

**ELDER JUSTICE: PROTECTING SENIORS FROM
ABUSE AND NEGLECT**

HEARING

BEFORE THE

**COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED SEVENTH CONGRESS**

SECOND SESSION

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JUNE 18, 2002
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ELDER JUSTICE: PROTECTING SENIORS FROM ABUSE AND NEGLECT

TUESDAY, JUNE 18, 2002

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:20 a.m., in room 215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Also present: Senators Breaux, Kohl, Gordon Smith, and Stabenow.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

Over the years, the Finance Committee has held many hearings to examine programs that serve and protect our senior citizens, including Social Security, Medicare, Medicaid, and programs funded by the Social Services Block Grant.

In this hearing, we will explore a problem that cuts across all these programs: elder abuse and neglect. Elder abuse and neglect is a tragic problem that, like child abuse and domestic violence, requires a coordinated response from health care, from long-term care, from Social Security, and law enforcement programs.

As a subject matter, this program does not fit neatly into a single Finance Committee box. Elder abuse and neglect occurs in nursing homes, in private homes, and in every other residential setting. It is committed by family members, by professional caregivers, by those who are overwhelmed but well-meaning, and by those who have malicious intent.

When it is identified—and experts tell us that the vast majority of cases are never reported—it may be detected by loved ones, by doctors, by social workers, or by the police.

My colleague Senator Breaux and others have coined a term for efforts to fight elder abuse and neglect. They call it elder justice. It is a compelling term. Promoting elder justice means improving our ability to prevent, identify, and intervene in situations involving elder mistreatment. It is a critically important task as our society ages.

As we will hear today, our efforts on elder justice are in their infancy. We do not know how often elder mistreatment occurs. We do not know very well how to spot it. Doctors who treat the elderly are not trained to tell the difference between a bruise caused by a fall and a bruise caused by a beating.

Our efforts at intervention can be misguided. Health care professionals often do not know who to call when they suspect elder abuse. They may fear bringing punishment onto a well-meaning, but poorly trained caregiver, or causing a community nursing home to be shut down.

Police may view elder abuse in the home as a social service program that does not require a strong law enforcement response.

These are just a few examples of the gaps in our response to elder mistreatment. We will hear many more today.

These gaps may be especially troubling in rural States like Montana, where seniors tend to be poorer, sicker, and more physically isolated from the systems that may help protect them.

I want to thank all of our witnesses for coming today from all over the country to share their expertise. Bob Blancato is president of the National Committee for Prevention of Elder Abuse, and he is up first.

We will also hear from Professor Catherine Hawes from Texas A&M, an expert on abuse and neglect in long-term health settings.

Dr. Carmel Dyer is a geriatrician from Baylor University. She will talk about how our health care system could better address elder mistreatment issues.

Joanne Otto, a former Adult Protective Services administrator, will talk about the role of APS.

Randy Thomas, a law enforcement educator, will tell us about the law enforcement perspective.

And, finally, professor Richard Bonnie will tell us about a newly-published study from the National Research Council which outlines how skimpy our knowledge is on this important subject.

Senator Breaux has announced a proposal on elder justice to address many of the problems we will hear about today. I applaud his leadership and advocacy on this issue. I also thank him for taking on the responsibility of chairing this hearing.

Elder abuse and neglect cause great suffering among our senior citizens. They strike fear into the heart of all of us who understand the vulnerability that may come with advancing age.

I look forward to the continued work of the Finance Committee and all others, the Aging Committee and all of us who are and will be interested in this subject, that is, to promote elder justice and protect our senior citizens.

Senator Breaux?

**OPENING STATEMENT OF HON. JOHN BREAU, A U.S.
SENATOR FROM LOUISIANA**

Senator BREAU. Thank you very much, Mr. Chairman. Thank you for that very thoughtful statement and for your encouragement and support as we attempt to move forward with elder justice legislation.

I appreciate very much your willingness to have this hearing, you and Senator Grassley, for allowing this hearing to occur. It is one more step in the advancement of legislation which I think is very important.

The baby boomers are aging and medical advances are allowing people to live longer, and live better lives. But we have really yet, as a Nation, to grapple with the bleakest aspect of our aging soci-

ety, and that is elder abuse and neglect, and exploitation of the elderly in this country.

Although we do not now know how often it occurs, the estimates range from somewhere between 500,000 to as many as 5 million cases every year. Most cases are not detected. Even fewer cases are even reported, and only a small handful of cases are ever investigated, or certainly prosecuted, by law enforcement.

What we do know, is that elder abuse and neglect has devastating consequences for the victims, resulting in the loss of autonomy, and suffering, and even premature death.

Despite over two decades of Congressional hearings, little progress has been made in addressing this very difficult issue. Astoundingly, our awareness of and response to elder abuse and neglect is about where we were on child abuse and neglect some 40 years ago.

A study just released by the National Academy of Science, which we will hear from and hear about for the first time today, confirms this. One thing is clear, we have devalued the lives of those who are old and frail. This is both un-American, and certainly unacceptable. The time for action is long overdue.

Over the past years, our Aging Committee has held a series of hearings focusing on various aspects of elder abuse, neglect, and exploitation, and how it devastates its victims.

On May 20, I announced a proposal for a comprehensive Elder Justice Act to provide for the leadership, the coordination, the study, and resources to protect those who need it the most.

I was encouraged that more than 20 very highly diverse groups and organizations stood up with me during that announcement in support of the elder justice legislation.

This hearing, called by Chairman Baucus, is critical. It is a critical next step in that process. I am extremely pleased that the Finance Committee, in particular, is addressing this issue.

As recognized by Chairman Baucus, there are dramatic gaps that prevent us from identifying, addressing, and preventing elder abuse and neglect, gaps in health care, gaps in social services, gaps in law enforcement, and gaps in research.

Each gap represents a serious systemic weakness that, if left unremedied, will continue to have real and harrowing consequences for millions of people. Examining these failures from several different perspectives, as we do today, will help us to understand why elder abuse and neglect have so long remained invisible.

The cost of elder abuse and neglect is very high. It is paid for in unnecessary human suffering, higher health care costs, and depleted public resources. If we can unlock the mysteries of science to live longer, surely we must be able to do a better job of preventing and addressing the indignities of elder abuse and neglect.

Hearings such as this one, and prompt passage of comprehensive elder justice legislation, is a very, very good start.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator.

We are also very honored to have with us a very distinguished member of the Aging Committee from Wisconsin, Senator Kohl. We would like to hear from you, Senator.

**STATEMENT OF HON. HERB KOHL, A U.S. SENATOR FROM
WISCONSIN**

Senator KOHL. Thank you, Senator Baucus, for holding this hearing today and for inviting members of the Senate Aging Committee to participate.

As often said at other hearings, there is no excuse for abuse or neglect of the elderly, especially by those who are supposed to care for them.

Our parents and our grandparents made this country what it is today, so when they need long-term care they deserve to live with dignity and the highest quality care.

Unfortunately, we know this is not always the case. We know the majority of caregivers are dedicated and do their very best, often under very difficult circumstances. But too often the elderly are abused, starved, shamed, and exploited, and the systems that are in place today are simply not enough to protect them.

I have introduced legislation that would be a good first step to prevent elder abuse by long-term care workers. I am pleased that this bill is co-sponsored by five members of the Finance Committee, as well as by Senator Reid.

Our bill would create a national registry of abusive long-term care workers which will prevent abusers from moving from State to State and facility to facility, thereby continuing to find work with vulnerable patients.

Second, this bill would require an FBI criminal background check to prevent people with violent criminal convictions from working with vulnerable patients.

Both of these components are critical to having an effective background check system. The FBI check is needed to make sure that people who have been convicted of serious crimes such as murder, rape, and assault are prevented from working in long-term care.

But only doing an FBI background check is not enough. As we will hear today, very few elder abuse cases end with criminal convictions. Instead, they are investigated by the State and any substantiated abuse is listed on that State's nurse/aide registry, making them ineligible to work in nursing homes in that particular State.

But there is no national system to prevent these abusers from getting a job in another State. We need a comprehensive national registry of abusive workers to make sure that these people cannot find a job in long-term care in any other State.

Both the national registry and the FBI check are a critical part of a background check system and both must be included if we are going to tell families that their loved ones are safe.

Our bill is supported by the National Citizens Coalition for Nursing Home Reform, SEIU, as well as the American Health Care Association and the American Association of Homes and Services for the Aging, which represent nursing homes all across the country. They recognize that background checks will greatly benefit their industry.

During the past 5 years, the Aging Committee has heard from the HHS Inspector General's Office and GAO, local prosecutors, State inspectors and auditors, patient advocates, and the nursing

home industry, and they all recommend establishing a national background check system.

I want to thank Senator Breaux for co-sponsoring this bill and for working with me to include it in his comprehensive elder justice proposal. I believe that this initiative will go a long way toward protecting our Nation's elderly citizens, and I look forward to working with Senator Breaux to get it passed.

I also want to acknowledge for the record and thank Senator Baucus for his willingness to work with me and my staff in the hope of passing the Patient Abuse Prevention Act this year. I know that by working together, we can act to help protect our elderly citizens from abuse.

Thank you very much, Mr. Chairman.

Senator BREAUX. Thank you very much, Senator, for your help and support, particularly on your leadership role in the select Committee on Aging, and for your contributions.

The Chairman has introduced a panel of members. We will get started with the testimony.

Mr. Blancato, welcome back. Glad to see you again.

Mr. BLANCATO. Thank you, Senator Breaux.

Senator BREAUX. We will be glad to hear your testimony. Excuse me. If you would just withhold for a second, Senator Smith is here.

Do you have any comments, now that you are here and caught your breath, and everything?

STATEMENT OF HON. GORDON SMITH, A U.S. SENATOR FROM OREGON

Senator SMITH. Thank you, Mr. Chairman, for inviting us on the Aging Committee to come to this very important hearing.

I will ask that my opening statement be put in the record so as not to delay the testimony.

Senator BREAUX. Without objection, so ordered. Thank you.

[The prepared statement of Senator Smith appears in the appendix.]

Senator SMITH. I appreciate all of our witnesses. This is a very important hearing. We are looking for comprehensive ways to prevent what is a serious problem in our aging society. Thank you, Mr. Chairman.

Senator BREAUX. Thank you, Senator.

Mr. Blancato?

STATEMENT OF ROBERT BLANCATO, PRESIDENT, NATIONAL COMMITTEE FOR THE PREVENTION OF ELDER ABUSE, EXECUTIVE DIRECTOR OF 1995 WHITE HOUSE CONFERENCE ON AGING, WASHINGTON, DC

Mr. BLANCATO. My name is Bob Blancato, president of the National Committee for the Prevention of Elder Abuse, the largest membership organization focused on elder abuse prevention.

NCPEA is also a partner in the National Center on Elder Abuse, which last December convened the first national summit on elder abuse. I appreciate the opportunity to testify.

This hearing is clearly warranted. The problem of elder abuse and neglect is worsening. It is not new, but it has new urgency, compelling new approaches.

This hearing has another benefit. It will present the issue of elder abuse to millions of people, some of whom may know very little about it.

We know of more than 470,000 reports of elder and adult abuse in the year 2000, a 60 percent increase since 1996. Another 18,000 complaints of elder abuse and neglect were reported in nursing and board-and-care, and other long-term care facilities.

As you know, Mr. Chairman, the Senate Aging Committee suggests the number of elder abuse cases could be as high as five million.

Federal involvement in elder abuse prevention spans almost 25 years, yet the Federal response to combatting elder abuse and neglect has been piecemeal and inadequate.

An example. A part of Title VII of the Older Americans Act is the only program specifically providing funds for elder abuse prevention. Its current appropriation: less than \$5 million. The total commitment is \$153 million, or 0.8 percent of all Federal funds spent on abuse prevention programs.

We need a new approach. Federal elder justice policy must be more proactive, coordinated, comprehensive, and goal-driven, perhaps even built around the seven goals of our summit, filling service gaps, educating the public, training professionals, enhancing adult protective services, increasing prosecution, maximizing resources, and eliminating policy barriers.

We are working with Senator Breaux on his proposed Elder Justice Act. His approach moves us from merely a Federal response to elder abuse to a comprehensive policy on elder justice.

Elder abuse is a public health, law enforcement, and social service crisis. Let us elevate elder justice as a priority within Federal Government so that there is leadership with responsibility, accountability, funding, and visibility.

Senator Breaux would do this through dual Offices of Elder Justice in HHS and Justice, and a dedicated funding stream for adult protective services.

We must have better data collection and dissemination. Under-reporting of abuse caused by bureaucratic obstacles is unacceptable. The 15,000 reported cases of institutional abuse came from only one source, the annual report of the state Long Term Care Ombudsmen Programs. Sadly, we know there are more cases.

We must identify and use current research on elder abuse. There is no need to reinvent the wheel. Much is being done on intervention, community strategies, and other multidisciplinary efforts. Let us see what we have and commit resources to filling research gaps, and let us do regular national incident studies.

Elder abuse and neglect must become a priority crime control issue. The justice system, at all levels, must work as a coordinated system to protect victims, hold offenders accountable, and prevent future offenses.

There must be a greater emphasis on training, including a national elder abuse education and training curriculum for all in the field.

Needless to say, elder abusers must never work in long-term care facilities. We must do all in our power to keep these facilities

abuse-free. Let us also continue to help consumers with good information on long-term care facilities.

Elder abuse is defined as any form of mistreatment that results in harm or loss to an older person, including physical, sexual, domestic, psychological, or financial abuse, as well as neglect.

Elder justice consists of efforts to prevent, detect, treat, intervene in, and where appropriate, prosecute elder abuse, neglect, and exploitation. Elder justice is also the right of older Americans to be free from abuse, neglect and exploitation.

Any new policy on elder justice has implications for key programs under this committee's jurisdiction, including Social Security, Medicare and Medicaid, the Social Services Block Grant, and even some possible future tax bills.

As experts who follow me will note, a new elder justice policy can help address key service gaps that exist today, especially in mental health services and caregiver training.

Elder abuse was an emerging issue in the 1970's. It has arrived today, and with the elderly population doubling by 2030, it is a real future issue.

But the stories tell the story. Last week, an Elderly Nutrition Project director from Orange County, California told me of a story of one of her participants, a man in his 70's.

He came that day and handed her an envelope with \$500 in cash. He said it was the start of his get-away money. It seems he was living with his son, who had gotten power of attorney over him and was denying him access to his assets. But he had managed to keep some cash aside.

Once he reached a certain amount, he was going to get away, but he only felt safe leaving the money with the Nutrition Program director.

Security was the foundation for our key senior programs, economic security and Social Security, and health care security, and Medicare. Today, we need to provide security to our most vulnerable of seniors, those victims of abuse, neglect, and exploitation.

Elder justice is more than a term. It should be a policy goal and a societal aspiration. The opportunity is before us to act on legislation this year. We all look forward to working with you. Thank you.

Senator BREAUX. Thank you very much, Mr. Blancato, for your excellent statement.

[The prepared statement of Mr. Blancato appears in the appendix.]

Senator BREAUX. Dr. Hawes?

STATEMENT OF CATHERINE HAWES, PH.D., PROFESSOR, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, SCHOOL OF RURAL PUBLIC HEALTH, TEXAS A&M UNIVERSITY SYSTEM HEALTH SCIENCE CENTER, COLLEGE STATION, TX

Dr. HAWES. Good morning, Senator Breaux, Senator Smith. Thank you for the opportunity to be here. I am grateful to the Finance Committee and the Special Committee on Aging for the leadership they are bringing to this topic.

My name is Catherine Hawes. I am a professor of health policy at Texas A&M University, and I have spent the last year inter-

viewing families, residents, certified nursing assistants, and others in long-term care about this issue.

In my testimony today I will be focusing on abuse and neglect in long-term care settings such as nursing homes, assisted living facilities, and residential care homes.

I am going to make, basically, five arguments. First, the 1.6 million nursing home residents and the 1 million residents in board-and-care homes are at particular risk for abuse and neglect. Most suffer from several chronic diseases and are dependent for their care on others.

Further, two-thirds of nursing home residents and an estimated 40 percent of board-and-care home residents have significant cognitive impairment. We know from research that these characteristics, particularly a diagnosis of Alzheimer's or other dementias, and challenging behaviors have been found to place residents at greater risk for both physical and sexual abuse.

In addition, most of these residents have outlived their family members, only 12 to 13 percent are married, and many others lack a relative who lives nearby. Thus, these individuals are extremely vulnerable, largely unable to protect themselves, and dependent for their care on the kindness of strangers.

My second point, is that there is no reliable data on the prevalence of abuse and neglect, but the available evidence suggests the problem is widespread and serious.

For example, a survey of 80 nursing home residents in 23 Georgia nursing homes found that 44 percent reported they had been physically abused, and 48 percent that they had been treated roughly. For example, one resident said, "They throw me around like a sack of feed and it leaves marks all over my body."

Similar numbers reported that they had seen other residents abused and treated roughly. For example, one resident said, "I saw the nurse hit and yell at the lady across the hall. She asked for something and the nurse said, "Shut up," and hit her."

Facility staff reported similar events. One-third of the CNAs in four different surveys of thousands of CNAs reported that they had witnessed at least one incident of physical abuse during the preceding 12 months.

The kinds of incidents they observed included excessive use of physical restraints, punishing, pushing, kicking, shoving, slapping, grabbing, pinching residents in anger, and denying food as punishment.

A total of 81 percent of the CNAs interviewed reported that they had observed over staff verbally or psychologically abusing residents, such as cursing, yelling, or threatening residents, and half of them said they had done these things themselves.

Finally, there are thousands of complaints, as Bob pointed out, from the ombudsman program, from the nurse/aide registries, from the Office of Inspector General, from deficiency statements that suggest as many as a third of nursing facilities have one or more incidents or allegations of abuse and neglect.

While abuse is horrible, the daily misery, indignity, and premature death caused by neglect in nursing homes is truly a national tragedy. This neglect may, in fact, be more widespread than abuse.

For example, 95 percent of those Georgia nursing home residents said that they had experienced or seen other residents being neglected, and 37 percent of the CNAs said that they had seen neglect of residents' care needs.

Ombudsmen reports, deficiency citations, and research reveal examples, such as failure to give residents enough help with eating so that they become malnourished, failure to keep residents hydrated, lack of attention, dramatic, unplanned weight loss, failure to manage pain and prevent contractures, and the list goes on.

One of the major predictors of unplanned weight loss in our Nation's elderly in nursing homes is that they need assistance with eating. That is criminal.

In residential care facilities, there are no national databases, there are no Federal regulation, there is no comparable nurse/aide registry where you get reporting of abuse and neglect. But, fortunately, we have some staff reports in the General Accounting Office.

In a 10-State study of board-and-care homes, 15 percent of more than 1,000 staff in 500 facilities reported witnessing other staff engage in verbal abuse and other forms of punishment, such as withholding food, excessive use of physical restraints, and isolating difficult residents.

Ombudsmen say that physical abuse is one of the five most significant complaints they get about residential care facilities. The GAO has revealed that medication errors, unqualified staff passing medications and giving injections, and high rates of psychotropic drug use are endemic.

Mr. Chairman, my written testimony contains information on a number of things, which I am not going to have a chance to say. But I would like to say that if I were asked to do one thing, it would be to increase staffing.

All of the stakeholders in long-term care, from survey agency directors, to families, to CNAs, to ombudsmen, say that the major cause of abuse and neglect in residential care facilities and nursing homes is short staffing, stress, burn-out, and inadequate training how to deal with Alzheimer's disease.

The Nation owes something to the elders who weathered the Great Depression, who rebuilt our economy, who fought fascism and won World War II, and who rebuilt our economy. They deserve more than being treated like sacks of feed to be thrown callously about.

I urge this committee not to fail this generation or future generations. We know what to do, and I hope that we will add increasing staffing levels to the Elder Justice bill.

Thank you.

Senator BREAUX. Thank you very much, Dr. Hawes.

[The prepared statement of Dr. Hawes appears in the appendix.]

The CHAIRMAN. Ms. Otto, your statement?

**STATEMENT OF JOANNE OTTO, M.S.W., EXECUTIVE DIRECTOR,
NATIONAL ASSOCIATION OF ADULT PROTECTIVE SERVICES
ADMINISTRATORS, BOULDER, CO**

Ms. OTTO. Mr. Chairman and members of the committee, thank you very much for inviting me here today. It really is an honor.

My name is Joanne Otto. I am the executive director of the National Association of Adult Protective Services Administrators.

Our volunteer organization represents adult protective services professionals in every State, the District of Columbia, and Guam.

We are the first responders to more than 500,000 reports of abuse, exploitation, and neglect of elderly and vulnerable adults every year. That is 500,000 reports.

Adult Protective Services staff take these reports, make face-to-face contacts with the victims in order to evaluate the types and severity of abuse, the physical and mental status of the victims, as well as the possibility of further abuse.

These workers also collaborate with a multitude of other professionals, including law enforcement, prosecutors, animal control officers, physicians, nurses, the list goes on and on.

The purpose of these collaborative efforts is to put in place the most appropriate and comprehensive assortment of services to assure the victims' safety and well-being.

Recently in a community very near where I live in Colorado, a 50-year-old man was jailed for the deaths of his mother, 81, and his father, 85. He told investigators that he killed his parents because he wanted the family ranch and they would not give it to him. He shot them while they were calling 911.

Abuse includes the elderly man who was beaten and set on fire by his son and a 96-year-old blind woman who was raped by her paid caregiver. Exploitation includes the 80-year-old woman who was given a 25-year home loan, the payments of which took 30 percent of her income.

Neglect includes the woman living in a trash-filled home—and I am talking about trash up to the ceiling—with 47 cats, the 89-year-old woman found wandering the streets in the winter, the 72-year-old resident of a board-and-care home who weighed 60 pounds and had over 30 decubitus ulcers on her body.

Because there have been no Federal laws relating to the delivery of adult protective services, each State has passed separate legislation with different definitions, eligibility requirements, and administrative structures.

Most States provide protective services to impaired adults age 18 and over. However, some States define elderly as 60 and over, and some 65 and older.

Adult protective services may be administered by Aging Services, Social Services, or private contractors. In most communities, if you try to look up “elder abuse” or “adult protective services” in the phone book, you will not find it listed.

Funding for adult protective services also varies from State to State. It is usually made up of the Social Services Block Grant, 16 percent; the Older Americans Act, 1 percent; State general funds, 61 percent; local funds, 3 percent; and other funds, such as Medicaid, 19 percent.

Since 1993, the percentage of the Social Services Block Grant has been reduced 12 percent and local funds have dropped 15 percent, while State funding has increased by 11 percent and other funding such as Medicaid has increased by 16 percent.

The recent downturn in the economy has resulted in staff freezes and in reductions, cut-backs on travel and training, as well as the

adoption of waiting lists for investigations. These reductions put victims in increased danger of additional and more serious abuse.

In addition to staff shortages, the States have identified the following gaps in services: lack of training for adult protection, law enforcement, and prosecutors; lack of emergency temporary housing and in-home care; lack of coordination between federal, State, and local agencies; lack of reliable national and State data; lack of public awareness about abuse; lack of protective services for disabled adults who are under the age of 60; and lack of responsible guardians to act on behalf of victims.

