be the primary investigators of abuse in these situations. There needs to be a separation of functions.” In California, it may be unclear to ombudsmen when they go into a facility what their role is supposed to be. “It puts more of a regulatory hat on them, which kind of blurs the line of what they’re there for,” she said.

### **Some local programs depend on volunteers to conduct investigations**

California’s ombudsman program depends on networks of volunteers overseen by paid staff. Some local programs don’t allow volunteers to conduct abuse and neglect investigations, reasoning that the cases are too complex, time-consuming and beyond the scope of what most volunteers expect.

But some local programs say that the demands are so great, and the paid staff stretched so thin, that they must depend on volunteers. A 2005 study found that half of California’s local programs allow volunteers to play a role in abuse and neglect investigations.

Tippy Irwin, executive director of Ombudsman Services of San Mateo County, said it would be impossible for her paid staff of six to investigate the 2,000 complaints it gets each year. “We could no more do that than fly to the moon,” she said.

Research presented at a summit of California ombudsmen in 2005 found a connection between the number of complaints and reliance on volunteers - the greater number of complaints, the more likely the local program was to allow volunteers to conduct abuse and neglect investigations.

San Diego’s local program relies on volunteers, and increased their role after Gov. Schwarzenegger cut state support for the program in October 2008. Paid staff was cut from nine to three, said co-coordinator Christine O’Connell. Before the cut, the paid staff handled complicated abuse cases. Now, O’Connell said, everything goes to the volunteers, with the staff overseeing and writing up referrals to state licensing agencies.

O’Connell notes that many of the volunteers have impressive backgrounds related to health care, including retired doctors and nurses. Still, Sharon Cordice, San Diego’s program manager, said it’s been a challenge to depend on volunteers in abuse and neglect investigations. They get 40 hours of training and up to 10 hours in the field. But the paid staff must constantly remind volunteers to seek consent.

Los Angeles decided several years ago to prohibit volunteers from doing abuse and neglect investigations. The volunteers didn't want to give up that role, but the program wanted more expertise and consistent and reliable results, said Molly Davies, program director for WISE & Healthy Aging.

Davies began her career as a volunteer. "I did not feel qualified to conduct elder abuse investigations with the training I got as a volunteer," she said.

Brooke Hollister, the UCSF researcher, also trained as an ombudsman volunteer. "Training is a major deficiency in the ombudsman program," she said. "I don't feel like I was prepared to go into a facility and follow this kind of thing from start to finish."

While ombudsman volunteers may be attuned to blatant abuse such as staff yelling at residents, they're less aware of medical issues such as pressure sores, malnutrition and dehydration, said Peggy Osborn, program manager of the Elder and Dependent Adult Abuse Prevention Program in the California Attorney General's Office.

"Those types of situations are well under the radar screen," she said.

A 2003 report by Protection & Advocacy, a non-profit, examined the role of ombudsmen in investigating complaints involving adults with developmental disabilities in long-term care facilities. It concluded that ombudsmen should no longer be in charge.

"Their training, experience and the focus of their work does not provide them with the level of expertise and skill in identifying and investigating abuse allegations comparable to APS (Adult Protective Services) or law enforcement," the report concluded.

### **State found problems in volunteer ranks**

In its monitoring of local programs, the state found shortcomings in some volunteer programs. In Del Norte and Humboldt counties, ombudsmen volunteers were acting more like "friendly visitors" than advocates for elderly residents who would sometimes have to take on administrators.

"It was also noted on several occasions Ombudsman representatives were overly friendly with facility staff and on another occasion acted in the role of facility staff by turning off an alarm and assisting with residents," the report noted. It goes on to observe the administrators and staff were "overly friendly toward the Ombudsman adding to the impression that the Ombudsman was there to visit with them rather than the residents."

The nursing home industry says some volunteers go to the opposite extreme. Although the industry values the presence of most ombudsmen, some seem to have an agenda based on a bad personal experience with nursing homes, said Nancy Reagan, director of legislative affairs for the California Association of Health Facilities.

In another of the state's reports in Merced County, the reviewer, after talking to volunteers about what they did, concluded, "It was clear that more training was needed."

### **Not your average volunteer job**

The demands of serving as investigators can take a toll on the volunteers, from threats and intimidation to the sheer time it takes to wrap up an investigation. The job goes far beyond what most volunteers sign up for.

