



**NATIONAL ADULT PROTECTIVE
SERVICES ASSOCIATION**

**A Report on Discussions
Regarding the Need for
Cooperation and Collaboration
Between
Adult Protective Services
And Long-Term Care
Ombudsman Programs**

**Prepared for
The National Center on Elder Abuse
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A Report on Discussions Regarding the Need for Cooperation and Collaboration Between Adult Protective Services and Long-Term Care Ombudsman Programs

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National Center on Elder Abuse

The National Center on Elder Abuse (NCEA) serves as a national resource for elder rights advocates, law enforcement and legal professionals, public policy leaders, researchers, and citizens. It is the mission of NCEA to promote understanding, knowledge sharing, and action on elder abuse, neglect, and exploitation.

The NCEA is administered under the auspices of the National Association of State Units on Aging.

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PURPOSE OF THIS PAPER

Since 1992, there have been periodic efforts on the part of the Administration on Aging (AoA) and the National Association of State Units on Aging (NASUA) to examine the relationship between two programs charged with protecting vulnerable adults: the Long Term Care Ombudsman (LTCO) Program, authorized under the Older Americans Act, and Adult Protective Services (APS) Programs, authorized under individual state statutes. A consistent finding from these efforts has been the need to strengthen the communication and cooperation between Ombudsmen and APS Programs.

In keeping with this need for increased communication, in 2003, the National Association of State Long-Term Care Ombudsman Programs (NASOP) and the National Adult Protective Services Association (NAPSA) conducted a joint workshop at the annual conference of state long-term care ombudsman. The outcome was the identification of a number of topics which need further discussion between the professionals in the two programs. As a result, NAPSA convened four regional meetings between NAPSA members and Ombudsmen. The meetings were funded, in part, by funds from the Administration on Aging to the National Center on Elder Abuse (NCEA), of which NAPSA is a partner. This paper reflects the scope of the discussions which occurred at those meetings, as well as recommendations from the participants. These discussions did not include the roles of other entities such as law enforcement, regulatory agencies and the personnel of long term care facilities.

It should be noted that, due to budget and travel constraints, the APS representatives at these meetings outnumbered the ombudsmen by a ratio of three to one. For this reason, many of the positive practice examples identified at the meetings, as well as in the subsequent discussions, tend to be weighted more heavily towards the APS professionals' experiences.

An initial draft of this paper was shared with Becky Kurtz, then president of NASOP, who kindly provided comments and suggestions, many of which have been incorporated herein.

Readers need to be aware that the material from these meetings represents the discussions that occurred at the events. While participants were directed to focus their conversations on specific areas, the actual discussions were wide ranging. Some topics were covered extensively in one meeting but not touched upon in others. The information in this paper does not represent any universal policy recommendations presented to and approved by the NAPSA Board of Directors, NASOP or the NCEA.

INTRODUCTION

Adult Protective Services (APS) and Long-Term Care Ombudsman (LTCO) Programs (LTCOP) share many similar values and objectives. Both seek to ensure the protection and well being of vulnerable adults who are victims of abuse, exploitation, and/or neglect, or who reside in long term care facilities, or, in some cases, are abuse victims who reside in facilities. Both programs honor victims' rights to confidentiality, self-determination and freedom of choice. Both are advocates for the vulnerable people they serve.¹

APS and LTCO programs are, however, governed by different laws that determine the roles and the approaches they take in responding to elder abuse. These differences may hamper cooperation between the two programs and can lead to conflicts. This report will examine some of these barriers and conflicts, and will provide suggestions for overcoming them.

Adult Protective Services

Adult Protective Services (APS) are state authorized, life saving services provided to vulnerable adults, usually age eighteen and over, who have physical or mental disabilities that prevent them from protecting themselves from abuse, exploitation and neglect by themselves or others. Ninety percent of the states provide services to vulnerable adults age eighteen and older. While APS always conducts investigations in domestic settings, there are twenty-six states in which agencies other than APS have responsibility for abuse investigations in institutions, such as long-term care facilities. In some states, APS and other state agencies, including the Long Term Care Ombudsman Program, share responsibility for institutional abuse investigations.²

Sixty percent of persons served by APS programs are elderly; many of them suffer from Alzheimer's or other forms of dementia. The types of mistreatment inflicted upon them include physical, sexual and emotional abuse, neglect of basic care needs (either by others or by the vulnerable adults themselves), and financial exploitation. In the majority of states, many professionals are mandated to report suspected abuse of vulnerable adults to the APS program. Estimates are, however, that only one in five 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.³

¹ *Coordination between Long-Term Care Ombudsman and Adult Protective Services Programs and Related Issues: Report on a Symposium*, U.S. Department of Health and Human Services, Administration on Aging, Washington, D.C. 1994. p.1.

² Teaster, Pamela B., Ph.D., *Response to the Abuse of Vulnerable Adults: The 2000 Survey of State Adult Protective Services*, National Center on Elder Abuse, Washington, D.C. 2003.

³ Administration on Aging, Administration for Children and Families, U.S. Department of Health and Human Services, 1998. *The National Elder Abuse Incidence Study*, Washington, D.C.: National Center on Elder Abuse and the American Public Human Services Association, with Westat.

The primary APS activities covered by most state statutes include: receiving reports; conducting investigations; evaluating client risk and capacity to agree to or refuse services; developing and implementing case plans; counseling clients; arranging for a large variety of services and benefits; as well as monitoring ongoing service delivery. These services protect elderly and/or vulnerable adults and enable them to live as independently as possible.

APS programs are intended to provide an emergency protective response, although many programs do not have after-hours hotlines and/or staff on duty twenty-four hours a day, seven days a week. In many parts of the country, APS after-hours crisis calls go either to child protection crisis workers or to law enforcement. However, once an abuse report is received, most states require an APS contact with the victim within twenty-four hours if there is a situation of immediate danger, or within one to three working days if danger is not imminent.

APS responds to reports of abuse to a specific vulnerable adult. In those states where APS conducts facility investigations, unless an abuse report is made, APS staff will not be present in a long-term care facility, and thus will not have knowledge about the ongoing quality of life there. Due to mandatory reporting laws in most states, however, APS programs are sometimes aware of abuse within a facility without the LTCOP being contacted. "Under federal law, and the vast majority of state abuse reporting laws, facilities are not required to notify the LTCO of abuse."⁴

Long-Term Care Ombudsman Program

The LTCO program is based in the Older Americans Act (OAA), federal legislation that includes LTCO program mandates for independence, advocacy, and a strong emphasis on residents' rights. The program is administered either directly or under contract by the State Units on Aging. In many states, the ombudsmen who work directly with residents are volunteers or employees of non-profit agencies, not state employees. While the majority of people served under the OAA are age sixty and older, the LTCO programs in some situations may also serve younger residents of long-term care facilities.

