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THE MINNESOTA VULNERABLE ADULT ACT:

AN OUTLINE FOR REFORM

A WORKING GROUP REPORT

to

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PREFACE

Attorney General Hubert H. Humphrey III

Our society must protect its most vulnerable members. The Minnesota Vulnerable Adult Act is a key component of that protection. This report sets the framework for an improved Vulnerable Adult Act system--one which will defend vulnerable adults against abuse, neglect and financial exploitation.

I urge readers to review this report carefully. The recommendations it offers are the result of an unusual collaborative process. The Working Group members represent divergent interests. However, they have come together to offer recommendations which do not serve one group's interest. Instead, the Working Group members used their varied perspectives to develop good public policy with one clear focus--providing the best and most effective protection for vulnerable adults.

These recommendations provide the foundation for a solid protection system which will efficiently, effectively and fairly satisfy our society's most basic protection obligation. I applaud the work accomplished by the Working Group and look forward to its legislative package in 1995.

EXECUTIVE SUMMARY

INTRODUCTION

Vulnerable adults need and deserve protection. In Minnesota, "the public policy is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to abuse or neglect."[1] When the Minnesota Legislature passed the Vulnerable Adult Act (VAA), Minn. Stat. § 626.557, it recognized our society's obligation to provide a safe living environment for some of its most helpless members--vulnerable adults. Consequently, the Legislature established the VAA reporting, response and penalty system in a landmark, comprehensive effort to protect vulnerable adults from abuse, financial fraud and neglect.

During the fourteen years the VAA has been in place, the many disciplines affected by the Act, the individuals in need of its protections, and the Attorney General's own experience have revealed that there are problems with the current system. The many parties involved, however, have offered widely differing perspectives on why the system has flaws. Yet, almost all agreed that despite its problems, the VAA was an integral part of providing much needed protection for vulnerable adults.

The Office of Attorney General Hubert H. Humphrey III and Care Providers of Minnesota, an association that represents nursing homes which care for vulnerable adults, came together to discuss how to assess the current system. It was clear that Minnesota needed a system to provide protection for vulnerable adults, while also making sure that the system treated dedicated care givers, who strive to provide quality care, fairly. It was also apparent that the current system did not always function efficiently and effectively to protect vulnerable adults. What was not clear, however, was how to fix what was broken, while preserving much that worked well.

Since there are so many different parties involved with the VAA, the Attorney General's Office and Care Providers of Minnesota recognized that a comprehensive assessment of the

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1. See, Minn. Stat. § 626.557 (1992).

VAA system required gathering information on how the system was actually working from the many parties involved. Therefore, Attorney General Humphrey and Care Providers reached out to these other parties and formed a Working Group to perform a comprehensive assessment of the current VAA system.

The mission of the Working Group, however, was not simply to assess the current system. The Group also agreed to provide the Attorney General with specific recommendations on how to improve the VAA process so it would operate efficiently, effectively and fairly to protect vulnerable adults. At the time the Working Group began operation, the Legislature mandated that the Minnesota Departments of Health and Human Services convene an Advisory Committee to "make recommendations on the means of preventing maltreatment of vulnerable adults and for the provision of protective services to vulnerable adults."[2] Since the mission of the Working Group and the Advisory Committee were similar, the Departments of Health and Human Services joined in the Working Group's efforts and will be using this report to fulfill, in part, the Advisory Committee's obligation to report its findings to the Legislature and the governor.

WORKING GROUP PROCESS

The Working Group included representatives from the Attorney General's Office, Care Providers of Minnesota, the Minnesota Departments of Health and Human Services, the Minnesota Association of Homes for the Aging, the Association of Residential Resources in Minnesota, the Minnesota Alliance for Health Care Consumers, the Minnesota HomeCare Association, the Office of the Ombudsman for Older Minnesotans, the Office of the Ombudsman for Mental Health and Mental Retardation and county social service agencies, including Hennepin County Adult Protection Services. Although these organizations provided the Working Group with many different perspectives on, and experiences with, the VAA system, the Working Group felt it was important to reach out to others who had important information about the process and how it did or did not function.

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2. See, 1993 Minn. Laws, ch. 338, sec. 11.

To gather the additional information, the Working Group launched two major projects. First, the Group drafted and widely distributed a survey designed to elicit information on how the VAA was actually working. The survey was sent to individuals and institutions throughout Minnesota that deal with vulnerable adult protection issues, including: police departments, sheriffs' offices, county and city attorneys' offices, adult protection agencies, regulatory agencies (the Office of Health Facilities Complaints and the Department of Human Services Licensing), Ombudsman's Offices, consumer advocacy groups, hospitals, nursing homes, intermediate care facilities for the mentally retarded, adult foster care homes, licensed home care providers and facilities for the mentally ill, and others. Second, on November 9, 1993, the Working Group held the Invitational Working Conference on Vulnerable Adult Act issues. Individuals from many different disciplines came together to exchange experiences and ideas on how to improve the current VAA process.

The conference discussions and survey data gave the Working Group additional insight into how the VAA process functioned. Based on this information, and extensive internal discussions, the Working Group identified thirteen major components of the VAA process which must improve before Minnesota's Vulnerable Adult Act can function effectively, efficiently and fairly.

SUMMARY OF THE WORKING GROUP'S RECOMMENDATIONS

The Working Group identified the thirteen broad topics, listed below, as key issues requiring reform. Each topic may be addressed in many different ways including, among others: legislative action, administrative policy changes, better coordination among actors in the VAA system, and improved education for those involved in the process. The body of this report contains additional detail on how the Group believes the specific ideas should be implemented.

As the Working Group progressed, however, it realized that the comprehensive and complex reforms it recommended must be done as a "package" to be effective. Therefore, the Group is not advocating that any single reform move forward separately, with one exception.[3]

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3. The Working Group is proposing that legislation be introduced this session to define the evidentiary standards for the investigative determinations required by the Act. See, Section 5 of this report.

Instead, the Working Group recommends that the Legislature mandate that the Working Group continue its work, with the specific mission of drafting detailed plans to implement all of the thirteen broad reforms, identified below, by January of 1995.

The Vulnerable Adult Act Reform Package

1. **Definitions** - The terms, including the definitions, contained in the Vulnerable Adult Act, must be defined more precisely.

2. **Investigation process** - The current investigative process should be redesigned to minimize duplication of effort, promote efficient use of investigative resources, and be responsive to the needs of all stakeholders in the VAA system.

3. **Standards of evidence for investigations** - The Legislature should specify and standardize the level of evidence which must be satisfied before a regulating agency may make a determination that abuse or neglect under the VAA did or did not occur.

4. **Common form for mandated reporters** - A multi-disciplinary group should develop a single, uniform reporting form for all reports into the Vulnerable Adult Act system.

5. **Penalty scheme** - The sufficiency of the current penalty scheme must be evaluated.

6. **Clearinghouse/point of entry** - The Legislature should establish a defined point of entry for reports into the Vulnerable Adult Act system.

7. **Screening and assessment for imminent risk and referral** - A process which identifies Vulnerable Adult Act reports requiring an immediate response must be developed.

8. **Education/outreach** - A training and education program for professionals and the general community on all aspects of the VAA reporting, response and penalty system should be developed and promoted.

9. **Timing throughout the system** - The Legislature should establish guidelines within the Vulnerable Adult Act system with specific times for reporting by mandated reporters to the point of entry, and for response by the appropriate agency.

10. **Database** - A single computer database that is accessible by a variety of agencies and individuals, and which would allow the tracking of Vulnerable Adult Act reports should be developed.

11. **Reprisals/Protections/Bad faith reports** - The VAA system should provide improved protection for both reporters, and those against whom reports are made, from retaliation and false reporting of incidents intended to injure the reputation or employment of an individual or entity.

12. **Team concept** - The use of multi-disciplinary teams for response to Vulnerable Adult Act reports should be encouraged.

13. **Legal consistency** - There is a need to review, clarify, and, if necessary, amend definitions and provisions contained within the VAA and other areas of the law to create overall legal consistency.

The remainder of this report provides: (1) an overview of the Vulnerable Adult Act; (2) detailed information about the survey process and survey results; (3) a complete description of the Invitational Working Conference; (4) a full explanation of the Working Group's recommendations for comprehensive change; (5) the Working Group's recommendations for immediate legislative action; and (6) concluding remarks.

I. OVERVIEW OF THE VULNERABLE ADULT ACT

The public policy at the core of the VAA is the premise that vulnerable adults should be protected from abuse, financial fraud and neglect. To accomplish that goal, the Act created an elaborate system requiring coordination and cooperation among providers of care for vulnerable adults, regulatory agencies, protective social service agencies and law enforcement. Essentially, the law sets out a coordinated reporting, response and penalty system.[4]

The VAA defines vulnerable adults as persons, 18 years or older, who are residents of institutions such as nursing homes, hospitals, residential facilities for the mentally ill or intermediate care facilities for the mentally retarded. The law also provides that persons 18 years or older who would be unable or unlikely to report abuse or neglect because of a mental, physical or emotional impairment, regardless of whether they live in an institution or any other setting, are also vulnerable adults.

The VAA mandates that certain individuals, generally providers of care for vulnerable adults, must immediately report incidents when there is reasonable cause to believe a vulnerable adult has been the victim of abuse or neglect.[5] The law then gives reporters a choice of locations to which they can report, including a police department, a sheriff's office,

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4. The appendix contains schematic diagrams which outline the VAA's requirements. See pp. A1-A13.

5. The VAA also requires that unexplained physical injuries be reported, as well as resident-to-resident abuse in certain situations. See, Minn. Stat. § 626.557, subds. 3 and 3a (1992).

a welfare agency or a licensing agency.[6] If the report involves the death of a vulnerable adult from suspected abuse or neglect, the law also requires that the reporter notify the medical examiner or coroner.[7]

The Act requires that the agency receiving the report must then immediately notify the other possible reporting agencies. For example, if a welfare agency receives a VAA report, it must immediately provide that information to the police or sheriff and the appropriate licensing agencies. The law then mandates that the responding agencies must all comprehensively and immediately investigate the report. Additionally, the welfare and licensing agencies are required to draft written investigative memoranda and determine whether the report was substantiated, inconclusive or false.