In San Diego, a state analyst accompanied a volunteer ombudsman to a "drab, dirty, depressing" facility in El Cajon that "smelled of urine and vomit." As soon as they walked in, the administrator confronted the volunteer about making a report to a state licensing agency about a resident getting out of a locked wing. The administrator claimed the incident was not neglect and didn't warrant a report.

Administrators have been known to follow ombudsmen as they make their rounds, said Clift Wilson, manager of program services for Ombudsman & HICAP Services of Northern California. In smaller board-and-care facilities, they might even listen from outside a window.

Geneva Carroll, the former regional manager, recalled a volunteer at a South Sacramento facility who got in the middle of a family feud and was threatened by a family member. Carroll herself has had to call police to stand by as she conducts an investigation. Once, she recalls, she was looking at medicines in a cupboard and the agitated owner pushed the cupboard door against her. Volunteers must deal with potential lawsuits, being served with subpoenas and mountains of paperwork.

"That's not a typical volunteer job," Carroll said. "That's very unnerving."

In the state's monitoring reports, volunteers talked to interviewers about some of these anxieties. In Fresno County, "one volunteer reported that volunteer Ombudsmen are expected to investigate and follow a large number of cases that appear to be too serious for volunteers to handle." This person was not an exception. Volunteers "prefer to have staff handle these types of cases," the program manager told the state.

In Riverside County, volunteers reported that one of their "dislikes" was "the tension of confidentiality requirements and wanting to protect residents, and the fear of becoming too invested with individual residents. One person expressed concern about potential burnout."

"For the volunteers, it's confusing" to have to run the gamut of consent laws," said Davies, the Los Angeles program manager. "They say, 'Aren't we here to help people?'"

## **With funding cuts, ombudsmen say almost all their resources are dedicated to investigations**

California ombudsmen have more responsibilities than their counterparts in other states. They are required by law to investigate abuse and neglect and to witness advance health care directives, legal documents that allow residents to express their wishes about future care. The elimination of almost half of their budget in October 2008 forced local programs to make decisions about what they could keep doing. All of the local coordinators who spoke to the Senate Office of Oversight and Outcomes said they gave top priority to continuing abuse and neglect investigations. That meant cutting back on routine visits to facilities.

That, in turn, led to a dramatic drop in the number of abuse and neglect cases being referred by ombudsman to state licensing units and the Attorney General's Office. Research has shown that the regular presence of monitors at facilities increases the number of complaints, as ombudsmen gain the trust and confidence of residents. When ombudsmen were forced to cut back on visits, complaints plummeted. Mandated reporters saw them less often, and were not reminded of their duty to report. Or they assumed that, with the ombudsmen not around, failure to report wouldn't ever come to light.

The effects of the budget cut, in most local programs, were immediate and dramatic. Ombudsman and HICAP Services of Northern California, the local program for 13 counties, cut its staff from 23 to 10. Volunteer ranks dwindled from more than 90 to 50. In Los Angeles, WISE & Healthy Aging laid off 22 of 32 paid staff, and closed four of eight regional offices. That meant much longer travel times to some of the facilities, said Davies, the program director. The remaining staff couldn't do as many training sessions for volunteers, resulting in a drop in the number of volunteers from as many as 100 to 70.

San Diego lost six of nine paid staff, and one of those who remained worked only half-time. One result was that the volunteers didn't get as much attention, O'Connell said. The staff used to do continuing education training, which the volunteers are required to take, four times a month in four regions. After the cut, it was down to once every other month in two regions.

Staff cuts were not universal. In San Mateo, executive director Irwin said the program over the years raised money from non-governmental sources and recently was able to add a position. Even so, it's a struggle to maintain volunteer ranks. "What you bring in on one end you lose on the other," Irwin said. "It's a constant revolving door."

### **Investigating abuse eats up remaining resources**

With fewer staff and volunteers, programs focused their remaining resources on the time-consuming task of responding to complaints.



*The posters that facilities are required to put up telling residents how to contact an ombudsman aren't enough to reach those who are bed-ridden or suffer from dementia. Only repeated visits from an ombudsman can.*

“That’s all we’re doing now,” Davies, the Los Angeles program director, said. “It’s taking up the majority of our time.” Investigating abuse and other complaints comes first, then witnessing advance health care directives. Last comes unannounced visits to facilities.

