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ABUSE OF OUR ELDERS: HOW WE CAN STOP IT

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

WASHINGTON, DC

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ABUSE OF OUR ELDERS: HOW WE CAN STOP IT

WEDNESDAY, JULY 18, 2007

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 12:30 p.m., in room SD–628, Dirksen Senate Office Building, Hon. Herb Kohl (chairman of the committee) presiding.

Present: Senator Kohl.

OPENING STATEMENT OF SENATOR HERB KOHL

The CHAIRMAN. All right. Well, we thank you all not only for being here today but for bearing with us as a result of activities on the floor. I think we were scheduled to start here at 10:30; now it is 12:30. So you are pretty sensational to wait for as long as you have.

The hearing itself is going to be conducted in a somewhat different way, because they put a hold on formal hearings as a result of activities on the floor. That is something that Senators, under unusual situations and conditions, are allowed to do.

So instead of a formal hearing, we will have an informal hearing, which will give all of those who are here to testify an opportunity to express yourselves and be heard. I will be somewhat more constrained in asking questions, but certainly we will get to hear everything you have to say. We are looking forward to it.

I would like to welcome our witnesses and everyone who is here, of course, and those who will be watching on television.

Today we are going to be talking about a really important subject: elder abuse in our society and what we can do to prevent it.

Naturally, we want to not just talk about it but we want to talk about solutions. We want to challenge ourselves here in Washington to do something more to combat elder abuse and to propose some concrete things for action.

I believe we need to enact a common-sense bill, a bill which is called the "Patient Safety and Abuse Prevention Act," which I introduced with my friend from New Mexico, Pete Domenici. This bill, if we can get it passed, will protect our most vulnerable Americans who need long-term care by making sure that people who care in these facilities and care for them do not have any criminal background in their record.

We need to keep predators out of our system, not just prosecute them after they have ruined people's lives. What we intend to do is set up a national registry of people who have criminal back-

grounds, and so that, when they apply for employment in any kind of a facility across the country, they will be immediately identified and denied employment.

I am pleased to say that several members of our Committee are cosponsors of this bill, including Senators Clinton, Lincoln, Collins, Senator Whitehouse and also Senator Casey. So I thank all of them very much for their support.

Also today, I am happy to say that this bill is going to be introduced in the House of Representatives by Congressman Tim Mahoney, who also understands how important this issue is to our Nation's seniors.

This bill is going to be modeled on a pilot program that has been occurring in seven States across our Nation over the last few years. The program, in its pilot aspects, has been very successful. Over the last 3 years, more than 5,000 individuals in these seven States who had a criminal background have been identified and denied employment in long-term-care facilities.

In Michigan, which is the State that had the most comprehensive pilot program, fully 5 percent of applicants for long-term-care jobs were excluded because their background check uncovered a serious criminal history. You can imagine the mayhem that they might have caused had they been able to become employed.

The bottom line is that, in every State where the pilot programs have been established, that they have worked. I believe that is very important, and that is a victory for our elders.

So we are going to be hearing from people about elder abuse, the "Elder Abuse Act," as well as this criminal background check registry, which is going to hopefully be part of the "Elder Abuse Justice Act," which is making its way through Congress.

My colleague, Senator Blanche Lincoln, introduced this bill, the "Elder Justice Act," and I am an original cosponsor. Both Senator Lincoln's bill and mine, as I said, protect seniors and save lives, and we need to pass those bills this Congress.

So we are going to start this hearing today with a story from a brave young woman who has traveled all the way from New York to talk to us today about what happened to her grandmother one day when a predator who never should have been allowed to work in a medical facility became employed and found her grandmother alone.

We will then have testimony from two Federal agencies about the Federal Government's attempts to address elder abuse.

Finally, we will hear in our third panel from four of the leading experts in the United States who are working at the front lines of advocacy, of law enforcement and of service delivery to stop the scourge of elder abuse.

We welcome you all here today.

I would like to introduce our first witness.

We are very happy to have you here, Jennifer.

Jennifer Coldren is here from New York, the community of Rome, NY. Ms. Coldren is here to testify about the needless suffering that her grandmother encountered while recuperating in a long-term-care facility. The horrific crime was perpetrated by a criminal who never should have been employed but slipped through because of the patchwork system of background checks.

So, Jennifer, thank you so much for coming. We are delighted to listen to whatever you have to say.

STATEMENT OF JENNIFER COLDREN, ROME, NY

Ms. COLDREN. Chairman Kohl and distinguished members of the Committee, thank you for inviting me to testify this morning. The place I had hoped one day to be being able to share and have the opportunity to tell what happened to my beloved grandmother and my family, hoping that by having this chance to tell her story somehow will make a difference and help change the laws governing all facilities that take care of our elderly so something this horrifying doesn't happen to anyone else.

My name is Jennifer Coldren. I live in Rome, NY, in the vicinity of Syracuse.

The nightmare for my family began last year when my grandmother, who was 90 years old at the time, who had never had one act of violence done against her, was raped and assaulted by an employee of the residential facility she was in.

He was 45. The man had a criminal record, and it was only the third time he had worked on the floor. He worked on the floor as needed, and his permanent job had been working on the surgical unit of the hospital.

Had there been an effective background check performed, he would not have had the opportunity to harm my grandmother.

Mr. Turtora's office prosecuted this criminal this spring, and this criminal received up to 25 years in prison for what he did to her. Her abuser showed no remorse for what he had done, and the judge called him a sick man and said what he did was second to murder.

Before we lived this, our family believed that, with society the way it is today, that safeguards were already in place to protect our elderly from abuse. Unfortunately, we had to learn a tragic lesson that they weren't.

I respectfully ask you to do something to prevent other similar crimes and further abuse of the elderly from happening in assisted care and medical facilities, for we were outraged that policies and laws were not in place to prevent something like this from happening.

In this situation, a background check could take 30 to 120 days to come back. A lot of damage can be done in that time. My grandmother's story is an example of what that timeframe can do.

This is what happened to my grandmother. First, to give you an idea what this did to her family, I would like to start by summing up our feelings into words, what we felt living this nightmare: disbelief, fear, numbness, pain, anger, bitterness, shock, outrage, and our hearts broken. We also shed a thousand tears for her.

But we also were proud, for my grandmother was not only a victim but a hero. She prevented him from hurting her again and from hurting anyone else on the floor that night. If she hadn't told anyone what happened, it made us wonder how long the abuse would have gone on before he had been caught and stopped and just how many more elderly people he would have harmed. See, my grandmother had dementia at the time, and we knew just how

lucky we were she got her story out, and terrified of what it could have been if she hadn't.

Before this took place, my grandmother had a smile for everyone. After this happened, she no longer smiled, cried all the time and had told us numerous times she wanted nothing more but to be an angel and for God to take her. She kept her feelings bottled up inside, did not discuss what happened with us or psychiatrists.

Through her depression, her mind and body weakened. About 5 weeks after, she had a stroke. She could no longer put full sentences together anymore and her words became mumbles. She had given up on life.

My family had made the decision to bring her home. See, I couldn't live with myself leaving her there. I didn't trust anyone for her care anymore and was scared that something else bad could happen to her. The day we took her out of the facility, she smiled ear to ear—the first time since this happened to her.

Our decision also came from when we found out that her abuser had also worked in another long-term-care facility and also in a State facility prior to this that works primarily with the elderly and severely handicapped people. He had also had numerous complaints of a sexual nature, inappropriate touching complaints, and they were all unfounded. He slipped through so many cracks. We felt we had no choice but to take her out of there.

My grandmother has lived with me and my husband now for the past 5 months. It hasn't been an easy road, for she has Alzheimer's dementia, which presents new struggles and challenges every day, but she is beginning to be happy again. For us, our family, we have peace of mind, knowing she is safe and sound and happy. We made the right decision.

The way things are, this tragedy can happen again in any nursing home, hospital, home care setting, and anywhere our vulnerable elderly are being taken care of by someone hired to take care of them.

I ask the Committee for a moment to put yourself in our shoes. How would you feel if this happened to your mother, grandmother or someone else you love?

We need to protect our aging loved ones who can't protect themselves, because if we don't, who will? Someday we will be old too.

For my family, we will never forget what happened, and I am reminded every time I look into my grandmother's eyes what happened to her. I will never forget for the rest of my life.

Our hope is something good will come out of this nightmare for us and that together we can come up with a solution for a growing problem so this never happens to another elderly person and their families again.

In closing, we cannot change the past or what happened to my grandmother, but we can change things for the future generations so no one will ever know the fear and pain my grandmother and family has endured through all this. This is our hope, to be a part of that by being here today.

Thank you for letting me speak and share her story today.

The CHAIRMAN. Jennifer, that is really a moving story and so, so very well told by you. We know how difficult it is for you to stand up and—or sit down, come here and speak today. This has not been

an easy experience for you but maybe somewhat cathartic, and certainly it does result in putting into place a system that will prevent, as you point out, prevent it from happening again. Certainly, I know you will feel that the time you spent here today was more than worthwhile.

Because I am sure that is your number-one goal to see happen and occur, is that a system is put in place. Is that right?

Ms. COLDREN. Yes.

The CHAIRMAN. How many years ago was that, Jennifer?

Ms. COLDREN. It was last year.

The CHAIRMAN. One year ago?

Ms. COLDREN. It was in May of last year that this happened.

The CHAIRMAN. Oh, just over a year.

Ms. COLDREN. Yes.

The CHAIRMAN. Your grandmother is now living with you?

Ms. COLDREN. Yes, 5 months now.

The CHAIRMAN. How is she doing?

Ms. COLDREN. She has her good days and her bad, but she is a lot happier now——

The CHAIRMAN. Happier with you?

Ms. COLDREN [continuing]. That she is with us—yes—than she was in the nursing home.

The CHAIRMAN. She does have dementia?

Ms. COLDREN. Yes.

The CHAIRMAN. Progressive dementia?

Ms. COLDREN. Yes. Some days she is her old self, and then other days she has really bad days. That is hard to watch.

The CHAIRMAN. She is in her 90's, did you say?

Ms. COLDREN. She had her 91st birthday this past April. We had a big party for her.

The CHAIRMAN. That is wonderful. She is pretty lucky to have you.

Thank you so much for coming.

Ms. COLDREN. Thank you.

The CHAIRMAN. You have done a real public service.

Ms. COLDREN. Thanks.

[The prepared statement of Ms. Coldren follows:]

Chairman Kohl and distinguished members of the committee, thank you for inviting me to testify this morning. The place I had hoped one day to be , being able to share and have the opportunity to tell what happened to my beloved Grandmother and my family. Hoping that by having this chance to tell her story somehow will make a difference and help change the laws governing all facilities that take care of our elderly so something this horrifying doesn't happen to anyone else.

My name is Jennifer Coldren I live in Rome, NY in the vicinity of Syracuse. The nightmare for my family began last year when my Grandmother who was 90 years old at the time, who had never had one act of violence done against her, was raped and assaulted by an employee of the residential facility she was in. He was 45. The man had a criminal record and it was only the third time he had worked on the floor. He worked on the floor as needed, and his permanent job had been working on the surgical unit of the hospital. Had there been an effective background check performed he would not have had the opportunity to harm my Grandmother. Mr. Turtora's office prosecuted this criminal this Spring and this criminal received up to 30 years in prison for what he did to her. Her abuser showed no remorse for what he had done and the judge called him a sick man and said what he did was second to murder.

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I ask the committee for a moment to put yourself in our shoes, how would you feel if this happened to your Mother, Grandmother or someone else you love? We need to protect our aging loved ones who can't protect themselves because if we don't who will? Someday we will be old too. For my family we will never forget what happened and I am reminded every time I look into my Grandmother's eyes what happened to her. I will never forget for the rest of my life.

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In closing, we can not change the past, or what happened to my Grandmother but we can change things for the future generations so no one will ever know the fear and pain my Grandmother and family has endured through all this. This is our hope to be a part of that by being here today.

Thank you for letting me speak and share her story today.

The CHAIRMAN. At this time, we will turn to our second panel.

Our first witness on our second panel will be Dr. Daniel Fridman, who is senior counsel to the deputy attorney general in the Department of Justice. In this capacity, Mr. Fridman advises the deputy attorney general on national criminal policy issues, including health-care fraud, child exploitation, immigration enforcement, as well as bankruptcy fraud. Mr. Fridman was an assistant U.S. attorney from the Southern District of Florida, where he had served as a trial attorney prosecuting violent crimes and other offenses. Currently, Mr. Fridman is on detail in Washington.

Accompanying Mr. Fridman is Marie-Therese Connolly, a senior trial counsel in the civil division. Ms. Connolly is charged with coordinating the Elder Justice and Nursing Home Initiative at DOJ.

Our second witness is Gregory Demske, who is the assistant inspector for legal affairs in the office of the Health and Human Services inspector general. Mr. Demske is responsible for administrative health-care fraud actions on behalf of the HHS OIG. He has worked in the OIG's counsels office for the past 15 years. He has also served as a special assistant U.S. attorney in the District of Columbia.

So we thank you both for being here.

Mr. Fridman, we will take your testimony.

STATEMENT OF DANIEL FRIDMAN, SENIOR COUNSEL TO THE DEPUTY ATTORNEY GENERAL, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC; ACCOMPANIED BY MARIE–THERESE CONNOLLY

Mr. FRIDMAN. Thank you, Mr. Chairman. Thank you for inviting the Department of Justice to discuss its work fighting elder abuse.

Appalling stories of abuse, like the one that Ms. Coldren had the courage to come here today and describe, remind us that there is still much work to be done.

We also want to commend and recognize the work of Mr. Turtora, the New York State prosecutor who works with the Medicaid fraud control unit there, who brought Ms. Coldren's grandmother's abuser to justice.

The MFCUs—the Medicaid fraud control units—State attorneys general offices, and local D.A.s, like Paul Greenwood, who is here today, bring most of the prosecutions against individuals who abuse and neglect elders.

The elder-abuse cases that the Department of Justice pursues primarily involve systemic wrongdoings in facilities. We pursue those Federal cases under civil and criminal statutes, such as health-care fraud and other legal theories, working closely with our colleagues at the HHS Office of Inspector General.

We also pursue financial crimes targeting elders, such as our identity-theft cases, our telemarketing cases, some Part D cases, which are described in my written testimony.

I know I speak for the thousands of dedicated prosecutors, litigators, agents and grant-makers in the Department when I say that these are the kinds of cases that really make our blood boil. These cases that involve egregious human harm and suffering really motivate us to work to find a way to find justice for the victims.

I am an assistant U.S. attorney from Miami on detail to Main Justice, where I advise the deputy attorney general on health-care fraud enforcement policy. In that capacity, I have a bird's eye view of what the Department's many components are doing to fight elder abuse and to hold their abusers accountable.

Within DOJ, this effort involves each of our 93 U.S. Attorneys Offices; the Criminal, Civil and Civil Rights Divisions; the Office of Justice Programs; the Office on Violence Against Women; and the FBI.

Let me give you some snapshots of some of the Department's most recent work.

In the Borne case in Louisiana, the owner of a small nursing home diverted millions of Federal health-care dollars to buy his $1.2-million residence and his opulent estate called Annedelle Gardens, which had 150 acres, man-made streams and waterfalls and ponds that were stocked with exotic black swans that cost $5,000 apiece.

At the same time, his nursing homes were chronically understaffed and rundown, lacking vital basics: soap, linens, sheets, wound-care supplies, and disinfectants. The relatives of one resident even brought in a truckload of turnip greens one evening so that everyone could be fed.

Many residents in Borne's facilities suffered terribly, including from bed sores and malnutrition. Borne was prosecuted, sentenced to 37 months' imprisonment, and forfeited his lavish estate and residence.

A recent St. Louis case, AHM, involved the suffering of numerous patients in three facilities. One woman had red ants crawling all over her eyes, mouth, ears and genitalia, as she lay there dying. Another patient died of a treatable bowel obstruction, which she had begged for staff to treat. Another was beaten to death by an aide. This case resulted both in a Civil False Claims Act settlement of $1.25 million, and the CEO of the three facilities pled guilty to felony charges.

When the facility in question is a publicly run facility, that is where our Civil Rights Division can pursue cases under the Civil Rights of Institutionalized Persons Act, also known as CRIPA, to address conditions that violate Federal statutory and constitutional requirements.

In a recent New Mexico case, a 71-year-old patient with life-threatening low blood sugar levels died when the staff failed to recognize and treat obvious signs of distress.

Another patient that was admitted for rehabilitation following hip surgery died a week later of aspiration pneumonia because staff didn't follow proper procedures in feeding her. This case was resolved with a court-enforceable agreement where New Mexico will correct the systemic problems in its nursing homes.

The focal point of the Department's elder-abuse efforts has been the Elder Justice and Nursing Home Initiative, which is spearheaded by my colleague sitting next to me, Marie-Therese Connolly. She supports prosecutors' failure-of-care cases, coordinates with numerous other entities on a broad scope of elder justice activities, and oversees a budget that funds grants for elder justice training as well as groundbreaking research in the field.

Let us talk about some of that research.

There is a consensus that there is a paucity of experts and research in the area of elder abuse. Responding to this, the Department's research arm, the National Institute of Justice, issued one of the first-ever solicitations for research grants relating to elder abuse in 2005. NIJ now has several research projects under way, and we have results from at least one of them already.

This project related to bruising in elders, and the conclusions were as follows: No. 1, contrary to conventional wisdom, you cannot date a bruise simply by looking at its color. No. 2, 90 percent of accidental bruises in the elders studied appeared on limbs and 10 percent on the torso. Well, why is this important? Well, now practitioners know that if an elder has a bruise in another location, someone should be asking more questions about where that bruise came from.

One of the most important sources of funding the Department relies on for this work are the funds provided by the Health Care Fraud and Abuse Control Account, which was established by HIPAA in 1996. Since 1997, these funds have helped the Department maintain dedicated prosecutors, litigators and FBI investigators who focus on health-care fraud cases. Our Elder Justice Initiative is funded out of these same funds.

But since 2003, those funds remained constant without inflationary adjustment under a statutory cap until this year, when Congress passed and the President signed an inflationary cap adjustment to the funds each year until 2010.

The President's 2008 budget requests an additional $17.5 million to supplement the Department of Justice's HCFAC allocation, and we would appreciate your support for full funding of the President's request so that we can continue growing in these important efforts.

I will conclude by saying that the cost of elder abuse, both human and economic, is high. The Department is committed to expanding the fight against this problem as America ages.

[The prepared statement of Mr. Fridman follows:]

Department of Justice

STATEMENT OF

DANIEL S. FRIDMAN
SENIOR COUNSEL TO THE DEPUTY ATTORNEY GENERAL AND
SPECIAL COUNSEL FOR HEALTH CARE FRAUD
U.S. DEPARTMENT OF JUSTICE

BEFORE THE

SPECIAL COMMITTEE ON AGING
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CONCERNING

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STATEMENT OF
DANIEL S. FRIDMAN

SENIOR COUNSEL TO THE DEPUTY ATTORNEY GENERAL AND
SPECIAL COUNSEL FOR HEALTH CARE FRAUD
U.S. DEPARTMENT OF JUSTICE

BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

JULY 18, 2007

Mr. Chairman, thank you for inviting the Department of Justice to testify on its role in preventing and prosecuting abuse against our vulnerable elder population. We are grateful for this Committee's bipartisan approach to and leadership on this increasingly important topic.

I am an Assistant U.S. Attorney from Miami, on detail to Main Justice where I advise the Deputy Attorney General on health care fraud enforcement policy. In that capacity, I have a bird's eye view of what the Department's different components are doing to fight elder abuse and to hold the abusers accountable. Elder abuse, neglect and exploitation comes in many forms ranging from physical abuse and neglect, to failures of care in institutional settings, to financial abuse in its many manifestations. The Department has pursued a multi-faceted approach in fighting elder abuse within the constraints of its statutory authority. We are pursuing criminal prosecution and civil litigation in major telemarketing and failure of care cases, organizing and participating in multi-agency regional task forces, funding research to enhance forensic tools to help us better identify and prove elder abuse, and partnering with other federal agencies such as the FTC to provide educational materials informing elders how to avoid becoming victims of fraud.

While we have successfully pursued civil and criminal prosecutions of systemic abuse and neglect in long term care, our local and state law enforcement partners have successfully pursued the lion's share of prosecutions of abuse and neglect in domestic and community settings, as primary jurisdiction over these crimes lies with them. In addition, our State Attorneys General and Medicaid Fraud Control Unit colleagues continue to successfully pursue abuse and neglect in facilities of various types. We also are pleased to describe groundbreaking elder abuse research sponsored by the National Institute of Justice (NIJ), the Department's research arm. While the human cost of elder abuse is more graphically presented in the individual stories revealed in the cases we have brought to redress abuse of older Americans, the research will make it possible to improve detection, prevention and how we bring those cases in the future.

As more than 70 million baby boomers age, the number of older Americans will skyrocket in the next three decades, along with them, the number of frail and disabled elders needing long term care. Americans 85 and older, "the oldest old" are the fastest growing segment

of the population. They also are the most vulnerable. Previous testimony before this Committee, as well as government, academic, and media reports, indicate that seriously inadequate care remains a persistent problem in some nursing homes and other long-term care facilities. Caring for growing numbers of frail and incapacitated elders at home also presents increasing challenges, significant demands on caregivers, and rising risk of abuse and neglect. Against this backdrop, and to respond to these growing problems, the Department is pursuing its Elder Justice and Nursing Home Initiative a primary objective of which has been to enhance enforcement, knowledge, training, coordination, public awareness, forensics, and research at all levels.

Given the complexity of the issues, and their increasing demographic significance, the Department is employing a multi-pronged approach: to hold abusers accountable (whether they be individuals or corporations), assist victims, train those on the front lines, develop a coordinated approach with other entities and disciplines, promote research that can be translated into practice, and prevent elder abuse before it occurs. Those are the topics I will touch on in my testimony today.

1. Prosecution of Federal Cases to Redress Elder Abuse, Neglect and Exploitation

The Department's United States Attorneys Offices (USAOs) and litigating divisions pursue a variety of elder abuse and elder justice activities. Individuals and corporate entities are prosecuted under criminal, civil and civil rights laws for failing to provide care to frail residents or targeting older people with financial fraud schemes. Some USAOs also are involved in outreach and training to providers, law enforcement, coroners and medical examiners. Several districts and states have working groups that meet regularly, including federal, state and local law enforcement as well as representatives of many of the regulatory agencies involved in the care of the elderly.

A. Failure of Care Cases

1. *Criminal Prosecutions*

Criminal prosecutions of nursing homes and other providers for failing to care for vulnerable elders can be complex, but several USAOs have brought successful criminal prosecutions. These cases, called "failure of care" cases, typically involve defendants that divert substantial portions of the Medicare and Medicaid reimbursements for their own gain while failing to provide adequate care to residents.

Cases that illustrate this approach include United States v. Melville Borne, et.al, (EDLA); United States v. AHM, (EDMO), United States v. Lemon, (WDTX), and United States v. Atrium I Nursing Home and Bell, (WDPA).

- In Borne, the owner of a chain of nursing homes was convicted of diverting large sums of money to purchase, among other things, a private plane and a 150-acre personal estate while staff members were forced to take up collections from residents and family

members to buy food for the residents' meals. He was sentenced to prison and ordered to forfeit nearly $4 million in property. The case won Honorable Mention as the 2006 National Healthcare Anti-Fraud Association Investigation of the year.

- In AHM, a Missouri nursing home management company, its CEO, and three of the homes, pleaded guilty to felony criminal charges in connection with the failure of care and abuse of elderly residents. A civil False Claims Act suit against the same defendants was settled for $1,250,000.

- In Lemon, the defendant pled guilty to funneling large amounts of Medicare and Medicaid dollars to his own personal gain. In the end, he abandoned all of his nursing homes and Texas authorities had to assume control and management of a number of those homes, with a loss Medicare of about $4.2 million.

- In Atrium I, the facility and Marta Bell, its administrator, were tried and convicted of several counts of health care fraud and multiple false statements relating to their failure to provide the required care to Atrium's residents, most of whom were diagnosed with Alzheimer's disease, and the falsifying the medical and staffing records. Atrium I is no longer in operation and Bell was sentenced in 2006 to 60 months imprisonment.

- In Angel Health Care, Inc., the home health care agency and its owner, Wilma Kpohanu were found guilty health care fraud and making false statements for billing for skilled nursing services that were not provided to homebound clients. In addition, an employee, Manjula Sankarappa pleaded guilty to obstructing an OIG investigation by destroying and altering documents.

2. *Civil Cases*

Civil failure of care cases are pursued by the Department under the civil False Claims Act where providers knowingly bill the United States for goods or services that were not provided or were worthless. Most of these cases are resolved for monetary damages under the False Claimse Act, in addition to ongoing monitoring either under a Corporate Integrity agreement monitored by HHS-OIG or a consent or settlement judgment.

These are difficult and time consuming cases, and many are currently in litigation so we cannot comment upon them,

- United States ex rel. Chadwick v. Forrest Preston, (NDGA) in which the Department alleged that Life Care Centers of Lawrenceville was so deficient in nursing staff that it failed to properly care for and treat residents with diabetes, failed to have proper care planning and nursing interventions, and allowed patient's wounds to fester and become infested with maggots. The case settled for $2.5 million and a five year Corporate Integrity Agreement. Under the terms of the Corporate Integrity Agreement, Life Care must report to an outside monitor and implement policies to improve patient

care.

- In United States v. O'Hara Regional Center for Rehabilitation in Colorado, (D. Colo.), the United States alleged that understaffing caused the facility's vulnerable patients to suffer malnutrition, dehydration, pressure ulcers, contractures, and, in some cases, death. The United States resolved the case for $1.9 million.

- Vencor, Inc (E.D. Ark., D. Nev., W.D. Ky., D. Mass., C.D. Cal., D.N.H., M.D. Fla., S.D. Ohio, S.D. Cal), was one of the nation's largest nursing home chains, with more than 350 nursing homes and long term acute care hospitals. Numerous allegations led to an investigation by the Department of Justice in conjunction with the Defense Criminal Investigative Service (DCIS) and HHS/OIG. The initial investigation uncovered the long history of non-compliance and poor care and thus was expanded, becoming the first investigation of its type to examine widespread systemic problems at a major nursing home chain. After it declared bankruptcy and as part of its Chapter 11 reorganization plan, Vencor agreed to settle False Claims Act claims with a payment to the United States of more than $100 million of which about $20 million was attributed to the failure of care portion of the case.

- In United States v. Twin Oaks (E.D. LA), owners of a small nursing home chain paid $100,000 and entered into a Corporate Integrity Agreement settling claims of significant harm to frail residents.

- In United States v. Maxwell Manor, (N.D. Ill.) the United States settled allegations of deplorable conditions in the facility for about $1,000,000 plus $610,000 for the State of Illinois.

- The United States settled United States v. Harbor Healthcare and Rehabilitation Centers, (D. Del.) for $130,000 settling claims of mistreatment at a facility housing both children and elders.

- United States v. Hillcrest Healthcare Center, (D. Conn.), another failure of care case was settled for $750,000 and permanent exclusion of the facility from federal health care programs.

- The Eastern District of Pennsylvania has settled numerous failure of care cases involving nursing homes and other providers. Remedies in those cases have included both monetary settlements and ongoing monitoring agreements. The most recently settled cases include United States v. Central Montgomery Medical Center, settled for $200,000; United States v. Green Acres Wyndmoor, settled for $143,000; and United States v. Brinton Manor, settled for $90,000.

- As noted above, the United States pursued both civil and criminal cases against AHM. (The civil False Claims Act suit was settled for $1,250,000.)

3. *Civil Rights Cases*

The Civil Rights Division conducts investigations of publicly owned and operated nursing homes pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. 1997. CRIPA authorizes the Attorney General to investigate and initiate civil lawsuits to address systemic deficiencies in care, as opposed to individual civil rights violations.

CRIPA investigations typically focus on allegations of staff abuse, failures to protect nursing home residents from harm at the hands of other residents, and grossly deficient medical, nursing, or mental health care.

The Civil Rights Division has successfully resolved CRIPA investigations in nursing homes in Georgia, New Mexico, Pennsylvania, Tennessee, Washington, D.C., and West Virginia. The Division has open CRIPA investigations of nursing homes in California, Maryland, New York, South Carolina, and Tennessee.

The Civil Rights Division's recent investigation of a nursing home in New Mexico is a good example of the Division's work in nursing homes. The Division uncovered numerous dangerously deficient violations in the nursing home. The Division found that medical and nursing care at the nursing home was so deficient that it was aiding and contributing to the needless suffering and untimely deaths of the residents. The following are just three of many examples of residents who died untimely deaths as a result of failures by medical and nursing staff to properly care several residents:

- Despite numerous findings of abnormal and even life-threatening low blood-sugar levels, a 71-year-old resident died because staff failed to respond to these obvious signs of distress.

- In a frighteningly similar example, a 56-year-old resident had, on at least two-separate occasions, tests that demonstrated that he was not receiving an adequate amount of anti-convulsant medication. Nursing home staff failed to respond to these findings. As a result, the resident developed continuous and uncontrolled seizures that contributed to his untimely death.

- A resident who was admitted to the nursing home for rehabilitation following hip surgery died a week after being admitted because staff did not follow proper safety procedures for feeding her, and she died of aspiration pneumonia.

The Division also found that the nursing home's dangerous medication practices were directly resulting in the untimely deaths of residents. For example:

- A resident died of aspiration pneumonia after being prescribed several different anti-psychotic medications, including nearly ten times the recommended dose of one such medication. (The sedation resulting from psychotropic medication is known to cause swallowing difficulties in elders.) There was no justification for the dangerous regimen.

- A 94-year-old resident was being treated with large amounts of psychotropic medication without adequate justification or monitoring. As a likely result of the side-effects of these medications, the resident suffered recurring bouts of aspiration pneumonia. Even though the resident was evaluated for swallowing problems, nursing staff failed to implement recommendations made to address the issue, and the resident died.

The Division also found that the nursing home residents suffered, and often died, in needless pain, making their last days a nightmarish existence. For example, a 66-year-old resident with terminal bone cancer was admitted to the nursing home for end of life of care. Despite the obvious need for pain management care, the nursing home horribly mismanaged the resident. At one point, she even had her pain-management medication reduced to one-tenth of what she had previously been prescribed. In the opinion of the expert for the Civil Rights Division, allowing a human being to die under such circumstances is "unconscionable."

The Division resolved this investigation with a court-enforceable agreement. New Mexico has agreed to address and correct all of the violations identified by the Division. The Division's findings letter and court-enforceable agreement in the New Mexico nursing home matter, as well as the Division's findings in other kinds of CRIPA cases, can be found at the Division's website, http://www.usdoj.gov/crt/split/index.html.

The Division is currently conducting an investigation of two veterans' nursing homes in Tennessee. Immediately following the Division's on-site tours, Tennessee announced that it was temporarily closing admissions to these two facilities. The Division has not yet concluded the fact finding portion of its investigation.

4. *Working Groups and Outreach*

Several jurisdictions have working groups that pursue outreach relating to abuse and neglect of frail elderly patients in long term care. The Eastern District of Pennsylvania, which has been extensively involved in nursing home issues for more than a decade, has had an active outreach program, including hosting a seminar entitled "Elder Abuse and Neglect Medical Forensics Seminar" attended by more than 120 federal, state, and local law enforcement personnel, co-sponsoring Grand Rounds Program at The Reading Hospital and Medical Center to address the signs and symptoms of elder abuse and neglect, and training for coroners and medical examiners. Similarly, all three districts in Louisiana were part of a working group that formed the Louisiana Abuse and Neglect Action Committee which lectured throughout the state to providers, medical schools and nursing schools on issues of fraud and abuse. Another example of such outreach is the participation of the United States Attorney's Office for the District of Columbia in the District's Adult Abuse Prevention Committee, comprised of both government and private-sector partners. That Committee has focused on the prevention of financial and physical abuse of senior citizens. In support of its mission, the committee provides training for professionals who work with seniors on such issues as financial abuse, predatory home lending, mortgage fraud and multi-cultural aspects of domestic violence.

B. Health Care Fraud

Federal prosecutors can only pursue cases where there is a basis for federal jurisdiction, and are limited by the statutes available to us. There is no federal abuse and neglect statute. But since the enactment of Health Insurance Portability and Accountability Act (HIPAA) in 1996 which included a number of new federal health care fraud criminal statutes, federal prosecutors have successfully brought a number of systemic failure of care cases as Medicare and Medicaid fraud, in addition to fraud, wire fraud, false statement, false claim and conspiracy theories. Civil failure of care cases are pursued under the False Claims Act and at common law.

Fraud against federal programs such as Medicare and Medicaid, inures to the detriment of all beneficiaries of those programs, including millions of older Americans. Thus, the Department's health care fraud efforts also benefit elders. Since HIPAA's enactment and through FY 2006, we have recovered a total of $11.87 billion of which $10.4 billion has been returned to the Medicare Trust Fund. Over the same period, the Health Care Fraud and Abuse Control account (HCFAC) funding for law enforcement, which includes the Department of Justice, FBI, and HHS-OIG, cost $2.59 billion. Thus, we can conservatively say that for every dollar the government spends on health care fraud enforcement in the HCFAC program, the Medicare trust fund recovers at least $4. This figure does not even capture the deterrence effects of our criminal prosecutions, which are harder to quantify but exist nonetheless, saving taxpayer money. Thus, the Department's health care fraud efforts result in substantial savings to Medicare and Medicaid, strengthening those programs so they can better fund quality health care services for beneficiaries.

Over the last 10 years, we have significantly increased the number of civil cases we file and criminal convictions we obtain. In FY 2006, we had 547 defendants convicted of health care fraud offenses, the highest number to date. This represents about a 50% increase in convictions since the start of the HCFAC program in 1997. Last year we filed 217 new civil health care fraud cases, which represents an increase of about 144% since the program started in 1997. Last year was also a record year for civil recoveries. Our Civil Division, working with the U.S. Attorney's Offices, obtained judgments and settlements totaling over $3.2 billion in fraud recoveries. Of that amount, $2.2 billion came from health care fraud cases.

C. Financial Fraud and Identity Theft

1. *Telemarketing Fraud*

In addition to failure of care cases, the Department also pursues financial crimes targeting older Americans. Telemarketing fraud costs Americans about $40 billion every year and the Federal Trade Commission estimates that 85% of the victims are 65 or older. For this reason, United States Attorneys Offices are also very involved in prosecuting these sorts of financial cases. In United States of America v. Payment Processing Center, LLC, et al., for instance, a permanent injunction that terminates PPC's operations, imposes a receivership over its assets, and establishes a multi-million dollar restitution fund for victims of PPC and fraudulent

telemarketers was obtained by the Eastern District of Pennsylvania. The restitution program will include mailed notices to all of PPC's victims who have not already received full refunds. The U.S. Attorney's Office anticipates that at least $4 million of the defendants' assets will be available to fund the restitution program. The injunction also imposes a lifetime prohibition against PPC's owners and managers from ever again engaging in any activity in which unsigned bank drafts are used to process payments for telemarketers and the defendants also are permanently restricted in their performance of other payment processing activities.

