Survey for the Vulnerable Adult Act

Stakeholder Reform Group

June - July 2008

This survey seeks to obtain information about improvements for the Minnesota Vulnerable Adult Act. The areas of focus include Education and Training, Protections, Scope of Statutes, Reporting, Investigations, and Definitions.

Your answers to the following questions are important. We ask that you consider the range of vulnerable adults who are protected by Minnesota's Vulnerable Adult Act. Your responses will only be used in the aggregate.

EDUCATION AND TRAINING looks at the implementation and understanding of the Vulnerable Adult Act for those who come in contact with and are charged with enforcement of its provisions.

PROTECTIONS focuses on safeguarding an individual from harm or exploitation while still respecting the person's right to autonomy.

SCOPE OF STATUTES addresses the strength of current statutes to enable legal entities to prosecute those who abuse, neglect, or exploit a vulnerable adult.

REPORTING analyzes the current reporting system in Minnesota, along with methods used, timing, and reporting requirements.

DEFINITIONS examines the current usage by the State and Federal governments of terminology involving vulnerable adults and seeks to clarify any variances.

INVESTIGATIONS determines the current tools investigators have, best practices to be used, and the criteria which comprise a thorough and complete investigation by a lead agency or multiple lead agencies.

Codes

Education & Training	**E&T**
Protections	**Prt.**
Scope of Statutes	**SoS**
Reporting	**Rpt.**
Definitions	**Def.**
Investigations	**Inv.**

BACKGROUND INFORMATION

1.) What type of agency, organization, or office do you represent?

County Adult Protective Services
County Social Services
Minnesota Department of Health
Office of Health Facility Complaints
Minnesota Department of Human Services
Ombudsman's Office
Law Enforcement
Care Providers
Government Attorney
Legal-Aid Attorney
Private Attorney
Consumer or Victim Advocacy Organization
Tribe
Other

Brain Injury Association of MN.
Managed Care and Payment Policy
Licensing
Division of licensing
licensing division
We also have a contract with the County to provide general case management for seniors in the community and EW case management.
Division of Licensing
Licensing, Maltreatment Unit
Licensing
Licensing Division - Investigations
Maltreatment Investigations
Licensing Division
Licensing
Common Entry Point
Licensing Division
Investigations
Licensing Division, Investigations Unit
division of licensing
Licensing Division
licensing-investigations
Licensing Division
Licensing
Licensing
Licensing Division, Investigations
licensing

DHS licensing division
Division of licensing
Long-term care campus with SNF, AL, IL, ADS & HH
Home Care Agency
Minnesota Alliance on Crime
I am a member of our county Common Entry Point and record the VA reports and distribute them to the correct investigative agency.
Social Services Supervisor
CSP/SSIS Training team
Aging and Adult Services Division-Adult Protection
Office of Ombudsman for Long term care
Disability Services Division
Disability Services Division
Long-Term Care

2.) Do you receive reports, either verbal or written, of abuse, neglect, or financial exploitation of residents in nursing homes or other care facilities?

Total of 220 reports received in 2005, total of 220 reports received in 2006, total of 208 reports received in 2007, and 161 reports rec'd thru 4/08.
We receive copies of reports about Intermediate Care Facilities/Developmental Disabilities.
DHS licensed facilities
Am able to receive reports but haven't received any yet.
For my case of residents.
When the perpetrator is in the community
Staff/volunteers are educated to notify social workers of any suspected or witnessed abuse/neglect.
Not sure how to answer this as we make the reports once an incident is reported to administration.
We are the CEP for Olmsted County.
I receive some reports but most go directly to our CEP, who is our intake social worker.
I am the CEP contact, after hours. My APS staff and I take reports during regular work hours.
Mostly financial exploitation, also if they leave against medical advice.
It would be great NOT to get incident type reports that just have explained issues or equipment failure.
Those go to our intake worker.
Yes, we are the common entry point. We forward these reports on the licensing entity.
Many are systemic issues that lead to people feeling abused like NH regulation not enforced.
Reports from DHS - Licensing on VA maltreatment investigations, VA reports of serious injury/death from Common Entry Point and health investigation
However, do receive complaints regarding such issues

3.) Do you receive reports, either verbal or written, of abuse, neglect, or financial exploitation of vulnerable adults who are not residents of nursing homes or other care facilities?

Not uniformly. Ad. Pro. calls with referrals of questionable a., n. or f. e., for monitoring by us. We may or not learn of a report on our clients.
From a family member, someone who may have worked in a facility
These reports are informal and occur when no one else listens or takes action.
Rarely, then we would forward to whomever has jurisdiction.
Licensing's jurisdiction is licensed programs
Reports come to Adult Protection- I represent Adult Protection when civil legal proceedings are required.
We are the CEP for Olmsted County.
Very rarely
I receive some reports but most go directly to our CEP, who is our intake social worker
Less frequent than NH but frustration with getting any remedies
See question number 2 comments section.

4.) Do you collaborate with adult protective service groups or agencies? If so, please check all of the groups or agencies below with which you collaborate.

No, we do not collaborate with anyone else.

County Adult Protective Services
County Social Services
Minnesota Department of Health
Office of Health Facility Complaints
Minnesota Department of Human Services
Ombudsman's Office
Law Enforcement
Care Providers
Government Attorney
Legal-Aid Attorney
Private Attorney
Consumer or Victim Advocacy Organization
Tribe
Other

Licensing
DSD.
St. Paul
DHS EW. Minneapolis Ombudsman; NH Ombudsman
Ombudsman Office for Mental Health and Developmental Disabilities
Disability Services Division (DHS) Ombudsman for MH-DD MN Disability Law Center
DHS - Licensing and Background Studies
OHFC and DHS licensing

DHS - - Adult Protection Ombudsman - - Developmental Disabilities
DHS licensing
Take reports by phone; distribute them to the appropriate lead investigative agency and to the local police and to the active case manager.
Office of Health facility Complaints
DHS: licensers in the Licensing Division; The Ombudsman's Office, Mental Health and Disabilities (Roberta Opheim)
Program Offices (Adult Mental Health - Chemical Dependency - Children's Mental Health)
MN DHS-Adult Protection, AMH, DHS Licensing, DHS - DSD; Ombudsman's offices for MI/DD/LTC/Aging; Dept of Health-Compliance office, local public health.
DHS Licensing
Long Term Care; Managed Care
Metro ombudsman
Class F division
It depends on what type of support is needed.
Ombudsman for aging, mental health and developmentally disabled, DHS Licensing
Through the VA incident reporting system.
MN Department of Health Licensing and Certification Division
Disability & Aging
licensing division
Adult protection division County Attorney
Upper Sioux Community
LTC, White Earth
Lower Sioux
MNHS - VA UNIT
depends on severity of complaint, I think other agencies could be involved (police etc)
Through MN Department of Health I consult with the Adult Protection Division. We send CEP's to DHS.
We have a great working relationship w/ our local agencies
Please do not expect a full answer to this question without leaving adequate room for the answer...
Ombudsman- for seniors and Dev. disability
County APS and Social Services - same agency. We collaborate with whoever is necessary - difficult though with DHS licensing and MDH
Send reports to DHS, Office of health facility complaints; and to Sheriff Department.
Adult protection div. Sylvia Hasara don't know what div.
MN Dept of Human Services - Licensing division
Deb & Jennifer
DHS investigations.
Licensing Division & Maltreatment Investigations unit.
We work with everyone to resolve the abusive situation so client can get needs met and feel safe in their environment
DHS, OHFC
Adult Protection, and Licensing
Our organization collaborates with all the above but not in the way I believe the question was written. As a trade organization we work with all.
OHFC

Minnesota Board on Aging

DHS - APS, Ombudsman's Office - Entire office

5.) On average, roughly how many reports involving vulnerable adults did you make or did your office receive in the past three years?

2005	**36,635**	
2006	**37,716**	
2007	**52,161**	
2008	**91**	**(This data was not asked for in the question, but collected from responses volunteered.)**
Aggregated	**65,480**	

50-75

7,000 in 2007
6,000 in 2006
6,000 in 2005
The only number I know for sure is 2007 the others are approximate

2005-3700
2006-3800
2007-4000

approximately 20

Approximately 15 per year. We don't track this in aggregate.

From April 2008 to July 2008 in Minneapolis I have seen over 110 reports of VA's.

Number indicated in 2. above:
2005 = 220 reports received
2006 = 220 reports received
2007 = 208 reports received

Approximately 15000 for the three year period.

In 2005, 6087 reports received
In 2006, 6443 reports received
In 2007, 6992 reports received

estimates are approximately 12 each year, we don't specifically track cases pertaining to vulnerable adults

2005 - - 27
2006 - - 60
2007 - - 28

Average 7000 per year, Hennepin County

2-2005
3-2006
5-2--7

I started working here in 2007. We took 7,000 maltreatment reports in 2007.

average of about 325 for the three years

I work in the field. I'm assigned reports that have been assessed and I am sent out on them. Therefore, my information is not 100% accurate. Based on our report numbers, in 2007 we got about 4800 reports. Of that 4800 about a 1000 were investigated for possible maltreatment.

3,000

Roughly 4000 each year.
13,500
office received approx 4,000 for each year of the last three for a total of 12,000
Our office reviews all the OHFC and DHS abuse/neglect/financial exploitation investigations. In addition, we receive reports from counties, law enforcement and citizens. In each year, we reviewed close to 2000, but independent investigations are limited to approximately 20 per year.
7
2
5
Received: 2005-2, 2006-1, 2007-5.
2,600
Stats given to this office are approx. 100-136 per month. That doesn't mean they all get to this office...screen outs happen
three reports were made
2005 10 2006 10 2007 10
2007-2 2006-5 2005-7
20
approx. 100
12
5-17 per year.
approx. 5
one
Fourteen (14)
15 for the three year reporting period.
Approximately 2 a year
2005 - 9 2006 - 3 2007 - 3
approx. 5, all of which did not have any negative findings of abuse/neglect. Some were initiated by us, others by family.
4
2005 received 42 2006 received 48 2007 received 39
2005- 2006- 2007-
2005 - 13 2006 - 1 2007 - 2
Approximately one per month, so for 3 years, it would be 36.
2005-one 2006-one 2007-one
15
10

10 reports to the point of entry. Involving various issues from possible physical or verbal abuse to a vulnerable adult, neglect, and financial exploitation.