Ombudsmen can’t check up as often on problem places. Davies’ program told the state about a board-and-care that wasn’t feeding residents enough. Lunch consisted of one level cup of macaroni and cheese. Normally, Davies said, an ombudsman would go back every week to monitor conditions while the state licensing agency did its investigation. With resources so limited, that wasn’t possible. When an ombudsman finally did return, Davies said, residents still weren’t getting enough food

Similar stories can be found throughout the state. Before the cut, Ombudsman and HICAP Services of Northern California used to send volunteers to nursing homes once a week. Afterwards, it was once a month. Residential care facilities for the elderly got visits once a month. After the cut, it was once a year.

When the weather heats up, Joan Parks, the administrator, used to send an email to volunteers asking them to make sure the facilities ran their air-conditioning. This year, she didn’t bother. She knew that the volunteers would only visit the nursing homes once a month and wouldn’t be able to check.

### **Fewer visits mean fewer complaints**

Curtailed visits have had a dramatic effect on the volume of complaints. The number of referrals made by local ombudsman programs to the Licensing and Certification Division of the Department of Public Health, which regulates nursing homes, dropped 41 percent in the nine months after the October budget cut compared to the previous 15 months. The Community Care Licensing division of the Department of Social Services, which regulates board-and-care facilities, saw an even bigger annual drop – 44 percent in the 2008-09 fiscal year. In that same year, the number of matters opened by the Attorney General’s Office in response to ombudsmen referrals fell by 29 percent. The budget cut is not the only explanation for that reduction, however. For reasons that are unclear,

ombudsman referrals to the Attorney General's office had already dropped 57 percent in the three years before the budget cut.

Local programs are not making the referrals to state agencies because, with fewer volunteers visiting facilities, they're not fielding as many complaints. Parks said her 13-county program in Northern California saw a 40 percent reduction in total complaints between March 2008 and March 2009.

Research has shown that the presence of ombudsmen increases abuse reporting. A 1995 evaluation of the national long-term care ombudsman program by the Institute of Medicine called the phenomenon "a sentinel effect." Local coordinators in California say they've seen it firsthand. The posters that facilities are required to put up telling residents how to contact an ombudsman aren't enough to reach those who are bed-ridden or suffer from dementia. Only repeated visits from an ombudsman can.

"When they see someone regularly, they know you're going to be back next week," Los Angeles program director Davies said. "They may not know the term ombudsman, but they know you're 'the nice lady who comes to visit me'."

The ombudsmen get to know residents and the facilities, which helps them gauge the seriousness of a complaint. An experienced ombudsman may be aware that a certain resident always thinks people are stealing from her, or that a facility routinely puts profit before the well-being of residents.

The budget cut disrupted this network, local programs say. When the Department of Public Health does its surveys of nursing homes, it used to check in with the ombudsmen about what to look for and who to talk to, Parks said. Now, it's harder for the ombudsmen to offer those kinds of tips.

In light of the stretched resources, ombudsmen are divided on the question of whether their offices should retain the lead role in conducting mandated reporter investigations. Some believe that, despite the problems, ombudsmen are in the best position to hear about abuse and neglect. Others would prefer to return to the original intent of the federal legislation.

"Ombudsmen are advocates and were never intended to be investigators," San Diego's O'Connell said. There's potential for the situation to do more harm than good, she said: "It's dangerous."

## **Considering California ombudsmen’s unusual investigative role, federal and state consent mandates can hamstring enforcement**

In other states, the federal requirement for ombudsmen to get consent to investigate or report complaints has always been a point of tension. But in California, these conflicts are heightened by two factors: the ombudsman’s role as official investigator of abuse and neglect, and California’s unusually strict interpretation of the federal law’s consent requirements.

Ombudsmen say that conflicting requirements inherent in the federal and state law, heightened by the state ombudsman’s legal interpretations, sometimes put them in the position of being unable to investigate or report abuse and neglect. Only one-quarter of residents in abuse and neglect cases gave consent, according to a sampling by the state ombudsman’s office.