2. *Identity Theft*

On May 10, 2006, by Executive Order 13402, President Bush established the President's Task Force on Identity Theft. In forming the Task Force, which was chaired by Attorney General Gonzales and co-chaired by Commissioner Deborah Platt Majoras, Chair of the Federal Trade Commission, the President recognized what many of you know from your own experience. Identity theft is an insidious crime that severely burdens our economy, and exacts a heavy financial and emotional toll on its victims. Millions of Americans are harmed every year by identity thieves, including elderly Americans. Not only are these victims cheated out of money - billions of dollars in losses - but they are also robbed of their good names, their good credit, and their invaluable time. A victim can spend months or years rebuilding a damaged credit history and cleaning up the damage caused by the thief. This can be a particularly bewildering and frustrating process for elderly persons.

Through the leadership of the Attorney General and Chairman Majoras, the Task Force announced the completion of a comprehensive Strategic Plan to combat identity theft on April 23, 2007. The plan focuses on improvements in certain key areas including victim assistance, and deterring identity theft by more aggressive prosecution and punishment.

Let me first address our efforts to prosecute and punish identity thieves. Consistent with the recommendations of the Task Force, each United States Attorney's Office has designated an identity theft coordinator who is responsible for designing a district-specific identity theft program. This could potentially include a focus on identity theft schemes which target the elderly. The United States Attorney's Offices are also reevaluating their minimum monetary thresholds in an effort to prosecute smaller identity theft rings that still cause a great deal of damage, particularly to persons living on fixed incomes. Each of the United States Attorney's Offices will also be meeting with our state and local partners to encourage additional prosecutions of identity thieves on state charges, and to discuss the creation of working groups and task forces.

We are also helping victims of identity theft. With our Task Force partners, especially the FTC, we are developing and promoting a universal police report that will make it easier for identity theft victims to report the crime. We are also actively encouraging and assisting the ABA to develop a pro bono referral program focusing on assisting identity theft victims, including elderly victims, with recovery. The Department is helping to train victim assistance counselors to respond to the specific needs of identity theft victims, including assisting them in coping with the financial and emotional impact of identity crime. The FTC and the Department

are developing educational materials for first responders that can be readily used as a reference guide for identity theft victims.

As part of a multi-year campaign, we are also increasing our outreach efforts to traditionally underserved communities, including the elderly. In doing so, we will enlist as outreach partners national organizations either that have been active in helping consumers protect themselves against identity theft, such as the American Association of Retired Persons (AARP), the Identity Theft Resource Center (ITRC), and the Privacy Rights Clearinghouse (PRC), or that may be well situated to help in this area, such as the White House Office of Faith-Based and Community Initiatives.

Identity theft ring using Social Security Administration (SSA) database to steal benefit payments from elderly (E.D. New York):

o On February 22, 2006, federal criminal charges were filed against four defendants in an identity theft ring that used information from the SSA's computer system to steal tens of thousands of dollars in Social Security benefit payments and other money from elderly and disabled beneficiaries in the New York City area and nationwide between January 2004 and February 2006.

o The charges allege that a former SSA Teleservice Representative ("employee") had access to the SSA's database of personal information, including names, social security numbers and bank account information, for Social Security beneficiaries throughout the country. That employee used her access to change the bank accounts designated by beneficiaries for direct deposit of their benefit payments to accounts controlled her and her three co-conspirators, who are also defendants in this case. Once a benefit payment was deposited into one of the controlled accounts, the defendants would switch the bank account back to the original information in order to conceal the fraud. They repeated this process several times in order to divert ongoing payments.

o Their scheme was uncovered when two of the defendants were arrested by the NYPD after attempting to cash a check drawn on the account of one of the victims whose personal information the employee had accessed in the SSA database. The NYPD, in cooperation with the U.S. Secret Service, the SSA OIG's Office of Investigations, and the Queens County District Attorney's Office, then executed a search warrant at the residence of two of the defendants. The three defendants have been charged with conspiracy to commit wire fraud. If convicted, each defendant faces a maximum sentence of five years' imprisonment, a $250,000 fine, and full restitution for the moneys they are responsible for stealing.

Defendant sentenced to 25 years in prison for his role in investment fraud and tax evasion scheme (S.D. Fla):

o Nicholas D. DeAngelis was sentenced in U .S. District Court to twenty-five years Imprisonment, followed by three years of unsupervised release. DeAngelis was also

ordered to pay restitution to his victims in the amount of $4,219,249.

- In June 2004, following a three week trial, a jury in West Palm Beach, Florida, convicted DeAngelis on every count of a fifty-one count indictment, which charged him with wire and mail fraud, money laundering, obstruction of justice, perjury, conspiracy, identity theft, and tax evasion.

- DeAngelis used false representations to induce investor victims, including several senior citizens, to send approximately $1.5 million to his investment companies: Velvet Hammer Consulting Group and GIASI (Godly Inspired and Spiritually Invincible), Inc. DeAngelis then laundered these funds for his own use. He also engaged in actions designed to defraud the government of $2.6 million in unpaid federal income taxes. Several investors lost their life savings by investing with GAISI and DeAngelis.

Caretakers for elderly sentenced for identity theft (D. Maryland):

- Geraldine Wooten, age 68, was sentenced in U.S. District Court to 41 months imprisonment followed by three years of supervised release in connection with her guilty plea to conspiracy in a scheme to defraud elderly individuals Wooten worked for as well as various financial institutions. Judge Alexander Williams, Jr. also sentenced Wooten to make restitution to two elderly victims in the amount of $150,021.56. Her husband, Sylvester Butler, age 61, was sentenced to 18 months of imprisonment followed by three years supervised release for his role in the conspiracy, and ordered to make restitution to one victim in the amount of $85,794.24.

- The indictment resulted from a U.S. Postal Service investigation which learned that Ms. Wooten, who had providing care for a 96 year-old woman, had used the victim's credit history, name and social security number to open numerous credit card accounts and to write fraudulent bank checks on other accounts. Prior to that investigation, Ms. Wooten worked as a caregiver to an Alzheimer's patient and had used the patient's personal information to purchase a house in Georgia and open other accounts.

Caregiver of elderly and terminally ill victim sentenced to two years for aggravated identity theft (S.D. West Virginia):

- Patty Lou Kelley, 51, of Charleston, WV, previously pled guilty on July 20, 2006 to aggravated identity theft. The charges arose out of an investigation conducted by the Charleston Police Department and the United States Postal Inspection Service, in which investigators learned that while employed as private care giver for the elderly victim, Kelley (1) forged the victim's signature on forty-seven (47) unauthorized checks drawn on the victim's personal checking accounts, totaling approximately $53,069; (2) made unauthorized purchases on the victim's credit cards, totaling approximately $15,757; and (3) used the victim's personal information and credit history to apply for additional credit cards which Kelley diverted to her home address.

U.S. Attorney's Office in the Northern District of Indiana indicted three individuals relating to a bank fraud identity theft ring that operated from July to September 2005. Each indictment alleges participation in the same scheme to defraud banks and individual holders of credit cards, and to commit aggravated identity theft. It is alleged that one of the defendants, while a prisoner in the St. Joseph County Jail, searched the obituary section of newspapers for elderly people who had died but had surviving spouses. Even while incarcerated, that defendant, with the help of outside accomplices, called the surviving spouses, posing as a person from "Credit Card Services." Under the guise of inquiring whether the surviving spouse wished to make any changes to their credit card upon their spouse's death, he urged them to divulge their credit card number, date of birth, and social security number. That defendant and his accomplices utilized the information gleaned from these malicious calls to make big-ticket purchases with the stolen credit card numbers. The investigating officers and agents estimated the total loss to be at least $80,000. Approximately fifty potential individual victims were allegedly contacted by that defendant from jail, and information was obtained from half of those persons. Most of the individual victims were elderly or vulnerable.

In the Northern District of Georgia, two individuals were sentenced in federal court on charges of conspiring to file false claims against the U.S. and fraudulently using other persons' social security numbers. Joseph Milligan received a two year prison sentence. Co-conspirator Rae Beavers received a year and 1 day in prison. Milligan and Beavers both worked at Eye Consultants of Atlanta, P.C when, in 2002, they began to steal the names, social security numbers, and dates of birth of elderly patients. They provided that information to a convicted co-conspirator, Terrence Edwards, who used it to file fraudulent federal income tax returns over the Internet. (Edwards is currently serving a federal prison term of 30 months, after pleading guilty to conspiracy to file fraudulent claims) Each fraudulent tax return claimed that a refund was due, and along with these returns Edward filed for a refund anticipation loan from Santa Barbara Bank & Trust.

In July 2002, Milligan began working for Greenville Radiology, P.A. in South Carolina. In this position, he compiled additional lists of elderly patients' names, social security numbers, and dates of birth for use by Edwards. Edwards paid Milligan between $200 and $500 for each list of patient identity information. Through Milligan's and Beavers' participation, Edwards filed approximately 70 returns that falsely claimed returns in excess of $200,000.

2. Research, Training and Programs to Fight Elder Abuse, Neglect and Exploitation

There is broad consensus among experts that research and practice relating to elder abuse lags behind research in the fields of child abuse and domestic violence. The Department, through the bureaus in its Office of Justice Programs (OJP), funds research, training, technical assistance, coordination efforts, and other programs, publishes statistics and reports, and identifies practitioners' needs. These efforts are beginning to make inroads into the elder abuse knowledge and program deficits. Through its activities, OJP works to enhance understanding, prevention, detection, intervention, and prosecution of crimes and promote assistance of elder victims.

Given the many entities with a stake in elder justice and the dire need to expand our knowledge and improve our programs, OJP has supported multi-disciplinary coordination and law enforcement efforts at all levels. OJP is uniquely situated to tap into expertise, apply lessons learned in other areas, sponsor innovation, and take a national view of this issue.

To better promote these goals, representatives from the National Institute of Justice, (NIJ), the Office for Victims of Crime (OVC), the Office for Violence Against Women (OVW), the Bureau of Justice Statistics (BJS), the Bureau of Justice Administration (BJA), the Elder Justice and Nursing Home Initiative, and the Civil Division meet periodically to discuss each entity's activities and identify potential opportunities, priorities and areas for collaboration.

The OJP Bureau's activities include the following:

A. National Institute of Justice Research

There is broad consensus that the evidence base relating to elder abuse lags decades behind that in other related fields. The National Research Council's National Academy of Science issued a report five years ago that said so little was known about the field that it would be premature to set a national research agenda. Indeed, the paucity of research has been a significant impediment to determining the most effective ways to address the problem.

Responding to that gap, the National Institute of Justice (NIJ) issued the first-ever solicitation for research applications relating to elder abuse, neglect, and exploitation (simultaneously with the National Institute on Aging) in 2005. Given the pent-up demand for research in this field, the solicitation yielded a large number of applications, as did solicitations in the two subsequent years. As a result, NIJ now has numerous of research projects underway, which will no doubt serve to inform the field on a number of important topics. For example, most medical professionals and other first responders do not recognize which physical or behavioral characteristics signal abuse or neglect rather than natural effects of illness or aging. There also are correspondingly few experts in the field available to provide expert consultation or to testify in court, making it even more difficult to prove elder abuse.

In response to these needs, NIJ has built a research program on elder mistreatment. Through this research we will make inroads to better understanding the prevalence of elder abuse, forensic markers of abuse and neglect, risk factors, and the effectiveness of intervention efforts.

Many of the NIJ research projects are currently underway, but we have already seen some important findings as the result of studies including the following:

- In the first study to examine physical markers for abuse in elders, the University of California, Irvine conducted a study to evaluate bruising in elders. They concluded that (1) contrary to the conventional wisdom, you cannot date a bruise by its color, and (2) 90 percent of accidental bruises in the elders studied appeared on the limbs and 10 percent

on the torso. Elders often did not remember how they got such bruises. What can we learn from this study? That if an elder has a bruise in another location, such as on the head, neck, genitalia, inner thigh, or if the bruise is a pattern bruise, someone should ask more questions about the genesis of that bruise.

- Another ongoing NIJ research project found that medical examiners encountering suspicious elder deaths have difficulty differentiating symptoms of illness from signs of abuse or neglect. Signs of abuse that might easily be recognized in a younger person are missed in the elderly. As a result, it appears that few medical examiner investigate, let alone designate abuse or neglect as the cause of death in an older person. The study's findings encourage additional research on both the decision-making practices of medical examiners and the forensic markers of elder mistreatment. The findings also highlight the need for additional training of medical examiner in this area.

- NIJ is also studying an Arkansas law requiring death investigations in all nursing home deaths. The study not only seeks to learn about forensic methods relating to elder deaths, but also whether the law itself improved conditions in nursing homes in jurisdictions where it was enforced, and what kind of an impact the law had on prosecution of nursing home abuse and neglect.

- Researchers also are examining non-nursing home long term care and the state oversight systems and standards that govern those entities, which differ dramatically from state-to-state. This project will survey programs designed to detect, prevent, investigate, prosecute or otherwise redress abuse of frail elders who live in residential care facilities (RCFs), and provide recommendations for strengthening these programs. To do so, the study will describe and assess the responsibilities and processes in state agencies that license RCFs for identifying, addressing, and preventing abuse of residents; describe and assess the role and performance of Adult Protective Services and ombudsmen in investigating and resolving abuse allegations; describe the role of law enforcement in investigating and prosecuting cases; investigate the causes of underreporting and potential solutions; identify and describe innovative practices or model systems, including coordination across agencies; assess the feasibility of their implementation in other states; and make recommendations for changes in policies and programs.

- A long-term study will spotlight the risks for abuse and what types of services victims have received. This will highlight which victims receive help and which do not and how reporting of victimization affects the course of abuse.

- The National Center on Elder Abuse reports that 92% of financial abuse victims are elderly women and the most vulnerable group are those over 80. Very little else is known about risk factors for financial abuse of the elderly. Thus the goal of this study is to identify factors associated with financial abuse of the elderly as opposed to other forms of abuse.

- In another study still underway, similar to the bruising study described first, researchers

will examine how practioners can determine whether a pressure ulcer was caused by neglect.

- Finally, NIJ is considering several additional areas of research on elder abuse, including understanding the capacity of elderly individuals to participate in the prosecution of elder abuse cases and evaluating the effectiveness of technologies for detecting elder mistreatment.

In sum, NIJ's elder abuse research portfolio is beginning to yield results important to the detection, prevention and prosecution of elder abuse. Importantly, one of the guiding principles in NIJ's grant-making in this area is that the research not occur in a vacuum, but that the results have the potential to assist practitioners and policy makers.

In addition to NIJ's efforts, OJP's Bureau of Justice Statistics also has examined the prevalence and types of crimes against the elderly. This study, of households, indicate that elders are less likely to be victims of violent crime, but the statistics do not capture crimes against elders living in any type of facility.

B. Support for Victims of Elder Abuse

Our Office for Victims of Crime (OVC) has worked steadily to increase awareness of elder abuse among law enforcement, care providers, and other professionals. OVC supports services to victims of elder abuse, efforts to investigate these cases, and initiatives to prevent further abuse.

Through an OVC grant, Baylor College of Medicine built on a multi-disciplinary effort to address elder abuse in Houston, Texas in a partnership involving law enforcement, adult protective services, the medical community, and the county attorney. Baylor developed a manual to guide other communities interested in undertaking similar efforts. The grant also funded Baylor to fund two additional pilot sites for its program.

Although there have been fatality review teams to analyze the deaths of children and younger adults for decades (identifying both systemic problems that led to the death and potential solutions) there was not a single known elder fatality review team until a few years ago. With funding from OVC, the American Bar Association Commission on Law and Aging (ABA) partnered with the National Association of Adult Protective Services Administrators (NAPSA) to enhance the fledgling elder abuse fatality teams that had been developed in a handful of jurisdictions. These multi-disciplinary teams identify the cause of fatalities in order to improve the handling of future cases and show great promise. The OVC grant also funded development of a "replication guide" providing guidance to communities that wish to establish their own teams.

OVC also is working with partners to develop training videos for a range of professionals who encounter elder abuse. Each video will target a specific discipline, such as law enforcement, the judiciary, probation and parole professionals, adult protective services, victim advocates and health care professionals. In addition, OVC has worked with organizations

such as medical schools, the International Association of Forensic Nurses, the Police Executive Research Forum, and the American Probation and Parole Association to develop curricula for identifying and responding to elder abuse cases. Like the videos, each curriculum will be targeted to a specific discipline. Curricula for physicians and probation and parole officers have already been completed. The curricula for law enforcement and forensic nurses are still in development.

C. Office of Violence Against Women Training Grants

The Department's Office on Violence Against Women (OVW) administers the Training Grants to Stop Abuse and Sexual Assault Against Older Individuals or Individuals with Disabilities program (Training Grants Program). That Program was authorized in the Violence Against Women Act of 2000 to address the obstacles encountered by victims of crimes who are older or who have disabilities. Through this program, OVW has awarded over $20,270,000 from FY 2002 through FY 2006. This grant program provides a unique opportunity for targeted training for law enforcement officers, prosecutors, and court officers to enhance their ability to identify, investigate, and prosecute abuse, neglect, exploitation, and violence (including sexual assault and domestic violence) against elderly individuals or individuals with disabilities. States, tribes, units of local government, nonprofit nongovernmental organizations, state or local government agencies, private nonprofit victim advocacy organizations, and public or private nonprofit service organizations for older individuals or for individuals with disabilities may receive funding under this grant program.

From July 1, 2003 to June 30, 2005, Training Grants grantees trained 12,991 individuals, including law enforcement officers (54 percent), prosecutors (8 percent), victim witness specialists (5 percent), court personnel (4 percent), and corrections staff (1 percent). The most common topics of training events were issues specific to victims/survivors who are isolated or institutionalized, the impact of aging and/or disabilities, effective communication with individuals who are older or with disabilities, law enforcement response to domestic violence, and law enforcement response to elder abuse and exploitation. A grantee from this program reports that, "[i]n a nutshell, the Training Grant has given us the opportunity to raise awareness about elder abuse, about resources available to address the problem, and to foster better communication between law enforcement and others in the elder services community."

Starting in FY 2005, OVW embarked on the development of a pilot program for systemic training on elder abuse for the criminal justice system which included the development of national training curricula for law enforcement officers, prosecutors, judges and training teams who provide training for law enforcement on the local level. In 2007 and 2008, ten communities will pilot the four curricula.

The Violence Against Women Act of 2005 resulted in significant changes to the grant program. The grantees may now address the issues of dating violence and stalking and no longer address only violence against women with disabilities. The age of victims to be the focus of the grant program activities was lowered to victims 50 years of age or older. In addition, the program purpose areas may include training for governmental agencies and victim assistants and

the provision or enhancement of services for older victims. The new OVW grant program, Enhanced Training and Services to End Violence Against and Abuse of Women Later in Life, will create or support multidisciplinary collaborative community response to older victims and conduct cross training for victim service organizations, governmental agencies, courts, law enforcement agencies, and nonprofit, nongovernmental organizations serving older victims.

D. Bureau of Justice Assistance programs

The National District Attorney Association (NDAA) and the American Prosecutor Research Institute (APRI) have a Center for the Prosecution of Child Abuse and a Center for the Prosecution of Domestic Violence to support the efforts of local prosecutors nationwide in pursuing those difficult cases. But it has no similar center for the prosecution of elder abuse. Thus the Department funded a review of what kinds of elder abuse cases local prosecutors are bringing around the country, case studies of a few jurisdictions, and an examination of some of the challenges and ingredients for success in such cases, to lay foundation for similar types of assistance for elder abuse cases. The reports that are the result of that grant are available on the APRI website.

3. **The Elder Justice and Nursing Home Initiative**

The Department's Elder Justice and Nursing Home Initiative, housed in the Civil Division, facilitates and supports failure of care cases, research, training, outreach, collaborative efforts, and the advancement of forensic knowledge relevant to elder abuse, neglect and exploitation. Some of the Initiative's ongoing projects include the following:

- Support for failure of care investigations and cases, such as those discussed above, by providing the assistance of nurse investigators, data analysis, coordination with relevant entities, and by balancing the United States' law enforcement, fiscal and public health interests on an ongoing basis.

- In 1999 and 2000, the Initiative organized regional conferences providing training on the investigation, prosecution and prevention of abuse, neglect and fraud in long term care and encouraged participants to create multi-agency, intergovernmental Working Groups to continue meeting and working together at the state and local level. (At the time of the meetings, many of the individuals working on these issues had never met, even if they worked in the same city, or even the same building.) Some groups continue to meet and pursue activities such as those described above. The working groups generally are comprised of state and federal, and sometimes local, law enforcement as well as state and federal regulatory agencies. Although they pursue varying missions, many of these groups strive to identify appropriate investigation targets and to promote cooperation in the investigations and cases that follow.

- The Initiative has organized training, conferences, roundtables, meetings and other events addressing specific elder abuse-related issues designed to advance the state of knowledge, enhance participants' expertise and foster collaborations. A September

2006 meeting brought together attorneys and investigators to discuss failure of care cases. An April 2004 forensics meeting brought together OJP's elder justice grantees and other stakeholders to discuss advances, challenges and new horizons in elder abuse research. In addition, the Initiative works with a myriad of other entities and individuals, federal, state and local, as well as public and private, on a broad array of elder abuse issues.

- The Initiative also has worked with most of the OJP Bureaus to launch elder abuse-related research, training and other projects designed to enhance the knowledge base, training and practice in the field of elder abuse, neglect and exploitation.

- These efforts have resulted in an elder abuse-related grant program, housed in the National Institute of Justice (NIJ), the first-ever elder abuse research solicitation (simultaneous with the National Institute on Aging) in 2005, and two additional solicitations in 2006 and 2007. This NIJ grant program has resulted in a dramatic increase in ongoing elder abuse research, particularly relating to forensic issues. There is a general consensus that research in elder abuse and neglect lags behind that in the fields of child abuse and domestic violence, posing significant impediments to detection, intervention and prosecution. As described below, the NIJ grant portfolio spans a broad range of topics, with a common feature that they are designed to yield results that are of real use to practitioners in detecting, intervening in, preventing, assessing and prosecuting elder abuse. (That research is described in greater detail below.) Specifically, this research redounds to the benefit of prosecutors because it is creating a body of data to rely on in supporting when a condition is the result of wrongdoing versus a condition of aging. In addition, the Department's efforts have fostered medical-forensic experts who are critical to pursuing elder abuse and failure of care cases.

- The Initiative also has worked on projects with OVC, OVW, BJS and BJA, for example to develop training DVDs, curricula and other materials and a project to examine the needs of local prosecutors in pursuing elder abuse prosecutions. In addition, representatives of several of OJPs Bureaus have been meeting regularly with Initiative representatives to coordinate and identify future opportunities for collaboration.

- The Initiative co-chairs an interagency Elder Justice Workgroup that meets periodically, bringing together federal entities with a role in elder abuse prevention. Participants include components from the Department of Justice (Civil Fraud, the Bureau of Justice Statistics (BJS), the National Institute of Justice (NIJ), the Office for Victims of Crime (OVC) and Violence Against Women Office (VAWO)), from HHS (Administration on Aging (AoA), Centers for Disease Control and Prevention (CDC), the National Institute on Aging (NIA), Office of Inspector General (OIG), Centers for Medicare and Medicaid Services (CMS), the Administration for Children and Families (ACF), and the Substance Abuse & Mental Health Services Administration), ACF (SAMHSA)) and occasionally from other agencies, such as the US Postal Service, the Veteran's Administration, and the Federal Trade Commission. In the past, this group has had presentations relating to various elder abuse-related issues, often about ongoing projects, research or innovations. Recently, the group has begun to address data

collection issues vital to the field.

Conclusion

The cost of elder abuse and neglect is high. The Committee can be assured that the Department of Justice will continue to pursue theses cases and work with this Committee in addressing the myriad issues which I have briefly discussed this morning.

The CHAIRMAN. Thank you for your testimony, Mr. Fridman. We will get back to you and Ms. Connolly in just a moment.

Now we have as our second witness, as I said, Mr. Demske, who has particularly made an effort to be here today, because, as we understand, your wife is having a baby as we speak or something like that. Is that correct?

Mr. DEMSKE. Well, in a few hours, yes. [Laughter.]

The CHAIRMAN. Congratulations.

Mr. DEMSKE. Thank you, sir.

The CHAIRMAN. Go ahead.

STATEMENT OF GREGORY DEMSKE, ASSISTANT INSPECTOR GENERAL FOR LEGAL AFFAIRS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. DEMSKE. Good morning, Chairman Kohl. I appreciate the opportunity to join you here this morning.

Stopping elder abuse requires a multifaceted commitment from Federal and State agencies, providers and other stakeholders, many of whom are represented here today.

The Office of Inspector General at HHS advances this important goal of preventing elder abuse in three ways: We do oversight, enforcement and guidance.

First, in our oversight role, we evaluate the programs and systems involved in regulating quality of care and make recommendations to the Centers for Medicare and Medicaid Services. OIG reviews have examined the effectiveness of oversight and enforcement by CMS and the States, screening of long-term-care employees, and the effect of reimbursement systems on access to care and the quality of that care.

As an example, in testimony before this Committee in 1998, we recommended enhanced efforts to require criminal background checks and development of a national-abuse registry for long-term-care employees.

The second broad area of our work is enforcement. Although most cases of elder abuse are investigated and prosecuted by States, the Office of Inspector General works with the Department of Justice to investigate cases of systemic substandard care.

You have heard some examples of those types of cases. Among the types of things that we have seen in nursing homes in cases we have investigated are patients suffering from dehydration, malnutrition, untreated broken bones, avoidable amputations, drug overdoses and deaths.

In order to better team with States to address these issues, OIG has, over the past year, initiated extensive joint training programs and enhanced coordination with MFCUs, with a particular emphasis on jointly developing failure-of-care cases.

With respect to administrative enforcement, OIG has excluded many individuals from participation in Federal health-care programs. Last fiscal year, we excluded over 2,000 individuals who either had been convicted of patient abuse or neglect or had lost their license to perform health care for reasons bearing on their professional performance or competence.

In cases involving failure of care in which we do not require exclusion, we require the organization to enter into a corporate integrity agreement with our office. These corporate integrity agreements require the organization to hire an independent quality monitor selected by the OIG. These monitors have access to the providers' facilities, staff, programs and records. Using that access, they make recommendations to the providers about how to make systemic changes to protect the safety and well-being of the patients.

The third major component of our quality-related work is our guidance to the health-care provider community. For example, in 2000, we issued the "Compliance Program Guidance for Nursing Facilities." As part of that document, we provided guidance to facilities about what they should include in voluntary compliance programs, including steps to safeguard the safety and security of patients.

OIG is also increasingly focusing on the role of boards of directors in safeguarding quality of care. We believe it is essential for board members to focus at least as much attention on the quality of care furnished by a provider as they do on the financial performance of the provider. Just last month, we issued a guidance document for members of boards of health-care providers to outline steps they could take to fulfill their oversight responsibilities with respect to quality of care.

In conclusion, elder abuse in our health-care system can only be stopped through a concerted, multidimensional effort by many parties. OIG is committed to advancing this goal through review of CMS and State oversight, vigorous investigation and enforcement of wrongdoers, and guidance to leaders at health-care providers about how they can enhance quality of care.

Thank you.

[The prepared statement of Mr. Demske follows:]

Testimony of:
Gregory E. Demske
Office of Counsel to the Inspector General
U.S. Department of Health and Human Services

Good morning, Chairman Kohl, Ranking Member Smith, and distinguished members of the Committee. I am Gregory Demske, Assistant Inspector General for Legal Affairs in the Office of Inspector General of the Department of Health and Human Services. I appreciate the opportunity to appear before you today to discuss our work related to identifying and preventing the abuse of the elderly. OIG shares your commitment to ensuring the proper oversight of programs designed to serve this Nation's elderly with particular emphasis on the safety and well-being of this population. I look forward to discussing with you today some of the ways OIG seeks to fulfill this goal.

A large portion of OIG's work is aimed at identifying and recommending methods to minimize inappropriate payments, identifying ways to close loopholes that enable unscrupulous providers to defraud Federal health care programs, and examining payment and pricing methods to ensure that Medicare and Medicaid, those programs' beneficiaries, and taxpayers realize good value for program expenditures. Ensuring that appropriate payments are made for properly rendered services also reduces the possibility that the elderly are incurring unnecessary financial liabilities, such as copayments and deductibles, stemming from fraudulently billed services.

However, OIG also conducts reviews to identify whether beneficiaries are able to promptly obtain needed health care services and monitors oversight activities designed to ensure that beneficiaries receive quality services. In particular, OIG has long been concerned with the quality of care rendered in nursing facilities. OIG efforts are threefold: to evaluate the programs and systems involved in oversight of quality of care, to work with State and Federal agencies to investigate and prosecute cases of egregiously substandard care, and to provide guidance to providers to aid in their efforts to promote high quality care.

In my testimony today, I will describe the spectrum of studies, enforcement actions, and initiatives that OIG has undertaken to identify cases of elder abuse, ensure that those who would harm the elderly are prosecuted to the fullest extent of the law and/or prevented from continuing to participate in Federal health care programs, identify where the programs and systems involved in the oversight of quality of care may be strengthened, and promote practices that will help prevent these abuses from occurring.

OVERSIGHT OF MECHANISMS DESIGNED TO ENSURE QUALITY OF CARE

OIG has produced a large body of work related to quality-of-care issues in Federal health care programs in a variety of settings, such as hospitals, nursing homes, and clinical trials. Quality-of-care issues in nursing homes have been of particular concern for OIG over the past decade because of the increasing number of beneficiaries in these settings and the vulnerabilities associated with this population.

With respect to Medicare and Medicaid services rendered in long-term care settings, we have examined a variety of factors that may affect the provision of quality care. First, we have done extensive work in examining the effectiveness of oversight and enforcement mechanisms used by the Centers for Medicare & Medicaid Services (CMS), its contractors, and the States. Second, we have reviewed mechanisms used to screen potential employees of long-term care facilities. And third, much of our work has focused on determining whether providers are potentially harming beneficiaries by taking advantage of financial incentives under various Medicare and Medicaid reimbursement systems to provide too few needed services, to end care too soon, "ping-pong" Medicare beneficiaries among different care settings, or limit access to potentially less profitable patients. I will discuss each of these in turn.

Oversight and Enforcement Mechanisms

Regulating nursing homes that participate in the Medicare and Medicaid programs is primarily the responsibility of CMS and State agencies through their survey and certification efforts. Through periodic facility inspections and individual complaint investigations, CMS and the State agencies assess nursing home performance and determine whether to certify facilities for participation in Medicare and Medicaid. Nursing facility certification is required by statute at least every 15 months, and the statewide average interval between certification of facilities cannot exceed 12 months. States are required to refer case information to CMS for enforcement action when facilities are found to be out of compliance for designated time periods or have deficiencies that put residents in immediate jeopardy. Enforcement actions are mandatory to address particularly egregious cases of noncompliance. Enforcement actions can include termination of the facility's Medicare contract and denial of payment for new admissions. Other enforcement actions include corrective action plans, civil monetary penalties, required changes in management, and decertification, all administered by CMS.

In a March 2003 report, OIG reviewed trends in survey and certification deficiencies as well as the effectiveness and consistency of the survey and certification process. For the time period studied (1998-2001), OIG determined that a large number of nursing homes had been cited for substandard care and that the number of deficiencies had increased. In addition, our work identified inconsistencies in the way in which deficiencies were cited by the various State survey agencies. These inconsistencies resulted from variations in survey focus, unclear guidelines, lack of a common review process for draft survey

reports, and high turnover of surveyor staff. We recommended that CMS improve guidance to State agencies on citing deficiencies by providing guidelines that are both clear and explicit and that CMS, together with States, develop common review criteria for draft survey reports. CMS has since issued guidance on assessing the severity of deficiencies related to quality of care and quality of life and is currently developing guidance to address other deficiencies.

More recent work has focused on CMS and State enforcement mechanisms against nursing homes that are out of compliance for designated time periods or have deficiencies that put residents in immediate jeopardy. For example, in an April 2005 report, OIG found that although $81.7 million in civil monetary penalties (CMP) were imposed during 2000 and 2001, CMS had collected only $34.6 million (42 percent) by the end of 2002. The unpaid portion included reductions resulting from nursing homes waiving their right to appeal, settlements and reductions resulting from appeals, payment delays caused by appeals or bankruptcy proceedings, and nonpayment of collectible CMPs. We also found that CMS did not utilize the full dollar range allowed for CMPs and impositions were frequently at the lower end of the allowed ranges. Low imposition rates and slow and/or difficult collection efforts may minimize the effect that CMPs ultimately have on noncompliant facilities. A more recent OIG report, issued May 2006, found that for the majority of cases requiring mandatory termination of nursing facilities, CMS did not apply the remedy because of both late case referrals by States and CMS staff's reluctance to impose this severe remedy. Based on the findings of these reports, we recommended that CMS provide guidance to regional CMS staff and States regarding appropriate CMP dollar ranges for types of violations and take required collection steps. We also recommended that CMS terminate noncompliant facilities' participation in the Medicare and Medicaid programs within the required timeframe. CMS has taken a number of actions, including implementing both case and incident-tracking systems, that should help to ensure that enforcement actions are properly taken when warranted and implemented more timely.

The Omnibus Budget Reconciliation Act of 1987 requires States to provide timely review of complaints and to investigate allegations of neglect, abuse, and misappropriation of resident property. In a July 2006 review, OIG found that State agencies did not investigate some of the most serious nursing home complaints within the required timeframe and that CMS's oversight of nursing home complaint investigations is limited. We recommended that State agencies be required to meet the 10-day timeframe for investigating complaints alleging actual harm (high) and that CMS eliminate its advance notice requirement for the Federal oversight and support surveys to allow its regional offices to more fully oversee State agencies' investigations of the most severe complaints. CMS has since updated the State Performance Standard, which it uses to hold State agencies accountable for the timeliness of their complaint investigations, to make the timeframe consistent with the 10-day requirement in its "State Operations Manual."

As part of our work looking at quality-of-care oversight in other long-term care settings, in April 2007, we released a report on the certification and oversight of Medicare

hospices. This report found that 14 percent of hospices were past due for certification and, on average, had not been surveyed for 9 years—3 years longer than the CMS standard at that time. OIG also found that health deficiencies were cited for 46 percent of hospices surveyed and for 26 percent of hospices investigated for complaints. The most frequent health deficiencies cited centered on patient care planning and quality. For instance, OIG found that written care plans often were not prepared, lacked important elements, or did not contain sufficient measures to ensure quality patient care. Of the hospices with deficiencies cited during complaint investigations, 49 percent had already been cited for the same deficiencies during the regular certification surveys. Based on our findings, we recommended that CMS provide guidance to State agencies and CMS regional offices regarding analysis of existing data and identification of at-risk hospices, include hospices in Federal comparative surveys and annual State performance reviews, and seek legislation to establish additional enforcement remedies for poor hospice performance. At present, CMS's only enforcement remedy is termination of hospices from the Medicare program. CMS indicated that it is exploring and implementing methods to better target hospices in need of closer oversight. CMS is also considering whether to pursue new enforcement requirements for poor hospice performance. However, citing budget constraints, CMS indicated that it does not plan to include hospices in the annual State performance reviews.

Screening of Long-Term Care Employees

Residents of nursing homes and other long-term-care facilities have a right to reside in a safe and secure environment, free from abuse and neglect. To help achieve this type of environment, each State is required to establish and maintain a registry of nurse aides, which includes information on any finding by the State survey and certification agency of abuse, neglect, or misappropriation of property involving the elderly. CMS prohibits facilities from employing individuals who have been found guilty by a court of law or who have had a finding entered into the registry for abuse, neglect, or mistreatment of residents or misappropriation of their property.

