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## **Elder Abuse Detection in Nursing Facilities: Using Paid Clinical Competence to Address the Nation's Shame**

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# Elder Abuse Detection in Nursing Facilities: Using Paid Clinical Competence to Address the Nation's Shame

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**ABSTRACT:** Each year, five million senior citizens are the victims of abuse in our country—and that figure is a likely underestimate. In California alone, it is estimated that over 225,000 seniors are abused annually. Nursing home residents are particularly vulnerable to abuse, with one-fifth to one-third of these institutions cited for abusive activities that result in actual harm. Regular violations of minimum care regulations by nursing homes have been documented in every state. Despite legal protections, as a practical matter, the review, assessment, and investigation of nursing home care and potential senior abuse is the primary responsibility of voluntary ombudsmen. These volunteers are responsible for regular visits and determination of nursing home quality and resident treatment. This Article contends that, despite their commitment to the cause, voluntary ombudsmen are not a sufficient cure for the scourge of elder abuse. Rather, clinically-trained personnel with legal knowledge must assume the role that lay volunteer ombudsmen are inappropriately expected to play. Use of clinical case managers, who have expertise in assessing clinical factors and can be trained in legal matters, offers significant potential to assist in the detection, and, further, reporting and prosecution of elder abuse. The author concludes that only through use of those with

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appropriate training and knowledge can the epidemic of elder abuse be effectively addressed.

The long-term care ombudsman program is a formal means for community involvement in overseeing nursing homes and long term care facilities. Created in response to concerns about the quality of nursing home care, the Older Americans Act and its amendments require that states establish long-term care ombudsman programs to protect elderly nursing home residents.<sup>1</sup>

Yet, there are clear weaknesses associated with current reliance on voluntary ombudsmen. Such limitations result in low abuse detection and, therefore, minimal reporting and prosecution. Indeed, it has been stated in law enforcement forums that many who are responsible for investigating elder abuse have limited or no training or knowledge of appropriate methods.<sup>2</sup> Nonetheless, although these observations are instructive, there have been no proposals that provide concrete policy solutions to address the problem of under-detection and under-reporting of abused seniors.<sup>3</sup> Specifically, the weak current infrastructure, which relies virtually entirely upon lay voluntary ombudsmen, has been entirely ignored.

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There have been some efforts on the federal level to address the social scourge of elder abuse. The Elder Justice Act has been introduced in the 109th Congress.<sup>4</sup> This bill, now present in its third Congress, is an effort to bring elder abuse to similar levels of effort and attention as the national fight against other abusive situations such as domestic violence and child abuse. Yet, even this comprehensive and laudable attempt does not address the issue of depending upon untrained, nonclinical personnel to detect whether a senior has been abused in a nursing home.

<sup>1</sup> 42 U.S.C. § 3058g(a)(1)(A)–(B) (2006).

<sup>2</sup> U.S. GEN. ACCT. OFFICE (GAO), GAO-02-312, NURSING HOMES: MORE CAN BE DONE TO PROTECT RESIDENTS FROM ABUSE 10-13, 29 (2002), available at [www.gao.gov/new.items/d02312.pdf](http://www.gao.gov/new.items/d02312.pdf) (last visited Sept. 24, 2006).

<sup>3</sup> Regrettably, there is a lack of research on elder abuse. See generally NAT'L RESEARCH COUNCIL, ELDER MISTREATMENT: ABUSE, NEGLECT, AND EXPLOITATION IN AN AGING AMERICA (Richard J. Bonnie & Robert B. Wallace, eds., 2003) [hereinafter ELDER MISTREATMENT].

<sup>4</sup> Elder Justice Act, S. 2010, 109th Cong. (2005); NAT'L COMM. FOR THE PREVENTION OF ELDER ABUSE, 2005 WHITE HOUSE CONFERENCE ON AGING, POST-EVENT SUMMARY REPORT (2005) [hereinafter WHITE HOUSE CONFERENCE], available at <http://tinyurl.com/yz4uxb> (last visited Oct. 27, 2006).

This Article attempts to integrate important interdisciplinary efforts to create appropriate infrastructures to detect, and, hopefully, address the problem of elder abuse. Part I reviews the problem and assesses the epidemiology of elder abuse in the institutional setting, and finds that there is a significant and hidden problem of senior abuse in nursing homes. Part II reviews the literature on the voluntary ombudsman programs, and shows that the current system of relying on lay ombudsmen is inadequate to detect the problems of elder abuse in the nursing home community. It is unfair to ask an individual with no clinical knowledge or experience to recognize and detect the clinical clues indicative of elder abuse. In Part III, the implications of the literature are discussed, including the need to reevaluate the policy reliance on volunteers to ferret out abuse in nursing facilities. Part IV then outlines the benefit of using clinical case managers in detecting and addressing associated patient needs because of abuse. Clinical case managers are particularly apposite because of their clinical knowledge, as well as their social services skill set. Further, with legal training, they may support law enforcement through reporting and assisting in potential elder abuse investigations. In Part VI, the Article provides some policy considerations to address the weaknesses identified through this analysis. The piece concludes in Part VII.

## I. Elder Abuse in the Institutional Setting

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### A. Institutional Residents

Nationally about 1% of persons aged 65 to 74 years old, 6% of persons aged 75 to 84 years old, and 24% of those 85 and older reside in nursing homes.<sup>5</sup> Thus, the number of nursing home residents will increase as the population continues to age.<sup>6</sup> A large number of the elderly reside in nursing homes operated by for-profit corporations.<sup>7</sup> Overall, it is estimated that more than 1.7 million Americans reside in nursing homes<sup>8</sup> and that some 43% of those age 65 or older will, at some point in their lives, utilize a nursing home.<sup>9</sup>

It is clear that seniors in nursing facilities are susceptible to abuse. As noted by one commentator, "Residents in nursing homes are

<sup>5</sup> Christine V. Williams, *The Nursing Home Dilemma in America Today: The Suffering Must be Recognized and Eradicated*, 41 SANTA CLARA L. REV. 867, 871-72 (2002).

<sup>6</sup> *Id.* at 872.

<sup>7</sup> Seymour Moskowitz, *Golden Age in the Golden State: Contemporary Legal Developments in Elder Abuse and Neglect*, 36 LOY. L.A. L. REV. 589, 593 (2003). A for-profit corporate status creates at least the potential for focusing on reducing costs and profit-maximizing behavior. In such a setting, it is ever more important to have rigorous and robust attention to how nursing home residents are treated.

<sup>8</sup> *Id.* at 623.