Becky A. Kurtz, former President of the National Association of State Long-Term Care Ombudsman Programs described the role and philosophy of Long Term Care Ombudsman Programs as follows:

The LTCO, as an 'ombudsman' program, has a unique role in serving long-term care residents. Part of a long tradition of problem-solving and conflict resolution, an ombudsman is a "safe" place to bring a complaint. A complainant choosing to contact an ombudsman is assured that the complaint will be investigated within the ombudsman program confidentially. No information is shared outside of the ombudsman program without the consent of the complainant (or, in the case of the LTCO Program, the resident on whose behalf the complaint is brought).

⁴ Kurtz, B.A., June 15, 2004 Letter to the Administration on Aging. p.3.

Confidentiality is not only a provision of the Older Americans Act; it is also a basic tenet of ombudsman programs across the country – and the world. The American Bar Association in 2001 approved standards for ombudsman programs in the United States, focusing on the basic principles of all ombudsman programs: confidentiality, independence, and impartiality in conducting inquiries and investigations.⁵

LTCO work at the direction of the resident/victim and are not authorized to take actions without consent. The LTCOP works in a preventative way as well as working to correct problems. Ombudsmen encourage others to report abuse, frequently make referrals to other agencies, work with the victims of abuse, and seek to protect other residents. The LTCOP also focuses on a range of quality of care and quality of life issues.⁶

The OAA requires the LTCO Program to advocate for resident interests. Therefore, the role of an investigation is not primarily to determine whether any entity is guilty of wrongdoing, but rather to determine whether the problem can be resolved ‘to the satisfaction of the resident’ (see the National Ombudsman Reporting System instructions). In this capacity, the LTCO is first focused on protecting the rights and the autonomy – and therefore the dignity – of the resident. Residents living in facilities have lost so much of their independence and have so few opportunities for self-determination. LTCO involvement seeks to restore opportunities for decision-making and promote the resident’s self-determination.⁷

Abuse is only one of the many types of complaints received by the LTCO Program. The National Ombudsman Reporting System (NORS) provides 133 complaint categories, but only seven relate to abuse, gross neglect, or exploitation. In Federal Fiscal Year 2005, only 6.8% of complaints from nursing homes and similar facilities (20,622 of 303,330 closed complaints made to the LTCO nation-wide) related to abuse.⁸ This is not to say that abuse complaints are not a critically important part of the LTCO work, but that response to abuse is not the sole purpose of the LTCO Program. In the vast majority of states, the LTCO is not the principal investigator of abuse in long-term care. Frequently, the LTCO gets involved upon request of the resident or resident representative and takes on the role of providing victim assistance, rather than as an investigator for the purpose of enforcement. The LTCO role related to abuse primarily is proactive, directed toward keeping abuse from happening and making sure that appropriate agencies are involved and responsive. The LTCO focuses on educating and informing residents, family members, and facility staff – and

⁵ Ibid. p.1.

⁶ Ibid, p.3.

⁷ Ibid. p.2.

⁸ See AoA website for 2005 National Ombudsman Reporting System Data Tables at:
http://www.aoa.gov/prof/aoaprogram/elder_rights/LTCombudsman/National_and_State_Data/2005nors

*even law enforcement. Ombudsman programs widely participate in the Older Americans Act Elder Abuse Prevention projects. Ombudsmen also train residents and staff to recognize and report signs of abuse.*⁹

Ombudsman programs also have a federal mandate to advocate for changes in the systems that provide or regulate long-term care services in their geographic area. In this regard, the program differs substantially from APS, which focuses its advocacy efforts solely on individual clients. As a system change advocate, an Ombudsman is authorized to review and comment on federal and state legislation, as well as to suggest changes to the way that service delivery systems interact with each other in their efforts to improve the quality of life of vulnerable elders.¹⁰ APS programs have no such legislative authorization.

Differing Roles

A critical difference between APS and LTCO programs is that APS *reacts* to incidents of abuse, exploitation and neglect, responding after the maltreatment has occurred or is suspected to have occurred. The role of APS is to receive an abuse report, conduct a thorough investigation of the allegations, including gathering information from a variety of sources, and develop a case plan to reduce or eliminate further victim risk. In most states, conducting an APS investigation does not require the consent of the victim, and generally APS may make a direct report to law enforcement if a crime has been committed.

In contrast, as stated above, the LTCO Program works proactively to prevent abuse through educating residents, families and facility staff to recognize and report abuse. The program is not designed to provide emergency crisis responses, but it is required under the OAA to ensure that residents have “regular and timely access” to ombudsman services. Most LTCO Programs attempt to make regular visits to facilities to check in with residents, although the frequency and timeliness of LTCO visits to facilities varies widely among programs. While some LTCO are able to make regular weekly or monthly visits to facilities, due to lack of resources many are not. Thus, some residents have only a limited opportunity to develop a trusting relationship with the LTCO in order to feel comfortable about revealing possible abuse.

BACKGROUND

In 1992 the National Association of State Units on Aging (NASUA) conducted a pilot study of five states on the relationship between the APS and LTCO Programs, which resulted in the following recommendations:

⁹ Ibid. p.2.

¹⁰ *Coordination Between Long-Term Care Ombudsman and Adult Protective Services Programs and Related Issues, Report on a Symposium*, October 25-26, Washington, DC. U.S. Department of Health and Human Services, Administration on Aging, March 1994.

- Guidance and technical assistance should be provided to both APS and LTCO programs in order to promote coordination, with a focus on addressing the Ombudsman's obligation in regard to state mandatory abuse reporting requirements while adhering to the OAA ombudsman confidentiality requirements.
- Mechanisms to increase resources available to monitor the care vulnerable adults receive should be expanded.
- Ombudsman services should be expanded to additional forms of long-term care, such as community-based agency operated residences and agency-provided in-home services.
- Research into the problems involved in enforcing existing laws and regulations designed to protect recipients of long-term care from abuse should also be expanded.¹¹

Following this initial study, in 1993 the Administration on Aging brought together representatives from APS and the LTCO programs to discuss the roles and responsibilities of the two entities as well as their relationships with each other. Among the recommendations from this symposium were the following related to roles:

- Issue guidance to States which discusses similarities and differences in roles between APS and Ombudsmen.
- Convene meetings at the state, regional and local levels to discuss and clarify the roles and functions of APS and the Ombudsman programs and explore ways that the two programs can work together and be mutually supportive.
- Keep the roles of APS and Ombudsman separate and distinct, recognizing that each is important to under-gird elder rights.