The VAA further mandates that the responding agencies--police, sheriff, local welfare and licensing--must coordinate their responses to VAA reports. The law also requires that licensing agencies develop and disseminate procedures to coordinate their investigations with the police, sheriff and local welfare agency.[8]

Finally, the VAA includes a penalty scheme to punish certain perpetrators of abuse or neglect, or an individual or institution who intentionally fails to abide by the reporting dictates of the VAA. For example, the law establishes that a provider of care who intentionally fails to file a VAA report is guilty of a misdemeanor offense. The Act also provides that a facility or person who retaliates against a good faith VAA reporter is liable for actual damages and a penalty of up to $10,000.[9] Conversely, the VAA provides that an individual who makes a false report is liable for actual and punitive damages.

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6. See Minn. Stat. § 626.557, subd. 2(g). Licensing agencies include the Departments of Health and Human Services, licensing boards and other agencies which are "responsible for credentialing human services occupations."

7. The appendix provides schematic diagrams which depict the reporting and coordination obligations if the VAA report involves death from suspected abuse or neglect. See pp. A2-A4.

8. See, Minn. Stat. § 626.557, subd. 13 (1992).

9. The appendix includes diagrams of the VAA's penalty scheme. See pp. A9-A13.

The VAA is a detailed law and includes many provisions beyond the reporting, response and penalty sections highlighted above. For example, the Act details how reporters should report, evidence rules which apply in certain cases, record keeping requirements and data privacy obligations. A copy of the VAA is appended to this report to provide complete information about the law's requirements.

II. VAA SYSTEM SURVEY

The Working Group drafted and distributed a survey to obtain information about and identify improvements for the VAA reporting, response and penalty system.[10] As discussed in the section above, the law is premised on an elaborate system of cooperation and coordination among the many agencies required to respond to VAA reports. Anecdotal evidence and the Attorney General's experience indicated, however, that coordination and cooperation among the various agencies did not always work well. Additionally, it appeared that considerable confusion existed among providers as to where they should file VAA reports.

The surveys were designed to elicit information about how the VAA system was actually operating from individuals and facilities who must follow the VAA's requirements. Specifically, the survey questioned respondents on where reports were being made and which, if any, agencies were responding. The survey also asked a series of questions on whether the coordination and cooperation dictates of the law were truly being followed.

The survey was not designed to be a scientifically-constructed data collection instrument. Instead, it was a means of obtaining general information and perceptions on how the system is functioning. Most importantly, the survey responses served to identify general themes and key issues which required further analysis and discussion. As will be discussed in Section 3 of this report, this information served as the basis for extensive discussion during the VAA Issues Invitational Working Conference.

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10. The appendix includes copies of the surveys which were distributed to facilities (F survey), prosecutors (P survey), regulating agencies (R survey), consumer advocacy groups (C survey), and law enforcement agencies (LE survey). See pp. A26-A64.

The surveys were distributed to many different providers of care for vulnerable adults including: all licensed hospitals; all licensed nursing homes; half of the facilities holding Rule 34, Rule 35, Rule 36 and Rule 38 licenses (residential programs serving persons with developmental disabilities, chemical dependency and chemical use problems, mental illness and non-residential day training services for persons with developmental disabilities); half of the Rule 18 facilities (providers of semi-independent living services for persons with developmental disabilities); half of the Rule 223 facilities (adult day care providers); three percent of Rule 203 facilities (adult foster care providers); and all of the home care agencies. The surveys were also sent to all chiefs of police, sheriffs, county attorneys and city attorneys in Minnesota. Regulating agencies, including the licensing division of the Department of Human Services, the Office of Health Facility Complaints (OHFC) and all county adult protection agencies also received surveys. Finally, the surveys were sent to many different consumer advocacy groups and ombudsmans' offices.

The survey response rate was impressive, despite the fact that no follow-up calls or letters were sent to urge people to return their surveys.[11] This positive response rate may indicate the anecdotal evidence that stakeholders in the system were frustrated and wanted a change was accurate.

The most striking information the Working Group gathered from the surveys was that the many different disciplines involved with the VAA identified similar problems with the system and offered similar solutions to remedy their frustrations. Key themes and recommendations included: (1) streamline the system to improve coordination among the responding agencies; (2) facilitate faster response to reports by clarifying terms in the law, increasing staffing and possibly using multi-disciplinary teams; and (3) provide training and education for all disciplines involved with the system. These themes served as the foundation for discussion at the working conference.

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11. Nursing homes - 37%, ICFs/MR - 25%, Hospitals - 25%, Home Care Agencies - 15%, Regulators, including adult protection agencies - 53%, consumer groups - 28%, DHS Licensed Facilities - 28%, Sheriffs - 29%, County Attorneys - 49%, Chiefs of Police - 23%, City Attorneys - 27%.

The survey also revealed important information about how reporting, response and coordination were actually working. The survey asked respondents to identify which agency in their locality had primary responsibility for investigating VAA reports. Respondents were also asked to indicate which agency they believed should have that responsibility. Survey respondents' visions of reality differed strikingly depending on the discipline of the respondent. Also, there was a great difference between what respondents believed actually occurred and what they believed should happen.

For example, the survey responses revealed that more than half of the law enforcement agencies responding believe that police departments and sheriff's offices currently have the primary responsibility for VAA investigations. However, virtually all of the county adult protection agencies which responded to the survey believe that they have primary responsibility for VAA investigations and view involvement by law enforcement as a rare occurrence. Consumer groups generally agreed that county adult protection agencies are primarily responsible for VAA investigations. Consumer groups' second most common answer was "don't know," rather than law enforcement or another agency. Prosecutors were fairly evenly divided between law enforcement, adult protection, and "don't know" in their response to which agencies currently have responsibility to investigate VAA reports.

When asked who should investigate VAA complaints, more than half of law enforcement agencies again identified their agencies as the group which should be responsible. Although county adult protection agencies responded that they currently investigate VAA reports, they did not view themselves overwhelming as the agency which should investigate these complaints. Instead, adult protection saw a role for their agencies and law enforcement, as well as many "don't know" responses. Prosecutors responded that county adult protection and law enforcement should investigate or indicated they did not know. Consumer groups generally saw this as a responsibility for county adult protection.

The survey revealed no clear consensus among the respondents as to who should investigate VAA reports. However, the survey identified that the agencies need to clarify their roles and better define their responsibilities.

The Working Group used this information in arriving at its recommendation that the Legislature should establish a defined point of entry for reports into the VAA system. As is explained in greater detail in Section 4 of this report, the Working Group believes that this clearinghouse would help eliminate the confusion revealed in the survey results and would result in more consistent responses from the appropriate responding agency. Given the broad array of opinions as to which agency should have the investigation responsibility, the Working Group is continuing to evaluate whether an existing agency should act as the clearinghouse, or whether a new entity should be created.

The coordination and cooperation issues were also of great concern to those surveyed. The survey revealed that very few of the agencies surveyed had written coordination policies. Additionally, although the Act requires that the licensing agencies develop and disseminate coordination procedures to police, sheriff and local welfare offices, the survey information indicated that aspect of coordination was missing. Again, the survey revealed that very few law enforcement agencies and local welfare agencies (adult protection offices) indicated they had received written coordination procedures.

The Working Group's recommendations to make the current VAA investigative process more consistent across agencies, establish a single reporting form, provide training programs and create a defined point of entry for VAA reports which will direct the report to the appropriate responding agency, are all designed to address these coordination and cooperation issues. The other Working Group recommendations were also generated, in large part, from issues raised in survey responses. The entire reform package is aimed at creating the consistent, efficient and effective VAA protection system survey respondents indicated they wanted.

In addition to the Working Group survey, the Minnesota Alliance for Health Consumers also surveyed individual residents of health care facilities and their families. The key theme which emerged from that process is that individuals believe there is a need for "more teeth in the law." Individuals expressed frustration with the apparent lack of consequences for perpetrators of abuse, neglect or financial fraud. The Working Group's finding that the

current penalty scheme is insufficient in some areas, and its recommendation that the entire penalty scheme be reevaluated, is in response to the consumers' and others' concerns.

III. VAA ISSUES INVITATIONAL WORKING CONFERENCE

On November 9 and 10, 1993, the Office of Attorney General Hubert H. Humphrey III, Care Providers of Minnesota, the Minnesota Association of Homes for the Aging, the Association for Residential Resources in Minnesota and the Minnesota Departments of Health and Human Services sponsored and participated in a landmark invitational working conference on Vulnerable Adult Act (VAA) issues. Individuals from many different disciplines came together to discuss the central issue the Working Group has been evaluating: how can our society ensure that vulnerable adults receive the protection they need and deserve, while also making sure that dedicated care givers, who strive to provide quality care, are treated fairly? Conference participants included police officers, sheriffs, county attorneys, city attorneys, adult protection workers, ombudsmen, consumer advocates, nursing home administrators and employees, intermediate care facility administrators and employees, other licensed facility representatives, representatives from unions, licensing boards, the Department of Human Services, the Department of Health, the home care association, trade associations, professional organizations and others.

During the conference, participants exchanged experiences and ideas on how to improve the current VAA process. Historically, discussions on how to change the VAA have been contentious and divisive. Although most groups believed the system did not always work efficiently and effectively to protect vulnerable adults, the different disciplines have not agreed on how to improve the VAA. The conference goal was to create an inclusive process so the groups who have historically disagreed on how to change the VAA, could work together to reach areas of consensus on how to improve the process. Participants enthusiastically praised the conference effort.

The conference opened with remarks from Attorney General Humphrey. He expressed his hope that this effort would result in concrete steps to improve the current VAA process.

During the conference, participants met in small multi-disciplinary groups to discuss essential issues including: making VAA reports, the response to VAA reports, coordination within and outside the VAA system and the current penalty scheme under the VAA. These issues were selected because they were raised by the survey responses, as well as the experiences of members of the Working Group. The discussions took place in multi-disciplinary groups so individuals would have a chance to understand how someone with a different responsibility under the VAA may have a different perspective on a particular issue.

Each multi-disciplinary group then presented their concerns and ideas for improvement on the topic they discussed to the entire conference group. The large conference group had the opportunity to discuss the smaller groups' suggestions. At the conclusion of the first day of the conference, all of the conference participants had the chance to comment on all topics discussed in detail in the small multi-disciplinary groups.