In several recent reviews, OIG found that States and nursing facilities use a patchwork of measures to identify persons posing a possible threat of elder abuse in nursing homes and to minimize and prevent such abuse. For example, in a July 2005 report, we found that although most facilities check their State nurse aide registries prior to employing an individual, they do not routinely check those in other States, thereby potentially jeopardizing the safety of their residents. Additionally, while most States require criminal background checks, the scope of these checks varies widely. We also found that although some of the nursing facilities in our sample conducted more comprehensive checks than required by their State laws, about half of the background checks done were limited in scope, e.g., limited to one State.

In another review, issued February 2005, that examined the accuracy of nurse aide registries maintained by States, OIG found that some States failed to adequately update registries with information on substantiated adverse findings against nurse aides. In fact, some individuals with criminal records in one State were actively certified in other States.

Without accurate nurse aide registry information, nursing homes may inadvertently hire aides who have committed offenses such as abuse, neglect, and theft, thus placing residents at considerable risk. Therefore, we recommended that CMS ensure that records of nurse aides with substantiated adverse findings are updated timely and work with States to ensure that registry records contain current information on nurse aides.

In a December 2006 report, OIG reviewed the requirements for, and State oversight of, Medicaid personal care service attendants. These attendants assist the elderly and persons with disabilities or temporary or chronic conditions with daily activities (e.g., bathing, dressing, meal preparation). This review found substantial variation, both across States and within States, in the requirements for these attendants and found that oversight and administration of personal care programs were fragmented.

In testimony before this committee in 1998, we recommended stronger Federal oversight, as well as stepped-up collaboration with the States, to improve the safety of the elderly. Specifically we recommended that CMS and the Administration on Aging (1) consider establishing Federal requirements and criteria for performing criminal background checks of all workers in nursing homes and other long-term care facilities and (2) assist in the development of a national abuse registry and expansion of the current State registries to include all workers who have abused or neglected residents or misappropriated resident property in facilities that receive Federal reimbursement. Our updated work continues to demonstrate that there is no nationwide assurance that nursing home staff who could place elderly residents at risk are systematically identified and excluded from employment. Therefore, to reduce the potential for nurse aides with substantiated findings to commit similar acts in another State, we again suggested in our 2005 reports that CMS could seek legislative authority to create a national nurse aide registry and recommended that CMS consider developing a Federal requirement for criminal background checks.

Impact of Reimbursement Systems on Access and Quality of Care

In recent years, OIG has also monitored the potential impact of various Medicare and Medicaid payment systems on the provision of services in inpatient hospitals, nursing homes, and home health agencies. For example, in reports issued in July 2006, we examined beneficiary access to home health and skilled nursing facility care since the implementation of the prospective payment system and found that, although the vast majority of Medicare beneficiaries have access to care, some with certain medical conditions, such as those needing IV antibiotics and/or expensive drugs and those with complex wound care needs, may experience delays in obtaining necessary care. In another report issued in 2006, we examined the hospital readmission and emergency department visit rates for Medicare beneficiaries discharged from hospitals to home health care to determine whether the rates have changed since the implementation of the home health prospective payment system in 2000. We suggested that CMS closely monitor beneficiaries with particular health care needs most associated with problems in access and cases in which there is a greater likelihood of hospital readmission or emergency care.

Most recently, in a report issued last month, we assessed services provided to beneficiaries with consecutive Medicare stays involving inpatient and skilled nursing facilities and found that 35 percent of consecutive stay sequences were associated with quality-of-care problems and/or fragmentation of services for which Medicare paid an estimated $4.5 billion. Quality-of-care problems that reviewers found included medical errors, accidents, failure to treat patients in a timely manner, inadequate monitoring and treatment of patients, inadequate care planning, and inappropriate discharges. We recommended that CMS (1) direct Quality Improvement Organizations (QIO) to monitor fragmentation and quality of care across consecutive stay sequences and the quality of care provided during the individual stays within those sequences and (2) encourage both QIOs and fiscal intermediaries, as appropriate, to monitor the medical necessity and appropriateness of services provided within these consecutive stay sequences. CMS concurred with our recommendations and indicated that it intends to place a greater emphasis on continuity of care in all settings and on measuring the rate of adverse events, such as hospital readmissions.

OIG is also concerned about whether payments to nursing homes are correct and whether the funds are being used for patient-care-related activities. For example, in a series of audits issued in 2004 and 2005, we examined the adequacy of Medicaid payments to nursing facilities in States that have enhanced payment programs for public nursing facilities. As part of these studies, OIG determined that Medicaid reimbursements to States for nursing home care are being diverted from the nursing homes to other State programs. To illustrate, OIG examined nursing homes from each of three States (New York, Tennessee, and Washington) and found that these nursing homes were required by their State or county to return 90, 96, and 94 percent, respectively, of their enhanced funding. These nursing homes had received the most unfavorable survey ratings the States can issue. These homes might have provided better quality of care had they been able to retain all the funding they initially received.

OIG INVESTIGATIONS AND ENFORCEMENT

Although OIG investigates cases of significant abuse or neglect and takes appropriate administrative actions, CMS and the States bear the primary responsibility for regulating and policing the quality of health care provided to patients as well as referring appropriate cases to law enforcement. CMS issues regulations and program guidance that set the requirements for quality of care in entities participating in Federal health care programs. And, as previously described, CMS and the States coordinate to conduct surveys and review providers under the certification process. When deficiencies are identified, CMS may take enforcement actions, such as imposition of CMPs, denial of payment for new admissions, and termination. In addition, State licensing boards for physicians, nurses, and other health professionals (including nursing home administrators) revoke or suspend the health care licenses of many individuals for poor care or patient abuse. Finally, through Medicaid Fraud Control Units (MFCU), States investigate and prosecute individuals and entities for patient abuse, as well as fraud.

To supplement or, when appropriate, substitute for CMS or State enforcement actions, OIG pursues administrative remedies, often in conjunction with civil actions brought by the Department of Justice (DOJ). The False Claims Act, the Federal Government's primary civil enforcement tool for fraud, has been used successfully to address poor quality of care. In addition, OIG has exercised its administrative authorities in these cases to exclude providers from participation in Federal health care programs and to impose substantial compliance requirements and monitoring on those providers that continue to participate. This combination of civil and administrative enforcement actions has effectively complemented the administrative and regulatory oversight by CMS and the States and criminal prosecutions by the States. .

Civil and Criminal Actions and Law Enforcement Coordination

OIG partners with DOJ, MFCUs, and other state law enforcement offices to investigate and prosecute instances of substandard care that led to patient harm. Under the False Claims Act, the Government is authorized to collect substantial penalties against anyone who has knowingly caused the submission of false or fraudulent claims to the Federal Government. DOJ is responsible for representing the United States in these civil cases, which often involve allegations that claims to Medicare or Medicaid are false because they misrepresent the services that have been provided to beneficiaries. Over the past decade, DOJ has successfully pursued False Claims Act cases under the theory that egregiously substandard care is a "failure of care" and that claims for such care are fraudulent. Medicare and Medicaid cover only costs that are reasonable and necessary for the diagnosis or treatment of illness or injury. The provision of medically unnecessary or substandard care exposes patients to health risks and imposes needless expenses on the Federal health care programs.

The Government has pursued this civil cause of action only in cases that involve systemic and widespread problems of quality or significant harm to patients. For example, United Memorial Hospital in Michigan pleaded guilty in Federal court to wire fraud based on its failure to properly investigate medically unnecessary pain management procedures performed by a physician on its medical staff. In another case, Redding Medical Center in California and its corporate parent, Tenet Healthcare Corporation, paid a total of $59.5 million to settle False Claims Act allegations that the hospital inadequately performed credentialing and peer review of cardiologists on its staff who then performed medically unnecessary invasive cardiac procedures.

In another example, the Government settled a False Claims Act case with Life Care of Lawrenceville, a Georgia nursing home, for $2.5 million. The Government alleged poor care in the following areas: (1) diabetes care, (2) resident nutrition and hydration, (3) assessments and evaluations of residents' needs, (4) care planning and nursing interventions, (5) medication management, (6) fall prevention and management, and (7) pressure ulcer care. Many of the problems were related to chronic understaffing. Among the examples of poor care alleged by the Government, a resident on coumadin medication died of toxic poisoning because the facility staff failed to check his blood levels. Another resident allegedly fell four times during her 4-month stay and fractured

and refractured her hip. Still another resident allegedly developed maggots in her mouth and died of larvae infestation because the facility staff failed to provide basic oral hygiene care.

Federal prosecutors in Missouri charged American Healthcare Management (AHM), a long-term care facility management company, its Chief Executive Officer, and three nursing homes with criminal conspiracy and health care fraud based on their imposition of budgetary constraints that prevented the facilities from providing adequate care to residents. The investigation found that numerous residents suffered from dehydration and malnutrition, went for extended periods of time without cleaning or bathing, and contracted preventable pressure sores. The corporate defendants were convicted and fined, entered into a False Claims Act settlement of $1.25 million, and agreed to be excluded. The primary owner was convicted of a false statement misdemeanor offense, sentenced to 2 months' incarceration, and agreed to be excluded for 20 years. Finally, in February 2007, AHM's former CEO was sentenced to 18 months of incarceration and fined $29,000.

In addition to our close collaboration with DOJ on these Federal cases, since the enactment of the Deficit Reduction Act of 2005, OIG has increased coordination with MFCUs, with particular focus on quality of care investigations. As part of these efforts, OIG organized a September 2006 national training conference with representatives from MFCUs, State Medicaid agencies, and DOJ. Since that time, OIG has continued this collaboration in regional conferences with MFCU and OIG investigators focusing on how to identify and build quality of care cases.

Exclusions

In addition to the administrative sanctions available to CMS and the States and the criminal and civil tools available to the States and DOJ, OIG often utilizes its administrative exclusion authority to address poor quality of care. Once a person is excluded, Federal health care programs will not pay for items or services furnished by that person. Exclusions related to quality of care arise in the following situations:

- OIG must exclude any person convicted of an offense related to the abuse or neglect of a patient in connection with the delivery of health care (Section 1128(a)(2) of the Social Security Act).
- OIG may exclude any person whose license to practice health care has been revoked or suspended for reasons bearing on the person's professional competence or professional performance (Section 1128(b)(4) of the Social Security Act).
- OIG may exclude any person who has furnished items or services to patients: (1) substantially in excess of the needs of such patients or (2) that fail to meet professionally recognized standards of care (Section 1128(b)(6)(B) of the Social Security Act).

- Based on the referral of a QIO, OIG may exclude a physician or other practitioner for failing to comply with the obligations to provide Medicare beneficiaries only medically necessary services that meet professionally recognized standards of care (Section 1156 of the Social Security Act).
- OIG may exclude anyone who has caused the submission of false or fraudulent claims to a Federal health care program (Section 1128(b)(7) of the Social Security Act). This provision parallels the False Claims Act and is implicated in any case in which the Government is asserting a failure-of-care theory in a civil case.

The exclusion actions described above fall under two broad categories: (1) derivative (based on an action by another Government agency or tribunal) and (2) affirmative (initiated independently by OIG). OIG has exercised all of these exclusion authorities to build upon and supplement enforcement actions taken by States, CMS, and DOJ. To provide protection to Federal health care program beneficiaries, OIG imposes derivative exclusions of persons who have been convicted of patient abuse or neglect or who have lost medical, nursing, or other health care licenses for reasons related to abuse or neglect of patients or professional competence. In fiscal year 2006, OIG excluded 295 persons based on convictions of patient abuse or neglect and 1,867 persons based on revocation or loss of a health care license.

In addition to imposing these large numbers of derivative exclusions, OIG initiates affirmative exclusions to strategically address serious quality-of-care concerns that have not been addressed through other enforcement actions. And, just as we exclude direct caregivers who pose a risk to patients, OIG investigates the owners and managers who are responsible for allowing the abuse of patients or provision of substandard care, as well as entities that have demonstrable, systemic poor quality of care. For example, OIG excluded a nursing home owner for causing the provision of substandard care in his facilities as a result of providing insufficient staffing and financial support. Because, the owner was not a licensed health care professional (or nursing home administrator), the exclusion was the best remedy to bar him from involvement in Federal health care programs. In another example, OIG initiated proceedings to exclude Redding Medical Center for conduct that resulted in the $59.5 million False Claims Act recovery. As described earlier, the Government found a pattern of inappropriate and medically unnecessary invasive heart procedures and a lack of appropriate controls to detect and address such problems. To resolve OIG's exclusion case, Tenet divested the hospital to a new owner/operator.

Corporate Integrity Agreements

As part of the resolution of False Claims Act cases, OIG often agrees to not exclude a defendant in exchange for the defendant entering into a corporate integrity agreement (CIA) with OIG. A CIA is a contract that imposes systems, monitoring, and reporting requirements on providers. A CIA generally requires the entity to employ a compliance officer, establish a compliance committee, implement a code of conduct and policies and procedures, train staff, establish internal reporting mechanisms for compliance issues,

report and repay overpayments, screen employees and contractors to prevent hiring of excluded persons, report and remedy probable violations of law, and hire an independent review organization to review claims submitted to Federal health care programs. The entity must also report to OIG annually and when certain significant events occur. If the entity fails to comply with the CIA, OIG may impose stipulated monetary penalties and, for substantial material breaches, exclusion. OIG currently monitors about 350 health care entities of all types operating under CIAs.

In CIAs arising from failure of care cases, OIG has also required the providers, often nursing home chains, to hire independent quality monitors selected by OIG. These quality-of-care CIAs place particular emphasis on the provider's policies and systems that affect the quality of care provided to individual patients. Under these CIAs, the monitors have extensive access to facilities, staff, patients, and records. Using that access, survey results, and other quality-related data, the monitors identify quality problems and, in consultation with the provider, recommend enhancements to systems and controls to improve the quality of care. The independent monitors effectively build upon and complement the actions of surveyors, who are necessarily focused on specific incidents at specific facilities. By examining and consulting on systems improvements and controls throughout an organization, quality-of-care CIAs help create an environment that promotes better care throughout a provider, whether it is a single site or a national chain.

Over the last 7 years, many major nursing home chains, smaller groups, and individual health care facilities have operated under CIAs with independent quality monitors. Since 2002, over 1,300 health care facilities, mostly nursing homes, have operated for some period of time under a quality-of-care CIA. OIG currently has 10 CIAs with nursing homes and psychiatric facilities (or chains) with independent quality monitor requirements. These 10 active quality-of-care CIAs cover operations in about 400 long-term care and psychiatric facilities across the country. In addition to conducting our ongoing monitoring efforts, OIG is examining the performance of nursing home chains operating under CIAs over the past several years to evaluate the effect of those CIAs on the quality of care and compliance by those chains.

COMPLIANCE GUIDANCE AND RESOURCES

In addition to conducting enforcement activities, OIG provides nonbinding guidance to providers regarding how to establish systems and controls to promote and monitor compliance with Federal health care program requirements. Much of this voluntary guidance focuses on the importance of providing high quality health care to patients. For example, in the "Compliance Program Guidance for Nursing Facilities," OIG identified quality of care as the first major risk area and outlined specific examples of circumstances that raised significant compliance concerns. This guidance next outlined the importance of safeguarding residents' rights. As part of our ongoing review of existing guidance in light of current concerns, OIG plans to begin the process of proposing and issuing an updated guidance for nursing facilities that will focus even

more on quality-of-care issues. These compliance guidance documents provide concrete information that can be applied by a provider's management to its own circumstances.

OIG has more recently increased its focus on the role of boards of directors or trustees in promoting and overseeing compliance and quality of care at health care providers. It is essential that members of boards of health care providers focus at least as much attention on the quality of care furnished by the provider as on financial performance. Like direct caregivers, those responsible for overseeing a health care provider have an obligation to safeguard patients and ensure the resources and conditions are present to allow for the provision of high quality care. Last month, OIG issued a resource document for board members of health care providers, "Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors." This document, developed jointly with leaders in the American Health Lawyers Association, outlines the relevant background and principles that apply to a board member's responsibility to oversee the quality of care furnished by a health care provider. The resource document suggests questions that a board member may want to ask as part of his or her inquiry into the organization's quality safeguards. These questions focus on the quality improvement infrastructure, leadership, policies and procedures, performance metrics, risk assessment, reporting mechanisms, resources, peer review and credentialing, and the handling of adverse patient events.

OIG plans to build on this recently issued resource document through holding a future roundtable discussion including representatives from the long-term care industry, OIG, and other stakeholders. This roundtable will explore the reasons that providing good quality of care is not only the right thing to do for the benefit of the patients but is also in the long-term interests of the provider. One goal of this roundtable will be to generate practical, concrete ideas regarding how board members can receive useful information about quality to fulfill their oversight role. One concept we plan to explore in this roundtable is guidance on how to construct a "dashboard" that would allow board members (and management) to monitor a discrete set of indices that reflect on the quality of care provided by the organization. After reviewing the results of this roundtable examining long-term care facilities, we hope to initiate a similar dialogue with representatives of the hospital industry and other provider groups. These efforts should raise board and management awareness of the importance of quality care as well as provide practical guidance to those individuals in positions of authority about how they can monitor and improve the quality of care.

CONCLUSION

Today I have described some egregious examples of abuse and neglect of the elderly, with the results ranging from dehydration and malnutrition to the provision of unnecessary heart surgery. I have also described our extensive work examining the oversight and enforcement systems designed to identify and prevent the continuation of abuse in a variety of health care settings, and our work with our law enforcement partners to investigate and sanction cases of abuse or neglect.

We are continuing to evaluate systemic issues that directly affect patient care. For example, studies are currently underway to examine the cyclical noncompliance of home health agencies with conditions of participation, the use of psychotherapy services in nursing homes, payments and care for hospice beneficiaries residing in nursing homes, the oversight of quality of care in Federal health centers, and the impact of Medicare Part D on dual eligible residents in nursing homes. OIG is also undertaking a congressionally mandated review of serious medical errors, referred to as "never events," because they should never occur, for example, a physician performing surgery on the wrong patient.

OIG will continue to work collaboratively with our Federal and State law enforcement partners to investigate and sanction those responsible for egregiously substandard care. In addition to direct care-givers, OIG will also hold managers and decision-makers accountable when beneficiaries are harmed as a consequence of placing financial interests over clinical needs. Because of the vulnerability of nursing home residents, we will continue our focus on quality of care in these facilities. As we look forward, we expect to expand our focus on quality of care to other types of facilities serving the elderly that are funded through the Federal health care programs, including Intermediate Care Facilities for People with Developmental Disabilities and Institutions for Mental Disease.

We recognize that these oversight mechanisms and enforcement actions are designed to identify and address quality-of-care problems after they have already occurred. Therefore, OIG is committed to working with stakeholders including Congress and industry representatives to identify practices that will help prevent these types of abuses from occurring. For instance, we have recommended establishing a national nurse aide registry and requiring long-term care facilities to conduct criminal background checks, steps that would help to ensure that this Nation's elderly are not exposed to those who would take advantage of their vulnerabilities.

In the next step of our ongoing efforts to provide guidance to the health care providers, we will build upon our recently issued resource document and engage in a dialogue with stakeholders about quality measures and how board members can effectively oversee the quality of care provided by their health care organizations. The guidance that arises from this process, as well as from the updating of our compliance program guidance for nursing facilities, will provide practical information about how leaders of health care providers can implement the systems, policies, and controls that will improve the quality of care and reduce the risk of abuse of patients.

This concludes my statement. Thank you for the opportunity to testify today.

At this time, I would be happy to answer any questions you may have.

Selected Reports and Resources

U.S. Department of Health and Human Services
Office of Inspector General

Consecutive Medicare Stays Involving Inpatient and Skilled Nursing Facilities (OEI-07-05-00340; June 2007) http://oig.hhs.gov/oei/reports/oei-07-06-00340.pdf

Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors, June 2007
http://oig.hhs.gov/fraud/docs/complianceguidance/Corporate%20Responsibility%20and%20Health%20Care%20Quality%206-29-07.pdf

Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight (OEI-06-05-00260; April 2007) http://oig.hhs.gov/oei/reports/oei-06-05-00260.pdf

States' Provider Safeguards for Medicaid Personal Care Services (OEI-07-05-00250; December 2006) http://oig.hhs.gov/oei/reports/oei-07-05-00250.pdf

Nursing Home Complaint Investigations (OEI-01-04-00340; July 2006)
http://oig.hhs.gov/oei/reports/oei-01-04-00340.pdf

Beneficiary Access to Home Health Agencies (OEI-02-04-00260; July 2006)
http://oig.hhs.gov/oei/reports/oei-02-04-00260.pdf

Medicare Beneficiary Access to Skilled Nursing Facilities Under the Prospective Payment System (OEI-02-04-00270; July 2006) http://oig.hhs.gov/oei/reports/oei-02-04-00270.pdf

Nursing Home Enforcement: Application of Mandatory Remedies (OEI-06-03-00410; May 2006) http://oig.hhs.gov/oei/reports/oei-06-03-00410.pdf

Effect of the Home Health Prospective Payment System on the Quality of Home Health Care (OEI-01-04-00160; February 2006) http://oig.hhs.gov/oei/reports/oei-01-04-00160.pdf

Nurse Aide Registries: Long Term Care Facility Compliance and Practices (OEI-07-04-00140; July 2005) http://oig.hhs.gov/oei/reports/oei-07-04-00140.pdf

Adequacy of New York State's Medicaid Payments to A. Holly Patterson Extended Care Facility (A-02-03-01004; April 2005)
http://oig.hhs.gov/oas/reports/region2/20301004.pdf

Nursing Homes Enforcement: The Use of Civil Money Penalties (OEI-06-02-00720; April 2005) http://oig.hhs.gov/oei/reports/oei-06-02-00720.pdf

Adequacy of Tennessee's Medicaid Payments to Nashville Metropolitan Bordeaux Hospital, Long-Term-Care Unit (A-04-03-03023; April 2005)
http://oig.hhs.gov/oas/reports/region4/40303023.pdf

Adequacy of Washington State's Medicaid Payments to Newport Community Hospital, Long-Term-Care Unit (A-10-04-00001; March 2005)
http://oig.hhs.gov/oas/reports/region10/100400001.pdf

Nurse Aide Registries: State Compliance and Practices (OEI-07-03-00380; February 2005) http://oig.hhs.gov/oei/reports/oei-07-03-00380.pdf

Adequacy of Medicaid Payments to Albany County Nursing Home (A-02-02-01020; June 2004) http://oig.hhs.gov/oas/reports/region2/20201020.pdf

Nursing Home Deficiency Trends and Survey and Certification Process Consistency (OEI-02-01-00600; March 2003) http://oig.hhs.gov/oei/reports/oei-02-01-00600.pdf

Final Compliance Program Guidance for Nursing Facilities (65 FR 14289; March 16, 2000) http://oig.hhs.gov/authorities/docs/cpgnf.pdf

The CHAIRMAN. Thank you, Mr. Demske.

I would like to ask all three of you—maybe we will start with you, Ms. Connolly, because you haven't had a chance yet to express yourself—how vital, how important, how urgent is it that we put in place a background check system that can be accessed and used by facilities all across the country?

Ms. CONNOLLY. Senator, first, thank you very much for holding this hearing.

I believe that the Department of Justice believes firmly that elders should be protected from convicted criminals. We have the legislation that you have introduced under review by our various components at this time.

Mr. FRIDMAN. Yes, Senator, the Department does agree that all people who come into contact with elders in a nursing home or long-term-care facility should have Federal background checks. We should be making sure that the background checks are complete and cover all the bases.

As you know, the FBI has been participating in the pilot project, the $25-million pilot project, that was started by the MMA. It is available in seven states right now. The FBI tells me that, as of March 2007, they have run 165,000 background checks and they have identified 1,100 individuals for disqualification from the checks. The pilot concludes in September, and the results of the pilot will then be analyzed.

The FBI tells me that they are working on getting some of the technology aspects that are called for in the bill, like the wrap-around technology that will, if a person passes with a clean check, gets employed by a nursing home, and then subsequently commits a crime, the system will then alert the State and the nursing home that the person has had an arrest or conviction.

They are working on the technology. They have seen the legislation, and they have some concerns about timing and logistics that we could certainly discuss with your staff. But the Department is available to work with you and your staff to address any issues.

The CHAIRMAN. That is very good.

Mr. Demske.

Mr. DEMSKE. The OIG believes that criminal background checks are one of several mechanisms that can be helpful in screening out potentially abusive caregivers at facilities.

We have been, as I mentioned in my testimony, on the record since 1998 as advocating criminal background checks as well as exploring ways to establish a national registry of employees at long-term-care facilities. With a national long-term care employee registry we can avoid some of the issues that arise from having a patchwork system in various States. In some of our reports, we have identified systemic problems of facilities in one State checking the registry in that State but not checking registries where the person may have worked before. As a consequence, people who are listed on one State registry for abuse can become employed in another State by a different facility.

The CHAIRMAN. Very good.

Well, we thank you, all three of you for coming here today.

We are talking, naturally, about physical but also financial abuse and emotional abuse, abuse of all kinds, on the elderly. That is

what we are focusing on with the "Elder Justice Act," as well as the background check system contained within the act.

We really do hope that, with the help that you are providing, we can get that act passed, and passed this year. I think, if we can, we will all feel as though we made jointly a real contribution to the elderly population and their security.

So we thank you so much.

Again, we wish you well with your impending arrival. If you would let me know, I would like to send your wife some flowers. [Laughter.]

So let me know what hospital she is in. Will you do that?

Mr. DEMSKE. I sure will. Thank you very much.

The CHAIRMAN. Thank you.

Thank you all for coming.

All right, well, we will get on to the organizations. Mr. Blancato is the recipient of many honors, including one in 1999 from the American Society of Aging for his contributions to the field of aging.

We do have a fourth witness, who is Daniel Reingold, president and CEO of The Hebrew Home for the Aged in Riverdale, NY. The Hebrew Home offers more than 3,000 older people a range of residential and long-term-care services.

Most importantly for our discussion today, The Hebrew Home for the Aged also created our country's first comprehensive elder-abuse center, known as the Weinberg Center, with the Pace Women's Justice Center. Accompanying Mr. Reingold here today is Joy Solomon, who is of the Justice Center.

So we will start now, and maybe we will go from my left to right.

Ms. Laubert, would you like to make your comments?

STATEMENT OF BEVERLY LAUBERT, OHIO LONG-TERM-CARE OMBUDSMAN AND PRESIDENT, NATIONAL ASSOCIATION OF STATE LONG-TERM-CARE OMBUDSMAN PROGRAMS, WASHINGTON, DC

Ms. LAUBERT. I certainly will. Thank you so much.

Thank you for the opportunity to talk with you today about the problem of abuse and neglect in long-term-care facilities. Calling abuse and neglect a problem sounds trivial; it is better identified as a horrific problem, a tragedy or a crisis that is an embarrassment to our country.

Every day of my 20 years as a long-term-care ombudsman, I have been touched by the bravery of residents and family members, like your first witness, who entrust their care to strangers.

Chairman Kohl, NASOP appreciates your many years of support for our important work advocating for residents who are often otherwise without a voice. Your leadership and the leadership of George Potaracke, the Wisconsin State ombudsman, give us hope.

Our network of 1,300 staff and 9,200 volunteer ombudsmen seek resolution of problems and advocate for the rights of residents of long-term-care facilities.

Tens of thousands of long-term-care professionals and paraprofessionals provide loving, compassionate and competent care to our Nation's older and disabled citizens. But today I want to tell

you about conditions that we have seen that can and must be changed.

Someday, with your help, perhaps we can say with confidence that all of our Nation's older citizens are receiving the care they deserve where they choose to receive it. However, in a few minutes I will introduce you to Anna's story, which provides evidence that we aren't there yet.

In 2005, ombudsmen received over 20,000 complaints of abuse, neglect and exploitation. Those are just the complaints in which someone used the words "abuse" or "neglect." We collect data on complaints that are not called abuse but result from abusive or neglectful behavior. Nationwide, we received 92,000 complaints related to resident care, such as improper handling and pressure sores.

I applaud the introduction of the "Patient Safety and Abuse Prevention Act." It would buildupon the work of States that have developed systems to check criminal records of caregivers. I have found that although most States do some type of screening at the time of employment, the methods are inconsistent.

Mr. Chairman, we thank you for your steadfast pursuit of this critical area for ensuring quality care. The pilot program that you helped to secure has led us to this important juncture where Congress should now step forward and ensure a national, consistent approach to doing background checks.

We are hopeful Congress will also address broader elder-abuse issues this year with the "Elder Justice Act," which is another stride along the critical path of justice for this Nation's older adults. The bill would establish a national, coordinated approach to elder justice and research, as well as support for building a well-trained long-term-care workforce.

Every provision in the groundbreaking "Elder Justice Act," including training for surveyors, improving ombudsman capacity and training, and funding Adult Protective Services in every State, must be passed as soon as possible.

Ohio's criminal background check law has been in place since 1997, and my written testimony provides details of what that law does. There are several areas of inconsistency among the States, so an older adult cannot rely on a blanket of safety wherever he or she resides.

My written testimony details examples of the variations: differences in whether fingerprints are used and whether they are obtained using ink cards or electronic equipment; differences in the timing of background checks; differences in the use of FBI searches; and differences in the data bases used.

It is time to establish a nationwide system to improve the effectiveness of screening. As written, the proposed Federal law would address the problem of caregivers moving from State to State, thereby avoiding effective scrutiny. Unsupervised volunteers having similar duties as direct-care staff involving one-on-one contact with residents would be included in screening requirements. A wrap-back provision would identify caregivers who committed crimes after employment.

To personalize the issue of abuse and neglect, as you have seen today, is heart-wrenching. I keep a folder in my office labeled "Re-

minders," and every now and then, I open that folder and bolster my resolve to help residents and to be their voice to people like you who have the power to truly make a difference.

I encourage you to read about Anna's story at the end of my testimony. Her family wrote to Governor Strickland in Ohio and sent pictures that are included in my written testimony of Anna and the problems that she had in a long-term-care facility. As my "Reminders" folder bolsters my resolve as an advocate, I hope Anna's story encourages and supports your efforts to make life better for America's older adults receiving long-term care.

My time is getting close to expiring, so I will stop now, but I welcome the opportunity to share additional examples and answer your questions.

Thank you.

[The prepared statement of Ms. Laubert follows:]

Long-Term Care Workers and Abuse of the Elderly
Hearing of the U.S. Senate Special Committee on Aging
Testimony of Beverley Laubert, President
National Association of State Long-Term Care Ombudsman Programs
July 18, 2007

Thank you for the opportunity to talk with you about the problem of abuse and neglect in long-term care facilities. Calling abuse and neglect a "problem" sounds trivial and is better identified as a horrific problem, a tragedy, or a crisis, which is an embarrassment to our country. Every day of my twenty years as a long-term care ombudsman I have been touched by the bravery of residents and family members who entrust their care to strangers.

Chairman Kohl, the National Association of State Long-Term Care Ombudsman Programs appreciates your years of support of our important work advocating for residents who are often otherwise without a voice. Your leadership and the leadership of George Potaracke, the Wisconsin State Ombudsman, give us hope. Mandated by the Older Americans Act, every state has an Office of the State Long-Term Care Ombudsman. Our network of 1,278 paid staff and nearly 9,200 volunteer ombudsmen seek resolution of problems and advocate for the rights of residents of long-term care facilities with the goal of enhancing quality of life and quality of care.

Tens of thousands of long-term care professionals and paraprofessionals provide loving, compassionate, and competent care to our nation's older and disabled

citizens. But today I want to tell you about conditions that can and must be changed. Someday, with your help perhaps, we can say with confidence that all of our nation's older and disabled citizens are receiving the care they deserve where they choose to receive it. In the meantime, however, in a few minutes I will introduce you to Anna's story which provides evidence that we aren't there yet.

In Federal Fiscal Year 2005, ombudsmen received 20,622 complaints of abuse, neglect, and exploitation. Those are just the complaints in which someone used the words. However, we collect data on many other types of complaints that might not be called abuse but result from abusive or neglectful behavior. For example, nationwide we received 91,974 complaints related to resident care. Detailed data is attached to the end of my remarks.

I applaud the introduction of the Patient Safety and Abuse Prevention Act of 2007 (S. 1577). The bill would build upon the work demonstrated by pilot states and others that have developed systems to check criminal records of caregivers. My interactions with colleagues around the country have found that although most states do some type of screening at the time of employment of long-term care facility staff, the methods are inconsistent and gaps have been identified.

Mr. Chairman, we thank you for your steadfast pursuit of this critical area for insuring quality care. The pilot program that you helped to secure in the MMA has led us to this important juncture where Congress should now step forward and ensure a national, consistent approach to doing background checks for all those serving vulnerable long-term care residents. The timing is also excellent because we are extremely hopeful that Congress will also address the broader elder abuse, neglect, and exploitation issues this year.

Senate Bill 1070, the Elder Justice Act, sponsored by Senators Hatch and Lincoln, is another stride along the critical path of justice for this nation's older adults. NASOP is a founding member of the Elder Justice Coalition, which has spent the last three Congresses working toward passage of the Elder Justice Act. The bill would establish a national coordinated approach to elder justice and research as well as support for building a well-trained long-term care workforce. Every provision in the ground-breaking Elder Justice Act including training for surveyors, improving ombudsman capacity and training, and funding Adult Protective Services must be passed as soon as possible. I should also mention that the original Elder Justice Act included a version of a national criminal background check program, which the Elder Justice Coalition supported, as well.

Ohio's criminal background check law has been in effect since 1997. The law requiring fingerprint background checks applies to applicants under final

consideration for employment with a direct care provider. Volunteers are exempted. Although there are five components of the definition of direct care, a key consideration is whether the employee would have opportunity be alone with older adults or have access to older adults' personal property. Fingerprints are used to check state criminal records. If the applicant has not lived in Ohio for the five years prior to application, an FBI check is done as well. At the time of enactment, a provider was permitted to conditionally employ an applicant for sixty days pending the results of the check. Due to the advocacy of family members, the conditional employment period was later changed to thirty days. The Ohio law includes personal character standards which a provider has the discretion to review in determining whether to employ or not. Some offenses such as adulteration of food, elder abuse, and sexually oriented crimes are not subject to reconsideration. In the attachments to my testimony, you will find a recommendation applicable to Ohio's law that was made by a regulatory reform committee of Ohio's Nursing Facility Reimbursement Study Committee a few years ago.

There are several areas of inconsistency among the states; therefore, an older adult cannot rely on a blanket of safety wherever he or she resides. This is important because we have worked with older adults who move from one state to another to be near family as they age. In Alaska, for example, fingerprint checks are submitted within thirty days of hire and every six years thereafter but

in most states, the background check is only done at the time of employment. Senate Bill 1577 would provide a remedy through the "rap back" provision. In Kentucky, federal records are not checked as they are in Ohio and Pennsylvania; Ohio's threshold is five years of residency and Pennsylvania's is two years of residency.

In Kansas, as in other states, the abuse registry required by federal law is checked before hiring but criminal background checks take weeks to be returned. Ohio has found that electronic fingerprinting expedites the process and the funding envisioned in Senate Bill 1577 would enable states to rise to a streamlined minimum standard.