### **The hurdle of consent**

A resident of a Placer County nursing home told ombudsman Geneva Carroll that, before being injured in a fall, she had been living at home with an In-Home Supportive Services aide who was using her debit card. Carroll checked with the bank and found that on the days that the woman had been in the hospital recovering from the fall, the aide had used the debit card to buy dresses, gasoline, and Subway sandwiches – a total of \$500 or so. At first the victim was open to the investigation, but after Carroll had done some work, she withdrew her consent. She explained to Carroll, “I give her my card to buy me things and she picks up a few extra things for herself.” When the victim returned home from the nursing home, she got a new IHSS aide. But the one who had used her debit card presumably went on to other clients.

Tippy Irwin, executive director of the San Mateo program, tells a similar story. A woman in a residential care facility told an ombudsman that her caretaker at her own home, now

*Residents tell ombudsmen that they feel vulnerable. They point out that the ombudsman won't be there at night when they are at the mercy of their abusive caregivers.*

her only visitor, had taken \$50,000 from her bank account. The money was supposedly for the caregiver's daughter to start a tanning salon. The caregiver scribbled an IOU on a scrap of newspaper, with no terms of repayment. The ombudsman wanted to investigate, but the nursing home resident wouldn't consent. She didn't want to risk losing her only visitor.

"When we don't get permission, we don't investigate..." Irwin said. "They should have been pursued. Our hands were tied."

Irwin herself responded to a call from a nursing home where a woman said her former roommate had been raped by a male assistant before being moved to another facility, where she died. By the time Irwin arrived for the interview, within an hour of the initial call, the sister of the woman who made the allegation had persuaded her not to talk. The sister argued that the resident couldn't be sure what had happened, as she was losing her cognitive abilities, and was jeopardizing the male assistant's career. "By the time we got there, this demented woman's lips were sealed," Irwin said. "That was the end of the case." A year later, the male assistant was convicted in another case at a different nursing home in which he forced a 15-year-old volunteer into a bathroom and sexually assaulted him.

### **Why residents balk**

Getting consent can be a challenge. Residents tell ombudsmen that they feel vulnerable. They point out that the ombudsman won't be there at night when they are at the mercy of their abusive caregivers. They worry about being evicted from the facility. Or the perpetrator may be a family member or a caregiver.

"I can't tell you the number of times we've had to drop financial abuse cases" because the residents don't want their relatives to go to jail, said Benson Nadell, program director of the San Francisco ombudsman program.

One particularly thorny problem is getting consent from residents who suffer from dementia, who may not be able to grant permission themselves. Ombudsmen can seek consent instead from a conservator or legally responsible party, such as a health care

agent. But local coordinators say that many residents either don't have conservators, or the conservators hardly know the resident and for various reasons are reluctant to give consent. The state has a procedure for going ahead with these cases anyway, coordinators say, but it is cumbersome and not often used.

Most local coordinators in California feel torn by the contradictions between various federal and state laws – on the one hand being asked to detect abuse and neglect, on the other to protect confidentiality. Research presented at a summit of long-term care ombudsmen in 2005 found that 59 percent experienced conflict between various laws and regulations. They overwhelmingly cited their role in investigating abuse. In New York, by contrast, only 16 percent of ombudsmen experienced such conflicts.

Clearly, the California program's dual emphasis on investigations and confidentiality creates these tensions.

### **Incorrect interpretation of Federal and State law has led to confusion on the local level**

Federal law is clear in its requirement that ombudsman get consent from long-term care residents before pursuing an investigation of their complaints or releasing the results to other parties. But California's Department of Aging has taken it a step further, creating unnecessary confusion statewide. The state ombudsman says that witnesses interviewed as part of the investigation must also give consent. Until last month, the state office even extended the consent requirement to alleged perpetrators.

Rodrigues said the office reversed course on the need for perpetrator consent after getting a legal opinion from the Health & Human Services Agency in response to a question that came up during a training session. The agency's legal counsel found that perpetrators did not have to give consent for their names to be included in ombudsman reports. Rodrigues said the fact that this office had questioned the interpretation was coincidental.

Nevertheless, the department still requires consent from witnesses, a position at odds with federal guidance, the practice in most other states and a plain reading of state law. As a result of the investigation by this office, the department's long-standing misinterpretation of consent requirements is apparently under further review.