What we need now are the following: specific Federal funds for adult protective services programs; a Federal agency to provide a national home for adult protective services; funds for training services staff, law enforcement, and prosecutors; uniform automated data collection; a national public awareness campaign; better coordination and cooperation between federal, State, and local agencies; improved training and best practice models; funding for research; funding for the development of emergency temporary housing.

With a half a million abuse reports coming in a year, and an additional 2 to 3 million incidents which are never reported, I would say that what we have is an epidemic. If this were an illness, we would call it an epidemic.

Abuse of elderly and vulnerable adults occur in every State, in cities and rural areas, to the rich, the poor, and those in between. It happens in our communities and in our own families.

I have often said that I do not expect to see any legislation passed on this issue in my lifetime. I really hope, for those of us who are getting older, that that is not the case.

Thank you.

Senator BREAUX. Thank you. We are going to try and prove you wrong on that. [Laughter.]

[The prepared statement of Ms. Otto appears in the appendix.]

The CHAIRMAN. Dr. Dyer?

STATEMENT OF CARMEL DYER, M.D., ASSOCIATE PROFESSOR OF MEDICINE, BAYLOR COLLEGE OF MEDICINE, CO-DIRECTOR OF THE TEXAS ELDER ABUSE AND MISTREATMENT INSTITUTE, HOUSTON, TX

Dr. DYER. Good morning, Chairman BreauX and Senators. Thank you for the opportunity to present to you here today.

My name is Carmel Dyer and I am a geriatrician from Baylor College of Medicine. When I joined the faculty, I had two goals in mind. The first, was to set up a geriatrics program at the Harris County Hospital District. The second, was to study surgery in older people.

But once we had accomplished the first, we were seeing so many cases of abuse and neglect that we changed our focus from operations in the elderly to elder abuse.

We looked to the medical literature and we found precious little, so we turned to our colleagues in adult protective services at the Texas Department of Protective and Regulatory Services and we started working closely.

We call our collaboration the Texas Elder Abuse and Mistreatment Institute, or TEAM. Together, we have cared for over 500 abused and neglected patients.

Now, we have worked hard to try to characterize the phenomenon and develop an intervention model, but there are still huge gaps in our knowledge of how to detect, intervene, and prevent elder abuse.

I will direct you to an X-ray here on the side. This is the case of an unfortunate woman who was admitted to our service about a year ago. It may not be absolutely clear, but the bone is sheared off where the arrow is just above the knee. When she came to us, the fracture was at least 3 days old and the bone was sticking out of her skin.

Now, this case never went to court because physicians, prosecutors, and police officers do not have the information they need to determine what patterns of injuries constitute a fall, as the caregiver claimed, versus a physical beating, which is what we suspected had happened.

We do not know when malnutrition, dehydration, or lethal bedsores are caused by illness or by severe neglect. There are no routinely used screening tools in our country and there are no guidelines to tell us when an elder death case should be autopsied.

What we need, are medical forensic studies. We need forensic centers. We need better screening tools, and we need the cross training of geriatricians and forensic pathologists. But we also need interdisciplinary intervention teams.

As you have heard today and I am sure you are well aware, elder mistreatment is a complex phenomenon. It has social, medical, and legal aspects that are best dealt with by health care professionals, prosecutors, police officers, and protective service specialists working in concert towards a single goal. There are only a handful of programs like ours, like TEAM, in the country. We need more.

We also need more geriatricians. You see, geriatricians and gerontologic professionals can actually help prevent elder abuse because we combat the frailty and vulnerability that make some older people prime targets for perpetrators.

We do this because, routinely, we assess social and functional states. We perform in-depth medication reviews and we are experts in the care of diseases that most commonly afflict older people.

The problem is, there are too few of us. The Senate's Special Committee on Aging has already held a very informative hearing on the shortages of geriatricians in this country.

But suffice it to say that, as an educator, I am seeing that young doctors are discouraged from entering geriatric medicine because of the Medicare cuts. What we need to do, is provide incentives to attract the best candidates to take care of the most complex of patients.

I want to conclude by saying to you that if you could walk in our shoes and see what we see, we see vulnerable people living in squalor. We have two pictures of that. You walk in these houses and you really want to cry.

Last year, we made over 500 house calls. These are the types of things we see. There is another picture as well. The woman here was found living sort of on top of all this garbage.

If you could see the bedsores, like the one drawing on Figure 3, the skin is weeping, they are very severe. Sometimes when they get to this point, we cannot treat them well.

If you could see the look on the face of a gentleman when he has been told that he was left destitute because his daughter spent his life's savings on bad investments, if you could have seen the 96-year-old admitted on Christmas Eve with her face bloody and swollen because her nephew beat her, then you would be able to see even more clearly the need for increased medical forensics research, interdisciplinary intervention teams, and increased numbers of geriatricians. All of this is clearly outlined in the Elder Justice proposal.

On behalf of my co-director, Nicolo Festa and the members of the TEAM Institute, I want to thank you for this opportunity to testify today and for your concern for our Nation's seniors.

Senator BREAUX. Thank you very much, Dr. Dyer.

[The prepared statement of Dr. Dyer appears in the appendix.]
The CHAIRMAN. Next, Mr. Thomas?

STATEMENT OF RANDOLPH THOMAS, M.A., LAW ENFORCEMENT INSTRUCTOR, SECTION COORDINATOR FOR DOMESTIC INVESTIGATIONS AND BEHAVIORAL SCIENCES UNIT, SOUTH CAROLINA DEPARTMENT OF PUBLIC SAFETY, CRIMINAL JUSTICE ACADEMY, COLUMBIA, SC

Mr. THOMAS. I, too, want to extend my thanks to the Senate for this hearing on what to me has become a very critical issue to law enforcement.

My name is Randy Thomas. I am an instructor with the South Carolina Department of Public Safety, and a police officer.

My primary mission is to train officers to be investigators, both in child abuse and elder abuse, and I have had the opportunity to do that throughout the United States, which gives me an interesting perspective on just what law enforcement faces throughout the United States.

First, as has already been stated, elder abuse is a very complex issue. It is very complex to law enforcement and it is critical, I think, that everyone understands that the majority of police departments in the United States usually have less than 30 people. The average experience now on the street is less than three years.

While this provides us with a wonderful opportunity to train and improve our skills, it also tells you the difficulty we have in improving our response to this problem.

There are three goals that I would like to focus on. First, is to enhance the detection skills, improve the collaboration between law enforcement and other people interested in this area, and ultimately, and maybe more importantly to the criminal justice system, is hold the offender accountable to more effective prosecution.

There are some barriers to this, and barriers that we encounter today. First, is the total lack of awareness on the part of law enforcement. There is a lot on our radar screen, so to speak, today. There are drug problems, gang problems, school violence.

Sad to say, elder abuse is not even on that radar screen. It is just very difficult to convince law enforcement agencies that it is a problem. We have already heard the data relative to how it is re-

ported, and where it is reported. Awareness generates interest, interest generates support. Until we get that awareness level up, we will not have the other two.

Resources. I want to bring up an interesting point about resources. You would expect me to say that law enforcement needs more resources. Of course I will say that. But is also important to understand that we face a problem in South Carolina right now that may be indicative of this whole general feeling.

That is, we need resources in other areas as well, to include adult protective services. We have had 35 slots transfer from adult protective services to child protective services and they have been given a pay raise.

Part of that is driven by the SSBG issue, and part of it is, it just kind of gives you some idea that our social service agency feels that children are more important than the elderly.

Ultimately, I am a trainer and I think we need to do better at that. I will probably come back and discuss that in a minute.

Let us talk about detection for just a second. All of you have had a chance to look at the pressure sore. People do not like to look at those for any length of time. But I started out my career as an investigator working homicides. I thought, that is pretty neat stuff. That is what law enforcement is all about.

But when you look at the complexity of homicides, and not to denigrate the victims, but if it is a gunshot wound, it is a gunshot wound and I basically know what that looks like, I know what causes it, I know what happened, and very often I can figure out how it happened.

I then graduated, so to speak, to doing child abuse cases, and the complexity really went up, particularly from a medical standpoint, and particularly with the victim dynamics, and the issues.

Then I was introduced to the subject of elder abuse. My first reaction was to go back to do homicides because it just seemed to be so much easier. These are extremely complex. They are complex for experienced investigators. I cannot imagine how difficult it would be to a young officer who sees his first pressure sore and has absolutely no idea what it is, he has never seen one before.

Collaboration. Collaboration is absolutely critical because no police officer will have the medical training, the forensics training to be able to work these cases. He needs to collaborate with those other professionals, with doctors, with APS workers, people who can do quality forensics interviews with this victim group, people who can interpret medical records.

Nursing home cases are a classic in somebody being able to go through and look at records. We have had some success with that in South Carolina. Our Medicaid Fraud Control Unit has actually provided some expert support, consulting services for lack of a better term, to our local agencies.

Even though it may not fall within their legal purview, they have got some trained folks who do not mind responding. That is easy in a small State; they are no more than two hours from anybody.

Ultimately, we need to hold the offenders accountable. When I entered law enforcement, I really thought that my mission was to put people in jail. When they committed a crime, I wanted to hold them accountable and put people in jail.

What I found out over a couple of years, is that we are the only public service agency that is very often open 24 hours a day, 7 days a week, and we respond to a lot of social problems that may be outside the realm of crime. Community policing. It certainly is recognized that we have a role greater than solving crime.

But we have to do that by building prosecutors, building case-building skills that will provide us with effective prosecutors as well. It does me no good to build the world's best criminal case if I cannot get it effectively prosecuted.

Are there solutions to this? Yes. I would urge that we look at this much like we looked at child abuse, violence against women, even community policing. We do have to have some resources directed at this. I think the Elder Justice proposal really does get to that.

Law enforcement will, in fact, follow the programmatic issues. They will do that, and we have seen examples of it. As a trainer, we need more training. Enough said.

I would like to leave you with the same thought that I leave my basic law enforcement students, most of whom are considerably younger than I am, to include some who went to school with my children, which is always not comfortable.

I tell them this. I say, this is not just a professional issue. Hopefully none of you have ever been a victim of child abuse; you certainly will not be now. Hopefully none of you have ever been a victim of spousal abuse; hopefully that will not happen to you again.

But if you bet the odds, you might just be a victim of this and it will happen to you when you can least protect yourself. Now, that does not mean you have to cast a glancing eye at your children, but it is not just professional, it is personal.

Thank you.

Senator BREAUX. Thank you very much, Mr. Thomas. Interesting statement.

[The prepared statement of Mr. Thomas appears in the appendix.]

Senator BREAUX. Mr. Bonnie?

STATEMENT OF RICHARD BONNIE, L.B., CHAIR, PANEL TO REVIEW RISK AND PREVALENCE OF ELDER ABUSE AND NEGLECT, COMMITTEE ON NATIONAL STATISTICS OF THE NATIONAL RESEARCH COUNCIL, CHARLOTTESVILLE, VA

Mr. BONNIE. Thank you, Mr. Chairman, members of the committee. I am Richard Bonnie, from the faculties of the Schools of Law and Medicine at the University of Virginia, and I am a member of the Institute of Medicine of the National Academy of Sciences.

I am appearing here today in my role as chair of the Study on Elder Abuse and Neglect that was recently conducted by the National Research Council, the operating arm of the Academy.

Our study committee was established in the spring of 2001, in response to a request from the National Institute on Aging, to assess the state of knowledge in this field and to make recommendations for future research.

Our report was released yesterday and I am very pleased to have the opportunity to present our conclusions and recommendations to you and to the American people today.

I have, basically, five points that I would like to make here. First, it is genuinely amazing to me how little we know about this important subject. A thorough search of the scientific literature turns up fewer than 50 original peer-reviewed scientific studies in this field, and that is a generous estimate, as I was just checking with Dr. Dyer.

No major foundation has identified elder mistreatment as one of its priorities, and Federal investment in this area has been modest at best. For example, fewer than 15 studies on this subject have been funded by the National Institute on Aging since 1990, and support from other agencies has been episodic.

As a result, very little is known about the nature and prevalence of elder abuse and neglect, its causes and consequences, the effectiveness and cost of current interventions, or measures that could successfully be taken to prevent it or ameliorate its effects.

The best metaphor to describe our current knowledge is a nearly blank slate. The gaps in our knowledge are truly enormous.

The second point: There is an urgent need for studies on the prevalence of abuse, neglect, and exploitation. You have heard this point made already, but it is worthy of repetition, I think.

There is no survey of the United States' population that has ever been undertaken to provide a national estimate for the occurrence of any form of elder mistreatment, and I mean, now, a population-based prevalence survey.

The magnitude of the problem among community-dwelling elders as well as those residing in long-term care facilities is basically unknown. Most of the research that has thus far been conducted in this field has relied on records of social service agencies.

But valid prevalence data and rates of abuse, neglect, and exploitation can be developed only by studying populations in communities, in institutions, or wherever people are found.

Studying reported cases is not sufficient because only a very small proportion, as you have heard, of such cases reach agency attention. We do not even have any idea what proportion that is.

Only a handful of population-based studies have been conducted, and most of them have been fielded in other countries. There are probably less than 10, and maybe even 5 would be about right, prevalence studies in the entire world.

The panel's report offers a sequential strategy for doing prevalence research, which is outlined in my statement and in the panel's report.

My third point is that even though the problem is unquantified, as I think you have already heard and you know, the problem is serious and certainly likely to grow.

Even in the absence of adequate prevalence data, available information, anecdotal information from social service settings and clinical settings gives us a sound basis for believing that abuse, neglect, and exploitation of elders are truly significant problems.

In terms of magnitude, rough estimates based on figures extrapolated from local studies suggest that the national prevalence of elder mistreatment, including physical abuse, psychological abuse, and neglect is likely to be between 2 percent and 4 percent of the older population, however defined, and perhaps twice that high if financial exploitation is included.

At any point in time—and this is a conservative estimate, you have heard the range that goes up to 5 million—between 1 and 2 million vulnerable elders may be experiencing, or are at high risk of experiencing, mistreatment.

It is also likely that mistreatment is associated with substantial added morbidity and disability in what is obviously an already vulnerable and suffering population.

I should say, however, we have no good data on the consequences of mistreatment. There is also some evidence, as you know, that mistreatment is associated with accelerated mortality.

Now, also it is worth noting, as you also have pointed out, that these problems are likely to increase as the population ages.

A fourth point I would like to make is that research is needed to respond effectively to the problem. You have heard, of course, many suggestions about programs that should be supported and initiated, and the Elder Justice bill includes a great deal of support.

As part of that effort, research should be conducted. Here are a few examples of what we need to know and why it would help. First, there is the issue of definition. How do we define elder abuse and neglect for various policy purposes?

Substantial variations appear not only in State law and in the legal definitions, but also in the research in this field. We have to have a better empirical understanding in order to know how to define elder mistreatment properly.

Second, what data systems do we need for monitoring the occurrence of mistreatment in various settings, including emergency room and long-term care facilities. Surveillance is absolutely critical to monitor trends over the long-term in order to know how we are doing.

Third, how can we identify elders who are being neglected or abused in order to intervene effectively and prevent harm? Dr. Dyer has already discussed this issue, and it is critically important that research be done, as she said.

How can we prevent mistreatment before it occurs or escalates in severity? Research on the effects of policies and programs aiming to prevent or stop elder mistreatment are urgently needed. We know virtually nothing about the effects of interventions.

Then, finally, are preventive and protective interventions that we are already undertaking cost-effective? We need to be able to put research in place in order to answer that question.

The final point, which I will not discuss here but is fully described in my statement, are specific recommendations about putting a research infrastructure in place in order to be able to answer these questions.

Senator BREAUX. Thank you, Mr. Bonnie. I thank all of our witnesses for their excellent statements.

[The prepared statement of Mr. Bonnie appears in the appendix.]

Senator BREAUX. In general, do all of you support the concept that is contained in the Elder Justice Act that I have introduced? Is there anyone who does not? statements.

[No response.]

The CHAIRMAN. Let me start with Mr. Blancato. You started off, and your background is very extensive in this area and you have

looked at this back in the days of the White House Conference on Aging, which included mini summits on Elder Abuse, but you said that the problem of elder abuse and neglect is worsening.

I mean, are there any studies as to why? Is it just because we have more elderly or is it something in the nature of how we treat the elderly that is getting worse?

Mr. BLANCATO. That is a good question, Senator. It is hard to necessarily answer it, except that part of it is that there is more activity in the area of reporting which allows the numbers to grow. Second, the population increase is clearly part of it.

Third, the circumstances, since it is community-based and institutional-based and the numbers are growing in those populations, that would also add to it. There is more attention on it. I think some people may not know what elder abuse is and may be close to committing it.

In some regards, matters that seem to be routine in the course of family transactions on financial matters, and whatever, have to be checked out to be sure that you are not contributing to some form of abuse in some fashion.

So I think that it is a combination of things. At this point, the more attention that is focused on it, I think the more likely we are to get people to focus on not only what the problem is, but how to approach the solutions.

Senator BREAU. Does anyone else have any response to why the problem is perceived to be getting worse? Dr. Hawes?

Dr. HAWES. I think one of the reasons is that people are living so much longer, that they have a lot more chronic disease and disability. That is a much more challenging individual and population to care for.

My mother lived with us for the last 8 years of her life and had a brief period of psychosis and delirium in which she routinely hit me when I tried to do things with her because she thought I was a stranger, poisoning her food.

I could turn and look at her and have 50 years of love and some clinical experience and knowledge about what was going on with her, but I did not have 15 other residents to care for, I was not making \$6.50 an hour, and I had a husband to help.

I think a lot of people do not have those advantages. When we have a population with dementia and behavioral problems and not much education available for caregivers, either formal or informal, it is almost inevitable.

Senator BREAU. Ms. Otto, what are your thoughts?

Ms. OTTO. About 10 years ago, financial exploitation really was not on the radar screen for adult protective services. But the reports are increasing. These are very complicated cases. I think, certainly, the problems in the economy have worsened, and that has exacerbated families' responses.

There seems to be, in some situations, a sense of entitlement, as the gentleman who was arrested; you know, it is my turn now. So we are seeing more of the financial exploitation cases and they are very often combined with threats of physical abuse or threats of nursing home placement against the victim's will.

Senator BREAU. Does anybody else have any thoughts as to why?

Mr. THOMAS. I might. Our experience in South Carolina, from a training standpoint, we would spend part of our curriculum for basic law enforcement for about the last five or 6 years, as well as an aggressive effort in a multidisciplinary setting, to train investigators from must purely an anecdotal standpoint. Once you raise that level of awareness, then they start seeing the cases. I think the cases have always been there.

Right now, the most prevalent thing to deal with is exploitation. In our State, very often we have people who are cash poor and land rich and do not know it, and we see a lot of the children going after the money. But I think, from my experience in State, has been mostly that, as we have increased the awareness, the reporting has gotten better.

Senator BREAUX. Mr. Bonnie, you had a comment?

Mr. BONNIE. Well, I could just add two points about that. I think the truth is, of course, we do not really know whether the rates are increasing or not because we do not have the data that would tell us.

What we do know is that reports are going up and that is going to be a function, at least, of greater awareness; and it is likely, because of the demographics and greater life expectancy, that point has contributed.

But what we also know, is that even if the rate is not going up and does not go up, the numbers of cases will go up simply because of the aging population.

Senator BREAUX. That is a good point. If it is bad today, it is going to get worse if there is a trend line here, because we are going to have a lot more people who are living a lot longer.

That is what I have said is good news and bad news: the good news is, people are living a lot longer; the bad news is, people are living a lot longer.

Because of the problems we are going to face as a society with a much larger group of baby boomers who are becoming seniors who not only are much larger in number, this much larger number of people are going to be living a lot longer so there are going to be a lot more people around for a lot longer, we are going to be having to resolve some of these problems, which we need to start yesterday in order to find a solution for tomorrow.

Let me ask, Dr. Hawes. Tell the committee a little bit more about the Wellspring Initiative.

Dr. HAWES. The Wellspring Initiative was started by a group of facilities in Wisconsin. It is sort of amusing. It was to deal with managed care. But when they figured out that that really was not affecting long-term care, they became committed to using their shared knowledge to improve quality of care.

There are 11 charter Wellspring facilities and they spread to two other sites in Wisconsin.

Senator BREAUX. Are these nursing homes?

Dr. HAWES. They are nursing homes.

Senator BREAUX. What is different about what they are trying to do?

Dr. HAWES. Well, there are two things that are different. One major sort of focus of their intervention is to empower CNAs. They

make CNAs responsible for setting their own schedules, for finding their own replacements.

If a resident they are caring for needs something different that maintenance can do in the room, they call up and order it. They have a lot more power. It is a wonderful model of empowerment.

One of the things that we found when we evaluated it, was that staff turnover dropped dramatically compared to all other facilities in Wisconsin.

The second thing it has done, is create what are called "Care Resource Teams" that involve people from housekeeping, laundry, maintenance, nursing, dietary, activities, and they receive training from geriatric nurse practitioners and from their peers in how to address particular problems. It is really to increase the clinical knowledge and skills of everybody in the facility and to make it a real team approach.

They have quarterly reports. They use data on what is happening with the residents to evaluate whether the care of their residents is improving, and they compare themselves to other facilities. If they find one of their peers is doing a better job in preventing falls or pressure ulcers, they ask that facility to come to training.

Senator BREAUX. Have they shown positive results as a result of this change?

Dr. HAWES. The only result so far is reduced staff turnover, increased staff satisfaction, which are non-trivial today because they have not increased wages, and reduced deficiencies. So, those are good effects and this is early on.

Senator BREAUX. Now, apparently that has been done under the existing reimbursement that we operate under under Medicaid.

Dr. HAWES. And one of the striking things, my husband did the cost evaluation. There is no increased cost. They have rearranged their spending. There is no overall increase in cost. They are now doing training of other facilities around the country.

Senator BREAUX. That is pretty important information. Some would argue that we could improve how people treat people by giving more money to the facilities that treat people, i.e., nursing homes, in most cases.

But I take it that this experience indicates that it is more than just more money, it is also attitude and a change perhaps in the way services are delivered and things are planned for within those facilities.

Dr. HAWES. And it is their longstanding commitment to improving quality. It is the best thing I have seen in 25 years in terms of facility-driven interventions.

Senator BREAUX. Can anyone comment, and I think Dr. Hawes, you mentioned it, and Dr. Dyer, I think you referred to it as well. We have a problem, it seems to me, in the number of people in this country that go into geriatrics.

We have about 125 medical schools. Every single one of them has an advanced degree in pediatrics. Yet, out of the 125 medical schools, I can really only find about 3 that really have advanced degrees in geriatrics and gerontology.

So the question is, number one, why do more people not go into this profession, in light of the fact that it is the largest-growing and

fastest-growing segment of the population of the United States? The question is, if they are not going into it, which they obviously are not, the question is, why are they not?

Number two, can we in government do anything to increase the number of professionals that go into this field? Anybody can comment on those two questions. Number one is why, and number two, how do we change that?