<sup>9</sup> SafeState, Preventing Crime & Violence in California, Elder and Dependent Adult Abuse, at <http://safestate.org/index.cfm?navId=11> (last visited Sept. 21, 2006).

a highly vulnerable population, often with multiple physical and cognitive impairments."<sup>10</sup> Further, due to their high level of disability and multiple chronic conditions, residents generally require extensive assistance with their care needs.<sup>11</sup>

As a formal legal matter, the quality of the care in nursing homes is the subject of extensive state and federal regulation and enforcement, as well as private civil litigation. However, the effectiveness of administrative enforcement has been questioned.<sup>12</sup> Regulations, customarily enforced by state agencies, are aimed at improving the quality of care rendered at nursing homes,<sup>13</sup> but written government standards by themselves clearly do not guarantee nursing home residents adequate service and care.<sup>14</sup> Without appropriate protection, many nursing home patients are susceptible to abuse in these settings.<sup>15</sup>

### ***B. Abusers and Injuries***

Although abuse allegations are usually made against nurse aides who directly care for residents, any person, including nurses, physicians, and other providers entering or working in the nursing facility or institution, can commit abuse.<sup>16</sup> Abuse often involves

<sup>10</sup> Moskowitz, *supra* note 7, at 594. As explained by another commentator, even the typical nursing home resident is in a vulnerable position:

[N]ursing homes . . . 'provide nursing care to sick, invalid, infirm, disabled or convalescent persons in addition to lodging and board or health care service[s]' . . . . These facilities provide patients with long-term treatment and care in a home setting. Nursing home patients are usually elderly and depend on others for their care and well-being; they often require assistance carrying out basic tasks such as dressing, bathing, and toileting. . . . Nursing home patients also require continuing medical care, which doctors and nurses provide.

Daniel N. Gitner, *Nursing the Problem: Responding to Patient Abuse in New York State*, 28 COLUM. J.L. & SOC. PROBS. 559, 564 (1995) (quoting N. Y. PUB. HEALTH LAW § 2801(2) (McKinney 1988)).

<sup>11</sup> Moskowitz, *supra* note 7, at 594.

<sup>12</sup> *Id.*

<sup>13</sup> See Gitner, *supra* note 10, at 565. While his article focuses on New York State's legal responses to regulation of abuse against nursing home patients, Gitner notes that the issues discussed apply generally to occurrences of patient abuse. *Id.* at 561.

<sup>14</sup> *Id.* at 565.

<sup>15</sup> *Id.* It should be noted that abuse is not just physical; financial abuse, isolation, and inappropriate use of restraints also represent abusive circumstances faced by the senior population.

<sup>16</sup> *Id.* at 566–67 (quoting N.Y. PUB. HEALTH LAW § 2803d (McKinney 1993)).

acts resulting in pain or injury to the resident<sup>17</sup> and can involve “forcible acts, such as grabbing, striking, or slapping an elderly patient, or neglecting to care for patients.”<sup>18</sup>

Allegations of abuse usually fall into certain categories. These include “(1) deaths of patients under suspicious circumstances or circumstances indicating deficient care; (2) assaults, including sexual abuse; (3) rough treatment; (4) unexplained physical injuries; (5) facility conditions or staff neglect that endangers patients’ health and safety; and (6) reckless treatment of patients.”<sup>19</sup>

### *C. Factors Associated with Abuse*

A number of factors contribute to abuse in the nursing home setting.<sup>20</sup> For example, these facilities “are often under-financed, resulting in under-staffing, low wages, high turnover rates, and a general lack of resources. Poor-quality working conditions can precipitate stress and frustration among staff, which may result in the abuse of care-dependent persons.”<sup>21</sup> Importantly, many nursing home workers are unprepared to address the specialized needs of institutionalized seniors. Even good faith workers “are often inadequately trained to deal with the physical, emotional, and psychological aspects of caring for the elderly. Inadequate training may result in abuse as an improper response to a stressful or confrontational situation.”<sup>22</sup>

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Worse yet, repeat abusers can work in these facilities because of insufficient personnel background checks. For example, although each state is required to maintain a nurse aide registry, including information regarding the previous acts of abuse committed by aides, there is no searchable national registry or database housing such information.<sup>23</sup> Consequently, aides who have abused patients as an employee in one state can often find similar work in another state without their abusive acts being detected.<sup>24</sup> Unlike the federal regulation that requires hospitals to perform background checks of healthcare providers,<sup>25</sup> there is no such requirement for staff hired at nursing facilities.

<sup>17</sup> Gitner, *supra* note 10, at 561.

<sup>18</sup> *Id.*

<sup>19</sup> *Id.* (footnotes omitted).

<sup>20</sup> *Id.* at 567.

<sup>21</sup> *Id.* (footnote omitted).

<sup>22</sup> Gitner, *supra* note 10, at 567 (footnote omitted).

<sup>23</sup> *Id.* at 568.

<sup>24</sup> *Id.* Note that some states may have criminal checks, but this requirement is not uniform.

<sup>25</sup> See HEALTH RES. & SERV. ADMIN., DEP’T OF HEALTH & HUMAN SERVS. (HHS), NATIONAL PRACTITIONER DATA BANK GUIDEBOOK D-1 (2001), available at [www.npdb-hipdb](http://www.npdb-hipdb).

Finally, the treatment of the elderly by our society, the condition of residents, and the culture within the nursing home makes elder abuse detection difficult. Nursing home patients generally receive few visitors, are isolated from society, and may lack the physical and mental capacity to complain.<sup>26</sup> Patients in nursing care facilities and their families may also be reluctant to report abuse for fear of retaliation by staff members, and residents may not be mentally alert enough to report or provide an accurate account of events.<sup>27</sup> Although a willful failure to report patient abuse is usually prohibited by state law, nursing home employees are, in practice, often hesitant to report their colleagues for committing abuse.<sup>28</sup>

### III. The Evidence: Ombudsman Program Assessment

#### A. The Ombudsman Role

Ombudsmen are expected to resolve resident complaints, visit facilities regularly, provide information and referrals about facilities and their quality, and promote and represent residents' needs and interests.<sup>29</sup> The latter role includes detecting and reporting elder abuse.

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Ombudsmen are critical in the detection and reporting of elder abuse. This is due to a wide variety of factors, but in particular because of the scarcity of reports that come from the healthcare community (estimated at two percent or less),<sup>30</sup> the inability of

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com/pubs/gb/NPDB\_Guidebook.pdf (last visited Sept. 21, 2006) (Hospitals must request information from the National Practitioner Data Bank (1) when new healthcare professionals apply for staff appointment or medical privileges, and (2) every two years for all healthcare providers who are on the medical staff or have clinical privileges.).

<sup>26</sup> Gitner, *supra* note 10, at 568–69.

<sup>27</sup> *Id.* at 569.

<sup>28</sup> *Id.* at 569–70.

<sup>29</sup> See OFFICE OF INSPECTOR GEN. (OIG), HHS, OEI-09-02-00160, STATE OMBUDSMAN DATA: NURSING HOME COMPLAINTS 4 (2003) [hereinafter OMBUDSMAN DATA], available at <http://oig.hhs.gov/oei/reports/oei-09-02-00160.pdf> (last visited Sept. 21, 2006).