I do not have exact information but can only guess at 60 reports a year

2005- 3
2006- 1
2007 3

2005 - 1
2006 - 10
2007 - 4
Number of reports made approximately.

Reports received 2005- 226
2006 - 255
2007 - 273

2005 - 649
2006 - 788
2007 - 1052
Reports Taken

approximately 200

25 approximately

We reported 25 potential Vulnerable adult incidents per year

2005 =6
2006 =4
2007 =5

20

2005-107
2006-101
2007-95
Total of 303

15

2005 - 14
2006- 37
2007 - 35

2005--5
2006--7
2007--10

2700

2005 - 52 APS; 45 AS
2006 - 52 APS; 28 AS
2007 - 38 APS; 89 AS

Received:
2005-39
2006-55
2007-45

We average around 100/month so over three years, that would be around 3,600 reports.

2005-33
2006-44
2007-59

2005-138
2006-140
2007-154

In the past 3 yeas--60 (some multiple alleged victims in one report)

2005-90
2006-119
2007-104

Received
Approximately 50 per year
10
14 in three years approximately
about 20 a year - total about 60 reports for the 3 years
60
3 or 4 that I reported to county, but I think they deemed it not enough to do formal report- because most involved resident to resident disputes
we received: 2005- 96 reports
15 reports monthly over three years = 540 reports, sometimes there are 20 + reports monthly
We typically received about 5-10 per month in 2005 and 2006; we received about 10 per month in 2007; we have received about 70 thus far this year.
2005- 6 2006- 8 2007- 8
We receive approximately 50 AP Intakes per year. Only a fraction of those are required to be accessed by our Agency; some of the others are screened out or referred to another county, DOH or DHS for further action.
I'm guessing that we have roughly 100-150 reports per year. We are still trying to train staff on taking reports and not calling them I & R (or not entering at all) We are a smaller county.
90+
2005 = 36 2006 = 52 2007 = 32
Don't have numbers in front of me but averaged 20 per month in 2005 (total 240) to close to 40 per month now.
2007 362 reports 2006 154 over 800 calls - some that might have been ruled out and no CEP taken 2005 105
25
150
Report received: 2005= 52 2006= 52 2007= 38 2008= 21
433
2005 - 90 2006 - 98 2007 - 123
'05-90 '06-98 '07-123
I only have information on the number of investigations: 2005 - 62 2006 - 59 2007 - 55
75
About 45 for years 06 and 07
2005 - 75 2006 - 122

2007 - 135
over 800
100
2005 - 256 2006 - 346 2007 - 450
Office averages between 80 and 120 CEP reports generated each month.
Approximately 300
We received approximately 1000 reports in the last 3 years
65 per year for all 3 years.
69
About 1200
14,000
I average about 150 cases a year. All are vulnerable adults seeking help or involved in situations that threaten their safety and well being.
350 for 2007
5-10
approximately 12
350 in 2007
our usual #s for all complaints each year is about 2000
Year 2005: 324 Year 2006: 378 Year 2007: 222 TOTAL: 924
Approximately 6 per year

EDUCATION AND TRAINING

6.) The current amount of training for Common Entry Point (CEP) intake reporters is adequate to enable effective intake of information to protect vulnerable adults in Minnesota. (Rating of 2.8 out of 5)

Due to variations in County practice of MN. Statutes and lack of consistency are issues.
It would be nice to see the CEP workers take more detailed reports and obtain enough information to avoid a lot of follow up phone calls.
The counties are inconsistent as to what reports to take or pass onto a lead agency. Many are unsure of their role in the investigation process.
We receive complaints from individuals and families that the CEP reporters do not take their complaints seriously.
I am not sure what training is provided to CEP workers, but at the state level we notice that numerous reports are not forwarded to us as required.
Some counties are much better than others.
Reporters need additional training on the definitions of maltreatment and how to make a report
I have to admit I'm not familiar enough with CEP to make any judgment
Some counties "screen out" reports made to them or they call the facility to ask questions when the facility isn't even aware a report has been made.
Some counties believe that they do not need to forward on reports if they do not think the report constitutes suspected maltreatment.

For the most part training is OK. In some counties CEP's screen out reports instead of leaving screening up to the agency.

We sometimes get reports that could use a little more information. It would be helpful if there was a statewide standard for intake.

I'm not familiar training the CEP workers receive, but I am aware of issues in some counties with reports not being accepted/referred to the lead agency.

The information is in a learning process at this time, since I have only been with this part of the agency for approx 1 year.

Specific instructions and specific feedback from CEP to save time. Public information campaign, so consumers know what they know for children.

The CEP has various workers on intake; these workers could be from Child Protection or Public Health. They are not educated on Vulnerable Adult.

Usually just type and enter data- no insight at all.

Not sure what the level is across the state. Our county is adequate at this point

There is a need for basis interviewing skills and walking thru step by step process in investigating forms, sending letters etc

We report to the Sheriff's office, not sure they understand the law totally and our reporting requirements.

Some intake reporters are better than others.

Staff went to APS training at MSSA and felt it was OK

They're not always familiar with what needs to be reported to the Ombudsman and what doesn't

I've only seen one training specific to intake reporters and that was very recently.

They are very good at sorting things out

More training is needed

I receive some reports but most go directly to our CEP, who is our intake social worker.

It is how the information is given. I believe many scenarios assists staff in learning the differences in what a report is and what is not.

Requirements in SSIS have changed.
New staff members are having a difficult time finding training. Not enough or incorrect information is being obtained.

Videoconferences are a great start, SSIS should help

with some prior knowledge

The SSIS module is horrible. Lacks intuitiveness and friendliness at the front end. Lousy SSIS architecture, slowing up a critical point.

Ideally I would like to see a separate meeting with DHS for intake workers/or screeners about intakes coming in (versus investigation questions).

I am not aware of any training for CEP intake workers other than SSIS training on the new computer system, not on taking a CEP report.

Especially with the changes on SSIS. We have changed staff over since the latest training, so I think there needs to be something for new staff.

We could use more training and refresher courses. The new ITV courses have been beneficial and a good start.

Our intake worker is part of the screening team She's part of the discussion on if something meets criteria as a VA and as maltreatment.

Need a funding source for SSIS training

The support at the work site needs to be there also.

I would like more training, specifically on what key information is needed for investigation.

Every County is Different, some screen, some do not, some accept faxes some do not, and many are rude and unprofessional.

The lack of consistency among county intake offices leads me to believe that training is not adequate.

One of the problems would be consistency and continuity across87different counties the gaps between reporting regarding safety and health victims, perpetrators

7.) The training provided to mandated reporters on what incidents of abuse they must report is adequate. (Rating of 2.5 out of 5)

Same as #6 narrative

A little more training would be helpful on the "gray areas."

It varies greatly by provider.

Our office knows that some agencies do not report incidents, problems, and deaths and they should.

Depending on what provider, but generally knowledge of VAA and MOMA is very good.

Some facilities have very good training others lack training completely. generally, I find people are better trained on the VAA than on the MOMA.

Good training available but not sure if it reaches all players.

I think more training is good

In child care centers the training generally focuses on maltreatment that may happen in the child's home but the focus should include co-workers.

For the most part. Neglect cases involving serious injury is sometimes confusing for reporters.

During interviews we get a wide range of responses regarding incidents people are required to report. However, some agencies do an excellent job.

Need more training

Facilities develop as policy to call in all reports of injuries more for liability issues than appropriateness.

Looking into who is on "what page"

Not specific enough

I am not mandated so I don't know

Online report has spelling errors; Med. error goes under "neglect" category. No Federal definition for maltreatment. No decision making tree.

There are still many areas that remain unclear.

Training? What training? We obtain the brochure and work with the local VA case worker on each case & situation.

Mandated reporters are unclear of what to report and what constitutes a vulnerable adult

It seems it is always different depending on who you talk to. This was made worse when looking more at the federal law

we always check with CEP to make sure it is a reportable incident if there is any doubt otherwise we report

Sometimes it's hard to determine what needs to be reported and what doesn't. I think a lot of times facilities over report rather than under report.

This is a prime example of trying to get our message across to you and you limit the number of characters which can be entered. I could not finish my

Need more training for new providers of home & community based waiver services and Adult Foster Care family homes.

We have an APS team and the community members, hospital staff, law enforcement, and nursing home staff have a lot of confusion about mandated reporting.

Facilities and staff other than DD staff don't seem to know what a VA report is.

There is still confusion on this, this is ongoing. Especially if not intentional- such as neglect of care (mistake or oversight) is involved.

mandated reporter trainings do not seem to be adequate

I receive some reports but most go directly to our CEP, who is our intake social worker
Again to attend and hear "Take a report" but what really is the reporter looking for? Why should they take this seriously?
There appears to be disagreement amongst reporters on what is mandated to report and what does not need to be reported.
Varies widely depending on the provider agency
The law and rule needs to be overhauled. Too much is left to judgment. Few people understand the breadth of the law and its institutional underpinning.
Public Health department could use some training on this.
Many questions at the intake level as to what is reportable and what is not. I would like to see more
Mandated reporters in our county do not use our agency for this training. I am not sure where they get this information.
depend who they receive the training from
Frequent questions from various agencies about what they need to report.
I think our mandated reporters know what to report, but they get into trouble for failing to report I&R by the surveyors.
Receive many reports from facilities that do not constitute maltreatment.
They report on anyone that it vulnerable and many do not meet the criteria under the law.
There is no standard curriculum. Providers and professionals are left to develop their own tools resulting in inconsistency and confusion.