Emphasizing the separate roles of the two programs, the symposium also recommended: "(a prohibition on) an ombudsman...also being an APS worker...If there is not enough money to fund both programs, acknowledge this reality, and do not claim both are being done.... Where State Adult Protective Services agencies are not currently investigating abuse, neglect and exploitation in long-term care facilities, work...to designate APS to perform this function; and advocate for funding for APS adequate to carrying out this responsibility."

The symposium report made other ground-breaking recommendations regarding LTCO confidentiality and mandatory abuse reporting requirements; balancing protection and self-determination for residents; and ombudsman reporting of abuse complaints.¹²

In 1995 the AoA conducted a series of Elder Rights Symposia around the country to encourage collaboration between the various entities funded by the Older Americans

¹¹ Hasler, Bonnie Sether. 1992. *Relationship Between Adult Protective Services and Long-Term Care Ombudsman Programs*. National Eldercare Institute on Elder Abuse and State Long-Term Care Ombudsman Services, Washington, D.C. pp ii-iii.

¹² *Coordination Between Long-Term Care Ombudsman and Adult Protective Services Programs and Related Issues. Report on a Symposium, October 25-26, 1993*. U.S. Department of Health and Human Services, Administration on Aging, March 1994.

Act. Both APS and LTCO programs were represented at these meetings, although APS is not funded through the Older Americans Act and in many states is not part of aging services. While this process generated much enthusiasm, little follow-up occurred.

In 2002, a two-day national retreat held by the National Association of State Long-Term Care Ombudsman Programs rekindled interest in the issue. A report from that meeting, *The Long-Term Care Ombudsman Program: Rethinking and Retooling for the Future*, provided a number of recommendations designed to further collaboration between APS and LTCO programs. These recommendations included proposing better communication and closer working relationships between NASOP and the National Adult Protective Services Association (NAPSA), as well as other entities. The purpose of this collaboration would be to encourage peer education and to support systems advocacy to improve the quality of residents' lives in long term care facilities.¹³

Recognizing that much still needed to be done to further this collaboration, NAPSA, a partner in the National Center on Elder Abuse (NCEA), agreed that the President of NASOP and the Executive Director of NAPSA would co-lead a workshop at the 2003 state LTCO spring training conference in Chicago. The purpose of the workshop was to gain a clearer understanding of each other's roles and to identify promising practice situations that demonstrated each program's ability to work collaboratively to provide the best services to residents. The following issues were identified as a result of focused discussions:

1. Each program must get all the information necessary to provide the most effective services to vulnerable adults.
2. Each must also initially screen to ascertain whether a resident has capacity to make informed decisions about his or her care or whether a capacity assessment needs to be conducted by a medical provider.
3. It is important to determine what information can be shared between the programs, consistent with the roles, responsibilities, and confidentiality requirements of each.
4. The issue of state APS mandatory reporting laws needs to be clarified, because of the difficulty that Ombudsmen encounter when attempting to comply with state law while still protecting residents' confidentiality in compliance with the federal requirements in the OAA.¹⁴

Both NAPSA and NASOP participants agreed that the session was helpful in gaining a better perspective about each other's roles and the complex issues that make the work so difficult. While this workshop benefited the participants, it was clear that additional opportunities for communication should occur. For this reason, NAPSA then convened four regional meetings of state and local APS and LTCO representatives supported by funds from the Administration on Aging. Prior to attending these meetings, participants

¹³ National Association of State Long-Term Care Ombudsman Programs. 2003. *The Long-Term Care Ombudsman Program: Rethinking and Retooling for the Future*.

¹⁴ Hunt, Sara. 2003. *Long-Term Care Ombudsmen and Adult Protective Services: Roundtable Discussion Session Summary*. 2003.

were provided with material prepared by NASOP consultant Sara Hunt, so that they would be familiar with the discussions that had occurred in Chicago.

A total of fifty-two people (forty NAPSA members and twelve ombudsmen) participated in the regional meetings that were held in New York City; Denver, Colorado; Portsmouth, New Hampshire and Shreveport, Louisiana. Participants from twenty-one states included representatives from Offices of the State Long-Term Care Ombudsman and state and local APS Administrators. To guide their discussions, participants were instructed to identify systemic problems that create barriers to APS/LTCO collaboration, share examples of cooperative activities between APS and LTCO programs, and agree upon shared concerns for further action. In addition, a follow-up discussion of collaboration practices between the two programs, also funded by AoA, was held at the annual NAPSA conference in October 2003.

SUMMARY OF DISCUSSIONS

Information from the discussions held at the four regional meetings and the national conference is summarized below.

Reporting Barriers

Reporting by LTCO to APS continues to be a challenge for both programs. Conflicts between federal LTCO statutes and state APS laws and regulations, as well as inconsistent interpretations of statutory intent, continue to confuse LTCO reporting and release of information procedures. Forty-four states have mandatory APS/Elder Abuse reporting laws. However, even though the federal Older Americans Act is clear about prohibiting LTCO from sharing resident information without the resident's consent, twenty-one state statutes mandate, and 11 states encourage, LTCO to report abuse to APS.

In the regional discussions APS professionals expressed concern that only 0.5% of the 472,813 reports came from Ombudsmen in 2000.¹⁵ It was apparent in these discussions that some APS professionals were unaware of the federal reporting limitations imposed on the LTCO program. Ombudsmen, however, must comply with federal language in the Older Americans Act that prohibits them from disclosing information without the resident's consent.¹⁶ Some of the Ombudsmen who participated in these discussions said that they often feel conflicted by the contradictory requirements of federal and state legislation.

On the other hand, while some state laws name Ombudsman as required reporters, there is no similar requirement for APS to report to the Ombudsmen. Ombudsmen complain that sometimes when they make abuse reports to APS, APS does not provide

¹⁵ Teaster, Pamela B, Ph.D., *A Response to the Abuse of Vulnerable Adults: the 2000 Survey of State Adult Protective Services*. National Center on Elder Abuse, Washington, DC. pp. 17, 23.