<sup>30</sup> See, e.g., R. M. Kruger & C. H. Moon, *Can you spot signs of elder abuse?*, 106(2) POSTGRAD. MED. 169 (1999), available at: [http://www.postgradmed.com/issues/1999/08\\_99/kruger.htm](http://www.postgradmed.com/issues/1999/08_99/kruger.htm) (last visited Nov. 14, 2006) (“The nature of the physician-patient relationship gives physicians a unique opportunity to detect elder mistreatment, yet physicians report only 2% of cases.”).

the lay public to recognize abuse,<sup>31</sup> and the presence of dementia patients in long-term care facilities who cannot articulate the abusive activities of staff for themselves or who are ignored when they attempt to notify caregivers.<sup>32</sup> But because of the severely limited number of paid state and local ombudsmen, it is voluntary ombudsmen that are the primary infrastructural component that detects and reports elder abuse. Such reliance is virtually nationwide; voluntary ombudsman programs are currently established in forty-five states.<sup>33</sup>

Supporting these efforts, under the Older Americans Act and its 1978 and 1987 Amendments, voluntary ombudsmen are empowered to advocate for individual long-term care residents through, for example, visits to facilities without previous announcement.<sup>34</sup> Further, beyond detection and reporting, ombudsmen are also responsible in three-quarters of the states with voluntary ombudsman programs for investigating potential elder abuse occurrences that may be taking place within long-term care facilities.<sup>35</sup>

These laws and roles for voluntary ombudsmen are, unfortunately, a virtually unbounded necessity in this country. Elder abuse in the United States is legion.<sup>36</sup> From 500,000 to five million seniors are estimated to be abused each year physically, emotionally, financially, through neglect, or through abandonment.<sup>37</sup> Indeed, between one

<sup>31</sup> STATE OF MICHIGAN, GOVERNOR'S TASK FORCE ON ELDER ABUSE, DRAFT RECOMMENDATIONS 3 (revised Apr. 27, 2006) ("The most significant factors influencing the rate of abuse . . . [include] the lack of: awareness of what constitutes abuse . . . ."), available at <http://www.miseniors.net/NR/rdonlyres/0E5BFE7E-BD49-4088-BF87-82A36BD83E11/0/ElderAbuseTFRecomm.pdf> (last visited Nov. 14, 2006).

<sup>32</sup> See NATIONAL RESEARCH COUNCIL, ELDER MISTREATMENT: ABUSE, NEGLECT, AND EXPLOITATION IN AN AGING AMERICA 109 (Richard J. Bonnie & Robert B. Wallace, eds. 2002) ("Several of the current tools depend on accurate responses from the possible victim, who may be unable to give reliable answers due to dementia, fear, or other cognitive or emotional factors."); *id.* at 114 ("Further complicating screening and case identification of elder mistreatment is the problem of cognitive impairment. Depending on the degree of impairment, different methods may be employed to elicit needed information. Some with mild impairment may be able to give a reasonably accurate history of neglect or abuse, but those with moderate or severe dementia may not be able to do . . . .").

<sup>33</sup> GAIL McINNES & ALICE H. HEDT, NAT'L LONG TERM CARE OMBUDSMAN CTR., VOLUNTEERS IN THE LONG TERM CARE OMBUDSMAN PROGRAM: TRAINING, CERTIFICATION AND LIABILITY COVERAGE 2 (1999), available at <http://teampublish.allsoldout.net/teampubv3/includes/Volunteers.pdf> (last visited Sept. 24, 2006).

<sup>34</sup> See 42 U.S.C. § 3058g(a)(5)(A)–(B) (2000).

<sup>35</sup> *Id.* § 3058g(c)(1)–(2); see McINNES & HEDT, *supra* note 33, at 2.

<sup>36</sup> See generally ELDER MISTREATMENT, *supra* note 3.

<sup>37</sup> John B. Breaux & Orin G. Hatch, *Confronting Elder Abuse, Neglect, and Exploitation: The Need for Elder Justice Legislation*, 11 ELDER L.J. 207, 208 (2003).

and two million Americans aged 65 or older have been abused or exploited by their caregivers.<sup>38</sup> Yet, even this shockingly high number is likely a severe underestimate. It has been noted that roughly 84% of elder abuse cases are never reported in any manner,<sup>39</sup> and only 16% of suspected abuse cases are actually communicated to the appropriate agencies for action.<sup>40</sup> Underestimates may also be a result of ombudsmen using enumerated categories inconsistently when reporting nursing home issues.<sup>41</sup>

Thus, given the high number and probable underestimate of elder abuse,<sup>42</sup> the first line of defense against it—voluntary ombudsman programs—should be assessed. Because of the ramifications of such abuse are broad, including a greater than 300% increased risk for premature death of the victim,<sup>43</sup> investigating the detection, report, investigation, and prosecution of abuse by voluntary ombudsmen is a pressing concern to protect the health and safety of the institutionalized elderly.

### *B. Ombudsman Perceptions of Effectiveness*

C.L. Estes and colleagues, in one of the most extensive reviews of the ombudsman infrastructure, have reviewed state long-term care ombudsman programs nationally.<sup>44</sup> In their study, using a semi-structured interview methodology, they assessed self-rated effectiveness as reported by state ombudsman leaders.<sup>45</sup> They found that most state ombudsmen reported that their programs meet statutorily mandated requirements, but with varying effectiveness.<sup>46</sup> Positive factors associated with perceived effectiveness included program funding, number of paid staff, and volunteer staffing levels.<sup>47</sup>

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<sup>38</sup> See ELDER MISTREATMENT, *supra* note 3, at 9; T. Fulmer, et al., *Elder Abuse and Neglect: Policy Issues for Two Very Different Problems*, 12 PUB. POL'Y & AGING REP. 15 (2002).

<sup>39</sup> NAT'L CTR. ON ELDER ABUSE, THE ELDER ABUSE INCIDENCE STUDY 5-1 (1998), available at [www.aoa.gov/eldfam/Elder\\_Rights/Elder\\_Abuse/AbuseReport\\_Full.pdf](http://www.aoa.gov/eldfam/Elder_Rights/Elder_Abuse/AbuseReport_Full.pdf) (last visited Sept. 16, 2006).

<sup>40</sup> *Id.*

<sup>41</sup> OMBUDSMAN DATA, *supra* note 29, at 2.

<sup>42</sup> For example, in California, the estimate that over 225,000 seniors are abused each year is likely too low. SafeState, *supra* note 9.

<sup>43</sup> Mark S. Lachs et al., *The Mortality of Elder Mistreatment*, 280 JAMA 428, 430–31 (1998).

<sup>44</sup> Carroll L. Estes et al., *State Long Term Care Ombudsman Programs: Factors Associated with Perceived Effectiveness*, 44 GERONTOLOGIST 104, 106–07 (2004).

<sup>45</sup> *Id.* at 106.

<sup>46</sup> *Id.* at 107–08.

<sup>47</sup> *Id.* at 111, 113.