The Working Group met on the second conference day to identify and discuss the VAA issues the conference participants and survey respondents had indicated merited action. Initially, the Group outlined consensus findings as to which issues raised the greatest concerns for participants in the VAA system. After that, informed by the conference discussions and survey results, the Group drafted general recommendations for action on each of the identified topic areas.

In the weeks since the conference, the Working Group has met many times to refine its recommendations. Working Group members also had the opportunity to solicit reaction to the recommendations from their respective organizations. In addition, all of the conference participants received copies of the recommendations and had an opportunity to comment on the ideas. The Working Group recommendations which follow are the product of this collaborative effort.

IV. RECOMMENDATIONS FOR IMPROVING THE VAA SYSTEM

The Working Group strongly endorses the protection premise of the VAA, and found that much works well in the current system. Many survey respondents and conference participants praised the current mandate that VAA reports must be filed, the local adult protection response to providers of care and the use of county adult protection/law enforcement teams where they currently operate.

Despite many positive aspects of the system, however, the Working Group's assessment of the current VAA process revealed that systemic problems do exist. Key problems the Group identified include confusion as to when, where, and how to "enter" the system, the lack of a coordinated, consistent, prompt response by the various entities charged with responding to VAA reports, an inability to effectively track perpetrators of abuse and neglect, and an inadequate penalty scheme.

The Working Group believes it is important that comprehensive remedies go forward to address these problems. The Working Group, while anxious to offer solutions to single problems, believes that solutions must be evaluated and implemented in a system-wide approach. Thus, the Working Group is not advocating that the individual concepts listed below be implemented separately. Instead, any solution to the systemic concerns must be established comprehensively to avoid creating new problems.

For example, as is detailed below, the Working Group is proposing that a uniform VAA reporting form be developed. It is not possible to develop that form properly, however, unless the Working Group further refines other important changes including the creation of a central clearinghouse to receive that form, and the development of a database to track the information which would be recorded on the form. Since the changes identified below are complex and comprehensive, the Working Group believes the package must be developed and implemented in its entirety to remedy the systemic problems identified.

The Working Group's recommendation for immediate action, therefore, is limited to advocating that the current Advisory Committee/Working Group be reauthorized with the

specific mission of drafting comprehensive plans to implement the thirteen broad concepts detailed below.[12]

Vulnerable Adult Act Comprehensive Reforms

1. There is a need for greater precision of terms contained in the Vulnerable Adult Act.

The Working Group's evaluation has concluded that the definitions in the VAA are inadequate. Certain definitions are ambiguous, important terms used in the Act such as accident and therapeutic conduct are not defined, and concepts, such as accidental events, are not included.

These definitional problems have resulted in a number of difficulties including the application of inconsistent standards when evaluating and assessing reported events, and the reporting of incidents which do not constitute abuse or neglect. Additionally, the ambiguities have resulted in the failure to identify instances of abuse or neglect, particularly regarding financial abuse, and vulnerable adult-to-vulnerable adult incidents. The definitional problems have also resulted in inequity in the imposition of penalties.

The Working Group believes it is necessary to further evaluate the definitions including determining whether definitions for incidents occurring in regulated entities and in the community should be the same, or if there are valid reasons for having different definitions. The Working Group has specifically identified that at least the following terms should be defined and/or amended: accident, neglect (including defining gradations of severity, frequency and persistent acts of neglect), abuse, caretaker, vulnerable adult and financial exploitation.

The Working Group believes any changes in the definitions must be made in concert with its other recommendations. For example, if the definitions narrow the conduct which

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12. The Group believes that legislation establishing evidentiary standards, can for forward before the entire package is implemented. Section 5 of this Report includes more detail about this narrow recommendation.

will be considered to be neglect, the severity of the penalties for the narrowed neglect definition should reflect the gravity of the conduct.

2. There is a need to develop an investigative process that minimizes duplication of effort, promotes efficient use of resources and is responsive to the needs of participants in the process.

The strongest theme expressed by participants in the VAA process was the need to streamline the system, including the duplicative investigative process. Since the current law allows reports to be made to either the police or sheriff or licensing or local welfare, and then requires that each agency notify the others, coordination is crucial. Information the Working Group gathered indicated that coordination and communication among the various responding agencies was not always effective. At best, this coordination gap results in frustration. At worst, it results in inconsistent, inadequate investigations when each agency believes the other is in charge or fails to consider the other agencies' needs when conducting its investigations.

The Working Group believes an investigative process should be developed which would: 1) minimize the potential for error which might jeopardize successful prosecution where criminal activity is involved; 2) provide necessary information to all regulatory entities for their follow-up action with licensed/certified settings; 3) eliminate conflicting findings; and 4) make efficient use of stakeholders' time. The clearinghouse concept and uniform reporting form, which are explained below are central to the development of this investigative process.

3. There is a need to identify and standardize the level of evidence the licensing agency must satisfy to reach each of the three administrative findings--substantiated, inconclusive and false--regarding the occurrence of maltreatment.

The Working Group recommends that all agencies conducting administrative investigations be required to satisfy the preponderance of evidence standard when making their findings. The Working Group found that the absence of consistent evidentiary standards created the potential for widespread variation and inconsistency in determinations between investigating agencies and within investigating agencies. In addition, it is important that an agency, when making an administrative finding, consider both the evidence that maltreatment did occur as well as the evidence that maltreatment did not occur, and must allow for a

weighing of both quantity and credibility of evidence. Section 5 of this Report includes more detail about this recommendation. The Working Group believes this change can go forward in advance of the comprehensive reform package.

4. There is a need for a single, uniform reporting form for all points of entry into the Vulnerable Adult Act system.

The survey respondents and conference participants indicated that confusion exists about when, where and how to file VAA reports. Law enforcement agencies also indicated they would prefer receiving reports on a uniform form. This would help them in classifying the report as a VAA report, and facilitate a quicker response.

The Working Group, in collaboration with law enforcement and other interested parties, intends to develop such a tool. The form should provide the base for uniform data as a case enters and moves through the Vulnerable Adult Act system. Also, the form should provide guidance to mandated reporters in properly defining the nature of the incident/situation of concern, and taking appropriate next steps.

The Group believes the form should include a "decision tree" format. This format would provide the central clearinghouse which receives the form with adequate information to screen the report and determine which agency should respond.

5. There is a need to evaluate the sufficiency of the current penalty scheme.

The Working Group endorses a key principle of the VAA that persons, including those other than caregivers in regulated settings, should be subject to sanctions for abuse or neglect of a vulnerable adult. The analysis the Working Group has done, however, indicates that the current penalty scheme is insufficient in a number of ways. The maximum criminal penalty available is a gross misdemeanor offense. Survey information reveals that most prosecutors are either not aware of the VAA or choose to not prosecute VAA gross misdemeanor offenses. Additionally, as is detailed in item 11 below, the VAA's penalties for retaliation against reporters and false reporting of VAA reports are burdensome.

Another issue which merits further analysis is whether it may be appropriate to have sanctions which are different for persons who abuse or neglect their own family members, as

opposed to the sanctions for other caregivers. The Working Group also believes the adequacy of the penalties for financial exploitation of vulnerable adults occurring in both regulated and unregulated settings must be evaluated. Information gathered to date indicates that the current financial exploitation penalties are not sufficient.

The penalty scheme revisions must be done in conjunction with the redefinition of terms. For example, if new definitions narrow the conduct which meets the definition of abuse or neglect, the acts which fit the new definitions should possibly carry a stiffer penalty. Therefore, although the Working Group has identified the penalty scheme as being in need of review, the Group does not want to make specific recommendations until the entire package is developed.

6. There is a need to establish a defined point of entry for reports into the Vulnerable Adult Act system.

The need to streamline the system was an important theme which emerged from the survey process and conference discussions. Participants in the VAA system expressed frustration and confusion about where they should report, and which agency would investigate and respond to individual VAA reports. There were also examples of multiple uncoordinated responses to the same reports. The entry point concept is designed to resolve these confusion and coordination issues.

This entry point or clearinghouse should be responsible for determining the appropriate response to the report by exercising a "sorting" or "dispatch" function. Specifically, the entry point should determine whether the VAA report requires a response, and if so, which agency should respond. The uniform report form should be designed to facilitate this dispatch function.

The clearinghouse should determine which reports require immediate response and communicate that to the appropriate agencies, generally law enforcement or county adult protection. A mechanism should be developed to ensure that the police or sheriff respond immediately when that is necessary. Additionally, the entry point should provide information to the reporter on how the report has been initially handled. The entry point would enter this

information into a database so all necessary parties could learn that a report was made and which agency is responsible for investigating the report.

Again, the development of the clearinghouse must be done in conjunction with the other recommendations, including amending the definitions, the development of the uniform reporting form and database, to create a consistent, understandable and responsive system.

7. There is a need to establish a screening and assessment for imminent risk and referral process that identifies Vulnerable Adult Act reports which require an immediate response.

As mentioned above, system participants expressed frustration and confusion with inconsistent and uncoordinated responses to VAA reports. Also, there were cases where law enforcement and/or adult protection should have been immediately involved, but either did not receive the report quickly, or declined involvement.

To alleviate this problem, the person receiving the report at the point of entry needs knowledge and criteria to assist in its dispatch function. The process established should allow the intake point to refer the report to the appropriate responding agency or agencies, while considering whether immediate action is necessary for protection or investigation. If so, law enforcement and/or adult protection must be notified immediately. In addition, the process should ensure that responding agencies are aware of other agencies' involvement and that the reporter is informed of who will be responsible or that no further action will be taken.

8. There is a need for training and education for professionals and the general community on all aspects of reporting, assessment/investigations and disposition of complaints or allegations arising under the Vulnerable Adult Act system.

The confusion expressed by participants in the VAA process arose, in part, because of inherent problems with the current VAA. Other confusion was created because individuals simply did not understand the system or were unaware of the law's mandates. Many survey respondents and conference participants requested that a multi-disciplinary training program be provided. It is clear that there is a need for outreach to specific target populations to make the vulnerable adult system accessible.

The form and content of the training should accent both statewide and regional needs. It should provide clarification of the purpose of the system, as well as the system's procedural requirements. While the legal requirements provide the outline for training, care should be taken to ensure inclusion of all vulnerable adult populations and their formal and informal support networks.

9. There is a need to establish guidelines within the Vulnerable Adult Act system which require a specific time for reporting by mandated reporters to the point of entry and for response by the appropriate responding agency.