¹⁶ Older Americans Act, Sec. 307 (12) (B).

follow-up information to them regarding the status of the report and case outcomes, nor does the LTCO have access to information in APS records, because of APS' own confidentiality requirements.

There was much discussion of this problem at all of the meetings covered in this report.¹⁷ Some of the discussion addressed shared concerns such as:

- Can/should both programs agree on similar definitions of abuse, exploitation, neglect and self-neglect?
- Can/should state statutes spell out APS and LTCO responsibilities to share information on clients and provide waivers for confidentiality?
- Does the federal Older Americans Act always supersede state law, even when victim safety is an issue?
- If the LTCO finds a resident who is seriously injured, should a report be made? If so, should the report go to APS (in those states where APS is responsible for facility abuse investigations) or directly to law enforcement?
- Are ombudsmen required to file reports in states that have elder/adult abuser registries? If so, can ombudsmen request perpetrator information from these registries? (It was noted that not all APS abuse registries include information on perpetrators in the community. Some only cover employees in health care, licensed long-term care facilities and home care services.)

Program Location: Pros and Cons

The administrative location of APS and LTCO programs in state and local systems may also contribute to the difficulty or ease of working together. In roughly half the states, the APS program is located within the State Unit on Aging.¹⁸ In some of these states, one staff person may be administering both the APS and LTCO programs. APS and LTCO professionals agreed that this situation presents at least a potential conflict of interest, particularly when the victim's confidentiality is involved, or when program responses differ. This can happen, for example, when APS places a family abuse victim in a facility to protect them, and the ombudsman, following the resident's wishes, then works to move the person back home. If one person supervises both programs, and backs the APS Program's decision to place the person in a facility for their safety, then the Ombudsman, in following the resident's wishes to help them leave the facility, is in direct conflict with their supervisor.

Some APS administrators whose programs are housed in state or local aging services programs feel that this location limits both APS program visibility and autonomy, and may confuse the roles of service provider, APS and LTCO programs. As an example, historically, aging services have not focused on situations with criminal implications that require a response from law enforcement and the justice system. If the APS and LTCO

¹⁷ Note: these concerns apply to states where APS investigates abuse in facilities, although some states such as Illinois require ombudsmen to report abuse to the non-APS facility abuse investigating agency.

¹⁸ Teaster, Pamela B., *PhD., A Response to the Abuse of Vulnerable Adults: the 2000 Survey of State Adult Protective Services*. National Center on Elder Abuse, Washington, DC. pp. 14.

programs are subsumed under traditional aging services and hence are not as visible to the larger community as they might be, it affects the number of abuse reports made. Not receiving abuse reports inhibits the ability of APS, law enforcement and regulatory staff from carrying out their statutory mandates and increases victim risk as well as program liability.

On the other hand, participants pointed out that sometimes co-location in the same agency enhances communication. As an example, in Arkansas the LTCO is housed in the same division as APS. Both APS and the LTCO conduct joint training and successfully work together on other projects. Illinois for many years also had the Elder Abuse and LTCO Programs co-housed at the State Unit on Aging in a Bureau of Elder Rights, where they operated independently of one another but jointly sponsored an annual statewide Elder Rights Conference, and occasionally trained together at other times on topics of mutual interest, such as investigation skills

Shrinking Resources

Both the APS and LTCO program representatives expressed frustration about constant government agency reorganizations and downsizing. As examples: New York City reported about 500 abuse cases per month from nursing homes that needed APS investigations, yet at the time of the meetings, more APS staff cuts were proposed, thus limiting the program's ability to respond to these reports. And in Texas, Health and Human Services was undergoing reorganization, and had budget cuts resulting in a 25% reduction in staff to investigate abuse in Mental Health/Mental Retardation (MHMR) facilities, as well reductions in mental health services, Medicaid waiver services and the nursing home allowance. These reductions could be expected to increase APS caseloads, and without these essential follow-up resources, APS would be less able to protect abuse victims from further harm.

When state statutes or organizational structures are changed without input from stakeholders, the way that agencies work together may be affected. It means that program staff must continually be reeducating new superiors and system partners about program requirements and limitations. The chaos that results from agency restructuring and reductions in staff seriously impacts productivity, as workers focus on job security, sometimes to the detriment of service delivery. Reduced funding for both APS and LTCO negatively impact both systems' ability to respond promptly and thoroughly to abuse reports. In addition, reduced finances can result in reduced LTCO presence in facilities, less ombudsman access for residents and less work on abuse prevention activities.

Positive Practice Collaborations to Address Shrinking Resources

Both APS and LTCO participants agreed that shrinking resources demand closer cooperation between the two programs, as well as more precise role definitions. Duplication of services is counterproductive. A willingness to share scarce resources, particularly in the area of staff training, can result in several positive outcomes. Cross-

training enhances communication and cooperation. It also provides mutual emotional support to staff. As an example, Texas provides cross-training for APS and LTCO staff so they will better understand each other's respective roles.

And in Maine, in collaboration with the APS program, the State LTC Ombudsman has been active with the Maine state legislature, working to change laws, regulations and policies that affect consumers of long-term care services. The State LTC Ombudsman has legal authority to advocate for system change directly with the legislature. APS does not have this authority, and thus relies on the LTCO to communicate to legislators about issues of mutual concern, including shrinking resources for both programs.

Another creative response to shrinking resources is the development of multi-disciplinary teams that meet on a regular basis to share responsibility for individual cases of vulnerable adult/elder abuse, as well as to address gaps in services and systemic problems. Both APS and LTCO program staff in Maine participate in these teams. Such face-to-face contacts over an extended period of time have done much to improve cooperation between team members and have resulted in better services to victims of abuse.

Inconsistent System Responses

Both APS and LTCO representatives agreed that inconsistent system responses contribute to miscommunication and frustration. The lack of written federal policies and/or program instructions for both APS and LTCO programs compounds role confusion and miscommunication. The current operation of APS and LTCO programs varies from state to state, and even from county to county within a state.

The following are examples of differing state responses to abuse in long-term care. In Illinois, APS does not conduct abuse investigations in long-term care facilities, and ombudsmen do investigate financial abuse of residents by family members. In Kansas, APS only investigates abuse which occurs in the community, unless an outsider abuses a resident in the nursing home. In Iowa and Minnesota, APS enters facilities when a resident is in immediate danger; and in Missouri, APS workers must respond to all abuse reports in long-term care facilities within 24 - 48 hours.