In another large study, with this assessment focusing exclusively on volunteer ombudsman, S.K. Ostwald and colleagues investigated the Texas volunteer long-term care ombudsman program.<sup>48</sup> They assessed volunteer ombudsmen's self-reported satisfaction, as well as issues affecting that satisfaction.<sup>49</sup> Using a mail-in survey methodology, they found that volunteer ombudsmen felt most effective in advocating for residents' rights and welfare, but least effective in dealing with financial exploitation or abuse and clinical issues such as adequacy of nutrition and hydration.<sup>50</sup> Perceived effectiveness was reported to be directly related to support from state and regional personnel, and, importantly, support from the long-term care facility nursing staff.<sup>51</sup>

In a related study, P.M. Keith also assessed perceived self-effectiveness characteristics of volunteer ombudsmen.<sup>52</sup> Using a questionnaire methodology surveying active volunteer ombudsmen, this study found that key factors associated with perceived effectiveness were related to support from facility personnel.<sup>53</sup> In this study, the key personnel identified were administrators of the long-term care facilities.<sup>54</sup> Keith's work is consistent with older studies that have also reported voluntary ombudsmen believe their effectiveness is related to the cooperation and attitudes of nursing home staff.<sup>55</sup>

Finally, effectiveness, defined as the occurrence of investigations and sanctions of long-term care facilities in relation to the presence of voluntary ombudsmen, has also been studied.<sup>56</sup> A direct, albeit older, study of investigations and sanctions of abuse in nursing homes found a relationship between the presence of voluntary ombudsmen and the number of investigations and sanctions.<sup>57</sup> This relationship is particularly observable after the 1987 Older Americans Act amendments that empowered these volunteers.<sup>58</sup>

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<sup>48</sup> Sharon K. Ostwald et al., *Texas Certified Volunteer Long-Term Care Ombudsmen: Perspectives of Role and Effectiveness*, 4 J. AM. MED. DIR. ASS'N. 323, 324 (2003).

<sup>49</sup> *Id.*

<sup>50</sup> *See id.* at 324–25.

<sup>51</sup> *See id.* at 325.

<sup>52</sup> Pat M. Keith, *Support from Others and Efficacy of Volunteer Ombudsman in Long-Term Care Facilities*, 52 INT'L J. AGING & HUM. DEV. 297, 297 (2001).

<sup>53</sup> *See id.* at 300, 306.

<sup>54</sup> *See id.* at 306.

<sup>55</sup> See Howard Litwin & Abraham Monk, *Volunteer Ombudsman Burnout in Long Term Care Services: Some Cause and Solutions*, 8 ADMIN. SOC. WORK 99, 102–3 & tbl.1 (1984).

<sup>56</sup> H. Wayne Nelson et al., *The Relationship Between Volunteer Long-Term Care Ombudsmen and Regulatory Nursing Home Actions*, 35 GERONTOLOGIST 509, 509 (1995).

<sup>57</sup> *Id.* at 512–13.

<sup>58</sup> *Id.* at 514.

H.W. Nelson, et al., found that the presence of voluntary ombudsmen was related to an increase in abuse reporting.<sup>59</sup> R.L. Cherry similarly found that the presence of ombudsmen in intermediate care facilities<sup>60</sup> and skilled nursing facilities<sup>61</sup> was related to better nursing care, although the study did not relate its findings to elder abuse detection or reporting.

### C. *The Institute of Medicine Report*

The Institute of Medicine (IOM) investigated long-term care ombudsmen programs shortly after the 1987 Older Americans Act amendments.<sup>62</sup> After a thorough review of many aspects of state level programs focusing on information from site visits, interviews, testimony, and commissioned papers, several relevant characteristics of these ombudsman programs became apparent.<sup>63</sup>

Inadequate funding of the ombudsman programs was found to be a significant issue.<sup>64</sup> Resource constraints prevented many residents of long-term care facilities in need of assistance from having meaningful access to ombudsman services, including volunteer ombudsmen.<sup>65</sup> Further, although it is strongly believed to be true, the IOM also noted there was very little evidence that causally connects ombudsman activities to positive outcomes for the elderly.<sup>66</sup>

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An interesting finding of the IOM Report was that ombudsman programs suffered from conflict of interest issues.<sup>67</sup> This situation was related to state offices located in political subdivisions that may not allow substantive advocacy for the senior population, nor criticism of government programs, due to the location of the state ombudsman program within the government infrastructure.<sup>68</sup> Such a situation may have created barriers to improvement in those programs, which may have impacted service delivery to the institutionalized senior.

<sup>59</sup> *Id.*

<sup>60</sup> Ralph L. Cherry, *Community Presence and Nursing Home Quality of Care: The Ombudsman as a Complementary Role*, 34 J. HEALTH & SOC. BEHAV. 336, 343 (1993).

<sup>61</sup> Ralph L. Cherry, *Agents of Nursing Home Quality of Care: Ombudsmen and Staff Ratios Revisited*, 31 GERONTOLOGIST 302, 308 (1991).

<sup>62</sup> INST. OF MED. (IOM), REAL PEOPLE, REAL PROBLEMS: AN EVALUATION OF THE LONG TERM CARE OMBUDSMAN PROGRAMS OF THE OLDER AMERICANS ACT 2 (1995).

<sup>63</sup> *Id.* at 2–3.

<sup>64</sup> *Id.* at 17, 147.

<sup>65</sup> *Id.* at 17, 150.

<sup>66</sup> *See id.* at 139–41.

<sup>67</sup> *See IOM, supra* note 62, at 101–26.

<sup>68</sup> *Id.* at 123, 134, 149.

The IOM Report specifically assessed volunteer ombudsmen in operational activities. They found that using volunteer ombudsmen carried significant costs.<sup>69</sup> State ombudsman programs and offices, as well as regional branches, must spend a great deal of time recruiting, training, and supervising volunteer ombudsman.<sup>70</sup> Due to the volunteer nature of the staff, the programs must also allocate continuous resources to maintain recruitment and retention efforts.<sup>71</sup> These efforts may have taken away means for evaluation and program improvement.

The IOM further reported that most of the problems with perceived poor-quality ombudsman programs have been centered on issues of selection, training, and supervision of ombudsmen—in particular, volunteers.<sup>72</sup> Ombudsman programs were also reported to lack volunteers with appropriate skills to perform effectively in the field. For example, the lack of local ombudsmen speaking languages other than English was considered a serious hindrance to effective performance.<sup>73</sup> One area of concern was specifically noted: ombudsman programs had a paucity of voluntary staff with experience in nursing and long-term care or with knowledge of health issues or the law.<sup>74</sup> Lack of volunteers with this clinical and/or legal knowledge hampered the ability of programs to advocate for their long-term care residents.<sup>75</sup>

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Moreover, the IOM Report noted that long-term care facilities were insufficiently covered because of the low numbers of volunteers.<sup>76</sup> This deficiency translated into inadequate response times to complaints and a general inability to conduct thorough investigations.<sup>77</sup> Staff turnover was also identified as a concern for local programs “owing to age and to role misunderstandings.”<sup>78</sup> The IOM indicated that the high turnover rates were also potentially due to lack of adequate training and/or the resources to provide that training in these programs.<sup>79</sup>

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<sup>69</sup> See *id.* at 185–204.

<sup>70</sup> *Id.* at 146.

<sup>71</sup> See *id.* at 150.

<sup>72</sup> See IOM, *supra* note 62, at 150.

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

<sup>75</sup> See *id.*

<sup>76</sup> *Id.* at 83–85.

<sup>77</sup> See IOM, *supra* note 62, at 82–83.

<sup>78</sup> *Id.* at 150.