Dr. DYER. Well, when there are only a few geriatricians at a medical school, you have to fight to get a place at the curriculum table. So geriatrics has been, sometimes, not offered, or it is an elective, and everybody else gets two- and three-month blocks to train medical students. We maybe get a lecture here or there.

But that is just because our numbers are fewer. When you have Departments of Geriatrics, you have the same place at the table as a Department of Surgery or Medicine.

The other thing is how society has valued older people. So, it is obviously important to take good care of children and younger adults, but it is just as important for all the reasons stated here to take good care of elderly people who built everything that we are sitting in and standing on today.

Good ways, I think, to encourage individuals are to try to create Departments of Geriatrics, as you have stated. The Geriatrics Care bill talks about not capping the number of trainees in geriatrics. There are caps in cardiology and general surgery, where we have had an over-abundance of doctors, but to also cap geriatrics is probably not wise.

Senator BREAUX. I would hate to think that the government is going to have to get involved in determining how many medical schools have geriatric programs or how many they have to graduate.

I mean, it would seem to me, with the birth rate fairly stabilized in this country and the number of seniors growing by leaps and bounds and living a lot longer, that the medical profession would look at it and say, hey, this is here we ought to be looking towards going into because there are going to be so many more of them around for so much longer.

Dr. DYER. Well, there are two things that motivate the medical schools. One is the research aspect, and the other is the practice aspect. With less than funded 15 research studies, that obviously tells the medical school administration that what is important is all the funding that is being sent to other places.

The other thing is, the Medicare cuts have really hurt. I mean, my physicians are sending me letters stating they are not accepting Medicare any more. The generalists are telling the young students who might go into geriatrics, you know, you are going to get the same amount of money that I am going to get taking care of an active 62-year-old, to take care of the frail, elderly, complicated patient. It is not worth your time. So, those are two areas where the government can be helpful to us.

Dr. HAWES. If I could just add to that, because I teach at Scott and White, which is a huge health plan in central Texas that serves rural and urban areas. I had the one geriatrician at Scott and White in my class. They had to merge the Department of Geriatrics with Internal Medicine because Geriatrics loses money.

The managed care organizations and Medicare pay for an average visit that is 10 to 15 minutes long, and you cannot cope with someone with multiple chronic diseases and disabilities in that amount of time. So, clinically, it is always a money-losing department and no one particularly wants that on their watch.

You do not have to maybe tell them how many Departments of Geriatrics there should be, but you could have additional funding for graduate medical education for geriatricians. You could change the way that they are reimbursed under Medicare.

In Ohio, instead of requiring a Department of Geriatrics, they simply required that all physicians receive a certain number of hours of training in geriatrics to get around that issue of an hour here and an hour there.

Senator BREAUX. And it may not be this panel's responsibility, but I think that in pursuing, how do we increase the number of medical professionals who have geriatric training and backgrounds, it may be that we have to something with the graduate medical education, either in terms of some type of loan forgiveness for medical students who agree to serve the elderly population for a certain amount of years, just like we have tried to do it with doctors who have agreed to go into rural areas where they have not had medical professionals with forgiveness of the loan or some economic incentive to say that this is something they need to consider because there are financial rewards that are attached to going into this particular area.

So, Dr. Hawes, if you have any ideas on that, I would be pleased to receive them.

Dr. HAWES. Thank you very much. It is a great idea. I would just like to add that in the Netherlands there is a board certified specialty in nursing home medicine, and every nursing home in the country has a medical director who is a board certified geriatrician in nursing home medicine. I think that is something we can all aspire to. Their nursing homes are totally different than ours. I mean, it is unbelievable.

Senator BREAUX. We have a real problem, because nursing homes continually tell us that there is not enough money, either from private insurance, or the Medicaid reimbursement rate is far too low for them to do the things they need to do.

Yet, every one of you could probably recommend additional things that they ought to be doing in terms of staff ratios, in terms of professional training. Their argument to us, is they are not making it now with the reimbursement rate we have, and if you increase the requirements and do not vastly increase the amount of money available, it is not going to work. That is why I was intrigued by the Wellspring Initiative that you talked about.

Mr. Thomas, where do you rank, from the standpoint of law enforcement, child abuse, spousal abuse, elderly abuse, in terms of the attention that it gets from law enforcement?

Mr. THOMAS. I think at this point it is probably almost a toss-up between child abuse and spousal abuse. We have spent a lot of resources, a lot of time, and a lot of training effort in dealing with child abuse, which has really kind of been on our agenda a lot longer than spousal abuse, but spousal abuse as well.

Right now, I do not think elder abuse is on anybody's agenda in any meaningful way. I have had the opportunity to train in a number of States, and it is not because they do not care, it is just that it is just not be emphasized, the awareness is fairly low.

Senator BREAUX. In terms of bottom-line numbers, is the number of incidences that you think may exist out there dramatically different for child abuse, spousal abuse versus elderly abuse or fairly close to being the same?

Mr. THOMAS. I do not know if we really know in any meaningful research way. I know from an anecdotal standpoint it may rival child abuse. Certainly, there is a shift in demographics. Of course, I am from a southern State, too, so our elderly population is going up just from retirees, so you get a little bit of that bubble as well.

Spousal abuse has always been a problem. We probably do the best job of counting those, and even that is under-reported. But I would say it would rival child abuse.

Senator BREAUX. Well, I think that all of you have been very helpful in your testimony. We picked up two co-sponsors this morning by members who were here. Senator Smith and Senator Stabenow both agreed to be co-sponsors of the bill. We would like to get everybody on the Aging Committee to be an original co-sponsor of the legislation, and then expand from there.

I really have not heard any opposition to it. I mean, obviously anything anybody produces can be improved upon. But to the extent that I will just ask you all that you can communicate to your folks that you have contacts with about this being a step in the right direction, I want to prove Ms. Otto wrong and show you that we actually can do this.

It is a good challenge. The history, you are correct, has been that we talk a lot about it, but we really have not done anything. We are really committed to actually doing something.

We have taken the first major step by putting together a comprehensive Elder Justice bill, which I think was a very important achievement that the staff was very much involved in, and provided legislation for this committee to consider.

So, I think we have the makings of a major, I think, effort as a Nation to try and address something that has gotten much worse, as Mr. Blancato has said. Our job is to make sure that not only do we stop it from getting worse, that we do everything we can to eliminate it.

All of you are involved in this, and I congratulate you for being involved in something that is critically important to this Nation. I mean, no Nation can be a great nation if we do not treat those who are in their golden years with dignity, with care, and with love.

That is what this is all about, trying to make their lives not only a life that lives longer, but one who also lives a better life. So, we are all working for the same goal.

With that, the committee will be adjourned.

[Whereupon, at 11:30 a.m. the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF ROBERT B. BLANCATO

Chairman Baucus, Ranking Member Grassley, Senator Breaux and Members of the Committee:

My name is Bob Blancato and I present testimony today in my capacity as President of the National Committee for the Prevention of Elder Abuse (NCPEA). NCPEA is the largest membership organization focused on elder abuse prevention throughout research, advocacy, public awareness, and training. We are pleased to note, Mr. Chairman, that NCPEA has three Affiliates in Montana: the Billings Chapter for the Prevention of Elder Abuse, a chapter in Cascade County and a Western Montana chapter. These three chapters are noteworthy for being innovative in the use of AmeriCorps Vista volunteers to spearhead local abuse prevention activities.

The National Committee is also a partner organization to the National Center on Elder Abuse, which last December convened a first ever National Summit on Elder Abuse and produced an Action Agenda from which a number of my comments, observations and recommendations will be drawn.

As we also noted, I did serve as Executive Director of the last White House Conference on Aging held which was held in 1995. One the priority issues at this conference was elder abuse. Delegates, including the one that you and other Finance Committee members appointed, approved important resolutions on elder abuse prevention.

I commend you Mr. Chairman, and this Committee for holding this hearing on elder justice. As a starting point, let me commend the use of the term "elder justice". It is an important new term that conveys a future plan and an important public policy goal.

This hearing is warranted because the problem of elder abuse and neglect is worsening. Elder abuse is not a new issue, but it has new urgency that compels some new approaches.

Statistically, based on the National Center on Elder Abuse's collection of data from states for the year including 2000, there were a total of 470,709 reports of adult/elder abuse. This represented a 60 percent increase from 1996. In addition, an estimated 15,000 complaints of abuse and gross neglect against older victims living in nursing homes and other long-term care facilities were reported, as well as 3500 similar complaints of abuse in board and care facilities.

Yet, estimates from the Senate Special Committee on Aging suggest the number of cases could be as many as 5 million, since more than eight out of every ten cases go unreported.

The federal involvement in elder abuse spans more than 23 years beginning with Congressional hearings before the House Select Committee on Aging. Eventually, federal programs were adopted and funding was provided for elder abuse prevention programs, adult protective services, and the Long-Term Care Ombudsman Program. This history includes the funding of a National Center on Elder Abuse, a Surgeon General's Report on Family Violence including elder abuse, and a National Elder Abuse Incidence Study. More recently, as I mentioned, the first National Summit on Elder Abuse was held under the auspices of the Administration on Aging and the Department of Justice in December 2001. We also note and commend the release of the National Academy of Sciences study on Risk and Prevalance of Elder Abuse and Neglect.

The reality is the federal response to combating elder abuse and neglect has been piecemeal and ultimately inadequate, as the problem has intensified. It is said in

policy that sometimes it is all about money. If that criterion were applied, the current federal commitment pales even further. Consider that the only federal program that appropriates funds specifically addressed to elder abuse, Title VII of the Older Americans Act, has national funding of less than \$5 million. It is estimated that the total federal commitment being spent today on programs addressing elder abuse, neglect and financial exploitation prevention is \$153 million. This is all but .08 percent of the funds currently spent on abuse prevention programs whether for children, women or the elderly. It is not surprising, but is nonetheless disturbing, as Senator Breaux recently noted, that there is not one single person working in the federal government full time on elder abuse prevention.

It should be noted that in addition to the Older Americans Act that also provides funds for the Long-Term Care Ombudsman Program, 32 states use funds from the Social Services Block Grant to help fund Adult Protective Services. Some elder abuse victims are served by programs funded under other umbrellas such as: the Violence Against Women Act, the Family Violence Prevention and Services Act, the Victims of Crime Act, as well as Medicaid, the National Institutes of Health and the National Institute on Aging.

We need to move to a new approach in our fight against elder abuse, neglect and exploitation. Today our policies are more reactionary. Tomorrow they must be proactive, coordinated, comprehensive and goal driven. We suggest that a future elder justice policy could be built around the following seven goals addressed at the National Summit:

- Filling Service Gaps;
- Educating the Public;
- Training Professionals;
- Enhancing Adult Protective Services;
- Increasing Prosecution;
- Maximizing Resources; and
- Eliminating Policy Barriers.

NCPEA is proud to be working with Senator Breaux and his staff on his proposed Elder Justice Act. We believe the approach embodied in his proposal is the genuine catalyst that will shift the focus, change the direction and will move us from a federal response to a comprehensive, policy on elder justice. We also believe it offers a strong balance in terms of the appropriate role of the federal government. Sometimes government is best when it supports and empowers. Sometimes its role is best when it is the engine developing and driving policy. Both will be needed here if we are to commit to a more serious and focused role of the federal government in elder justice.

We must first recognize that elder abuse is a public health, law enforcement and social services crisis. Therefore as a starting point, we must move from the current fragmentation and invisibility that exists within the federal government around elder abuse to one that is focused and will elevate elder justice as a priority.

The federal commitment to the future of elder justice must show leadership through responsibility, accountability, funding and visibility. One approach is offered in Senator Breaux's proposal. He would create Dual Offices of Elder Justice in both the Departments of Health and Human Services and the Department of Justice. This combined with a distinct federal home and a dedicated funding stream for Adult Protective Services is a major step in the right direction.

We must go beyond what is done inside the federal government in the new approach to elder justice. There must also be an entity created that represents the very valuable state, local, private and multidisciplinary perspectives that are working every day in the field of elder abuse prevention. This public-private entity could be charged with annually assessing the state, of elder justice in our nation and could be the sponsoring entity of annual summits on elder justice.

Let me also add that important to any new and expanded federal commitment to elder justice must be regular Congressional oversight of existing and new programs and policies on elder justice to make them as coordinated as possible in the most cost effective manner.

This new commitment to elder justice must absolutely include better data collection and dissemination. The underreporting of elder abuse, neglect and exploitation has several causes. Some are intensely personal relating to the victim. Others are intensely bureaucratic and must be remedied. We can begin by doing research in the areas of data and statistics, determine needs and costs, existing responsibilities and how best to measure outcomes.

As an example, the 15,000 cases of abuse in nursing homes mentioned above came from one source: the annual report of the Long-Term Care Ombudsman Program. It did not necessarily include reports that might have been submitted to state Medicare or Medicaid Fraud age agencies or state licensure or survey offices or even law

enforcement. Why? Because there is no identifiable vehicle to collect, analyze or report this other data. This must be remedied. A new federal policy on elder justice must have the authority and the ability to achieve better reporting of abuse cases wherever it may occur.

The case for greater federal resources for elder justice is made much stronger with good data that justifies the need. We strongly believe that we must do more to identify, disseminate and utilize research being done today around elder abuse prevention. Further, where such research does not exist or if new areas of research should emerge, this new elder justice policy must commit dedicated new resources for research. Part of what should be in the research agenda is how to develop and track state-specific training outcomes, research on diverse populations relative to abuse and, something very critical, the development of uniform definitions and standardized reporting criteria. Good research is important for prevention of elder abuse neglect and Financial exploitation and therefore is a good investment of federal money.

With respect to future research it is far wiser to sharpen the wheel than to reinvent it. Under a new elder justice policy we should do a basic inventory of what is being done in areas such as intervention, research or community strategies and other multi-disciplinary efforts and activities. These state and local models could be evaluated and recommended for possible national replication.

Extremely pivotal to the research agenda under a new elder justice policy must be a commitment to supporting regular national incidences and prevalence studies. These studies in so many ways could drive the elder justice policy as it could put researchers, front line workers and policymakers on the same page in terms of understanding the statistical extent of the problem as well as possible future trends.

It is also important that a future elder justice policy support in different ways all the sectors involved in the fight against elder abuse and neglect. This is especially true for law enforcement. To achieve elder justice, the justice system needs to be made more aware of the elder abuse problem. As was noted at the National Summit, elder abuse and neglect must become a priority crime control issue. The justice system including law enforcement, prosecution, correct corrections, judiciary, medical examiners, coroners, public safety officers, victims advocates, APS workers and Ombudsmen must work as a coordinated system to protect victims, hold offenders accountable and prevent future offenses.

In the future, there must also be an emphasis on training on an interdisciplinary, multidisciplinary and cross-educational basis. One of the suggestions from the Summit was a national elder abuse education and training curriculums that could be used by a variety of those involved in the field.

An obvious and critical goal in a future elder justice policy must be the goal of ensuring that elder abusers are never allowed to work in long-term care facilities or board and care facilities. This is a challenging and controversial issue that warrants deeper attention by Congress. Law enforcement must have the ability and tools to achieve swift prosecution against those who might already be employed, but commit abuse against an older person in the facility. In addition, some resources should be committed to training and educating of personnel in these facilities. In the book *Abuse Proofing Your Facility* (Pillemer), it is advanced that there are eight risk factors for someone to become an abuser in a facility: attitudes, burnout, conflict, disruptive/aggressive residents, education and training inadequacy, failure to enforce, gaps in staffing, hiring and screening deficiencies. The key point in this book is that these risk factors are all preventable. Let us commit more time and attention to this.

We also need to enhance the knowledge base of consumers who are considering long-term care facilities for a loved one. This process to some extent has been started by CMS, but there must be much greater attention paid to distinguishing those facilities with clean records relative to abuse and those who have had problems in the past.

Today elder abuse is any form of mistreatment that results in harm or loss to an older person. It is generally divided into the following categories, yet a sad reality is there seem to be new categories appearing every day:

- Physical abuse;
- Sexual abuse;
- Domestic abuse (involving a family member);
- Psychological;
- Financial; and
- Neglect, including self-neglect.

Elder justice has individual and systemic definitions. From a policy perspective, elder justice consists of efforts to prevent, detect, treat, intervene in and, where appropriate, prosecute elder abuse, neglect and exploitation. From the individual per-

spective it is the right of older Americans to be free of abuse, neglect and exploitation.

We believe a new commitment to elder justice is as important as any initiative that has been undertaken to improve the quality of life for seniors in need. It reaffirms our commitment to the priority that federal policy has always given to those most vulnerable as older persons.

The proposed Elder Justice Act has implications for a variety of programs and initiative, under this Committee's jurisdiction. Social Security is an example. Often it is the misappropriation of the monthly Social Security check by a relative that constitutes abuse. Medicare and Medicaid factor in through the new efforts to address quality of care and abuse prevention in long-term care facilities. This could be a key tool in reducing institutional-based elder abuse. On the other side of the coin is the victim of elder abuse, who may need extended acute care under Medicare to recover from the abuse and the demand that could cause on the program in the future. There is also support for having more Medicaid waiver programs offer community-based services for elder abuse prevention such as respite care. Any new elder justice policy will impact heavily on the Social Services Block Grant, which today is a main source of funding for adult protective services.

A new approach to elder justice could play into some future and pending tax bills including those that would provide incentives to recruit more qualified persons into healthcare, especially those who wish to specialize in geriatric medicine. In addition, as the committee works further on caregiver legislation, elder justice and the need to provide assistance to caregivers to prevent abuse will come into play. Other areas that were presented at the summit for consideration are the establishment of a national toll-free number dealing with elder justice and a special Elder Justice awareness resolution.

A new elder justice policy will rely on public-private partnerships. One area of this will be especially true: we need a sustained national strategic communication program to educate the public especially baby boomers and younger on elder abuse and elder justice. It will involve a national public awareness campaign on elder abuse. It must also work to apply pressure to prevent those occasional advertising campaigns that make light of issues around elder abuse such as exploitation.

The point is this Committee will have a very direct and important role in the development of a new Elder Justice Act. NCPEA looks forward to working with the committee and looks forward to your active consideration of legislation, which will form the basis of a new elder justice policy.

As the witnesses who follow me will note, this elder justice proposal can also help to address key service gaps that exist today in elder abuse prevention. At the summit, mental health issues were identified as the top need in terms of filling service gaps. The summit called for appropriate and specialized mental health services to be available and accessible. Other service gaps commonly cited include preventive, early intervention and support services.

In closing, 29 years ago as a staffer in the House of Representatives, I worked with former Congressman Mario Biaggi and others including former Senator Walter Mondale on behalf of the first Child Abuse Prevention Act in history. Five years later, as Staff Director of the Subcommittee on Human Services of the House Select Committee on Aging, I organized some of the early hearings held on elder abuse and worked on the later amendments to the Older Americans Act that provided funding for elder abuse prevention. Then, as now, we have a troubling problem of intergenerational abuse in this nation from children to the elderly, which has only grown worse over time. We must confront all abuse aggressively and with a commitment to reducing it as much as possible.

Our commitment to child abuse and family violence prevention has been good. I believe we have been more remiss with respect to elder abuse prevention. The opportunity to remedy is before us now. It may have been an emerging issue in the late 1970s, but it has fully arrived today. To not direct the same level of commitment to elder abuse as to other abuse constitutes a new and deeply troubling form of ageism.

Let us make elder justice more than a new term. Let's make it a new policy goal as well as a societal aspiration. For the sake of that victim of elder abuse who cannot be here today to present testimony, let us commit to making elder justice a reality.

PREPARED STATEMENT OF RICHARD J. BONNIE

Mr. Chairman and members of the Committee:

My name is Richard Bonnie. I am John S. Battle Professor of Law, Professor of Psychiatric Medicine, and Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia. I am a member of the Institute of Medicine of the National Academy of Sciences, and I am appearing before you today in my role as the chair of a study on elder abuse and neglect recently conducted by the National Research Council, the operating arm of the Academy. Our study committee was established in the spring of 2001, in response to a request by the National Institute on Aging, to assess the state of knowledge in this field, and to make recommendations for future research. Our report was released yesterday, and I am immensely pleased to have the opportunity to present our conclusions and recommendations to you and the American people today.

I have given the Committee's staff a pre-publication copy of the report, entitled *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America*, and am appending to my written statement the Executive Summary of that report. In my testimony here today, I would like to make five points:

Very Little is Known

First, it is genuinely amazing how little we know about this important subject. A thorough search of the scientific literature turns up fewer than 50 peer-reviewed studies. No major foundation has identified elder mistreatment as one of its priorities, and federal investment has been modest at best. For example, fewer than 15 studies on this subject have been funded by the National Institute on Aging since 1990, and support from other agencies has been episodic. As a result, very little is known about the nature and magnitude of elder abuse and neglect, its causes and consequences, the effectiveness and cost of current interventions, or measures that could successfully be taken to prevent it or to ameliorate its effects. The best metaphor to describe current knowledge is a nearly blank slate, a *tabula rasa*. The gaps in our knowledge are enormous.

Prevalence Data are Urgently Needed

Second, there is an urgent need for studies on the prevalence of abuse, neglect and exploitation. I have participated in ten studies on behalf of the National Academy of Sciences. Reports in this genre typically begin by calling attention to the magnitude and social cost of the problem being explored, before going on to identify opportunities and priorities for research, programmatic action and policy initiatives. There is simply not enough information to describe the magnitude and social cost of elder mistreatment. That fact is a telling indication of the compelling need for the panel's report, as well as for an intensified program of research.

No survey of the U.S. population has ever been undertaken to provide a national estimate for the occurrence of any form of elder mistreatment. The magnitude of the problem—among community-dwelling elders, as well as those residing in long-term care facilities—is basically unknown. Most of the research thus far conducted in this field has relied on records of social service agencies. But valid prevalence data (rates of abuse, neglect and exploitation) can be developed only by studying populations (in communities or institutions, or wherever people are found). Studying reported cases is not sufficient, because only a very small proportion of cases reach agency attention—and we have no idea what proportion it is. Only a handful of population-based studies have been conducted, and most of them have been fielded in other countries.

The panel's report offers a sequential strategy for prevalence research:

- Improved definition, measurement and instrument development for each of the various forms of mistreatment;
- Methodological studies to identify the best methods for ascertaining occurrence rates among different populations in different settings (e.g., in the home, in assisted living locations, and in nursing homes), taking into account variations in cognitive capacity of the elder subjects, and the availability and reliability of proxy respondents;
- Local area studies using multiple modes of case ascertainment for different settings (e.g., family homes, assisted living facilities, nursing homes).
- Adding small modules on aspects of elder mistreatment to ongoing national surveys of the elderly population; and
- Eventually, a full-scale national prevalence study.

Though Unquantified, the Problem is Serious and Likely to Grow

Even in the absence of adequate prevalence data, available information from clinical and social service settings and agency records gives us a sound basis for believing that abuse, neglect and exploitation of elders are significant problems. In terms of magnitude, rough estimates, based on figures extrapolated from local studies, suggest that the national prevalence of elder mistreatment (including physical

abuse, psychological abuse, and neglect) is likely to be between 2% and 4% of the older population, and perhaps twice that high if financial exploitation is included. At any point in time, between one and two million vulnerable elders may be experiencing (or are at high risk of experiencing) mistreatment.