In a number of states there has been little cross-training between APS and LTCO programs, and as a result, local ombudsmen and APS workers are not clear about each other's roles. Because of different standards and procedures, there are organizational and personal conflicts that have occurred over the years in some areas that must be healed before true collaboration can occur. In addition, often the public is unaware of the existence of either program, or unaware of the differences between the two programs. Concerned family members from one state or locality may have unrealistic expectations about how APS and/or LTCO program staff in another location should respond to the abuse of a loved one. Without clear and consistent guidelines, misunderstanding and blaming may occur during the highly charged atmosphere of an abuse investigation.

Positive Practices to Improve System Responses

In an effort to overcome some of this role confusion, Kentucky developed a *Memorandum of Understanding with the Long-Term Care Industry*. This agreement requires facilities to share patient abuse findings with the LTCO. It also calls for regular quarterly meetings to clarify program roles and responsibilities, particularly as they relate to facility closures and patient relocation. According to participants at one of the regional meetings, this process has done much to standardize LTCO responses when a patient is abused or facility relocation occurs. A cautionary note was expressed, however, by some ombudsman advocates subsequent to the meetings, noting that this arrangement has the potential to confuse the LTCO's role by making it appear that ombudsmen are involved in enforcement activities, and that it might also skew the program's use of resources.¹⁹

Georgia has also developed a *Memorandum of Understanding of Responsibility for Receiving and Investigating Allegations of Abuse, Neglect or Exploitation of Disabled Adults and Elder Persons*, which has been included in this report as Appendix B.

In New Hampshire, the state LTCO convened a meeting of representatives from the State Licensing and Certification Agency, the Medicaid Fraud Control Unit, which investigates facility abuse and neglect in Medicaid/Medicare certified facilities, and APS to discuss their roles and responsibilities. A training outline was developed for joint presentations by APS, LTCO and the State Facilities Licensing staff to explain to facility staff each individual agency's role, protective responsibilities and procedures.

Problems in Assisted Living Facilities

Both APS and LTCO participants expressed strong concerns regarding the proliferation of licensed and unlicensed assisted living facilities. They identified many problems relating to quality of care due to lack of regulation and oversight. They noted the industry's strong lobbying presence, and that few federal or state standards have been passed, and fewer are enforced. A national assisted living group worked for two years but members were unable to agree on definitions of terms. Participants at the APS/ombudsman regional meetings said that while many facilities claim that they self-regulate, consumer advocates question that assertion. There is also a perception, according to participants, that the government should not regulate private enterprise, so whatever regulations do exist are not enforced.

Often families see assisted living as a more home-like living option than a nursing home. However, many of the residents in assisted living have medical needs that require a higher level of care than can be provided in assisted living, and may not be appropriate for placement there. In addition, often abuse by assisted living home care providers is not being reported to the Ombudsman, APS, or other appropriate investigating agency.

¹⁹ Comments provided in August, 2007 by Sue Wheaton of AoA.

As with many other areas of discussion at these meetings, it is apparent that states treat assisted living regulation in a variety of ways. For example, while Iowa certifies all assisted living facilities, in Missouri, regulators only enter licensed residential care facilities. The Montana LTCO spent a year trying to upgrade standards for assisted living, but was unsuccessful.

Positive Practice Responses to Assisted Living Problems

In an effort to improve the quality of care in assisted living facilities, Wyoming planned a conference on assisted living that included LTCO and APS staff.

Guardianship Issues

The lack of affordable, trained, and appropriate guardians and public administrators to act on behalf of incapacitated adults is an issue for both programs. In some cases, people such as realtors and auctioneers have been appointed as guardians and have benefited materially from handling the ward's estate, which is a conflict of interest. In other situations, guardians have swindled their wards out of money and property. It is not unusual for nursing homes to demand that APS assume guardianship of residents in order to recover unpaid bills or authorize medical care. Participants raised several guardianship related issues, including:

- Whether it is a conflict of interest for APS staff to act as guardians themselves, particularly when they work for agencies that also provide services and benefits to wards, such as Medicaid, home and community waiver services, home care, etc. LTCOs questioned whether APS can be objective in these situations.
- By the same token, it was agreed that LTCOs also should not serve as guardians, but should focus on advocating for effective guardianship services and alternatives to guardianship.
- Since, ideally, neither APS nor LTCOs should serve as guardians, who should? Often APS programs have clients who suffer from a combination of mental health, mental retardation, and substance abuse problems, as well as dementia and violent behaviors, making finding a guardian particularly difficult.
- How can a guardianship system be organized that does not result in abuse?
- Can APS or the LTCO assist a resident in overturning a guardianship action? If so, who would initiate the court action?

As with other issues, a number of problems related to guardianship emerged. For example: in Wyoming a private, non-profit agency acts as guardian for indigent clients, but the program is under-funded. In Colorado there is no office of the public guardian, and sometimes no one but APS is available to assume guardianship. APS is seen as the last resort in a guardianship appointment, and decisions made on behalf of wards are often limited by the court. In Illinois, APS may petition for guardianship but may not be appointed guardian, and Ombudsmen never initiate guardianship actions.

Collaborative Solutions to Guardianship

There are some APS programs that have developed specialized approaches to guardianship in order to assure that the interests of wards are well represented. The Iowa Department of Elder Affairs allows APS to petition on behalf of a client. However, someone else is designated by the court to actually serve as the guardian, similar to what happens in Illinois. Texas has specialized APS workers who act only as guardians and do not have other APS roles. In Denver, Colorado there is a community Bioethics Committee that advises APS guardians on difficult medical and end-of-life decisions that they need to make on behalf of their wards. Oklahoma has developed an advocacy program for all wards. Court Appointed Advocates for Vulnerable Adults (CAAVA) is a new organization authorized by Oklahoma state statute in 2002. The law gives the local judge the authority to appoint a CAAVA volunteer in every adult guardianship proceeding, not just APS guardianships.

Problems Related to the Olmstead Decision

From the perspective of the participants, the Olmstead decision of the U.S. Supreme Court, requiring the states to provide community-based alternatives to persons with disabilities who can appropriately live in the communities, has resulted in client relocations, as well as increased demand for follow-up supportive services in the community. These factors have put a strain on LTCO and APS staff. In Minneapolis, a number of voluntary facility closures that occurred simultaneously with implementation of Olmstead made it necessary for APS to hire additional staff to handle the relocations, resulting in a funding crisis for the program.