<sup>79</sup> *Id.*

In follow-up research published in 2001, Estes, in a self-reported survey study of fifty-two state level ombudsman offices, found that these ombudsmen believed their effectiveness was high.<sup>80</sup> Nevertheless, "insufficient numbers of paid staff," funding, and autonomy were again reported to reduce effectiveness of the programs.<sup>81</sup> Interestingly, in this updated work, state ombudsmen reported overwhelmingly (ninety-six percent) that local collaboration and cooperation with local nursing home providers were significant factors contributing to effectiveness.<sup>82</sup> This characteristic trailed only training and response time to complaints as being a factor prominently considered to relate to the effectiveness of long-term care ombudsman programs.<sup>83</sup>

The follow-up report also emphasized the need for a focus on nursing home residents as a primary target for ombudsman services. Consistent with the previous report, clinical issues such as malnutrition, dehydration, physical abuse and neglect, and depression, were noted as needing attention as defined by state level ombudsman program offices.<sup>84</sup> The 2001 report also reiterated the need for adequate funding to support the ombudsman programs.<sup>85</sup>

#### *D. Paid Ombudsman, Legal Training*

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Other, more limited work has investigated the relationship between paid ombudsmen and voluntary ombudsmen. Although not relating solely to elder abuse, one study found that "[volunteer staff] were less likely to fully resolve complaints than paid ombudsmen."<sup>86</sup> Moreover, clinically trained personnel, such as nurses, working in collaboration with U.S. Department of Justice attorneys, have been successful at detecting and assisting in the prosecution of abuse.<sup>87</sup> Success in these efforts was attributed to providing the clinical staff with legal training and partnering with law enforcement personnel.<sup>88</sup>

<sup>80</sup> CARROLL L. ESTES ET AL., EFFECTIVENESS OF THE STATE LONG TERM CARE OMBUDSMAN PROGRAMS 18 (Institute for Health & Aging 2001).

<sup>81</sup> *Id.*

<sup>82</sup> *Id.* at 21.

<sup>83</sup> *Id.* at 23.

<sup>84</sup> *See id.* at 26–27.

<sup>85</sup> *See* ESTES ET AL., *supra* note 80, at 30, 41.

<sup>86</sup> F. Ellen Netting et al., *Volunteer and Paid Long Term Care Ombudsmen: Differences in Compliant Resolution* 13 J. VOLUNTEER ADMIN. 10, 19 (1995).

<sup>87</sup> OFFICE OF JUSTICE PROGRAMS, U.S. DEP'T OF JUSTICE, OUR AGING POPULATION: PROMOTING EMPOWERMENT, PREVENTING VICTIMIZATION, AND IMPLEMENTING COORDINATED INTERVENTIONS 67 (2000).

<sup>88</sup> *Id.* at 65–67.

## IV. The Problem: Knowledge and Focus of Voluntary Ombudsman

### A. Self-Reports

Although some evidence suggests that the presence of voluntary ombudsmen is beneficial, there are significant concerns and challenges raised by the results of previous studies. Critically, much of the work on effectiveness of voluntary ombudsmen and ombudsman programs is based on self-reported notions of effectiveness. That is, it is perceived self-effectiveness of voluntary ombudsmen (or even further removed, the perceptions of paid ombudsman on the regional or state level), rather than any objective determination of reporting or knowledge of abuse characteristics, that is measured and then reported for evaluation.

There is no doubt that these self-evaluations are important, yet the absence of data on actual effectiveness raises the issue of whether voluntary, front line ombudsmen are obtaining the relevant skills and knowledge to be able to assess, detect, and investigate issues of elder abuse. This is particularly true in the context of the paucity of reports as compared with the estimated incidence of institutional senior abuse. Report levels approaching these estimates would be necessary to show at least some modicum of effectiveness.

Further, as a methodological matter, each ombudsman may have a highly subjective definition of his or her effectiveness. Hence, measurement of these self-reported characteristics may only provide limited insights into policy changes necessary to promote better abuse detection, reporting, and evaluation as well as eventual prosecution of abuse.

Indeed, because of the significant extent of elder abuse documented and the epidemic proportions of its prevalence, it is highly unlikely that the voluntary ombudsman programs around the country are effective in detecting and reporting elder abuse. It should be emphasized that the good faith and commitment of voluntary ombudsmen are not in question here. It is laudable that there are community-oriented and socially concerned people willing to voluntarily engage in efforts to try to protect some of our most vulnerable citizens. Yet, no matter what their compassion and commitment, they can never outperform the system that constrains them. Without the appropriate knowledge, training, and skills regarding elder abuse, they cannot be expected to effectively detect, report, and investigate potential elder abuse situations or circumstances.

## B. Site Cooperation

In addition to concerns regarding ombudsman self-reported effectiveness, it is of great concern that ombudsmen deem their perceived effectiveness directly related to the cooperation and relationships between themselves and the clinical providers and administrative staff at long-term care facilities. After all, these are the very persons the ombudsmen are to evaluate when assessing, detecting, reporting, and investigating elder abuse. Even if voluntary ombudsman were to have the requisite legal and medical knowledge regarding the mandates and clinical aspects of elder abuse, ombudsmen may not report such abuses for fear of jeopardizing relationships with key facility representatives and potential perpetrators.

This conflict of interest is very different from that identified by the IOM Report. Here, to avoid conflict with the facility's providers and administrators, voluntary ombudsmen may not act in the interest of the resident because of potential future conflict with administrative and clinical individuals in the long-term care facility with whom they have established a relationship.

Such acts of omission on the part of the voluntary ombudsman may not be malicious or even fully conscious. The relationship between the voluntary ombudsman, the facility providers, and its administrators may be subtle and complex. A volunteer ombudsman not reporting or investigating a potential elder abuse circumstance in one case may actually allow for more cooperation from the facility in other, perhaps more "important" cases that impact a greater number of residents (such as issues of overall facility safety).<sup>89</sup> Because of the robust findings across studies that suggest that voluntary ombudsmen associate these relationships with their effectiveness, they must be taken into account when designing policy or considering policy changes. This is particularly true in the context of poor levels of reporting.

Reliance upon cooperation and good relationships between themselves and the facility staff and the voluntary nature of frontline ombudsmen activity may explain the research finding that paid ombudsmen are more effective. The latter may not expect, rely, or be influenced by cooperation of facility staff when making abuse assessments at the facilities for which they are responsible, while

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<sup>89</sup> Nursing home safety, beyond quality of care, represents a significant issue for seniors residing in these facilities. See generally GAO, GAO-06-117, NURSING HOMES: DESPITE INCREASED OVERSIGHT, CHALLENGES REMAIN IN ENSURING HIGH-QUALITY CARE AND RESIDENT SAFETY (2005) [hereinafter GAO, NURSING HOMES], available at [www.gao.gov/new.items/d06117.pdf](http://www.gao.gov/new.items/d06117.pdf) (last visited Sept. 24, 2006).

voluntary ombudsmen may be too embedded culturally within the institution and be biased or constrained by that role.