8.) My local law enforcement is adequately educated on the concerns to be considered when investigating a case of potential vulnerable adult abuse. (Rating of 2.5 out of 5)

Varies from Officer to Officer with consistency being an issue.
There is wide variation between different law enforcement agencies. Some departments are excellent and others are fair or poor.
However, this varies.
It varies greatly by jurisdiction. We deal statewide and have seen some people who specialize in VA reports and others who do not know what a VA is.
It depends on what local law enforcement agency. I think the bigger metro counties are better informed but have higher case loads and less time
Again, some much better than others.
There are many law enforcement personnel, especially out state, who are woefully uninformed.
We have 37 law enforcement jurisdictions in our area and all of them could use additional training, especially as law enforcement officers rotate duty
I think more training opportunities wood be good
the larger agencies more so
However, it differs from jurisdiction to jurisdiction.
Our office sometimes needs to do education on what to report.
it has gotten better over the years
Dialogue is currently addressing this topic.
Does law enforcement feel they are adequately trained? How do they feel about protections of act?
Usually give the response that there is not much they (police) can do until "something" happens.

We haven't had to consult with them
Our law enforcement typically will not take the lead on any investigation.
Law enforcement could use some resources to assist them in VA investigations.
They don't tend to take VA's seriously or don't understand what constitutes a vulnerable adult
I have contacted law enforcement on people driving who should not be driving, (wrong side of street, etc) but they got license renewed anyway.
Depends on which le agency we work with, some Officer have had no experience investigating financial exploitation for example
Through MN Department of Health I consult with the Adult Protection Division. We send CEP's to DHS.
I would love for DHS to educate law enforcement officials who help us.
More training is needed for smaller police dept and the county sheriff's department; they do not seem to have equal training as the bigger departments do.
Recent training has improved relationships with law enforcement.
Our law enforcement does NOT take AP seriously. They don't prosecute or investigate. It is easier to say they don't have enough to go after.
The right to choice is overlooked Nuisance is reported as abuse/neglect Increase in requests for emergency guardianships
Tends to vary over time as well with turnover issues and their current workloads
Again, the law, rule and a strong state wide push to educate law enforcement.
Especially around domestic violence/physical abuse (victims needing to indicate they have been abused before charges files).
But they are willing to work in tandem with the APS investigator and give the APS investigator a lot of room to do the APS piece of the investigation.
Generally, they are but there are a few who could use more information.
They send police reports to us on domestic disturbances where there is no vulnerable adult.
Police routinely tell providers to take money and belongings away from residents, something they are prohibited to do (resident rights).
Unable to evaluate this, as our interaction with law enforcement is limited.

9.) I know the correct phone number to call when making a report to my Common Entry Point (CEP). (Rating of 4.4 out of 5)

I work for DHS which is a lead agency. If I need to contact the CEP, I have a list by county.
No common understanding of the entire process and confusion about who to call when.
I do not know it by memory, but can find it
It is clear in the Act. At facilities I visit the number is usually posted.
Know where to find it. Too difficult. Need central number for state or nation. I would call 911.
We fax our information instead of making phone calls.
We are the CEP
Phone numbers keep changing!
We took several reports in 2005.
I have a current listing of county sites--which would be helpful to have community directories if they don't have access to a computer.
I am the CEP
Work at Common Entry Point

I know where to look for the number

While I know where/how to access the CEP, having 87 different points of contact fragments the system and is confusing for professionals and consumers.

10.) Additional comments on Education and Training:

The problem isn't the education and training. It's budget cuts and what used to be investigated is no longer because they need to prioritize being they can't do it all. (Inv.)

More is needed on Financial Fraud of VA's.

It appears that the training and understanding of the VA statute, CEP, and adult protection rules are highly diverse. Too many people interpreting the statute. A high turnover at the county level adds to this inconsistency.

Illinois has what is called the SCR-state central registry. This agency takes ALL calls statewide (1-800-25-ABUSE) and that agency is trained in disseminating the reports to the proper jurisdiction. MN seems to have 87 interpretations and 87 applications of 1 statute. (Rpt.)

The process must be clearly set out, there must be a common understanding of the responsibilities of all parties who may be involved, people must communicate with each other, training must teach to competencies not merely activities.

A professor from Minnesota State University (Mankato) completed an online curriculum entitled, Shadow Victims, and made it available to POST for law enforcement officers. We are not sure if it has been used, but it is a resource.

The annual training for investigators was very well received and appropriate. Unfortunately, such is no longer provided.

The Common Entry Point staff also need additional training

As I mentioned earlier, I believe more training for reporters and law enforcement would benefit everyone.

In-depth training on financial exploitation (data collection, forensic accounting).

I frequently run into staff persons who think they need to make reports to their supervisors before the CEP. Many companies promote this as a policy so that they can be knowledgeable about what is happening, but it can discourage reporting. It needs to be clear to staff persons that they can go directly to the CEP and not their supervisor. I don't know how you would get facilities to comply uniformly.

The new CEP form that some counties are using seems to be such a waste of paper and you can not fine where the information is and often the info is incomplete. also there is not relationship to who the caller is and sometimes/often that is important to know when you call them and what questions you will or need to ask. (Rpt.)

Wondering if DHS offers training for mandated reporters and law enforcement? We never hear about this on county level. Local PD is not always responsive when requesting their assistance/presence.

This is a continuing process, it is being worked out so that the "terminology" is understood and not assumed by any group that works with this area.

Simple. Direct. Consistent. Communities.

I heard a speaker once ask an audience if they knew the speed limit was 55. Everyone raised their hand. She then asked how many people drive over the speed limit even though they know what it is. Almost every one raised their hand again!!! She went on to say that education isn't the end all be all. There must be a positive outcome that the person can see, feel, and hear. I know the speed limit is 55 more education will not help. I will drive 65 except the higher cost of gas has made me slow down.

Law does not address training staff why?

We have not received the video from the 4-14-08 state-wide training for our facility.

Law enforcement needs more mandatory training on this. Ours are good guys, but have no idea what their role is and won't quite believe that we aren't trying to pass things off on then when we

ask for assistance (especially in financial exploitation cases).

There needs to be less grey areas. In most nursing home they strive to provide the best care. When looking at incidents of unknown origin especially with bruising truly no matter what you can never be 100% for sure on anything and with that one should report and then we would be doing this ALL the time which is a lot more work now with the new reporting guidelines.

Overall I know that in our case we need to make sure that the training takes place and information is kept available including phone #'s to call and facility policy and procedures for employees to follow.

Our staff are educated every year and new staff every year at orientation

There needs to be further clarification on what actually needs to be reported based on severity of the alleged abuse. We are over cautious at this point based on our last survey so we are reporting just about everything.

Coming from a county, would like a refresher in appeals, and reconsiderations and VA Review Panel.
Would like to know circumstances of actual appeal cases and how they turned out

More collaboration between County APS and DHS/OHFC about what reports they really need/want. Seems to be a lot of duplicate and unnecessary reports going to the state. In addition, seems to be a lot of duplicate reporting by the nursing homes with their new reporting system to the state. If no immediate APS need, why report twice?

Our county has really appreciated the Adult Protection Trainings that has been provided this year. Trainings have been relevant, informative, and helpful.

I would like to see a CORE training for adult protection workers much like the CORE trainings for child protection workers.

The new policy of the CEP taking the incident reports from facilities that are not alleging any abuse or neglect is confusing. The facilities are not alleging abuse or neglect but the new SSIS system forces the CEP to choose an allegation and there is no alleged perpetrator. I think this is confusing to the facilities and the CEP workers.

I am the lone APS worker in a rural county and it would be wonderful if there were collaborative meetings for us rural areas to discuss our struggles. Design training to address rural issues.

In order for Education and Training to both Law Enforcement and Attorneys to be effective, they (and their Superiors) must be interested in receiving the training.

Clarify, clarify, clarify! Please put things in writing for us!!

I would prefer more detailed information than generic. Everyone interpretation is different on what they think that they are hearing needs to be reported. What are the true dangers in the environment to one person may be "over looked" by another person. The importance that is someone is "capable/competent" is difficult to everyday reporters. They usually want the county to "fix" the issue and get the person to change the behavior.

There needs to be working protocols on the various aspects of abuse and neglect. Also, better legal distinctions between mental health – suicidal thoughts and domestic violence in respect to VA maltreatment.

I would like to see at least annual mandated trainings for investigators and law enforcement.

The trainings are improving; however, our agency would like to see a more advanced level of training for investigators. We would also like to see some training for investigators when interviewing people with developmental disabilities, mental health issues, and dementia.

The local city police do not follow up timely on financial exploitation reports. These are most difficult

I think that a lot of the problems with this issue could be alleviated by making a single, centralized Common Entry Point. The number of OHFC and DHS reports FAR outweigh the number of county reports. DHS/OHFC could do their own reports and then send the few county reports to the appropriate agency. That way only a handful of people would need to be trained, there would only be one reporting number, and it just makes more sense.

Continue efforts to include law enforcement personnel in trainings.

I think there should be some core training (as in child protection) given to each county worker before they start.