A small number of states, including Washington and Wisconsin, have passed laws to protect the identity of witnesses. Others deal with the question of witness confidentiality case-by-case, said Smetanka of the national ombudsman resource center. They may protect witnesses' names if they ask for confidentiality, or if disclosing them would jeopardize the safety of the resident. But California seems to be alone in adhering to a policy of always requiring witness consent, absent a state law to that effect. In addition, the state has no clear protocol for when witness names should be protected.

Sue Wheaton, ombudsman specialist at the federal Administration on Aging, said that the federal law does not give the accused or other witnesses the right to demand confidentiality. This office found no support for California's interpretation among any of the experts interviewed for this report.

The state's interpretation relies on Section 9725 of the state Welfare & Institutions Code. The statute says that ombudsman records, including the identity of witnesses, must remain confidential unless the resident gives consent. However, the statute does not say that witnesses themselves must give consent. The state office's interpretation also ignores an exception listed in section 9725 for release of records to "a law enforcement agency, public protective service agency, licensing or certification agency" in a manner consistent with federal laws and regulations. Rodrigues' office does not release witness identities even to these agencies. "We try and play it very conservatively," he said.

In most other states, this conservative approach might not pose a major hindrance to ombudsmen, who are not charged with getting and investigating mandated reports. But California ombudsmen do have that responsibility, and they say the state's narrow approach makes it even harder to balance conflicting demands. It also allows witnesses to limit the release of information that victims themselves want to be made public.

### **Interpretation caused dissent**

The state office's policy has caused dissent among some local coordinators and advocates.

"It's a huge conflict," said Karen Stenson, the executive director of Long-term Care Ombudsman of San Luis Obispo County. "The state office says we don't cross report. We don't give anything to anyone at all."

Mike Connors, an advocate for California Advocates for Nursing Home Reform, said the state's policy sends the message to local programs that they are not supposed to report. That runs counter to federal law, he said, which intended ombudsmen to alert outside agencies when abuse has occurred. "None of it makes any sense to us," he said.

Police and licensing agencies may still get redacted reports, he said, but they're less likely to act with gaps in the information. "Handicapping them at all is not a good idea...," he said. "When you're reporting things to them, you want to make it as easy as possible."

Other state officials also question the state ombudsman's interpretation. "I think it's a spin that's gone a little too far," said Mark Zahner, chief of prosecutions for the Attorney General's Bureau of Medi-Cal Fraud and Elder Abuse. In a recent memorandum of understanding with Zahner's bureau, the state ombudsman agreed to at least ask all parties for consent, and forward redacted complaints if they don't get it. But "it's very frustrating" not to know more detail, Zahner said.

*The department does still require consent from witnesses, a position at odds with federal guidance, the practice in most other states, and a plain reading of the state law.*

The state ombudsman's office has never put its interpretation into regulations, despite a requirement to do so in the Welfare & Institutions Code. It has issued few policy directives to local programs. The California State Plan on Aging, a four-year plan issued in 2005, declared that a "key action" for the ombudsman would be to promulgate regulations. Four years later, that has not happened. State ombudsman Rodrigues said there seems to be little point clarifying procedures through regulations when the laws themselves are so confusing and contradictory. Also, the department lost its only regulations writer. The department did try more than a decade ago to write regulations, but they were found to be deficient by the Office of Administrative Law, and "the fixes were never done," Rodrigues said.

Likewise, a program guide that advised local programs has not been updated since the 1990s, also because of short staffing, he said. "There is a need for additional clarification," Rodrigues said.

Smetanka, executive director of the national ombudsman resource center, said that California's lack of regulations or other guidance makes it hard to get local programs to be consistent. Indeed, local coordinators around the state contacted by this office had much different understandings of the state's policy for getting consent. The coordinators were interviewed before the state's recent reversal on the need to get consent from alleged perpetrators.

### **Locals confused by state rules**

One coordinator said that she believes the program is allowed to forward a standard mandated reporter form called an SOC 341 to other agencies without getting permission from witnesses, but that a written referral from her office requires witness consent. Another coordinator said that she has to get witness consent to forward the SOC 341.