### C. Deeper Issues

The literature suggests other considerations that may indicate profound system weaknesses involving the voluntary ombudsmen model. As noted above, elder abuse is ubiquitous. In the nursing home environment, it is no short of appalling. There appear to be systemic flaws associated with regulatory enforcement of laws designed to protect nursing facility residents. For example, a recent GAO report found nursing homes in every state that regularly violate minimum care regulations.<sup>90</sup> Further, one out of five nursing homes in this report were cited for actual harm or even worse deficiencies.<sup>91</sup> This statistic is likely a clear underestimate since actual harm violations are routinely under-cited by inspectors.<sup>92</sup> These data indicate severe process problems in a system that relies on voluntary ombudsmen nationwide to detect abuse conditions.

Furthermore, the Committee on Government Reform of the House of Representatives found that roughly one-third of all nursing homes were actually cited for elder abuse, which purportedly encompassed verbal, physical, and sexual abuse.<sup>93</sup> This figure, too, is likely a tremendous underestimate because it has been reported that between thirty-five and eighty-five percent of nursing home residents are malnourished and thirty to fifty percent have substandard body weight.<sup>94</sup> It should be noted that malnourishment and substandard body weight both represent elder abuse and their presence is a direct contravention of specific tenets of the Nursing Home Reform Act of 1987.<sup>95</sup> These problems occur despite state mandates to inspect each nursing home on an annual basis.<sup>96</sup> Such findings also indicate systemic failure involving the voluntary ombudsmen's weaknesses in evaluating potential abuse.

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<sup>90</sup> GAO, GAO-03-561, NURSING HOME QUALITY: PREVALENCE OF SERIOUS PROBLEMS, WHILE DECLINING, REINFORCES IMPORTANCE OF ENHANCED OVERSIGHT 56–57 (2003), available at [www.gao.gov/new.items/d03561.pdf](http://www.gao.gov/new.items/d03561.pdf) (last visited Sept. 24, 2006).

<sup>91</sup> *Id.* at 57.

<sup>92</sup> *See id.* at 19.

<sup>93</sup> STAFF OF H. COMM. ON GOV'T REFORM, 107TH CONG., ABUSE OF RESIDENTS IS A MAJOR PROBLEM IN U.S. NURSING HOMES 4–5 (Comm. Print 2001).

<sup>94</sup> SARAH GREEN BURGER ET AL., NAT'L CITIZENS' COAL. FOR NURSING HOME REFORM, MALNUTRITION AND DEHYDRATION IN NURSING HOMES: KEY ISSUES IN PREVENTION AND TREATMENT, at vii (2000).

<sup>95</sup> Federal Nursing Home Reform Act, 42 U.S.C. § 1395i-3(b)(4) (2006); 42 U.S.C. § 1396r(b)(4) (2006); 42 C.F.R. § 483.25 (2005).

<sup>96</sup> 42 U.S.C. § 1395i-3(g)(2)(A)(iii) (2006).

In sum, the voluntary ombudsman is the primary point person for detection of elder abuse in the long-term care setting. Voluntary ombudsmen report being uncomfortable in assessing clinical issues associated with facilities that they oversee.<sup>97</sup> Voluntary ombudsmen's perception of self-effectiveness appears dependent upon their cooperation and relationship with facility staff, which may result in a conflict of interest. Large studies and reports indicate that there may be a significant need for clinically and legally trained volunteers to improve effectiveness of ombudsman programs.<sup>98</sup> Although state ombudsman programs report great effectiveness in their activities, the significant underreporting, lack of detection, documented ubiquity of elder abuse, and resultant paucity of prosecutions suggest that a fundamental systemic problem requiring a reevaluation of the current voluntary ombudsman model.

## V. Case Management and Elder Abuse Detection

### A. Case Management

"Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, [using communication and available resources] to promote quality and cost-effective outcomes."<sup>99</sup> Case management focuses upon oversight and care coordination.<sup>100</sup> The foundation of case management is the principle that the "active involvement and oversight of health care delivery by trained personnel will enable individuals to receive appropriate and quality service in a cost-effective manner."<sup>101</sup>

Case management can be highly effective even for the most challenging of patients. For example, frail elderly, disabled, and/or cognitively impaired patients are high-risk populations that have benefited from ongoing case management involvement.

<sup>97</sup> GAO, NURSING HOMES, *supra* note 89, at 39.

<sup>98</sup> See generally IOM, *supra* note 62.

<sup>99</sup> CASE MANAGEMENT SOCIETY OF AMERICA, WHAT IS CASE MANAGEMENT?, available at [www.cmsa.org/PDF/WhatIsCaseManagement.pdf](http://www.cmsa.org/PDF/WhatIsCaseManagement.pdf) (last visited Sept. 22, 2006); see Arlene Luu & Bryan A. Liang, *Case Management: Lessons from Integrated Delivery to Promote Quality Care to the Elderly*, 9 J. MED. & L. 257, 265 (2005).

<sup>100</sup> This is in contrast to direct, patient-by-patient care. Eric M. Wall, *Case Management in Family Practice: Assuring Cost-Effective Care for High-Risk Patients*, 12 J. AM. BOARD FAM. PRAC. 346, 348 (1999).

<sup>101</sup> Luu & Liang, *supra* note 99, at 265. Policymakers, health plans, hospitals, and managed care executives have utilized case management to help reduce increasing healthcare costs and to improve the quality of care for patients who are critically injured, suffer from multiple chronic diseases, or who are otherwise at risk. *Id.*

Because the senior population's treatment is frequently fragmented, particularly for the institutionalized elderly, their overall quality of care may suffer. Case management programs have been effective in the care management efforts for the elderly<sup>102</sup> in both acute and long-term care settings.<sup>103</sup> In this context, the case manager connects relevant private and public agencies, disciplines, and practitioners,<sup>104</sup> which results in individualized, coordinated care for the elderly population.<sup>105</sup>

Clinical case managers are usually licensed nurses.<sup>106</sup> Effective and efficient clinical case managers have several years of healthcare experience, usually in the area they case manage.<sup>107</sup> In addition, successful case managers have a working knowledge of area facilities, providers, and benefits structures so as to best advocate in the social service component of their activities.<sup>108</sup>

This training and background provides case managers with a knowledge base to assist patients and their families to navigate through and make informed decisions about the complexities of the healthcare system that can result in better outcomes for the elderly.<sup>109</sup> The case manager thereby promotes the health and safety of the elderly patients through coordinating the clinical as well as the social welfare and financial issues to address the complex, multifaceted circumstances of the senior patient.<sup>110</sup>

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### ***B. Case Management and Elder Abuse***

Seniors who reside in nursing homes and other long term care facilities are often isolated from external contact. Clinical care may therefore be the only point at which anyone can detect and report potential abuse.

<sup>102</sup> Jeffrey P. Harrison et. al., *The Effect of Case Management on U.S. Hospitals*, 22 NURSING ECON. 64, 64 (2004).

<sup>103</sup> *Id.*

<sup>104</sup> See generally CATHERINE M. MULLAHY, *THE CASE MANAGER'S HANDBOOK* 85–105 (Aspen 1995).

<sup>105</sup> See *id.* at 350.