Very limited options for lead agencies.
The Intake staff needs training and hands on experience would be best to then apply to their job.
Need one CEP. **(Rpt.)**

PROTECTIONS

11.) A system of "Silver Alert" for vulnerable adults, similar to the "Amber Alert" or "Code Adam", would be helpful in protecting vulnerable adults with physical disabilities or cognitive impairments. (Rating of 3.6 out of 5)

I can't imagine how a system like that would work since the numbers could be huge. I would want more details.
Too many alerts and no one will take notice when needed.
A lot of law enforcement agencies are already familiar with the VA's in their jurisdiction that have a tendency to be unsupervised.
When issues of abuse and neglect of vulnerable adults are hardly on the radar screen, another "system" would not resolve current system failures.
Not sure it is needed. The media seem to handle the issues well.
However, we do already have systems in MN to find missing people, including vulnerable adults.
Not until the terminology is in place. When does it get to be a Silver Alert?
I am not sure I understand. A large percentage of the "reports" turn out fine and there must be too many reported per day to do that.
How many VA's are abducted?
Most reports are of abuse and not missing VA's.
I would have to know a little more about how exactly this works to be able to give better feedback on this
probably if they wander away or have been missing
Amber alerts are for kidnapped kids - would this be for kidnapped vulnerable adults. Adults? Or, lost vulnerable adults? Not really PROTECTION, but rather a response.
Need more information on "Silver Alert"
That type of system would be helpful in times of emergency but the current response to these situations usually seems very appropriate.
Need more information to make an informed response.
I would need more information on how this was supposed to work & what would activate it
I think that it is a start!
Get the basics down before getting fancy.
Not helpful in protecting vulnerable adults but in locating a missing person possibly.
It may help with wandering dementia patients.
Possibly for Alzheimer's patience that have a tendency to wander.

12.) County Adult Protective Services, County Social Services, Department of Human Services, or Consumer Advocacy Organizations should be allowed to apply for an Order for Protection or a Hardship Waiver on behalf of a vulnerable adult. (Rating of 3.9 out of 5)

Will VA be able or willing to call 911? What about self determination? I think this could put vulnerable adults in more danger.
I am unsure what this is, but each VA should have a guardian and case manager who is better equipped to make these decisions.
And if so, so what? How long would that take? And who would act on those?
Provided that the vulnerable adult and/or his/her guardian are involved to the extent that they are able.
The first three make sense, but not sure about consumer advocacy organizations, unless they were approved by the first three.
Need more info to decide.
Who would provide the legal services and who would pay for the costs?
That is fine when the person is at home-good idea. What about the nursing homes? I hope someone else knows they will then have to care for the person
need protections against an over zealous social worker and on the other hand to protect the VA over a crafty responsible party
not sure what consumer advocacy group you refer to all others yes
Depends on the situation. Some county workers let power go to there heads and my over react to a situation.
Perhaps a Guardian Ad Litem type role?
Depends on situation and person.
Careful consideration of the VA's desire and capacity to participate in the process of filing an OFP and Hardship Waiver should be considered.
I am not sure of the implications of this-would need more information on what the Order for protection, and hardship waiver does
This has its good and bad points--plus who would have the additional time needed to carry these tasks out?
Only if there is no family to assist. Family needs to be held responsible
Probably some but not certain all these groups should have that ability
There are a variety of legal actions that should be the purview of the APS. How about an executive order from the Commissioner.

13.) Vulnerable adult victims have an adequate amount of appeal rights from a final disposition concerning abuse, neglect, or financial exploitation. (Rating of 3.5 out of 5)

Adequate may suggest that the individual has the cognition available to use the opportunities.
I have no background on this issue.
I don't know that they always understand their rights.
Sometimes it seems that they have so many appeals and rights that it leaves them more vulnerable in the interim.
I suspect not, but I am not familiar
I would need more information to answer this
I'm not really tracking what they want to appeal. That their abuser did wrong but I don't want them punished?
Most of the time they can comprehend their rights.
Victims can ask the appeal panel to review the investigation-they don't really have appeal rights

14.) Substantiated perpetrators have an adequate amount of appeal rights from a final disposition concerning abuse, neglect, or financial exploitation. (Rating of 4.0 out of 5)

There needs to be a process for persons on the Nurse Aide registry to have neglect findings "set aside" just as there is with the state process.

I have no background on this issue. However, if it refers to criminal matters- there is a process for appeals.

I suspect so... most perpetrators do.

I think a lot of people are getting away with it, yet sometimes innocent caregivers are loosing their career for an unintentional oversight or 1 slip

at times the appeal process seems to strongly favor the alleged perpetrator

15.) Additional comments on Protections:

It is very difficult to protect a client from financial exploitation when it's a family member using manipulation, emotional bribery, and verbal coercion. Many times, our client will complain about their lack of funds, how an adult child is using them, etc. but is unwilling to take legal action for fear of reprisals (most often, not physical).

Most problems we at DHS see are when people do not follow the laws that are in place to protect vulnerable adults. I don't see an inadequacy in the law, but perhaps some lack of training to direct support staff persons on the law and what it means. **(E&T)**

This is evolving at this time, I believe we are on the right track, however, it will take time to weed out all the problems, when that happens, I believe it will work quite well.

These questions are pertinent if one knows the definition of the VAA. Are you changing the definition? There is no explanation of the rights of the perpetrators or vulnerable adults. You are assuming everyone doing the survey knows this information. It may not be true.

Process can take WAY too long. Begin filing reports, need to build the file and then told nothing can be done until something happens. Drs. know they are vulnerable, housing knows they are vulnerable, family and case workers and the county attorney yet their hands are tied because of the process and when or if to step in. Most responses from these departments is there is nothing they can do at this time and then one has to just watch them deteriorate because of "choices" they are making. Sad

More advocacy needs to be made available for people with impaired cognition who need help with housing, decision making, medication management, financial decisions - paying bills, selling property, etc. People without family or someone to become POA need representation.

It is notoriously hard to define with words. Especially the verbal abuse piece. Verbal abusers cloak abuse in pretty language and can still be devastating, some master manipulators are extremely cruel exploiters, (think guilt) but the language is never directly abusive. Alternately, sometimes an exclamation in frustration is just that. It all depends on the perception of the viewer. So much depends on if person feels victimized, or if someone decides there IS a victim. That can be so subjective. **(Def.)**

financial exploitation substantiated in Jan; Court did not remove the conservators until months later resulting in thousands of dollars being lost for victim; alleged perpetrators now appealing the maltreatment decision, appeal hearing is scheduled for three days long and have 25 witnesses; seems like this is overkill and not productive

The people that hear the appeals need more training in VA laws and issues.

I'd like to see a tip sheet on what community options should be sought for VA's that maybe not all counties have at their finger tips. **(E&T)**

The protections in the existing law and rule are outdated and show a total lack of creativity. For example there should be provisions in the guardianship law and also in

areas such as injunctive relief giving counties and county attorneys' offices much more latitude to take legal action if necessary on a moments notice. What would happen if CHIPS were taken away from the child world - could you imagine the uproar? (SoS)
I would like to see a change in language in 626.557, Subd. 10 (2) replacement of a guardian or conservator "suspected" of maltreatment. Just because they are suspected does not mean they are a perpetrator of maltreatment. (Def.)

SCOPE OF STATUTES

16.) There should be a civil form of action, in addition to the criminal action, to recover funds when a vulnerable adult has been financially exploited. (Rating of 4.3 out of 5)

POA seems to be a license to steal. I feel anyone wishing to have one should go through the court system.
I believe many of these cases are also processed criminally.
So both avenues could be pursued? How long to reach a judgment? And how is the vulnerable adult supposed to manage during lengthy legal actions?
If there is a criminal action, and conviction I think the victim would be best served by the criminal courts for restitution before civil court.
Financial exploitation cases continue to grow.
I would think it would depend on each situation I'm not sure that each case would require civil action.
This has occurred but the court system slapped the hands of the individual with 300 day in jail with work release. Not much punishment for $300,000.
Whenever a crime is perpetrated, civil action is an option.
often no criminal charges filed, even when sufficient evidence; or criminal investigation takes much longer than the AP investigation; months longer
This should be done by an Agency other than the county AP people, however.
I think that it is a start!
Currently, this process takes too long. Usually additional funds have been stolen or misused before legal action has been taken or completed.
Financial exploitation can be done with impunity.
But! county should not be responsible for this action
It is frustrating for all especially if criminal action can not be substantiated and the person/family/facility go without payment
Information is not always accurate.

17.) It would be beneficial to create a legal mechanism, such as the Revenue Recapture Act, to withhold certain financial gain (income tax refund or certain inheritance rights) from a substantiated perpetrator of financial exploitation. (Rating of 4.4 out of 5)

We deal with a preponderance of the evidence, which does not match the level of a criminal case. We cannot impose stricter penalty than the law allows.
Possibly, depends on who it is worked out for, making sure all have access.
Awesome idea

What a great idea!

THIS SHOULD BE AUTOMATIC WHEN THE PERPETRATOR IS SUBSTANTIATED!!!!

This has its good and bad points--plus who would have the additional time needed to carry these tasks out?

Yes, but again crawl before walking. How about developing forensic legal experts ala BCA who can work with local law enforcement.

18.) A thorough background check should be performed on any individual who acts in a substitute decision-making capacity or is an informal, paid caregiver. (Rating of 4.1 out of 5)

The system doesn't seem to be working well now so add another layer?

I do not believe that family members should be subject to background checks.

Most are family members with good intent and should not have to have a background check. This would be like making all parents have checks

Not a bad idea but wondering who will be responsible for paying for this?

if individual is not family

Formal caregivers and agents such as guardians should be screened. trusted individuals that are chosen by the person should not

The volume of work this could create could out weight the benefit.

there already is for caregivers that are paid

Although most perpetrators may not have records, therefore org. policies must address risk ID of staff and volunteers.

How will we know? Who would enforce it? Who would pay for the background studies?

State and local checks need to be coordinated. DHS only looks at state level and misses quite a bit of information at the local level.