Another key theme the Working Group identified is that the system is overwhelmed and often responds slowly. In addition, reporters may not report as quickly as possible. The current VAA does not give reporters specific guidance on how much time they have to file VAA reports. The comprehensive reform package should alleviate some of these concerns by reducing the need for duplicative investigations and by redefining what must be reported.

The time requirements which are developed should be reasonable and stated in measurable terms, such as "immediate to 72 hours," with penalties for noncompliance.

10. There is a need for a single computer database that is accessible by a variety of agencies and individuals to track Vulnerable Adult Act reports.

The Working Group discovered that perpetrators of abuse and neglect are able to continue to work with vulnerable adults by changing the type of facility in which they work. This is possible, in part, because the various licensing agencies use different methods of registering perpetrators. In addition, the investigating agencies have not been successful at tracking complaints against a single perpetrator across facilities. Reporters have also expressed dissatisfaction with their ability to obtain information about how their report is being handled.

The database the Working Group is recommending could remedy these concerns. The database would allow the agencies to track information and report as to which agency responded and when that response was made. The database would also allow regulators to track perpetrators across different care settings and serve as a prevention tool.

11. There is a need in the Vulnerable Adults Act system for improved protection for both reporters, and those against whom reports are made, from retaliation and false reporting of incidents intended to injure the reputation or employment of an individual or entity.

Participants in the VAA system expressed their concern that good faith reporters may suffer retaliation, and providers who may be subject to bad faith reports, must resort to private civil suits to enforce their rights. This protection was not viewed as adequate by those concerned.

The Working Group believes that good faith reporters should be protected from retaliation, and caregivers should be protected from bad faith false reporting of incidents intended to injure the reputation or employment of an individual or entity. The Act must, however, more clearly define what is a bad faith report, what remedies are available, and help to reduce the ability of a disgruntled employee/reporter from using the Vulnerable Adults Act to deliberately sabotage a provider or unduly burden a responding agency. The Working Group is considering possible mechanisms for increasing protection including providing for civil monetary penalties, civil actions the State could bring and/or licensing actions.

12. There is a need to facilitate the use of multi-disciplinary teams in the investigation of Vulnerable Adult Act reports.

The Working Group process revealed that many survey respondents and conference participants believe that a law enforcement/adult protection team was a very effective way to respond to VAA reports. Many pointed to the current child protection teams as good examples. These teams help alleviate the coordination problems which currently exist in the VAA system.

The team approach should facilitate a quicker response to and disposition of reports, enhance the quality of the investigation, and enhance the ability to provide protective services when needed. The Working Group believes it necessary to gather more information before making a recommendation as to whether such teams should be mandatory or optional.

13. There is a need to review, clarify, and, if necessary, amend definitions and provisions contained within the VAA and other areas of the law to create overall legal consistency.

Another key area of frustration the Working Group uncovered was the inconsistency between systems which involve VAA reports. For example, there have been situations where an investigating agency has made a finding of abuse or neglect involving a vulnerable adult; however, this finding was not honored in a subsequent unemployment compensation hearing. Consequently, the provider was obligated to pay unemployment for an individual who lost his or her job because he or she was found to have abused or neglected a vulnerable adult.

The Group believes it is necessary to conduct a comprehensive evaluation of the areas of of the law which involve VAA issues. After that evaluation is complete, the Working Group plans to issue specific recommendations so that there is legal consistency. Other areas of the law requiring analysis include the unemployment/labor relations area, the patient bill of rights and data privacy requirements.

V. RECOMMENDATIONS FOR IMMEDIATE LEGISLATIVE ACTION

The Working Group has made tremendous progress. Most importantly, the Group has worked toward good public policy goals, instead of simply promoting individual representatives' best interests. Moreover, the consensus building process has been positive in and of itself as it has allowed individuals with different perspectives on the system to come together and work to understand each others' views. Therefore, the Group wants to continue its work with the mandate and authority to carefully develop and implement the comprehensive, complex reforms outlined above.

To that end, the Working Group recommends that the Legislature pass legislation which would reauthorize the Working Group under the Attorney General's direction. This legislation would mandate that the Working Group draft comprehensive plans to implement the thirteen broad recommendations explained above. To date, the Working Group has been an ad hoc organization and the Advisory Committee's mission was limited. Therefore, the Working Group believes the Legislature should formalize its existence, recognize its recommendations

and mandate the creation of a detailed reform package to be completed by January of 1995. This legislative recognition and responsibility would provide an important incentive for the varied interests which have worked together to continue their collaborative efforts and conclude their work.

Additionally, the Working Group recommends that the Legislature provide a small appropriation to fund its work. The Working Group will use the appropriation to continue to fund the professional facilitator who, in large part, is responsible for creating a process which enabled the Working Group to work well together and accomplish its goals. This money would also be used to provide administrative support and to fund a follow-up conference to solicit additional information and support from the many individuals involved in the VAA process. Successful change in this system is dependent on involving the system's stakeholders. The November 9, 1993 conference was very effective at creating this involvement.

To date, funds for the Group's efforts have been voluntary contributions from many of the Groups' members. Unfortunately, those sources are depleted and the Working Group requires new funding.

As mentioned previously, the other legislative recommendation the Working Group believes can go forward in advance of the complete package is that the Act mandate the preponderance of evidence standard for administrative findings. Although the law currently requires investigating agencies to make a finding as to whether an abuse or neglect report is substantiated, inconclusive or false, the law is silent on the evidentiary standard for that determination.

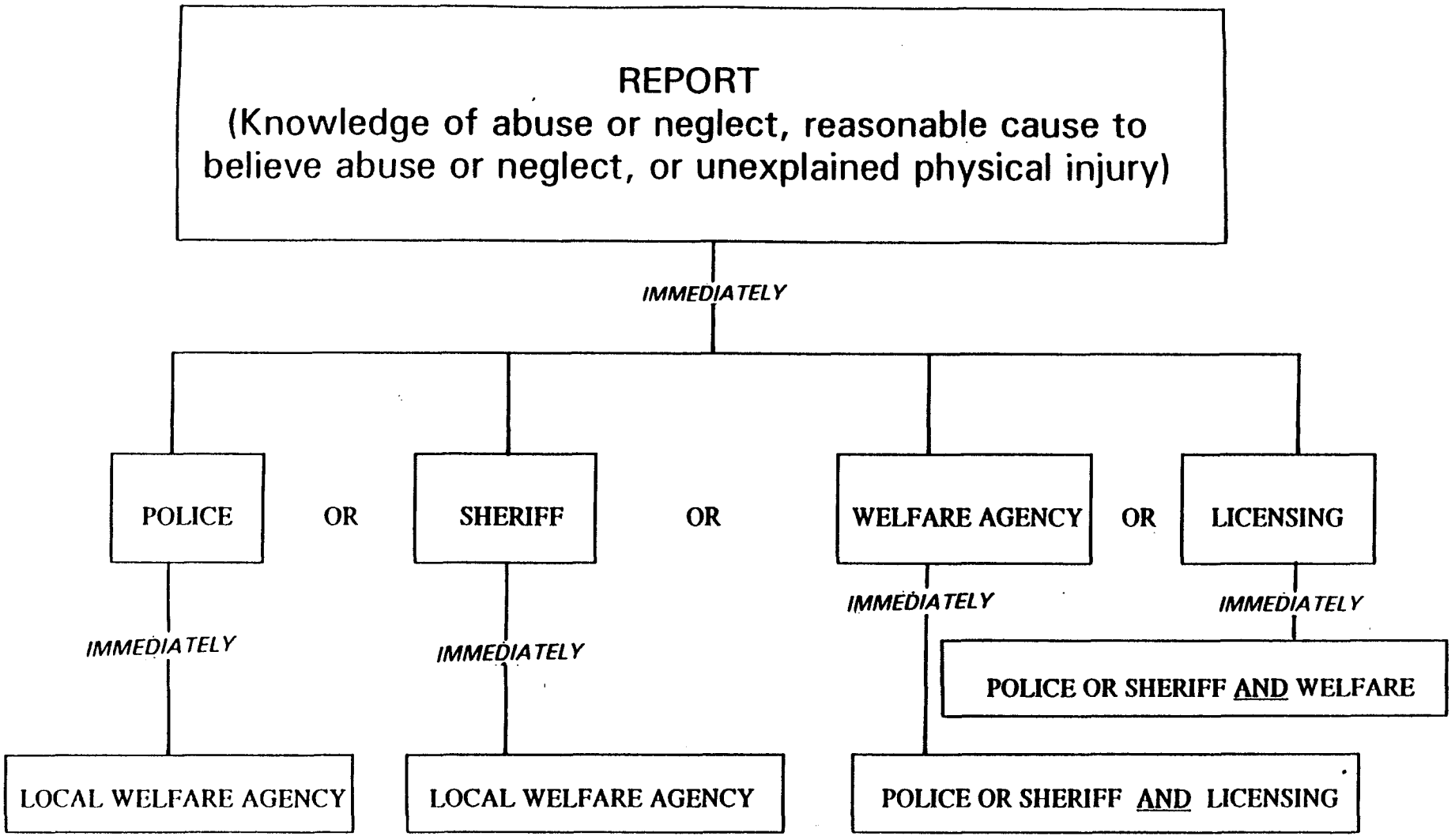
Information gathered during the Working Group's process and the Attorney General's own experience revealed that different investigating agencies use different standards of evidence when making determinations. In addition, it appeared that even within the same agency different investigators may use varying standards when making findings. Fairness and consistency call for a uniform standard in administrative determinations. Since the presumptive standard in administrative proceedings is the preponderance of the evidence standard, the Group recommends that this standard be specified in the Act.

VI. CONCLUSION

The Working Group's collaborative process has been very successful. Groups which have historically engaged in contentious, divisive debate have worked together to identify good public policy ideas. The reform package recommendations do not serve one group's interests, but are designed to improve the entire process. The Working Group was able to identify systemic problems with the current process and propose an outline for a system which would satisfy the critical concern of the VAA -- protecting vulnerable adults -- while also treating care givers fairly.