Indiana mandates background checks for certified nursing assistants, but most states apply the law more broadly. New Jersey checks the records of staff usually considered direct care – nurse aides, nurses – but has a gap where activity aides, housekeeping, and maintenance staff fall through the net. In Missouri, staff of unlicensed assisted living facilities are not required to undergo a background check. New York does not require checks in residential facilities and North Dakota does not require checks for assisted living. Kentucky and Minnesota do not require checks of crimes committed in other states but others use the FBI check similar to Ohio's law.

Methods also differ. In Oklahoma, the background checks are not done by fingerprinting but there is an additional requirement to look for the individual's name on the sex offender and violent offender registries. In Delaware, the state takes an extra precaution in mandating drug testing for all applicants for affected positions.

The California State Ombudsman told me about an aide who was taking a resident's pain patches. The facility did the right thing and called law enforcement. Although at the time the aide did not have the patches in her possession, she was arrested on prior warrants. In Ohio, unless she had been convicted in the past, she would be able to work in long-term care. If arrest records were checked, providers would have information leading to additional precautions such as more direct supervision.

The experiences of the Long-term Care Ombudsman Programs around the country tell us that it is time to establish a nationwide system to improve the effectiveness of screening. As written, the proposed federal law would address the problem of caregivers moving from state to state, thereby avoiding effective scrutiny. Unsupervised volunteers having similar duties as direct care staff involving one-on-one contact with residents would be included in screening requirements.

To personalize the issue of abuse and neglect is heart-wrenching. I keep a folder in my office labeled "reminders" and every now and then I open that folder and bolster my resolve to help residents and to be their voice to people like you who have the power to truly make a difference. Now I will tell you about Anna.

> Anna was admitted to a nursing home six years ago. When she was admitted, she had mild dementia but could communicate many of her needs and could walk on her own. In fact, she loved to walk and was traveling the halls of the facility whenever she could. The family felt Anna was getting good care because the home invited her to activities and took her to get her hair done. But that didn't last for long.
>
> As Anna declined, so did her quality of life and the quality of care provided. Anna was put on multiple medications that kept her "doped up." Due to those medications, Anna was not able to walk on her own safely so she was tied to a wheelchair and forced to sit up all day. As a result, Anna developed pressure sores.
>
> Anna was taken to the dining room for meals but was seated at a table alone. Everyone received their meal tray at the same time but there wasn't enough staff to assist everyone so Anna's meal often sat for long periods of time until staff was available to feed her. By that time, the meal was unappetizing and Anna didn't want to eat. As a result, she rapidly lost weight.
>
> When Anna lost her ability to walk, the staff stopped taking her to the bathroom and she was forced to wear incontinence briefs. When family visited, they could smell the urine and feces that Anna was forced to endure. This also contributed to pressure sores.
>
> The care continued to decline until the pictures at the end of my testimony were taken shortly before Anna's death. The family felt certain that Anna had been physically abused and neglected.
>
> Anna's family has since discovered that one of the aides at the facility where Anna lived for six years had a criminal record, was

addicted to drugs, and had taken Anna's credit card and charged $5000.00 at a hardware store.

As my "reminders" folder bolsters my resolve as an advocate, I hope Anna's story encourages and supports your efforts to make life better for America's older adults in long-term care.

Thank you for inviting me to speak with you today.

Supplement to Testimony of Beverley L. Laubert
Senate Special Committee on Aging
July 18, 2007
Long-Term Care Ombudsman Data from the National Ombudsman Reporting System 2005

Complaint type National Total 306,867 (includes all provider types)	**Nursing Home 241,684**	**Board & Care 61,646**	**Total Facility-Based 303,330**	**Common Outcomes/Risks**
ABUSE, GROSS NEGLECT, EXPLOITATION	*15,814*	*4,808*	*20,622*	*Injury, pain, fear, decline, loss, depression, withdrawal*
Physical abuse	4,137	1,132	5,269	
Sexual abuse	868	294	1,162	
Verbal/mental abuse	3,056	1,014	4,070	*Fear of retaliation resulting in under-reporting*
Financial exploitation	1,011	512	1,523	
Gross neglect	2,399	761	3,160	
Resident to resident abuse	3,372	906	3,561	
Other abuse	971	189	1,160	
AUTONOMY, CHOICE, EXERCISE OF RIGHTS, PRIVACY	*24,072*	*6,401*	*30,473*	*Fear of retaliation resulting in under-reporting*
Confinement in facility against will (illegally)	1,423	439	1,862	Inability to obtain better care
Dignity, respect, staff attitudes	9,062	1,962	11,024	Verbal abuse, fear, lack of self-determination
Response to complaints	1,562	391	1,953	Problems are perpetuated
RESIDENT CARE	*78,198*	*13,776*	*91,974*	
Accidents, improper handling	8,998	1,516	10,514	Injury, loss of function, decline
Call lights, requests for assistance	14,391	1,184	15,575	Unmet needs often resulting in injury, decline, loss of function
Care plan/resident assessment	8,944	1,585	10,529	Unmet needs, negative outcomes
Contracture	177	23	200	Result of neglect
Medication administration/organ.	7,735	2,955	10,690	Pain

Complaint type National Total 306,867 (includes all provider types)	**Nursing Home 241,684**	**Board & Care 61,646**	**Total Facility-Based 303,330**	**Common Outcomes/Risks**
Personal hygiene	7,554	1,357	8,911	Odors, pressure sores
Pressure sores	2,179	293	2,472	Neglect – almost entirely preventable
Symptoms unattended, no notice to others of change in condition (includes not contacting physician)	5,760	873	6,633	Neglect resulting in harm
Toileting	4,095	474	4,569	Incontinence often resulting in loss of mobility, pressures sores
Tubes – neglect of catheter, NG tube	980	88	1,068	Neglect resulting in infection, weight loss, decline
REHABILITATION OR MAINTENANCE OF FUNCTION	*9,110*	*1,263*	*10,373*	*Physical & psychological decline*
Bowel and bladder training	155	21	176	Incontinence often resulting in loss of mobility, pressures sores
Mental health/psychosocial services	982	316	1,298	Distress, anxiety, pain
Range of motion/ambulation	1,060	81	1,141	Loss of mobility/independence often resulting in incontinence, pressure sores, depression
RESTRAINTS – CHEMICAL & PHYSICAL	*1,247*	*506*	*1,753*	Loss of mobility/independence often resulting in incontinence, pressure sores, depression
QUALITY OF LIFE (i.e. Activities, Social Services, Dietary))	*60,936*	*15,607*	*76,543*	*Distress, anxiety, depression, weight loss, withdrawal*
DIETARY (i.e. Assistance Eating, Fluid Availability, Menu, Weight Loss)	*21,903*	*5,866*	*27,769*	*Neglect resulting in dehydration, weight loss*
ADMINISTRATION	*21,149*	*6,949*	*28,098*	*Inadequate prevention resulting in abuse*
Abuse investigation, reporting	1,316	335	1,651	Perpetrators harm additional victims
STAFFING	*16,793*	*4,320*	*21,113*	*Insufficient quantity and/or quality resulting in any or all of the above*

Source: Administration on Aging

The CHAIRMAN. That was very good, Ms. Laubert.
Ms. LAUBERT. Thank you.
The CHAIRMAN. Mr. Greenwood.

STATEMENT OF PAUL GREENWOOD, DEPUTY DISTRICT ATTORNEY, OFFICE OF THE DISTRICT ATTORNEY, SAN DIEGO, CA

Mr. GREENWOOD. Good afternoon, Chairman Kohl. Thank you for allowing us this opportunity. I am honored to speak not just on behalf of my office, the San Diego D.A.'s office, but on behalf of a growing list, fortunately, of dedicated local prosecutors around the country who are seeing elder abuse as a significant major problem in our society today.

Over the 11 years that you have indicated I have been able to prosecute these cases, I have become a true believer in the collaborative system. I believe the reason that our unit has prospered is because we have seized the opportunity to work with agencies such as Adult Protective Services and law enforcement and medical personnel.

If I can just briefly mention five areas that we feel that we have made an indent in the road: First, we have created an elder-death review team, which has been very significant.

Second, my office arranges, every 3 to 4 weeks, brown-bag lunches in the community, all around the county, where we invite members of the public and other agencies to come and address issues of elder abuse. That has been tremendously helpful to all of us.

Third, we have been very involved with training banks, credit unions and other institutions, first responders such as paramedics and law enforcement, in what to look for in terms of red flags of elder abuse.

Fourth, Adult Protective Services have created a tremendous awareness campaign called "Silence is not Golden," and we have put our weight behind that too, to ensure that the public know who to call if they suspect that elder abuse is occurring in their community.

Finally, I am proud of a project that has been funded by Archstone, a nonprofit organization, that allowed my office to have wrap-around services for elderly victims of crime through the Family Justice Center.

Senator, I believe one of the major important steps as a prosecutor is to try to educate prosecutors around the country and to destroy the misconceptions that seem to stay with elder-abuse prosecutions.

For example, there is a myth that elderly witnesses are going to make poor witnesses. In my 11 years, to the contrary: They make the most compelling, fascinating and believable witnesses in the courtroom.

Second, there is a myth that financial elder-abuse cases are difficult to prosecute because of cognitive issues of the victims. But we are learning new ways to overcome that.

Third, that even though victims of physical abuse, who may have been assaulted by their own loved ones or by a nurse in a nursing home, will be reluctant to testify, nevertheless there are ways that

we can learn how to prosecute those cases, because we can learn from the tremendous example given to us by domestic violence prosecutions.

Fourth, there is this myth that, for example, home repair fraud, which is rampant amongst elderly homeowners in your State and every other State in this country, that those cases are somehow civil in nature. They are not. These are insidious criminal cases, and we should aggressively prosecute them.

Senator, I have thought long and hard about this, but I have outlined seven areas which I think are crucial for us to move forward in this country with regard to prosecuting elder-abuse cases.

First, absolutely we need the passage of the "Elder Justice" bill this year. Thank you for your lead in trying to make sure that this is happening. This will create such encouragement amongst the rank and file of prosecutors, law enforcement, Adult Protective Services, so many dedicated agencies who see this bill as being absolutely pivotal in helping them do their job.

With that, we urge the passage of the "Patient Safety and Abuse Prevention Act." For those people who will say that this act would be too expensive, let me tell them that if we can prevent folks like this gentleman that we have heard about today in New York from working amongst elders, how much will we save from having to prosecute those people? Over the past 11 years, I have prosecuted countless numbers of prior-convicted felons who have abused elders.

Second, we need to improve State laws and make sure that every State has laws that reflect the severity of the crime, so that they should be felonies and not misdemeanors.

Third, to create or expand the list of mandated reporters in each State, so that there are classes of groups of people who are mandated by law to report elder abuse.

Fourth, to make the courts more accessible to elderly victims and witnesses and for us to take a leaf out of the book of Judge Julie Conger from Alameda County, who has made her court so elder- and user-friendly.

Fifth, that every urban area in this country should have a dedicated police unit that has investigators just primarily focusing on investigating elder-abuse cases. I am very blessed that in San Diego we have such a unit.

Sixth, for district attorneys around the country to develop these multidisciplinary teams and to realize that collaboration is the way to go. We cannot prosecute these cases on our own; we have so much to learn from everyone else.

Finally, for everyone to invest in awareness campaigns so the public can feel confident that if they suspect elder abuse in a nursing home or in a private setting that there is a number that they can call and that they have the confidence that their call will not go unanswered.

So I want to take this opportunity to thank you, Senator, for your listening. It has been a difficult day for you. But thank you for the priority you place on this terribly important issue.

[The prepared statement of Mr. Greenwood follows:]

Statement of Paul R. Greenwood, Deputy District Attorney, Head of Elder Abuse Prosecution Unit, San Diego DA's Office

Good morning, Mr Chairman and distinguished members of the Special Committee on Aging. My name is Paul Greenwood and I have the privilege of heading up the San Diego District Attorney's Office Elder Abuse Prosecution Unit, a position which I have held for the past eleven years. I am also co-chair of the California District Attorneys Association Elder Abuse Committee.

Six years ago I appeared before this same committee. At that time I made the statement that "elder abuse will become one of the most serious issues facing law enforcement and prosecutors in this country within the next five years." Based on everything I see and hear, I believe that this prediction is now a reality.

The demographics about elders – of which you are so familiar – and the blatant targeting of elders as crime victims should give us all a wake up call and a renewed challenge to do more to protect our seniors and pursue their perpetrators.

When I was given the task of establishing an elder abuse prosecution unit in January 1996, my office previously had rarely filed elder abuse charges. Today I am responsible for overseeing multiple prosecutions that are being handled by experienced prosecutors throughout our county – ranging from homicides, sexual assaults, neglect, physical beatings and financial exploitations. With each case comes challenges, but we are constantly learning new techniques and are absolutely committed to protecting and enhancing the lives of senior citizens in the County of San Diego.

One of the major reasons for our ability to expand elder abuse prosecutions is our multi-disciplinary approach to such cases. We have formed excellent working relationships with law enforcement, first responders, Adult Protective Services, the Medical examiner's Office, and with various older adult service organizations. Such cooperation has allowed us to develop the following innovative projects:

1. An Elder Death Review team that reviews suspicious deaths of elders – and suggests recommendations for improved responses to potentially life threatening situations
2. Lunch time community meetings that are held throughout our County to discuss emerging issues in elder abuse
3. Trainings for financial institutions, the clergy and first responders in recognition of red flags of elder abuse
4. A continuing public awareness campaign entitled "Silence is not golden" – to promote the 1 800 telephone number that the public is encouraged to call when observing elder abuse

5. A wrap around model offering comprehensive services to elderly crime victims – through our San Diego Family Justice Center and funded by the Archstone Foundation.

I am convinced that collaboration by prosecutors with multiple agencies – where the local prosecutor's office takes the initiative – is the key to making an impact on the escalating crimes being committed against seniors. There are encouraging signs that prosecutors in several states are capturing the same vision but much more needs to be done. The National College of District Attorneys is currently drafting a training curriculum on Elder Abuse Prosecution. Once this curriculum is published it is hoped that prosecutors throughout the country will avail themselves of this excellent resource.

We also need to get the message out to state prosecutors' associations so that the elected District Attorneys understand the challenges and resolve to commit existing resources within their respective jurisdictions to combat elder abuse. There has been a tendency in the past for prosecutors to avoid grappling with such cases because of certain outdated misconceptions such as :

1. Elders make poor witnesses in court
2. Financial exploitation cases are difficult to prove because of mental capacity issues
3. Victims of physical abuse cases are reluctant to testify for fear of retaliation or isolation
4. Cases involving home repair fraud allegations are best dealt with as civil matters

We need to ensure that these misconceptions are put to rest and that prosecutors are trained to handle such cases in an approach similar to the successful models used in domestic violence prosecutions.

Having prosecuted felony elder abuse cases for over eleven years, I see the following areas as crucial in our nation's ability to react to the escalating problem of elder abuse:

A. We desperately need the passage of federal legislation in the form of the Elder Justice Act. So much has been achieved at the grass roots County & State level in recent years – but we need some leadership and responsibility from the Federal branch of government in tackling elder abuse.

B. We need to look at state laws dealing with elder abuse. For example, we should be very concerned at the fact that convicted felons can easily get employment working as caregivers. Surely, more can be done to protect the unsuspecting public from hiring felons to look after an aging relative. Additionally, we should evaluate whether state laws relating to physical and financial elder abuse are correctly earmarked as felonies rather than as misdemeanors.

C. We should consider creating or expanding lists of mandated reporters of elder abuse. California recently added financial institutions to the list. This is making banks and credit unions much more vigilant in protecting the assets of their elderly customers or members. Other logical mandated reporters would be health care workers, first responders, caregivers, medical personnel, the clergy and notary publics.

D. We need to make the court room more elder accessible and learn from such judges as Her Honor Judge Julie Conger of Alameda County Superior Court who has gained national attention for the way she operates her Elder courts.

E. All major urban communities should consider having a dedicated investigative law enforcement unit that handles elder abuse investigations. San Diego Police Department has had such a unit since 2000; it consists of six detectives and one sergeant.

F. Prosecutors should be encouraged to implement multi disciplinary networks with their local Adult Protective Services, mental health agencies, first responders and law enforcement. Elder Death review teams and Elder Financial Abuse Specialist Teams are now emerging across the country.

G. States should invest in more awareness campaigns so that the public knows exactly how and where to report elder abuse quickly and efficiently.

I am proud of the efforts that have been made thus far to protect the seniors of our country. But I am also aware that there is so much more to be done. We have excellent foundations; we now need to move forward with concrete proposals in a spirit of multi-agency collaboration on a national basis.

Investing in the long term protection of our senior population is a noble cause. The passage of the Elder Justice Act will serve as a rallying call. Today we can commit to making that happen.

Paul Greenwood
Deputy District Attorney
Head of Elder Abuse Prosecutions
San Diego District Attorneys Office

The CHAIRMAN. That was great testimony. Thank you so much. Mr. Blancato.

STATEMENT OF ROBERT BLANCATO, NATIONAL COORDINATOR, THE ELDER JUSTICE COALITION, WASHINGTON, DC

Mr. BLANCATO. On behalf of the nonpartisan, 545-member Elder Justice Coalition, I am pleased to participate in today's hearing.

We applaud the bipartisan leadership of this Committee and its work over several Congresses to promote elder justice. Today is another important contribution.

Mr. Chairman, we commend your steadfast efforts to fight elder abuse and promote a national criminal background check system for those working in long-term care. Our coalition supports your bill, S. 1577. We hope for its consideration either as a stand-alone bill, part of the "Elder Justice Act," or in some other legislation. We also appreciate your cosponsorship of S. 1070, the "Elder Justice Act."

But with all due respect to all this work, the Nation has waited long enough. We have good bills before the House and the Senate, the product of much work, negotiation and concession by major stakeholder groups. It is time for Congress to finish the job.

Mr. Chairman, your "Patient Safety and Abuse Prevention Act" is critical to the effort to help stop elder abuse. The 2003 legislation instituted the seven-State, 3-year pilot projects to determine ways States can implement systems to cost-effectively screen applicants for employment in long-term care. Data provided by pilot States show that each program has successfully excluded individuals with histories of substantiated abuse and criminal backgrounds.

However, as pointed out, these pilots expire in September. How do we go beyond the pilots, take their successes, and move to a more national system?

Your bill has one approach: Expand the pilot framework into all States between 2008 and 2010, and in 2011 institute a permanent prohibition for providers who knowingly employ an individual with a history of substantiated elder abuse or a criminal conviction for a relevant crime.

The issue of national criminal background checks needs to be addressed by this Congress. Elder abuse is increasing. A 2004 report points to a 19.7 percent increase in reported elder and vulnerable adult abuse cases just since 2000. Adult Protective Service agencies received 566,000 reports of suspected elder and vulnerable adult abuse. We also know of at least 20,000 cases of abuse in nursing homes from just one reporting source, the 2003 report of State Long-Term-Care Ombudsmen.

Far more elder abuse goes unreported. A 2000 Consumers Digest article says that only one in 25 cases of financial exploitation is reported. Consumer Action estimates that while adults 60 and over make up less than 15 percent of the population, they make up 30 percent of fraud victims. This Committee has made estimates of up to 5 million overall victims of elder abuse, neglect and exploitation.

Elder abuse is also current news. Three headlines just in this past week: Arizona Daily, "A nurse in a Flagstaff nursing home was arrested after allegedly punching a 93-year-old patient in the face." ABC–2 News in Baltimore, "A Westminster woman, hired to

clean and run errands for an elderly woman, has pleaded guilty to embezzling nearly $250,000 from the woman's estate." Ann Arbor, MI, "The daughter of a Salem Township woman who froze to death in March has been charged with vulnerable adult abuse for leaving her mother, who had Alzheimer's, alone for 26 hours. The mother was found dead in a ditch five miles from home, and she was not wearing a coat." The current Federal response to elder abuse is piecemeal and minimal. Less than 2 percent of all Federal funds spent on abuse prevention goes to prevent elder abuse.

As our population ages, so this problem grows. Today, the most common victim is an older woman, 75 years or older, living alone. Today, half of women 75 and over live alone. As financial abuse increases more quickly than other abuse, more and more wealth is being controlled by people 50 and over.

The "Elder Justice Act" offers a comprehensive response. It provides dedicated funding for Adult Protective Services, grants to improve ombudsmen's capacity, create a national training institute for surveyors of long-term-care facilities, grants for stationary and mobile forensics centers, and require the immediate reporting to law enforcement of crimes in long-term-care facilities.

Our focus needs to be directed, as this Committee has always indicated, to first helping victims of elder abuse; second, preventing new victimization; and third, helping those who are working with victims and on prevention.

It will be 30 years next year when Congress first addressed elder abuse in hearings of the old House Select Committee on Aging. This is the fourth consecutive Congress with an elder justice act and criminal background legislation that is waiting to pass. It is, frankly, incomprehensible, but not impossible to remedy.

As advocates, we say, let us work together—Administration and Congress, Senate and House, Democrats and Republicans, national, State and grassroots groups—to achieve the final passage of elder justice legislation so we can genuinely help some of the most vulnerable people in our society: victims of elder abuse.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Blancato follows:]

SENATE AGING COMMITTEE TESTIMONY

CHAIRMAN KOHL AND MEMBERS OF THE COMMITTEE:

On behalf of the nonpartisan 545 member Elder Justice Coalition, I am pleased to participate in today's hearing *"Long-Term Care Workers and Abuse of the Elderly."* The Coalition recognizes that this is more than a hearing to cover a specific crisis; it is also part of a strong and steady drum beat from this committee and others leaders for Congress to pass meaningful legislation to help combat elder abuse, neglect and exploitation. And we must do it this year.

So we applaud the bipartisan leadership of the Senate Special Committee on Aging that has for several Congresses led the way in promoting elder justice. Over the past decade, important hearings, reports, press conferences, and legislation from this Committee have helped to create an irrefutable case for Congressional action.

Today is another important contribution to this record.

First Mr. Chairman, let me commend you on your steadfast efforts on behalf of elder abuse prevention and in particular for a national criminal background check system for those working in long-term care. As you know, the Elder Justice Coalition is pleased to be a supporter of your bill S. 1577. We hope it has an opportunity to be given complete consideration either as a stand-alone bill, part of the Elder Justice Act, or as part of another piece of legislation.

We also appreciate your co-sponsorship of the Elder Justice Act as well as that of Ranking Member Smith and Senators Lincoln, Clinton, Specter, Collins, Bayh, and Salazar.

As the national advocacy voice for elder justice in America, the Elder Justice Coalition is proud to have many strong members in Wisconsin and Oregon and in all of the states of Senators on this Committee.

We are united in strong belief that more has to be done to combat elder abuse, neglect and exploitation, and soon.

We are in the fourth successive Congress where the comprehensive bipartisan Elder Justice Act awaits action. This seems incomprehensible to many of us.

Mr. Chairman, as you know, Wisconsin has recently taken on the issues of elder abuse through legislation that among other things has expanded the role of elder abuse adult protective service workers to work with law enforcement and other investigative authorities, which is similar to the model the EJA puts forth. We already have some evidence that this is helping the situation, but like many states it needs all of the EJA provisions and the funding to move forward adequately.

It is important for Congress to take action this year to help ensure enactment of the Elder Justice Act (EJA) by the end of the 110th Congress. The EJA is good policy and worthy of wide bipartisan support in both the House and Senate. The pending EJA is the product of much work, negotiation, and concessions by the major stakeholder groups who are involved in elder abuse prevention and elder justice. It is time for Congress to act.

Mr. Chairman, your legislation, the Patient Safety and Abuse Prevention Act is an important element in the effort to help stop the abuse of older Americans. As we are all aware, legislation in 2003 instituted a seven state three-year pilot project to examine ways in which states can implement systems to cost-effectively screen applicants for employment in long term care. The law addressed the disturbing fact that individuals with criminal backgrounds or backgrounds including substantiated abuse are more likely to pose safety risks for frail, highly vulnerable elders and those with disabilities.

Based on data provided by the pilot states each of the programs is successfully excluding individuals with histories of substantiated abuse and criminal backgrounds. That clearly is effective prevention. But these pilots programs will expire in September.

The question seems to be—how to go beyond the pilots, take the successes that have been achieved and move this to a more national system. One approach is embodied in S. 1577: expand the pilot framework into all states between the years 2008 and 2010 and then in 2011 institute a permanent prohibition for providers who knowingly employ an individual with a history of substantiated elder abuse or a criminal conviction for a relevant crime. Other provisions in this bill include funding of the background checks by Medicare and Medicaid. The key point here is the issue of national criminal background checks needs to be addressed by this Congress because it is a significant part of the overarching elder abuse crisis.

Another thing is not in dispute this morning. Elder abuse, neglect, and exploitation are increasing. It can be shown in aggregate numbers. A 2004 Survey of State Adult Protective Services revealed a 19.7 percent increase in the combined total of reports of elder and vulnerable adult abuse and neglect along with a 15.6 percent increase in substantiated cases since 2000.[i]

Overall Adult Protective Services (APS) agencies received 566,000 reports of suspected elder and vulnerable adult abuse. We also know of at least 20,000 cases of abuse in nursing homes from the report of the State Long-Term Care Ombudsman Programs funded through the Older Americans Act by the Administration on Aging.

Yet the sad reality is far more elder abuse cases go unreported. We have reports from the Long-Term Care Ombudsmen about abuse in long-term care facilities, but what about Medicare or Medicaid fraud agencies, state licensure or survey offices or even law enforcement? A 2000 Consumers Digest article suggested that only one in 25 cases of financial exploitation is reported suggesting there may be at least 5 million victims a year. This Committee has estimated that there are over 5 million victims of elder abuse each year. Further, according to estimates by Consumer Action, a consumer education and advocacy group, while adults age 60 and older make up 15 percent of the U.S. population, they account for roughly 30 percent of fraud victims.[ii] Individuals with disabilities are also extremely vulnerable, particularly in long-term care settings.

Mr. Chairman, in Wisconsin, according to 2005 data, there was a 7.5 percent increase in reported abuse and neglect cases from 2004 leading to a total of 4234 cases. Of these cases, 21 were fatal and another 353 were life threatening.

And sadly enough Mr. Chairman and members of the Committee elder abuse cases are current event news—let me share some sample headlines from stories just in the past week:

Arizona Daily Sunday, July 7 - Nursing home RN charged with assault. A nurse in a Flagstaff nursing home was arrested Wednesday evening after allegedly punching a 93 year old patient in the face.

ABC 2 NEWS in Baltimore - Caregiver pleads guilty to embezzlement. In Westminster Maryland a woman hired to clean and run errands for an elderly Westminster woman has pleaded guilty to embezzling nearly $250,000 from the woman's estate.

From the Ann Arbor Michigan News July 12 - the daughter of a Salem Township woman who froze to death in March has been charged with vulnerable adult abuse for reportedly leaving her mother who had Alzheimer's disease alone for 26 hours. The 45 year old daughter left her 67 year old mother alone starting at noon on March 15 and found her gone when she returned on March 16. The mother was found dead in a ditch five miles from home and she was not wearing a coat.

And it goes on-every day-and is reported in large national newspapers and the regional and local media in your States. It is not hypothetical. It is very real and these are less graphic examples than the norm.

So why do the facts and headlines not catch the attention of this Congress and Administration and lead to action?

The federal commitment is piecemeal in approach and minimal in substance. Consider of all the funds we spend on abuse prevention less than 2 percent goes to elder abuse (Congressional Research Service).

Also not in dispute are demographics. The most common victims of elder abuse are elderly women age 75 years and over often living alone. According to the Profile of Older Americans 2006, half of women 75 and over live alone and older women outnumber older men 21 million to 15 million. We also know the expected growth of the elderly population with the aging of boomers. This will include building on a current demographic that 70 percent of all wealth in the US is controlled by those over 50. Meanwhile financial abuse and exploitation is one of the fastest growing forms of elder abuse.

The Elder Justice Act, S. 1070 and H.R. 1783, represent the most comprehensive approach to helping to stop elder abuse. I submit for the hearing record a summary of the major provisions prepared by the Elder Justice Coalition. Let me just highlight a few of the key provisions of the bill:

1. **The Elder Justice Act would provide dedicated funding for adult protective services, the critical program across the nation in assisting victims.**

2. **It would provide grants to improve ombudsman capacity, conduct pilots, provide support and improve training.**

3. **Create a National Training Institute for Surveyors of long-term care facilities.**

4. **Awards grants to establish and operate both stationary and mobile forensic centers and to develop forensic expertise pertaining to elder abuse, neglect and exploitation.**

5. **Require immediate reporting to law enforcement of crimes in a long-term care facility.**

6. **Establish an Elder Justice Coordinating Council to foster coordination throughout the federal government on elder abuse topics and an Advisory Board to the Coordinating Council of experts on elder abuse, neglect and exploitation.**

Elder abuse takes many forms. It includes physical and emotional abuse, neglect, self-neglect, and financial exploitation. It takes place in homes as well as long-term care facilities.

As we look to the enactment of the Elder Justice Act and S. 1577, Patient Safety and Abuse Prevention Act of 2007, we hope passage will occur sooner rather than later. Simply stated, later means that thousands and thousands more will be abused.

Next year will mark the 30th anniversary of the first acknowledgment by Congress of elder abuse in the hearings of the House Select Committee on Aging.

Do we want to come upon this 30th anniversary with so little to show?

Mr. Chairman, Thank you for all you and this Committee have done to prevent elder abuse. I respectfully ask that you, Mr. Smith, and other members of the Committee make that final push to get these bills passed by the full Senate this year.
Thank you.

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[i] National Center on Elder Abuse: Abuse of Adults Aged 60+ 2004 Survey of Adult Protective Services http://www.elderabusecenter.org/pdf/2-14-06%2060FACT%20SHEET.pdf

[ii] Consumer Action Statistic on Elder Fraud http://aging.senate.gov/issues/elderfraud/index.cfm

The CHAIRMAN. That was very good. Thank you so much.
Mr. Reingold.

STATEMENT OF DANIEL REINGOLD, PRESIDENT AND CEO, THE HEBREW HOME FOR THE AGED, RIVERDALE, NY; ACCOMPANIED BY JOY SOLOMON

Mr. REINGOLD. Thank you, Mr. Chairman.

I am pleased to testify today on behalf of The Hebrew Home at Riverdale and the American Association of Homes and Services for the Aging. We strongly support "Patient Safety and Abuse Prevention Act" and the "Elder Justice Act."

The Hebrew Home is a nonprofit organization in New York, founded 90 years ago. We are a long-term-care provider, and we are very much in favor of a national registry. It will make our lives easier and the care of our residents better.

AAHSA represents 5,700 nonprofit, mission-based organizations who are providing services to over 2 million people a year, and all of our members have been protecting elders for all of their history.

The Hebrew Home provides nursing care, housing, home care and daycare, and today I will describe the Nation's first comprehensive elder-abuse shelter.

In our written testimony, we detailed the numerous activities of AAHSA, but today I want to focus on the shelter as a template and prototype for our Nation. So today, what I am presenting to you and to the Committee is the role of a nonprofit long-term-care facility stepping in to provide shelter and resources for victims of elder abuse in the community.

Elder abuse is often invisible. Unlike children, elders are isolated, they are shut in, they don't have public places where their abuse may be observed.

As difficult as it is for women, as well, to escape an abusive relationship and find a safe haven, it can be even more difficult for the elderly. Victims we have seen in the shelter suffer from cognitive and physical frailties, and they are frequently lacking in financial resources. So domestic violence shelters that exist can not serve the elderly. Many of the victims are men, who are not appropriate for the typical shelter that exists.

So victims are frequently brought to emergency rooms, homeless shelters, or, worse, they are returned to the abusive situation. We observed that, and we decided that we needed to step in and make a change. We came up with the model which allows The Hebrew Home and the Weinberg Center to provide shelter for these victims.

It exists in a nonprofit, mission-based long-term-care facility. We provide short-term emergency housing. We provide legal assistance and support services, with the goal of returning victims to their home. This is a short-term emergency shelter.

It is a prototype, and we are seeking, through our partnership with AAHSA to replicate this model in every community, because every community has a nonprofit nursing home that can be used as an emergency shelter.

We have the expertise. We have the facilities. We are elder-friendly. We operate 24–7. It is in keeping with our faith-based mission and our tax-exempt privilege.

Joy Solomon, who is the director and managing attorney of the Weinberg Center, is joining me today and will describe some of our partnerships and the unique training initiatives, some of which Mr. Greenwood alluded to, which we are implementing in New York City.

Ms. SOLOMON. Thank you for allowing me to testify, Senator Kohl.

One of the most significant features of the Weinberg Center is its partnerships with law enforcement and community agencies. We successfully collaborate with area district attorneys' offices, Adult Protective Services, area offices on aging, and hospitals to prevent duplication but to assure that all the victims' needs are met.

We train judges, law enforcement professionals, EMTs, social service personnel and other people who may come in contact with victims who are shut in.

The beauty of our model is that it can be adapted by any community. In New York City, doormen know everything. In a unique partnership with their union, we are training New York City doormen to identify abuse and contact us. In a rural community, on the other hand, this model could reach letter carriers, clergy, or other eyes and ears.

The center also has an extensive outreach program, visiting senior centers, retirement communities and shopping centers to disseminate information. Awareness, as Mr. Greenwood said, is critically important.

The Hebrew Home Research Division also tracks and documents our cases to identify the prevalence and incidents of elder abuse. Our work will be even more effective with the creation of forensic centers, as called for in the act, with your support.

Mr. REINGOLD. Senator, I wish to stress, in closing, three major points.

First, as mission-driven organizations, nonprofit providers have a moral obligation to assist elder-abuse victims, and we have the knowledge and ability to do so. There are nonprofit homes in every community. We can provide the physical shelter. Through our existing or newly created network, we can provide medical care, social work and legal assistance.

Second, protecting elders requires education and collaboration. We are training these people in the community to recognize and respond to elder abuse, and we collaborate with the police, prosecutors, hospitals, domestic violence shelters and seniors directly. This is not about doing it alone. It involves all of us in the community who come into contact with elders and who can provide assistance.

Third, we see the Weinberg Center as a way to raise awareness about elder abuse and to help Federal and State policy. For example, we would hope to convince the Center for Medicare Services to make elder abuse a diagnosis for which Medicare or Medicaid reimbursement can be issued. Right now, we accept people without regard to pay and without regard to the possibility of payment.

As with child abuse and domestic violence, the problem is multidimensional and multidisciplinary. Our model can be replicated throughout the United States, and we commend you for including in the act grants for creating new and innovative programs.

In closing, Senator, creating the elder-abuse shelter has been an extraordinarily rewarding experience for our staff, our board of directors and our community. An elder-abuse shelter housed in nonprofit facilities throughout America is a goal that The Hebrew Home, in partnership with the American Association of Homes and Services for the Aging, is aggressively pursuing.

We appreciate the opportunity to discuss these issues with you today. On behalf of AAHSA and The Hebrew Home, we congratulate you on your efforts and your leadership. We look forward to working with you in protecting our Nation's most vulnerable citizens.

Thank you.

[The prepared statement of Mr. Reingold follows:]

Statement by Daniel Reingold

President and CEO

The Hebrew Home for the Aged at Riverdale

5901 Palisade Avenue

Riverdale, New York

Before the

Senate Special Committee on Aging

Hearing on

"Abuse of Our Elders: How We Can Stop It"

July 18, 2007

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creating the future of aging services

Statement by Daniel Reingold
President and CEO
The Hebrew Home for the Aged at Riverdale
July 18, 2007

Introduction

Chairman Kohl, Ranking Member Smith and members of the Committee, I am pleased to have the opportunity to testify today on behalf of The Hebrew Home for the Aged at Riverdale (Hebrew Home) and the American Association of Homes and Services for the Aging (AAHSA), of which we are a member.