It is likely that mistreatment is associated with substantial added morbidity and disability in an already vulnerable population (though, as I said, we have virtually no good data on the consequences of mistreatment). There is some evidence that mistreatment is associated with accelerated mortality.

Moreover, the occurrence and severity of elder mistreatment are likely to increase markedly over the coming decades, as the population ages, caregiving responsibilities and relationships change, and increasing numbers of older persons require long-term care.

Research is Needed to Respond Effectively to the Problem

Aside from prevalence research, here are some examples of what we need to know, and why it would help:

- *How should we define elder abuse and neglect for various policy purposes?* Although we emphasize in our report that scientific definitions need not track legal definitions, it seems clear that legal definitions and responses should be grounded in empirical understanding of the types of conduct that are most harmful and that pose the most serious risks. Right now, we have very little systematic knowledge about the phenomena that could potentially be characterized as abuse, neglect or exploitation, and about the antecedents, clinical course and outcomes of various forms of mistreatment. For all this, we need to have good longitudinal studies of vulnerable elders who have (and have not) been mistreated.
- *What data systems do we need for monitoring occurrence of mistreatment in various settings, including emergency rooms and long-term care facilities?* Issues of definition and measurement must be studied and resolved in order to implement useful surveillance systems that go beyond the APS case reports. For example, the NRC panel endorses a recent IOM recommendation concerning the need for uniform definitions and data elements for characterizing the components, processes and outcomes of long-term care across different settings of care. We emphasized that uniform data elements relating to mistreatment should be included in the outcome measures.
- *How can we identify elders who are being neglected or abused in order to intervene effectively and prevent further harm?* A key component of any effective strategy for protecting vulnerable elders from mistreatment whether they are in the community or in nursing homes—is careful screening and, where indicated, individual assessment. Two major challenges arise in connection with screening and case-identification.. One is developing markers for otherwise hidden mistreatment to facilitate efficient screening in clinical and social service settings. The other is the development of clinical criteria for differentiating symptoms of the natural conditions and illnesses that are associated with physical frailty and aging from evidence of mistreatment. Forensic research on elder mistreatment is a high priority. Research is needed, for example, to illuminate the characteristics of common injuries, such as their etiology, natural course, distribution and severity so that the process of identifying cases of elder mistreatment can become more accurate and reliable. While certain physical signs (such as burns and ligature marks) are likely to be more reliable indicators of elder mistreatment than others (such as fractures and pressure sores), neither the challenge nor the importance of advancing knowledge in this area should be underestimated. We need to avoid both false negatives and false positives: On the one hand, mistakenly attributing nutritional deficiencies to the course of an illness, overlooking signs of neglect, can prolong and magnify the victim's suffering. On the other hand, mistakenly characterizing a spontaneous bruise or other injury as intentionally inflicted may lead to substantial clinical, social and legal jeopardy for all concerned.
- *How can we prevent mistreatment before it occurs (or escalates in severity)?* Research on the effects of policies or programs aiming to prevent or stop elder mistreatment is urgently needed. (The panel uses the term "interventions" in the broad sense to refer to the full array of activities aiming to prevent mistreatment from starting, to prevent it from continuing or escalating, and to protect a victim or remove a perpetrator.) Existing community interventions to prevent or ameliorate elder mistreatment have not been evaluated, and it is possible that some programs make things worse. In the NRC panel's view, agencies funding new intervention programs should require and fund a scientifically adequate evaluation as a component of each grant. The panel also recommends re-

search on the effectiveness of APS interventions, and encourages the development of APS/university research teams whose mission would be to evaluate existing data, recommend improvements in the collection of data, analyze incident reports, and design studies to assess outcomes. Another important research priority concerns the effects of nursing home staffing levels and configurations on the occurrence of mistreatment.

- *Are preventive and protective interventions cost-effective?* Ultimately, it will be important to know whether preventive and protective interventions reduce morbidity and mortality, including Medicare and Medicaid expenditures. Our capacity to answer ultimate policy-relevant questions of this kind depends on systematic longitudinal research in various settings, with appropriate comparison groups. This research is feasible, but not in the short term. The groundwork first needs to be laid.

We Need to Build an Infrastructure for Research

In *Understanding Child Abuse and Neglect* (1993) and *Violence in Families* (1998), the National Research Council was able to map out a comprehensive blueprint for research in the adjacent domains of child mistreatment and intimate partner violence. However, so little is now known about elder mistreatment that it would be premature to draw up detailed research agenda. Instead, the panel's report is best seen as laying the foundation for a much-needed effort to "jumpstart" this nascent field of scientific investigation.

An important part of this effort is to establish an infrastructure for research, and to recruit researchers from the range of disciplines whose collaboration is needed. Here are a few ideas about how we might propel this field forward at a sensible and productive pace:

- A one-time investment will not do the job. *An adequate long-term funding commitment to research in elder mistreatment must be made* by relevant federal, state, and private agencies to support research careers and to develop the next generation of investigators in the field.
- *Research on elder mistreatment should be connected to the mainstream research agendas of agencies other than those already in the field.* Most research on elder mistreatment has been supported by the National Institute on Aging, the Administration on Aging, and a few other agencies in DHHS and DOJ. Funding agencies with interests in aging or disabled or vulnerable populations, or in health care delivery (especially long-term care) and health/social policy research, should invest in research in this important and understudied domain affecting older adults.
- *Some aspects of elder mistreatment research require agency collaboration.* Recognizing that elder mistreatment crosses categorical boundaries in both health research and social science research, federal funding agencies (e.g., the National Institute on Aging, the Administration on Developmental Disabilities and Rehabilitation Research, and the National Institute of Justice) should work collaboratively to promote research on the abuse and financial exploitation of vulnerable adults, including older persons as well as younger adults with disabilities.
- *Another promising idea would be to locate aspects of elder mistreatment research relating to caregiving in the domain of quality assurance in longterm care.* According to the prevailing conceptualization of healthcare quality (easily extended to other human services), patient (or client) safety is one of the four components of quality in services (together with effectiveness, patient-centeredness, and timeliness) It is already understood that prevention of mistreatment is a core element of quality assurance in nursing home regulation. However, 80 percent of vulnerable elderly persons live in community settings, not in nursing homes. Protecting elderly people in these settings, including their own homes, represents a parallel challenge for public policy and an overlapping agenda for researchers aiming to understand the phenomenology, etiology, and consequences of mistreatment and the interventions that can reduce it. By viewing elder mistreatment through the prism of quality assurance (safety and security) in long-term care, it is possible to draw together the frameworks and methods of researchers studying the needs of, and services provided to, vulnerable elderly people in various long-term care settings, as well as those used by researchers studying power and conflict in human relationships
- In other fields of research needing a "jumpstart," *one particularly useful device for infrastructure-building has been the creation of multidisciplinary research centers.* This mechanism has been used effectively in the field of injury prevention and treatment, as I learned in chairing an IOM study on this subject. (See IOM, *Reducing the Burden of Injury*, 1999). Although the NRC elder mistreatment panel did not discuss this idea, I personally believe that creation of three

to five Centers for Research on Elder Mistreatment—drawing together researchers and service agencies—could quickly propel the field forward.

Concluding Comment

Although the magnitude of elder mistreatment is unknown, its social importance is self-evident. Abuse and neglect of older individuals breaches a widely embraced moral commitment to protect vulnerable people from harm and to ensure their well-being and security. To carry out this commitment, society cannot rely on good intentions alone. A substantial investment in scientific research along the lines outlined in the NRC panel's report is an essential component of a comprehensive and effective national response.

PREPARED STATEMENT OF CARMEL BITONDO DYER, M.D.

Good morning Chairman Baucus, ranking member Grassley and Members of the Committee.

Thank you for convening this hearing and for allowing me to testify today about protecting seniors from abuse and neglect.

I'm Dr. Carmel Bitondo Dyer, a trained geriatrician. Geriatricians are physicians who are experts in caring for older persons and in gerontology, the study of the aging process itself. After Geriatrics fellowship, I began my academic career at Baylor College of Medicine with two goals in mind:

- 1.) To develop a geriatrics team at the Harris County Hospital District, Houston's public hospital system AND
- 2.) To study surgical operations in older people.

Once we had accomplished the first goal, our team began to see so many abused or neglected patients that we changed our focus entirely from operations in the elderly to elder abuse.

We proceeded to do the first thing that any good medical team would—we looked to the medical literature for guidance. There was precious little.

To learn what we needed to care for the ever-increasing number of mistreated patients we were seeing, we began working closely with the Texas Department of Protective and Regulatory Services—Adult Protective Services Division (APS). We formalized this unique state-medical school collaboration in 1997 and we call ourselves the Texas Elder Abuse and Mistreatment Institute or TEAM. Together we have care for over 500 mistreated elders.

Although through TEAM we have done a lot to characterize elder mistreatment and develop an intervention model—big gaps in the knowledge of this serious public health problem still exist. Health care professionals and others do not have all the information they need to accurately detect, effectively intervene and/or prevent elder abuse.

The members of the TEAM Institute, the American Geriatrics Society and the Texas Geriatrics Society believe that further research, training materials, an increased focus on geriatric research and efforts to increase the numbers of geriatricians in general would achieve that goal.

The Detection of Elder Abuse and Neglect Requires Medical Forensics Research and Practical Screening Tools.

The first step in addressing the public health problem of elder mistreatment is to detect it. An actual case seen in my hospital best describes this all too common occurrence.

An elderly woman was admitted to our hospital with mental confusion, bruises and with a piece of fractured bone sticking out of her leg. The bone was dry—it was obviously not a recent fracture. Her caregiver said that she had fallen; we were suspicious for abuse and called both the police and APS, but actually there are no medical forensics studies to demonstrate the difference between bruises, lacerations and fractures caused by a fall versus a beating. There are no studies to guide physicians and prosecutors about the malnutrition, dehydration and bedsores caused by illness versus caregiver neglect. Since there are no well-studied brief screening tools suitable for use by physicians in busy settings, abuse would probably not have even been suspected in a less obvious case. If the patient succumbed chances were that she would have not gotten an autopsy.

The Elder Justice Proposal provides remedies for these issues since it calls for medical forensics research, the development of screening tools and forensics centers. The suggested cross training of geriatricians and forensics pathologists will permit better chart abstraction and autopsy data.

The Need for Interdisciplinary Intervention Teams

We believe that interdisciplinary teams are an ideal intervention strategy to combat elder abuse and neglect. Again, an actual example best describes the clinical needs of victims of elder abuse and starkly illustrates the importance of policy solutions.

An elderly woman was noted to live in squalor as a result of elder self-neglect. She was plagued by paranoid delusions. She began to start fires in her home to ward off the devil. APS, the Houston Police Department and our geriatric team worked together to extricate her from her house. We diagnosed and treated depression and severe vitamin B12 deficiency. Her delusions were treated and the patient was eventually discharged into a safe community environment. This woman's situation was resolved because of the collaborative efforts of all the involved disciplines.

Elder mistreatment is such a complex phenomenon of social, medical and functional problems that it requires an interdisciplinary approach. In this case, the interdisciplinary approach was critical in properly intervening in the woman's case, developing a plan of care to improve her clinical and psychiatric condition and return her to the community.

There are only a handful of interdisciplinary teams in the country like ours made up of health care professionals, lawyers, law enforcement officers and APS specialists. Members of other disciplines such as psychiatry, ethics, and physical or occupational therapy are added on an ad-hoc basis.

The interdisciplinary team allows for more comprehensive evaluations, the detection of underlying disease and effective legal and clinical interventions. A recent New England Journal of Medicine article demonstrated that the geriatric care delivered by a team versus usual care resulted in a better sense of well-being, the patients were more functional and there were no increased costs incurred. The TEAM Institute model incurs minimal costs since it simply links existing organizations. There is no research detailing the best intervention models based on types of abuse or the setting. The Elder Justice Proposal calls for demonstration projects to study best practices.

The Geriatric Medicine Approach Can Lead to Elder Abuse Prevention

Geriatric medicine promotes wellness and preventive care, with emphasis on care management and coordination that helps patients maintain functional independence in performing daily activities and improves their overall quality of life. Geriatric Medicine is the cornerstone of the Texas Elder Abuse and Mistreatment Institute or TEAM approach.

We were recently asked to see a 90 year-old man who was living in a nursing home. He had become bed bound, incontinent of urine and so delirious that he could only mumble. Physical exam showed a seriously low heart rate. He was on two medications that although appropriate for middle-aged adults, should not be given to elderly people. We stopped the medications and the patient began to improve. We diagnosed depression, treated it, and worked with physical therapists to get the patient walking again. Since the patient could now walk and had a clear mental state, we were able to transfer him from the nursing home back into the community.

Had our geriatric team not been called to see the patient a number of things could have happened. The patient could have developed bedsores, become unable to ever walk, and had an expensive and unnecessary hospitalization (it has been estimated that nearly 20% of Medicare admissions are due to the adverse effects of drugs) or he could have died.

The Geriatrics approach differs from the traditional medical approach since geriatricians often take away medication or therapy rather than add to it. Geriatricians are taught about the pharmacology of aging, they understand normal aging and disease of old age. They are trained to work on interdisciplinary teams and screening for neuropsychiatric disease, functional impairment, and social situations are all routine procedures.

Teams of geriatric professionals can help prevent elder victimization through a more comprehensive approach. Geriatricians and other gerontology professionals address more than the medical care, they strive to improve functional status and social support systems.

There are more people over the age of 65 living in this country today—than there are in the entire population of Canada—but there are presently only 9,000 geriatricians in this country—an estimated 20,000 are needed by the year 2020. In 1998, Medicare funded 98,000 residency slots—only 324 were filled by trainees in geriatrics. As an educator, I can tell you that Medicare cuts have discouraged young doctors from entering the field of geriatrics. Many practicing physicians are declining to see any more Medicare patients due to the financial losses incurred. The Geriatric Care Act (S. 2075 / H.R. 3027) addresses this issue.

The Elder Justice Proposal calls for incentives to increase not only the number of geriatricians, but also of other gerontology professionals. We must increase the number of persons in this specially trained workforce if we want to treat or prevent the physical and/or mental decline that leads to an increased vulnerability and victimization.

Conclusion

If each of you could walk in our shoes for a day and see the vulnerable elders living in squalor, the homes full of roaches, rats, multiple cats and dogs because of self-neglect;

If you could see the look on the face of a senior when he realizes that his offspring made “bad investments” and that he can no longer stay in his home or pay his bills;

If you could see the 96 year-old woman admitted on Christmas Eve with her face swollen and bloody because her niece physically abuse her . . .

Imagine further, knowing these cases exist but that the resources and proper treatment options do not. In Houston we are lucky to have a model program; we need to duplicate this effort around the country.

If you could shadow us for a day, you would see even more clearly the need for an Elder Justice Bill. The proposal is comprehensive, endorses the appropriate studies and brings this country closer to effective detection, intervention and even prevention of elder abuse that we have ever been before.

We look forward to working with you to enact this bill. On behalf of my co-director, Nicolo Festa and the members of the TEAM Institute, I want to thank you for the opportunity to testify today.

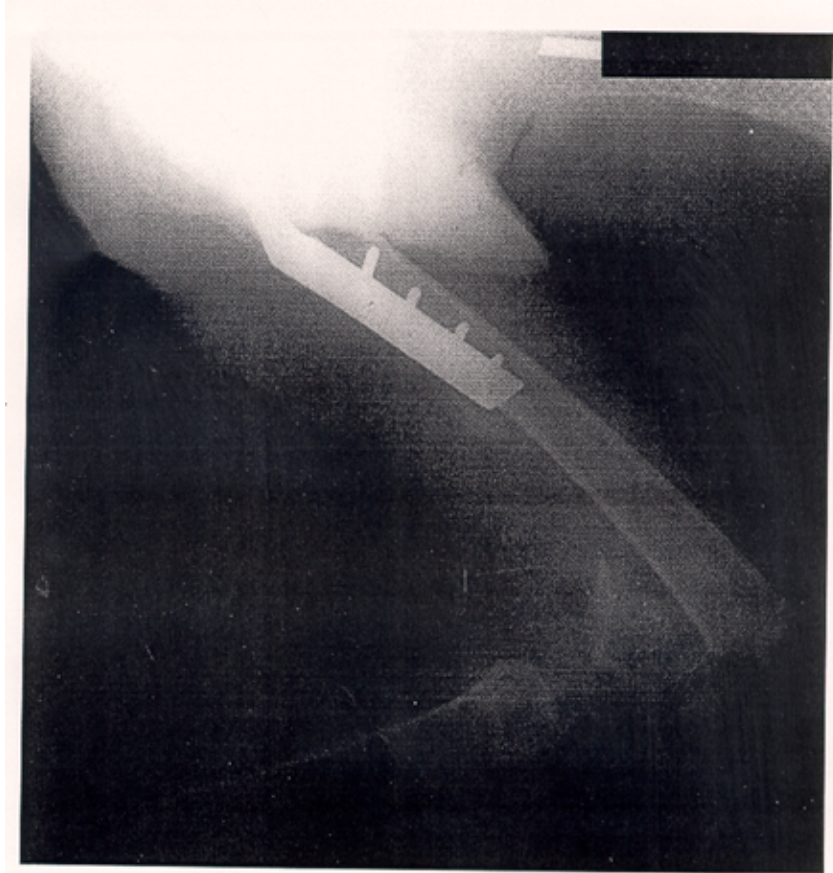


Figure One: Fracture of the distal leg bone above the knee at 4 o'clock
Metal pin from previous hip fracture repair also noted.



Figure two: Home of elder living in squalor

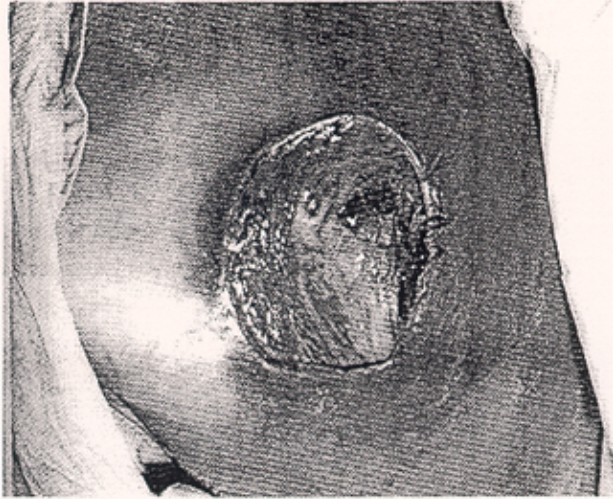


Figure Three: Full-thickness bedsore of the hip

PREPARED STATEMENT OF CATHERINE HAWES, PH.D.

Good morning Chairman Baucus, Senator Grassley and members of the Committee. Thank you for the opportunity to be here and, with other panel members, to address the critical issue of how to prevent abuse and neglect of the elderly. I am grateful to this Committee and the Senate Special Committee on Aging for bringing this topic to the national agenda.

My name is Catherine Hawes. I am a Professor and Director of the Southwest Rural Health Research Center at the School of Rural Public Health, Texas A&M University System Health Science Center.

In my testimony today, I will be focusing on residential long-term care settings, such as nursing homes, assisted living facilities, and residential care homes. This testimony is basically a summary of information provided in greater detail in a paper prepared for the National Academy of Sciences report on elder abuse that was just released.

I intend to make four basic arguments:

1. The elderly in residential long-term care settings are particularly vulnerable to abuse and neglect, and the scant evidence available suggests abuse and neglect are serious and widespread.
2. The most significant preventable causes of abuse and neglect are low staffing levels and inadequate staff training.
3. There are exemplary regulatory policies, facility practices, and training programs that appear to be successful in minimizing abuse and neglect in nursing homes.
4. Little attention has been directed toward these issues in residential care.

1. RESIDENTS AT RISK FOR ABUSE AND NEGLECT

On any given day, approximately 1.6 million people live in approximately 17,000 licensed nursing homes, and an estimated 900,000 to one million persons live in approximately 45,000 residential care facilities, variously known as personal care homes, adult congregate living facilities, domiciliary care homes, homes for the aged, and assisted living facilities.¹

These residents are at particular risk for abuse and neglect. Most suffer from several chronic diseases that lead to limitations in physical functioning and are thus dependent on others for assistance in the most basic daily activities, such as bathing, dressing, eating and using the toilet. Further, two-thirds of nursing home residents and an

¹ Sources: Strahan, 1997; Hawes, Rose & Phillips, 1999; Hawes et al., 1995. While only 2.5 million persons live in a residential long-term care facility on any given day, over their lives many elderly will be at risk during a period of long-term care facility use. Research suggests that more than two-fifths (43%) of all persons who turned 65 in 1990 or later will enter a nursing home at some time before they die, a figure that rises to 60 percent for persons who live to be 85 or older (Kemper & Murtaugh, 1991; Murtaugh, Kemper & Spillman, 1991).

estimated 40 percent of residential care facility residents have significant cognitive impairment, many from diseases such as Alzheimer's.² These resident characteristics, particularly a diagnosis of Alzheimer's or other dementias, or challenging behaviors, have been found to place residents at greater risk of both physical and sexual abuse. Finally, only 12 to 13 percent of the residents are married, and many of the others lack a close family member who lives within an hour of the facility. Thus, these individuals are extremely vulnerable, largely unable to protect themselves, and dependent for their care on the kindness of strangers.

"I saw a nurse hit and yell at the lady across the hall because the nurse told the lady she didn't have all day to wait on her. The lady made some remark. The nurse hit the lady and said 'shut up.'"
Georgia Nursing Home Resident (Atlanta, 2000)

Estimates of Prevalence of Abuse³ and Neglect⁴

There are no reliable data on the prevalence of abuse or neglect in nursing homes or residential long-term care facilities. However, the piecemeal evidence we do have suggests the problem is serious and widespread.

Abuse in Nursing Homes. For decades, nursing homes have been plagued with

"Have I seen abuse? No, not directly. But I've come in and found my mom battered and bruised. I mean, her whole face was bruised and swollen, the backs of her hands and arms were bruised, as if she tried to protect herself."

Daughter of a Texas Resident
(Hawes, Blevins & Shanley, 2000)

reports suggesting widespread and serious maltreatment of residents, including abuse, neglect, and theft of personal property. In addition, a number of case studies, participant-observation studies, interviews with nursing home staff, and

interviews with residents and ombudsmen provided some evidence of abuse. However, there has never been a systematic study of the prevalence of abuse in nursing homes. Much of what we know is based on individual stories or focus group interviews with residents and families. These do not provide reliable estimates of the prevalence of

² Sources: Hing, 1995; Hawes et al., 1995

³ The Administration on Aging (AoA, 1998, 13) in its instructions to long-term care ombudsmen, defines abuse as "the willful infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm, pain, or mental anguish or deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness."

Physical abuse is generally thought to include hitting, slapping, pushing, or striking with objects. In nursing homes, other types of actions have been included, such as improper use of physical or chemical restraints. Physical abuse also typically includes **sexual abuse** or nonconsensual sexual involvement of any kind, from rape to unwanted touching or indecent exposure. In residential LTC settings, it also includes **verbal** or **psychosocial abuse**. This is generally thought of as "intentional infliction of anguish, pain, or distress through verbal or nonverbal acts" and includes threats, harassment, and attempts to humiliate or intimidate the older person (Clarke & Pierson, 1999, 632).

