

REPORT OF THE INVESTIGATIONS SUBCOMMITTEE
Vulnerable Adult Act Stakeholders Work Group
August 28, 2008

Task: *In preparation for the Sept. 12 Large VAA Stakeholders Group Meeting, the Investigations Subcommittee examined three goals: to finalize the group's own legislative recommendations; to prioritize 3 to 4 legislative issues for the Stakeholders Group; and to review any other priority items for legislative action.*

Subcommittee Members: Carmen Castaneda (Co-Chair), Hennepin County Adult Protection Services; Maura McNellis-Kubat (Co-Chair), Department of Human Services Licensing Division; Janet Reigstad, Stearns County Human Services; Randy Snyder, Board of Examiners for Nursing Home Administrators; Tara Widner, United Steelworkers Union; Kris Lohrke, Office of Health Facility Complaints; Arlene Wegener, Office of the Ombudsman for Mental Health and Developmental Disabilities; Mary Brown, ElderCare Rights Alliance

Members Present: Carmen Castaneda, Maura McNellis-Kubat, Randy Snyder, Kris Lohrke, Arlene Wegener,

I. Investigations Subcommittee Legislative Recommendations

The Investigations Subcommittee met on April 7, June 13, July 11, and August 28, 2008. It reviewed a total of 12 issues submitted by the Stakeholders Group as well as additional items that came out of the Survey Results. The Subcommittee is recommending one item for legislative consideration, two items for policy development, and one item for consideration by the Large Stakeholder group for assignment elsewhere:

Legislative Recommendation

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| <p>Add a definition of the term “investigation” to the Vulnerable Adult Law in Section §626.5572</p> |
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- This recommendation comes out of the lists of issues raised by the Stakeholder's Group to “*Clarify how an investigation is conducted, clarify what will or will not be investigated, and communicate the results of the investigation when completed*”. The Committee recommends that the public understand what an investigation is by defining it in the statute.
- Minn. Stat. §626.556, Subd. 2 (b), the Reporting of Maltreatment of Minors Act, defines “investigation”. It would be reasonable to duplicate a comparable definition in the Vulnerable Adult Law. The Committee did not have time to research definitions of “investigation” in other state APS laws, but could continue with this assignment or refer it to the Definitions Subcommittee.
- Example of a definition: “Investigation means fact gathering related to the current safety of a vulnerable adult and the risk of subsequent maltreatment that determines if regulatory or protective services are needed.”

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Recommendations for Policy Development

Each Lead Investigative Agency should have policies and procedures which provide guidelines for how an investigation is conducted. DHS should develop a policy and procedures manual with investigative guidelines for all county Adult Protection Units.

- This recommendation comes out of the lists of issues raised by the Stakeholder’s Group to “*Clarify how an investigation is conducted, clarify what will or will not be investigated, and communicate the results of the investigation when completed*”.
- The Subcommittee previously recommended against detailing investigative procedures in statute or in rule. Because the Vulnerable Adult Law incorporates investigations by three separate lead agencies, identical investigative procedures are not uniformly appropriate and may have too many variables to quantify in statute. The Subcommittee likewise wants to avoid having the law be so prescriptive that it could create challenges to the validity of investigative findings on the basis of form rather than content.
- Both DHS Licensing and the Office of Facility Complaints have existing Policy and Procedures Manuals that outline how an investigation is to be conducted. County investigations are governed by DHS Protective Services Rule 9555.7300, which now is partially outdated. The Subcommittee recommends against operationalizing investigative procedures in a Rule due to the legal and technical difficulties inherent in making Rule changes.
- In order to bring conformity between the three Lead Investigative Agencies, the Subcommittee recommends that DHS develop a policy and procedures manual with standards, procedures and guidelines for county Adult Protection Staff on how to conduct investigations.

OHFC, DHS Licensing, and County Adult Protection Units should post their Guidelines for Prioritizing Reports for Investigation on their websites.

- This recommendation comes out of the lists of issues raised by the Stakeholder’s Group to “*Clarify how an investigation is conducted, clarify what will or will not be investigated, and communicate the results of the investigation when completed*”.
- The Subcommittee recommends educating the public and professionals about the guidelines each Lead Investigative Agency uses to make decisions about case assignments for investigation. Increased transparency about how these systems work can also correct misperceptions about why cases are not assigned for investigation.

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New Item for Stakeholder Group Review –Request from OHFC

Change the Disqualification Standards in the Licensing Act for more equalized treatment of persons determined to be substantiated perpetrators of vulnerable adult maltreatment.

- Per former OHFC Director Arnie Rosenthal’s description of the problem:

“If someone is found to have unintentionally injured a resident due to a one-time incident, such as failing to use a transfer belt, failing to have someone assist with a transfer or leaving a resident for a moment, that person is immediately disqualified from working with VAs. If the person is a nursing assistant on the nurse aide registry, s/he may not work in a NH again.

However, if an employee slaps, kicks, punches, sprays water in a residents face and there is no serious harm/physical injury and it is only done one time, the employee is not disqualified, even though most such acts are done intentionally (if on the nurse aide registry, they cannot be "flagged" as an abuser until all due process has been completed).

Perhaps someone can make an attempt to change the DHS statute that relates to Disqualifications.”

II. Top Legislative Priorities

The methodology used by the Investigations Subcommittee to arrive at its top legislative priorities was as follows:

- Members reviewed the top 10 highest scoring questions on the Stakeholder Survey and all of the comments in these sections.
- Members reviewed the recommendations of the Investigations Committee.
- Members were individually asked to list their own recommendations.

1. Eliminate Dual Reporting Requirements for Certified Nursing Homes

- The Investigations Subcommittee defers to the CMS Subcommittee for recommendations on this issue.
- If the CMS Subcommittee does not come to agreement on how to resolve this problem, the Investigations Subcommittee recommends proposing statutory language to set up a Task Force to Study the Problem and make recommendations to the legislature.

2. Consolidate the 87 County-Operated Common Entry Points into a Centralized Entity operated by the Department of Human Services.

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3. Allow Permissive Reporting of Vulnerable Adult Maltreatment by the Banking Industry and Immunity for Reporting in Good Faith.

- Committee members did not recommend making bankers mandatory reporters. We believe that this requirement would bring opposition from the banking industry. Our immediate goal is to make incremental gains in protecting vulnerable adults from financial exploitation and other forms of vulnerable adult maltreatment. This could include providing immunity for bankers for reporting in good faith and allowing them discretion about what they report.

4. Strengthen the Vulnerable Adult Maltreatment Review Panel to build in Additional Rights for Victims and some Interested Persons.

- The Subcommittee reviewed Minn. Stat. §256.021 and was of the opinion that the statutory language is sufficient as stated, but that improved implementation of the review process could be made. Changes could include allowing victims and some interested persons to make an appearance before the Panel and provide their input, as well as more frequent meetings of the Panel.

III. Additional Recommendations

1. Add the definition of “Self-Neglect” to the Vulnerable Adult Law and operationalize the definition by incorporating the concept of “lack of capacity”.
2. Change the disqualification standards in the Licensing Act for more equalized treatment of persons determined to be substantiated perpetrators of vulnerable adult maltreatment. See recommendation listed above.