The members of the American Association of Homes and Services for the Aging (www.aahsa.org) serve as many as two million people every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. Our 5,700 members offer the continuum of aging services: adult day services, home health, community services, senior housing, assisted living residences, continuing care retirement communities and nursing homes. AAHSA's commitment is to create the future of aging services through quality people can trust.

The Hebrew Home has been dedicated to community service since its founding in 1917, when a small synagogue in Harlem opened its doors as a shelter for poor, homeless, elderly people. The Hebrew Home has become one of the nation's leading elder care centers and has continually renewed and expanded its commitment to provide the best possible care and the highest quality of life for older people.

Today, the Hebrew Home, located on 19-acres along the Hudson River in the Riverdale section of the Bronx, serves more than 3,000 people in the Bronx, Manhattan and Westchester County and includes residential healthcare, rehabilitation and palliative care facilities, senior housing communities, The Harry and Jeannette Weinberg Center for Elder Abuse Prevention and Elderserve, the Home's community services division. Elderserve offers a full spectrum of healthcare and supportive services to help maintain the independence of older persons who choose to remain in their own homes. This includes long term home health care, in-home personal care, medical and social adult day programs as well as overnight respite programs.

In my testimony today, I will focus on the ground-breaking work of the Weinberg Center to prevent abuse of elders in the community, to intervene to protect abused elders, to conduct research to identify the prevalence and incidence of elder abuse, and, in partnership with AAHSA and the Brookdale Foundation, to replicate the program to reach elders in other communities. I am pleased to have with me today Joy Solomon, an attorney with the Pace Women's Justice Center, who jointly created the Weinberg Center with The Hebrew Home and now serves as our Director. In addition to overseeing the day-to-day operations of the nation's first long-term care based elder abuse shelter, Ms. Solomon has developed and implemented a variety of unique training and public awareness campaigns which are described below.

Elder Abuse is a Serious and Complex Problem

Elder abuse is a large yet poorly understood problem that is not readily solved by the existing infrastructure for addressing domestic abuse.[1] Elder abuse can be physical, sexual, emotional and financial. Experts believe that almost 90% of abuse occurs in the community,

[1] See, e.g., Otto and Quinn, Barriers to and Promising Practices for Collaboration Between Adult Protective Services and Domestic Violence Programs (National Center on Elder Abuse, May 2007).

often perpetrated by family, friends, caregivers, and financial "advisors". As with child abuse and domestic violence, elder abuse is under reported, for many of the same reasons as well as reasons unique to the population. Elders may feel shame; they may be dependent on the perpetrator financially or emotionally; they may be unable to access care because of physical or mental disabilities (e.g., dementia). In addition, it may not be clear to elders and others where to report. And as the Otto and Quinn report notes, there is a dearth of appropriate resources and interventions for victims of elder abuse. This was the impetus for the Hebrew Home to create its own elder abuse shelter.

We therefore congratulate Chairman Kohl, and Senators Hatch, Lincoln and Smith for introducing legislation that is essential to addressing the causes, treatment and prevention of elder abuse – S. 1577, the Patient Safety and Abuse Prevention Act, and S. 1070, the Elder Justice Act.

Before we discuss ways to address abuse in the community, we will address prevention of abuse in group settings such as nursing homes and other long-term care entities.

Prevention of Abuse in Long-term Care Settings

In a number of respects, it is easier to address prevention of elder abuse in nursing homes and other long-term care entities than it is in the community at large. These are contained settings; the owner/provider hires, fires and trains staff; and the requirements for care are set by regulation and contract.

As not-for-profit, mission-driven and primarily faith-based organizations, AAHSA members are committed to preventing all forms of elder abuse, neglect and exploitation. In addition to my own organization, many other AAHSA members have established or participated

in programs that provide safe and consumer-focused services for seniors. Just a few examples of the work we are doing include:

- Long support of the work of the Center for Advocacy for the Rights and Interests of the Elderly (CARIE), a consumer advocacy organization, encouraging our members to implement *Competence with Compassion,* CARIE's highly regarded and successful training program for abuse prevention in nursing homes and personal care homes. This program has trained thousands of direct care workers and supervisors.
- Collaboration with the Centers for Medicare and Medicaid Services (CMS) to develop guidance and educational materials for providers to heighten awareness and to facilitate abuse prevention and reporting;
- Encouragement of its members, like The Hebrew Home, to partner with district attorneys, law enforcement agencies, financial institutions and social service agencies to help them recognize signs of physical and financial abuse.
- Recognition that improving the quality of life and care for residents and the quality of the working environment for staff are essential elements of preventing abuse. AAHSA members originated the culture change movement, developing, among other programs, the Eden Alternative (www.edenalt.org); the Green House Project (www.ncbcapitalimpact.org); the Wellspring Alliance (www.wellspringis.org); and the LEAP workforce development program (www.matherlifeways.com).
- Supporter of the Alzheimer's Association Campaign for Quality Residential Care. AAHSA is one of the 24 provider, consumer and professional organization Supporters of

the association's dementia care practice recommendations. We continue to work with the Alzheimer's Association as they expand the practice areas studied.

- Leadership in voluntary quality improvement efforts such as the Achieving Excellence in America's Nursing Homes campaign, an unprecedented national coalition of long-term care providers, consumers, state and federal governments and others to improve nursing home performance in targeted areas.[2] In addition, this year marks the 5th anniversary of Quality First, AAHSA and the long-term care field's quality improvement initiative. Focusing on continuous quality improvement and the importance of leadership at all organizational levels fosters an environment that does not tolerate abuse or neglect of residents. AAHSA recognizes the leadership of Senators Smith and Wyden as members of the National Commission for Quality Long-Term Care. The non-partisan Commission, which grew out of the Quality First initiative, is tasked with evaluating the quality of long-term care in America, identifying factors influencing the ability to improve quality, and recommending national strategies for sustainable quality improvement.

The Patent Safety and Abuse Prevention Act (S. 1577)

AAHSA has long been a supporter of a national system of criminal background checks for employees of long term care providers with direct access to residents and clients and strongly supports S. 1577, the Patent Safety and Abuse Prevention Act. Timely and accurate criminal background checks are an important component in efforts to prevent abuse of our elderly

[2] Advancing Excellence's goals are 1) reduce pressure ulcers; 2) reduce use of physical restraints; 3) improve pain management for long-term residents; 4) improve pain management for short-term residents; 5) establish individual targets for quality improvement; 6) assess resident/family satisfaction with care; 7) improve staff retention; and 8) improve staff assignment so residents receive consistent care. In just 9 months, more than a third of the nation's 160,000 nursing homes have signed on to the campaign.

residents and other vulnerable adults. In our mobile society, the ability to access national criminal records is an essential component to prevent the hiring of abusive workers.

S. 1577 contains important provisions to ensure that AAHSA members are able to meet our resident's needs and comply with the provisions of the statute. The bill allows for provisional employment during the criminal background check process. This will allow our members to hire otherwise qualified staff while the check is completed, an important consideration for providers continuing to face critical shortages of direct care employees. The bill also protects employers from liability for any employment action that must be taken based on the results of the background check. These are critical components and AAHSA is pleased to support their inclusion in S. 1577.

As not-for-profit and faith-based providers, most AAHSA members utilize volunteers to enhance the quality of life for the residents we serve and create import links to our local communities. Volunteers make an important contribution to the overall wellbeing of our residents in many diverse ways, from participating in a wide variety of group activities with residents to simply being there to talk with residents and share their memories. AAHSA is pleased that S. 1577 exempts volunteers from background checks unless the volunteer performs duties equivalent to an employee with direct access to residents and those duties involve one-to-one contact with residents.

S. 1577 also recognizes the costs to the employer of a criminal background check system, and provides a mechanism for reimbursement of those costs and authorizes appropriate funding. This, along with the provisions of the bill which require a single state agency to oversee the program and to notify providers of the results of the background check, will help assure an

efficient and timely process to meet the goal of preventing employment of persons who pose a risk to the safety of our residents.

The Elder Justice Act (S. 1070)

AAHSA has supported the Elder Justice Act since its original introduction in 2002. We are proud to be members of the Elder Justice Coalition and serve on the Coalition's Coordinating Council. Our members are committed to preventing elder abuse wherever it occurs. The findings enumerated at Section 2 of the Act succinctly identify the nature of the problem, barriers that have prevented resolution over the years, and the importance of taking action now. As the 16th finding states, "All elements of society in America have a shared responsibility in responding to a national problem of elder abuse, neglect and exploitation".

This Act provides a comprehensive approach to understanding and preventing abuse. The Act establishes an Elder Justice Coordinating Council to foster coordination throughout the federal government on elder abuse topics and an Advisory Board to the Coordinating Council composed of experts on elder abuse, neglect and exploitation. Coordination across federal agencies is a critical component to successfully addressing the role that the federal government will play in providing resources, funding, education and support to those who are in the field – law enforcement, consumer advocates, long term care providers, caregivers, and community groups. For long term care, in addition to establishing stringent mandatory reporting requirements for long term care facilities, the Act includes a number of affirmative initiatives including:

- Grants and incentives to enhance the training, recruitment and retention of staff in long-term-care facilities, including grants to improve management skills;

- Grants for long term care facilities to offset "the costs related to purchasing, leasing, developing, and implementing standardized clinical health care informatics systems designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors;"
- Direction to the Secretary of HHS to develop and adopt uniform open electronic standards for transactions involving clinical data by long term care facilities;
- Creation of a national institute to improve the training of surveyors investigating allegations of abuse in long term care facilities;
- Grants to enhance and improve the work of Adult Protective Services agencies and the Long Term Care Ombudsman program; and
- Funding to evaluate the success of abuse prevention programs.

Sheltering Abused Elders: The Weinberg Center for Elder Abuse Prevention

Elder abuse in the community is difficult to detect, and when it is suspected, to address. Unlike children, elders don't go to public entities regularly, like schools, where they can be observed and where mandatory reporting can be required. As another example, we know that it is difficult for victims of domestic violence to escape the cycle of violence, to find the resources and emotional wherewithal to leave the abusive relationship, as well as to find a safe haven. But it is even more difficult for abused elders, who can suffer from cognitive and physical disabilities, as well as the frailties accompanying aging, in addition to lacking financial resources. Domestic violence shelters are simply not equipped to deal with the needs of the elderly, as the Otto and Quinn paper note. This was the experience of the Pace Women's Justice Center in New York as

well, and led to the collaboration between the Center and The Hebrew Home to integrate a shelter for abused elders into the infrastructure of the Home.

We believe that not-for-profit long term care providers can and do play a unique role in preventing elder abuse and protecting abused elders. The Weinberg Center is the prototype for an elder abuse sheltering system that we expect to replicate throughout the United States through a grant by the Brookdale Foundation and in partnership with AAHSA.

The Weinberg Center runs a shelter that provides emergency short term housing, legal assistance and support services to victims of elder abuse. In addition, the Center continues the long-standing partnership that the Hebrew Home has had with the Bronx and Westchester County District Attorneys to provide education and training to community, social services and law enforcement professionals. The Center also has an outreach program to those most at risk, visiting senior centers, retirement communities and shopping centers to disseminate information about available resources. In addition to prevention and intervention, Hebrew Home has a research division that tracks and documents all Center cases with the ultimate goal of helping to identify the prevalence and incidence of elder abuse.

Attached to my testimony are three articles that describe the Center and its history and operations in greater detail, but I want to stress three major points.

First, as mission-driven, mostly faith-based organizations, not-for-profit long term care providers have a moral obligation to assist elder abuse victims, and we have the knowledge and ability to do so. We provide not only a physical place for shelter, but also medical care, social work, and legal assistance. Our goal is to safely return the elder to the community.

Second, preventing abuse in the community, and protecting elders who have been abused, requires education and collaboration. We train pharmacists, doormen, and others in the community to recognize and respond to abused elders; we collaborate with police and prosecutors, hospitals and domestic violence shelters; and we go directly to seniors. This is not about going it alone; it is about involving everyone in the community who can come in contact with an elder who needs assistance and protection.

Third, we see the shelter as a way to raise awareness of the extent of the problem of elder abuse and to help influence state and federal policies. For example, we hope to convince Medicaid to make elder abuse a diagnosis for which care can be reimbursed. As with child abuse and spousal abuse, fixing an abused elder's broken bone does not fix the problem – the problem is multi-dimensional and multi-disciplinary.

Conclusion

Creating the elder abuse shelter has been an extraordinarily rewarding experience for our staff, our board, our elders and our community. We would like to see an elder abuse shelter housed in every not-for-profit aging services provider in America.

I appreciate the opportunity to discuss these issues with you today. On behalf of AAHSA and the Hebrew Home, I congratulate you on your efforts to bring justice to our elders and we look forward to working with you.

The CHAIRMAN. We thank you.

We thank you.

Your testimony was really good.

Mr. Greenwood and Ms. Laubert, to what extent are crimes against the elderly going underreported? Why is that so in our society?

Mr. GREENWOOD. Senator, yes, it is going unreported by the victims themselves for several reasons.

Obviously, some of our victims don't have the mental cognitive ability to know how to report or to be able to articulate what happened to them.

Second, many of our victims, particularly victims of financial elder abuse, are ashamed and embarrassed to report to the police. In fact, I have sat down with many elderly victims, and we found out about these crimes from other sources. When I sit with them and gently ask them, "Why didn't you want to tell anybody this happened to you?", the answer I keep getting is, "Mr. Greenwood, I would rather lose $50,000 to the crook than run the risk of losing my independence." Because, unfortunately, there is a misconception in the elderly population that, if you are a victim, that we are all going to gather around and take away their independence. We are not in that business. We want to take away the independence of the perpetrator and not the victim.

The CHAIRMAN. That is very good.

Ms. Laubert.

Ms. LAUBERT. Mr. Greenwood makes very good points.

The experiences that we have seen with people who are receiving home-care services—I remember one woman in particular who said that the home health aide, or the homemaker, who went grocery shopping for her would come back and wouldn't give her change or would have lost the receipt. So when we said, "Well, let us do something about that," she said, "Well, Jackie has been taking care of me so well for so long, and she had to have her car repaired last year, so she really needs the money, and I will be OK."

What we see in home care is that the relationships that are formed between the client, who is vulnerable and feeling alone in their home, and the caregiver are very strong, and they don't want to make waves.

I think about my own personal experiences with my parents having medical issues and being hospitalized for long periods of time. "Well, Mom, what do you mean they kept you awake all night cleaning the carpet? Let us do something about that." "Oh, it is OK. I don't want to make waves." I think that that is a part of that generation. My generation is not going to accept those things. So, I think we need to be ready.

I want to also tell you something very quickly, to give Congress a deadline. In 1998, my office received a call from a man named Daniel Broadman, who wanted to complain about a nurse in a nursing home where he worked who had not responded to a resident who was in distress and the resident died. The ombudsman got involved, investigated. The State survey agency got involved.

About four years later, Daniel Broadman was in jail for passing bad checks. He confessed that he was the one who had killed that

resident 4 years earlier. So he had three or four years, moving from one long-term-care facility to another.

He is due to get out of prison for involuntary manslaughter in 2009 in Ohio. I know he won't be able to work in long-term care in Ohio again, but without a comprehensive Federal law, he may be able to go to a neighboring State and work in long-term care.

The CHAIRMAN. That is very——

Ms. LAUBERT. So there is a deadline.

The CHAIRMAN [continuing]. Very good.

So we take it that, in many ways, you are much like your mother, but, however, you are much more assertive than your mother.

Ms. LAUBERT. Right. [Laughter.]

The CHAIRMAN. Good for you.

OK. Mr. Blancato, you talked about the importance of getting that national registry included as part of the "Elder Justice Act," which, as you know, is one of our priorities. Would you like to make any other comment on that, as we move forward?

Mr. BLANCATO. Well, all I would add is that, as a coalition, that we have a wide group of people from the nursing home industry, the nursing home rights groups, and we believe that the strongest possible elder justice legislation needs to emerge in this Congress, and we include that in that. The work that you have done, I think, deserves being given serious consideration this year.

I think the issue—and we have watched this advocacy movement around elder justice emerge over the past 4 or 5 years. Senator, I assure you, it has strong grassroots components. It has strong interdisciplinary elements to it. I think this is the year where, you know, we can see that come to fruition with the passage of meaningful legislation. We, again, commend you for your leadership in that area.

The CHAIRMAN. Thank you.

Folks, what can you tell us by way of things we can and should be doing to encourage the development of Weinberg Centers across the country?

Mr. REINGOLD. The act provides for grants for innovative programs, and these are very cost-effective programs that we are describing. We are currently working with three other organizations to replicate the Weinberg Center. The startup time to open a shelter and get it running could be as soon as 30 days.

There are some innovative ideas that have to be adapted to a particular community's needs. But with very little support, very minimal financial support, we believe that nonprofit long-term-care providers can step in, as they have stepped in on so many other issues, to provide a very innovative solution that is cost-effective, that is appropriate and that is nurturing.

The CHAIRMAN. Ms. Solomon.

Ms. SOLOMON. I just wanted to go back to the question that you asked before, about the underreporting. What we are seeing a lot of is that it is the family member who is abusing their parent or grandparent, whether it is financial, physical or sexual abuse.

So, when you ask, "Why is there underreporting?", I think that the reality is that it takes a lot of incidents to occur before a grandmother is willing to report her grandson to a prosecutor or to the

police. That is one of the reasons that things are not being reported.

But if, as a community, we create these partnerships together to provide support, then that grandmother could get some support and her grandson could get some support too. It wouldn't necessarily mean that he goes to jail, but that they get some support in the community to live safely together.

Because, often, elder-abuse victims want to maintain these "loving" relationships even when they have gotten to a point of lack of safety or theft or some of the other things we are hearing about.

So we need to create safety nets for the families and for the older people, certainly.

The CHAIRMAN. That is a very important point that you are stressing, that elder abuse often occurs within a family.

Ms. SOLOMON. Yes.

The CHAIRMAN. That is something that we need to note and understand.

Well, we thank you all for being here today. Your testimony has been just great.

I want to tell you, on behalf of the Committee, that we are going to work extremely hard to get the "Elder Abuse," as well as the national registry, passed this year. I think we have a good chance to get it done. I think you will all feel more than recompensed for your efforts in being here today if we can get that done. You can be assured we are going to do our very best.

So we thank you for coming, and we thank you all for your patience in awaiting this hearing. It has been a great hearing, and it gives a lot of inspiration to those of us who are listening to you to get the job done. So thank you for coming.

We thank you all for being here. This hearing is finished.

[Whereupon, at 1:35 p.m., the Committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR GORDON H. SMITH

I want to thank Senator Kohl for holding this important hearing today. The issue of nursing home quality and safety has long been an issue of particular interest for me and I thank the panelists for being here today. The essential work that they do—whether monitoring care or advocating for nursing home residents—supplies the framework that helps so many of our elderly family members age with dignity.

The past two decades have revealed a true culture shift occurring within the world of long-term care, including services that put the patient at the center of care, encourage inclusion of families in decision-making and giving more choices in the location of the care, such as community-based and in-home settings. However, with those advances has come the need to pay greater attention to the quality of care that is provided to seniors in all types of long-term care settings.

Ensuring patient safety is a responsibility that rests with no one party or entity. It is shared by the federal and state governments, law enforcement agents, local agencies and community advocates. It is a responsibility that I take very seriously, as I know my colleagues do. I believe there is a need for all stakeholders to work more collaboratively to curb the incidence of elder abuse. We owe that to the millions of seniors who have placed their trust in our nation's long-term care system.

Apart from improving communication and cooperation of enforcement activities, there may need to be new, stronger policies in place to ensure that seniors receive the safest long-term care possible. I plan to reintroduce the "Long-Term Care Quality and Modernization Act" with Senator Lincoln. This bill will encourage a number of important improvements to nursing homes and the long-term care system that aim to enhance the quality and safety of care provided to our seniors. I look forward to working with many of the advocates, industry representatives and regulators here today to ultimately pass this legislation.

I would like to applaud the work Senator Kohl has done in this area as well, especially in regard to helping nursing homes and other facilities better identify potential bad actors in the workforce. It is essential that we find more effective ways to help poorly performing facilities operate at a much higher level of care, or consider ways that they can be phased out of the system. We cannot let the inappropriate actions of a few continue to destroy the trust our nation's seniors have placed in the long-term care system.

I am confident that the fine panels of experts Senator Kohl has assembled today will be able to provide a fresh insight on the work that is being done at the federal, state and local levels to reduce elder abuse and provide the safest, highest quality care possible.

Thank you.

PREPARED STATEMENT OF SENATOR HILLARY RODHAM CLINTON

I would like to thank Chairman Kohl and Ranking Member Smith for convening today's listening session on the growing problems of elder abuse in our country and what we can do to reduce and prevent incidents of neglect, mistreatment, and violence against older Americans.

I'd also like to thank the panelists—several of whom traveled from New York—to share their expertise and personal stories on this critical issue.

I'd like to personally extend a special thank you to Ms. Coldren for being here today to share her grandmother's harrowing experience in a residential care facility.

My heart goes out to your grandmother for what she endured and to you and the rest of your family for the pain and suffering you've experienced. Although it was under horrific circumstances that your grandmother came to live with you in your home, I am very glad to know that she is in the good care of you and your husband

and that her happiness is beginning to return now that she is in a safe and loving environment.

I am also relieved to learn that your grandmother's abuser has been brought to justice, thanks in large part to the work of Mr. Tortora who has accompanied you here today.

Mr. Tortora and others like him in Medicaid Fraud Control Units are on the front lines of looking out for older Americans, who constitute one of our nation's most vulnerable populations. Older adults with Alzheimer's and other dementias, such as Ms. Coldren's grandmother, are especially in need of protection.

As the baby boomers begin to reach retirement, it becomes increasingly important to have federal policies that promote positive aging and protect the well-being of our nations' seniors.

I am proud to represent a state that has model examples of how residential care facilities can incorporate elder abuse shelters, such as the Hebrew Home for the Aged in Riverdale, NY, which provides support and health care services as well as legal advocacy for older adults who have been victimized. I welcome Mr. Daniel Reingold, president and CEO of Hebrew Homes, and commend you for the work you're doing nationally to expand the number of nursing homes that include elder shelters.

We all know that there are thousands of competent and compassionate long-term care professionals that provide care for seniors in a loving and respectful manner. We are indebted to their professionalism and commitment.

But the available information on elder abuse is truly sobering and staggering. Every year, as many as 5 million older Americans are subjected to gross neglect, abuse, or exploitation. According to a 2003 report by the National Academies, up to two million older Americans over the age of 65 have suffered abuse or mistreatment by those who were charged with their protection and care.

According to a 2004 Survey of State Adult Protective Services, there was nearly a 20 percent increase in reported cases of abuse and neglect of older and vulnerable adults between 2000 and 2004. A separate investigation in 2001 found that there's been a national increase in elder abuse in nursing homes, with a three-fold increase in abuse violations between 1996 and 2000.

Abusive behavior has serious consequences: according to an article published in the Journal of the American Medical Association, older Americans who are abused are three times more likely to die prematurely than older Americans who have lived in safe and healthy environments.

In less than ten years, the first wave of baby boomers will turn 65. In light of the growing longevity of Americans, we must consider how we will meet the increasing needs of this elder boom including the protection of their mental, emotional, and physical wellbeing.

This is about more than statistics: it's about safeguarding the dignity and happiness of older Americans—our grandparents, parents, senior members of our communities—and doing all that we can to support the countless husbands, wives, sons, daughters, loved ones and caretakers who give their time to provide support and comfort for their grandparents and parents.

Safety is particularly important for individuals who suffer from Alzheimer's disease or other dementias. All of us here realize that as the Baby Boomer generation ages, there will be a dramatic increase in the number of Alzheimer's cases. By the year 2050, if we do not make headway, up to 16 million Americans are expected to suffer from this devastating disease.

As co-chair of the Senate Task Force on Alzheimer's Disease with my colleague Senator Collins, I have worked to address issues faced by Alzheimer's patients and their caregivers.

Diseases such as Alzheimer's can contribute to depression and anxiety for both those who suffer from the disease as well as their caretakers. Access to mental health services are also crucial for older adults who have been mistreated or victimized. That is why Senator Collins and I introduced the *Positive Aging Act of 2007*, which will integrate mental health services into primary care and community settings, making it easier for older Americans to get the support and treatment they need.

But we need to stop cases of abuse and neglect before they occur. That's why I am proud to join my colleagues in supporting both the *Patient Safety and Abuse Prevention Act* and the *Elder Justice Act*. As an original cosponsor of the *Patient Safety and Abuse Prevention Act*, I recognize that we need to strengthen states' abilities to safeguard against abuse and neglect in long-term care facilities.

This bill would meet these needs, by authorizing and funding a nationwide expansion of programs that screen applicants for employment in long-term care facilities.

Among other provisions, this bill will also provide protections for long-term care facilities that fire employees with troublesome histories while also protecting employees from wrongful termination.

Long-term care workers who pass the background checks would have certification of employment that they could take to any long-term care employer for two years.

In order to recruit and maintain a quality long-term care workforce, we should not burden prospective employees with the financial cost of the background checks—the *Patient Safety and Abuse Prevention Act* would authorize funds to cover these costs.

As a long-time supporter of IT as an important tool to help improve health care, I am especially pleased that this bill would help states establish IT infrastructures for screening job applicants at long-term care facilities.

Improving our ability to detect physical abuse is crucial as well. The *Elder Justice Act*, of which I am a proud cosponsor, would, among other provision, support advances in forensics specific to elder abuse.

Both the *Patient Safety and Abuse Prevention Act* and the *Elder Justice Act* are important steps towards ensuring that all older Americans, wherever they may live, are able to enjoy their golden years in safe and nurturing environments.

Again, I thank Chairman Kohl and Ranking Member Smith for convening today's listening session, and for their leadership on this issue. I look forward to continuing to working with my colleagues to make progress for our seniors and families on these important issues.

PREPARED STATEMENT OF SENATOR ROBERT P. CASEY, JR.

I want to thank Chairman Kohl for raising this very critical issue and for all the work he has done over the years to protect our older citizens from abuse and ensure that they are treated with dignity, respect and compassion by the individuals who care for them. As a Senator, I have an abiding obligation to do all I can to protect those who fought our wars, worked in our factories and taught our children—those who gave us life and love.

I want to also add that I am proud to co-sponsor Chairman Kohl's bill, The Patient Safety and Abuse Prevention Act (S.1577) which he introduced a few weeks ago and which will address the issue of background checks for workers who care for older citizens. Chairman Kohl, you have been a tireless and powerful advocate for our older citizens and I thank you for your good work.

We are here this morning to examine what we can do to stop the abuse, neglect and exploitation of our elders. The Bible tells us to "honor thy mother and thy father." There are no words to truly and adequately convey how very wrong it is that our seniors should suffer any kind of neglect or abuse in the twilight of their lives. Whenever we have a vulnerable population that suffers abuse or neglect—whether it be children, those with disabilities, or our older citizens—it is heartbreaking.

Elder abuse is a particular problem because we have neither a comprehensive system for collecting data nor a uniform reporting system. Even the definition of elder abuse varies from state to state. But regardless of how statutes may define such abuse, we are talking about emotional, physical and sexual abuse as well as exploitation, neglect and abandonment. Sadly, shame, vulnerability and the fragility of many older men and women often render them unwilling to report crimes against them.

What data we do have suggest strongly that there is a largely silent epidemic of elder abuse. Data on elder abuse in domestic settings, for example, suggest that only 1 in 14 incidents, excluding incidents of self-neglect, come to the attention of authorities. With respect to financial exploitation, current estimates indicate that only 1 in 25 cases are reported, suggesting that there may be at least 5 million financial abuse victims each year. A study by the National Center on Elder Abuse estimated that for every one case of elder abuse, neglect, exploitation, or self neglect reported to authorities, about five more go unreported.

Pennsylvania has the third largest elderly population in the country—15 percent of the state population or 1.9 million citizens. The numbers of elders will dramatically increase as our baby boomer generation continues to age. Nationally, we know that approximately 1 in 20 people will experience elder abuse during their lifetime. This is an alarming statistic. For Pennsylvania, this means that approximately 95,000 older citizens will be abused during their lifetimes. This is unacceptable to me. I know it is equally unacceptable to the members of this committee and to all of you who have come to testify today.

Before being elected to the Senate, I spent 10 years in state government, eight of them as Auditor General, the state's fiscal watchdog. During that time, I con-

ducted performance audits of Pennsylvania's oversight of long-term care, home health care and personal care homes and advocated changes in legislation and policy that improved the quality of care. Our audits exposed that Health Department bureaucrats were letting weeks and months elapse before investigating life-threatening complaints about nursing home care and that the state was licensing personal care homes without verifying that administrators and staff were properly qualified or trained. As a result of our audit work and our advocacy, nursing home residents are safer today and the laws governing home health care and personal care homes have improved. I am grateful to have the opportunity to continue this critical work in the Senate and particularly on this Committee.

There is no denying this is a very complex issue. We have a health care system that has long been geared to address symptoms rather than focus on prevention that could provide better health and lower costs in the long run. Consequently we have growing numbers of seniors who experience multiple and chronic conditions that rob them of their independence and ability to care for themselves, becoming increasingly dependent on others to meet their needs. Institutions are under-staffed and have unsafe patient-staff ratios. We also have a workforce of direct care workers, many of whom face deplorable working conditions and professional stagnation. We must offer these dedicated workers decent salaries, professional respect and opportunities for training and upward mobility. That is the only way we will attract the caliber of workers who will care for our older citizens the way we would care for them as a family.

We must do more to stop the abuse and neglect of our older citizens. Chairman Kohl's bill is a positive step in that direction. I welcome the opportunity this hearing affords us and I look forward to the experience, expertise and suggestions of the three panels of witnesses from whom we will hear this morning. I know you all have very important information and stories to share and I thank you for being here.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM GREGORY DEMSKE

Question 1: The Federal/State Disconnect

LEAD IN: In the most recent GAO report on nursing home enforcement, one of the findings that struck me was the level of disconnect between CMS here in Washington and the regional offices and state agencies that are tasked with implementing the statutes and guidelines regarding the nursing home industry.

Question. From your perspective in the Office of the HHS Inspector General, can you comment on this discrepancy and offer a few ideas on how this can be remedied so that everyone can get on the same page and work towards more uniform enforcement and oversight?

Answer. OIG's extensive work related to the nursing home enforcement mechanisms highlights inefficiencies and inconsistencies in how enforcement actions are referred and implemented. To illustrate, in one report, *State Referral of Nursing Home Enforcement Cases* (OEI–06–03–00400; 12/05. *http://oig.hhs.gov/oei/reports/oei–06–03–00400.pdf*, we found that States failed to refer about 8 percent of cases to CMS as required and that late State referrals caused the delay or failure to impose mandatory denials of payment. Failures in the referral process were caused by insufficient or incorrect CMS-regional office guidance, inaccurate enforcement data, and CMS not recognizing cases as referrals. Inefficiencies in the enforcement tracking systems mean that even when enforcement actions are required, they may not be implemented timely or in a manner that would motivate a facility to return to compliance. CMS has taken a number of actions, including implementing both case and incident-tracking systems, that should help to ensure that referrals are properly identified and communicated by the States and CMS and that enforcement actions are implemented more timely.

OIG, like GAO, has also found inconsistencies in the citation of all levels of deficiencies (not just the most severe) among States, between Federal and State reviews, and even among individual survey reports. In a March 2003 report, *Nursing Home Deficiency Trends and Survey and Certification Process Consistency* (OEI–02–01–00600), *http://oig.hhs.gov/oei/reports/oei–02–01–00600.pdf*, we found that in 2001, one-third of the nursing homes in Virginia were deficiency-free while none in Nevada were. In the same report, we also noted inconsistencies between Federal and State surveys-Federal survey teams normally find a larger number of, and more serious, deficiencies than state teams. These inconsistencies resulted from variations in survey focus, lack of clarity in guidelines, lack of a common review process for draft survey reports, and high turnover of surveyor staff. We recommended that CMS improve its guidance to State agencies on citing deficiencies by providing guidelines that are both clear and explicit, and work the States to develop a com-

mon review process for draft survey reports. CMS has taken steps to implement these recommendation and is also currently conducting training for state surveyors to promote consistency among reviewers regardless of the State. OIG continues to monitor the implementation of these recommendations.

In two other reports, *Nursing Home Enforcement: Application of Mandatory Remedies* (OEI–06–03–00410; 05/06) *http://oig.hhs.gov/oei–06–03–00410.pdf* and *Nursing Homes Enforcement: The Use of Civil Money Penalties* (OEI–06–02–00720; 04/05) *http://oig.hhs.gov/oei/reports/oei–06–02–00720.pdf*, OIG found that CMS does not apply all mandatory remedies (mandatory denial of payment and mandatory termination) against noncompliant nursing homes are required by statute, that CMS does not collect a large portion of Civil Money Penalties (due in part to reduction related to waiver of appeal rights, settlements and reductions resulting from appeals), and that CMS frequently imposes CMPs at the lower end of the allowed ranges. For the majority of cases requiring mandatory termination of nursing facilities, CMS did not apply the remedy because of both late case referrals by States and reluctance to impose this severe remedy. We recommended that CMS provide guidance to regional CMS staff and States regarding appropriate CMP dollar ranges for the varying types of violations and take required collection steps. We also recommended that CMS terminate noncompliant facilities' participation in the Medicare and Medicaid programs within the required timeframes.

In summary, States and CMS should properly and consistently identify deficiencies and demand corrective actions at the earliest possible point. Further, to be effective in promoting compliance, civil monetary penalties and other graduated sanctions must be implemented fully, and not compromised down unless appropriate corrective action has been taken.

Question 2: Targeting Worst Offenders

LEAD IN: GAO identified in its 2005 report on nursing home enforcement that CMS's efforts have been further hampered by an expanded workload due to increased oversight responsibilities and initiatives that compete for staff and financial resources. The latest GAO report found that we are still not succeeding in removing the worst offenders from the system.

Question. Is there a way to refocus CMS's energy on oversight tasks and initiatives that are the real underperformers?

Answer. OIG has identified a number of needed improvements to the survey and certification system and enforcement mechanism if CMS and States are to properly address the worst offenders. First, deficiencies should be properly cited in the first place, so that all poor performers can be identified. Second, it is important to pinpoint the cause of the deficiency so that an appropriate corrective action can be taken. For certain facilities, the problems that lead to deficiencies are not only at the facility level. OIG has worked with companies under quality of care CIAs to address those systemic issues that gave rise to substandard care at the facility level. As one example, a regional director of a nursing home chain placed extraordinary pressure on nursing home administrators to keep the census in their nursing home high. As a consequence, one facility was accepting dozens of patients each month with complicated medical needs; however, the facility did not have staff with the specialized skills needed to appropriately meet the needs of these residents. The root cause of these issues and the appropriate corrective actions to resolve the issues cannot always be identified through the current survey process.