⁴ Neglect is thought of as including "the refusal or failure of a caregiver to fulfill his or her obligations or duties to an older person, including...providing any food, clothing, medicine, shelter, supervision, and medical care and services that a prudent person would deem essential for the well-being of another" (Clarke and Pierson, 1999, 632).

abuse. However, there are a few studies that suggest the problem is both serious and widespread.

Reports from Residents. The Atlanta Long Term Care (LTC) Ombudsman Program (Atlanta, 2000) conducted the most recent study of abuse in nursing homes under a grant funded by the National Ombudsman Resource Center. In this study, ombudsmen interviewed 80 residents in 23 nursing homes in Georgia.⁵ This survey found that 44 percent of the residents reported that they had been abused, while 48 percent reported that they had been treated roughly. For example, one resident noted:

"They throw me like a sack of feed...[and] that leaves marks on my breast."
Georgia Nursing Home Resident (Atlanta, 2000)

In addition, 38 percent of the residents reported that they had seen other residents being abused, and 44 percent said they had seen other residents being treated roughly. For example, as one resident reported:

"My roommate - they throw him in the bed. They handle him any kind of way. He can't take up for himself." Georgia Nursing Home Resident (Atlanta, 2000)

Reports from Facility Staff. A 1987 survey of 577 nursing home staff members from 31 facilities found that more than one-third (36%) had witnessed at least one incident of physical abuse during the preceding 12 months.⁶ Such incidents included excessive use of physical restraints (21%), pushing, shoving, grabbing or pinching a resident

"Oh, yeah. I've seen abuse. Things like rough handling, pinching, pulling too hard on a resident to make them do what you want. Slapping, that too. People get so tired, working mandatory overtime, short-staffed. It's not an excuse, but it makes it so hard for them to respond right."

CNA from South Carolina
Hawes, Blevins & Shanley, 2001

(17%), slapping or hitting (13%), throwing something at a resident (3%), kicking or hitting with a fist or object (2%). Ten percent of the staff members surveyed reported they had committed such acts themselves. A total of 81 percent of the staff reported that they had observed and 40

percent had committed at least one incident of verbal or psychological abuse during the same 12-month time period.

Subsequent surveys of nursing home CNAs have shown similar results. For example, a 1993 survey found that 17 percent of CNAs reported they had pushed, grabbed or

⁵ The ombudsmen initially identified what they considered 10 problem facilities and recruited residents from those nursing homes. The process was subsequently expanded to a total of 23 facilities, based on local ombudsman identification of residents willing to speak with the interviewers about issues of abuse and neglect. The authors reported, "Almost all those approached agreed to be interviewed." Those who declined cited fear of retaliation. Finally, the ombudsmen used CMS Survey protocols to identify "interviewable" residents in long-term care facilities (Atlanta, 2000).

⁶ Source: Pillemer & Moore, 1989. 31 of a potential sample of 77 facilities in one state met the facility size criteria, agreed to participate in the study, and provided complete lists of staff.

shoved a resident. More than half (51%) reported they had yelled at a resident in anger during the last year, while one-quarter (23%) had insulted or sworn at a resident.⁷

In a training project designed to reduce abuse and neglect in nursing homes, 77 CNAs from 31 different nursing facilities were interviewed (MacDonald, 2000). More than half (58%) of the CNAs said they had seen a staff member yell at a resident in anger; 36% had seen staff insult or swear at a resident; 11% had witnessed staff threatening to hit or throw something at a resident (MacDonald, 2000). They also reported witnessing incidents of rough treatment and physical abuse of residents by other staff.

Twenty-five percent of the CNAs witnessed staff isolating a resident beyond what was needed to manage his/her behavior; 21 percent witnessed restraint of a resident beyond what was needed; 11 percent saw a resident being denied food as punishment. CNAs also reported witnessing more explicit instances of abuse. For example, 21 percent saw a resident pushed, grabbed, shoved or pinched in anger; 12 percent witnessed staff slapping a resident; seven percent saw a resident being kicked or hit with a fist; three percent saw staff throw something at a resident; and one percent saw a resident being hit with an object (MacDonald, 2000).

Reports from Ombudsmen. An estimated ten percent of the complaints or about 20,000 complaints received by ombudsmen during FY 98 involved allegations of abuse, gross neglect, or exploitation (AoA, 2000). However, it is well-known that formal complaints provide an underestimate of the actual instances of abuse or neglect, since residents and families are often unwilling to file a formal complaint. Residents and family members report fear of retaliation and a belief that complaining would be futile as common reasons for not reporting incidents (Atlanta LTC Ombudsman, 2000; Haley et al., 1996; Hawes, Blevins & Shanley, 2001).

Analysis of Deficiency Data by the Office of the DHHS Inspector General. The OIG reviewed data from the CMS Online Survey Certification and Reporting System (OSCAR) for one full survey cycle (1997-98) in ten States. The OIG found 4,707 abuse complaints, involving nearly one-third of the facilities certified to participate in the Medicare or Medicaid programs in those states, although most were not substantiated.⁸

U.S. House of Representatives, Committee on Government Reform. Recently, the Minority Staff of the Special Investigations Division of the House Committee on Government Reform issued a report asserting that abuse of residents "is a major problem in U.S. nursing homes (US House, 2001). This report analyzed data from the OSCAR system and the nursing home complaint database covering all surveys and complaint investigations during a two-year period (i.e., January 1999 – January 2000) and included four deficiency codes related to abuse (F223, 224, 225 and 226). The report concluded:

⁷ Pillemer and Hudson, 1993

⁸ The vast majority of complaints (e.g., about 2/3rds) were not substantiated, an issue discussed at greater length in the body of this report.

- During the two-year period, nearly one-third of all certified facilities had been cited for some type of abuse violation that had the potential to cause harm or had actually caused harm to a nursing home resident.
- Ten percent of the nursing homes in the U.S. were cited for abuse violations that caused actual harm to residents or placed them in immediate jeopardy of death or serious injury.
- The percentage of homes with abuse violations has been increasing, probably as a result, at least in part, as a result of more stringent reporting requirements and increased vulnerability among residents.
- The cases involving abuse included physical and sexual abuse as well as verbal abuse involving threats and humiliation.

Reports from the Nurse Aide Registries. One potential source of data on abuse in nursing homes is the Nurse Aide Registries. Under federal law, states are required to establish a nurse aide registry and investigate any complaints of abuse, neglect, and misappropriation of resident property by any nurse aide in a nursing home that participates in the Medicare or Medicaid program.⁹ In a recent study for CMS, researchers surveyed the state agencies administering the Nurse Aide Registries (Hawes, Blevins & Shanley, 2001). Forty of the 51 agencies responded, but those agencies varied widely in their ability to provide data and in the operation of their systems, from intake to investigation and resolution. Most states could not provide a breakdown of the complaints by type. However, among the 14 states that could provide data, most complaints were about abuse. If these states were representative, there were between 17,000 and 34,000 allegations of abuse, neglect or misappropriation in 1999, with an estimated 11,900 to 23,900 formal complaints of abuse. This is probably a severe underestimate of incidents, since residents and families were reluctant to file a formal complaint and since most states did not have extensive outreach practices.

Neglect in Nursing Homes. The daily misery, indignity, preventable decline, and premature death caused by neglect in nursing homes is truly a national tragedy. Moreover, it is probably more widespread than abuse.

Resident and CNA Reports of Neglect. Ninety-five percent of the residents who were interviewed as part of the Atlanta Long-Term Care Ombudsman study reported that they had experienced neglect or witnessed other residents being neglected (Atlanta, 2000). Similarly, in one study, 37 percent of the CNAs reported they had seen neglect of a resident's care needs (MacDonald, 2000). The kinds of things residents and CNAs identified and reported as neglect included residents being left wet or soiled with feces; residents not being turned and positioned, which can lead to pressure ulcers; staff shutting off call lights without helping the resident seeking assistance; residents not receiving enough help at mealtimes; staff failing to perform prescribed range of motion

⁹ Sections 1819 (e) (2) (A) or 1919 (e) (2) (A) of the Social Security Act.

exercises to prevent residents from developing contractures; and staff failure to respond to residents' requests or need for something to drink.

Ombudsman Reports. The 1998 compilation of complaints received by the State Long-Term Care Ombudsman program reported that 27 percent of the complaints ombudsmen received had to do with the types of inadequate care that are typically thought of as neglect (e.g., improper handling, accidents, neglected personal hygiene, and unheeded requests for assistance) (Administration on Aging [AOA], 2000).

Deficiency Citations and Research. It is sometimes difficult to distinguish neglect from what might be termed poor quality of care in nursing homes. However, some areas can be classified as neglect. For example, the OIG (1999) found an increase in the frequency with which deficiencies were cited for neglect and poor quality of care. In recent years, deficiency citations increased in 13 of 25 quality of care areas, including such problems as improper care for pressure ulcers, inadequate care to maximize physical functioning in activities of daily living (ADLs), and lack of adequate supervision to prevent accidents. Other research studies have raised similar concerns. For example, in California facilities, the GAO found unacceptable care, including lack of appropriate attention to dramatic, unplanned weight loss, failure to properly treat pressure ulcers, and failure to manage pain. In another study, a review of records and care practices in 14 facilities in 11 States documented inadequate treatment in one-third of the facilities in the areas of nutritional support, pressure ulcer care, prevention of contractures, pain management, and personal assistance (Johnson & Kramer, 1998). Other studies and hearings by the U.S. Senate Special Committee on Aging have documented similar problems.¹⁰ For example, one study found that a major predictor of unintended weight loss and low body-mass index among nursing home residents was that the residents needed help with eating. Similarly, Kayser-Jones and Schell (1997) found that many facilities were so understaffed that even though trays were taken into rooms, residents who needed help were not fed.

Abuse and Neglect in Residential Care Facilities. There are no federal standards that govern residential care facilities, which are known by more than 30 different names across the country.¹¹ As a result, there are no national databases containing information on deficiencies, no uniform mechanism for reporting allegations of abuse or neglect, and no uniform role for ombudsmen in residential care and assisted living. Thus, it is even more difficult than with nursing homes to generate anything approaching reliable estimates of the prevalence or nature of abuse or neglect.

Staff Reports. In one ten-state study of board and care homes, funded by the US Department of Health and Human Services, 15 percent of a random sample of staff reported witnessing other staff engage in verbal abuse (e.g., threats, cursing, yelling) or

¹⁰ Bernabei et al., 1998; Blaum, Fries & Fiatarone, 1995; Fries et al., 1997; Hawes et al., 1997; Hawes, 1997; Kayser-Jones, 1997; Phillips et al., 1997.

¹¹ Those names include personal care homes, adult care homes, adult congregate living facilities, residential care homes for the elderly, shelter care homes, homes for the aged, domiciliary care homes, board and care homes, and assisted living facilities.

forms of punishment, such as withholding food, excessive use of physical restraints, or isolating difficult residents (Hawes et al., 1995b).

Ombudsman Reports. The ombudsman presence in residential care facilities is much more limited than in nursing homes (Phillips et al. 1994). For example, ombudsmen handled 121,686 cases in FY '98, but only 17 percent were about residents in residential care facilities. However, of the cases handled by ombudsmen in residential care facilities and reported in NORS, physical abuse was one of the five most common complaints registered with the ombudsman program (AoA 2000).

Neglect. Because there is no federal reporting system and state systems are highly variable, it is impossible to generate useful estimates of neglect in residential care. The only available evidence is from scattered studies of care in these facilities. As a result, it is difficult to separate estimates of neglect from reports of quality problems. These problems included medication errors, high rates of psychotropic drug use, poor management of behavioral symptoms among residents with Alzheimer's disease or other dementias, including inappropriate use of physical restraints, and poorer functional outcomes for RCF residents compared to nursing home residents, which suggested neglect of care needs.¹² In addition one study asked a national probability sample of assisted living residents who could respond about whether they had unmet care needs (Hawes, Phillips and Rose, 2000). A few residents reported needing more help with dressing (12%) and locomotion (walking or using a wheelchair) (12%); however, slightly more than one-quarter (26%) of residents who were receiving some assistance with toilet use reported they had unmet needs for assistance in toileting.

Limitations of the Estimates. Several factors make it difficult to rely on these estimates. First, there are multiple reporting agencies, and they use different definitions of abuse and neglect. Second, there is widespread underreporting, particularly of abuse, among residents and families, regulatory agencies, ombudsmen, and health professionals.

2. PREVENTING ABUSE AND NEGLECT: THE ROLE OF STAFFING AND STAFF TRAINING

Although there has been only minimal research on the causes of abuse and neglect in residential long-term care settings, there is remarkable consensus across diverse studies and surveys of stakeholders. Three factors are generally viewed as causing or significantly contributing to abuse and neglect in nursing homes. They are:

- Staffing shortages that cause neglect and create stressful working conditions in which abuse is more likely to occur.
- Staff burn-out, often a product of staffing shortages, mandatory overtime, and the fact that many staff must work two jobs to survive financially; and

¹² Baldwin, 1992; Bates, 1997; Spore, Mor, Hiris, Larrat, & Hawes, 1995; Spore, Mor, Larrat, Hiris & Hawes, 1996; Spore, Mor, Larrat, Hiris & Hawes, 1997a and 1997b; Stark, Kane, Kane & Finch, 1995; U.S., GAO, 1992.

- Poor staff training, particularly about the impact of dementia and how to interpret and manage challenging behaviors among residents.

I should note that if I were going to do only one thing to reduce abuse and neglect, it would be to increase staffing in the nation's nursing homes.

As part of several studies, including two funded by CMS as part of their initiatives to improve nursing home quality, my colleagues and I interviewed state survey agency directors, the managers of the state nurse aide registries, residents, family members, ombudsmen, and CNAs working in nursing homes. There was universal agreement that inadequate staffing was the major preventable cause of abuse and neglect.

"A male nurse grabbed me, slung me on the floor and threw me into the bed. He was in a bad mood because we were short-staffed, and he had to work two floors."
 Georgia Nursing Home Resident (Atlanta, 2000)

- 85 percent of the nurse aide registry directors argued that staffing shortages, too few staff, and poor staff to resident ratios were the main cause of abuse and neglect.
- 71 percent of these managers asserted that staffing shortages & difficulty hiring qualified staff were major causes of abuse and neglect.
- 78 percent of the aide registry directors argued that low wages paid to CNAs made it difficult or impossible to hire and retain good staff, thus exacerbating staffing shortages and turnover.
- 92 percent of 43 state LTC ombudsmen identified staffing shortages as the major cause of neglect and poor quality in nursing homes.

"The best [thing about the job of CNA] is doing something for residents. You can see they appreciate it. The worst is working short [staffed] and you can't provide quality of care."
 CNA from Illinois

Several other studies have reached the same conclusion. For example, in 10 States surveyed by the OIG (1999), survey and certification staff, State and local ombudsmen, and directors of State Units on Aging identified inadequate staffing levels as one of the

"The worst [thing about being a CNA] is the sense of powerlessness. To see residents suffering, but you've got 15 on your hands, and can't get to a resident. You tell charge nurse what's going on; she just looks at you like you're a fool, says nothing she can do. Yeah, it's that hopelessness of not being able to make a difference."
 CNA from Florida
 (Hawes, Blevins & Shanley, 2001)

major problems in nursing homes. The OIG report concluded that the type of deficiencies commonly cited "suggest that nursing home staffing levels are inadequate" (OIG, 1999). More recently, the CMS staffing study concluded that most facilities were understaffed, with a significant number dangerously

understaffed.

In focus group interviews, CNAs explained why staffing shortages caused or contributed to abuse and neglect. First, the CNAs noted that when they were working short-staffed, there was no way to meet all of the residents' needs. There was strong agreement among the CNAs that the first things to be neglected were range of motion exercises and other types of restorative nursing care, keeping residents hydrated, and giving residents enough time and assistance with eating. Each of these has dire long-term consequences for residents.

The CNAs made it clear that they found such a situation profoundly demoralizing, particularly if it persisted over time. They also noted that this inability to meet resident needs was a major cause of staff turnover among good staff, since they could not tolerate the guilt they felt when neglecting residents.

CNAs also described the way in which the stress associated with short-staffing made abuse more likely to occur. Sometimes, short-staffing meant that a CNA would be asked or "required" to work all or part of a second shift, leading to exhaustion and frayed tempers. Other times, short-staffing meant that a CNA might have more than 20 residents to care for on the day shift, the shift that is busiest in terms of the care to be provided. During night shifts, a single CNA might have 30 or more residents to care for, which might involve waking residents as early as 4:30 am to get them dressed and in the breakfast room. As several state survey agency staff noted, such situations make abuse and neglect nearly inevitable.

"Facilities place CNAs in situations where abuse is bound to happen."
Aide Registry Director
(Hawes, Blevins & Shanley, 2001)

Finally, it became clear that inadequate training of staff was a major factor in abuse. The current federal requirement for CNA training is only 75 hours. This is inadequate in the view of key stakeholders, including state agency staff, LTC ombudsmen, and CNAs.

- 61 percent of the aide registry directors argued that poor training was a significant factor causing abuse;
- 58 percent of the ombudsmen identified inadequate training of CNAs as a major obstacle to quality of care in nursing homes.

CNAs listed inadequate training as one of the top three problems they encountered. Moreover, this became obvious in their discussions of how to handle residents who

"We hear, if they have Alzheimer's, they don't know what they're doing. But I mean it, if our husbands hit us like some residents do, he would be in jail. Somebody sneaks up and hits you or pinches. You jump; you might hit someone. It's automatic."
CNA from Oregon (Hawes, Blevins & Shanley, 2001)

exhibited challenging behaviors, such as resisting nursing care or ADL assistance or physically aggressive behaviors. The current "best practice" model for managing behaviors involves viewing behaviors as

a mode of communication for residents with dementia who have difficulty making

themselves understood through verbal communication. Moreover, behaviors should be understood in the context of the neurological changes associated with dementia. In general, this leads to a non-confrontational and accommodating approach to dealing with resident behaviors.

Despite this, many staff viewed resident behaviors as purposive, intentional. Thus, a resident who resisted care or struck out at staff was often viewed as intending to harm the staff or as deliberately "being difficult." Given these views, some staff believed that treating such residents "roughly" was acceptable, particularly if the staff member had been "startled" by the resident or if, in their view, the resident might hurt the staff member. Addressing this situation is clearly complex and must involve vastly improved basic training and continuing education for CNAs. It may also involve steps designed to improve management and oversight in nursing homes.

"Individuals come in who are not adequately trained, and then they have a heavy workload, [are] frustrated, under-oriented, under-supervised, under-paid, under-trained."
Aide Registry Director (Hawes, Blevins & Shanley, 2001)

3. WHAT CAN BE DONE: STATE AND FACILITY-BASED INITIATIVES

It is important to note that there are a number of state policies and facility initiatives that appear to be quite promising in terms of preventing abuse and neglect in nursing homes. Some of these may also apply to residential care facilities.

"As a society, we need to respect our disabled elderly enough to want to care for them and, in addition, to care enough to foster caring in the staff, for example, with career ladders, proper pay, decent work loads."
Aide Registry Director

First, some states have instituted a number of policies and practices designed to make the complaint system more responsive to resident and families and to address cases of abuse and neglect more effectively. For example:

- Some states have extensive outreach programs to inform the public about what abuse and neglect are and how to report them.
- A few states have toll-free abuse hotlines that are manned 24-hours a day, 7 days a week.
- One state routinely communicates all complaints about abuse and neglect – as soon as they are received – to the ombudsman, the Medicaid Fraud Unit, and, as appropriate, to local law enforcement, inviting them to participate in the on-site investigation.
- A few states have developed more sophisticated investigative protocols for abuse and neglect complaints, particularly for how to handle incidents in which the alleged perpetrator of abuse was not identified by the facility or in which there was not an "independent" third-party witness.

- A few states analyze data on the types of complaints they receive about abuse and neglect and develop training programs for providers around the most common problems, with a particular focus on preventing abuse.
- One state has developed an investigative protocol that requires an examination of the care received by residents who did not complain but who have similar conditions to those of the resident whose care generated a complaint of abuse or neglect.

Many long-term care facilities have also developed and implemented policies and practices that seem promising in terms of preventing abuse and neglect. These are important practices to examine in terms of their effectiveness and exportability.

- Many facilities provide training that goes well beyond the required 75 hours for CNAs. For example, one facility in the greater Cleveland, Ohio area provides three additional weeks of training for CNAs at the start of their employment, as well as substantial continuing education.
- Many facilities, particularly non-profits and some Alzheimer's Special Care Units, have staffing ratios of one CNA for every six to eight residents and have more staffing and supervision by registered nurses than is found in the average facility.
- Some facilities have been active with ombudsmen and consumer advocates in sponsoring or participating in special training programs designed to prevent abuse. Examples include facilities in Pennsylvania that have worked with the advocates at CARIE, and facilities working with ombudsman programs in Georgia and Massachusetts.
- Many facilities are participating in quality improvement initiatives that may well have positive effects in terms of preventing abuse or neglect. The Wellspring Initiative, started in Wisconsin and spread to Texas and Illinois, is one example. It involves both empowerment of CNAs and enhanced clinical training for all staff from a Geriatric Nurse Practitioner as well as peer facilities. An early evaluation found reduced staff turnover and reduced deficiencies among the participating facilities. Other facilities, such as the Pioneers, those participating in the Eden Alternative, and innovators such as Kendall-Crossland in Pennsylvania and Benedictine in Oregon may also shed light on how to prevent abuse and neglect.

4. PAUCITY OF INFORMATION ABOUT RESIDENTIAL CARE

Unfortunately, we do not have the same kind of information about residential long-term care outside nursing homes. While information on the nature and extent of abuse and on ways to prevent abuse and neglect in nursing homes is scant, similar knowledge is non-existent with respect to board and care homes. This is true despite the fact that between 900,000 to 1 million people live in these settings. Moreover, they are a much more complex mix of persons in terms of their care needs. People who live in these facilities include the frail elderly, persons with significant cognitive impairment, including

Alzheimer's disease, persons with developmental disabilities, and persons with persistent and severe mental illness. In addition, considerable tax dollars are spent on these facilities, including payments from SSI and Medicaid. Further, significant Medicare dollars are spent on the fairly high rate of hospital, emergency room, and home health use by these residents.

Despite these factors, we know next to nothing about the prevalence of abuse and neglect, what types of regulatory systems states have in place to address abuse and neglect if they arise, and whether there are institutional or environmental factors that are associated with different levels of abuse or neglect in board and care homes and assisted living facilities. The last federally-funded study of regulation took place nearly a decade ago, except for summaries of legislation aimed at assisted living. Analyses of different regulatory models, staffing models, and quality improvement initiatives are largely absent. Indeed, we do not even know whether abuse and neglect are significant problems in these settings, only that the residents are particularly vulnerable.

PREPARED STATEMENT OF JOANNE OTTO, M.S.W.