Not sure what you mean by this. Example?

in financial exploitation cases, often the offender is the legal rep

Only agree if substitute decision maker is not a family member and VA is found mentally incapacitated

I'm not really tracking what they want to appeal. That their abuser did wrong but I don't want them punished?

This would be an additional cost to either the individual and/or the county It would also be time consuming and would not be adequate for emergencies

This is way to much big government.

These people are often perpetrators and should never have been put in that position. I think background check would weed them out.

I strongly agree and also to include family members needing a background check as that should not be excluded in protecting vulnerable adults.

I believe this would be very difficult to enforce though

These two should be split out -- I strongly agree on substitute decision makers. Neutral on INFORMAL caregivers (choice vs. risk).

The question contains too many variables; background checks should be completed for any paid caregivers; but not needed or practical for all informal caregivers.

19.) A legal mechanism should be enacted to “freeze” a vulnerable adult’s assets, such that the vulnerable adult would still have access and that the

assets would be protected from a potential perpetrator while an investigation of financial exploitation is conducted. (Rating of 4.3 out of 5)

This could have a paradoxical effect from the intent of protecting.
And if the vulnerable adult has someone else managing their finances? How long to get a "freeze?" Who would guide people through this morass?
I think a lot of perpetrators have either left or have been terminated when the exploitation is discovered, so this may not be pertinent
It is difficult for law enforcement to freeze suspect's accounts before they are charged.
EDUCATION for investigators and knowledge of HIPPA, banking restrictions. (E&T)
Make sure VA rights not violated no over zealous social worker (Prt.)
What if the VA themselves mismanages their money too and "wastes" their money during this time. What safeguards are in place? (Prt.)
The exploitation has generally already occurred before an investigation is conducted.
As long as it does not further disempower a victim.
yes, see answer on previous page, victim lost thousands as Court didn't act quickly to remove conservators
I agree, but what is the funding source for this????
Too many VA financial exploitation cases are family feuds. There should be criteria or counties will be tied up as ersatz probate courts.
Financial exploitation had become a big concern. This would assist us in stopping the abuse as soon as possible.
Only if money was still made available to those providing day-to-day care and services to the VA.

20.) Additional comments on Scope of Statutes:

There definitely needs to be more protections in place for adults with means who lose money to exploitation
There need to be consequences for substantiated findings other then just a name submitted to a data based. This is no penalty or consequence that would effect most perpetrators or detour most perpetrators.
In financial exploitation cases where there is a single incident (no matter the amount of money) we cannot disqualify. Recurring and serious should apply to abuse and neglect. Financial exploitation (especially when law enforcement is not able to prosecute) should be treated as "serious" maltreatment based on the dollar amount.
Protection of individual rights as important.
Our legal system has to improve and the punishments need to fit the crime. **When someone gets away with over $300,000 and only gets 300 days in jail with work release then we need to do something with the judges who are overseeing these cases. (E&T)**
County Adult Protection needs to be able to obtain temporary relief quickly, ex parte if necessary, "freezing" assets and preventing further withdrawals from the VA's account without the cumbersome paperwork required for an emergency guardianship.
I'd like to see a tip sheet on what community options should be sought for VA's that maybe not all counties have at their finger tips. (E&T)
The statute and rule need to be brought up to date. It is incredible that the rule has not been. **The statute should be reworked to separate out community v. institutional reports and investigations. Much more focus should be given to the fundamental role of the county social services as a "social services" agency, not as a social police force. (Def.)**
We receive a lot of Financial exploitation reports and are powerless to assist without the help of

better statues that allow us to communicate with banks and stop the AP. Having background studies for those people listed about would weed out those who should not be in that position.

REPORTING

21.) Minnesota should move to a state-administered Centralized Reporting System for intake of vulnerable adult reports, but all county lead agencies would still be responsible for their investigations. (Rating of 3.4 out of 5)

This is adding another layer of structure that could hamper timeliness and compromise health and safety.

It would take too long to get the reports.

I don't know enough about how that would operate.

One system for intake and investigations would be best for consistency and efficiency.

This may alleviate some of the concerns with local agencies not reporting to DHS and have a more consistent approach to what is investigated.

Don't know enough about the benefits and consequences. Might help with consistency overall.

It might make the process more consistent.

I strongly support a centralized reporting system and maintaining investigations as they are.

County CEP's already have the local contacts and relationships with LE/APS/etc established. Centralized would increase consistency in report intake.

Everybody would be on the same page...

especially if this would eliminate the need for dual reporting

DHS should house this-allow for better tracking statistics

Utilize what's already in place locally - don't expand more government.

Better to report to the agency that will investigate-less possibility of missing information

This would help on the variation in counties.

I would support this as long it was timely and effective.

If reports got prompt attention, then having a centralized place to call would make sense.

I would have to see what type of system is proposed and weigh the pros and cons.

Not sure; now at least we can have an idea of what is going on within our community regarding facilities/programs if we are the CEP.

There would be too big of a lag between when the report comes into DHS and when the county is notified.

This takes away from the person feeling like they are getting the attention needed if the reports go to the state initially.

I believe this is already in place with the new on line reporting

not sure of implications of this - need more info

That way it is done correctly as to where it needs to go and nothing is lost in the shuffle as each county may have a different style.

Horrible idea. Ask OHFC and DHS licensing how it is to investigate state wide.

I think Facility reports should go to the facility (lead agency). The counties should still be responsible for investigating community reports.

I'd prefer counties receive community reports and the facility reports go directly to DHS or OHFC.

A Centralized Reporting System would help communities conform to a state-wide standard.

Not sure what this means. Would this delay counties getting info?

Outside agencies should do the investigations.
There is a need to streamline reporting processes and improve consistency around the State.
Can you say streamline continuity, increase both efficiency and accuracy.

22.) Reports of vulnerable adult abuse, neglect, and financial exploitation made to the Common Entry Point (CEP) are taken by the CEP in an efficient, timely, and user-friendly manner. (Rating of 3.6 out of 5)

Yes, although very few reports lead to a case being opened.
Overall, there seem to be many disparities and inconsistencies.
Hasn't happened thus far.
The reports are taken by the CEP in a timely manner but not always forwarded to DHS in a timely manner.
Some counties are better than ever
In Hennepin County they are - I can't speak to any other county.
See earlier note regarding CEP screening out reports.
I have heard complaints from reporters about who they talked to at the CEP.
At times they "screen" the report and it does not move on to the investigative authority.
Human emotions tend to get in the way sometimes.
Most of the time when I call the CEP, I need to leave a message and they return the call at their convenience.
I am usually called back the next day from the intake worker in Scott Co.
We always have to leave a message and then they need to contact us back and this results in a lot of phone tag and this is time sensitive at times
After hours can be an issue and weekends.
As timely as can be
We fax our reports.
Why should we have this step when we have to report directly to MN Dept of Health based on the CMS requirement? Eliminate the CEP reporting step.
I just do not have experience with this - sorry.
The new SSIS install has made it twice as time consuming and not at all user friendly making it much more difficult to be efficient and timely.
I think that there is variation on this depending on the individual CEP screener.
This has improved and is better than it was when the protection act first became a law.
Far too cumbersome, volume of calls and SSIS result in a decrease in these elements.
The SSIS CEP can be cumbersome and time consuming for the Caller to go through with the Intake Worker.
In Yellow Medicine County they are. I don't believe that is true for all counties.
We are the CEP - I think we're friendly
Dakota County has been very good.
SSIS is NOT user friendly!
WE ARE DOING THE BEST WE CAN RIGHT NOW, WITH THE SYSTEM BEING NEW!
I think SSIS makes this process more cumbersome.
The SSIS system is hindering quick action.
If information is missing it gets difficult to determine what should really happen. There may be issues but what to do with them. We get late reports.

IF it's not happening in certain counties then that's a training or county specific issue
There are glitches, but for the most part this is so in our county.
At least in my county. I can't speak for other CEP's in other counties.
Most of the time the reports are current. Some facilities report CEP's very late.
I've personally experienced too many failures along these lines to agree.
Every county is different in their approach, willingness to accept a report, demeanor, and professionalism.
Though this varies from county-to-county.

23.) The current statewide database adequately provides for the entering and accessibility of Common Entry Point (CEP) intake information by all agencies permitted to have such information under current statute. (Rating of 2.9 out of 5)

SSIS is slow and cumbersome for taking reports.
Not familiar with this.
Don't know what it is now so can't answer.
In my position I do not access this database.
I do not access this system.
Current database is too cumbersome for efficient direct entry of reports.
All of the information that is required is not collected.
The SSIS forms are not user friendly, are overly time consuming and meet the needs of collecting data rather than taking data.
Still learning.
I haven't made a report since the new program started.
Unsure.
No experience on this - sorry
Obviously Hennepin does not think so.
What database?
I am not sure about the accessibility of the information.
Not yet but we are hopeful that this will soon be the case.
I AM STILL TRYING TO BECOME COMFORTABLE WITH THE NEW SYSTEM, SO CANNOT ANSWER.
LEC does not currently have access to SSIS, so entry information is unfairly left up to county staff when LEC is CEP
The new CEP has some good points but it can be difficult to work in. One little thing can hold you up and we can't figure out what is wrong.
too soon in implementation to know
The current system is awful.
I feel like it is a project that is not finished (the electronic sending to lead agency and perpetrator list)
SSIS is not functioning to electronically submit the report to LE, DHS or OHFC as was described when it was first presented to the counties.
We still must fax up info to Licensing and OHFC. SSIS intake is cumbersome and we find that we are not able to eliminate the paper copy when taking the CEP
MN Dept of Human Services-Licensing division
The new SSIS maltreatment report is difficult and more time consuming.