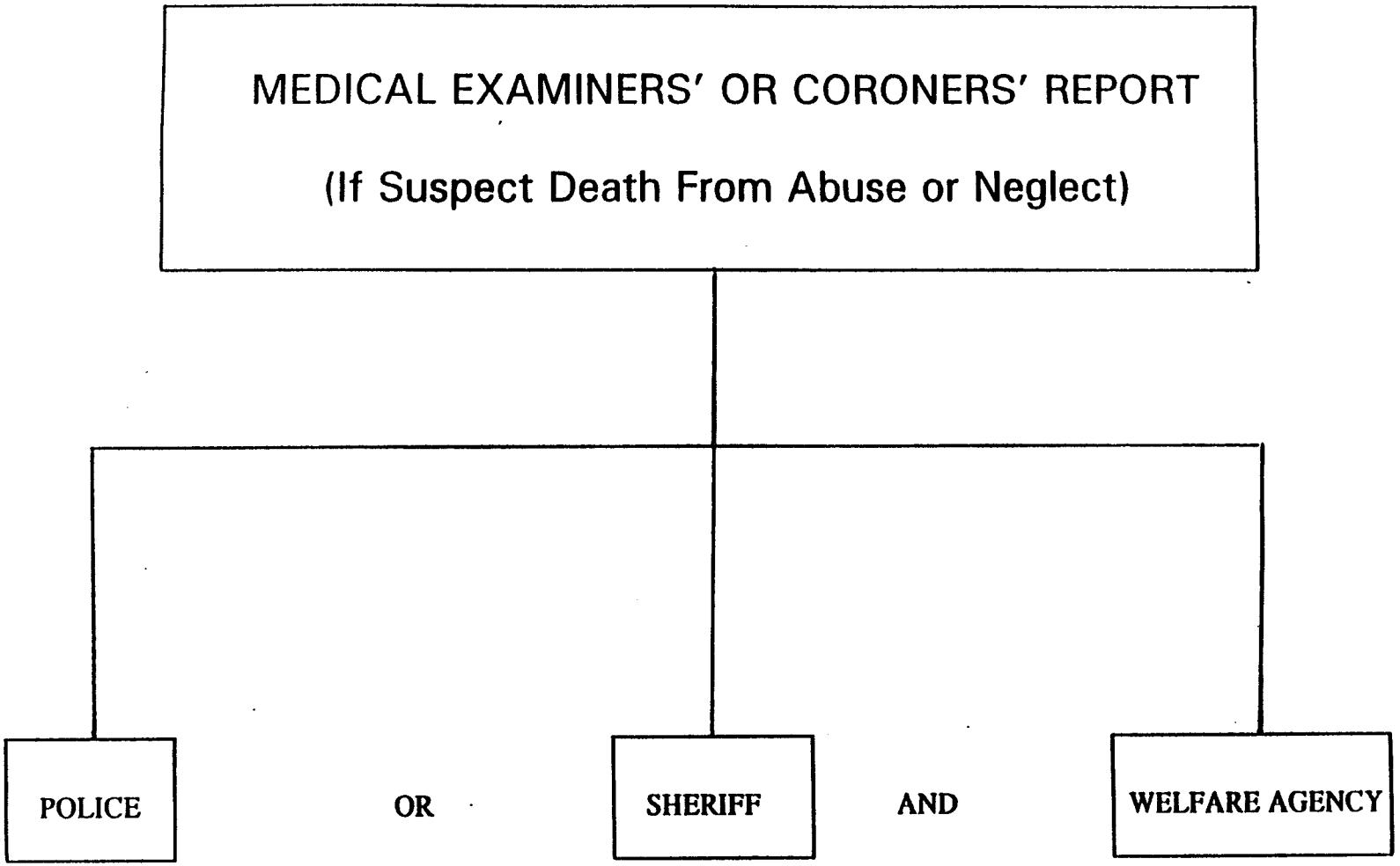
The Working Group looks forward to finishing its work in 1994, culminating in the production of a detailed proposal for legislative, rule and policy change.

APPENDIX



VAA REPORTING SCHEME

Minn. Stat. § 626.557, subd. 3, Subd. 13



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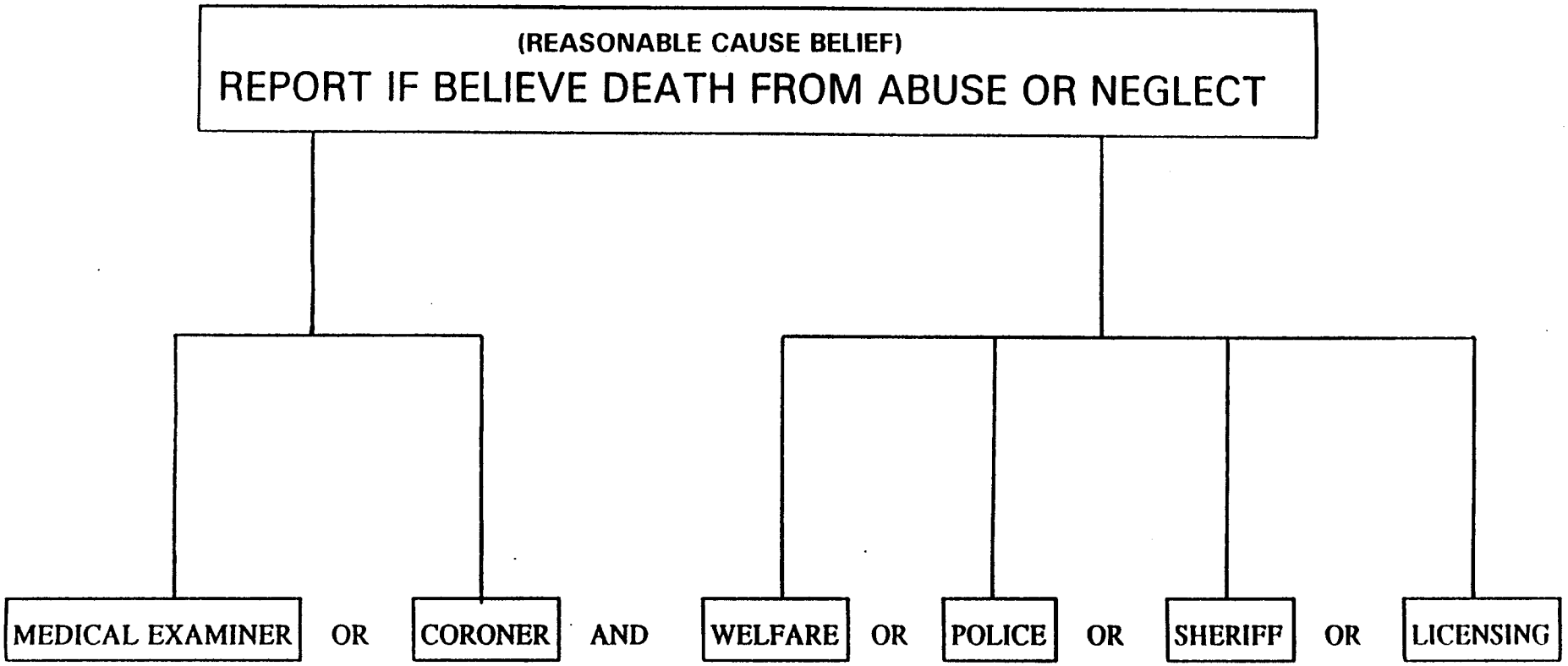
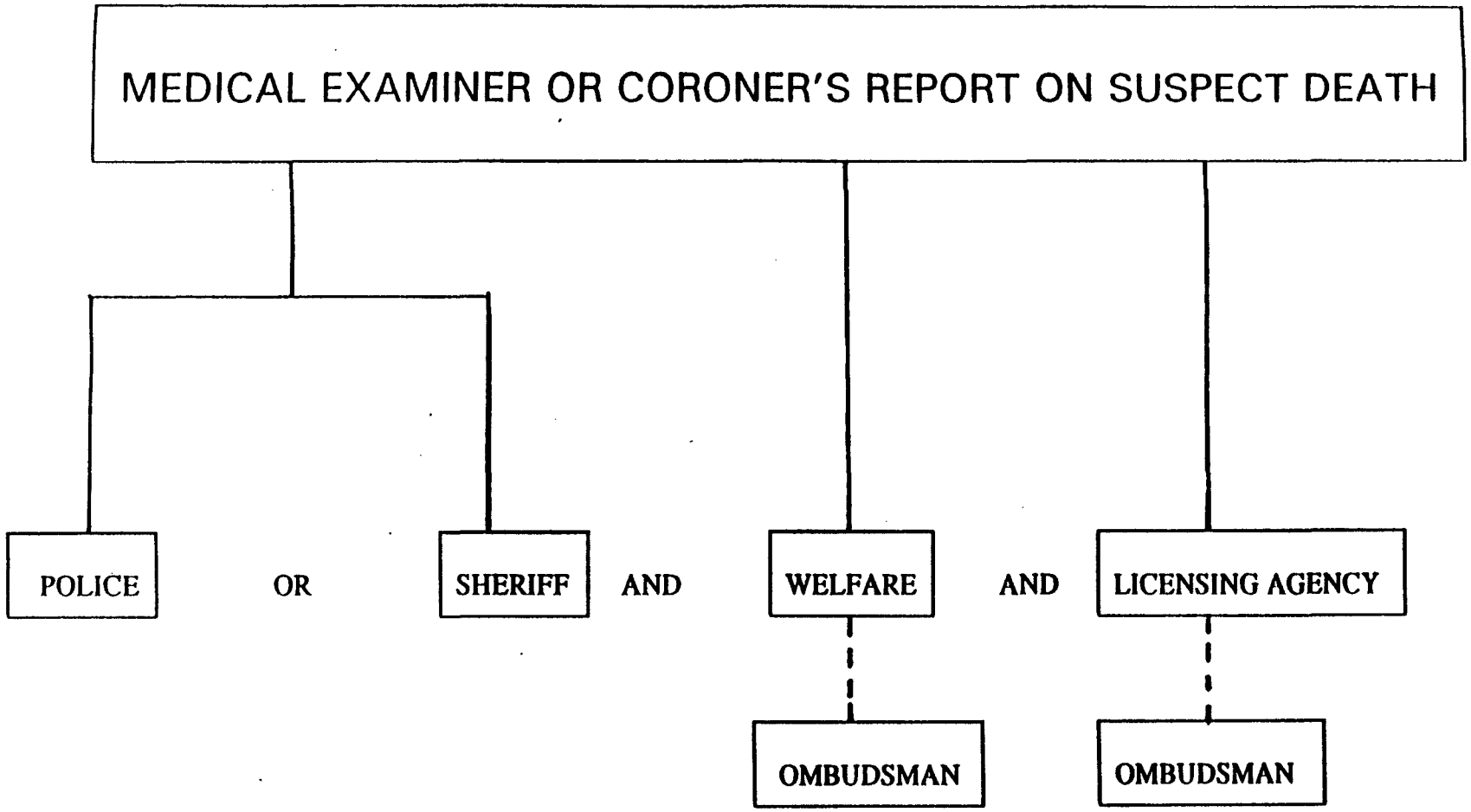