Finally, when deficiencies are noted, appropriate sanctions should be applied consistently by CMS and States. Without a sense that enforcement remedies will necessarily have an impact on a facility, some owners and managers will not be sufficiently motivated to maintain compliance. CMS and States impose graduated sanctions that become increasingly harsh as the provider fails to comply—termination being the most severe. If CMS or the State fails to implement these sanctions as they are designed, ensuring compliance may become more difficult. Both State and CMS enforcement staff have reported to OIG that they are reluctant to impose what are perceived to be harsh remedies that risk putting a nursing home out of business or have a negative impact on a facility's ability to care for residents. For example, deficiencies are often related to insufficient staffing and monetary penalties can put a further strain on facilities' financial stability and risk maintaining even the prior level of staffing.

CMS has implemented several initiatives aimed at targeting especially poorly performing nursing facilities. For example, in January 1999, CMS implemented a Special Focus Facility program that involves enhanced monitoring of two nursing homes in each State. In December 2004, CMS expanded the scope of its Special Focus Facility program from about 100 homes nationwide to about 135 homes. CMS also revised the method for selecting nursing homes by reviewing 3 years rather than one year of deficiency data to better target homes with a history of noncompliance. Addi-

tionally, CMS strengthened its enforcement regarding Special Focus Facilities by requiring immediate sanctions for homes that failed to significantly improve their performance from one survey to the next, and by requiring termination of homes with no significant improvement after three surveys over an 18-month period.

Question 3: Marginalizing Lesser Harms?

LEAD IN: Nursing home quality reports have focused most of their reporting on CMS's oversight of serious harm to residents, those rated at the G level and above. Where this focus is addressing the critical and immediate needs of residents, I am concerned that the enforcement efforts are neglecting the lower level harms that still create dangerous environments for residents and result in lower quality of care for our loved ones.

Question. If CMS and the states are already overextended in monitoring homes for the worst offenses, what can be done to assist victims of the lower level harms who are still deserving of better treatment?

Follow Up: What's to say that a facility will allow harm up to that G threshold level, but not beyond, knowing that enforcement efforts likely will not occur unless it crosses that point? Are we gambling with resident's health and well being through this approach?

Answer.

It is imperative that all deficiencies, including those below a level G, be addressed in a timely and complete manner in order to protect facility residents from actual and potential harm. CMS and States have a variety of tools to make this happen. The survey process, corrective actions plans, and graduated sanctions are the simplest tools that can be used to address deficiencies to prevent them from becoming serious deficiencies that cause actual harm to a resident.

In earlier OIG work examining trends in nursing home deficiencies (see question #1), OIG examined all deficiencies, including those below the G level. Although GAO noted that serious deficiencies have declined somewhat, our work at that time indicated that deficiencies overall had increased. This increase could be due to a variety of factors. For example, a greater number of deficiencies could result from States conducting more thorough surveys, while a smaller number of deficiencies could be due to surveyors possibly down-coding deficiencies.

Although OIG has not done work focusing on the compliance of facilities with deficiencies below a "G," we do not believe there is a high risk that nursing facilities would willingly allow harm up to a certain level. By statute, every nursing home receiving Medicare or Medicaid payment must undergo a standard survey no less than once every 15 months, and the statewide average interval for these surveys must not exceed 12 months. Even though a facility may not have been cited for serious deficiencies in a prior survey, it is still subject to regular surveys. Additionally, homes with D-level or higher deficiencies are all considered noncompliant. CMS and States can demand corrective actions to address the deficiency and can use a variety of sanctions to help coerce compliance with quality requirements ranging in severity according to the scope and severity of the deficiency, a facility's prior compliance history, and the desired outcome. Serious deficiencies (H or higher, and repeated G-level deficiencies), however, are subject to mandatory sanctions. If a facility with a D-level or higher deficiency does not become compliant within a certain time period, then the sanctions are increasingly elevated, with the potential end result of termination of the facility.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM DANIEL REINGOLD

Question: Dissemination of their innovative program

LEAD IN: I was intrigued by the groundbreaking work being done at the Weinberg Center to prevent the abuse of elders. I believe such programs are key to the broader effort in improving the type of care we provide our seniors.

Question. What have you done in helping other communities replicate the success of these programs?

Answer. We, too, believe the Weinberg Center model is uniquely effective in the intervention and prevention of elder abuse and have made great efforts to encourage replication throughout the nation.

First, we have partnered with AAHSA (American Association of Homes and Services to the Aged) to encourage all of its members to replicate the Weinberg model. In doing so, we have set up a link from the AAHSA web site to the Weinberg Center, so that interested affiliates can have access to our model, policies and procedures, and easy connections to the Weinberg Center team for direct communications. The Weinberg Center team has given workshops at numerous AAHSA conferences specifically on how to replicate.

Second, through a grant from the Brookdale Foundation for dissemination and replication of the Weinberg Center, we have created a how to manual, provided consultations to assist in adapting the Weinberg model, and held day long training for replication.

Finally, The Weinberg Center team has given numerous presentations to professionals, law enforcement, and others who come in contact with older adults on elder abuse and the Weinberg Center model. In addition to creating collaborative partnerships, the Weinberg Center Team is nationally and locally active on numerous elder abuse coalitions and partnerships, spreading the word about the Weinberg model.

Illinois Department of
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HEALTH

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Testimony of Dr. Eric Whitaker M.D., M.P.H.
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Testimony Submitted to the Senate Special Committee on Aging

Assessing the Impact of the Illinois Department of Public Health Health Care Worker Background Check Program

July 18, 2007

Honorable Chairman Kohl, Ranking Member Smith, and distinguished members of the Senate Special Committee on Aging, the Illinois Department of Public Health offers the following written remarks regarding our Department's proactive response on the issue of elder abuse. We would like to share with you the results of our participation in the federal demonstration program on health care worker background checks, what we as a State have learned and implemented through this demonstration program to improve our State's current health care worker background check program.

Overview of the Illinois Health Care Worker Background Check Program
Illinois, with a population of 12,831,970, ranks as the fifth most populated state in the United States after California, Texas, New York and Florida. Twelve percent of Illinois' inhabitants are 65 years of age or older. Considering these individuals along with our residents who are mentally or developmentally disabled, and even those who are just spending short term visits within health care facilities, it becomes quite apparent why Illinois puts so much emphasis on protecting those of its citizens who cannot readily look out for themselves from possible harm through criminal background checks. Illinois has a statute called the "Health Care Worker Background Check Act" (Act) that governs background check requirements for direct care workers retained by health care employers and direct access workers employed in licensed or certified long-term care facilities. Background checks have been required under this Act since 1997. While the original Act names several disqualifying convictions, in 2004 additional convictions were added as disqualifying. Currently there are 96 convictions that prohibit an individual from working as a direct care worker or an access worker in long-term care. Illinois does have a waiver process that provides relief of that prohibition of work if all required criteria are met. The prohibition to work is only waived under the condition that the individual not

be convicted of additional disqualifying offenses.

In summary the Health Care Worker Background Check Act:

- Requires a Uniform Conviction Information Act (UCIA) name-based background check for a new hire if the record of their last back ground check on the Health Care Worker Registry (formerly Nurse Aide Registry) is more than a year old.

- Requires a UCIA fingerprint background check if there are multiple common names that are retrieved from a name-based check.

- Requires a UCIA fingerprint background check if the name-based check reveals disqualifying convictions and to request a waiver.

- Requires a UCIA fingerprint background check if the applicant challenges the results of a name-based check.

- As long as a person stays at the same facility no additional background check is ever required.

- Name-based checks can be submitted by form or, if set up to do encrypted email, by email to Illinois State Police. Forms take anywhere from two weeks to a month to process. Emailed requests take about a week.

- UCIA fingerprint checks can be submitted by form (ink and role) or by livescan vendor (electronically). Forms take anywhere from two weeks to a month to process. Livescan is generally processed within 48 hours.

- All background checks are requested by the health care employer and the results of the check goes back to the employers. The employer must make the determination as to whether any convictions are disqualifying. The employer is responsible for mailing Illinois Department of Public Health a copy of the results which is manually entered into a computer system to be displayed in the on-line Health Care Worker Registry.

- Each state agency affected by the Act is responsible for processing waivers for the entities they license. State agencies do not always accept the waiver processed by another state agency.

- There is no requirement to check any other registry than the Health Care Worker Registry.

Federal Pilot Program

Illinois was invited to participate in a federal Centers for Medicare & Medicaid Services (CMS) pilot project for fingerprint background checks. The original scope of the pilot

was to incorporate 13 provider types across the entire State of Illinois. This would have been 2,494 facilities in 102 counties. Since the grant money was not allowed to be spent on the cost of background checks, Illinois became very concerned about the high cost of background checks for the facilities and low paid workers. There is about a 100% turnover rate in the long-term care industry.

Illinois State Police utilizes the "Rap Back" system. Rap Back is a database system that provides notification and flags future convictions associated with a fingerprint previously captured thereby allowing an employee to only need one background check during the period of the pilot, irregardless of the number of times they may move from one facility to another. The Federal Bureau of Investigations (FBI) does not have the Rap Back function. This difference between the State and Federal systems would have required a redundant FBI background check for each person that was hired the second and proceeding times by a facility.

There was also a large concern for all the manual processes that would have to be done by Illinois Department of Public Health because our registry, where the background check results are stored, was on an old mainframe system.

These concerns led to Illinois negotiating with the federal CMS on the scope of the project. The goal was to reduce the number of counties involved and the number of mandated provider types. We also sought to have the ability to spend grant funds on the background checks to relieve the financial burden on the facilities and workers. Illinois also requested that the FBI provide a Rap Back, but that was beyond their abilities for the grant. The FBI does have intention of getting the Rap Back but that is projected to be in about five to ten years.

Through the assistance of the federal project director we were able to come to terms that Illinois could agree to and participate in the pilot.

- The number of counties was reduced from 102 to 10 that represented the social-economical flavor of the entire state.

- There were only five mandated provider types.

- Grant funds could be used to pay for background checks for all but the state police portion of the Certified Nurse Aids (because Illinois law required background checks for Certified Nurse Aids prior to the grant).

- Federal CMS would increase Illinois' grant funds and provide additional grant funds for a new modernized computer system to automate the process.

Illinois experienced many challenges in implementing the pilot. There were technical computer problems and problems with state contracts that had to be worked out. But this type of difficulty should always be expected when starting a new program and having to provide training to so many individuals on how it is to be done. Overall the pilot has

been a tremendous success for Illinois. The providers that participated have been well pleased and Illinois has learned some valuable lessons.

- Name-based background checks are not as effective as fingerprint background checks.

- Name-based background checks do not provide the degree of protection that Illinois desires for its citizens who cannot protect themselves.

- Name-based background checks often require fingerprints to be done additionally for common names and when there is a conviction under the name check.

- This "double checking" slows down the hiring and waiver process.

- When name-based background check forms are sent to Illinois State Police they can take anywhere from a week to a month to get processed. Using the fingerprint check and the automation we have developed, allows accurate results in about two days and no manual entry on Illinois Department of Public Health's part.

Using the technology available is the only way to go.

- The facilities that submit applications frequently expressed how much they like being able to see how far along an applicant is in the background check process. It also helps us to catch any that need a special inquiry if the results are not back within a week.

- Facility users have caught on to the application very quickly and required minimal support from the Illinois Department of Public Health after the initial group training was provided.

- Automatic notifications have worked well, especially for those facilities that do not like to actually hire a person until the background check results are received.

- Illinois Department of Public Health's manual processes are drastically reduced for the grant background checks.

- Waivers are processed faster because the background check is the first thing received instead of the last.

From Pilot to Statewide Implementation

The Illinois Department of Public Health has proposed legislation in place that would require the entire State to use fingerprint background checks for health care workers.

- The legislation has recently passed the Illinois General Assembly and is on its way to the Governor's desk for signature.

- If signed into law it will take advantage of the Rap Back that Illinois State Police offers.

- The automatic processes used in the pilot will be implemented throughout the State of Illinois for those health care employers affected by the Health Care Worker Background Check Act.

- The waiver process is being revised through the rules process to incorporate an automatic waiver for those who meet the criteria.

There is a profound need for a FBI Rap Back system. FBI background check results are only a picture in time that may change within days of getting the background check. While the cost of electronic submissions are being reduced the expense is still burdensome to health care providers, who have very little profit margin, and for the low paid worker, if several FBI checks have to be done throughout an individual's career.

Illinois supports the idea of a national background check law that would require fingerprint background checks from both the state and the FBI, if the FBI would provide the Rap Back feature. This law would provide better protection for those who cannot protect themselves, promote consistency amongst the states, and allow individuals who do not have disqualifying convictions to obtain work much faster.

Should you have any further questions regarding the Illinois Health Care Worker Background Check Program, please do not hesitate to contact Denise Gaines, Chief of the Division of Governmental Affairs, at 217-782-6187.

UNITED STATES SENATE

Special Committee on Aging's

Hearing Titled:

Abuse of Our Elders: How We Can Stop It?

July 18, 2007

Dirksen Senate Office Building
Washington DC

Written Statement of the

National Association of Medicaid Fraud Control Units

NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

Chairman Kohl and Members of the Committee, thank you for the opportunity to submit written testimony to discuss the role of the Medicaid Fraud Control Units in investigating and prosecuting cases of abuse, neglect, and exploitation in our long-term care facilities and other Medicaid-funded facilities across the country. The Medicaid Fraud Control Units have been the vanguard in law enforcement efforts to combat abuse, neglect, and exploitation that tragically occur everyday in our nursing homes, residential care facilities, home health programs, and hospitals. We applaud the efforts of the Special Committee on Aging, and are particularly interested in the "Patient Safety and Abuse Prevention Act of 2007." The purpose of our written statement today is to give you the background of the Medicaid Fraud Control Units and highlight the types of cases we have investigated and prosecuted in the last several years. We would also like an opportunity to specifically comment on S. 1577 once our entire membership has had an opportunity to review it and provide comment.

Respectfully Submitted,

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INTRODUCTION

Medicaid provider fraud costs American taxpayers hundreds of millions of dollars annually and hinders the very integrity of the Medicaid program. State Medicaid Fraud Control Units (MFCUs) have long been in the forefront of health care fraud enforcement. The need for the MFCUs came about when the public and Congress realized that too many nursing home patients were held hostage by the greed of a small number of facility operators and often dishonest health care practitioners who used the Medicaid program as their own private "ATM machine."

In 1977, Congress enacted the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95-142) to "strengthen the capability of the government to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs..." The legislation specifically provides that MFCUs were to (1) conduct a statewide program for the investigation and prosecution of health care providers who defraud the Medicaid program; (2) review complaints and prosecute cases of abuse or neglect against residents in long-term care facilities, defined as anywhere where two or more individuals reside and pay for care; (3) review complaints and prosecute cases of the misappropriation of patients' private funds; and (4) investigate and prosecute cases of fraud in the administration of the Medicaid program. The Medicaid Fraud Control program was voluntary until 1995. Federal law now requires each state to have a Medicaid Fraud Control Unit (MFCU) unless the state can demonstrate to the satisfaction of the Secretary of the U.S. Department of Health and Human Services that it has a minimum amount of fraud in its Medicaid program and that Medicaid beneficiaries will be protected from abuse and neglect. Forty-nine states and the District of Columbia have MFCUs, North Dakota has been granted a waiver and does not have a MFCU.

Since 1978, the MFCUs across the nation have prosecuted thousands of billing fraud cases and in the course of these cases recovered billions of dollars for the Medicaid program. Perpetrators of Medicaid billing fraud run the gamut from the solo practitioner, who submits claims for services never rendered, to large institutions that exaggerate the level of care provided to their patients and then alter patient records to conceal the resulting lack of care. The MFCUs have prosecuted large pharmaceutical manufacturers who engaged in schemes to underpay Medicaid drug rebates; psychiatrists who demanded sexual favors from their patients in exchange for prescription drugs; and even funeral directors who billed the estates of Medicaid recipients for funerals they did not perform.

But the MFCUs also focus significant attention, and resources, on the patient abuse, neglect and exploitation cases that get reported to the MFCUs. When Congress created the MFCUs, it did so, not only because of the evidence of massive fraud and chicanery in the Medicaid program, but also because of the horrendous tales of nursing home abuse and resident victimization. The MFCUs are the only law enforcement agencies in the country specifically charged with investigating and prosecuting abuse and neglect of residents in nursing homes, other Medicaid-funded health care institutions, and in board-and-care facilities.

SELECTED SIGNIFICANT STATE RESIDENT ABUSE AND NEGLECT ENFORCEMENT EFFORTS BY THE MEDICAID FRAUD CONTROL UNITS

Many MFCUs use their criminal and civil enforcement authority to enforce different types of resident abuse cases that underscore the insidious, hidden, and often neglected concerns about the financial and physical safety of vulnerable, "at-risk" adults who can no longer care for themselves and who are disproportionately subject to abuse and debilitating injury. These cases include homicide and manslaughter, sexual abuse, physical abuse, misappropriation of patient trust funds, corporate neglect, failure to report, drug diversion and failure to check caregiver's criminal records. In addition, the MFCUs across the country have launched innovative programs that include training and public outreach to help prevent resident abuse. Other important activities by the MFCUs include legislative efforts to enhance and reform the laws that protect residents from these abuses and referring state criminal convictions, judgments, and licensing actions to the HHS Office of the Inspector General so that individuals who are convicted of these crimes may be excluded from working in any facility or program that receives Medicaid funding.

Examples of elder/resident abuse cases prosecuted by the MFCUs in recent years include:

Involuntary Manslaughter/Homicide

Some of the most egregious types of crimes prosecuted by the MFCUs involve caregivers at nursing homes and group homes who commit negligent homicide, involuntary manslaughter, and homicide.

- The Louisiana MFCU opened a case upon the discovery of 34 bodies that drowned at a nursing facility from the Hurricane Katrina storm surge and flooding. The investigation involves negligence by the owners of the facility for allegedly ignoring evacuation orders and refusing offers of transportation to evacuate residents prior to the storm's landfall.

- The Arkansas MFCU investigated a homicide at a nursing home. Two certified nursing assistants (CNAs) beat a resident to death with a set of brass knuckles. One CNA pled guilty and was sentenced to 30 years in prison.

- The manager of a group home in Missouri pled guilty to involuntary manslaughter and admitted to recklessly causing the death of a resident. She admitted that she failed to make adequate provisions for the appropriate treatment of decubitis ulcers developed by the resident. The victim, who was confined to a wheelchair, suffered from cerebral palsy and was physically and mentally handicapped. He was moved into the facility, and later admitted into a hospital, where he died due to severe ulcers.

- After a fire broke out at the group home and two residents died, the Nevada MFCU investigated and prosecuted the owner of the home for one count of Elder Neglect Resulting in Death and one count of Involuntary Manslaughter. The MFCU investigated criminal negligence and focused on licensing and regulatory compliance requirements of

group home operations. This included the need to have qualified care-givers present for residents. There were enough regulatory compliance shortcomings to support filing a criminal complaint. The owner agreed to plead to one count of Involuntary Manslaughter and was sentenced to prison for 12 to 30 months.

- The Oregon MFCU prosecuted an adult foster home owner and two caregivers on Criminally Negligent Homicide charges, for the death of a resident of the home. When paramedics responded to the home, they found the resident malnourished, dehydrated, hypothermic, and suffering from Dilantin toxicity. The victim, who died at the hospital, was 6'1" but at the time of death weighed 110 lbs and was suffering from approximately 60 decubitis ulcers.

Sexual Abuse

A type of abuse, which is unspeakable but occurs all too often, is sexual violence against elderly and disabled residents. Unlocked rooms and the fact that residents regularly submit to physical contact in order to receive care make them easy prey for sexual predators.

- A physician pled guilty to three counts of Unlawful Sexual Contact involving three separate patients. The physician was sentenced to a consecutive 30-day term of imprisonment and restitution to Medicaid in the amount of $6,380. As a result of the convictions, the Maine Board of Licensure in Medicine summarily revoked his license to practice in the state.

- In Washington State, a caregiver at a residential facility for the mentally retarded was found guilty of Indecent Liberties and Kidnapping in the Second Degree. The defendant took the victim to a vacant room in the facility and had sexual relations with the victim. The case was ultimately solved based upon DNA evidence recovered from the victim that matched the defendant's DNA. He was sentenced to 48 months in prison and ordered to make restitution in the amount pf $6,375. This sentence was "exceptional" because of the victim's vulnerability and the status of the defendant as a caregiver.

- In Vermont, a mobile x-ray technician was prosecuted by the MFCU for the molestation of a 93-year-old female nursing home resident. The defendant was convicted of Lewd and Lascivious conduct based on his visit to a nursing home when he inserted his tongue in the elderly patient's mouth and touched her breast during a routine x-ray for a broken hip. He also pled guilty to violating a court order concerning his place of residence. The New Hampshire MFCU also prosecuted the same health care worker for a similar incident, which occurred at a nursing home in New Hampshire just ten days after the incident occurred at the Vermont facility. He was sentenced to serve 1 year of a 3 to 5 year sentence in Vermont.

Physical Abuse

It is difficult to conceive of a more vulnerable, less threatening group than residents of long-term care facilities. Yet, too often they are the target of cruel and, at times, sadistic violence and mistreatment. Most reprehensibly, in long-term care facilities, perpetrators of physical abuse are usually those charged with the care and well-being of patients.

- In Kansas, the owners and operators of a group home were found guilty on multiple counts of conspiracy, forced labor, involuntary servitude, health care fraud, money laundering, mail fraud, and obstructing a federal audit.

  They owned and operated a residential facility for mentally ill adults where more than 20 residents lived. The owners and operators controlled virtually every aspect of the lives of the residents, determining which rooms they would sleep in, what furniture they were allowed to have, when they would eat, what recreational activities they could engage in, when they could be downstairs, and who could enter leave the houses. Rather than lawfully and responsibly carrying out their duties as caregivers, they used physical force and threats to intimidate the residents, to isolate them from their families, and to sexually humiliate them. At times, residents were forced to strip naked and were confined to a seclusion room, forced to urinate and defecate into a wastebasket, shocked on the genitals with a stun gun, and forced to perform sexual acts while being videotaped. Repeatedly, the residents were warned that if they did not obey their abusers they would wind up in jail or in state mental institutions.

  Some of the residents of the home had previously attempted to report the abuse. However, because the abusive conduct was so horrific, the owners had been successful in concealing it for years by convincing local authorities, family members, and others that the reports of abuse were the unbelievable delusions of mentally ill residents. Verification of the abuse and the validation of the residents' reports were contained in over 100 hours of videotapes that were made by the owners and discovered by search warrant in their private residence – including some that were discovered under their bed.

  The defendants received sentences of 30 years and 7 years and were sent to federal prison following sentencing.

- A caregiver at a group home for mentally retarded adults in the District of Columbia was found guilty of assault of a vulnerable adult, following a bench trial. According to trial testimony, the defendant pushed a vulnerable adult in his care to the ground, slapping his face and "kneeing" him in the back to restrain him. The victim of the assault testified at the trial. The defendant was sentenced to the maximum 180-day term of imprisonment, 90 days suspended, 2 years probation, and a fine of $500. The defendant was permitted to serve the remaining 90 days with "work release privileges." In addition, the defendant was ordered to stay away from the victim and the group home where the offense occurred.

In imposing sentence, the court stated that crimes against vulnerable citizens – children, elders, and persons with mental retardation and other cognitive deficits – must be taken seriously, especially when a perpetrator occupies a position in which he is entrusted with the care and protection of a vulnerable person. The court noted that government entities, the courts, and communities are taking notice of these crimes and are not taking them lightly, stating, "These crimes will not be tolerated." The MFCU also requested that the defendant be suspended from participating in all federal health care programs for a term of five years.

- In Alabama, a nursing assistant was sentenced to one year and one day in jail and a suspended sentence of two years on supervised probation for injuring an elderly woman when moving her from a chair to a bed and dropping her. The judge ordered the defendant to complete an alcohol treatment program and banned her from working in any nursing home or other long-term care facility. The nursing assistant was administered a blood alcohol test that revealed she had an alcohol content that was more than three times the legal limit to operate a motor vehicle.

- An employee for a group home in Arizona which housed five developmentally disabled individuals was accused of abusing three vulnerable adults who resided in the group home. The defendant allegedly slapped the first victim on the left shoulder twice and pulled a second victim's stomach hair to move him from one room to another. Additionally, she engaged in a pattern of verbal emotional abuse with the third victim. She was sentenced to 36 months of probation under the supervision of the adult probation department.

- A certified nurse assistant (CNA) in Arkansas pled to a misdemeanor assault for picking up a nursing home resident who did not want to get into bed and throwing him on the bed, slamming the resident's head into the wall. He then took his tennis shoe and swatted the resident on the head. Although the resident suffered little actual injury and no permanent damage as a result of the assault, because he had suffered surgery to repair a ruptured blood vessel in his brain within months of the assault, a physician was prepared to testify that the resident was placed at actual risk of serious bodily harm or death by the CNA. The CNA was placed on a registry banning him from working in nursing homes, fined $500, and given a one-year suspended sentence.

- In Kentucky, two CNAs were convicted of abusing elderly and medically fragile patients by administering laxative suppositories that were not medically necessary and not ordered as part of the patients' treatment. The acts, which took place during a bed check at the end of the second shift on that date, were apparently done to harass the nurse assistants on the next shift. Some of the patients suffered pain and rectal bleeding after the suppositories were administered.

- A licensed practical nurse was indicted in Kentucky for punching and torturing a mentally retarded man for over 20 minutes as punishment for the victim's act of overturning his lunch tray. The entire abusive encounter was captured on videotape. The nurse was sentenced to five years in prison and probation was denied. After completing his sentence, he will be unable to work in the health care industry again, as his license was revoked.

- A certified nursing assistant in Massachusetts was found guilty of multiple counts of patient abuse and assault and battery for deliberately tripping a nursing home resident and striking him in the head and tormenting another resident by repeatedly striking him in his hearing aid. He was sentenced to serve eight months in the House of Corrections and ordered to pay $2,550 in fines, in addition to losing his certification as a nursing assistant.

- A Rhode Island mental health worker was convicted of assaulting a patient at a hospital. The prosecution proved that he brought the patient into the shower room along with another patient who was needed to interpret for the worker. After a few brief words, the worker punched the patient in the eye, breaking his glasses and causing a laceration. He threatened the patients not to say anything about the assault. The next day, the patient-witness told another mental health worker what had happened. This case was particularly challenging because both patients were incarcerated at the mental hospital and they were incompetent to testify at trial. They suffer from low-level intellectual functioning and various mental illnesses. The defendant received a three-year suspended sentence and three years probation with community service.

Patient Funds

Federal regulations provide that the MFCUs may review complaints of the misappropriation of patients' private funds. Today, many of the Units investigate and prosecute these financial crimes.

- The business manager at a Minnesota nursing home was charged with 12 felony-level counts of Theft, Theft by Swindle, and Theft of Personal Needs Allowances. One of her responsibilities was to manage the nursing home's resident trust account and the individual resident funds that were deposited in and withdrawn from the account. Using various schemes, including writing checks on the account for petty cash or for false resident expenses, she stole resident funds from the trust account over the course of two and a half years. During the audit of the nursing home's records, she confessed to the crimes. She pled guilty and was sentenced to serve 45 months in prison on five of the counts. In addition, she was ordered to pay restitution to the victims in the amount of $61,217.31.

- In New Jersey, a nursing home owner was sentenced to three years in state prison and ordered to repay $110,000 in patient trust funds that she misappropriated. The MFCU investigation established that she used this money to pay an overdue mortgage on another

nursing home she operated and thousands of dollars in past due utility bills in yet another nursing home.

- In North Carolina, the administrator of a health care center pled guilty to two counts of Felonious Embezzlement of Recipient Funds. She was sentenced to 60 months of supervised probation and ordered to pay restitution of $70,666.90 to the health care center resident trust fund. Her husband and a friend pled guilty to misdemeanor Solicitation of Embezzlement and were found jointly and severally liable for payment of part of the restitution. She deposited residents' checks into the patient trust fund and then moved the funds into the petty cash fund, from which she wrote checks totaling $70,666.90 to herself, her husband, and her friend. She disguised these transactions by using the facility's automated patient trust fund and account receivables systems to create credit applied transactions that created false credit postings to the residents' accounts receivables.

- An administrator who managed the patient trust funds for an Oklahoma facility cashed Social Security checks of some residents of the facility, converted the funds to her own use, and did not use the funds to pay for the residents' care at the facility. She also used other resident trust funds for purchases of personal items including a camera, clothing, and videos at various businesses in the area. She pled nolo contendere to six counts of Felony Caretaker Exploitation and was sentenced to a five-year deferred sentence on each count to run concurrent, ordered to make restitution of $30,592.30 and pay court costs of $2,474.20.

- A residential coordinator for a residential program for the mentally retarded in Tennessee pled guilty to 13 counts of theft over $500 and was sentenced to six years in a Department of Corrections facility. The court also ordered restitution to each of the 13 victims for a total of $28,690.86. Through bank records and patient financial records, a MFCU auditor was able to show how much of the money was stolen.

- In Oregon, a home health care aide was sentenced on five counts of Criminal Mistreatment in the First Degree, four counts of Theft in the First Degree, one count of Aggravated Theft, and two counts of Possession of a Controlled Substance in the Second Degree. Despite having no prior criminal record, she was sentenced to a total of 36 months in prison and 36 months post-prison supervision. Additionally, she was ordered to pay $22,760 in restitution, to undergo substance abuse evaluation and treatment, and prohibited from seeking or obtaining employment as a caregiver.

  The aide was employed by an Oregon home health care service that received Medicaid funding. The aide was assigned by the agency to work for a woman who was looking for minor assistance in such things as light housekeeping, cooking, and shopping; she was paid by the victim's family. The family discovered that the aide had been ordering excessive amounts of prescription medications for the victim, and that many of those medications were missing. Shortly thereafter, the victim and her family discovered that

during the aide's five months of employment, approximately $25,000 of unauthorized ATM withdrawals had been made from the victim's bank accounts. In the last months of employment, the aide withdrew over $17,000 from the victim's accounts and during that same period, paid cash for a brand new car.

- In Vermont, a nursing home employee with access to patient trust accounts, in the course of three years, wrote 198 checks for her own benefit from the resident trust account, totaling $41,152.21, and stealing from at least 22 nursing home residents.

Patient Neglect

Those who accept the position of trust as caregivers to dependent, vulnerable adults should be held accountable for neglecting those in their charge. Failure to provide care and treatment to residents of nursing homes and/or board and care homes is every bit as dangerous and harmful as intentional assaultive behavior. Many states have prosecuted patient neglect cases of caregivers in facilities, and sometimes owners, who have failed to provide adequate care and treatment to residents, resulting in residents suffering from decubitus ulcers, dehydration, and malnutrition.

Some states have utilized Medicaid fraud statutes to prosecute corporate owners of nursing homes. Others have reached civil settlement in lieu of prosecuting criminal charges against the facility. Imposing corporate liability may not always be the best course of action. There may be insufficient evidence or shutting down the facility may not be in the best interest of all patients or the community.

- The Colorado MFCU has been involved in an ongoing federal case against the proprietors of a nursing home that is now closed. The allegations are that the nursing home owners committed cost report fraud against the Medicaid program. The nursing home owners filed cost reports alleging a high level of a care and staffing for the nursing home. The per diem for the nursing home was set based on the representations made in the cost report. In fact, the nursing home was providing a much lower level of care and staffing than represented in the cost reports, which resulted in negative outcomes for several residents.

- The Delaware MFCU was involved in a criminal and civil fraud and neglect investigation/prosecution involving a nursing home. After reviewing the evidence and conducting dozens of additional interviews, five former nurses from the facility were arrested for allegedly engaging in a "chart party" during which Medicaid residents' medical charts were altered in order to maximize reimbursement.

- The Florida MFCU received a referral from Adult Protective Services alleging abuse in a nursing home. The investigation revealed that the defendant, an LPN, was not giving insulin injections to six insulin-dependant patients. Further, the LPN was then falsifying the medication logs to indicate that such injections were being given. The defendant

admitted that the allegations were true and the defendant entered a plea of no contest to Neglect of the Elderly.

- A caregiver for an elderly woman in Hawaii failed to deliver the services for which she was being paid. As a result, the woman suffered serious gangrene and premature sores. The caregiver was sentenced to 60 months probation with 200 hours of community service and a $2,000 fine.

- The Illinois MFCU conducted an investigation at a nursing home as a result of complaints of drug and alcohol abuse. The Illinois Department of Public Health ordered that an independent monitor be put in place to run the day-to-day operations of the facility. Eventually, the home was forced to close after a complaint was filed by the Illinois Attorney General.

- After a week-long trial, a Baltimore City, Maryland jury found a licensed practical nurse guilty of felony neglect for his failure to provide care for an 89-year-old nursing home patient. In spite of instructions in the patient's chart that she was not to be fed on his shift, and although the nurse found that the patient had received three times as much fluid as was called for during the previous shift, he hung another bag of tube feeding and kept the feeding tube running throughout the night. Although he was aware that the resident was in severe distress, sweating, moaning, and groaning, with a distended abdomen during the night, he failed to provide her with necessary and essential medical treatment and failed to call 911. The nurse on the next shift took action but the resident could not be revived and was pronounced dead at the hospital from asphyxia due to overfeeding. The licensed practical nurse received a suspended sentence of five years, was place on supervised probation for three years, and ordered to refrain from providing patient care during the period of probation. The Board of Nursing also summarily suspended his license.

- The New Mexico MFCU is involved with the on-going criminal prosecution of a nursing home management corporation for harm caused to six residents, two of whom died from lack of adequate care.

- The New York MFCU used an investigative strategy never before used in a quality of care investigation in New York. The MFCU installed hidden cameras in patient rooms in two facilities in upstate New York to record care as it was delivered. One of the cases resulted in the arrest and conviction of numerous nurses and nurse aides.

  With the permission of the family of a bedridden and comatose resident, the MFCU installed a hidden camera in the room of a resident. The evidence produced by this camera proved that nursing home staff repeatedly failed to deliver required care and routinely lied in patient care records by falsely recording that care had been delivered. Significantly, the records of one resident contained hundreds of false entries made by nearly 20% of the facility's staff. MFCU investigators compared events recorded by the camera with the care records prepared by staff, which purported to memorialize the care

rendered to the patient. The records repeatedly falsely reported that the patient had been given treatments and care when, in fact, the care had not been given. Indeed, during the 39-day period, nurses and aides made more than 300 false entries in the patient's records. These fabrications involved almost every aspect of the patient's care, including false entries regarding turning and positioning, temperature and blood glucose readings, skin treatment, pneumonia-preventive nebulizer treatments, oral hygiene, incontinence care, and tube feeding.

Based on the evidence developed through the video recording, facility management admitted under oath that the treatment of this patient constituted neglect. Moreover, they conceded "that if [the neglect] was true of [this patient], then it had to be true elsewhere in the facility, and in fact that it had to be widespread."

- A Texas Grand Jury returned an indictment against a registered nurse (RN) for Injury to the Elderly and Tampering with a Governmental Record. An elderly resident of the nursing home was noted to have swelling and bruising in her leg due to poor circulation. The nurse made the decision to wait to have the resident seen by a physician. However, the leg became much worse, causing a staff member to have the resident transported by ambulance to a hospital emergency room where the attending physician stated the resident was brought in much too late to save the leg, which was amputated shortly thereafter.

- For the first time in Vermont, the MFCU charged a residential care homeowner for criminal neglect of residents. The Vermont Medicaid Fraud and Residential Abuse Unit convicted the registered nurse and residential homeowner who admitted to recklessly failing to provide care for the residents of the home.