A Proactive Response to Olmstead Induced Relocations

As a way of being proactive in these situations, Georgia has developed a facility relocation team, including APS and LTCO, so that roles and responsibilities will be clearly in place and understood before facility relocations occur.

Problems Related to Consumer Directed Care

While both APS and LTCO respect and support clients' and residents' right to self-determination, including the right to choose and oversee their home health care providers, there was agreement that the consumer-directed care movement has the potential to generate abuse and exploitation of vulnerable seniors, and that safeguards must be incorporated into the programs to reduce or eliminate these threats.

As one aspect of Consumer-Directed Care, consumers may choose family members as care providers because they know them, and/or want to help them financially, even if the family member may not be the most qualified care provider. In some situations, consumer-directed care can be an invitation for financial exploitation, neglect and abuse, especially for patients with diminished capacity. Consumers may be too

intimidated to fire the care provider they have chosen, or there may be family or other pressures not to do so.

In addition, consumer-directed care often does not accommodate changes in the patient's functioning levels in a timely manner. Consumers should not have to wait until their conditions deteriorate to the point that APS is called in order to have safe and adequate care. While the advantages of consumer-directed care have been widely publicized, participants agreed that not enough information has been provided to consumers or families on the potential for abuse, exploitation and/or neglect.

States Responses to Consumer-Directed Care

Some states are taking a proactive approach to consumer directed care. Idaho has a monitoring service that allows only adults who are competent to make decisions regarding their care providers. If the consumer is found to lack decisional capacity, a guardianship action is initiated. And Illinois has specialists who oversee the recipients of Consumer-Directed Care. They take the approach that what the consumer wants and what is in his/her best interest should be the same. Illinois also has informational materials sponsored by NASUA and the Robert Wood Johnson Foundation that can be found at: www.healthaffairs.org, and www.consumerdirection.org.

ISSUES FOR FURTHER DISCUSSION:

As has been previously mentioned, each of the discussion groups had various ideas for improving coordination between APS and LTCO programs. The process did not provide for achieving general consensus. However, a number of issues for further consideration were identified as follows:

Location of LTCO programs:

Participants indicated that a separate Office of the LTCO is one model that appears to enhance LTCO independence. An independent LTCO program may be better able to conduct effective systems advocacy which benefits both APS and LTCO clients. Another model for APS and LTCO programs provides for physical co-location but separate program administration.

System Responses:

Both programs need to keep their focus on the client/resident. Some ways to accomplish this include having APS and LTCO programs conduct cross-training, or perhaps schedule their respective state conferences back-to-back and encourage each other to attend. It was also suggested that state APS and LTCO program staff should meet at least twice a year, as should local program staff. If in-state travel is a problem, video conferencing might be arranged.

Participants supported passage of the Elder Justice Act to provide federal guidelines and standards for APS as well as additional resources for advocates for long-term care residents. Participants felt that NASOP and NAPSAs should work together for the passage of the Elder Justice Act and a realistic appropriation to implement it.

Participants also agreed that there need to be national standards for the LTCO program.

Assisted Living Facilities:

NAPSAs and NASOPs should work together at the national level on assisted living and home care issues. Assisted living facilities need to be regulated with definitions, standards and enforcement. All agreed that there must be bottom line standards. Any assisted living facility that is registered or certified should be open to LTCO programs, APS, and other appropriate investigating agencies. LTCOs should be visiting residents of all assisted living facilities on a regular basis.

At the state level, NASOPs and NAPSAs should encourage meetings between regulatory agencies, LTCOs and APS regarding their respective roles and responsibilities related to assisted living facilities. Model memoranda of understanding could do much to resolve differences.

Guardianship:

Hospital and nursing home associations could be asked to provide funds for guardianship services for long-term care residents who are indigent. However, no one from the facility should be appointed as guardian, as that would be a conflict of interest. In some situations, mediation may be a better alternative than a court ordered guardianship.

Olmstead Decision:

States need to develop clear written protocols before resident relocation occurs—not during the process. Constant communication must be maintained among all the players during relocation activities. Federal funding for relocation activities would be helpful.

Consumer-Directed Care:

An article could be solicited for *Victimization of the Elderly and Disabled* on concerns regarding consumer-directed care that points out the differences in these care plans depending on the type of consumer disability: mental illness, physical disability, developmental disability, and/or frail elderly. A national study would be useful to determine the impact of consumer-directed care on abuse, exploitation and neglect of the consumers.

Promising practices from the states should be compiled. A checklist could be developed which would be used to determine if consumer-directed care is appropriate, including the patient's capacity to make informed choices regarding his/her care, background check requirements, and the ability of the program to provide oversight when consumers pay with their own funds.

CONCLUSION

In the past, a number of recommendations have been made for improving collaboration between APS and LTCO programs that, due to their broad nature and lack of specificity, have been difficult to implement. The meetings described in this paper provided many specific suggestions that could result in better cooperation and collaboration between APS and LTCO programs. The discussions held at these regional meetings were helpful in identifying mutual areas of concern and establishing greater levels of trust between APS and LTCO. It is recommended that they be continued at the national, state, and local levels.

NAPSA and NASOP have agreed to work together for system changes that benefit vulnerable adults. Clearly, APS and LTCO programs share many passionately held values concerning the safety and wellbeing of victims of abuse, exploitation and neglect. By providing strong leadership and joining together at the national, state and local levels, this collaboration has the potential to strengthen advocacy on behalf of vulnerable adults.

APPENDIX A

RESOURCES

Administration on Aging, Administration for Children and Families, U.S. Department of Health and Human Services, 1998. *The National Elder Abuse Incidence Study*, Washington, D.C.: National Center on Elder Abuse and the American Public Human Services Association, with Westat.

Coordination Between Long-Term Care Ombudsman and Adult Protective Services Programs and Related Issues, Report on a Symposium, October 25-26, Washington, DC. U.S. Department of Health and Human Services, Administration on Aging, March 1994.

Hasler, Bonnie Sether. 1992. *Relationship Between Adult Protective Services and Long-Term Care Ombudsman Programs*. National Eldercare Institute on Elder Abuse and State Long-Term Care Ombudsman Services, Washington, D.C.

Hunt, Sara. 2003. *Long-Term Care Ombudsmen and Adult Protective Services: Roundtable Discussion Session Summary*. 2003.

National Association of State Long-Term Care Ombudsman Programs. 2003. *The Long-Term Care Ombudsman Program: Rethinking and Retooling for the Future*. January 31-February 2, 2002. Peachtree City, GA.