Still trying to learn and understand the SSIS program.
Still have some wrinkles to iron out with this system
Unable to answer, as inadequate knowledge.

24.) Minnesota should change its definition of "maltreatment" to align with the Federal definition used by the Center for Medicare and Medicaid Services (CMS). (Rating of 3.6 out of 5)

I don't know what those definitions are but many of our VA's are not in a facility so the definitions maybe lacking.
I don't know enough about this issue.
And what is that definition?
I don't know enough about the Federal definition to make a decision on this.
Not enough info, what is the Federal Definition?
I don't know the Federal definition.
The federal definitions (if I found the right ones) seem too minimal/not descriptive enough to me.
Maltreatment is undefined
Not sure how the definition differs
Why would this be different, because we have to follow both laws?
If it helps strengthen our laws to protect elders and vulnerable adults. YES.
I don't know what the Federal definition is.
Looked and looked and could not find the CMS definition.
Well, wouldn't that make sense?
Would need to study definitions before making a decision on this question
I think federal has problems, but might be better for administrative reasons -especially for nursing homes who have to report to both
I do not know what that definition is.
I'm not sure of their definition. It might be easier if CMS, county/state and law had similar terms since that can be a hang up when investigating.
unaware of CMS definition
No, the state needs to work out the kinks in the current language.
Not sure what that definition is. Would have been helpful to have it in the question.
don't know what the definition is for CMS
I have no knowledge of this definition
Need more information on Federal definition.

25.) The Common Entry Point (CEP) should be allowed to take written or faxed reports of suspected maltreatment, instead of only oral reports. (Rating of 3.6 out of 5)

This will limit information and aid in less than adequate responses to the report itself. Nothing can replace the ability to ask real time questions.
The information can be poor or not there. Name to call back is important. Can we read the writing?

And what difference would that make? If reports aren't processed properly now, how would two more ways change that?
Written reports are harder to enforce timelines on, since it takes time to write the report. This may leave a lag in critical response time.
An interview regarding the allegations is very important for clarifying and gathering info and ascertaining immediate health and safety of VA.
I believe they should be able to take reports in the way they see best fit to assist them with their job/investigation.
Too much needed information is missed.
We (CEP) usually have to call the reporter back and get additional information.
That would mean more follow up calls because not everyone reports the necessary info.
It is helpful to ask questions in certain situations.
Describing the entire situation while they type is so time consuming, tedious. Anything that gets the information and can then be passed on is great.
BUT reports by mandated reporters should be thorough.
We do fax info.
They should follow up to obtain more info if needed.
We fax ours at the present time.
I think it is important to speak to the reporter so that information is not missed
We used to do that. Reading handwriting was a big problem. The amount of information provided was often inadequate so that you had to call anyhow.
We do take written/faxed reports in addition to the initial call.
we do
We receive reports via fax and letter, but then follow up with a verbal report.
We receive written reports that do not have all the information asked by the SSIS CEP system.
Sometimes need more details that a written or faxed report doesn't give
As long as reporter's name and phone number are available for follow up
I believe the CEP currently is allowed to take written or faxed reports.
This would be a huge time saver.
Written CEP reports aren't always legible.
There may be information missing that needs to be asked if the reporter is on the phone or in person.
Fairly redundant process if we just turn around and re-fax to the licensing agency. Sometimes I feel like an overpaid secretary forwarding on info
However a report comes in.
Written or faxed reports often do not contain all the information that DHS is requiring us to get to complete the CEP. We would screen more of them out
Depends on the situation.
It is very difficult at times to get a hold of reporters especially if in a facility. If they fax it, it is the same as it shows the time and date
I believe this would already be true.
Fax reports often do not contain the needed information. When interviewing the caller you can get more information
As long as they're all timely (whatever we decide "timely" means!)
We currently take faxed police reports to determine if they need to go on a CEP
Duh. Verbal is terribly inefficient if faxed, written information is available, plus the tracking of the report is easier.

26.) Additional comments on Reporting:

There is the opportunity for follow up questions and more information if the report is taken orally. The issue of what constitutes a report comes up if written letters from people are considered reports because they are asking questions or complaining. Faxes can get cut off or only partially sent.
The new SSIS system does not work for counties that have large numbers of reports.
Nursing Homes are doing dual reporting so the CEP should be eliminated since we are to follow the CMS regulations.
Eliminate the need for nursing homes to report to the common entry point and to the Department of Health directly.
Some intakes get "screened out" by the Supervisor even though they do not have that authority, i.e. reports that should be sent to OHFC.
reports should be accepted in whatever format they arrive in; fax, telephone, oral, in person, document etc
Dislike the idea that County agencies can not "screen" calls of what is maltreatment and what is not- prior to sending to the licensing agency. Why not have the reporter talk right to the licensing agency- and if they determine an immediate protection need- then the licensing agency can contact the county to respond.
Overhaul the statute and the horrible, horrible SSIS monstrosity and we will all be better off. Why all the questions about financial exploitation. Most of the calls we get are about neglect. Counties that handle and do neglect cases well are the ones who have tapped into the real issues in AP. For too long the state has focused on a narrow issue - investigations. The reality is that the focus day to day is services.

DEFINITIONS

27.) As more vulnerable adults are choosing to live in the community, rather than in a facility, clarification is needed on what an "informal caregiver" status may entail, including any associated obligations, required training, and penalties. (Rating of 4.1 out of 5)

As long as it doesn't prove as a barrier to living in the community.
How much time, how many people, how much money spent in coming up with a definition? And people are still without services that make any sense.
I do not know what the current guidelines are, but I agree that as much clarification and training possible is best.
Without exception to rights of family members and volunteer nurses.
How do you require association obligations and training for care partners who are married and may face other financial, health and time burdens?
Wouldn't hurt but do not see it as a main issue.
This could get very interesting.
When is a friend a friend? Or a good neighbor not "obligated" to take care of you if they did do something to help you out.
The legal notion of caregiver lacks any real clout or has any real legal meaning by consumers.
People do not realize or appreciate the responsibility that they take on as informal caregiver and the consequences of inadequate care abuse/neglect.

28.) The definition of self-neglect within the Vulnerable Adult Act should be clarified to ensure the vulnerable adult's lack of mental capacity is taken into consideration when an agency acts on behalf of that individual. (Rating of 4.2 out of 5)

Does common sense ever come into play at all any more?
I don't understand this question as I thought mental capacity or lack thereof was taken into consideration.
I do not like the word "lack" of mental capacity. Just mental capacity.
Make sure cultural differences don't impact judgment about mental capacity.
This is a tough area to define: what is a VA issue and what is informed choice? Families really struggle with this when concerned about a loved one.
Self-neglect calls are increasing and the statue is very vague.
I think it needs clarification and strengthening, because self neglect is hard to prove and differentiate from being just contrary or different.
self neglect is confusing if the person is "unable" to care for or make decisions for themselves how are they intentionally "self neglecting".
This is a tough one. At what point is a person no longer allowed to live as they currently are or have been for years? At what point is it dangerous?
Again, where in the statute does it say self-neglect? Mental capacity should be clarified throughout not just for self-neglect.

29.) Guardianship and conservatorship fiduciary responsibilities need to be further clarified in Minnesota statutes. (Rating of 3.9 out of 5)

For what purpose?
My experience working with guardians and conservators left me confused as different people interpret their responsibilities differently.
There needs to be better oversight than the overburdened district courts.
All of their duties seem to fall to the nursing home staff.
Again, I do not know how current statute reads. Sorry.
Also training should be required on an annual basis and before becoming a guardian
It needs to be state-regulated similar to the guardian ad litem program. Too many untrained guardian/conservators.
Great deal of confusion over these.
Again, what is the funding source for this?
I think that proven training to take on the responsibility should have to be documented by a certified trainer.
Our agency has experienced a large increase in requests for guardianship Majority of requests are not appropriate or family has not been looked at
We find that guardians do not know what they can do.
This is clear to me as a worker, maybe having more materials for potential guardians/conservators would help.
I am unfamiliar with MN Statutes regarding Guardianship and Conservatorship fiduciary responsibilities.

30.) When an individual abuses their power over another individual (using a power of attorney, guardianship, conservatorship, etc.), the penalties for such abuse are adequate to punish the perpetrator. (Rating of 2.2 out of 5)

And what are those penalties? Who is enforcing? Does anyone really care?
I am not sure what the penalties are at this time.
The criminal statutes need to specifically address these issues. (SoS)
How determined?
Criminal charges enforced
County attorney needs more training on how to prosecute. (E&T)
Courts seem to view this as "white collar" crime and are very lenient.
The Statutes my be adequate, but the Law Enforcement and County Attorney time or interest is not adequate
I think they should be more severe, because responsibility is greater
What penalties? It seems that often no criminal charges, no restitution, perpetrators are allowed to take all the $$ and no real consequences
What penalties? Removal from duty if we are lucky but no pay back for loss of money or emotional distress for the victim.
There should be higher standards for responsible parties. It seems POA's and others get away with much more misuse of funds than someone without POA.
I am unfamiliar with the current penalties for this type of behavior.
We regard POA as license to steal as there are rarely if ever criminal repercussions

31.) Additional comments on Definitions:

Examine cultural differences closely
It's difficult because in many cases when a guardianship is in place there is not a lot they can do to stop a person from leaving, buying things, doing things without their consent because they are still in home or housing community. We in housing report yet are continually told, "Well there is nothing I can do. I am not with them 24 days a week." Person continues to buy cars, open checking accounts, find a job and never has to disclose that they even have a guardian. Numerous issues.
MN statute needs more guidelines for how much and for what guardian/conservators can reimburse themselves with VA's assets. Current statute allows guardian/conservator to deplete assets of VA for guardian/conservator fees that may be unreasonably high, or other costs that are not beneficial to the VA.
need stiffer penalties that are imposed in a timely manner, courts and law enforcement often take many months to come to a resolution on the case and the VA suffers
I struggle with the issue of whether it really is maltreatment or a way of life. Financial exploitation is going wild and nobody has to re-pay back if they are found guilty. You remove that person but the "damage" is already done.
Clarification and refocus will help. Again, look at what counties really do when they are protecting the client they serve. There should be alternative legal devices that are expectations for all counties and courts (e.g. protective orders etc.)
We have a perpetrator who continues to harass his parents and guardian (county) although guardianship has been established. The judge does not honor the guardian's wishes even to the point when a harassment order was filed and approved by the judge the judge ordered the county to supervise visitation with the son (perpetrator) so we have a victim responsible for supervision of visitation. It is not going well. Judges need mandatory training. (E&T)

INVESTIGATIONS

32.) Local law enforcement agencies are actively involved in an investigation of financial exploitation of a vulnerable adult. (Rating of 2.9 out of 5)

Varies from jurisdiction to jurisdiction and the volume of work they have.
The perpetrators only seem to get a slap on the hand.
Too many cases, not enough police.
Unfortunately, some jurisdictions regard VA issues as "less important."
Have no idea.
This is the area that law enforcement is most likely to investigate.
Some are better than others.
It apparently depends on the amount in some jurisdictions - and that may be quite high.
Most financial exploitation is not investigated by law enforcement.
Depends upon the department or city.
It depends on how much money is missing and what kind of evidence they have. Often times they don't bother.
Depends on the dollar amount.
This really depends on which agency you contact.
It often depends on the LE agency.
Theft is difficult to investigate due to the fact that these investigations take time and involve financial spreadsheets and analysis.
I do not believe law enforcement is totally aware of our statutes and the timelines that occur. (E&T)
They refused to take a report and referred to the exploitation a theft by swindle and told me to call 311 to report it.
They often tell VA worker to send them the results of their investigation and then they will decide what they need to do.
Depends again on the situation.
They were active in one case, but nothing was ever done. In another case, nothing was done.
This is a frustration to me. I see little interest in law enforcement to investigate and refer these matters for prosecution.
It is not a priority.
Really have to push them to get involved
I don't think they get involved unless someone presses charges
Most often they are actively involved but as before, takes many months longer than AP investigation at the county
There is room for improvement
Not equal training to all departments, so some dept do not know how to be involved. (E&T)
Not in our county!! They try to avoid involvement if they can!!
Are actively involved, but is not a high priority. Short staff and time delays the investigation.
These cases are difficult and time consuming and they have difficulty making them a priority
Not always high on the investigator's agenda - so doing joint visits is difficult
Lack of expertise. Willingness on part of the victim to prosecute.
Sometimes these cases are not a top priority of our law enforcement.
This is not a priority for them. We had one case that they began their investigation almost a yr. later. NO evidence. Surprise, surprise.

Depending on their case load and the initial information we give them. Hesitant on doing search warrants, subpoenas etc.
They use the criminal system and those guidelines to be or stay involved.
Only sometimes. I would like to see more law enforcement involvement.
We have made an effort to build a strong relationship with law enforcement in order to team investigations
Depends upon the location.
If they are aware of the allegation.

33.) Financial exploitation investigations are difficult to conduct because of many financial institutions' requirements to get a subpoena or warrant before any bank records are disclosed. (Rating of 3.9 out of 5)

If that's the real problem, who is addressing it?
I have not had problems with this because law enforcement has been willing to seek the subpoenas and warrants. Also facilities often keep the records.
I have not experienced difficulty in this area, but have not had to do a lot of info collecting from financial institutions.
Financial institutions commonly require warrants/subpoenas and that is just part of the process in the investigation which makes it time consuming.
We can usually obtain these records form the victim. However, it would be helpful if we could obtain records directly from the bank.
It's getting better but still if difficult.
I work out a small community and the banks are usually pretty helpful.
Banks routinely ignore the statutes allowing the county to access private data during an investigation.
I am not sure how that works.
Also, so confusing at to what jurisdiction they are in; where is the bank, where does the perpetrator live, the victim etc; law enforcement not sure either.
Local institutions in this county have been helpful.
It can be done though, just lots of work.
I'd like to see them become mandated reporters since they have valuable information that we need access to.
I think they have to try to get one first!!
If a client is cooperative with signing a release we can get records.

34.) All financial institutions in Minnesota (banks, financial advisors, mortgage advisors, credit unions, etc.), and their employees, should be mandated reporters under the Vulnerable Adult Act. (Rating of 4.3 out of 5)

At this rate, who isn't reporting on someone??
We do get reports that are generated by banks, and I believe they are in a good position to raise alarms.
But if they then cannot or will not give financial information as it is protected then this will be difficult to investigate.
I like this idea - very much.
If not mandated reports, at least be able to share information w/o a release in the course of an

investigation
This would be nice because it would perhaps allow for earlier reporting and less money being stolen.
Often they are the ones that notice something funny going on; they are the ones most likely to see odd transactions.
We could have saved some people thousands of dollars had the bank or credit union been considered a mandated reporter. This is a must
I totally agree! They are part of the big picture!!

35.) It would be helpful to enact a system to “flag” an alleged perpetrator of abuse, neglect, or financial exploitation while the perpetrator is under investigation. (Rating of 3.7 out of 5)

Flag for what? It could impact employment and not be a true allegation.
For what purpose? What's the problem this would resolve?
Our current system is set up to "flag" at some level, I would be concerned that people who have been falsely accused would be caught in the system.
We get false reports. Anyone can make a report and thus, anyone could be an alleged perpetrator, but the system could prevent repeated acts of abuse.
Hard to say because if the determination is false than the perpetrator was flagged incorrectly, but if not it may protect the VA and others while investigating.
In some ways this seems harsh....most alleged perpetrators are not substantiated against and this could very well be a hardship for them.
As long as this information is not used to impose consequences before a determination is made.
Come on what part of our legal system is this? Key word is "alleged". This goes beyond reason.
This may not be appropriate because an active investigation does not mean maltreatment did occur. Could be helpful in some situations.
I agree that the "flag" system would be good to have if the AP is a staff person in a facility or employed by a licensed agency, not family members.
Don't know what this would be or how would work. I think can't do, because hasn't been proven guilty.
While I think the concept would be great, it could cause hardship if the person truly is "innocent". But I like the idea if they are not.
Would "innocent until proven guilty" apply here?

36.) The lead agency investigation of an incident of maltreatment should receive the same priority, despite an internal investigation required by CMS or when an alleged perpetrator (employee) has been terminated. (Rating of 3.8 out of 5)

I am unsure what this comment means.
And what is that priority? Who determines? How does this protect the person who is being maltreated?
There are so many reports that they need to be prioritized on risk of harm. If the AP has been terminated, this usually lowers the risk of harm.
Risk of harm is reduced and should be taken into consideration.

This is currently the process!

There are not resources for this and priority has to be given to situations that have not been resolved and where safety continues to be an issue.

The timing of the investigation might be a lower priority, but the investigation should be just as thorough and objective in all cases.

Depends on the situation.

Not quite sure what you're asking.

Not sure what your point is here....

Not sure of implications of this.

Not sure what is really being asked here.

As the employee may be working for another agency or still have contact with other vulnerable adults.

The alleged perpetrator can resign or get fired but move on to other facilities to work with vulnerable people.

37.) Government agencies (Ombudsman, County APS, DHS, OHFC, etc.) should be allowed access to information necessary to protect a vulnerable adult when the vulnerable adult is unable to access the information himself/herself (for example, due to cognitive incapacity).
(Rating of 4.3 out of 5)

We need to be very careful about this so we don't cross the line into information we don't need. Also who assesses the capacity/incapacity?

There are pros and cons to this. Of course the intent is good, but there is always a chance for internal abuse.

Have no idea what this would do for anyone. So anyone in a government agency is going to assess and evaluate the "cognitive capacity" of whom?

Back to background checks on individuals who have access.

Some safeguards need to be in place to make sure the person's privacy is protected and this procedure is only used in appropriate situations.

Depending on family involvement.

While maintaining the utmost dignity and privacy for that adult.

Generally, have never been denied information that I have requested, but yes, we need information and need it quickly at times.

This is a huge hurdle during investigations, statue language is not clear.

Not sure what you mean here. Are you talking bank accounts? If so, yes.

This has a great concept but who is that access only available during an investigation or open case management?

More effort needs to be given to Minnesota Data Privacy laws.

38.) Additional comments on Investigations:

What instruments or tests would be used to determine capacity? It would need to be very specific so that professionals don't override a person's right to make bad decisions.

Coordination with courts and law enforcement are sometimes difficult. (Inv.)
Are there specific trainings available to law enforcement and court personnel? (E&T)

My wish is for actual detailed information on how to do an investigation. The manual is reading material that

leaves empty gaps of what to do in different situation. Similar cases but why each may turn out differently and what needs to occur.