<sup>106</sup> Alison P. Smith, *Case Management: Key to Access, Quality, and Financial Success*, 21 NURSING ECON. 237, 239 (2003).

<sup>107</sup> *Id.*

<sup>108</sup> *Id.*

<sup>109</sup> See *id.*; see also Luu & Liang, *supra* note 99, at 265. Case management has had a long history in coordinating care for complex patients. Early clinical case managers were used to coordinate care for injured soldiers returning from World War II. *Id.*

<sup>110</sup> See Luu & Liang, *supra* note 99, at 265.

Hospitals, and in particular their emergency departments, may be the sole occasion that victims are seen outside the institutional setting. It is therefore imperative that these opportunities are used not only to address acute clinical conditions but to also assess suspected cases of elder abuse.<sup>111</sup> In this way, abuse can be identified and reported on a much greater scale that it is now.

Clinical case managers are familiar with, and in fact may be responsible for assessing, planning, coordinating, monitoring, and evaluating the care and social service needs of seniors across settings, including the emergency department. Since they are both clinically trained and knowledgeable social service professionals, they possess the tools and skills to undertake an encompassing assessment for elder abuse, including detecting, reporting, and addressing patient social service needs associated with it.<sup>112</sup> In contrast, nurses or other healthcare providers do not have the social service knowledge and training to perform both the evaluation and the planning for the social service components needed to address the needs of an abused senior.

Clinical case managers also routinely screen virtually all patients who enter the healthcare system, particularly those that reside in the institutional setting. They monitor these patients and address their potential needs, assess their hospitalization requirements, and coordinate resources, including obtaining referrals to various providers and agencies.<sup>113</sup> They may therefore have greater substantive and frequency of contact to apply their skills in determining whether abuse has occurred.

Hence, as clinically trained healthcare providers with significant access to patients, case managers can be trained to recognize the signs and symptoms of elder abuse so as to detect its presence. They also have social service training to address important nonclinical needs. But further, they can be trained as to the legal details on

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<sup>111</sup> See generally *id.* at 267–69. Another means to support such efforts is to mandate that seniors who enter the emergency department must obtain an elder abuse evaluation by clinical case managers as part of an appropriate medical screening examination (MSE). An appropriate MSE is mandated for any patient who presents to the emergency department under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, which applies to all hospitals in the United States, and a policy requiring abuse evaluation would detect at least some if not many abusive circumstances for investigation. See BRYAN A. LIANG, HEALTH LAW & POLICY 204, 205 (2000).

<sup>112</sup> See Luu & Liang, *supra* note 99, at 268.

<sup>113</sup> *Id.*

reporting abuse and supporting its prosecution.<sup>114</sup> Accordingly, the case manager can evaluate each senior when they access the healthcare delivery system and, as a routine part of their assessment, identify cases of potential abuse for effective treatment and social service coordination. These cases can then be reported to enforcement authorities for investigation and potential prosecution on a regular basis. As a corollary benefit, case managers can also educate other providers, caregivers, families, and patients regarding the signs and symptoms of abuse to allow them to actively monitor for and report abuse.

### *C. Strategic Placement and Function*

To most effectively support the detection and reporting of potential elder abuse, clinical case managers must be in appropriate places to best assess the senior population. A strategic means to promote this effort would be to focus on common locations where seniors are seen and reside. As noted above, clinical case managers with elder abuse training routinely assessing all patients from institutionalized settings entering the emergency department would be a good start.

Locating clinical case managers in facilities where seniors enter to obtain healthcare, as well as at other important locales that provide significant opportunities to assess senior health, increases the potential to detect senior abuse. Beyond the emergency department, key clinics, screening facilities, and community centers that are used regularly by the senior population are also important to monitor. Review by case managers at these sites should be a standard part of the senior care regimen and replace the reliance upon episodic reports or, even less frequent, provider requests for an evaluation of potential abuse.

But as noted previously, only a fraction of particularly vulnerable seniors are commonly seen outside their residential facility. To fully maximize the detection and reports of senior abuse for prosecution, it is here clinical case managers trained in elder abuse should replace volunteer ombudsmen in their oversight role. Clinical

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<sup>114</sup> Indeed, in the author's community, the author and a clinical case manager provide training on elder abuse signs and symptoms as well as caregiver signs and symptoms to laypersons. As part of this educational program, legal topics are also included, such as reporting mandates, phone numbers, and prosecution details. Such educational activities can easily be extended to case managers, and take only two to four contact hours, which could be counted towards continuing education, accreditation, and certification requirements. See, e.g., Case Management Society of America, *Accreditations & Certifications*, at <http://tinyurl.com/yxu5lf> (last visited Nov. 14 2006).

case managers should be regularly evaluating and determining the potential presence of senior abuse within long-term care institutions.

Clinical case managers should be empowered to make unannounced visits to nursing homes to which they are assigned. Because of the case managers' neutrality, they will be able to avoid the conflicts voluntary ombudsmen face in attempting to detect and report abuse. The previously noted potential conflict of interest that may impede reporting by voluntary ombudsman will, hopefully, not exist for the clinical case manager, allowing a more thorough and deeper assessment of the institutionalized senior. Further, through a consistent, recurring assessment process, clinical managers' skills can be used to fundamentally assess and reassess residents of nursing homes to determine care, lack of care, and new signs and symptoms that could raise questions regarding whether the senior has been subject to abuse. This will allow a consistent evaluation and a continuity of assessment that allows for even subtle changes in a resident's status to be noted.

Note that this role for clinical case managers does not eliminate the need for voluntary ombudsmen. Voluntary ombudsmen and clinical case managers can work together to improve the health and care of the institutionalized senior. Identification and communication of clinical and nonclinical problems, senior abuse detection, reporting and remediation, social services recommendations and follow-up, education of caregivers and family members, and other functions can be effectively performed by coordination and cooperation between voluntary ombudsmen and clinical case managers. Through active and effective participation by both, the institutionalized senior will benefit.

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## VI. Policy Recommendations

The nursing home and institutionalized senior administration and regulation system is broken. The epidemic of elder abuse in these settings shows that reform is long past due. Reform cannot rely solely upon well meaning but untrained volunteers. A policy mandate to focus attention and resources on the plight of seniors in institutionalized settings is therefore vital. Unfortunately, at the present time, there is limited attention to this topic, and previous efforts have been unsuccessful.<sup>115</sup>

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<sup>115</sup> For a review on the legislation affecting elder abuse, see Donna Schuyler & Bryan A. Liang, *Reconceptualizing Elder Abuse: Treating the Disease of Senior Community Exclusion*, 15 ANNALS HEALTH L. 275 (2006).