Mr. Chairman and Members of the Committee:

Thank you for inviting me to speak at this hearing. My name is Joanne Otto. I am the Executive Director of the National Association of Adult Protective Services Administrators. Our organization represents Adult Protective Services professionals in every state, the District of Columbia and Guam. These are the professionals who are the first responders to more than 500,000 reports of abuse, exploitation and neglect of elderly and vulnerable adults every year.

Adult Protective Services staff takes these reports and makes face-to-face contacts with victims in order to evaluate the types and severity of abuse, the physical and mental status of the victims, as well as the likelihood of future abuse.

These workers also collaborate with a multitude of other professionals including law enforcement; prosecutors; physicians; nurses; emergency medical technicians; hospital staff; home health agencies; financial institutions; senior centers and mental health care providers. The purpose of these collaborative efforts is to put in place the most appropriate and comprehensive assortment of services to assure the victim's safety and well-being.

Abuse of elderly and vulnerable adults occurs to victims in every state; in cities and rural areas; to the rich, the poor and those in between; to people of all racial and cultural backgrounds. It happens in our communities, and to our family members.

Recently, not far from where I live, a 51 year old man shot his parents as they were frantically calling for help. He killed them because they would not give him the deed to their farm.

My own mother-in-law had been a nursing home administrator for many years. When she finally lived in a nursing home as a patient at the age of 87, her favorite ring was pried from her fingers while she slept. It was written off as "lost" and no report was filed with the police.

Abuse includes the elderly man who was beaten and set on fire by his son; the 96 year old blind woman who was raped by her paid caregiver; the 72 year old resident of a board and care home who weighed 60 pounds and had 30 bedsores, some of them to the bone.

Neglect, includes the man who subsisted on a diet of canned cake frosting and the woman living in a trash filled house with 47 cats. Each case is unique, and each one requires time, expertise and a wide variety of responses and resources.

Because there have been no Federal laws relating to the delivery of adult protective services, each state has passed separate legislation with different definitions, eligibility requirements and administrative structures. Most states provide protection services to all impaired adults age 18 and older; some define "elderly" as 60 and older while others use 65 and older. Adult protective services may be administered by aging services, social services or private contractors. Most telephone directories do not have a listing for "elder abuse" or "adult protective services." All of these variables make it difficult to know where to report the abuse or where to get help.

Funding for adult protective services also varies from state to state. It usually is made up of a mixture of funds including the Social Services Block Grant (16%); Older American Act (1%); local money (3%) and other funds such as medicaid (19%).

Colorado, Michigan, Mississippi and the District of Columbia rely exclusively on the Social Services Block Grant which has been severely reduced in recent years. Louisiana and Hawaii are totally state funded, with state general funds making up 61% of all the states monies for Adult Protective Services. The recent down-turn in the economy has resulted in freezes and reductions of adult protective service staff, cutbacks on travel and training, as well as the adoption of waiting lists for abuse investigations. These reductions put victims in increased danger of additional and more serious abuse.

In addition to staff shortages, states have identified the following gaps in services for abused elderly and vulnerable adults:

- Lack of training for Adult Protection, law enforcement and prosecutors
- Lack of emergency temporary housing and in-home care for abuse victims
- Lack of coordination between federal, state and local agencies
- Lack of reliable national and state data
- Lack of public awareness about abuse of elderly and vulnerable adults
- Lack of protective services for disabled, people under the age of 60
- Lack of responsible guardians to act on behalf of victims who lack the capacity to manage their own affairs

What we need now to combat elder and vulnerable and adult abuse:

- Specific federal funds for adult protective services staff
- An office in a federal agency to provide a national home for adult protective services
- Funds for training adult protective services, law enforcement, prosecutors, and other relevant professionals
- Uniform automated data collection at the state and national level
- A national public awareness campaign
- Better coordination and cooperation among federal, state and local agencies
- Improved training and best practice models
- Funding for the development of emerging shelters and in-house support services

With half a million abuse reports a year, and an additional two to three million incidents which occur but never are reported, the abuse of elderly and vulnerable adults has reached epidemic proportions.

Hearings such as this one, and legislation initiatives such as the proposed Elder Justice Act of 2002, are helping to finally move things forward. I have often said that I did not think I would see the enactment of this type of federal legislation in my lifetime. For the sake of all if us who are growing older, I hope I am wrong.

ATTACHMENTS TO JOANNE OTTO'S TESTIMONY

Attachment A: Adult Protection Case Examples (p-1)

Attachment B: NAAPSA STATES' APS REPORTS AND EXPENDITURES 2001 (p-2)

Attachment C: Adult Protective Services NAAPSA (pp 3-4)

Attachment D: NAAPSA Ethical Principles and Best practices Guidelines (p 5)

ATTACHMENT A

ADULT PROTECTION CASE EXAMPLES

Lucy, an 83-year-old Iowa woman moved in with her son on the family farm following surgery. Eighteen months later, the woman's health had deteriorated to the point where her physician was recommending that she be placed in a health care facility. The woman's son had obtained both a voluntary guardianship and power of attorney for his mother, and had received in excess of \$150,000 dollars worth of the woman's resources. This amount included cash payments and the cancellation of a \$40,000 loan he owed his mother. Adult Protective Services substantiated a dependent adult abuse report on the son, finding the son had used undue influence to get his mother, who was confused at the time, to sign the voluntary guardianship papers and power-of-attorney. A civil suit against the son restored the woman's resources.

Bill is a 33 year old Native American from Utah. He suffered traumatic brain injury after being severely beaten and left to die by his attackers. Because of his brain injury he is unable to take care of basic activities of daily living or ensure his own personal safety, so he cannot be left alone. His family cares for him during the evening and weekends, but are not available during weekdays, as they work. Adult Protective Services arranged to have Adult Day Care services, funded by SSBG, to provide for him during the day. Staff report that since his placement in Day Care he has "just blossomed."

Maria, a 73 year-old Texas woman with multiple health problems allowed her reformed alcoholic 50 year-old son to move in with her. He agreed to provide care in exchange for room, board and a small stipend from the Department of Human Services. During a time when he had "fallen off the wagon", which he did occasionally, he left his mother for an extended length of time, without making arrangements for someone else to provide care for her. She suffered a stroke and a neighbor found her lying unconscious on the floor. Adult Protective Services arranged to have another son take responsibility for the mother's care by becoming her guardian and moving the mother to a health care facility.

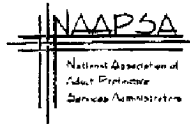
James, age 42, is a paraplegic due to an automobile accident. He lived with his wife Sandra, who refused to take him to the physician or refill his medications, even though his bedsores were getting worse. Sandra initially refused to allow Adult Protective Services to see her husband. Law enforcement was called to help the APS worker gain access to James. James was taken to the hospital, at which point his wife relinquished all duties as his caregiver. He was placed in a community-based alternative to nursing home care where he could receive 24 hour medical attention.

Mrs. C., age 70, was bedfast, catheterized and on continuous oxygen. Her husband, who was solely responsible for her care, became suicidal and threatened to kill his wife and himself. He was hospitalized under the mental health statute. Adult Protective services used Emergency Client Services funds to provide a nurse for Mrs. C until her husband was discharged, and for 45 days after his discharge, giving him time to recover from the exhaustion that had prompted his murder/suicide threat.

ATTACHMENT B

NAAPSA STATES' APS REPORTS AND EXPENDITURES 2001							
	APS RPT	SSBG	GAA	STATE	LOCAL	OTHER	TOTAL
AK	651		25300	2922400		105700	3053400
AR	3347		47000	853341		284446	1189787
AL	4098			12173514		2327950	13199652
AZ	8312	1,400,000		3,000,000			
CA	82226			67458000	10936173	20352999	98746173
CO	5019	1900000					1900000
DE	689		46000	21000			67000
DC	1162	1794304					1794304
FL	39516	4293575		16416788		4415463	25125826
GA	12041			42374504		14892241	57266745
HI	511			116581			116581
ID	2983		55000	865000			920000
IL	7360		212269	7375800			7588069
KS	5336	164062		215212			379274
KY	28230	6063200		16836400		9168900	32068500
LA 1	1170			1002135			1002135
LA 2	3591			2002961			2002961
MA	4605			1717026		276863	1993889
ME	12151		23660	3500000		487516	4011176
MD	4750	2196179		1762632			1543960
MI	9369	600000					600000
MS	1412	190922					190922
NC	9142	5099034		1788718	434693		7322445
OH	11352		2818210			120227	2928437
OK	14046	5800000		1365503		169491	7334994
OR 1	2705			1280000	250000	1170000	2700000
OR 2	10429		50000				50000
PA	11451		160400	5484852	114723	33972	5793947
RI	2102	349079	142526				491605
TN	5700	3199800		741000		1818600	5759500
TX	66052	21923434		7350075	45000	7071866	36390175
UT	2165	275000		2902000			3177000
VA	10942			800000	200000		1000000
VT	1528			425098			425098
WY	523			106578			106478
32	386666	55248589	3580365	202857118	11980589	62696034	328240033
		16.80%	1.10%	61.80%	3.70%	19.10%	
AVERAGE EXPENDITURE PER STATE FOR 33 STATES REPORTING							\$9,946,668
AVERAGE EXPENDITURE PER APS REPORT							\$849.00

ATTACHMENT C



ADULT PROTECTIVE SERVICES
 NAAPSA
 NATIONAL ASSOCIATION OF ADULT PROTECTIVE SERVICES

In the next twenty-five years, the population of Americans over the age of 60 will almost double. At this moment, many vulnerable older persons and persons with disabilities are being subjected to abuse, neglect and financial exploitation, usually by their own family members or other caregivers. They are hit, punched, tied to their beds, made to lie in their own waste, not fed or given adequate water, and made the victims of every kind of financial fraud, theft and exploitation. The growth of the vulnerable adult population will greatly increase the number of potential victims, and this pattern of abuse, neglect and exploitation of vulnerable adults is expected to continue.

Adult Protective Services (APS) are life saving services provided to vulnerable adults age eighteen and over, adults who have physical or mental disabilities which prevent them from protecting themselves from abuse, exploitation and neglect by themselves or others. Two thirds of persons served by APS programs are elderly; many of them suffer from Alzheimer's or other forms of dementia. The types of mistreatment include physical, sexual and emotional abuse; neglect of basic care needs either by others or by the vulnerable adults themselves; and financial exploitation of every variety. In the majority of states, many professionals are mandated to report suspected abuse of vulnerable adults to the local APS program. Estimates are that only one in fourteen cases of elder abuse is ever reported, meaning that the majority of victims are suffering, often for years, because no one knows or cares to report the problem.

Because there is no federal statute or funding directly related to APS, these programs are state administered, each state having developed its own system. In about half the states, the APS program is operated through the state unit on aging. In other states, it is part of the human services agency, often having evolved out of child protective services. Definitions, classifications of protected persons and services provided differ from state to state. As just one example, in some states APS conducts investigations of abuse and neglect in long term care facilities, while in others, APS is only involved in abuse which occurs in community settings.

APS workers must make critical and life changing decisions in very complex situations. Many cases involve life and death medical problems, legal issues including questions of capacity, undue influence, guardianship, powers of attorney and the rights of the client to self determination vs. the duty of the state to protect its helpless citizens. Other situations involve complicated financial matters, mental health concerns including all forms of mental illness; problems of substance abuse, domestic violence and dysfunctional family situations.

The *National Association of Adult Protective Services Administrators (NAAPSA)* was formed in 1989 in order to provide state APS program administrators and staff with a forum for sharing information, solving problems, and improving the quality of services for vulnerable adults. NAAPSA holds an annual conference at which the majority of states are represented. NAAPSA

also has a twice-yearly newsletter; an expert assistance guide; and a number of publications. The organization is in the process of developing national best practice standards. Members regularly provide publications, ideas, and copies of state statutes and materials for new projects to one another.

NAAPSA is one of six partners in the *National Center on Elder Abuse (NCEA)* funded by the U. S. Administration on Aging. Other partners include the *National Association of State Units on Aging (NASUA, the lead agency)*; the *National Committee for the Prevention of Elder Abuse (NCPEA, which publishes the Journal of Elder Abuse and Neglect)*; the *American Bar Association's Commission on the Legal Problems of the Elderly*; the *Goldman Institute on Aging*; and the *University of Delaware's Clearinghouse on Abuse and Neglect of the Elderly (CANE)*. The NCEA publishes a monthly newsletter; administers a national elder abuse listserv; has completed a survey of all states on the number and types of reports made to APS throughout the country; operates the Clearinghouse; publishes periodic reports of areas of interest in elder abuse; and conducts one time projects such as training "sentinels" to recognize and report elder abuse.

To address the complex nature of many APS cases, APS programs have developed or participated in the development of a number of multi-disciplinary approaches including:

- **Local Multi-Disciplinary Teams (M Teams or MD Teams)** composed of a variety of professionals from legal, medical, guardianship, criminal justice, mental health, substance abuse and other social service fields. Members are usually volunteers or staff from government agencies who agree to strict confidentiality requirements and willingly share their professional expertise.
- **Financial Abuse Specialist Teams (FAST)** These are broadbased county wide multi-disciplinary teams which focus on financial crimes, with an emphasis on prosecuting persons who criminally exploit vulnerable adults.
- **Medical Teams** These teams are becoming increasingly common, and involve gerontologists and other medical specialists, along with APS and other community professionals who work together to address the unmet medical needs of vulnerable adults. In most cases physicians go on visits to clients in their own homes. In some models, medical residents are assigned to an APS unit as part of their medical education.
- **Triads/SALT Councils** Triad is a national effort to bring together law enforcement and seniors. Many local Triads/SALT (Seniors and Law Together) Councils sponsor elder abuse prevention activities, training, crime prevention, public education and other efforts to reduce the victimization of elder people in their communities. Some sponsor annual conferences, training for "Elderly Service Officers" (law enforcement officers who specialize in service older persons) and special projects such as bank reporting initiatives to recognize, report and prevent financial exploitation of vulnerable adults.
- **Elder Abuse Coalitions** Many APS programs around the county have led the development of coalitions focused on raising public awareness of vulnerable adult abuse, supporting local resources, training professionals, and sponsoring conferences and other public awareness activities. Some coalitions are affiliates of the National Committee for the Prevention of Elder Abuse, and some receive grants from the National Center on Elder Abuse to train community members to recognize and report elder abuse.
- **Statewide Elder Abuse/Vulnerable adult Abuse Task Forces** In some states the Governor appoints a statewide task force on elder abuse to examine the state's response and to make recommendations for improvement. Some states also have domestic or family violence councils which include a committee on elder abuse.

NAAPSA
Adult Protective Services
Ethical Principles and Best Practice Guidelines
Dedicated to the memory of Rosalie Wolf

Adult Protective Services are those services provided to older people and people with disabilities who are, or are in danger of being mistreated or neglected, are unable to protect themselves, and have no one to assist them.

Interventions provided by Adult Protective Services include, but are not limited to, receiving reports of adult abuse, exploitation or neglect, investigating these reports, case planning, monitoring and evaluation. In addition to casework services, Adult Protection may provide or arrange for the provision of medical, social, economic, legal, housing, law enforcement or other protective, emergency or supportive services.

***Guiding Value:** Every action taken by Adult Protective Services must balance the duty to protect the safety of the vulnerable adult with the adult's right to self-determination.*

***Secondary Value:** Older people and people with disabilities who are victims of abuse, exploitation or neglect should be treated with honesty, caring and respect.*

Principles

- Adults have the right to be safe.
- Adults retain all their civil and constitutional rights unless some of these rights have been restricted by court action.
- Adults have the right to make decisions that do not conform with societal norms as long as these decisions do not harm others.
- Adults are presumed to have decision-making capacity unless a court adjudicates otherwise.
- Adults have the right to accept or refuse services.

Practice Guidelines

- Recognize that the interests of the adult are the first concern of any intervention.
- Avoid imposing personal values on others.
- Seek informed consent from the adult before providing services.
- Respect the adult's right to keep personal information confidential.
- Recognize individual differences such as cultural, historical and personal values.
- Honor the right of adults to receive information about their choices and options in a form or manner that they can understand.
- To the best of your ability, involve the adult as much as possible in developing the service plan.
- Focus on case planning that maximizes the vulnerable adult's independence and choice to the extent possible based on the adult's capacity.
- Use the least restrictive services first—community based services rather than institutionally based services whenever possible.
- Use family and informal support systems first as long as this is in the best interest of the adult.
- Maintain clear and appropriate professional boundaries.
- In the absence of an adult's expressed wishes, support casework actions that are in the adult's best interest.
- Use substituted judgment in case planning when historical knowledge of the adult's values is available.
- Do no harm. Inadequate or inappropriate intervention may be worse than no intervention.

PREPARED STATEMENT OF HON. GORDON SMITH

Thank you, Mr. Chairman. I would like to thank you and the Finance Committee for holding this important hearing today and for inviting those of us on the Aging Committee who also care about this critical issue.

I would also like to thank the expert witnesses who have taken the time out of their busy lives to help us understand the problem of elder abuse and neglect.

I think it is important to note that this is one in a long series of hearings related to elder abuse. For nearly a quarter of a century, Congress has held hearings related to the vulnerability of older Americans, but there has been no effective federal response to what, by all accounts, is a large and growing problem in our country.

Although little reliable research on this subject exists, we know that anywhere from 500,000 to 5 million older Americans suffer from abuse each year.

And no matter how many instances we know about, many more go unreported, as we learned in a recent GAO study of nursing homes.

Clearly, older Americans are some of our most vulnerable citizens, if only because we don't seem to be paying enough attention to their wellbeing.

I, for one, am particularly concerned by the fact that much abuse takes place in institutional settings, like nursing homes, where our friends and loved ones are supposed to feel safe, healthy, and secure.

The institutions that are entrusted with the care of our most vulnerable Americans must be of the highest quality.

We may all need the services of a nursing home one day, and when I push that red button, I want to feel confident that a well-trained and compassionate caregiver will come to my bedside.

And not only do I want to know that there will be highly-qualified caregivers in our long term care settings, but I want to be sure that there will be enough of them to meet the growing needs of an aging population.

Some of the problems in institutional settings like these might be solved by concentrating on recruiting, training, and retaining good health care professionals and by dedicating enough resources through Medicare and Medicaid to run first rate facilities. I have legislation with Senator Torricelli and others to try to do those things.

But the problems of elder abuse and neglect in a wide range of settings, including in the home, must be addressed on a larger scale, and will require coordinated action on the part of many Americans, including health care professionals, social service professionals, and law enforcement officials.

I understand that Senator Breaux is working on a bill to try to tackle the problem of elder abuse, and I look forward to working with him, and with the rest of my colleagues, on legislation that may—and *should*—result from today's hearing.

Thank you again for inviting me here today.

PREPARED STATEMENT OF RANDOLPH W. THOMAS

Mr. Chairman, members of the committee, my name is Randy Thomas. I am a law enforcement officer and instructor at the South Carolina Department of Public Safety, Criminal Justice Academy. I would like to thank the committee for holding this hearing and giving me the opportunity to provide input on this important issue. I supervise the instructional unit responsible for training in the areas of child abuse, sexual assaults, domestic violence and behavioral science. However my primary instructional interest has been in the area of elder abuse. I was one of a group of individuals that treated South Carolina's Omnibus Adult Protection Act and I currently represent my agency on the Adult Protection Coordinating Council as well as assist agencies in elder abuse investigations. My experience is not limited to South Carolina because I also present training in elder abuse investigations throughout the United States. My experience in teaching and investigating elder abuse, complimented by my knowledge of what works in child abuse and domestic violence, gives me insight into the problems that law enforcement and other agencies face in addressing this devastating problem.

My experience as a detective has shown me that elder abuse cases are one of the most complex criminal incidents that an officer can face. In my travels around the United States to provide training to the law enforcement and social services communities, I have found that we share a common set of challenges due to a lack of resources and a resulting lack of training and collaboration. Senator Breaux's Elder Justice Proposal provides an excellent framework for meeting these challenges and improving the response of those communities to elder abuse and neglect. I have structured my presentation around three of the goals, enhancing detection, collaboration, and prosecution. All are common issues to every level of the criminal justice system. While my major focus will be the linkage between training and an improved response by law enforcement, it is certainly not the only issue.

The key barriers to an effective law enforcement response to elder abuse are the lack of resources, training and interest and support of some law enforcement leadership. As one of the only public service agencies with a 24-hour, 7 days a week response capability, law enforcement is a critical component of any effort to address elder abuse and neglect. But there are many competing demands for the time of law enforcement officers and the majority of law enforcement agencies in the United States serve small to medium jurisdictions with less than 30 officers. All agencies, whether large or small, urban or rural, have limited resources. Training about elder

abuse has not been a priority. Interest in addressing elder abuse has not been institutionalized resulting in a loss of expertise through personnel turnover. Each of these factors impedes an effective, quality response by law enforcement.

As we have learned from our experiences in addressing child abuse and domestic violence, law enforcement can only improve its response by providing officers with the necessary skills. This can only be accomplished by presenting routine, comprehensive training throughout the system and such training requires resources and support from agency leadership. Unlike child abuse, which calls forth instant law enforcement and community response, elder abuse is a largely a hidden problem that has received little attention from the criminal justice system. Training can only increase awareness and understanding within this community. This training must incorporate the latest in information with a firm foundation in well-researched and tested techniques. Our experience in South Carolina has demonstrated the effectiveness of this approach. We have been training officers and social service providers for the past 10 years in elder abuse investigations. This training has been provided in a multidisciplinary environment by our agency, the state's Medicaid Fraud Control Unit and the United States Attorney's Office. It is our contention that this has produced a gradual increase in reporting, law enforcement involvement and prosecution. Very simply, increasing officer awareness of the vulnerability of this population and the crimes that can be perpetrated against them has contributed significantly to our success. Similar efforts are also taking place in other states such as California, Florida and Louisiana with the same results. However, there are other issues of equal concern.

It is critical that we protect the victims and hold the offenders accountable. These goals can be accomplished by addressing three major areas: detection, collaboration and prosecution. However, these are not stand-alone issues. Successful intervention requires a continuing effort, from initial response to successful prosecution. Law enforcement officers must be able to identify a crime, collect the evidence, build a prosecutable case and protect the victim(s).

As I mentioned earlier, elder abuse cases are often very complex. Law enforcement first responders and investigators are faced with the need to understand difficult medical issues (i.e. dementia, pressure sores, etc.) as well as specialized interview techniques and other more complicated issues not often confronted by law enforcement. This is particularly true of nursing home cases that require a sophisticated understanding of medical issues, standards of care and the general operating environment of a nursing facility. All of these factors can overwhelm the majority of police officers. The forensic component is absolutely critical if we are to be able to detect abuse, neglect and exploitation as well as collect critical evidence. Officers must possess the necessary knowledge to determine whether a criminal act has taken place and to recognize the evidentiary possibilities. These issues are time sensitive and can be extremely problematic. Nursing home cases can be overwhelming if there is any delay in reporting to law enforcement. Cases outside a nursing home environment are equally time-sensitive. Early detection and reporting are the cornerstones to success in elder abuse cases in any setting, but those actions must be backed up by forensic expertise in the law enforcement and health care communities and access to that expertise. In order to improve law enforcement's response to victims of elder abuse and neglect, Congress needs to fund more and better training of law enforcement officers and the development of forensic expertise to support their work.

