Elder Abuse Reporting Under Scrutiny

PROVIDERS SHOULD RE-EXAMINE WHETHER POLICIES AND APPROACHES TO ELDER ABUSE REPORTING WOULD PASS MUSTER UNDER STATE AND FEDERAL SCRUTINY.

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On Aug. 24, 2017, the Office of Inspector General of the U.S. Department of Health and Human Services (HHS-OIG) released an early alert with preliminary findings of its ongoing nationwide investigation into the adequacy of skilled nursing care centers' elder abuse reporting (Early Alert, available at https://oig.hhs.gov/oas/reports/region1/11700504.pdf.).

The Early Alert explains that HHS-OIG is gathering data from emergency room admissions of patients coming from skilled nursing centers and analyzing the records for potential reporting failures, ultimately finding that 28 percent of the emergency room visits involved potential elder abuse or neglect incidents occurring at the originating center that likely should have been reported to state authorities but were not.

Most importantly, HHS-OIG referred those allegedly unreported incidents to the relevant state law enforcement officials, raising the possibility that state authorities will soon be pursuing aggressive investigations and prosecutions of reporting failures.

OVERREACHING AT ISSUE

What may be concerning about the Early Alert is that state authorities in their enforcement of elder abuse reporting requirements have at times overreached, and federal scrutiny on this issue may cause that to happen even more.

In 2014, a client of Gibson, Dunn & Crutcher was the unfortunate victim of that overreaching. He was chief quality officer of a California-based hospital group, and was one of many hospital managers who were internally apprised that a nurse had used soft ties to restrain and bathe a patient who was belligerent and under conservatorship, without first obtaining a physician's order. Though the patient was not physically

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harmed in any way, the letter of California's Welfare and Institutions Code defines "physical abuse" as "use of a physical . . . restraint . . .for any purpose not authorized by the physician and surgeon."

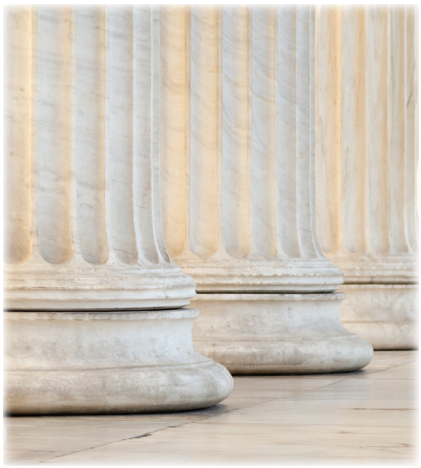
After his own analysis, the hospital's in-house attorney advised management that, given the lack of harm and nurse's benign intent, the incident did not qualify as "physical abuse" under the law and therefore no report was needed under the code's elder abuse reporting requirement. That requirements says that a mandated reporter must notify state authorities if the reporter "reasonably suspects" abuse or "is told by an elder or dependent adult that he or she has experienced behavior . . . constituting abuse."

POSITIONS TAKEN BY STATE ATTORNEY GENERAL

In criminally prosecuting the client (as well as the chief executive officer) for the felony offense of failing to report a potential elder abuse incident—notwithstanding the legal advice that was provided and followed—the California attorney general's Bureau of Medi-Cal Fraud and Elder Abuse took three aggressively broad positions as to the reporting law's scope. First, the California attorney general argued that, when a mandated reporter is told by the elder or dependent adult that abuse occurred, the mandated reporter must report the incident to state authorities—full stop.

According to the California attorney general, when an elder or dependent adult reports abuse, no reasonable suspicion of abuse is required to trigger a reporting requirement.

Second, even were reasonable suspicion required, the California attorney general argued that a mandated reporter is not authorized to conduct a full investigation into whether a specific set of facts even constitutes "abuse" in the first place. Instead, a mandated reporter may only conduct an inquiry to determine whether there are facts supporting potential abuse—a very low



bar—and then must report the incident to state authorities, who have the sole responsibility to investigate and determine whether any abuse in fact occurred.

Third, the California attorney general emphasized that failure to report is a "strict liability" crime—meaning that a mandated reporter does not need any criminal intent or any particular state of mind to be guilty. In such a scenario, the client's reliance on the advice of legal counsel was, in the state's view, irrelevant as a matter of law, regardless of how unfair that was to the client.

The judge ultimately agreed with the California attorney general on its reading of the statute, finding after trial that the client was technically guilty of a failure to report but also mitigating the consequences by agreeing to dismiss the complaint and restore the client's non-guilty status following 18 months of good behavior, upon the state's application.

IMPLICATIONS FOR PROVIDERS

Putting aside the terrible and life-shattering consequences of what happened to the client and others similarly situated (which can include criminal conviction, imprisonment, fines, and exclusion), this kind of aggressive interpretation of state reporting requirements also has profound implications for how providers receive, handle, investigate, and report alleged elder abuse and neglect incidents, no matter the quality or credibility of the accusation. Nor is the potential for aggressive prosecution limited to California.

Other state statutes arguably are worded also to require reporting even when there is no reasonable suspicion that abuse actually occurred. Vermont, for example, requires reporting where a mandated reporter "receives information of abuse," and Texas requires reporting where there is "cause to believe" abuse occurred.

TIME TO RE-EXAMINE

It remains to be seen if and how the Early Alert and the ongoing HHS-OIG investigation might lead to a wave of aggressive criminal prosecutions for reporting failures similar to the one described here. Such activity at the state level may even feed back into the federal government's own enforcement efforts, for example, under Section 1150B of the Social Security Act—the federal mandatory reporting law for long term care facilities—which relies on state law to define what constitutes "reasonable suspicion" of a crime that must be reported. Or even serve as fodder for an attempt at an implied certification-based False Claims Act lawsuit (for systemic reporting issues).

But for the time being, providers should re-examine whether their policies and approaches to elder abuse reporting, and reliance on intervening internal investigations and legal advice, would pass muster under state authorities that adopt the expansive positions that the California attorney general did in the case above. ■

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