Minn. Stat. § 626.557, subd. 9



Minn. Stat. § 626.557, subd. 9

RESPONSE

* LOCAL WELFARE AGENCY *

- IMMEDIATELY INVESTIGATE -

(Not limited to records, but every other available source of information)

(Offer emergency and continuing protective services)

- OTHERS IN JEOPARDY? -
- TAKE ACTION -

- NOTIFY LICENSING AGENCIES -
- NOTIFY LAW ENFORCEMENT -

- IF NECESSARY: -

- SEEK COURT ORDER, -
- APPOINT GUARDIAN, -
- REFER FOR CRIMINAL PROSECUTION, -
- ETC. -

- DRAFT WRITTEN -
- INVESTIGATIVE -
- MEMORANDUM -

(Substantiated, inconclusive, or false)

Minn. Stat. § 626.557, subds. 3, 10 and 10a

RESPONSE

* LICENSING AGENCY *

- IMMEDIATELY INVESTIGATE -

(not limited to records, but every other available source of information)

- TAKE LICENSING ACTION -

- NOTIFY LOCAL WELFARE AGENCY -
- NOTIFY LAW ENFORCEMENT -

- DRAFT WRITTEN -
- INVESTIGATIVE -
- MEMORANDUM -

(Substantiated, inconclusive, or false)

Minn. Stat. § 626.557, subds. 3, 11 and 12

RESPONSE

* PROSECUTOR'S OFFICE *

- IMMEDIATELY INVESTIGATE -

- PROSECUTE WHEN WARRANTED -

- TRANSMIT FINDINGS -
- TO REFERRING AGENCY -

Minn. Stat. § 626.557, subd. 11a

COORDINATION

* POLICE *
* SHERIFF *
* LOCAL WELFARE AGENCY *
AND
* LICENSING AGENCY *

SHALL COOPERATE IN
COORDINATING INVESTIGATIONS

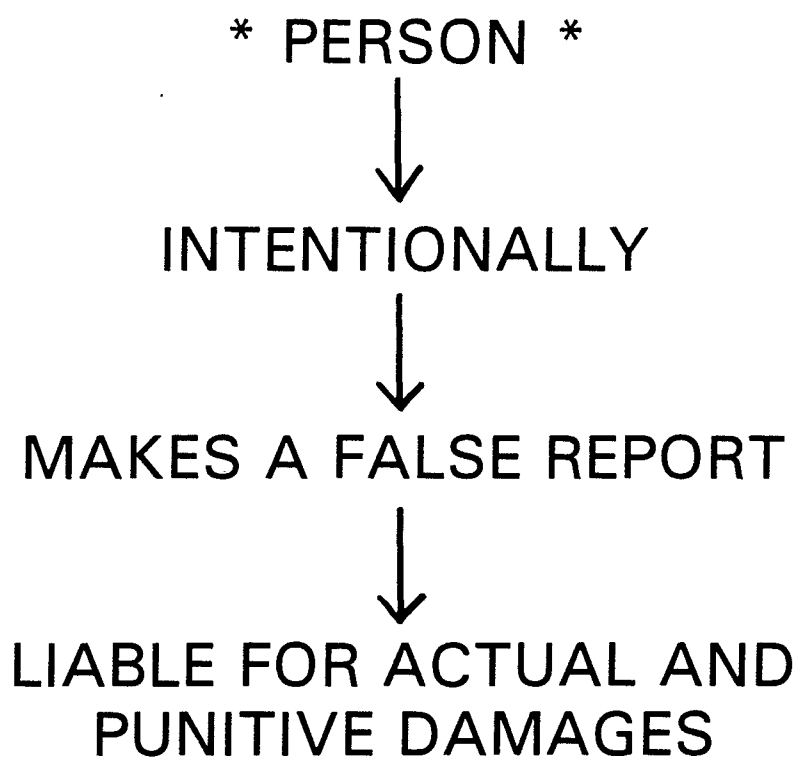
LICENSING AGENCY SHALL:

DEVELOP AND DISSEMINATE
PROCEDURES TO COORDINATE
ITS ACTIVITIES WITH

- POLICE -
- SHERIFF -
AND
- LOCAL WELFARE AGENCY -

Minn. Stat. § 626.557, subd. 13

PENALTY



Minn. Stat. § 626.557, subd. 6

PENALTY

* MANDATED REPORTER *

↓

INTENTIONALLY

FAILS TO REPORT

↓

GUILTY OF A
* MISDEMEANOR *

Minn. Stat. § 626.557, subd. 7

PENALTY

(Retaliation)

* FACILITY *

OR

* PERSON *

↓

RETALIATES AGAINST PERSON WHO MAKES A GOOD FAITH REPORT

↓

LIABLE FOR ACTUAL DAMAGES AND PENALTY UP TO $10,000

Minn. Stat. § 626.557, subd. 17

PENALTY

* CARETAKER *

* OPERATOR *

* EMPLOYEE *

* VOLUNTEER WORKER *

↓

INTENTIONALLY ABUSES
OR NEGLECTS

(Fails to Supply Necessary Food, Clothing, Shelter, Health Care or Supervision)

↓

VULNERABLE
ADULT

↓

GUILTY OF A
* GROSS MISDEMEANOR *

Minn. Stat. § 626.557, subd. 19

PENALTY

* CARETAKER *

(Individual Or Facility With Responsibility
For All Or A Portion Of The Care)

↓

KNOWINGLY

↓

PERMITS CONDITIONS TO EXIST

RESULTING IN

↓

ABUSE OR
NEGLECT

Failure To Supply Necessary
* Food, clothing, shelter, health care or supervision *

or

Absence of Necessary
* Food, clothing, shelter, health care or supervision *

or

Likelihood of Absence of Necessary
* Food, clothing, shelter, health care or supervision *

↓

GUILTY OF A
* GROSS MISDEMEANOR *

Minn. Stat. § 626.557, subd. 19

§ 626.557 REPORTING OF MALTREATMENT OF VULNERABLE ADULTS

Subdivision 1. **Public policy.** The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to abuse or neglect; to provide safe institutional or residential services or living environments for vulnerable adults who have been abused or neglected; and to assist persons charged with the care of vulnerable adults to provide safe environments.

In addition, it is the policy of this state to require the reporting of suspected abuse or neglect of vulnerable adults, to provide for the voluntary reporting of abuse or neglect of vulnerable adults, to require the investigation of the reports, and to provide protective and counseling services in appropriate cases.

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given them unless the specific context indicates otherwise.

(a) "Facility" means a hospital or other entity required to be licensed pursuant to sections 144.50 to 144.58; a nursing home required to be licensed to serve adults pursuant to section 144A.02; an agency, day care facility, or residential facility required to be licensed to serve adults pursuant to sections 245A.01 to 245A.16; or a home care provider licensed under section 144A.46.

(b) "Vulnerable adult" means any person 18 years of age or older:

(1) who is a resident or inpatient of a facility;

(2) who receives services at or from a facility required to be licensed to serve adults pursuant to sections 245A.01 to 245A.16, except a person receiving outpatient services for treatment of chemical dependency or mental illness;

(3) who receives services from a home care provider licensed under section 144A.46; or

(4) who, regardless of residence or type of service received, is unable or unlikely to report abuse or neglect without assistance because of impairment of mental or physical function or emotional status.

(c) "Caretaker" means an individual or facility who has responsibility for the care of a vulnerable adult as a result of a family relationship, or who has assumed responsibility for all or a portion of the care of a vulnerable adult voluntarily, by contract, or by agreement.

(d) "Abuse" means:

(1) any act which constitutes a violation under sections 609.221 to 609.223, 609.23 to 609.235, 609.322, 609.342, 609.343, 609.344, or 609.345;

(2) nontherapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce mental or emotional distress;

(3) any sexual contact between a facility staff person and a resident or client of that facility;

(4) the illegal use of a vulnerable adult's person or property for another person's profit or advantage, or the breach of a fiduciary relationship through the use of a person or a person's property for any purpose not in the proper and lawful execution of a trust, including but not limited to situations where a person obtains money, property, or services from a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

(5) any aversive and deprivation procedures that have not been authorized under section 245.825.

(e) "Neglect" means:

(1) failure by a caretaker to supply a vulnerable adult with necessary food, clothing, shelter, health care or supervision;

(2) the absence or likelihood of absence of necessary food, clothing, shelter, health care, or supervision for a vulnerable adult; or

(3) the absence or likelihood of absence of necessary financial management to protect a vulnerable adult against abuse as defined in

paragraph (d), clause (4). Nothing in this section shall be construed to require a health care facility to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

(f) "Report" means any report received by a local welfare agency, police department, county sheriff, or licensing agency pursuant to this section.

(g) "Licensing agency" means:

(1) the commissioner of health, for facilities as defined in clause (a) which are required to be licensed or certified by the department of health;

(2) the commissioner of human services, for facilities required by sections 245A.01 to 245A.16 to be licensed;

(3) any licensing board which regulates persons pursuant to section 214.01, subdivision 2; and

(4) any agency responsible for credentialing human services occupations.

Subd. 3. **Persons mandated to report.** A professional or the professional's delegate who is engaged in the care of vulnerable adults, education, social services, law enforcement, or any of the regulated occupations referenced in subdivision 2, clause (g)(3) and (4), or an employee of a rehabilitation facility certified by the commissioner of jobs and training for vocational rehabilitation, or an employee of or person providing services in a facility who has knowledge of the abuse or neglect of a vulnerable adult, has reasonable cause to believe that a vulnerable adult is being or has been abused or neglected, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained by the history of injuries provided by the caretaker or caretakers of the vulnerable adult shall immediately report the information to the local police department, county sheriff, local welfare agency, or appropriate licensing or certifying agency. The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency. The local welfare agency, upon receiving a report, shall immediately notify the local police department or the county sheriff and the appropriate licensing agency or agencies.

