Reporting Sub Committee Meeting, 06/17/08, Notes

Attendance: Cynthia Carlson, Kris Lohrke, Deb Siebenaler

Three topics given to subcommittee by VAA stakeholder's group to review include:

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

Agenda for 6/17/08 Subcommittee meeting:

I. Review 5-22-08 meeting Minutes
II. Discuss item # 3, ECRA provided some clarification
III. Review Concept of Centralized Common Entry Point
IV. Prepare for presentation to Large Stakeholder's Group
V. Other

I. Meeting minutes were reviewed and discussed. No corrections or additions were made to minutes.

II. ECRA provided clarification to topic number 3.

Clarification from ECRA:

Issue number three, regarding internal vs. external reporting and investigating, might have been worded in a confusing manner. The goal behind that bullet point was that there was concern over an external investigation, by OHFC or DHS or whomever, ending when the internal investigation resulted in the termination of an employee. A few members voiced concerns that too much weight was given to the investigation findings from the facility's own self-investigation rather than ensuring a complete investigation by the lead investigative agency (with potentially more objective

standards than what a facility may use upon itself) was conducted such that an employee being terminated wasn't a cover-up for a bigger problem at the facility, for example.

I agree that state law cannot contradict a Federal regulation. However, 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.

In summary, this is a request to mandate, in certain circumstances a lead agency investigation. Similarly this issue is reflected within topic number two and the subcommittee’s suggestion that lead agency shall develop guidelines for prioritizing reports for investigation.

Because these two issues relate to investigations and not to reporting they have been referred to the Investigations Subcommittee for review. On 06/17/08 Deb Siebenaler received a response from Investigations subcommittee Co-Chair, Carmen Castaneda that they have agreed to review the issue of prioritization of reports for investigations by the lead agencies.

III. Because 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. Based upon this statement, the Reporting Subcommittee is recommending Centralization of the CEP.

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
- Statue 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

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.

Next Step for Subcommittee:

- Present to VA Stakeholder's group
- Coordinate strategic planning session

IV. Deb will distribute handout outlining subcommittee's decisions on each issue and discuss Subcommittee's recommendations. Subcommittee members will participate in answering questions.

V. Other:

- Based upon the second topic that was to be reviewed by this committee a suggestion was made that there could be a review of the disqualification process for DHS Licensing, background Studies unit. (245C.14 DISQUALIFICATION). The review of this topic item would fall under the jurisdiction of either the Scope of Statutes Subcommittee or the Protections Subcommittee. Deb will contact the chairs of said committees to determine who will review the issue and then report back to the Subcommittee.

- Cindy distributed a report flow chart (See attached)