In the 109th Congress, the Elder Justice Act was introduced for the third time in as many Congresses.<sup>116</sup> The Elder Justice Act is a bipartisan bill that attempts to elevate the epidemic of elder abuse to the national agenda.<sup>117</sup> It would provide additional funds to support elder abuse research. In addition, Adult Protective Services, usually state agencies that are chronically underfunded and that are responsible for addressing elder abuse, would become federally funded and coordinated. The Act would also support prosecution and victim assistance and a public awareness campaign about elder abuse.<sup>118</sup>

Although senior abuse has been characterized as the nation's "shame,"<sup>119</sup> passage of this legislation does not seem likely. Moreover, even if it were to pass, the Act would not go far enough—while it raises awareness of abuse of seniors, it continues to rely upon volunteer ombudsmen efforts to detect senior abuse. Although research monies would be allocated to study the issue—an important part of the proposed legislation—seniors would have to wait years before any substantive change might occur. Furthermore, while additional monies would be made available for law enforcement and prosecution as well as educational campaigns, such monies, although necessary to support an infrastructure and additional staff, presume that adequate detection and reporting are occurring, which they are not.

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The focus of the proposed Act and other recent policy efforts is misplaced. To address the issue of senior abuse in the United States, a concentration upon detection must be primary. We cannot address a social policy scourge unless we know where it is occurring. We can have the best infrastructure ever devised to prosecute senior abuse, but if there are no reports because detection is ineffective, the status quo will continue for millions of vulnerable seniors now and in the future.

Substantive funds must be allocated to directly address the detection and reporting problem of elder abuse. Resources must be provided to employ clinical case managers, train the case managers in senior abuse issues, and place them in emergency departments, clinics, and other locales as well as assign them as reviewers to a specific set of institutions with resident seniors.

<sup>116</sup> *Id.* at 282.

<sup>117</sup> Elder Justice Act, H.R. 4993, 109th Cong. (2006); S. 2010, 109th Cong. (2005).

<sup>118</sup> WHITE HOUSE CONFERENCE, *supra* note 4, at 2–3.

<sup>119</sup> See generally STAFF OF H. COMM. ON AGING, 101ST CONG., ELDER ABUSE: A DECADE OF SHAME AND INACTION (Comm. Print 1990).

To do this, provisions should be added to the Elder Justice Act. Creation of a section that allocates funding to training, emergency department service codes for billing elder abuse assessments, and empowering trained clinical case managers to assess institutionalized elderly on a regular basis for potential abuse would be effective. Because of the doubts surrounding passage of this bill, however, *de novo* creation of legislative language will not assist the suffering, institutionalized elderly.

In an effort to address this issue under current law, creating educational programs on clinical case management and elder abuse would be a start.<sup>120</sup> These trained individuals could be considered Home Care Medicare providers within the meaning of the Medicare statute,<sup>121</sup> allowing them to bill for abuse assessments of seniors, similar to the manner under which Visiting Nurse Association nurses bill for their substantive clinical activities under Medicare and other programs,<sup>122</sup> with presumptive certification of services through regulation.<sup>123</sup>

The benefits associated with consistent monitoring of the senior population and avoidance of the high costs of abuse would make such reimbursement programs an incredibly valuable and cost-beneficial investment in the healthcare delivery system, particularly as the population continues to age and a greater number of seniors are impacted by this protection. The use of appropriately trained personnel and gains to the senior population would replace the shame of our current reliance upon volunteers who cannot hope to effectively detect and report elder abuse.

Of course no single solution is a panacea. Paid ombudsman can address at least part of the problem of current minimal reporting. Nevertheless, there may be similar infrastructural risks associated with these reporters if they become embedded within the nursing home culture as the voluntary ombudsmen have. This may have to be addressed through a rotation of paid ombudsmen to ensure

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<sup>120</sup> Case Management Society of America, *supra* note 114 (describing clinical and legal educational program on elder abuse).

<sup>121</sup> Medicare Act, 42 U.S.C. §1395–1396(d); see 70C AM. JUR. 2D, *Social Security and Medicare* § 2193 (2006).

<sup>122</sup> See Visiting Nurses Association of America, *How Is Home Care Paid For?*, at [www.vnaa.org/vnaa/g/?h=HTML/HowIsHomeCarePaidFor.html](http://www.vnaa.org/vnaa/g/?h=HTML/HowIsHomeCarePaidFor.html) (last visited Sept. 22, 2006).

<sup>123</sup> See 42 C.F.R. § 424.22(a) (2006). Clinical case management could be deemed presumptively certified and approved by an institution's medical director for elder abuse services for appropriately trained clinical case managers. Participating case managers may have to aggregate into Case Management Associations, similar to Visiting Nurses Associations, and follow similar regulatory licensing requirements.

there is limited "attachment" occurring between nursing home personnel and the ombudsmen responsible for assessing them. On the other hand, there may also be risks of over-reporting—a luxury that is almost unfathomable to contemplate, but still a potential reality. To err on the side of safety is preferable, however, and administrative processes that encourage improvements in care and allow for appeals can address this possibility, as remote as it may be.

Finally, it should be noted that much of the senior abuse problem in nursing homes, as well as outside of them, is focused upon the lack of community integration that these citizens experience in our society and culture. Increased participation by and community focus on seniors, and a mutual respect of their needs, contributions, and dignity, would allow for detection of abuse, and has the potential to prevent it from occurring in the first place.<sup>124</sup>

## VII. Conclusion

Elder abuse in this country is at epidemic proportions. The number of those subjected to this heinous activity will only increase as the population in this country grays. Yet current efforts almost completely rely upon well-meaning volunteers with neither clinical skills nor effective legal training, and the cooperation of the very people that may be perpetrating the harm. This system is ineffective, inappropriate, and leaves the vulnerable, institutionalized senior to carry the burden of a broken, disrespectful, and dysfunctional public policy.

Instead, seniors should be served by professionals who have the expertise and training to detect, report, and assist in prosecuting the crime of abuse. Importantly, consistent assessment and reassessment should be the stalwart of a policy using clinical case managers to limit and prevent senior abuse. Gone should be the days when institutionalized elderly are physically abused, smeared in feces, or subject to other indignities.<sup>125</sup> Only through attention

<sup>124</sup> See generally Schuyler & Liang, *supra* note 115 (elder abuse is symptom of senior community exclusion).

<sup>125</sup> See, e.g., Press Release, Office of the N.Y. State Attorney Gen. Eliot Spitzer, Two Nurse's Aides Charged with Elder Abuse at Brooklyn Nursing Home (June 28, 2002), available at [www.oag.state.ny.us/press/2002/jun/jun28d\\_02.html](http://www.oag.state.ny.us/press/2002/jun/jun28d_02.html) (last visited Oct. 23, 2006). For example:

Attorney General Eliot Spitzer today announced that two employees at the Buena Vida Continuing Care and Rehabilitation Center in the Wyck-

to this Nation's shame can we ensure that respect, care, and compassion are given to those who often are the most vulnerable and made the greatest sacrifices for us—our elderly.

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off Heights section of Brooklyn have been arrested for twice abusing an elderly female patient suffering from dementia and a broken hip.

...

According to the charges, while providing care to the 84-year-old patient on the morning of November 4, 2001, Matthews and Francis-Guzman were observed spitting in the patient's face. Guzman then allegedly expectorated into the patient's mouth and held her mouth closed.

Later that morning, the patient was observed in the shower area with feces on her face. Without removing the feces, Matthews and Francis-Guzman each took turns spraying disinfectant at the patient's face while the other aide restrained her.

*Id.*