Older Americans Act of 1965.

Teaster, Pamela B, Ph.D., *A Response to the Abuse of Vulnerable Adults: the 2000 Survey of State Adult Protective Services*. National Center on Elder Abuse, Washington, DC.

APPENDIX B

Georgia Memorandum of Understanding of Responsibility for Receiving and Investigating Allegations of Abuse, Neglect or Exploitation of Disabled Adults and Elder Persons

Whereas, the health, safety, welfare and rights of disabled adults and elder persons is a priority for the Georgia Department of Human Resources (DHR); and

Whereas, several divisions and offices of the Department of Human Resources have separate mandates or other oversight responsibilities that may overlap with regard to the investigation of alleged abuse, neglect and exploitation of disabled adults and elder persons in DHR services; and

Whereas, it is critical that the Division of Aging Services (DAS), the Office of Regulatory Services (ORS), and the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) utilize their resources efficiently and effectively to investigate instances of possible abuse, neglect or exploitation; and

Whereas, a Memorandum of Understanding of Responsibility for Receiving and Investigating Allegations of Abuse, Neglect and/or Exploitation of Disabled Adults and Elder Persons was developed in 1996,

Now, therefore, it is mutually understood and agreed by the parties that the 1996 Memorandum of Understanding is hereby revised and updated as follows:

The provisions of this memorandum are established within the framework of the following statutes, rules and policies:

DISABLED ADULTS AND ELDER PERSONS PROTECTION ACT, O.C.G.A. § 30-5-1 through § 30-5-10, Assures the availability of protective services to all disabled adults and elder persons in need of such services.

MEMORANDUM OF UNDERSTANDING BETWEEN THE GEORGIA DEPARTMENT OF HUMAN RESOURCES AND ITS DIVISION OF AGING SERVICES CONCERNING ADULT PROTECTIVE SERVICES provides for the transfer of all administrative and operational responsibility and authority for Adult

Protective Services (APS) to the DAS. The DAS is designated by the Department as the adult protective services agency.

LONG-TERM CARE FACILITY RESIDENT ABUSE REPORTING ACT, O.C.G.A. § 31-8-80, The DHR has placed responsibilities for this Act with ORS.

LONG-TERM CARE OMBUDSMAN PROGRAM ACT, O.C.G.A. § 31-8-50, Duties of the State and community ombudsman in receiving, investigating and attempts made to resolve complaints made on behalf of residents in long-term care facilities are the responsibility of the Office of the State Long-Term Care Ombudsman administratively attached to the DAS.

MISTREATMENT, NEGLECT OR ABUSE OF PATIENTS, O.C.G.A. § 37-3-165, Mistreatment, neglect or abuse in any form of any patient is prohibited....

DEPARTMENT OF HUMAN RESOURCES RULES AND REGULATIONS FOR CLIENTS RIGHTS 290-4-9-.04, REMEDIES FOR VIOLATIONS AND PATIENTS RIGHTS 290-4-6-.07, Procedures for investigations alleging abuse, neglect and exploitation in DMHDDAD operated nursing homes and State funded group homes.

DEPARTMENT OF HUMAN RESOURCES RULES AND REGULATIONS FOR PERSONAL CARE HOMES, CHAPTER 290-5-35, Minimum standards for the operation of homes that provide residential services to disabled adults or elder persons.

DEPARTMENT OF HUMAN RESOURCES RULES AND REGULATIONS FOR COMMUNITY LIVING ARRANGEMENTS, CHAPTER 290-9-37, Minimum standards for the operation of community living arrangements that provide residential services exclusively to MHDDAD consumers.

DEPARTMENT OF HUMAN RESOURCES, DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND ADDICTIVE DISEASES, POLICY 2.101, "Reporting and Investigating Deaths and Serious Incidents."

I. REPORTS ALLEGING ABUSE, NEGLECT OR EXPLOITATION OF DISABLED ADULTS OR ELDER PERSONS WHO ARE NOT RESIDENTS OF FACILITIES LICENSED AS NURSING HOMES, INTERMEDIATE CARE HOMES, PERSONAL CARE HOMES OR COMMUNITY LIVING ARRANGEMENTS

Such reports will be received at the Adult Protective Services Centralized Intake call center that will receive APS inquiries and referrals for the State of Georgia.

A. Allegations of abuse, neglect or exploitation received by ORS or MHDDAD or a contracted provider shall be immediately referred to APS. MHDDAD will verify that a contracted provider has made the report to APS.

B. The report may be made to DAS APS either by oral or written communication.

C. The DAS APS will send written acknowledgment to the reporter and conduct a prompt and thorough investigation/assessment to determine whether the disabled adult/elder person is in need of protective services and what services are needed.

D. The DAS APS investigation/assessment includes a visit to the disabled adult/elder person, consultation with the reporter and others having knowledge of the facts surrounding the allegations, assessment regarding the overall safety/vulnerability of the adult at risk, case determination and report to law enforcement when warranted.

E. The DAS APS will immediately provide or arrange for protective services for any disabled adult/elder person who is at risk and consents to services.

F. The DAS APS may contact the staff and physicians of local health departments, mental health clinics, and other public agencies for their full cooperation in the performance of duties mandated under the Disabled Adults and Elder Persons Protection Act.

G. The DAS APS will make reports to law enforcement agencies as directed by the Disabled Adults and Elder Persons Protection Act.

H. The DAS APS will document investigative findings and will provide a summary of the findings to the referring Division within 15 business days following the completion of the APS investigation. The referring agency agrees to not redisclose confidential DAS APS findings.

I. The regional office of the DMHDDAD will be available to consult or share information if the disabled adult or elder person is receiving publicly funded services for mental illness, developmental disabilities or addictive diseases.

II. REPORTS ALLEGING ABUSE, NEGLECT OR EXPLOITATION OF RESIDENTS OF NURSING HOMES, INTERMEDIATE CARE HOMES, PERSONAL CARE HOMES, AND COMMUNITY LIVING ARRANGEMENTS

A. Allegations of abuse, neglect or exploitation received by APS, the Community Care Services Program (CCSP) or MHDDAD or a contracted provider shall

be immediately referred to ORS. MHDDAD will verify that a contracted provider has made the report to ORS.

B. ORS will investigate all allegations of abuse, neglect or exploitation in accordance with established protocols and to comply with the Long-Term Care Resident Abuse Reporting Act, O.C.G.A. § 31-8-80.