One said that if she talked to the alleged perpetrator, then that person was a witness and would have to give consent. If a third party gave her the name of the perpetrator, however, she believes she can use it without consent. But if she wanted to forward the

SOC 341 with names included, she would have to get consent from all parties. Another said that she needed witness and perpetrator consent to release documents, but if she was making a referral to a state licensing or law enforcement agency, the only consent she needed was from the resident.

Still another was unaware of the state's policy on witnesses and the perpetrator, and was aghast when it was described to her. "That would tie us up," she said.

Some local programs choose to ignore the state's direction when they feel a pressing need to report. Parks, the administrator of Ombudsman and HICAP Services of Northern California, did not agree with the state's earlier interpretation that federal law required the perpetrator's name to be redacted from the SOC 341. So she included it. Nadell, the San Francisco program manager, tries to work around the prohibitions by, for instance, telling a mandated reporter to also call the police. But in those few cases where he can't, he'll call the licensing agencies anyway. If you're dealing with a woman with pressure sores who can't communicate because of strokes, he asked, "What are you going to do?"

Rodrigues said he would consider such practices "troubling" if they came to his attention, and would be forced to take action to rein them in.

Other local ombudsmen don't follow the state edicts because they are unaware of them. The state ombudsman's monitoring reports of local programs over the past five years found that almost half – 10 of 23 – did not follow proper consent procedures.

"On review of case files, consent to report to (licensing agencies) or other agencies was not documented," according to a June 2008 review of the program in Area 1 Agency on Aging, which includes Eureka. "A discussion between the State Analyst and Ombudsman staff confirmed that cross-reporting was often done prior to receiving consent from the resident or their legal representative." Sometimes, even when staff members were aware of consent requirements, the system breaks down with

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the volunteers. In a 2006 review of San Joaquin County's program, the coordinator "described the correct method for obtaining medical or personal records," the state analyst found. "However, upon review of program case files, proper protocols for obtaining records were not being followed by Ombudsman representatives."

### **Ombudsmen look for ways to sidestep consent rule**

Most local coordinators said that they have found ways to get around the various restrictions. Some simply tell the person who comes to them with an abuse or neglect report, whether a mandated reporter or a resident's family member, to also go to local law enforcement. Stenson, the San Luis Obispo coordinator, asks local police to meet her at the facility where she's conducting an investigation, taking advantage of a provision in the law that allows ombudsman to ask for help. Once the police are there, she said, they generally figure out on their own what's going on without her telling them.

Another common strategy, if a resident is unwilling to give consent, is for ombudsmen to ask other residents if they have been having the same problem. In San Diego, program manager Sharon Cordice might try to determine if bedsores are common in a certain facility's wing or if a Certified Nursing Assistant is known for verbally abusing the residents. A group complaint doesn't have to name any of the individuals, thereby sidestepping the need for consent.

In some cases, though, the ombudsmen may not be hearing about the abuse at all. Many facilities tell mandated reporters that they must go to their superiors with abuse complaints, said Peggy Osborn, program manager of the Elder and Dependent Adult Abuse Prevention Program in the Attorney General's Office. The facility then is likely to forward the complaint to a state licensing agency, as required by law. But the mandated reporter may never fulfill the personal obligation to make a report to an ombudsman or the police. The licensing agency's investigation may take more than a year, Osborn said. She cautioned that any changes to the ombudsman program's responsibilities should take into account that they are in long-term care facilities more often than any other outside agency. When they do get consent from residents, she said, ombudsmen investigate promptly.

Adding to confusion over consent is the lack of clear guidelines on when ombudsmen can waive the need to get resident permission because the situation poses an immediate danger. Federal officials acknowledge that ombudsmen are likely to encounter such cases. In 1993, the federal Administration on Aging convened a symposium of ombudsmen, adult protective services officials and experts on elder abuse law. The symposium agreed that, even absent consent, ombudsmen should alert outside agencies if "failure to report may result in imminent, extreme, or life threatening harm to a resident or third party."

The federal government never officially adopted regulations that came out of the symposium. But Wheaton told this office that the symposium's recommendations still represent the federal government's "best thinking."

State ombudsman Rodrigues said that he believes ombudsmen should figure out ways to report if it's urgent. "Common sense has got to prevail at some point," he said. But this would not include suspending the need for resident consent, he said.