A person not required to report under the provisions of this subdivision may voluntarily report as described above. Medical examiners or coroners shall notify the police department or county sheriff and the local welfare department in instances in which they believe that a vulnerable adult has died as a result of abuse or neglect.

Nothing in this subdivision shall be construed to require the reporting or transmittal of information regarding an incident of abuse or neglect or suspected abuse or neglect if the incident has been reported or transmitted to the appropriate person or entity.

Subd. 3A. **Report not required.** (a) Where federal law specifically prohibits a person from disclosing patient identifying information in connection with a report of suspected abuse or neglect under Laws 1983, chapter 273, section 3, that a person need not make a required report unless the vulnerable adult, or the vulnerable adult's guardian, conservator, or legal representative, has consented to disclosure in a manner which conforms to federal requirements. Facilities whose patients or residents are covered by such a federal law shall seek consent to the disclosure of suspected abuse or neglect from each patient or resident, or a guardian, conservator, or legal representative, upon the patient's or resident's admission to the facility. Persons who are prohibited by federal law from reporting an incident of suspected abuse or neglect shall promptly seek consent to make a report.

(b) Except as defined in subdivision 2, paragraph (d), clause (1), verbal or physical aggression occurring between patients, residents, or clients of a facility, or self-abusive behavior of these persons does not constitute "abuse" for the purposes of subdivision 3 unless it causes serious harm. The operator of the facility or a designee shall record incidents of aggression and self-abuse behavior in a manner that facilitates periodic review by licensing agencies and county and local welfare agencies.

(c) Nothing in this section shall be construed to require a report of abuse, as defined in subdivision 2, paragraph (d), clause (4), solely on the basis of the transfer of money or property by gift or as compensation for services rendered.

Subd. 4. **Report.** A person required to report under subdivision 3 shall make an oral report immediately by telephone or otherwise. A person required to report under subdivision 3 shall also make a report as soon as possible in writing to the appropriate police department, the county sheriff, local welfare agency, or appropriate licensing agency. The written report shall be of sufficient content to identify the vulnerable adult, the caretaker, the nature and extent of the suspected abuse or neglect, any evidence of previous abuse or neglect, name and address of the reporter, and any other information that the reporter believes might be helpful in investigating the suspected abuse or neglect. Written reports received by a police department or a county sheriff shall be forwarded immediately to the local welfare agency. The police department or county sheriff may keep copies of reports received by them.

Copies of written reports received by a local welfare department shall be forwarded immediately to the local police department or the county sheriff and the appropriate licensing agency or agencies.

Subd. 5. **Immunity from liability.** (a) A person making a voluntary or mandated report under subdivision 3 or participating in an investigation under this section is immune from any civil or criminal liability that otherwise might result from the person's actions, if the person is acting in good faith.

(b) A person employed by a local welfare agency or a state licensing agency who is conducting or supervising an investigation or enforcing the law in compliance with subdivision 10, 11, or 12 or any related rule or provision of law is immune from any civil or criminal liability that might otherwise result from the person's actions, if the person is acting in good faith and exercising due care.

Subd. 6. **Falsified reports.** A person who intentionally makes a false report under the provisions of this section shall be liable in a civil suit for any actual damages suffered by the person or persons so reported and for any punitive damages set by the court or jury.

Subd. 7. **Failure to report.** (a) A person required to report by this section who intentionally fails to report is guilty of a misdemeanor.

(b) A person required by this section to report who negligently or intentionally fails to report is liable for damages caused by the failure.

Subd. 8. **Evidence not privileged.** No evidence regarding the abuse or neglect of the vulnerable adult shall be excluded in any proceeding arising out of the alleged abuse or neglect on the grounds of lack of competency under section 595.02.

Subd. 9. **Mandatory reporting to a medical examiner or coroner.** A person required to report under the provisions of subdivision 3 who has reasonable cause to believe that a vulnerable adult has died as a direct or indirect result of abuse or neglect shall report that information to the appropriate medical examiner or coroner in addition to the local welfare agency, police department, or county sheriff or appropriate licensing agency or agencies. The medical examiner or coroner shall complete an investigation as soon as feasible and report the findings to the police department or county sheriff, the local welfare agency, and, if applicable, each licensing agency. A person or agency that receives a report under this subdivision concerning a vulnerable adult who was receiving services or treatment for mental illness, mental retardation or a

related condition, chemical dependency, or emotional disturbance from an agency, facility, or program as defined in section 245.91, shall also report the information and findings to the ombudsman established under sections 245.91 to 245.97.

Subd. 10. **Duties of local welfare agency upon a receipt of a report.** (a) The local welfare agency shall immediately investigate and offer emergency and continuing protective social services for purposes of preventing further abuse or neglect and for safeguarding and enhancing the welfare of the abused or neglected vulnerable adult. Local welfare agencies may enter facilities and inspect and copy records as part of investigations. In cases of suspected sexual abuse, the local welfare agency shall immediately arrange for and make available to the victim appropriate medical examination and treatment. The investigation shall not be limited to the written records of the facility, but shall include every other available source of information. When necessary in order to protect the vulnerable adult from further harm, the local welfare agency shall seek authority to remove the vulnerable adult from the situation in which the neglect or abuse occurred. The local welfare agency shall also investigate to determine whether the conditions which resulted in the reported abuse or neglect place other vulnerable adults in jeopardy of being abused or neglected and offer protective social services that are called for by its determination. In performing any of these duties, the local welfare agency shall maintain appropriate records.

(b) If the report indicated, or if the local welfare agency finds that the suspected abuse or neglect occurred at a facility, or while the vulnerable adult was or should have been under the care of or receiving services from a facility, or that the suspected abuse or neglect involved a person licensed by a licensing agency to provide care or services, the local welfare agency shall immediately notify each appropriate licensing agency, and provide each licensing agency with a copy of the report and of its investigative findings.

(c) When necessary in order to protect a vulnerable adult from serious harm, the local agency shall immediately intervene on behalf of that adult to help the family, victim, or other interested person by seeking any of the following:

(1) a restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to section 518B.01;

(2) the appointment of a guardian or conservator pursuant to sections 525.539 to 525.6198, or guardianship or conservatorship pursuant to chapter 252A;

(3) replacement of an abusive or neglectful guardian or conservator and appointment of a suitable person as guardian or conservator, pursuant to sections 525.539 to 525.6198; or

(4) a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under chapter 609.

The expenses of legal intervention must be paid by the county in the case of indigent persons, under section 525.703 and chapter 563.

In proceedings under sections 525.539 to 525.6198, if a suitable relative or other person is not available to petition for guardianship or conservatorship, a county employee shall present the petition with representation by the county attorney. The county shall contract with or arrange for a suitable person or nonprofit organization to provide ongoing guardianship services. If the county presents evidence to the probate court that it has made a diligent effort and no other suitable person can be found, a county employee may serve as guardian or conservator. The county shall not retaliate against the employee for any action taken on behalf of the ward or conservatee even if the action is adverse to the county's interest. Any person retaliated against in violation of this subdivision shall have a cause of action against the county and shall be entitled to reasonable attorney fees and costs of the action if the action is upheld by the court.

Subd. 10a. **Notification of neglect or abuse in a facility.** (a) When a report is received that alleges neglect, physical abuse, or sexual abuse of a vulnerable adult while in the care of a facility required to be licensed under section 144A.02 or sections 245A.01 to 245A.16, the local welfare agency investigating the report shall notify the guardian or conservator of the person of a vulnerable adult under guardianship or conservatorship of the person who is alleged to have been abused or neglected. The local welfare agency shall notify the person, if any, designated to be notified in case of an emergency by a vulnerable adult not under guardianship or conservatorship of the person who is alleged to have been abused or neglected, unless consent is denied by the vulnerable adult. The notice shall contain the following information: the name of the facility; the fact that a report of alleged abuse or neglect of a vulnerable adult in the facility has been received; the nature of the alleged abuse or neglect; that the agency is conducting an investigation; any protective or corrective measures being taken pending the outcome of the investigation; and that a written memorandum will be provided when the investigation is completed.

(b) In a case of alleged neglect, physical abuse, or sexual abuse of a vulnerable adult while in the care of a facility required to be licensed under sections 245A.01 to 245A.16, the local welfare agency may also provide the

information in paragraph (a) to the guardian or conservator of the person of any other vulnerable adult in the facility who is under guardianship or conservatorship of the person, to any other vulnerable adult in the facility who is not under guardianship or conservatorship of the person, and to the person, if any, designated to be notified in case of an emergency by any other vulnerable adult in the facility who is not under guardianship or conservatorship of the person, unless consent is denied by the vulnerable adult, if the investigative agency knows or has reason to believe the alleged neglect, physical abuse, or sexual abuse has occurred.

(c) When the investigation required under subdivision 10 is completed, the local welfare agency shall provide a written memorandum containing the following information to every guardian or conservator of the person or other person notified by the agency of the investigation under paragraph (a) or (b): the name of the facility investigated; the nature of the alleged neglect, physical abuse, or sexual abuse: the investigator's name; a summary of the investigative findings; a statement of whether the report was found to be substantiated, inconclusive, or false: and the protective or corrective measures that are being or will be taken. The memorandum shall be written in a manner that protects the identity of the reporter and the alleged victim and shall not contain the name or, to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed during the investigation.

(d) In a case of neglect, physical abuse, or sexual abuse of a vulnerable adult while in the care of a facility required to be licensed under sections 245A.01 to 245A.16, the local welfare agency may also provide the written memorandum to the guardian or conservator of the person of any other vulnerable adult in the facility who is under guardianship or conservatorship of the person, to any other vulnerable adult in the facility who is not under guardianship or conservatorship of the person, and to the person, if any, designated to be notified in case of an emergency by any other vulnerable adult in the facility who is not under guardianship or conservatorship of the person, unless consent is denied by the vulnerable adult, if the report is substantiated or if the investigation is inconclusive and the report is a second or subsequent report of neglect, physical abuse, or sexual abuse of a vulnerable adult while in the care of the facility.