  The investigation revealed that the owner was responsible for allowing conditions at the facility to deteriorate significantly, exposing the residents there to a reckless environment of filth, inattention and substandard care. Specific instances of neglect included the careless dispensing of inappropriate medications, failing to properly treat diabetic residents, which necessitated emergency care on several occasions, and the serving of meals lacking required nutritional value that was inconsistent with the care plans of numerous residents. Further, the facility was often found in an unsanitary condition, perpetuating a climate of depression and disregard.

  The consistent absence from the facility of the owner, the only facility nurse, left the management of daily operations in the hands of ill-equipped and poorly trained staff members. The owner failed to consistently communicate with staff members or be available to make crucial decisions relative to the care of residents. As a result, the facility failed to provide a level of care appropriate to the needs of the residents and their families, and in violation of the law.

The Vermont Nursing Board suspended the owner's RN license, and she can no longer work in any capacity with vulnerable adults. She was sentenced to 18 months prison time and placed on probation. She served 30 days of her sentence on a work crew run by the Department of Corrections.

Failure to Report

Reporting requirements play an important role in protecting residents from abuse and/or neglect. Most states that have statutes dealing with patient abuse include a mandatory reporting section. The statutes differ, however, as to who are considered mandated reporters. State statutes also differ regarding which agency the report goes to. Some states require the report to go to the Department of Health, while others require that state agencies report to a law enforcement agency or to the MFCU. It is important for MFCUs to investigate and prosecute failure to report abuse when their state laws make it a crime. It is necessary because many victims are unable to speak coherently, and some witnesses may fear repercussions from the abuser, their associates, or, at times, the facility itself.

Drug Diversion

One of the most common types of neglect occurs when the professional caregiver fails to follow a plan of care or fails to provide medication pursuant to a physician's orders.

- An Indiana licensed practical nurse was charged with Theft and Possession of Drugs as a result of having taken morphine sulfate from the nursing facility where she was employed. She pled guilty and was sentenced to one and one half years, which was suspended, and was placed on probation and six months of home incarceration.

- In Iowa, a director of nursing was charged with four counts of Possessing Controlled Substances and one count of Second Degree Theft for stealing medications from nursing home residents. She pled guilty and received a deferred sentence, credit for jail time served, was ordered to pay $3,471.31 in restitution, and was assessed fines and costs totaling $2,820. She was referred to the State Board of Nursing Examiners and was placed on the State Caregiver Abuse Registry.

- In the first case in Mississippi for Felonious Abuse Due to Failure to Give Pain Medication, a licensed practical nurse pled guilty to taking the prescribed pain medication of a resident for her own benefit. She was sentenced to serve three years in jail, all suspended, and three years probation. She was also ordered to pay a fine totaling $1,979.50 and restitution of $100 to the state Crime Victims Compensation Fund.

- In Oregon, a registered nurse was convicted on four counts of Theft of Prescription Medications from three different long-term care facilities where she had worked as a nurse. At the time of her arrest, she was suspected of stealing over 1,000 pills from patients at one facility over the last five months. She only sought employment as a long-

term care facility nurse in 2003, after she was fired and prosecuted for stealing drugs from an area hospital where she was then working.

- A South Carolina registered nurse was convicted of Obstruction of Justice and Unlawful Possession of a Controlled Substance. She took controlled substances from a patient at a nursing center. She made an anonymous report to the local police department that a co-worker had been stealing drugs from patients at the nursing home. When local police arrived to investigate, she planted the controlled substance she had stolen on a medicine cart used by the co-worker. She was interviewed and said that she had stolen the controlled substances and had provided false information to the police. She pled guilty to Obstruction of Justice and Possession of a Controlled Substance.

Criminal Background Checks

An important step in preventing abuse in nursing homes or long term care settings is to prevent those with a criminal background from working as caregivers for the elderly or disabled in a care-giving capacity. While a number of states require various types of employers or facilities to check an applicant's record prior to hiring, in too many instances the requirements differ depending on the type of facility; there is broad discretion to waive the requirement; or the requirement is not enforced. Many individuals employed as caregivers for vulnerable seniors have been convicted of a crime or even a series of crimes.

- The Michigan Health Care Fraud Division conducted two comprehensive criminal background studies of nursing home employees. The first study reviewed criminal histories for all certified nurse's aides (over 5,500) in five metropolitan areas of the state. The second study reviewed the criminal histories for the entire staff (618) employees of four geographically diverse nursing homes.

  The studies revealed that almost 10% of the employees who care for Michigan's vulnerable adults have criminal backgrounds. Some of the criminal backgrounds included homicide, criminal sexual conduct, weapon charges, and drug offenses. As a result, the Attorney General issued a formal report and submitted a legislative proposal to the Michigan Senate, which was enacted into law.

  A second phase of the project continues. This involves the systematic checking of criminal histories of nursing home staff at facilities statewide. Finally, "abuse alerts" advising of the problem and warning of select individuals who are using false identification to gain employment, have been sent to all nursing homes in Michigan.

- In Vermont, the Director of Social Services at a nursing home pled guilty to one count of False Pretense, two counts of Abuse of a Vulnerable Adult, and a violation of probation charge for financially exploiting two elderly residents at the facility. She was ordered to serve one year in jail of a suspended 7 to 10 year sentence. While employed as the Director of Social Work the defendant put her own name on the credit card account of a

seventy-nine-year-old resident of the nursing home and then used the card to transfer $500 to her own account. The employee also used the credit card for purchases and forged the nursing home resident's signature. The defendant also applied for and received another credit card in the name of an eighty-seven-year-old resident of the nursing home, without that resident's knowledge and permission, and then used the card to make purchases of $2458. She also applied for a $6000 personal loan in her name and that of an eighty-seven-year-old nursing home resident without that resident's permission or knowledge.

When she committed the new offenses, the employee was on probation for a 2002 Grand Larceny conviction. She had hidden her criminal convictions by intercepting the written confirmation of her convictions from the nursing home business mail before the administrator could receive it.

- A nursing assistant, who lied about her criminal conviction for purposes of her job application in a long-term care facility in Washington, pled guilty to one count of Forgery and was sentenced to 12 months probation, ordered to pay $500 to the Crime Victim's Compensation Fund, $200 in attorney fees, and $110 in court costs.

  The defendant applied for employment as a nursing assistant. The criminal background check revealed a conviction for theft in the first degree that the defendant claimed was a juvenile conviction. In fact, the defendant was 24-years-old at the time of her prior conviction making her ineligible for employment as a nursing assistant.

CONCLUSION

We live in a time of heightened concern for security. When our health becomes infirm, and we must depend on caregivers to assist us with or to supply the basic needs of daily existence, we have no security except what we can trust our caregivers to provide. Sometimes when we place that trust in a caregiver, what we find is a predator or abuser. The cases we have highlighted for you show that the resulting harm may be irreparable. The direct cost to victims may include death and maiming. As in any situation requiring security, the first line of defense is knowledge. A comprehensive, reliable system of criminal record background checks for employees and applicants for employment at care giving facilities would provide the information needed to help prevent many cases of abuse, neglect and exploitation. Long-term care workers should be carefully checked to make sure they don't have a history of substantiated abuse or serious criminal history before being hired and entrusted with the care of our defenseless elders.

ahca
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June 12, 2007

The Honorable Herb Kohl
Chairman,
United States Senate, Special Committee on Aging
Room G31 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Kohl,

I am writing on behalf of the American Health Care Association (AHCA) to express our support for S. 1577 – *The Patient Safety and Abuse Prevention Act of 2007.* This bill would build upon the success of the provisions enacted as part of the *Medicare Modernization Act* that created a three-year pilot program to examine ways in which states can implement systems to cost-effectively screen applicants for employment in long-term care facilities.

AHCA has long been a supporter of efforts to conduct criminal history background checks on potential nursing home employees. Nursing homes are caring for our nation's frailest and most vulnerable population – and they need a system that helps them prevent hiring those people with criminal record histories who may harm our residents without imposing undue administrative or financial burdens. We appreciate the requirement in your legislation that such background checks be reimbursed by the Medicare and/or Medicare programs.

AHCA's members are committed to providing the highest quality care for the more than 1.5 million Americans who receive care in a nursing home every day. AHCA looks forward to supporting your efforts to advance this issue and to enact this important piece of legislation.

Sincerely,

Bruce Yarwood
President & CEO

cc: Tom Moore, Wisconsin Health Care Association

ahca
American Health Care Association

Statement of
Bruce Yarwood
President & CEO
American Health Care Association

for the
U.S. Senate Special Committee on Aging

Hearing on
"Abuse of Our Elders: How We Can Stop It"

July 18, 2007

As representatives of nearly 11,000 non-profit and proprietary facilities that provide professional, compassionate long term care and services for frail, elderly, and disabled citizens living in nursing facilities, assisted living residences, subacute centers, and homes for persons with mental retardation and developmental disabilities, we at the American Health Care Association (AHCA) know that patient safety and security is paramount for long term care providers. That is why AHCA has championed a wide range of initiatives to enhance the quality of care in long term care facilities nationwide, and ensure that the nation's frail, elderly, and disabled are safe while in our care. While instances of abuse are rare, AHCA believes that abuse cannot, and should not be tolerated.

The long term care profession has made tremendous strides in improving both the quality of care and quality of life for the nearly three million Americans who require critical skilled nursing care and services every year. Mr. Chairman, I am proud to say that our commitment to quality long term care has never been greater.

The most effective ways to enhance the safety and security of all long term care residents are through family involvement in patient care, ongoing staff education, careful screening of potential employees, and responsible abuse prevention programs.

AHCA has long been a supporter of a national, interstate background check system that enables long term care providers to conduct effective and fair criminal history background checks on potential nursing home employees. Recently, AHCA endorsed the introduction of Chairman Kohl's *Patient Safety and Abuse Prevention Act of 2007,* stating that, "nursing homes are caring for our nation's frailest and most vulnerable population – and they need a system that helps them

prevent hiring those people with criminal record histories who may harm our residents without imposing undue administrative or financial burdens. We appreciate the requirement in your legislation that such background checks be reimbursed by the Medicare and/or Medicare programs."

Specifically, the *Patient Safety and Abuse Prevention Act of 2007* would build upon the success of the provisions enacted as part of the *Medicare Modernization Act (MMA),* which created a three-year pilot program to examine ways in which states can implement systems to cost-effectively screen applicants for employment in long term care facilities.

We concur with Chairman Kohl's recent statement that, "the vast majority of long term care workers are selfless and dedicated." Still, we recognize that there is a serious workforce shortage in our nation's entire healthcare system – and particularly in long term care. Not only do we need to check the full criminal background of every potential employee, but we need to ensure that all long term care providers have the ability to recruit the highest quality caregivers to provide critical care and services to America's seniors and people with disabilities.

As the Centers for Medicare & Medicaid Services (CMS) and others have repeatedly acknowledged, the continuing improvement of care quality in our nation's skilled nursing facilities depends upon adequate, stable funding levels. AHCA also understands the critical need for annual cost of living increases – not only to improving quality, but to ensuring that there is a stable, well-trained workforce and that our profession can recruit enough long term caregivers to meet the growing needs of our nation as 77 million "baby boomers" stand virtually on America's retirement doorstep.

Our nation faces a serious nurse shortage. Sadly, while nursing schools around the country are flooded with applicants, many qualified potential nurses are turned away because we do not have enough nurse educators nor funding for nursing education. We also must do more to promote careers in the field of long term care. Nursing homes and assisted living facilities, for example, are in dire need of additional caregiving staff – especially the Certified Nursing Assistants (CNAs) who perform as much as 80 percent of the direct, hands-on patient care.

These key workers are indispensable to our collective mission to provide quality care to our most vulnerable population of seniors and persons with disabilities. It is critical that we work together to increase interest in long term care as a career while simultaneously ensuring that we have the educational infrastructure in place to accommodate prospective nursing students.

The current long term care workforce shortage is projected to worsen over the next decade. In fact, the Bureau of Labor Statistics predicts a 45 percent increase in demand for new long term care workers between 2000 and 2010 alone – the equivalent of approximately 800,000 new jobs. Vacancies and turnover in the long term care profession lead to increased costs and threaten quality. A recent study estimates that costs due to staff turnover in nursing facilities is more than $4 billion a year, while other studies indicate that the supply of nursing staff is a key factor in the quality of care patients receive.

To help alleviate existing and future long term care nursing workforce shortages, AHCA encourages Congress to reauthorize and amend the *Nurse Reinvestment Act:* 1) to remove permanently the exclusion on loan repayment for nurses working in for-profit health care settings; 2) to create and fund a national nursing database of common data elements to forecast future supply and demand changes – the database should include workforce data across all provider settings, including nursing educators, for use in trend analysis and to better forecast workforce needs; and 3) ensure that *Title VIII* grant awards require that grantees report the number of nursing educators and nurses produced and/or hired, the increase in the number of nurse education slots, and the decrease in the number of qualified applicants turned away from nursing programs.

We look to you, Mr. Chairman, to address this critical issue in the coming months to ensure that an adequate, well-trained long term care workforce is in place to care for the increasingly frail, elderly, and disabled populations who rely on them.

It is important to note that the profession's progress has been achieved due to the fact that the entire long term care stakeholder community – providers, regulators, lawmakers, and consumers – has established a more productive "culture of cooperation," which is undoubtedly contributing to the rising care quality standards in America's nursing homes. It has been working as a private/public partnership and toward our goal of improving care quality that we have been able to move the needle on quality.

We have been able to achieve these positive advances due to our collective commitment to quality – and the government's recognition of how critical economic stability is for our sector has enabled us to continue these trends.

Improving care quality is a continuous, dynamic, ongoing enterprise. While AHCA and our entire membership is enormously proud and pleased by our care quality successes, we agree with each of you here today in recognizing that there is far more to accomplish. We look forward to working with you, Mr. Chairman, to ensure the safety and security of all individuals in long term care.

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Practice Concepts

Advancing the Field of Elder Mistreatment: A New Model for Integration of Social and Medical Services

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Purpose: The purpose of this work is to describe the development and operation of a new model for integration of medical and social services. The Vulnerable Adult Specialist Team (VAST) provides Adult Protective Services (APS) and criminal justice agencies with access to medical experts who examine medical and psychological injuries of victims of elder abuse. ***Design and Methods:*** This retrospective, descriptive analysis included community-dwelling elders and adults with disabilities who were reported for mistreatment and referred to VAST (n = 269). ***Results:*** Most cases came from APS for mental status and physical examination for evidence of abuse. Cases referred to a medical response team (n = 269) were significantly different from cases that were not referred (n = 9,505). ***Implications:*** Ninety-seven percent of those who referred cases to VAST indicated that the team was helpful in confirming abuse, documenting impaired capacity, reviewing medications and medical conditions, facilitating the conservatorship process, persuading the client or family to take action, and supporting the need for law enforcement involvement. As a result, VAST has become institutionalized in our county. Amenable to replication, medical response teams for elder abuse may be useful in other counties across the nation.

Key Words: Elder mistreatment, Medical, Financial abuse, Neglect, Self-neglect, Demonstration model, Forensic

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Across the nation, law enforcement agencies, district attorney (DA) offices, and Adult Protective Services (APS) report the need for medical input in cases of elder mistreatment (U.S. Department of Justice, 2000). Advanced age and accompanying medical conditions can resemble or mask the indicators of mistreatment (Panel to Review Risk and Prevalence of Elder Abuse and Neglect, 2003). For example, whereas bruises may be a manifestation of physical abuse, they also are a common and innocent physical finding on many older adults. Determining whether injuries or conditions (e.g., bruises, fractures, pressure sores, malnutrition) suggest mistreatment often requires medical expertise to determine whether the observed condition is consistent with the given history.

The physiologic complexity of older adults is compounded by their psychosocial complexity, and thus the complexity of elder mistreatment. As an autonomous person, it is acceptable for an older adult who is cognitively and emotionally intact to choose to live in an unsafe, unkempt environment or give away his or her life savings to a stranger. It may, however, be unacceptable for a demented or psychologically impaired older adult to experience the same circumstance. Determining mental status (both the cognitive and the psychological factors surrounding undue influence) enables an appropriate response in these situations. Given the severe consequences of elder mistreatment, appropriate response can mean the difference between life and death for society's most vulnerable adults (Lachs, Williams, O'Brien, Pillemer, & Charlson, 1996).

Despite guidelines published by the American Medical Association in 1992 (Aravanis et al., 1992), few clinicians receive training in the recognition of elder mistreatment, and fewer still in the medical forensic aspects of elder mistreatment (McCreadie, Bennett, Gilthorpe, Houghton, & Tinker, 2000; Mosqueda, Burnight, & Heath, 2001; Voelker, 2002). The increased

mortality rate for older adults who have been victims of elder mistreatment underscores the pressing need for an effective response from the medical community (Lachs et al., 1996). Elder mistreatment includes physical abuse, sexual abuse, psychological abuse, financial or material exploitation, neglect, self-neglect, and abandonment. The only national incidence study on elder mistreatment estimated that in a single year (1996), approximately 550,000 adults aged 60 and over experienced some form of mistreatment. They estimated that only one in five cases was reported to APS (Department of Health and Human Services [DHHS], 1998). The authors of this study suggest that this finding may represent only the "tip of the iceberg." The perpetrators of elder abuse are generally individuals on whom older adults depend for care or protection. In cases of self-neglect, mistreatment arises from the need for care coupled with no identified caregiver. More than 90% of perpetrators are family members (DHHS, 1998).

Created in June 2000, with a 3-year grant from the Archstone Foundation, the Vulnerable Adult Specialist Team (VAST) was developed to provide the county's APS, law enforcement, and DA's office with access to trained medical experts who are available to examine the medical and psychological injuries of alleged victims, assess capacity to consent to the situation of concern, document injuries for subsequent legal action, answer medical questions, and testify in legal proceedings. This medical response team was made available at no cost to the referring agency for the duration of the grant period. Orange County, the demonstration site for the project, has a total population of 2,846,289 (U.S. Bureau of the Census, 2000). The services of the VAST medical response team were made available to cases involving the mistreatment or neglect of adults aged 65 and older (9.9% of the county's population) and of adults with disabilities aged 18–64 (10.1% of the county's population). The protocol was approved by the University of California, Irvine, institutional review board.

Design and Methods

The first step in constructing the VAST model was to assemble a medical response team. The team consisted of two geriatricians, a psychologist, a gerontologist, a social worker, and a project coordinator. Each discipline brought specific expertise to the team. The geriatricians on the team were fellowship trained with extensive experience in a variety of health care settings. Given the prevalence of dementia and depression and other mental health issues in the participant population (Dyer, Pavlik, Murphy, & Hyman, 2000; DHHS, 1998), the role of a geropsychiatrist or geropsychologist was thought to be critical to our success. The social worker assisted in the development of intake procedures and helped the team understand the needs of the APS social worker. Our social worker's role was instrumental in the beginning but diminished as VAST established closer ties to the social workers of APS, and this position was phased out after the first year. The gerontologist's roles included establishing a tracking system and designing the study. The coordinator oversaw logistical aspects of the medical response team and served as a liaison between the referring parties and VAST.

The second step was to integrate VAST into the existing system. Given the complexity of mistreatment, input from community experts (social services, law enforcement, victims' services, the legal community) was critical. In April 1999, before VAST was implemented, we convened the first of a series of meetings that were attended by representatives from APS, law enforcement, DA and public guardian offices, and county mental health, ombudsman, and domestic violence agencies, along with a criminologist and an ethicist. These groups were asked what organizations would benefit from medical input in addressing elder and dependent adult abuse, how such groups could best access such input, which victims would most benefit from a medical evaluation, and what barriers exist to implementing such an approach. There was consensus that the three agencies in the elder abuse network that would most benefit from medical expertise were APS, law enforcement, and the DA's office. The participants encouraged the team to provide easy access to referring parties and to ensure an efficient response. They strongly recommended we perform house calls, given the transportation difficulties of the population and the important information that is ascertained only through a home visit. The agencies also highlighted the need for the team to assist in the evaluation and documentation of abuse cases involving adults with disabilities.

After creation of the team, the next step was to create a practical and replicable system for implementing it. Members of VAST met with the referring agencies to explain the services provided by a medical response team, and a dedicated phone line and e-mail address were established.

In the early stages, the team social worker took cases by phone or e-mail and presented them at the weekly VAST meeting at the university medical center. The team discussed each case and formulated recommendations for further action, such as evaluation for evidence of physical or financial abuse, capacity evaluation, medical record review, answering a medical question, and/or reviewing a photo, record, or videotape. The VAST coordinator took the recommendation back to the referring party. Once the action or actions were complete, reports of the findings and a conclusion as to the likelihood and type of abuse were generated by the VAST team and submitted to the referring party.

After several months, when it became clear that the majority of cases (89%) were from APS, the team moved the weekly meeting from the university to APS headquarters to enable the referring parties to present their cases directly to the team. This critical change allowed a direct dialogue between the medical team and the referring party. APS workers who were not involved in the case were invited to attend. The ensuing discussions were educational and served to inform subsequent cases. Physical and attitudinal barriers that had previously prevented helpful interactions between APS workers and the medical team were broken. Sitting together and discussing cases provided each group with

an expanded understanding of the issues. The meetings were also an administrative success, as appointments for evaluations could be arranged immediately. Given the direct connection of the team to APS social workers, the functions of the VAST social worker were no longer required. Intake and follow-up systems also were affected by the change. APS suggested that intake forms would be more useful if they were electronic, could be accessed from APS's shared drive, and e-mailed to the VAST. Together with APS, the medical team developed a standardized electronic form with drop-down menus and options with check boxes. Similarly, the follow-up system was implemented so that case outcomes and evaluations of the effectiveness of the VAST could be conducted through electronic forms and e-mailed to referring parties and then back to the VAST for entry in the database.

Results

In the first year of the project, VAST received 98 referrals, and in the second year, it received 171 referrals. The majority of the 269 referrals in the first 2 years were from APS (89%), with law enforcement referring 4% of the cases, the DA's office referring 3% of the cases, and 4% coming from other sources.

Table 1 summarizes the frequency and types of requests that were made to the medical response team. Requests for in-person evaluation accounted for 78% of the referrals to VAST. The most common request was for mental status evaluation (35%). A medical evaluation was requested in 22% of referrals, and the referring party requested both a mental status and a medical evaluation in 21% of the referrals.

Requests for medical information or referrals accounted for 10% of the cases, and 5% of the requests were for reviews of records or photos. In 6% of the cases, the referring party did not know what medical input was necessary but prefaced such requests with, "Help! I have this case... ." The VAST geriatricians often served as liaisons between APS and the medical community. These calls included contacting the primary care physicians for additional information, especially when the APS worker could not get through. This also included educating the primary physician about elder abuse, specifically about mandated reporting and warning signs and definitions of abuse and neglect.

Between April 2000 and April 2002, there were 9,505 reports made to the county's APS. Table 2 summarizes the demographic characteristics of cases referred to VAST ($n = 269$) as compared with all APS reports during the first 2 years of the project. Of the 9,505 reports made to APS, 63% of the cases involved female victims, and in 74% of the cases, the victim was an older adult. Seventy-six percent (76%) of the victims were White, 10% were Hispanic, 4% were Asian, and 1% were African American. The gender distribution was similar between the VAST cases and the overall APS case sample, but there was a significant difference in the proportion of cases involving dependent adults. Dependent adults accounted for 26% of the overall APS reports but only 17% of VAST referrals. Cases involving Hispanic victims accounted for 10% of the APS overall case reports but 4% of the VAST referrals.

Table 1. Requests for Medical Input

Request	Frequency	%
Mental status evaluation	94	35
Medical evaluation	60	22
Mental status and medical evaluation	56	21
Medical information or referral	27	10
Review records/photos	14	5
Vague or "help!"	17	6
Total	269	100

In the 9,505 reports, there were 12,308 allegations of abuse because many reports contained allegations of multiple types of abuse. In the cases referred to VAST, the most common type was self-neglect (35%), followed by emotional abuse (19%), neglect (17%), financial abuse (16%), physical abuse (10%), and sexual abuse (2%). There was a significantly greater proportion of financial abuse reported to the medical response team (29% vs. 16%) and a significantly smaller proportion of emotional abuse cases (6% vs. 19%). In all other abuse types, there were no significant differences in frequency.

Of the 269 cases referred to VAST, 7% of the cases referred were not appropriate for the services offered by VAST (Table 3), for example, a request for medical care that did not relate to abuse or neglect. In 54% of the cases referred, a home visit was conducted. In potentially violent situations or a situation in which the suspected perpetrator would not allow access to the victim, visits were made jointly with law enforcement support. For 51 referrals (19%), VAST clinicians answered medical questions and provided input during the case review, but the cases did not require an in-home medical assessment.

After a case was closed, the VAST coordinator sent the referring party a five-item follow-up survey: (a) Was VAST helpful? (b) If it was helpful, how was it helpful? (c) What was the disposition of the case? (d) How can VAST improve? (e) Do you have any additional comments? Of the first 269 cases referred to the VAST, 220 were appropriate for the follow-up survey. Forty-nine were not appropriate for the following reasons: Participant canceled the appointment, participant refused consent, or case was not an appropriate VAST referral. Of the 220 cases appropriate for follow-up, 156 follow-up forms were returned for a response rate of 71%. To the question "Was VAST helpful?" 152 respondents (97%) indicated "yes" and 4 (3%) indicated "no" (Table 4). The responses to the open-ended question querying how VAST was helpful grouped into 11 themes, with the 3 most common being confirmed abuse (33%), documented impaired capacity (33%), and reviewed medications and/or clarified a medical problem (22%). As respondents indicated multiple areas of assistance on a given case, the responses add up to >100%. Responses to the question regarding the disposition of the case grouped into eight categories, with many respondents indicating more than

Table 2. Demographics and Abuse Type

Demographic	All APS Reports (N = 9,505) Frequency	%	VAST Referrals (N = 269) Frequency	%	p Value from χ^2
Female	6,017	63	178	66	.65
Male	3,213	34	90	33	.93
Not identified	275	3	0	0	N/A
Older adult	7,024	74	215	80	.40
Dependent adult	2,481	26	47	17	.01*
Not identified	0	0	7	3	N/A
White	7,270	76	205	76	.96
Asian	345	4	6	2	.24
Hispanic	911	10	11	4	.005**
African American	138	1	5	2	.60
Other	87	1	4	1	.34
Unknown	754	8	38	14	N/A
Self-neglect	4,363	35	98	28	.06
Emotional	2,269	19	20	6	.0001***
Neglect	2,088	17	73	21	.08
Financial	1,999	16	101	29	.0001***
Physical	1,222	10	37	11	.65
Sexual	186	2	9	3	.11
Abandonment	147	1	4	1	.96
Abduction	34	.2	2	.5	.30
Total	12,308 allegations in 9,505 APS reports	Mean of 1.29/victim	344 allegations in 269 VAST referrals	Mean of 1.27/victim	

Notes: APS = adult protective services; VAST = vulnerable adult specialist team.
*$p < .05$, **$p < .01$, ***$p < .001$.

one outcome. The most common outcomes included care plan established (48%), conservatorship process initiated (29%), refusal of suggested services (15%), hospitalization of victim (12%), and victim remained safely at home (12%). Seven respondents offered recommendations for improving VAST by encouraging more interaction between VAST and the public guardian and mental health services, changing report formats, streamlining the follow-up form, and scheduling home visits more quickly.

Discussion

VAST was developed to provide APS, law enforcement, and the DA's office with access to trained medical experts. Preliminary results are encouraging: Ninety-seven percent of those who referred cases indicated that the team was helpful. Specifically, VAST was found to be helpful in confirming the absence or presence of abuse, documenting impaired capacity, clarifying a medical problem, facilitating the conservatorship process, persuading client or family to take action, and supporting the need for law enforcement involvement.

Table 3. Action Taken on Referrals

Action	No. of Participants	%
Total number of referrals	269	100
Home visit completed	144	54
Medical input in case review (w/o home visit)	51	19
Record/photo review	11	6
Talked to a client's physician	14	5
Inappropriate referral	26	7
Visit scheduled but appointment cancelled	16	6
Participant refused consent	7	3

The higher percentage of financial abuse cases referred to VAST may be due to that fact they are often more complex and extend beyond the scope of training for most APS or law enforcement personnel (Tueth, 2000). Assessment often comes down to the victim's vulnerability, and this usually translates into a determination of cognitive function and capacity. VAST receives fewer dependent adult referrals and fewer cases of emotional abuse than generally referred to APS. This may reflect the fact that VAST is focused on medical issues. This difference also may represent a relative comfort of the APS social workers in dealing with younger clients and with emotional issues or a perception that VAST may not be useful in these types of cases. The significant difference in the referral of Hispanic victims may be due to the absence of any VAST member who speaks Spanish; based on this finding, the team has incorporated a geriatrician who is fluent in Spanish.

Although the majority of referrals come from APS, medical consultations for cases referred by law enforcement and the DA are equally important. During the initial phase of this project, the dominance in

referrals from APS was appropriate because our initial outreach effort was focused on APS. Current and future efforts are planned to reach out to law enforcement and the DA. This collaboration also will assist the physicians and psychologist in improving their forensic skills and expertise.

The majority of requests were for mental status evaluation, especially for capacity determination. This determination is often key to the investigation of abuse (Coyne, Reichman, & Berbig, 1993). Unlike child abuse, elders and dependent adults are presumed competent until proved otherwise. They thus have the right of autonomy even if that choice leads to abuse or neglect. If, however, they lack capacity, the family and ultimately society have the right and the responsibility to step in and protect them (Older Americans Act, 1992). Reasons why people lack capacity extend beyond the presence or absence of dementia and may include common conditions in the elderly such as depression, grief, or delirium (DHHS, 1998). This evaluation also helps to establish the type, severity, and reversibility of the mental status impairment, especially in cases of delirium or "pseudodementias." These mental status evaluations are often the trigger for conservatorship applications or appropriate placement or support groups. Members of VAST may intervene with the family or primary care physician in order to help the situation. Many of the referrals from law enforcement or the DA are for a review of records or photos or for medical information. In these cases, the victim may already be deceased. These forensic cases pose additional clinical challenges such as differentiating innocent causes of trauma from those inflicted, knowing how to document and collect evidence in suspected cases of mistreatment, and serving as an expert witness in court (Kane & Goodwin, 1991; Langlois & Gresham, 1991; Marshall, Benton, & Brazier, 2000).

Ethical issues also arose during this project. Concerns were raised about obtaining consent from people who were suspected of being cognitively impaired or otherwise vulnerable to undue influence. This issue was discussed with our advisory board, which included a geroethicist, and with our institutional review board human subjects committee. In questionable situations and where possible, consent was obtained both from the participant and from the legal representative. Our visits were made with the APS social workers who witnessed the consenting process and who helped ensure the absence of coercion. We were surprised at the few numbers of potential participants who refused consent (3%). Refusals included family members and caregivers who served as the legal representatives who were actually the suspected perpetrators of the abuse or neglect.

Conclusion

This project showed that a medical response team may be successfully integrated into the existing elder mistreatment system of a large county. Physicians and psychologists with expertise in geriatrics needed to be educated about elder mistreatment and willing to learn "on the job." A relationship with APS was cultivated before a working partnership was formed. All parties were able to listen, argue, maintain openness to new ideas, and deal with the uncertainty that accompanies a new project.

Our geriatricians dedicate a combined 30% of their time to VAST, as does our psychologist. Therefore, the cost of such a model is the reimbursement for the part-time medical experts. Their time is primarily devoted to team meetings, consultations, and report preparation. In our case, VAST is coordinated by a master's-level gerontologist, but an APS employee assigned to the task could also facilitate the project. This county's APS agency has institutionalized the VAST model by funding it through tobacco settlement funds. Amenable to replication, medical response teams for elder abuse may be useful in other counties across the nation.

Table 4. Follow-Up Survey of Referring Parties (n = 156)

Survey	%
Was VAST helpful?	
Yes	97
No	3
If it was helpful, how was it helpful?	
Confirmed a form of abuse, neglect, or self neglect	33
Documented impaired capacity	33
Reviewed medications and/or clarified a medical problem	22
Facilitated conservatorship process	21
MD persuaded client/family to take action that APS/others recommended	17
Assisted with referral for medical care	14
Reviewed file or video	13
Contacted client's physician	9
Supported the need for law enforcement involvement	8
Confirmed absence of abuse	6
Helped get victim hospitalized	5
Disposition of case	
APS plan established	48
Case referred for conservatorship	29
Victim refused services	15
Victim hospitalized/psych admission	12
Victim safely at home	12
Case referred to law enforcement and/or DA	11
Victim died	6
Victim placed (SNF, B & C, AL)	5

Notes: VAST = vulnerable adult specialist team; APS = adult protective services; DA = district attorney; SNF = skilled nursing facility; B & C = board and care; AL = assisted living.

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CHAPTER 32

Elder Mistreatment and Neglect

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OBJECTIVES

Upon completion of this chapter, the reader will be able to:

- Discuss the risk factors associated with elder mistreatment and neglect.
- Describe the different types of abuse and neglect.
- Understand components of the history and physical exam that should raise suspicion of possible abuse.
- Discuss barriers to the identification of abuse.
- Describe initial assessment and management strategies.

PRETEST

1. The national incidence of elder abuse is:
   a. Approximately 100,000
   b. Likely to decline over the next 20 years
   c. Higher in the "old old," that is, people over the age of 80
2. Some of the likely risk factors for being a victim of elder abuse include:
   a. Being cognitively intact
   b. Exhibiting combative behavior
   c. Being of low socioeconomic status
   d. Living with a family member
3. Some of the risk factors for being a perpetrator of elder abuse include:
   a. Depression
   b. Alcohol abuse
   c. Being a family member
   d. Being dependent on the older adult

Ms. Johnson

Ms. Johnson is an 86-year-old woman who comes to your office for a routine visit. She has been living in her own home by herself ever since her husband died 12 years ago. Despite the fact that she has Parkinson's disease, diabetes, and hypertension, she has remained independent. Over the past year, she has had some decline in her function, and is requiring meals-on-wheels and other services to remain at home. Her daughter Betsy recently moved from another state to live with her mother and provide assistance.

The physical exam reveals a pleasant woman who has a moderate amount of tremor at rest and who can ambulate slowly with the aid of a walker. You notice that Ms. Johnson seems withdrawn on this visit, and she tells you that it's been difficult to adjust to having a new person in the house even though she knows she needs help to stay there. The next visit is an urgent appointment because Ms. Johnson fell, and has multiple large bruises on her upper arms and forehead. Betsy brings her to see you, and tells you that "I just found Mom on the floor this morning." Ms. Johnson nods in agreement but says little else. No treatment is needed and she goes home.

Three weeks later another urgent appointment is made: Ms. Johnson has a dislocated shoulder and bruises on her upper chest wall. Again, her daughter says she fell. Despite Betsy's protests, you ask her to leave the exam room so that you may speak privately with Ms. Johnson. When you ask Ms. Johnson what happened, she breaks down in tears and reports that her daughter has been taking her money for years. Betsy moved in because she had no other place to live but promised that she would care for her mother in exchange for room and board. Once she was living there, Betsy asked her mother to sign over bank accounts. Initially, Betsy "just yelled at me and threatened to put me in a nursing home. But over the past month, Betsy became more aggressive and pushed me down several times. Last night she grabbed me and punched me because I would not sign the house over to her. I'm so ashamed.... I never thought my own daughter would do this to me."