C. ORS may request assistance from APS for concurrent investigation or other action, including the potential voluntary relocation of residents. ORS may also contact the LTCO, CCSP Medicaid waiver, or MHDDAD to request assistance in determining the extent of the situation or to protect the individual. Where relocation is necessary, MHDDAD and CCSP will assist in relocation of residents funded by their respective programs, and the LTCOP will assist residents and their representatives by providing information and support.

D. ORS will make abuse, neglect or exploitation referrals to law enforcement agencies as appropriate

1. in situations where there is immediate and serious threat to resident health and safety,
2. when alleged sexual abuse is involved,
3. when agencies investigating alleged abuse, neglect or exploitation are denied access to the facility or to the residents and
4. in cases of alleged criminal exploitation.

In such cases, ORS will request copies of pertinent police reports to determine the extent of the situation and to protect the individual.

E. When allegations of abuse, neglect or exploitation occur in a licensed community living arrangement or nursing home, intermediate care facility, or personal care home operated by MHDDAD or under contract with MHDDAD:

1. The facility must:
 - a. immediately report such allegation to ORS,
 - b. also report to MHDDAD in accordance with Division policy, and
 - c. for nursing homes certified to participate in Medicaid, report to ORS within 5 working days the results of all investigations.
2. MHDDAD will, upon receipt of a facility report, verify with the regional office or the provider that ORS has been notified.
3. ORS will, upon receipt of such reports, notify MHDDAD for review/investigation and whatever action deemed appropriate to protect residents, up to and including relocation of residents.

F. APS will assist persons to make reports of alleged abuse, neglect or exploitation in long-term care facilities as necessary. If the situation is one of imminent danger, APS staff will notify ORS immediately.

G. APS will accept from ORS, the long-term care ombudsman, or MHDDAD as an APS referral, a report of alleged abuse, neglect or exploitation of a disabled adult or elder person, residing in a long-term care facility, when:

1. the alleged act is reported to have occurred outside the facility and the resident is not under the supervision of the facility; or
2. the alleged perpetrator is not an employee or a resident of the facility; or
3. the abuse, neglect or exploitation is alleged to have been committed by a guardian.

H. ORS will notify the reporter about the outcome of the investigation of the alleged abuse, neglect or exploitation.

I. ORS will maintain all reports involving nursing homes, intermediate care homes, personal care homes, and community living arrangements. Records of the report, investigation and current condition will be recorded in a manner that will result in efficient data retrieval regarding number, type, location and disposition of the reports and investigations.

J. If the alleged victim is a resident of a facility operated or funded by MHDDAD, ORS and MHDDAD will exchange information and maintain communication regarding the investigations and findings. If the alleged victim receives services through DAS CCSP, ORS and DAS CCSP will exchange information and maintain communication regarding the investigation and findings.

III. THE ROLE OF THE LONG-TERM CARE OMBUDSMAN PROGRAM IN RECEIVING AND INVESTIGATING ALLEGATIONS OF ABUSE, NEGLECT AND EXPLOITATION IN LONG-TERM CARE FACILITIES

A. The Long-Term Care Ombudsman Program (LTCOP) receives, identifies, investigates and works to resolve complaints made by or on behalf of residents of long-term care facilities (including nursing homes, intermediate care facilities, personal care homes, and community living arrangements). The LTCOP works to resolve complaints to the satisfaction of the resident and to protect the resident's health, safety, welfare, and rights.

B. Complaints to the LTCOP include, but are not limited to, complaints regarding abuse, neglect and exploitation. In abuse, neglect or exploitation cases, the focus of the LTCOP is to assure that the alleged victim receives needed protection and support.

C. The purpose of the LTCOP investigation is to verify the truth of the complaint for purposes of determining strategy for resolving the complaint. The LTCOP does not have the authority to take regulatory or criminal action based on

its findings, but may make appropriate referrals to regulatory and/or law enforcement agencies.

D. The LTCO shall make a referral of a complaint involving abuse, neglect or exploitation to the ORS (or to APS, as appropriate) where:

1. the resident gives permission to do so,
2. the resident is unable to communicate his or her wishes, or
3. the LTCO personally witnesses the abuse of a resident (unless the alleged victim requests the LTCO to not make such report).

Where a resident refuses to provide permission to report, the LTCO shall continue to take steps to support the alleged victim and to encourage reporting of the abuse, pursuant to LTCO policies and procedures.

E. Where the facility provider, employee or any other mandated reporter informs the LTCO of the alleged abuse, the LTCO shall inform that individual of his or her duty to report to ORS. Where any other person informs the LTCO of the alleged abuse, the LTCO shall inform him or her of the role of ORS in investigating abuse in long-term care facilities, provide contact information to ORS, and encourage the reporting of the alleged abuse.

IV. GENERAL RESPONSIBILITIES OF ALL PARTIES

A. In addition to the specific responsibilities outlined in this agreement, the parties agree to maintain ongoing communication and to consult, cooperate, coordinate, and collaborate at all levels on matters of common obligation relating to allegations of abuse, neglect and exploitation of disabled adults and elder persons consistent with their legally mandated rules and limitations. The parties shall take all actions necessary to ensure the health and safety of disabled adults and elder persons at risk of abuse, neglect or exploitation.

B. Each division or office shall take all steps necessary to educate and train staff to implement this agreement.

C. Each division or office shall provide the parties of this agreement with current contact information as well as updated information as changes are made for the purposes of this agreement.

D. Each division or office shall document referrals and other contacts made regarding cases covered by this agreement.

E. Confidentiality of information:

1. In general, documents may be shared among parties to this agreement. However, all documents shared between divisions and offices must be maintained subject to the confidentiality requirements of all applicable state and federal laws and Department policy.

2. All records of the DAS APS program remain the records of the Department and confidential as mandated by O.C.G.A. § 30-5-7 and the Department Memorandum of Understanding.

3. The LTCO, as required by federal and state law, is not permitted to reveal the identity of, or information from, any complainant or resident who is the subject of a complaint to the LTCOP without their permission to do so, including to other programs and agencies within the Department.

The provisions of this Memorandum of Understanding are hereby adopted by the respective Directors of the Division/Office referenced herein:

Maria Greene, Director
Division of Aging Services
Date

Martin J. Rotter, Director
Office of Regulatory Services
Date

Gwen Skinner, Director
Division of Mental Health, Developmental Disabilities and
Addictive Diseases
Date