FINAL COMMENTS

- Affordable housing with supports as needed - Affordable services to support optimal independence and functioning - Informed CEP regarding resources in the community especially if VA report is not warranted. - Skilled and trained personnel	**Prt.** **Prt.** **E&T** **E&T**
There needs to be a way for the general public to know how a provider is doing (i.e. a report card). This information can be acquired for construction companies, plumbers, etc...It is necessary to promote a higher standard and fits with the notion of market and competition while moving another step toward transparency and accountability. Complaints need to be compiled similar to New Jersey. Check with Jason Flint on this.	**Prt.**
More education of the community including the general community and those who work with vulnerable adults. Some education about what standards should be used to determine things: and example is whether a house is a garbage house or clutter house or a house where cleaning is not a priority. More restrictions and leverage on personal care attendants.	**E&T** **SoS**
As stated in this survey, financial offices should be aware of potential abuse and how to report it. I also feel that POA's are way to easy to obtain.	**SoS** **E&T**
Money Gram & Western Union should report VA's when sending money orders overseas. The money order should have a delayed payment so when the scammer does not provide the service, the money can be returned to the VA. In addition, banks should not release funds to VA's until the bogus check actually clears the bank. The bank should wait until the check clears, to many VA's get into trouble. Also there should be some way to get an order to keep suspects away from the VA's while under investigation.	**Prt.** **SoS** **Inv.**
People, such as community people, often do not know what abuse of a VA is. They may witness acts that they think are allowable and therefore do not report. Perhaps annual law enforcement training to the public on who a vulnerable person is, what abuse of a VA is, and how to report it may help.	**E&T**
Additional APS staff and more training in self neglect and engaging clients with case managers, particularly contracted case managers and those working with health plans	**E&T**
PCA's need to be regulated. So many reports about abuse or neglect and there are really no consequences or way to track them.	**SoS** **Rpt.**
Allowing APS access to financial reports from banks or other financial institutions. Also the more clear definition of what constitutes financial exploitation. Something similar to the misuse of a VA's funds not for the purpose of the care for the VA.	**Inv.**
More agencies working together, have common data bases, have common training, so most individuals hear and see the same info. Remind counties not to screen out reports. Ask counties to attach or send along with the CEP, any info that they get from the facility (internal reviews, incident/accident reports, written documents etc., etc. and not just file them with their report).	**Rpt.** **E&T**
Finding better ways to enable VA's to access services and community resources.	**E&T**
Change the wording on CEP or policy so that if in fact an eviction is the main complaint to be investigated, the eviction notice should accompany the CEP form. If it isn't written, it didn't happen...	**Inv.**
Public Information (What to do?) Education (Why do it?) Too restrictive will cause problems for adults trying to be out of institutions they have fought for years to out of institutions and so have their families. We are actually all vulnerable some more than others and if we squelch all risks we are all in jail.	**Prt.**
From my experience in social services, there have been several cases where parents have been assessed because of child protection concerns, but yet are still working with vulnerable adults (for example at the local DAC) - because these CP assessments are not traditional where parent has been found as a perpetrator - DAC can then not be notified of assessment and parent is still working with VA's.	**Prt.**

I think we need to be careful. Most people, including myself make poor health decisions everyday. If that has been my lifestyle, why should I have to change just because I am elderly or for some other reason vulnerable? As long as they have all the information they need to make an informed decision why interfere?	**Prt.**
Allow home care or informal caregivers to make a report of self neglect with out having to stop services.	**Rpt.**
Actually having the investigating person or "team" actually care that the person is ok. One "check" on the person may not be enough to get the whole picture. Someone can usually present really well for one sitting. Really speak to many involved to formulate an opinion.	**Inv.**
A better system for cognitively impaired people to have protection - often times we are told people who live in the community are free to make their own decisions even if it puts them or others at risk (cooking and forgetting to turn off the stove, etc) living in a "garbage house". If there is proof they are not safe to live without services, supervision, etc. I don't believe it is a life of dignity.	**Prt.**
Education to clarify VA versus informed choice in area of self neglect. Very tough and touchy area.	**E&T**
State funds to assist the counties in hiring positions to complete mandated Vulnerable Adult county job requirements.	
There are already enough laws to protect people but needs some tweaking to address family caregivers or friends of clients care giving as mandated reporters as well. There will way too many vulnerable people with consumer directed care. Your problem isn't with facilities or home and community based services it related to self, family and relatives friends,	**Def.**
The financial exploitation of the elderly is happening all over the state. There are not enough safeguards in place to ensure this doesn't happen. The county attorney/sheriff's office/family services do not ensure that a resident is not being financially exploited & that the resident's care in a nursing home is paid for. Even when it is obvious that the resident has the money to pay for the services and the family is using the money for personal use, the nursing home has no recourse.	**Prt.**
Good Luck! The court systems and judges need to impose stiffer penalties for abusers.	**SoS**
There needs to be far more cooperation between the criminal and civil parts of the legal system. Law enforcement should be encouraged to give VA protection the same kin of priority that is given to child protection and domestic abuse. There should be mandated training of law enforcement and criminal prosecutors re: financial exploitation and abuse and neglect of vulnerable adults.	**E&T**
More training to the general public, banks and human service agencies.	**E&T**
Better information and resources.	**E&T**
More social and cultural awareness about the problem translated to system action designed to protect people (like the work of this group). I would like to see more activities focused on some of the higher levels on the spectrum of prevention such as org and leg policy, etc. This is such good work! THANKS	**E&T**
DHS offer more technical assistance/training to county agencies that is readily available regarding VA and adult protection issues.	**E&T**
The content of the questions in this survey brings up excellent ideas on how the whole system could be improved.	
Issues of fees and collections from credit card companies who do not approve credit responsibly. The most vulnerable are not reading the fine print, and are not able to understand the consequences. There needs to be more oversight of PCA providers.	**Prt.**
Banks should be mandated reporters. They usually are the first to be aware of "something's not right".	**SoS**
Each county should develop a policy of how to determine the capacity of a VA. The county attorney's office and legal advisors should assist with this process. It can be unclear what types of evaluations and who can determine the capacity of a VA. If the VA has the capacity to make their own decisions about the way they want to live in the community, that should be respected and supported with any services that they qualify for after a determination has been made of their capacity.	**Inv.**
Clarify definitions and responsibilities, give APS easier / clearer access to records	**Def.**
Encouragement to have protection of vulnerable adults to be of interest and priority to local County Administration and Law Enforcement.	**Prt.**
I think if the laws are too complicated, it will be hard to understand. I also think that elder abuse for financial is going to continue more.	**SoS**

We are all "vulnerable" in one way or another; it is a matter of degree. You can't be totally independent and also be "protected". Many choose to live with manipulative/abusive partner because there are certain rewards. Many move from one abusive situation to another. Also some "vulnerable" people are not nice people. Some are mean, or crazy, and they have been that way their whole lives. Some "vulnerable" people enjoy pushing other's buttons, manipulating etc. who is really the abuser.	**Prt.**
Finding the balance between due process / living in the community with dignity & creating a more concrete method to determine level of incompetence, so that APS workers can act more quickly	**Inv.**
There are so many areas to address but I think if we had to prioritize, I would look at the financial exploitation area. Educating banks, credit unions, etc... I have heard so many times "We knew something was going on" but didn't call or didn't think we should call.	**E&T**
The big picture is to have the community watching out for anyone and everyone. Not turning their backs on a situation--or thinking that it is not as bad as they may think. Years back neighbors and friends took care of each other and in today's world it become the "ME" world. More community awareness from the State level might be good.	**E&T**
Make it mandatory that people who become a POA or guardians have to take a class to educate them on their responsibilities and how to avoid getting into legal problems. Criminal background check on everyone. IF the POA or guardian depends on the ward's income to survive they should not be their agent. Better ways to educate the public about con artist.	**SoS**
Refocus the work on services rather than investigations on the part of the counties. Make it as easy for a small rural county to take a report as an urban county in respect to SSIS. Simplify the rules and law; split out investigations and roles related to facilities and community.	**Rpt.**
I would like to see more clarification in statute as to classification of vulnerable adult. Also stricter penalties for perpetrators of vulnerable adults. More community support programs for community based adults.	**Def.** **SoS** **E&T**
The statute should more clearly define what a vulnerable adult is. Criminal offenses for adult maltreatment perpetrators should be harsher and fit the crime.	**Def.** **SoS**
Train law enforcement. Have clear standards on evaluation of the adults' capacity. Train judges.	**E&T**
All those caring for VA's should be required to have training on VA act/law/responsibilities. All should need to have a background check done and some type of monitoring done.	**E&T** **Prt.**
Reform of the Power of Attorney Statute to make POA's more accountable.	**SoS**
More information/education to families on how to deal with self-neglect. More information to families on how to approach elder when they need to stop driving due to safety concerns. Terminate POA - license to steal, put in checks/balances. Monitoring of PCAs and their activities.	**E&T** **SoS**
We need to have adequate funding for protective service organization. Need to improve the visibility of protective services to better act as a deterrent.	**Prt.**
Prosecute PCAs for Fraud/Abuse when they are found guilty instead of just holding the agency accountable. Agencies are frequently unaware that a PCA is doing something illegal but currently agencies must return money to DHS but the PCA is not prosecuted and moves on to another agency.	**SoS**
The substantiated perpetrator list needs to be accessible to all, not just licensed agencies and should be more comprehensive. Counties maintain their own lists, but a person may have committed an offense in one county and reside in another. Normally, only the county of residence is checked	**Prt.**
Start to focus the MN VAA on community-based adults and services, and remove it from nursing-home based, now that nursing homes are on-line reporting via the CMS definitions. This will help improve protection in the fastest growing sector of senior services.	**Def.**
Counties need to be fully funded to meet VA investigation and Adult Protection service needs otherwise VA is low priority. VA Laws need to reflect the issues of those living in the community. Financial exploitation laws need to be improved. State wide CEP intake would free up county SW time to provide expand Adult Protection Services. County time and money should not be used to provide data collection for MN Dept of Health and Dept of Human Services.	**Inv.** **Def.** **SoS** **Rpt.**
We must make these issues a priority and ensure adequate funding to meet the needs of our most vulnerable citizens.	
Try to balance both protective activities by key stakeholders and the individual's right to make choices as an "adult" i.e. The dignity of risk and self-determination.	**Prt.**

Thank you for your time filling out this survey. Your responses are greatly appreciated and will be essential to the stakeholder group working to reform the Vulnerable Adult Act to protect Minnesota's vulnerable population.

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