STUDY QUESTIONS

1. Did you notice anything at the first visit that may lead you to worry about the possibility of abuse?
2. Do you think Ms. Johnson would have told you what happened if you did not ask her directly?

CASE DISCUSSION

The sad reality is that this is not an uncommon scenario. This primary care provider did the right thing: she was observant, noting that the patient was withdrawn and that the bruises were in unusual locations for a fall; she had the daughter leave the room so that Ms. Johnson could tell her story; she was reassuring but direct in asking Ms. Johnson what happened. This case also illustrates the common finding that victims of abuse are often subject to multiple types of mistreatment over a prolonged period of time. In this case, Ms. Johnson experienced financial, psychological, and physical abuse for many years.

Abuse and neglect of older adults is a common yet underreported problem that will be getting worse. While the number of older adults is increasing, the number of available caregivers is decreasing. This demographic trend of more vulnerable adults and fewer people to care for them combined with a national trend of decreasing social services is a harbinger of a new epidemic.

Translating the definition of abuse (Box 32–1) to a diagnosis of abuse is not easy nor is it straightforward: It is often difficult to distinguish between injuries that occur through innocent mechanisms (e.g., falling) and injuries that occur as a result of abuse (e.g., being punched). While some acts of commission or omission are blatantly abusive, there is no simple method to tell when some acts, such as poor care, cross the line to become "abuse." But these are not good excuses to avoid making a diagnosis. Primary care physicians are in a unique position to prevent, recognize, and respond to abuse. They are often the first to identify both victim and perpetrator and so must be mindful of the possibility and know how to respond. Interestingly, though, health care professionals, particularly physicians, are among the least likely to report suspicion of abuse to Adult Protective Services.[1]

INCIDENCE AND IMPACT

The 1996 National Elder Abuse Incidence Study estimated that 551,011 persons age 60 and over experienced mistreatment over a 1-year period.[1] Utilizing sentinels in the community, this study estimated that for every reported, substantiated case, at least four go unreported.[1] Furthermore, those aged 80 years and older were two to three times more likely to suffer elder mistreatment than their younger counterparts.[1] The types of elder mistreatment are shown in Fig. 32–1. Contrary to many people's preconceived notions, family members, particularly adult children and spouses, are the most common perpetrators of abusive acts (Fig. 32–2).[1]

In 2000, a 50-state survey found that 472,813 reports of elder mistreatment were received by Adult Protective Services. Of those reports received, more than 80% were investigated and almost 50% were substantiated, confirming that adults over 80 years of age were the most likely victims of abuse, excluding self-neglect.[2]

In 1996, it was estimated that between 1 and 2 million Americans aged 65 and older had been mistreated by an individual expected to provide care or protection.[1] With the aging of the Baby Boomers, the number of older adults is expected to almost double in size to comprise 20% of the U.S. population by 2030.[4] The pool of potential victims is growing at a rapid rate.

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RISK FACTORS AND PATHOPHYSIOLOGY

Mr. Greenwood

Mr. Greenwood has been your patient for many years. You diagnosed him with Alzheimer's disease 3 years ago, and lately he has been quite agitated. He requires assistance with some ADLs, but gets upset when his daughter Camille tries to help. He also follows her around the house and asks her the same questions repeatedly.

Camille brings him in for his appointments, and it is clear that she is unhappy and resentful. You ask how she is doing with her dad; she tells you "my father was never around when I was growing up. Now that he needs help he has come back into my life and is ruining it! I can't spend the time I want to with my own kids, and my husband is getting annoyed because the house isn't as organized as I used to have it." You smell alcohol on her breath when she was telling this to you. Although

you have seen no evidence of abuse, you recognize that the potential exists.

STUDY QUESTIONS

1. What interventions might you implement to help calm this situation?
2. What issues might you discuss with Camille during this office visit?

CASE DISCUSSION

The primary care provider is in an excellent position to prevent abuse if one recognizes the warning signs. The family cycle of violence, substance abuse on the part of the caregiver, anger and resentment of the daughter toward her father, and his increasing dependency on her are all warning signs. Interventions such as counseling, support groups, and day care programs may stop this from progressing to a violent situation.

Camille and her father have never had a good relationship, he is resistant to care, she is feeling overwhelmed and angry, she may be abusing alcohol, and her family is pressuring her to spend more time with them. Because you have recognized these as red flags (Box 32–2) for possible abuse, you intervene to prevent this situation from escalating into abuse. You ask Camille if she has ever hurt her father, and she tells you that she hasn't but that she is worried she might hit him when she gets upset and out of control. After empathizing with her situation and thanking her for her honesty, you explain how you will help her: You give Camille information about adult day care programs close to her home, support groups through the Alzheimer's Association, books on Alzheimer's disease, an appointment with a counselor, and information on assisted living facilities that specialize in caring for people who have dementia. You have them follow up with you in 1 week. As a result of your efforts, Mr. Greenwood starts attending the day care program 3 days a week, Camille understands more about the illness her father has, and she gets appropriate emotional support. When you see them again several months later, both Mr. Greenwood and his daughter are calmer and happier.

Elder mistreatment may be discovered during daily clinical practice, yet many health care providers do not recognize the potential or actual victims. Risk factor assessment is an important part of one's ability to identify potential victims and initiate treatment. Risk factors are found in the victim, perpetrator, and sociocultural environment in which they are embedded (see Box 32–2).

Patients with Alzheimer's disease living in a shared residence are at significantly increased risk of mistreatment.[5,6] By increasing the likelihood of interaction, a shared living situation can escalate from experiencing day-to-day annoyances to daily conflict and ultimately to mistreatment. While living alone places an older adult at less risk of being abused by others,[7] social isolation is dangerous because abuse may go unnoticed.

Simply having a dementing illness places a person at increased risk for mistreatment, particularly if the person with dementia displays disruptive behavior.[3] The estimated prevalence rate of abusive caregivers ranges from 5% to 14% in the dementia population, as compared to 1% to 3% in the general population.

Mental health problems such as depression are often present in perpetrators of abuse. Of note, in a study examining the care of Alzheimer's disease patients, caregiver depression was a strong predictor of physical abuse.[6,9] Physical abusers are more likely to be classified as depressed when compared to those who abuse through neglect.[10] Alcohol and/or drug abuse among the perpetrators of elder mistreatment is also common.[11]

Furthermore, several studies have demonstrated that perpetrators are more likely to be dependent on the victim they are mistreating. Financial exploitation was estimated to affect 20% of victims of elder mistreatment as reported by the National Aging Resource Center on Elder Abuse in 2003.[12]

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PEARL: Simply having a dementing illness places a person at increased risk for mistreatment, particularly if the person with dementia displays disruptive behavior.

DIFFERENTIAL DIAGNOSIS AND ASSESSMENT

Barriers to Diagnosis

Several barriers to diagnosis exist. Often the primary care provider is uncertain as to what constitutes abuse. In these times of short outpatient visits, detecting, questioning, and confronting abuse issues can be daunting. However, the primary care provider may be the only person with adequate contact to suspect and protect when abuse is present.

As most abuse occurs in the victim's home, it is easily hidden from health care providers and other witnesses. The victims are often feel ashamed and embarrassed

that they actually allowed it to happen, or that their "loved one" did this to them, or they may be fearful that they will be deemed incompetent and put in a nursing home. Some would rather be abused than be taken out of their home. Many abused older adults are depressed and find it difficult to confront their abuser or voice their concerns to health care workers. Many patients may aggressively hide their abuse, unlike patients seeking early detection for other medical disorders.

Dementia may interfere with an elderly person's ability to report abuse or to even understand that she or he is being abused. People with dementia are often dependent on their abuser for daily living, and may be socially isolated from third-party observers who may detect abuse.

While bruises and fractures can be clues to incidents of abuse, they can also be common findings in frail older adults as a result of falls and injury to delicate tissues. For this reason, it is important to understand the context in which these injuries occurred. In children, retinal hemorrhages and long bone fractures make up a constellation of findings that would trigger a provider to have an immediate suspicion of abuse. Unfortunately, such pathognomonic findings do not exist for abuse of the older adult. Awareness, suspicion, and a comprehensive assessment are required to detect elder mistreatment.

Assessment

Abuse can span many years or present as a one-time, isolated incident. It is difficult to identify when events cross the line from inappropriate care to mistreatment because there is no clearly defined line. If a provider is unsure, it is prudent to make a report. Cases of abuse and neglect may be found during a routine visit at a primary care provider's office of a regular visit to a long-term care facility.

A thorough evaluation is indicated for patients who are thought to be victims of abuse. The patient should be examined alone, away from family members, or the suspected abuser as the victim may be embarrassed or may fear retaliation.[13] Direct questioning by the primary care provider in a nonthreatening manner should be conducted. Home environment and safety issues should be evaluated. Information regarding inciting factors, and frequency and type of abuse should be elicited. Factors suggestive of abuse include a delay in seeking treatment, confusing or unlikely causes of injury, or a past history of suspicious incidents.[14] A history of "doctor shopping" and caregiver avoidance of appointments should also raise suspicions of abuse.[15]

A complete physical examination should be performed on all patients suspected of abuse (Box 32–3). A full skin assessment should be undertaken. Areas hidden from plain sight should be examined, including soles of feet, inner thighs, axillae, and palms, with all areas of bruising, burns, tenderness, or abrasions documented. Weight loss, hygiene, and a history of fractures should be noted. Sexual abuse cannot be overlooked, and a gynecological evaluation may be necessary. Assessment of patients suspected of any type of abuse warrants not only a physical but also a cognitive evaluation. Cognitive impairment as well as visual or auditory deficits can make an already challenging evaluation that much more difficult.

Care providers should be asked about their level of stress and their ability to function in their role of caregiver. Financial difficulties, anger, and resentment toward the patient should also be assessed. Caregiver burnout should be suspected when primary caregivers begin to complain about the patient, and blame the patient for situations that are out of their control.[16]

Confirmatory laboratory testing can be done to corroborate unusual findings. A complete blood count, blood urea nitrogen, creatinine, total protein, and albumin levels can help establish whether dehydration or malnutrition is present. Radiographs depicting old and new fractures can help suggest patterns of long-term abuse.

Contextual factors are often as important as the injury itself. For example, if a person presents with a stage IV pressure ulcer of his coccyx, the health care provider may know that this person is on hospice, and that all appropriate steps are being taken to prevent skin breakdown. However, if a patient who had been walking and talking 2 months ago suddenly appears in your office with the same wound, this is an unexpected finding that deserves careful questioning.

PEARL: Factors suggestive of abuse include a delay in seeking treatment, confusing or unlikely causes of injury, or a past history of suspicious incidents.

MANAGEMENT

The first step in management when elder mistreatment is suspected is an open conversation with the patient. If the patient understands his situation, he can take an active role in deciding about next steps. However, a patient who is depressed or demented may be incapable of meaningful participation in the planning process. Multidisciplinary teams consisting of social workers, physicians, and legal counsel are available in many communities when difficult management issues arise. How are they accessed?

Most health care workers are mandated reporters of elder mistreatment and neglect in the 47 states that have a mandated reporting law. The definitions,

requirements, and mandated reporters vary from state to state, so it is important for providers to be familiar with the laws in their state. Adult Protective Services (APS) is the agency responsible for taking and investigating reports of abuse in community-dwelling older adults. In some states, they also investigate abuse in licensed facilities, and in others this is done by the state ombudsman. Police should be contacted in addition to APS in emergent situations. It is not a HIPPA violation to share medical information with police or APS when abuse is suspected.[17]

Careful documentation of physical findings such as bruises or abrasions is important. Photographs should be taken of unusual skin findings with a reference object in the visual field for an estimation of size. All lesions should have accurate documentation of their dimensions and locations. It is useful to describe the location of lesions in reference to two distinct fixed body parts; for example, a lesion on the upper back should have measurements to the lateral aspect of the shoulder and base of the neck. Diagrams are also helpful in charting locations of skin lesions. All facets of the history and physical exam can be used as evidence if a case goes to trial. For this reason, records should be legible and complete. Objective information should be recorded, including statements made by both the victim and perpetrator in addition to physical exam findings.

SCREENING

Most primary care providers and emergency room personnel do not screen routinely for elder abuse. However, in 1992 the American Medical Association encouraged physicians to "incorporate routine questions related to elder abuse and neglect into daily practice."[18] Current screening tools are limited, as several of them require accurate responses from victims, who may be cognitively or emotionally impaired, as well as from their caregivers. Fast and accurate tools need to be developed, but meanwhile, the provider can ask: "Are you afraid of anyone? Has anyone threatened you or harmed you?"

Prevention strategies can be employed during routine medical visits. At each visit, both the caregiver and patient should be questioned regarding stress in the living environment and observed for signs of feeling overwhelmed or discouraged. Respite services should be readily offered. Senior centers, adult day health care services, and other community programs may offer the caregiver and patient much needed time away from each other.

SUMMARY

Elder mistreatment is a national tragedy that has a serious impact on the health and happiness of elders and those who love them. Victims suffer from more illness and premature death. When all other risk factors are taken into account, elder abuse by itself imposes a threefold increase in the risk of death of community-dwelling older adults.[19] These patients have more psychiatric and physical disorders manifested by increased numbers of hospitalizations and emergency department visits.

Elder mistreatment and neglect are serious and complex issues that a primary care provider must face in clinical practice. A reasonable suspicion, identification of risk factors, and a multidisciplinary team approach will help victims and abusers obtain the treatment they need.

POSTTEST

1. Some of the barriers to detecting elder mistreatment include:
   a. The tendency for many older adults to falsely claim they are being abused.
   b. The fear that one might be institutionalized if one admits to being abused.
   c. The shame that older adults feel if they have been a victim of abuse.
   d. The inability of a health care provider to make a determination regarding abuse if the victim is demented.
2. Physical manifestations of elder abuse often overlap with common age-related changes. Some physical findings that should lead a clinician to consider abuse rather than a common age-related change are:
   a. Bruises on the breasts
   b. Skin tears on the dorsal forearms
   c. Midtibial fracture in an older adult who has no history of falling
   d. Stage II pressure ulcer in a hospice patient who has stopped eating
3. Clues that may lead one to suspect abuse include:
   a. "Doctor shopping" by a caregiver
   b. Delay in seeking care for a stage IV pressure ulcer
   c. Malnutrition in a hospice patient
   d. A caregiver who attends Alzheimer's disease support groups

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Web Resources

1. National Center on Elder Abuse: www.elderabusecenter.org.
2. National Committee for the Prevention of Elder Abuse: www.preventelderabuse.org.
3. Continuing Medical Education, Elder Abuse and Neglect: http://www.ageworks.com/elderabuse.

PRETEST ANSWERS

1. c
2. b, d
3. a, b, c, d

PostTEST ANSWERS

1. b, c, d
2. a, c
3. a, b

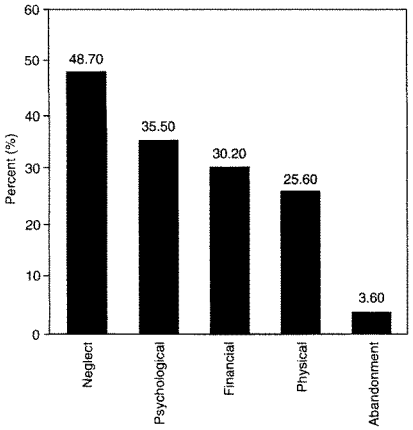

FIGURE 32-1

Types of elder mistreatment. Note: Total percent is greater than 100 because people are often victims of more than one type of abuse. *(Adapted from National Center on Elder Abuse. National Elder Abuse Incidence Study: final report. Washington, DC: Department of Health and Human Services Administration for Children and Families and Administration on Aging, September 1998.)*

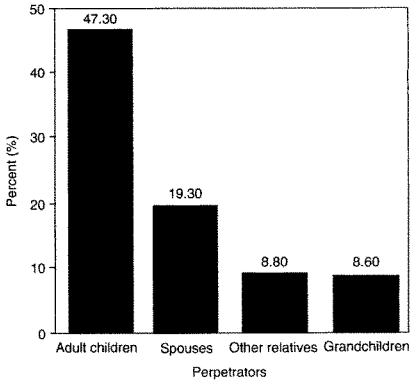

FIGURE 32-2

Breakdown of suspected perpetrators. Note: Only 16% of perpetrators are nonfamily members. *(Adapted from National Center on Elder Abuse. National Elder Abuse Incidence Study: final report. Washington, DC: Department of Health and Human Services Administration for Children and Families and Administration on Aging, September 1998.)*

Box 32-1 Elder Mistreatment: Definition

- Intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder.
- Failure by a caregiver to satisfy the elder's basic needs to protect the elder from harm.

From Bonnie R, Wallace R. Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America. Washington, DC: National Academy Press, 2003.

Box 32-2 Risk Factors for Elder Mistreatment

Victim

- Advanced age
- Dependent for basic activities of daily living
- Dementia
- Combative behavior

Perpetrator

- Depression/mental illness
- Alcohol or drug dependence
- Financial dependence

Box 32-3 Possible Abuse Indicators

- Weight loss
- Dehydration
- Poor hygiene/elongated toenails
- Depression
- Inappropriate attire (e.g., not dressed warmly in cold weather)
- Abrasions/lacerations
- Hematomas
- Traumatic alopecia
- Bruises in unusual locations (e.g., breasts/genital area)
- Welts
- Burns
- Pressure ulcers
- Rectal/vaginal bleeding
- Signs of sexually transmitted diseases

The Life Cycle of Bruises in Older Adults

Laura Mosqueda, MD, Kerry Burnight, PhD, and Solomon Liao, MD

OBJECTIVES: To summarize the occurrence, progression, and resolution of accidentally acquired bruises in a sample of adults aged 65 and older. The systematic documentation of accidentally occurring bruises in older adults could provide a foundation for comparison when considering suspicious bruising in older adults.

DESIGN: Between April 2002 and August 2003, a convenience sample of 101 seniors was examined daily at home (up to 6 weeks) to document the occurrence, progression, and resolution of accidental bruises that occurred during the observation period.

SETTING: Three community-based settings and two skilled nursing facilities in Orange County, California.

PARTICIPANTS: One hundred one adults aged 65 and older (mean age = 83).

MEASUREMENTS: Age, sex, ethnicity, functional status, handedness, medical conditions, medications, cognitive status, depression, history of falls, bruise size, bruise location, initial bruise color, color change over time.

RESULTS: Nearly 90% of the bruises were on the extremities. There were no bruises on the neck, ears, genitalia, buttocks, or soles of the feet. Subjects were more likely to know the cause of the bruise if the bruise was on the trunk. Contrary to the common perception that yellow coloration indicates an older bruise, 16 bruises were predominately yellow within the first 24 hours after onset. People on medications known to affect coagulation pathways and those with compromised function were more likely to have multiple bruises.

CONCLUSION: Accidental bruises occur in a predictable location pattern in older adults. One cannot reliably predict the age of a bruise by its color. **J Am Geriatr Soc 2005.**

Key words: bruising; location; duration; color change; causation

A combination of normal age-related changes, common age-related changes, and medications conspire to increase the likelihood of accidental bruising in older adults. Normal age-related changes include a thinning epidermis, increasing capillary fragility, and decreasing subcutaneous fat.[1] Common age-related changes include medical conditions such as diabetes mellitus and leukemia and functional conditions such as falls and gait instability. Many pharmaceutical agents, prescription and nonprescription, may prolong bleeding time. Older adults are more likely to have medical conditions such as atrial fibrillation and osteoarthritis that lead to the use of these medications.

When a child is seen with suspicious bruising, child protective agencies routinely request that pediatricians document the injury, estimate the age of the injury, and support or refute claims of child abuse.[2] With the increased awareness of the estimated 1 million to 2 million cases of elder abuse, people such as Adult Protective Services workers, law enforcement officers, and prosecutors are similarly looking to geriatricians and others in the medical community for input in elder mistreatment cases involving clients with extensive bruising.[3]

This poses a special challenge to geriatricians, given the high prevalence of accidental bruises in older adults. Although there is a body of research on the site, pattern, and dating of bruising in children, similar research in the geriatric population does not exist. The first step in building this literature is the documentation of common bruising patterns in the geriatric population. The systematic documentation of accidental bruising in older adults could provide a foundation for comparison when considering suspicious bruising, as may occur in situations of abuse. To that end, the goal of this study was to summarize the occurrence, progression, and resolution of accidental bruises in a sample of adults aged 65 and older.

Given the paucity of research on bruises in the geriatric population, it is helpful to review what is known about bruising in children. A study of accidental bruising in children and adolescents (n = 1,467) found that most children had one or more bruises (76.6%), with less than 2% of the bruises occurring on the buttocks, pelvis, abdomen, or thorax and less than 1% of the bruises occurring on the chin, ears, or neck.[4] Another study compared children who had been bruised as a result of abuse (n = 133) with children who had been accidentally bruised (n = 189). Children who were abused had more bruising, especially on the head, neck, and trunk than those who had not been abused.[5]

Because of the biochemical changes in the bilirubin molecule as it is broken into its constituent parts, bruises

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0002-8614/05/$15.00

tend to change color in a predictable sequence from purple/black to green to yellow, with red appearing anywhere throughout the duration of the bruise. The only study to compare bruising color changes between young and old (≥65) found that bruises in older subjects developed yellow color at a slower rate, although the time difference was not specified.[6] Textbooks on forensic medicine have included charts on dating a bruise by color,[7–9] but the American Academy of Pediatrics' Continuing Medical Education course on bruising and skin trauma (2000) states "that bruising charts for determining the age of bruises are unreliable. The scientific basis for these charts is tenuous and does not allow for accurate dating of bruises."[1,10] Moreover, physician estimates of the age of bruises have been shown to be inaccurate when the bruises are presented as photographic evidence,[11] as well when bruises are observed directly in a physical examination.[1]

Based upon what is known about bruising in children and what is known to differ between children and older adults, five research questions guided this study.

1. Do accidental bruises occur in predictable locations in older adults?
2. Do color changes in bruises occur in a predictable pattern in older adults, and is it possible to date a bruise by its color?
3. How do medications and medical conditions that interfere with normal blood clotting affect bruising in older adults?
4. Do older adults with compromised mobility or functional ability have more bruises?
5. When a bruise occurs in an unusual location, is the older adult more likely to know how it occurred?

METHODS

Study Population

Between April 2002 and August 2003, 101 subjects were recruited from three community-based independent living settings (n = 77) and two skilled nursing facilities (n = 24) in Orange County, California. Inclusion criteria required that subjects be aged 65 and older, able to provide informed consent or assent to surrogate consent in accordance with California law, and reside in the community or a skilled nursing facility (SNF) research site. If a bruise had been suspected to be the result of abuse, the subject would have been excluded from the study and the case reported to Adult Protective Services or ombudsman. A research team trained in elder abuse detection made this determination through home visits. The assessments included subjects and their caregivers or family members living with them. In the recruitment and study periods, there was no suspicion of elder mistreatment.

Similar to the population of the surrounding community and SNF settings, the study population was 66% female, had an average age of 78, and was all Caucasian. Seventy-seven percent of study participants ambulated independently at home, and 55% of the sample was independent with all activities of daily living (ADLs). Twenty-one percent were competent in all instrumental activities of daily living (IADLs), whereas 27% were unable to perform IADLs, even with help.

All of the subjects were queried on their medical conditions and use of prescription and over-the-counter medications. All of the subjects, except one, were on prescribed medications with a mean of 6.7. Eighty-six percent of the sample was taking over-the-counter medications with a mean of 3.6.

Eighty-nine percent of subjects scored 10 or under on the 30-item Geriatric Depression Scale indicating not depressed. On the Folstein Mini-Mental State Examination, 88.3% of the sample scored 24 or greater. A subject was considered cognitively impaired if he or she had a legally authorized representative as a result of documented incapacitation; or was deemed to be impaired by the geriatrician on the research team who evaluated capacity of all potential subjects who showed any confusion or disorientation to time, place, or person. Seventeen subjects assented to surrogates in the informed consent process.

Data Collection

Once a subject was enrolled in the study, one of two trained research assistants went to his/her home each day at approximately the same time of day (±2 h) and examined the subject from head to toe for any bruises. The subject undressed fully so that the entire body was examined. If a bruise was present at the first visit, this bruise was documented and that bruise was not included in the study. If a new bruise appeared during the 14-day inspection period, it was known to have occurred during the prior 24 hours and was then documented every day until resolution or until 6 weeks had passed. Subjects and/or caregivers were asked if they knew what caused the bruise.

Because subjects were examined every day for as much as 6 weeks, it was necessary to have two interviewers collecting data. Because of the subjective nature of color perception, the color assessments of both interviewers were compared daily to address interrater reliability. Color charts (including paint chip samples); a clear, pliable, circular measurement tool; review of notes and photographs; and periodic in-person inspection of bruises by both researchers at the same time were used to assure agreement among raters throughout data collection.

MEASURES

The location, size, and colors of each bruise were measured every day until resolution. Each bruise was inspected, documented, and digitally photographed. Functional status was measured using the Katz ADL[12] and Lawton IADL[13] scales. Mobility was measured using the Tinetti Gait and Balance[14] and Ambulation Scale. Subjects or their proxies were asked to report how many falls they had had in the previous week, month, 6 months, and year. The names, dosage, and frequency of usage were recorded for each prescribed and over-the-counter pharmaceutical.

ANALYSIS

Quantitative data were analyzed using SPSS version 11.0 (SPSS Inc., Chicago, IL). The distribution of all variables was examined through inspection of frequencies. *T* tests were used to test differences in means, chi-square tests were used to determine relationships between categorical variables, and correlations were used to summarize relationships between continuous variables.

RESULTS

Location and Size of Bruises

One hundred one participants were screened; 73 had at least one bruise occur in the 2-week initial inspection period. Of the 73 participants with bruises, 49 had one bruise, 17 had two bruises, three had three bruises, three had four bruises, and one had five bruises, for a total of 108 bruises. Of the 108 bruises, 89% were on the extremities, and of those, 76% were on the dorsal arms. Those who needed assistance with ADLs were more likely to have multiple bruises, but there was not a significant difference in the location, size, or color of the bruises. No bruises were observed on the neck, ears, genitalia, buttocks, or soles of the feet. Figure 1 depicts the location, size, and primary initial color of the 108 bruises.

The area of the bruises varied from 0.12 cm^2 to 50.0 cm^2 (mean ± standard deviation = 3.42 ± 6.72) with widths ranging from 0.3 cm to 10.0 cm. There was not a statistically significant difference between the occurrence of bruises on one side of the body and the other or a correlation between handedness and location.

Ability to recall the cause of a bruise varied by location of the bruise. When the bruise was on the trunk (n = 12), 42% of subjects knew how the bruise occurred. In contrast, when the bruise was on the extremity (n = 96), 17% of subjects knew how the bruise occurred ($P = .04$). Of those who knew the mechanism of the bruise, most reported bumping into something, and two reported falling.

There was not a significant correlation between depression and bruising.

Timing and Sequence of Color Change

The period that the bruises were visible varied from 4 to 41 days (mean = 11.73 ± 7.13). Half of the bruises (54%) resolved by Day 6, and most (81%) resolved by Day 11. As depicted in Figure 2, in the first 48 hours, most bruises were observed as red (90%) and/or purple (80%), with fewer displaying black (25%), yellow (20%), green (10%), and blue (8%).

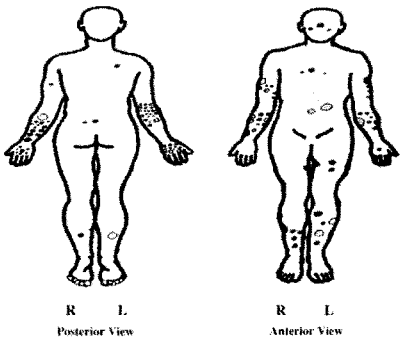

Figure 1. Combined summary of 108 bruises observed on 73 subjects at Day 1.

Table 1. Bruise Area by Location Cross-Tabulation

Size of Bruise in Greatest Dimension cm	Bruise Locations by Trunk and Extremities: Trunk n (%)	Extremities n (%)	Total
Small (0.1–1.0)	5 (41.7)	31 (32.3)	36 (33.3)
Medium (1.1–4.9)	6 (50.0)	46 (47.9)	52 (48.1)
Large (5.0–50)	1 (8.3)	19 (19.8)	20 (18.5)
Total	12 (100.0)	96 (100.0)	108 (100.0)

Consistent with the pediatric literature, red was observed throughout the duration of the bruise. On Days 1 through 6, 90% of the bruises contained red, and more than 20% of bruises contained red for 2 weeks, with some bruises containing red all the way up to 6 weeks. Purple was prevalent in the first 3 days of the bruises' life cycle (> 80% contained purple color), declined rapidly over the next 11 days, and was uncommon (< 5%) thereafter.

Yellow increased over time for the first 6 days, with nearly 60% of bruises showing yellow at Day 6. Sixteen percent of the bruises included yellow on Day 1. After Day 6, yellow was present in 30% of the cases and was the most common color present in bruises that were more than 3 weeks old.

Relationship to Medications and Medical Conditions

All of the subjects except one were taking at least one prescribed medication, with a mean of 6.7 medications. Eighty-six percent of the sample was taking over-the-counter medications, with a mean of 3.6 over-the-counter medications.

With advice from a pharmacist who specializes in geriatric pharmacology, medications were divided into three categories: no effect (53%), minimal effect (7%), and at least moderate effect (40%) on bleeding time/bruising. Of those on medications expected to have at least a minimal effect on bleeding time/bruising, 46% had multiple bruises. Of those not on such medications, 26% had multiple bruises ($P = .08$). There was no significant correlation between medications known to interfere with coagulation pathways and the duration of bruises or color change.

Residential to Function

There was a statistically significant difference in the number of bruises between those who required assistance with one or more ADLs and those who required no assistance. Fifty percent of those who required ADL assistance had two or more bruises, as opposed to 25% of those not requiring ADL assistance ($P = .04$). There was no relationship between ADLs and the location of the bruises or days until resolution.

Residential Setting

Of those residing in a SNF, 79% developed a new bruise during the 2-week observation period, which was similar to the rate of 71% of those living in the community. Eighteen

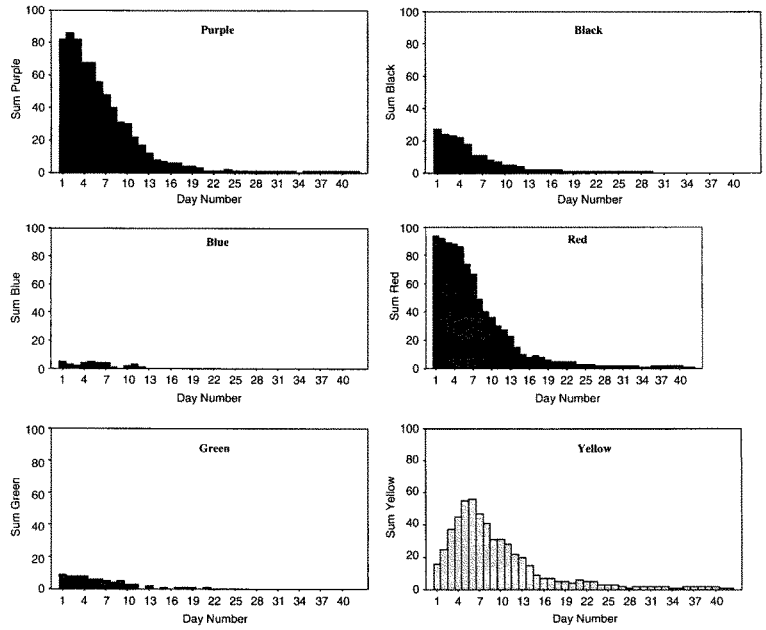

Figure 2. Progression of color by day.

percent of SNF subjects with bruising had bruising on the trunk, compared with 9% of those in the community, although the difference was not statistically significant. There was no correlation between residential setting and location of the bruise on the trunk as opposed to the extremities or to days to resolution.

Mobility

No significant difference was observed in the number, location, or duration of bruises between those who ambulated independently and those who used assistive devices at home or in the community.

Three subjects had fallen in the preceding week, seven in the previous month, 10 in the previous 6 months, and 23 in the previous year. Two of the bruises in this study were reported to have been the result of a fall.

On the Tinetti Gait Assessment, a score of 12 indicates a steady gait.[15] Scores ranged from 1 to 12, with a mean of 9.25 ± 2.19. On the Tinetti balance assessment, a score of 16 indicates steady balance, and 0 indicates significant problems with balance. Scores ranged from 3 to 16, with a mean of 11.82 ± 3.27. No significant correlation was observed between gait or balance and number or location of bruises.

DISCUSSION

In a first step toward building knowledge on the medical forensic aspects of bruising, this study sought to document the occurrence and progression of accidental bruising in the geriatric population. The results of this study suggest that accidental bruises occur in a predictable pattern in older adults. Nearly 90% of the bruises were on the extremities, and in daily observation of 101 older adults, not a single accidental bruise was observed on the neck, ears, genitalia, buttocks, or soles of the feet. Most large bruises that occur accidentally are on the extremities. Of the 20 large bruises (5–50 cm) in this study, only one was on the trunk. Moreover, older adults are significantly more likely to know how the bruise happened if the bruise is on the trunk.

Although a discernible pattern is observed in the location of the bruises, the initial color and color change over time are less predictable. Contrary to the perception that yellow indicates an old bruise, 16 bruises were predominately yellow on the first day of observation, and 30 bruises were largely purple on the 10th day of observation. Consistent with the pediatric literature, red was observed throughout the life of the bruise.

Medications that interfere with normal blood clotting have an effect on bruising in older adults. Subjects taking

medications known to have at least a minimal effect on coagulation were more likely to have multiple bruises, although the bruises were not larger and did not take longer to resolve. It is not surprising that older adults with compromised functional ability were more likely to have multiple bruises because they are more likely to bump themselves and more likely to be touched/handled by others.

Research is needed on accidental bruising in older adults from various racial and ethnic backgrounds. In addition to increasing understanding of bruising in seniors with various skin tones, data from an ethnicity study could be coupled with existing data to increase the sample size and potentially provide more definitive results on such variables as medications, medical conditions, and functional ability.

A limitation of this study is that it was not possible to be 100% sure that all bruises were accidental. Subjects were asked about abuse, and the research assistants were trained to look for suspicious circumstances such as poor interpersonal dynamics between subjects and caregivers, evidence of physical restraint use, evidence of fear on the part of subjects, or evidence of attempts to isolate the subjects. No such suspicious circumstances were identified.

Another limitation of the study was that the study population was not randomly selected. Because participation in the study required a great commitment on the part of the research subjects (willingness to be seen every day, without clothing, for up to 42 consecutive days), logistical/funding constraints necessitated that participants live close to one another. It was helpful that the independent and skilled nursing communities had a culture supportive of research participation as a way to contribute to society.

It is critical to learn more about bruising in older adults. It is a common phenomenon and may therefore be accepted as normal, unavoidable, usual, and expected. Although this is the case in many circumstances, there is also the reality that millions of American seniors are injured, exploited, and mistreated by people on whom they depend for care and protection. The next step in building this literature is to conduct research on bruising known to have been inflicted as a result of physical elder abuse. Understanding the etiology and life cycle of accidental and inflicted bruises in older adults can help identify older adults who have been abused and, equally important, protect caregivers from being unfairly accused of abuse.

ACKNOWLEDGMENTS

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Author Contributions: All authors were involved in the study concept and design, acquisition of subjects, analysis and interpretation of data, and preparation of the manuscript.

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