Collaboration with other professionals and agencies addressing elder abuse and neglect is critical. It is absolutely imperative that law enforcement establishes a continuing and productive relationship with those professional that can provide the necessary expertise essential to successful case building. Child abuse and domestic violence have provided us with a successful model of collaboration including multidisciplinary teams, specially trained investigators and prosecutors. This same approach works in elder abuse and neglect cases. A major obstacle to that approach is the lack of resources devoted to adult protective services. When one considers the Federal dollars that flow to child abuse and violence against women, it becomes readily apparent that elder abuse receives little support. The situation is worsening as many states, like South Carolina, struggle with resource constraints. There has already been a shifting of resources from adult protective services to child protective services in our state and further budget cuts and declining revenue make it difficult to argue with this decision. Cuts in adult protective services means that law enforcement is increasingly finding it difficult to access the social services that victims need. For example, if law enforcement arrests the caregiver for abuse or neglect, then the victim may be in further jeopardy unless social services is available to fill the breach in care. To enhance the response of law enforcement, Congress should authorize legislation and appropriate funding that will support and foster collabora-

tion with a strong adult protective services system, just as it has done in child abuse and violence against women.

Finally, prosecution is a key component of the criminal justice response. Until we improve our ability to hold the offender accountable, society will not recognize the importance of this problem. This can lead to deterrence and a subsequent reduction in economic and human cost to society. Successful prosecution at the Federal, state and local level requires trained law enforcement officers and investigators who can build quality cases for trained prosecutors who will bring these cases to the courts. Once again, child abuse and violence against women provide effective models, such as the national resource center and specialized training and support provided to prosecutors by the American Prosecutor's Research Institute. Trained prosecutors also benefit law enforcement by providing guidance in the investigative effort.

Several law enforcement experts have had the opportunity to address the Senate Special Committee on Aging at its recent hearings on elder abuse. Both St. Martin Parish (LA) Sheriff Charles Fuseliar and retired Los Angeles Detective Chayo Reyes emphasized the key role that law enforcement training plays in improving the response to elder abuse and neglect. It provides the firm foundation upon which we can build a system that protects the victims while holding the offenders accountable. Our experience in South Carolina as well as my experience providing training throughout the United States demonstrates law enforcement's strong desire to "do the right thing" and a recognition that they need the training to be able to detect, collaborate and prosecute elder abuse and neglect cases. The Elder Justice Proposal of 2002 provides a comprehensive structure to address many of the concerns of law enforcement and prosecutors. Once again, thank you for the opportunity to express my thoughts on this issue.

COMMUNICATIONS

STATEMENT OF THE AMERICAN PROSECUTORS RESEARCH INSTITUTE

[SUBMITTED BY NEWMAN FLANAGAN, PRESIDENT]

Dear Mr. Davis: I am taking this opportunity to comment on the topic of “elder justice,” which is presently before your Committee.

The American Prosecutors Research Institute (APRI) strongly supports initiatives to respond to the important national issue of elder abuse. As the training, technical assistance and research affiliate of the National District Attorneys Association, APRI is keenly aware of emerging issues and challenges for the nation’s local prosecutors, who prosecute 99 percent of the violent crime in this nation.

The magnitude of crimes against the elderly—including physical abuse and neglect, psychological abuse, and financial exploitation—is likely to increase dramatically as the nation ages. According to projections from the U.S. Census, the 65 and over age group will double to 70 million by 2030. In fact, the 85 and over age group is currently the fastest growing segment of the older population.

Surveys of our membership reveal that prosecutors’ offices are already coping with increasing reports of elder abuse—averaging nearly 80 elder abuse cases each year. These cases most commonly involve financial exploitation and physical abuse. The most likely perpetrators are adult children, grandchildren, and in-home caregivers.

Unfortunately, prosecuting cases with elderly victims can be especially difficult. Physical impairments, diminished mental capacity, embarrassment, shame and fear—all can seriously compromise senior citizens’ ability to comply with the expectations of the criminal justice system. In addition, ageism sometimes leads criminal justice personnel to treat elderly victims insensitively and discount them as witnesses. To surmount these obstacles, prosecutors require specific training and ongoing support.

Despite growing awareness of this need, **there is no single source of expertise dedicated exclusively to helping local prosecutors mount successful cases against the perpetrators of elder abuse and neglect.** A National Center for Prosecution of Elder Abuse would be an important vehicle to achieve this level of expertise. Such a Center would offer the following services:

- **Training**, to address identified needs and help prosecutors build strong cases;
- **Technical assistance**, to support prosecutors as specific issues arise;
- **Publications**, providing up-to-date information on relevant research findings and case law;
- **Opportunities to share innovative and successful strategies and ideas**, through regional or national conferences and workshops or peer mentoring relationships;
- **Identification, documentation, and dissemination of promising practices**;
- **Research**, to assess the current capacity of prosecutors’ offices to address the challenges of working with elderly victims; and
- **Evaluation** of the Center’s training, technical assistance and outreach activities to ensure currency, quality, and utility for the prosecution community.

The American Prosecutors Research Institute is the premier provider of quality training for the nation’s state and local prosecutors. APRI offers specialized programs on telemarketing and Internet fraud against seniors, child abuse and neglect, and violence against women (among others)—all of which have direct relevance to the challenges of prosecuting elder maltreatment cases.

With a National Center for Prosecution of Elder Abuse serving as a central repository and clearinghouse of knowledge and expertise specifically geared to their needs, local prosecutors will be far better equipped to combat the tidal wave of elder abuse cases that will soon break over them.

Thank you for this opportunity to contribute to the Committee's deliberations. I remain available to answer questions or provide additional information.

VICTORIA ARNOLD TRAVIS, ELDEST CHILD AND DAUGHTER OF ADAM WESLEY ARNOLD,
PALMDALE, CA

Distinguished Members: It is time to actually do something to protect the seniors of this country. Attached is what good our country's current laws did my father. If anything they were misused to hurt him.

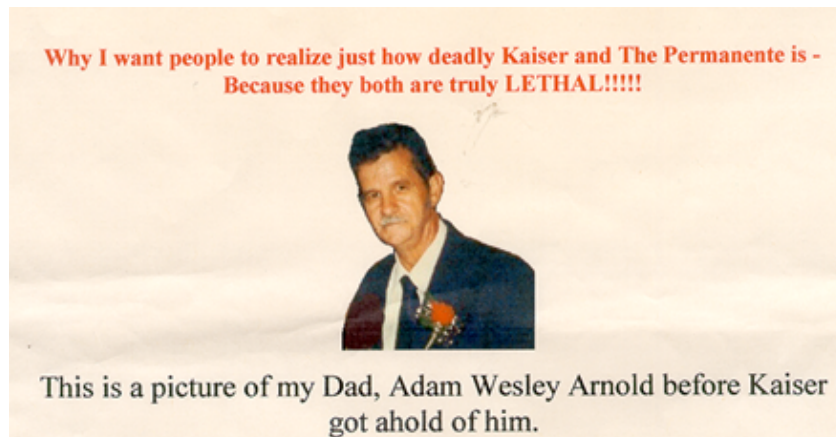
Are you aware that in the State of California that Sanctions against Kaiser Permanente/Sunset regarding the lack of protection of the elderly have been intercepted before they get to the Enforcement Division of Medicare? How many other HMO's have such protection from reporting to the Federal Government after they have been caught red handed in such activities?

Are you aware that for numerous forms of abuse against the elderly within a medical facility or while under the care of a medical entity that very little is done to either punish the offender or take precautions to prevent a repeat offense by law enforcement?

Are you aware that if any of you, or I, or just about any non medical citizen in this country did half the things that are done to harm our senior citizens while under the care of a medical entity, we would be incarcerated for many years and people would say that we deserved to be labeled a criminal?

The medical system today is run as a joke on the people of this country. A felon can be released from prison, get a job in a hospital or nursing home, rape a patient, or beat a senior and seldom is an investigation even conducted.

I strongly suggest that you all think about what I have just said. Our legal system allows criminal conduct to harm our elders. It condones criminal conduct against our seniors. It encourages the unbalanced to work in this industry. That is where you should begin to make change.



On September 11, 2000, Kaiser Permanente Staff euthanized him against his and his family's wishes. He was 70 years old and the father of 6 living children. He had been married 51 years to our mother.

Kaiser euthanized him because his health insurance had become too expensive for this HMO to honor the contract they had with him.

His death was painful as he had blood poisoning. Kaiser denied him any and all medical care either regular or emergency treatment. Under Kaiser's care he was denied any antibiotics and was needlessly prescribed a lethal dose of potassium chloride.

The government did sanction Kaiser for this patient abuse. The sanction amounts to more frequent self regulated inspections. The Sanction never made it to Medicare Enforcement Division for unknown to the government reasons.

I urge everyone to contract with a different insurance company. Not just to spare your family the grief that we have and still are going through but to also avoid the threats of medical retaliation against your family's that we have had to endure.

I am pretty sure that our father has the same low opinion of Kaiser's treatment as we do. I very much wish that he were still with us today. I promised my Dad that Kaiser was not going to get away with what they did to him.

September 11, 2001—The first anniversary of his death.

The synopsis of the Kaiser abuse on him is as follows:

HMO Commits Fraud—Enrolls Non-terminal Patient in Hospice; Causes Infection and Makes Patient Terminal by Withholding Antibiotic Treatment—Resulting in Fatal Infection. Also Overdoses Patient on Potassium, Shuts down Heart Function but Never Informs Family that High Dose of Potassium is Lethal!

(A Medical Doctor's Analysis of this case Follows Below)

This account of an involuntary euthanasia comes from Victoria Travis whose father was lied to, misdiagnosed and treated with inappropriate medications and even inappropriate surgeries, denied needed care for an infection resulting from Kaiser's own actions, and overdosed on potassium resulting in death. In this case, the family itself was instructed by Kaiser Permanente to give the potassium resulting in cardiac failure and death, and for the family, ongoing anguish and regrets.

Misdiagnosis and Inappropriate Treatment Equivalent To Assault and Battery In the spring of 1999, my father fainted and was transported to Huntington Memorial Hospital in Pasadena, California. At the time his medical insurance was with SCAN. The attending physician in the emergency room made a major mistake and deduced that our father had serious heart problems. As it turned out our father was having a panic attack, which can resemble a heart condition, but you are supposed to check the patient's vital signs, and this was not done.

Thus our father was placed on life support and sent to the intensive care unit. The head of ICU that first night informed us that our father did not have a heart problem and that he was "perfectly fine."

However, as his children we did not have the legal right to release him; as our father was heavily sedated, he could not release himself from the hospital. A legal nightmare began at that point for us!

The attending physician transferred my Dad to St. Luke's hospital in Pasadena, California acute care unit, without permission from my Dad or our family, where the doctor had a tracheostomy tube inserted and a gastro-intestinal tube placed (both of which were totally unnecessary and medically not indicated).

I was, however, able to prevent the doctor and hospital from transferring my father to the doctor's own private nursing home (where she could personally continue to collect money for room, board and unwanted medical care). At this point we had family members with him nearly 24 hours a day—we had to! When we learned that the attending physician was attempting to gain conservatorship over our father, we were shocked and were forced to go to court. This doctor had at this point indicated that our father suffered from everything from Leukemia to Parkinson's disease, and the doctor also refused to honor our father's demand to be released from the hospital.

My sister became the legal conservator at this point. Still the family had to take legal action to have our father transferred to Barlow Respiratory Center to undo the serious damage to our father's body that was done by the attending physician. This doctor falsely made claims of her affiliation with Barlow Center in an attempt to intimidate us into complying with her wish to transfer him to her nursing home. She also forced a contract with Barlow to receive payment for referrals in order to have our father transferred to their hospital. The family also had to promise that once he was released to Barlow that they would discontinue the SCAN medical insurance. The hospital there did what they could, but they did not get him completely off oxygen before the money ran out. Dr. Angela Ross Hay is the doctor that created this medical fiasco and is currently not disciplined by the CA Medical Board. She has also had her hospital privileges recently reinstated from another incident, which resulted in the cruel tortuous death of another patient. In short, Angela Ross Hay made a lot of money off of my father's body and weakened him physically to the point he never recovered.

Beginning of HMO Failure to Provide Care

Finally we converted part of the family home into a care unit for our father including specialized medical equipment, heating and air conditioning, and an emergency electrical generator. We thought that we were prepared for just about everything. He was transferred to the family home where the family signed him up for Kaiser Permanente Senior Advantage Plan. He became a home health patient.

After the family paid for \$350.00 per day for nurses that did not provide proper care nor did they exercise his body, the family members took care of him. With six brothers and sisters we all took shifts and were fully trained (probably more so than

the licensed professionals that we had hired). We now laugh at the quality of care by these “professionals,” because we did a far better job. As is normal with a large family there were squabbles amongst us children.

Some family disagreements arose and in order to stop the family fighting, a private conservator was hired to oversee the family matters. Under his direction I became the official designated caregiver. Now, I drove 100 miles each day to and from the house to care for my father. I left my home at 5 in the morning and returned home after 10 at night. I was dedicated and honored to have the chance to be of assistance.

HMO Commits Medicare Fraud by Enrolling Non-Terminal Patient in Hospice

Kaiser’s “assistance” amounted to a nurse visiting once a week and asking me how my father was doing. Occasionally they brought bandages for his stomas. When his Medicare funding for home health ran out he was transferred to their hospice plan even though he was not terminal. The conservator, Daniel Stubbs and my father’s “hidden” Kaiser doctor, Dr. James Robert Evans, made this arrangement. Dan Stubb’s openly told the family, myself included that while my father was not terminal this would ensure that he received decent medical care as his benefits, according to Kaiser had run out for the year. I advised Dan Stubb’s that this was fraud upon the Federal Government and I advised him to not do this. I was ignored.

HMO Intimidation to Force DNR Status and HMO Abuse Begins

The hospice nurse, Dennis Kane, M.D. repeatedly terrified my father. Who could blame him for being afraid after the treatment that he had already received? The nurse yelled at him, “you’re going to die” and “you’ll never walk again.” During this time, Kaiser staff intensively pressured us to make my father’s status DNR, or “do not resuscitate.” This was against my father’s and our family’s firm convictions. He, and all of us as well, wanted him to receive all medical treatment that would be appropriate when necessary and under all circumstances to resuscitate him. This was documented in writing several times.

For the entire time my Dad was enrolled in Kaiser’s hospice “program,” his nurse refused to change the foley urinary catheter nor would he change the trach tube. Dennis Kane, RN also told us that he was a PA (physician’s assistant) which was not true. These urinary drainage catheters are usually changed a minimum of once per month and sooner if they become blocked. The nurse also told the family in the presence of our father that if we wanted the g-tube changed that he would have to stand over our father on his bed and rip it out of his stomach without any anesthesia and then use an hard object to shove in a new one. Kaiser even refused to provide an adult-size wheel chair for our father, but they did provide a small, child size one that my father was obviously unable to use.

I repeatedly requested physical therapy assistance for my Dad and was told several times that they had been billing Medicare for physical therapy, but no one performed any physical therapy on my Dad other than myself. Kaiser said that they did in fact have a report from a physical therapist. If they had a report, it would be fiction, because no physical therapist ever came out to work with my father, even though they were billing the government for therapy services. He was also supposed to have a respiratory therapist, and they did bill for that also. But there was none. There was a man that came out to check the equipment twice, but that is all. As for assistance with bathing, there was a health aide that every fifteen days or so would call and say she would be out to help us. She seldom showed up. I was his bather and again it was an honor to serve my father. Of course we complained to Kaiser about their not honoring their contract with our father. We were always informed that they had budget and scheduling problems and “nothing could be done” to help us.

Still, we as a family continued to go forward and our father kept getting healthier and much stronger. After one of the physically painful incidents that my father had to endure under the care of Dennis Kane, R.N., I finally told him that I knew medicare fraud was being committed and that I was going to talk. The following week Kaiser officially upgraded my father’s health and they commented that it certainly didn’t look like he was going to die any time soon. He was to be transferred to the palliative section of the Kaiser/Sunset home health department, but not until they actually formed a palliative section or department, so we patiently waited.

HMO Nurse Causes Fatal Septic Infection and Sepsis

When they finally got this department created for their patients, Dennis Kane, R.N. was ordered by Kaiser to finally change our father’s catheter and trach in order to finalize his work and complete his reports. He came out to the house under duress, informing me that he was acting as a “Closer”, and without washing his hands nor wearing gloves he proceeded to change the foley catheter immediately

after using the bathroom where he did not wash his hands. Then, still without washing his hands, nor wearing gloves attempted to change the trach tube. After a lot of blood being spread around, the nurse informed me that he was unable to change the trach tube because it was stuck and it was now a detriment to our father's health if he continued to try do so.

We later were informed that Kaiser rules require two nurses to change a trach tube. My father did develop an infection, and to us, it is obvious it resulted from the complete failure to follow sterile technique required to change an indwelling foley urinary catheter and the tracheostomy tube. Finally a new nurse came to see our father. She actually examined him, but we never heard from the bather again. The new nurse did try to get us to help her go after Dennis Kane, R.N. for his terrible medical treatment of all of his patients. She did change the catheter and the trach was changed. For several weeks we demanded that our father be treated for his infection, but Kaiser refused him treatment.

HMO Practices Medicine Without License

Does Not Have Actual Doctor Making Orders, Directing Care

We took a urine sample for Kaiser and the nurse finally took it with her. Previously we were always informed that they could not take a urine sample or a blood sample without a doctor's order. Unfortunately, Kaiser never did assign a doctor that we knew of for our father. No Kaiser doctor ever did examine our father, nor did any doctor specifically make the orders that decided what care our father would not or would receive. The new nurse did take care of the wheelchair matter but it took a few weeks because as we learned, Kaiser had falsely recorded in their computers for several weeks before our father's death that he was already deceased! Kaiser never corrected that matter. The doctor's named on the prescription for potassium denied he was our father's doctor.

For the next three weeks the new nurse repeatedly told us that our father did not have an infection and that we "did not know what we were talking about." Those were her words. She also pressured us again to make our father a DNR patient, however our father and we did not want that and we refused to cave in to Kaiser's manipulations. We all wanted our Dad to be resuscitated if his breathing or heart stopped. He had been getting better. We just wanted his infection treated to allow him to recover!

On Monday, September 11, 2000 when I arrived at the house I saw a drastic change in his health. He was seriously ill. Kaiser staff threatened me that if I tried to treat him with antibiotics that they would have me incarcerated. So, to my regret I did not. Throughout the day and that night we repeatedly contacted Kaiser Permanente/Sunset begging for medical assistance. One nurse informed us that our father had a septic infection and that it was very serious. Apparently this information was tied into their computer problem that said he was deceased. After it was clarified that he was very much alive, the nurse asked what antibiotics he was on. We explained that we had been repeatedly told that no antibiotics could be given. The nurse told us that she did not know what to do about the matter then, and she did nothing to make sure our father's infection was immediately treated?

HMO Director of Home Health Laughs At Us When We Pleaded for Help.

We all kept calling the various departments of Kaiser and finally reached the head of the Kaiser Permanente home health department/Sunset Division. The head of this Kaiser department refused to have medical assistance provided and laughed at us and said, "If you don't like the care your father is receiving under our care, get coverage under a different health care plan." Our father's conservator also unsuccessfully attempted to get medical care for our father that night we were told by him.

Our father developed severe edema and his catheter was entirely plugged up with a grainy material. Kaiser told us that if we wanted to do anything about the plugged urinary catheter, that we would have to take care of it ourselves. Urinary catheters that become plugged can back urine up into the kidneys causing kidney failure and death. We learned that night how to remove a foley catheter because he had become a medical emergency at this point. However we replaced it with a common sheath catheter as not being trained in insertion of objects into a bladder we did not want to cause any more harm than had already been done. As it turns out, my Dad passed away within a few hours.

Unfortunately, because no Kaiser physician, ever saw or participated in any way with the medical decision-making made by Kaiser with regard to our father, the paramedics could not declare his death until a day later. September 12, 2000 Kaiser finally found a doctor to come up with a cause of death that would not implicate Kaiser's actions in causing his death and who was willing to sign the death certifi-

cate. This man that had never even seen our father had over the phone decided that our father died of Parkinson's Disease, which he most likely never had!

Were We Used by Kaiser Permanente to Harm Our Own Father?

During the course of our father's "treatment," Kaiser had made sure that our father got 100 MeQ of Potassium every day. We thought that this was just standard medication, however, we later realized that potassium is often given as a replacement when a diuretic like Lasix (furosemide) depletes the potassium found in the blood. We were later informed that potassium given when not medically indicated, can cause severe adverse reactions, including shutting down the heart. Drug references warn that potassium can cause death. Now we wonder if the HMO had us help our Dad take his pills, including the potassium, so that our Dad could die from the potassium. There were no lab tests for several months, and we now have learned that periodic lab tests are necessary to determine the medical need for added potassium. In fact, now we learn that some "angels of death" like Jack Kevorkian and Elian Saldivar/Glendale Adventist respiratory therapist, have used potassium to kill their patients. A potassium death is not painless nor is it peaceful. A potassium death causes terror and is a form of torture. The heart and lungs stop working yet the person's mind is clear. This goes on at the least many minutes. It is not in any manner a compassionate death.

HMO Falsifies Death Certificate to Cover Its Tracks

I thought that no one can die just from Parkinson's Disease, but then who am I, I was only there. The current death certificate falsely states that he died of Parkinson's disease! In the presence of impartial witnesses, at the time of death the bodily fluids were properly collected and taken to an independent laboratory for analysis. The following day, again with proper chain of command and great legal documentation, under the direction of the mortuary director, photographs were taken by my husband and myself of the blisters and oozing sores that broke out on our father the day of his death. These sores were an indication of sepsis as the body was trying to eliminate the poison through the skin. The laboratory informed us that our father had two different types of bacterial infection, common in cases of septic infection, and that in our father's condition they certainly were serious enough to have killed him.

I requested an investigation by Kaiser Permanente as to why our father received this type of treatment and they denied us that right. Following through Kaiser chain of command I finally reached a supervisor that asked me "What is it going to take to make you go away?" I informed her as I do everyone to this day that I want Kaiser Permanente to change the way they treat their patients. She in turn offered me \$219,000.00 to go away.

HMO Threatens to Retaliate if We Go Public

I refused the Kaiser money. The Kaiser supervisor then threatened me that "Your family will most likely receive medical retaliation unless you keep quiet and don't talk about what happened."

That of course has spurred me on. How dare they threaten me for such a matter? The arrogance of this organization is revolting. Finally, under duress because Kaiser was not acting in the spirit of the law, The State Board of Managed Health Care had a formal investigation conducted by Kaiser themselves. Unfortunately, Kaiser refuses to release to the family or to the State of California the results of their investigation. Whether the State or other government agencies are going to force the issue to get the investigation report is still unknown. Needless to say, all of this has been extremely hard on our family. We all find ourselves extremely angry, hurt and depressed by the unspeakable violation of our father as a human being. The HMO not only caused terrible suffering for him, but also killed him, quite literally. This is something that we will never let go of. For our father's sake, we will fight this type of HMO atrocity to the very end.