## **California’s state ombudsman lacks sufficient independence to fulfill federal mandates**

One of the original intents of the federal legislation was for ombudsmen to advocate publicly for system-wide changes to improve life for residents of long-term care facilities. This might include speaking on legislation, talking to the media, or otherwise taking public stances on issues affecting long-term care residents. But in California, some local coordinators say the state office and local programs have a hard time meeting this mandate because the state ombudsman is a political appointee, constrained by the state bureaucracy from being fully candid.

As part of the administration, they say, the state ombudsman lacks the independence to take stands that might contradict or get out in front of the governor on legislation or budget cuts. This filters down to the local programs. Susan Osborn, former regional manager for the ombudsman program in the San Gabriel Valley, said her hands were tied in alerting the public to problem facilities. “We’re not allowed to say anything or speak to the press,” she said.

The state office cannot weigh in on important proposed federal legislation like the Elder Justice Act, which Congress has considered repeatedly in the past decade, said Wilson of the Northern California ombudsman program. For example, when the Legislature considered AB 2100, which requires ombudsmen to forward reports to district attorneys, Rodrigues claims he was unable to appear before a committee to discuss the bill because the governor’s office had not taken a position on it. Rodrigues’ testimony might have avoided confusion over the law’s effect.

Some local coordinators say they plan to push for an independent ombudsman not appointed by the governor.

*In eight states, the ombudsman's office is not part of government at all, operated instead by non-profits or legal assistance organizations.*

By statute, the state ombudsman is appointed by the director of the Department of Aging. As a practical matter, though, the appointment comes through the governor's office, Rodrigues said. Further compromising his independence, Rodrigues is exempt from civil service and can be dismissed without cause or notice.

Only Kansas, Pennsylvania, New Jersey and a handful of other states have state ombudsmen appointed by the governor, according to Smetanka from the national resource center.

In eight states, the ombudsman's office is not part of government at all, operated instead by non-profits or legal assistance organizations. Several more are independent agencies outside the state's department of aging.

Smetanka said other states have struggled to establish the independence of the ombudsman's office. As long ago as 1995, an influential Institute of Medicine study recommended that all the states consider making the ombudsman an independent office or a separate entity such as a non-profit.

As important as the organization chart, Smetanka said, is the culture within the government office where the state ombudsman is located. In Kansas, for instance, even though the ombudsman is appointed by the governor, officials have recognized that the federal intent was that the ombudsman be an advocate for the program and for long-term care residents. As a result, the state ombudsman is able to testify at hearings, talk to the media and comment on legislation.

## Recommendations

The Senate Office of Oversight and Outcomes suggests that the Legislature consider the following measures:

- Revise the state’s mandated reporter law to make it consistent with federal law and other state law, taking into account the necessity of obtaining consent from long-term care residents.
- Transfer the responsibility of receiving mandated reports and investigating abuse to another entity, such as state licensing units or local Adult Protective Services not bound by the Older Americans Act, while also requiring that the ombudsman program continues to be informed of mandated reports.
- Require mandated reporters to go to ombudsmen AND local law enforcement, instead of being able to choose between the two. Alternately, the reports could go to ombudsmen and some other agency, such as state licensing offices.
- Prohibit ombudsman volunteers from conducting investigations or require ombudsmen who conduct investigations to get more training.
- Instruct the ombudsman program to seek consent for any future abuse investigations at the time a resident is admitted to a long-term care facility.
- Set a deadline for the state ombudsman to promulgate regulations and other policy directives to clarify the state’s legal interpretation of consent laws and make sure local programs follow uniform procedures.
- Require the ombudsman program to collect data on the cost to the program of fulfilling its role in the mandated reporting law, including figures such as the cost and labor requirements per case.
- Give the ombudsman program the necessary resources to perform investigations as well as its many other duties under federal and state law.
- Pass legislation to enhance the ability of the ombudsman to act as an independent voice for the elderly, as required under the Older Americans Act, and require the state ombudsman’s office to develop a comprehensive plan of advocacy.
- Require long-term care facilities to inform mandated reporters who come to them with reports that they are obligated by law to also report to ombudsmen and/or police.
- Require the state ombudsman’s office to develop a detailed protocol for reporting elder abuse even without resident consent if the situation poses an imminent threat to long-term care residents or others.

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