

# Reporting Subcommittee

- a) Standardizing the reporting and follow-up process so there is consistency across all 87 counties and among the Tribes.
- b) Providing a method for tracking and excluding perpetrators from providing care to other individuals (preventing them from moving around from facility to facility or from county to county...similar to the "flagging" requirement in Investigations)
- c) Clarifying or modifying language such that a current internal investigation doesn't stop the obligation of external reporting (clarify for those doing an internal investigation)

## **I. Standardizing the reporting and follow-up process so there is consistency across all 87 counties and among the Tribes.**

### **Background:**

- ▶ The current common entry point system does not have state funding base, local capacity varies greatly from County to County, resulting in delays in investigation, reports of maltreatment not being taken or errors in distribution to the correct lead investigative agency.
- ▶ There is approximately 437 staff, in the State of Minnesota, trained and performing the function of common entry point, during business hours (according to 2007 snap survey of counties). After hours the reports are taken by a number of different agencies, mostly law enforcement.
- ▶ Approximately 13,000 reports of suspected maltreatment are taken every year. DHS adult protection policy unit is aware that this number may be skewed due to human error and failure to report results to DHS adult protection for data collection purposes.

## **Reporting Subcommittee members agreed that the primary suggestion to come from this committee is the Centralization of the CEP.**

### **Assumptions:**

- ▶ Management of the CEP would control for quality in work
- ▶ Statute Guidelines would be met
- ▶ Lead Agency's business needs are met
- ▶ Adequate funding
- ▶ Counties would have a functioning protocol to manage emergency protective services
- ▶ Call center would have voice over IP, phone, web and email capacity
- ▶ Secure data center
- ▶ Call tracking, including call monitoring/call review.
- ▶ The calls that came into the one number would then be routed using a prefix routing system
- ▶ Provide for 24 hour 7 day per week staffing
- ▶ Utilize blended media for taking reports (telephone or online reporting system)
- ▶ Centralized CEP staff would have ongoing and extensive training
  - There is an art form to taking a CEP report. CEP staff would have to be knowledgeable of Adult Protection, criminal/law enforcement issues, and lead agency roles

## Centralization of the CEP

### Potential benefits:

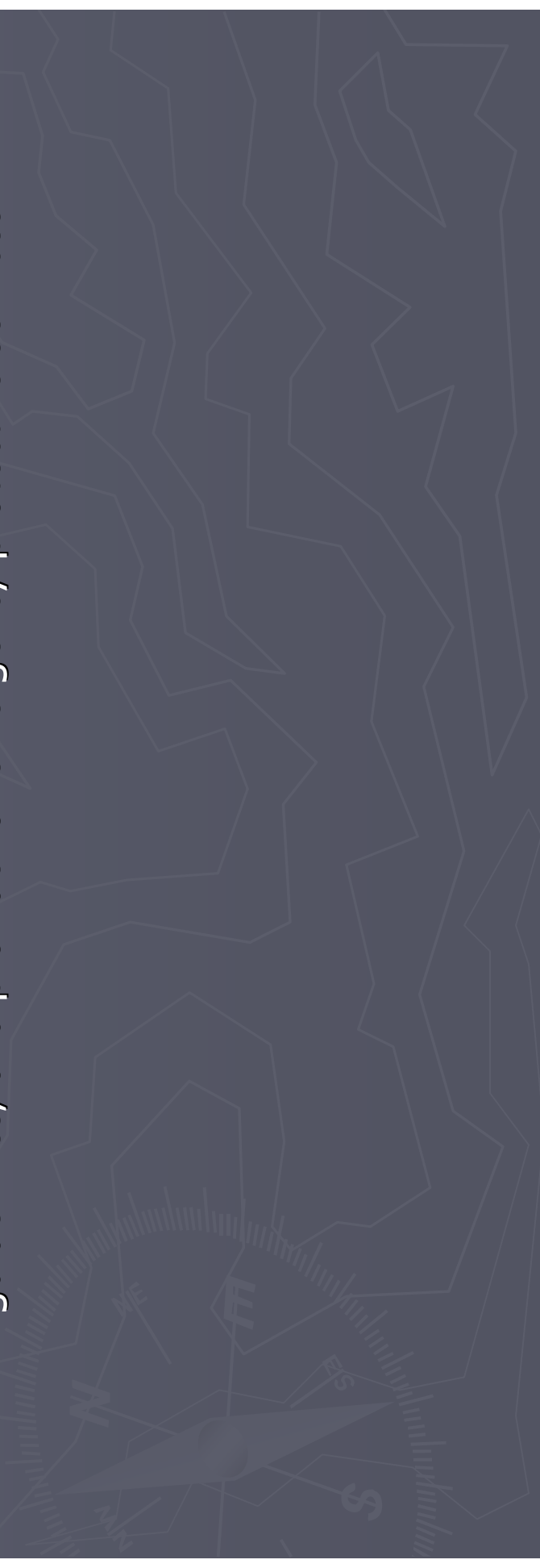
- ▶ Increased Consistency in reports based upon guidelines and protocols
- ▶ Cost effective for Counties

### Potential Impact:

- ▶ Lead Agencies could see an increase in reports
- ▶ Counties may need to increase Adult Protection staff
- ▶ Counties may need to create an Adult Protection Intake or protocol for screening CEP reports.

## Centralization of the CEP

The success of this system would be on the ability to assure for quality, in the system and staff. That the system could respond to the reports in a timely manor, distribute to lead investigative agency within statute guide lines, and provide for emergency protective services.



## II. Providing a method for tracking and excluding perpetrators from providing care to other individuals (preventing them from moving around from facility to facility or from county to county...similar to the "flagging" requirement in Investigations)

Concern: tracking people who have not been substantiated as a perpetrator of maltreatment. Raising the issues of fair hearing, due process and civil rights. Given consideration to a persons rights there are two areas that the subcommittee thought could be explored that may provide for more protections to vulnerable adults.

- 1) A review of the disqualification process for DHS Licensing, background Studies unit.

### 245C.14 DISQUALIFICATION

\*\*\***This item will be referred to the Protection or Scope of Statute Subcommittee**

- 1) Revision to tighten Counties Investigation requirement.  
626.557 Subd. 9b. Response to reports. . . . Each lead agency shall develop guidelines for prioritizing reports for investigation.

\*\*\***This item has been referred to the Investigations Subcommittee**

**III. Clarifying or modifying language such that a current internal investigation doesn't stop the obligation of external reporting (clarify for those doing an internal investigation)**

Federal Rule requires Nursing Facilities to conduct an internal investigation if there is an allegation of Maltreatment. It is beyond the scope of this subcommittee to suggest modification to Federal Statute. However, the subcommittee acknowledges that perhaps there is some loophole in the language in 626.557 Subd. 4a. (a) that they are currently not aware of. Further clarification of this issue was given to the subcommittee by the ECRA.

## **Clarification from ECRA:**

*. . . the state requirement to investigate even though a facility may be performing its own investigation can remain and the concern voiced at the large group stakeholder meeting seemed to revolve around strengthening that state requirement to protect vulnerable adults from a faulty self-investigation, similar to what you've identified as the "loophole" in Subd. 4a. of Minn. Stat. 626.557.*

**\*\*\*\*Based upon the clarification the Subcommittee has referred this issue to the investigations subcommittee for further consideration.**