We refuse to accept any financial bribe to keep quiet from Kaiser or anyone else in this matter; thus we choose not to handle this through the civil courts and the tiny cap that California allows. It would not harm of reform Kaiser in any manner. Numerous people in this community have . come up to me and informed me of similar events that have occurred to their family "In The Hands of Kaiser." I sincerely am attempting to turn these needless deaths into good by making these arrogant corporations that purport to be not-for-profit health care organizations reform themselves. If they can't do that then they should be put out of business once and for all! The patients' relationship with the health care professionals and Kaiser's should be one of trust. You may not be aware that many highly educated people are refusing to seek basic medical care. I thought that was silly, but now I understand and

I am very sorry that I do. And my father had to suffer so terribly for all of us in our family to directly learn this lesson!

I respectfully request any of you who read this to bring this matter to the attention of the American government officials and the general public. I am confident that our entire family will be willing to cooperate with you in most any way that you request and will provide you with any and all documentation that you request.

STATEMENT OF THE LATINO COALITION FOR FAMILIES

[SUBMITTED BY JENNIE TORRES-LEWIS, AND MARISA DEMEO, ESQ., CO-CHAIRS]

Thank you Chairman Baucus and Members of the Committee for holding this hearing and for accepting this testimony on behalf of the Latino Coalition for Families, and ad-hoc coalition of national organizations advocating for the advancement of Latino Families. Coalition members include the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), the Labor Council for Latin American Advancement (LCLAA), MANA; A National Latina Organization (MANA), the Mexican American Legal Defense & Educational Fund (MALDEF), the National Campaign for Jobs & Income Support, the National Conference of Puerto Rican Women (NACOPRW) the National Council of La Raza (NCLR), the National Latina/o Lesbian, Gay, Bisexual, and Transgender Organization (LLEGO), the National Puerto Rican Coalition (NPRC), the National Puerto Rican Forum (NRPF), the Poverty and Race Research Action Council (PRRAC), and the Puerto Rican Legal Defense & Educational Fund (PRLDEF), of which MALDEF and NPRC serve as Co-Chairs of the Latino Coalition for Families.

The LCF was formed to provide recommendations for the 2002 federal reauthorization of Temporary Assistance to Needy Families (TANF). The coalition's top priorities for TANF include providing access for immigrants, overcoming language barriers for clients with limited English proficiency, and addressing disparities in Puerto Rico.

We believe all hard working families, and especially their children, should have access to the tools that allow people to move from welfare to work and achieve independence. Latinos still lag behind other groups when examining poverty level, median income and unemployment rates. Through this reauthorization of TANF Congress can further improve the TANF law so as not to exclude Latinos.

The Chairman's mark gives states the opinion to use federal TANF dollars to provide needed work support services to legal immigrants. This is a great improvement to the current law's ban on serving legal immigrants during their first five years, which undermined the health status of many Latino children and placed an undue financial burden on states with large and emerging immigrant populations. Unfortunately, the proposed Senate WORK Act is silent on Medicaid and the state Children's Health Insurance Program (SCHIP) although there is widespread support from the National Governors Association, National Conference of State Legislatures, and the American public for restoring health benefits to immigrants. Historically we are an immigrant nation and still today our economy relies on the labor of millions of immigrants who live and work in the United States. Immigrants make significant economic contributions to our nation and should not be denied the basic safety net services supported by their own tax dollars.

Improved English proficiency is key to moving many Latino parents off of the TANF rolls. The Chairman's mark makes some effort to help Latino parents gain the skills needed to participate fully in the labor market by allowing full-time participation in programs that improve English proficiency for three out of twenty-four months and for an additional three months when combined with work activities. However, this six-month time frame underestimates the significant investment needed to improve English proficiency. The ability under current law to include English language instruction in the definition of vocational education must be encouraged and used by states in addition to the WORK Act's improvements in order to effectively train TANF recipients to move into higher-paying jobs that will provide a ladder out of poverty.

Puerto Rico's obligations and regulatory requirements under TANF are the same as the states. However, resources available to the Island differ significantly from those available to other TANF grantees. Puerto Rico's TANF funding is limited by law because it falls under a single statutory cap that constricts total overall funding for three separate programs: TANF, IV-E Foster Care, and Aged, Blind, and Disabled Assistance (ABD). Therefore, though the Chairman's mark did increase Foster Care funding for Puerto Rico, as long as Foster Care is included in the cap there

will always be a limit in funding. Abused and neglected children should not have to compete with the elderly and other vulnerable populations for needed services.

The Chairman's mark also included the authorization of Puerto Rico for participation in the mandatory childcare program; this is a very significant and commendable step. Yet participation in the Contingency Fund was denied for Puerto Rico. The Contingency fund is intended to assist states in times of economic downturns that cause high unemployment rates or increased food stamp caseloads—all TANF grantees should be provided this insurance. Also Supplementary grants, which are intended to give extra assistance to states with high population growth or low Federal spending per poor person, were denied for Puerto Rico despite the fact that Puerto Rico's TANF grant is only 6.5% of the national average. In FY 2000 the states received TANF grants that averaged \$533.97 per person in poverty, while Puerto Rico's TANF grant is \$34.78 per person in poverty per year. In addition, the Senate proposal includes an additional 12 months of reimbursements to states for transitional healthcare coverage for families moving to work. However, no coverage was extended for Puerto Rican families confronting the same challenges. With an unemployment rate of 12 to 13 percent (three times the national average), a poverty rate of nearly 50 percent, and without access to the same support programs as the states, it will be challenging for Puerto Rico to continue to meet all of the requirements under the chairman's mark.

The LCF thanks the Senate for the improvements made thus far and encourages further improvements. Thank you for your time and attention to our nation's Latino population.

STATEMENT OF PHYLLIS J. ELAM

I am submitting this letter as a public outcry against Nursing Home neglect and abuse. My mother has been a victim of Neglect and abuse at the hands of several employees at one facility. The most "blatant" act was committed in my presence with me standing across the bed from the Registered Nurse that committed the act.

I have been forced to watch this "strong willed" woman become reduced to a whimpering, fearful, despondent, and remorseful person. "MY MOTHER PREFERS THAT ONLY WOMEN BATHE HER OR CHANGE HER INCONTINENT PADS," they still allow a male to do this anyway because; "THERE IS A MAN ON THAT HALL THAT NIGHT AND IT WOULD BE TOO MUCH TROUBLE TO HONOR HER WISH.

I was trained "extensively" on how to care for her without causing more injuries while changing her pads or transferring her from bed to wheelchair and etc. while she was hospitalized. From day one, my mother has NEVER had the "proper techniques" applied to moving her from her wheelchair to the chair or bed etc. There is Never a *gait belt* used. This is not only for her own care to avoid injuries to the parts of her body that can be rehabilitated, it also protects her from being injured if moved improperly. I have seen her lifted under her arms more times than I can count by one person and "put to bed." I have also seen one nurse at a time (and this has been different nurses) almost lose her and *bang her backbone against the edge of the bed* to keep her from missing the bed. And everyone wonders why her tailbone hurts all of the time. This is an everyday occurrence. It doesn't matter that I HAVE TALKED TO THE DIRECTOR OF NURSING, THE ADMINISTRATOR, AND THE NURSING STAFF REGARDING THIS, BUT IT JUST CONTINUES.

There has been numerous times that there has only been one (1) or two (2) nurses to handle a hall of at least thirty (30-35) residents. The State office says that they are allowed to do this. I have watched this and it might be okay for the State to allow it, but it denies the residents the basic care they should be getting. I have watched the nurses (usually 2 Certified Nurses Assistants and a charge nurse) try to handle the situation and they will admit that they are fighting a losing battle because the facility is pitifully "understaffed". I have been a witness to nurses sitting out in their cars after work crying because *they didn't have time to feed everyone that required it. I have had numerous nurses from Certified Nursing Assistants—Registered Nurses literally beg me to call the State and report the facility because they are working them to death without enough help and they were dog-tired when they got off work (usually after working 8-12 hours per shift)* and a lot of times they were asked to stay over because someone had called in. And they do stay over a lot of times if they don't have another job to go to. Imagine the short tempers after working such long shifts. Although that is no excuse for abuse, it is very easy to see how it can rear up it's ugly head. It is also *common practice at a facility to refuse to schedule someone to cover for another nurse when she takes her vacation. I have been a witness to this several times. I have seen only 3-4 nurses in a building*

with 80–90 residents and at least 30 requiring critical care. It is virtually IMPOSSIBLE for the residents to be cared for properly. Imagine having 2 nurses to work a hall to care for the 30–35 patients and do the following; answer call lights requiring everything from falls to hemorrhages, to seizures, other medical emergencies requiring Emergency room visits that requires a LOT of paperwork, changing beds and patients as well as turning some every 2 hours, giving 30–35 a bath, take phone calls, deal with residents' families, do the laundry, do any mopping that needs to be done (since housekeeping only works day shift while the office is open and the State is liable to show up), take out trash, do the required paperwork for charts, and then try to play maintenance man and check the breaker boxes because all of the electricity on one side of the hall won't work and "Mr. Jones' Oxygen isn't working because of it."

My mother developed a Stage III bedsore exposing the bone, and Urosepsis because of understaffing and the nurses not caring enough to clean her properly after her pad changes. Both of these "avoidable atrocities" could have been avoided, but weren't. She was also rehabilitated to the point of walking again with the assistance of a walker and she was using both hands until a cocky "Male Registered Nurse" became angry with her and lifted her from the bed by her legs and tore a diaper halfway off of her in a fit of anger. THIS IS INHUMANE TREATMENT AND IT HAS GOT TO STOP. WHEN THE STATE OFFICE WAS CALLED, THE INCIDENT WAS FOUND "UNSUBSTANTIATED." WHEN I CALLED HCFA, AND IT WAS REINVESTIGATED, IT WAS THEN FOUND "SUBSTANTIATED"

Just checking back through the last four (4) years, there is documented proof at one of the facilities that the neglect and the violations ARE caught some of the times and then the facility is allowed to "correct" the problem in a matter of days. After the problem has been addressed and then corrected, you have the same things coming up EVERY YEAR. I am talking about at least four (4) years straight!!!! THIS IS WRONG!!! THIS IS ALLOWING THESE PEOPLE TO BE ABUSED AND NEGLECTED OVER AND OVER AGAIN!!!!

It is a known fact that The State Offices are closed after business hours. It is also a known fact that ALL of these facilities have nurses running over each other during the day shift from 6:00 am. through 4:00pm. But at night, 2 or 3 nurses are left to fill the shoes of nurses, housekeepers, electricians, cooks, sitters, and Administrators. This is wrong!!!! When you call the State office and ask if they would please send someone down to verify that there are only 2 or three nurses in a building on second and third shift, caring for the residents, you are told that THEY ARE NOT ALLOWED TO WORK OVERTIME AFTER HOURS, THEY ARE NOT ALLOWED TO WORK DURING WEEKENDS!!! BUT, THE FAMILIES SEE THESE THINGS HAPPENING AND THEN EVERYONE WONDERS WHY THERE ARE SO MANY LAWSUITS AND THEY FEEL THAT THE LAWYERS ARE GETTING RICH OFF OF THE POOR NURSING HOMES AND THE NURSING HOMES HAVEN'T DONE ANYTHING. I am so happy to see so many Attorneys advertising their services for the abused in the Nursing Homes. Well, I can vouch for the families that I have seen who are not happy campers with the services they are receiving. It is pitiful how the facilities are allowed to just set back and reap the harvest, but let the elderly and the infirmed suffer needlessly.

There is no doubt in my mind that we do need and should be allowed to have video cameras in our loved ones rooms in Nursing Homes. Getting documented proof of how well a facility does as well as documenting the shameless acts of abuse, rape, torture, and many more things that these poor people have to endure will confirm what Advocates have been screaming for years. There is no medical procedure known to man that I wouldn't mind having performed on camera if it will guarantee that I or a family member will not be abused, will be fed and given fluids, will be properly turned, bathed regularly, and all other things that are expected of a Nursing facility. The loss of privacy outweighs the benefits of assuring that I or a loved one is being care of when we are too sick and frail to do it ourselves. It blows my mind after 3 years of research how Congress has just DISMISSED AND ALLOWED these atrocities to occur!!! Congress has the power to see that these despicable acts are stopped!!!

President Clinton saw that it was put into the budget that the State Offices would do their yearly inspections on weekends, holidays, and at night. THIS HAS NOT BEEN DONE EITHER!!! IF IT WAS, THERE WOULD BE MORE STORIES ON THE 6:00 NEWS BECAUSE WHAT THEY WILL FIND WILL BLOW THEIR MINDS. But as I have learned; "out of sight, out of mind" isn't just a saying. Because I truly believe that if the State came down during these times and saw the residents being fed scrambled eggs,

mixed vegetables, and peas, I think they would kind of lose it too. Oh, by the way, this is always done after the "offices" closes.

I have talked to many family members and there are a lot of unhappy families out there, they just don't know what to do or who to contact, because someone just isn't getting this. *For some reason, It's just not sinking in.*

It should be mandatory for the Emergency room doctors to report when a resident comes into the ER with "unexplained bruising." We have endured this also, but I also know that the doctors DO NOT want to make waves because we are talking about something that has been going on for ages and they have developed a technique to just "turn their heads" unless someone pushes them. It should become mandatory for a doctor to be held responsible whenever something occurs like that. After all, if you brought a child in with unexplained bruises, black eyes, or suffering from malnutrition, SOMEONE is going to jail. What makes our elderly loved ones exempt from these same rules regarding their Civil and Human rights?

I have noticed that a lot of people assume the mentality that the elderly have lived their lives and they should just shut up and go on and die. But we are talking about someone's mother, father, aunt, uncle, grandfather, or grandmother, not to mention the people that aren't so "old" that have fallen prey to sicknesses, accidents, and diseases and can't be cared for at home.

THERE IS ONE FEDERAL REGULATION THAT IS BEING VIOLATED EVERY DAY OF WHICH I LEARNED OF IN 1999. I AM CONCERNED FOR ALL OF THE RESIDENTS IN THE BUILDING AND MADE HCFA AWARE OF IT IN October OR November, 1999. THE FACILITY WHERE MY MOTHER WAS ABUSED HAS HALLWAYS SO NARROW THAT IT IS IMPOSSIBLE FOR SOMEONE TO WALK BESIDE A WHEELCHAIR. MY DAUGHTER HAS WITNESSED THE AMBULANCE WORKERS PACKING PEOPLE DOWN THE HALLWAYS IN SHEETS TO PUT THEM ON THE STRETCHER BECAUSE IT IS TOO MUCH TROUBLE TO EVEN GET THE STRETCHER'S DOWN THE HALLWAYS IN A HURRY IF THEY CAN AT ALL. I WAS TOLD BY THE HCFA OFFICE IN EITHER WASHINGTON, DC. OR THE ATLANTA, GEORGIA OFFICE THAT THE PROBLEM SHOULD HAVE BEEN TAKEN CARE OF BY EITHER WIDENING THE HALLWAYS OR A NEWER BUILDING. WHEN I EXPLAINED TO THEM THAT THE STATE OFFICE TOLD ME THAT THE CODE FOR THE HALLWAYS HAD BEEN "GRANDPA'D IN", I WAS TOLD BY HCFA THAT THERE WOULD HAVE BEEN A "WAIVER" WITH THE OWNERS BEING GIVEN A CERTAIN AMOUNT OF TIME TO CORRECT THE PROBLEM, BUT IT WAS TOO STRICT OF A VIOLATION TO BE "GRANDPA'D IN." IT HAS BEEN AT LEAST 5 YEARS AND THE PROBLEM STILL EXISTS. IF THERE IS A FIRE, THERE IS NO WAY THAT THEY CAN GET THE PEOPLE OUT OF THERE. THE STATE KNOWS THIS, HCFA KNOWS THIS, THE OWNERS KNOWS THIS, AND THE NURSES ALL KNOW THIS!!!! THIS IS AN ACT OF NEGLIGENCE AND ABUSE IN ITSELF. THIS IS; "WILLFULLY PUTTING SOMEONE'S LIFE IN IMMEDIATE JEOPARDY." WHEN I QUESTIONED THE STATE OFFICE HOW IT WAS ALLOWED, I WAS TOLD THAT IT WAS IN THE HOPES THAT IF THE BUILDING CAUGHT FIRE, THEY ARE HOPING IT ISN'T IN THE PART OF THE BUILDING WHERE THE HALLWAYS ARE NARROW. THE AREA THAT HAS NARROW HALLWAYS COVER A LARGE AMOUNT OF THE BUILDING. I AM ASKING CONGRESS TO PLEASE PUT YOUR FOOT DOWN ON THIS "CARELESSNESS." IF THERE WAS A FIRE AND ALL OF THE FAMILIES SUED THE FACILITY, IT WOULD MOST DEFINITELY BE SAID THAT THE LAWYERS ARE TRYING TO GET RICH, BUT YOU CAN SEE THAT THIS IS A TRAGEDY WAITING TO HAPPEN. BUT WHY WAIT FOR IT TO HAPPEN? THE NURSES ALL KNOW ABOUT IT AND TALK ABOUT IT ALL OF THE TIME. AND I HAVE SURELY SEEN IT.

There was an instance recently where my mother's condition required her to be released from the hospital with a "Central IV Line" in her neck. The doctor that was filling in for her doctor refused to discharge her because there was not a Registered Nurse at the facility on the day she was scheduled for discharge. The next doctor refused to discharge her also because there wasn't one when she was in his care either. But, her regular doctor has learned how to "beat the system;" He had the former Director of Nursing to come to the facility while the ambulance was there and stay long enough to get her settled in (an hour tops), then she left. MY MOTHER WAS STILL IN THE FACILITY WITH THE CENTRAL LINE STILL ATTACHED WITH SOMEONE THAT IS NOT LICENSED TO HANDLE HER SITUATION. WHEN I QUESTIONED THIS AT THE FACIL-

ITY AND WITH THE STATE OFFICE, I WAS TOLD THAT AS LONG AS THERE IS A REGISTERED NURSE ON CALL WITHIN 10 MINUTES AWAY, IT IS OKAY. NOW, THEY USUALLY HAVE ONLY A LICENSED PRACTICAL NURSE ON DUTY. AGAIN, THE REGISTERED NURSES ARE RESERVED FOR DAY SHIFT WHILE THE OFFICE IS OPEN AND THE STATE JUST MIGHT MAKE AN APPEARANCE. AN INCIDENT DID ARISE WHERE SHE NEEDED FLUIDS AND IT TOOK ABOUT 3-4 HOURS TO GET A NURSE TO COME IN. BUT, IF I FILE SUIT, IT IS CONSIDERED "FRIVOLOUS." IT DOESN'T TAKE A ROCKET SCIENTIST TO SEE THAT SOMETHING IS WRONG WITH THIS PICTURE.

Abuses happen every day in these places. The Administrators call a meeting and let the nurses know that if they tell that a nurse was let go because they found that she had been stealing the patients' medicines and taking it, or if a male nurse gets mad because he has to give someone a bath and gives a resident a bath in ice cold water while there is snow on the ground, they will lose their jobs. **THIS IS WRONG!!!!** Then the facility just dismisses the worker with a great letter of recommendation without alerting anyone. **THIS IS WRONG!!!!**

There was even a time when the washcloths in the other facility was so gross that I asked the Investigator that came down to please ask for 20-25 and see what shape they were in. *Upon seeing them, he immediately had the facility to dispose of the "old ones" and go and buy all new ones.* **BUT THIS WAS NEVER PUT IN THE REPORT!!!!** The reason I asked him to look at them was because they had such bad feces stains in them and you could even still smell it after they were washed and they made my mother sick to her stomach all of the time. The other residents deserve better also.

The last report that was filed at the facility where my mother was abused revealed some very disturbing information. There were several instances in the report where some of the EXACT SAME INSTANCES PROVING NEGLIGENCE AND LOSS OF DIGNITY WAS STILL BEING PRACTICED IN THE FACILITY. WHEN YOU CONTINUE TO HAVE THE SAME THINGS HAPPENING OVER AND OVER AGAIN, ALTHOUGH YOUR STAFF CONTINUES TO CHANGE PERIODICALLY, YOU EVIDENTLY HAVE PROBLEMS WITH THE MANAGEMENT AND THE ADMINISTRATION DEPARTMENTS. **JUST LOOK IN THE REPORTS, THEY SPEAK FOR THEMSELVES!!!!**

In all of the "Residents' books," nobody ever tells you that your loved one will never get to go outside because there *most definitely aren't enough staff to take them outside*. If you aren't able to get in a wheelchair or your family isn't able to take you, the closest you get to outside, is looking out of your window. Or excuse me, If you are lucky enough to have a Gospel singing outside once every 3 years, you will get to go out then *because it will be on the front page of the Newspapers about what a wonderful job the administrator is doing with the elderly*. Why not bring the newspapers in at night? **WHY DON'T YOU ALL MAKE IT MANDATORY FOR A COPY OF THE STATE REPORT TO BE INCLUDED IN EACH RESIDENT'S ADMISSION PACKET? IT SHOULD BE NO PROBLEM IF EVERYONE FEELS THAT THEY ARE DOING THEIR BEST!!!! IF WALLS COULD TALK!!!!**

Whenever I used to hear someone say that they are suing someone because of "pain and suffering," I used to think that they were just using someone else's misfortunes to get rich. I now understand what it means to not be able to sleep at night because it bothers you that every time you go to see your loved one in a facility, they are reeking of Urine, their fingernails are dirty, they are hungry.

My mother used to love church, it was her lifeline. Now she usually refuses to go now just out to the lobby of her facility because she knows that she usually has to sit there for MUCH LONGER than she desires, because just how long can 2 or 3 nurses get 60+ residents back into their rooms when half of them have to be lifted in and out of beds and wheelchairs?

I have watched the nurses and have come to the conclusion that you do have some nurses that really don't need to be in a nursing home. But the majority of the nurses really care and their hands are tied because they can't make the facility hire more help. They stay on because they feel sorry for the residents. I have seen so many nurses quit because they have walked into a facility and saw that there was only going to be anywhere from 1-3 nurses in the whole facility (1 of them being the charge nurse to handle all 3 halls). They have told me that they had to leave because every time they walked into the facility and were so short-staffed, their licenses were in jeopardy.

I sincerely hope that something can be done to remedy these "horrific" situations that our loved ones and the elderly have had to endure. These are just a few of the

things that I have had to watch my mother and my family endure, to tell you everything will take too much time on paper and make you so depressed like I am that you will probably think that I am making up stories. So, I have picked "a few" of the instances and hope that my testimony will make a difference in some Nursing Home Residents' life. It is Past Time for Congress to step up to the plate and make these facilities accountable for their actions. If the for profit or the nonprofit corporations are NOT going to comply with the Rules and Regulations that Congress sets forth ensuring that our loved ones aren't continuing to be mistreated, THEN CLOSE YOUR DOORS AND SELL YOUR FACILITIES TO SOMEONE WHO WILL!!!! IF THIS IS NOT DONE, LET THE LAWSUITS CONTINUE!!!! SOMEONE WILL WAKE UP ONE DAY!!!! I TRUST THAT YOU WILL DO THE RIGHT THING BY OUR LOVED ONES.