(e) In determining whether to exercise the discretionary authority granted under paragraphs (b) and (d), the local welfare agency shall consider the seriousness and extent of the alleged neglect, physical abuse, or sexual abuse and the impact of notification on the residents of the facility. The facility shall be notified whenever this discretion is exercised.

(f) Where federal law specifically prohibits the disclosure of patient identifying information, the local welfare agency shall not provide any notice under paragraph (a) or (b) or any memorandum under paragraph (c) or (d) unless the vulnerable adult has consented to disclosure in a manner which confirms to federal requirements.

Subd. 11. **Duties of licensing agencies upon receipt of report.** Whenever a licensing agency receives a report, or otherwise has information indicating that a vulnerable adult may have been abused or neglected at a facility it has licensed, or that a person it has licensed or credentialed to provide care or services may be involved in the abuse or neglect of a vulnerable adult, or that such a facility or person has failed to comply with the requirements of this section, it shall immediately investigate. Subject to the provisions of chapter 13, the licensing agency shall have the right to enter facilities and inspect and copy records as part of investigations. The investigation shall not be limited to the written records of the facility, but shall include every other available source of information. The licensing agency shall issue orders and take actions with respect to the license of the facility or person that are designed to prevent further abuse or neglect of vulnerable adults.

Subd. 11a. **Duties of prosecuting authorities.** Upon receipt of a report from a social service or licensing agency, the prosecuting authority shall immediately investigate, prosecute when warranted, and transmit its findings and disposition to the referring agency.

Subd. 12. **Records.** (a) Each licensing agency shall maintain summary records of reports of alleged abuse or neglect and alleged violations of the requirements of this section with respect to facilities or persons licensed or credentialed by that agency. As part of these records, the agency shall prepare an investigation memorandum. Notwithstanding section 13.46, subdivision 3, the investigation memorandum shall be accessible to the public pursuant to section 13.03 and a copy shall be provided to any public agency which referred the matter to the licensing agency for investigation. It shall contain a complete review of the agency's investigation, including but not limited to: the name of any facility investigated; a statement of the nature of the alleged abuse or neglect or other violation of the requirements of this section; pertinent information obtained from medical or other records reviewed; the investigator's name; a summary of the investigation's findings; a statement of whether the report was found to be substantiated, inconclusive, or false; and a statement of any action taken by the agency.

The investigation memorandum shall be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not

contain the name or, to the extent possible, the identity of the alleged perpetrator or of those interviewed during the investigation. During the licensing agency's investigation, all data collected pursuant to this section shall be classified as investigative data pursuant to section 13.39. After the licensing agency's investigation is complete, the data on individuals collected and maintained shall be private data on individuals. All data collected pursuant to this section shall be made available to prosecuting authorities and law enforcement officials, local welfare agencies, and licensing agencies investigating the alleged abuse or neglect. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by the court that the report was false and there there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the rules of criminal procedure.

(b) Notwithstanding the provisions of section 138.163:

(1) all data maintained by licensing agencies, treatment facilities, or other public agencies which relate to reports which, upon investigation, are found to be false may be destroyed two years after the finding was made;

(2) all data maintained by licensing agencies, treatment facilities, or other public agencies which relate to reports which, upon investigation, are found to be inconclusive may be destroyed four years after the finding was made;

(3) all data maintained by licensing agencies, treatment facilities, or other public agencies which relate to reports which, upon investigation, are found to be substantiated may be destroyed seven years after the finding was made.

Subd. 12a. [Repealed, 1983 c 273 s 8]

Subd. 13. **Coordination.** (a) Any police department or county sheriff, upon receiving a report shall notify the local welfare agency pursuant to subdivision 3. A local welfare agency or licensing agency which receives a report pursuant to that subdivision shall immediately notify the appropriate law enforcement, local welfare, and licensing agencies.

(b) Investigating agencies, including the police department, county sheriff, local welfare agency, or appropriate licensing agency shall cooperate in coordinating their investigatory activities. Each licensing agency shall cooperate in coordinating their investigatory activities. Each licensing agency which regulates facilities shall develop and disseminate procedures to coordinate

its activities with (i) investigations by police and county sheriffs, and (ii) provision of protective services by local welfare agencies.

Subd. 14. **Abuse prevention plans.** (a) Each facility, except home health agencies, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility shall develop an individual abuse prevention plan for each vulnerable adult residing there. Facilities designated in subdivision 2, clause (b)(2) or clause (b)(3) shall develop plans for any vulnerable adults receiving services from them. The plan shall contain an individualized assessment of the person's susceptibility to abuse, and a statement of the specific measures to be taken to minimize the risk of abuse to that person. For the purposes of this clause, the term "abuse" includes self-abuse.

Subd. 15. **Internal reporting of abuse and neglect.** Each facility shall establish and enforce an ongoing written procedure in compliance with the licensing agencies' rules for insuring that all cases of suspected abuse or neglect are reported promptly to a person required by this section to report abuse and neglect and are promptly investigated.

Subd. 16. **Enforcement.** (a) A facility that has not complied with this section within 60 days of the effective date of passage of emergency rules is ineligible for renewal of its license. A person required by subdivision 3 to report and who is licensed or credentialed to practice an occupation by a licensing agency who willfully fails to comply with this section shall be disciplined after a hearing by the appropriate licensing agency.

(b) Licensing agencies shall as soon as possible promulgate rules necessary to implement the requirements of subdivisions 11, 12, 13, 14, 15, and 16, clause (a). Agencies may promulgate emergency rules pursuant to sections 14.29 to 14.36.

(c) The commissioner of human services shall promulgate rules as necessary to implement the requirements of subdivision 10.

Subd. 17. **Retaliation prohibited.** (a) A facility or person shall not retaliate against any person who reports in good faith suspected abuse or neglect

pursuant to this section, or against a vulnerable adult with respect to whom a report is made, because of the report.

(b) Any facility or person which retaliates against any person because of a report of suspected abuse or neglect is liable to that person for actual damages and, in addition, a penalty up to $10,000.

(c) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of a report, is retaliatory. For purposes of this clause, the term "adverse action" refers to action taken by a facility or person involved in a report against the person making the report or the person with respect to whom the report was made because of the report, and includes, but is not limited to:

(1) Discharge or transfer from the facility;
(2) Discharge from or termination of employment;
(3) Demotion or reduction in remuneration for services;
(4) Restriction or prohibition of access to the facility or its residents; or
(5) Any restriction of rights set forth in section 144.651.

Subd. 18. **Outreach.** The commissioner of human services shall establish an aggressive program to educate those required to report, as well as the general public, about the requirements of this section using a variety of media.

Subd. 19. **Penalty.** Any caretaker, as defined in subdivision 2, or operator or employee thereof, or volunteer worker thereat, who intentionally abuses or neglects a vulnerable adult, or being a caretaker, knowingly permits conditions to exist which result in the abuse of neglect of a vulnerable adult, is guilty of a gross misdemeanor.

(Optional)
Facility Name _____
Contact Telephone#_____
Contact Person (optional)_____

VULNERABLE ADULT ACT
REPORTING, RESPONSE AND PENALTY SYSTEM
EVALUATION

This survey seeks to obtain information about and identify improvements for the vulnerable adult response, reporting, and penalty system in Minnesota. A "vulnerable adult report" is a complaint, verbal or written, which claims that a "vulnerable adult" has been the victim of physical, sexual or emotional abuse, financial fraud, or neglect. "Vulnerable adults" are persons 18 years or older who are residents of facilities such as nursing homes, hospitals or intermediate care facilities for the mentally retarded. "Vulnerable adults" are also any persons 18 years or older who would be unable or unlikely to report abuse or neglect because of a mental, physical or emotional impairment, regardless of their residence. For a complete definition, see Minnesota Statute section 626.557.

I. REPORTS

1. Is your facility located in a community with a population of:

   ____ Less than 25,000 ____ 25,000 or more

2. In 1991 and 1992, did your facility make any reports (verbal or written) of abuse, neglect or financial fraud of residents in your facility to an external reporting agency?

   Yes ____ No ____

3. If so, how many vulnerable adult reports did your facility make to all external reporting agencies in

   1991 ____ 1992 ____

4. Please indicate whether your facility made vulnerable adult reports to any of the following external reporting agencies by placing an "X" in the space to the left of each of the applicable agencies listed below. If you have specific numbers of reports your facility made to each agency, please note the number for each of the years 1991 and 1992.

		1991	1992
____	Police	____	____
____	Sheriff	____	____
____	Office of Health Facility Complaints	____	____
____	County Adult Protection	____	____
____	Department of Human Services Licensing	____	____
____	Medical Examiner/Coroner's Office	____	____
____	Other, please specify: _____		

5. If your facility usually makes its vulnerable adult reports to one particular agency, please place an "X" in the space next to that agency below.

____ Police
____ Sheriff
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ Medical Examiner/Coroner's Office
____ Other, please specify: _____

6. Please describe your reasons for preferring to report to that agency.

7. What changes, if any, would your facility recommend in the Vulnerable Adult Act reporting system?

II. PROCEDURE FOR RESPONSE

1. Do you have person(s) within your facility designated to receive/screen the vulnerable adult report?

   Yes ____ No ____

   If yes, position title _____

2. Does your facility use specific criteria (for example: personnel resources, seriousness of injury, credibility of reporter, etc.) to evaluate a vulnerable adult report to determine whether to make a report to an external agency?

   Yes ____ No ____

   If yes, please list those criteria or attach any written materials which contain those criteria.

3. Does your facility have a written policy which directs your facility's reporting of vulnerable adult complaints to an external agency?

   Yes ____ No ____

   If yes, please attach your policy.

4. Does your facility have staff who are specifically assigned to conduct your facility's investigations of reports involving abuse, neglect or financial fraud of vulnerable adults?

   Yes ____ No ____

   If yes, position title_____

5. Does your facility conduct its own investigations of reports involving abuse, neglect or financial fraud of vulnerable adults?

   Yes ____ No ____

6. Does your facility make its vulnerable adult report to the external agency before your facility conducts its own investigation?

Never	Sometimes	Usually	Always
_____	_____	_____	_____

7. Does your facility make its vulnerable adult report to the external reporting agency after your facility conducts its own investigation?

Never	Sometimes	Usually	Always
_____	_____	_____	_____

8. Does your facility make a vulnerable adult report to the external reporting agency both before and after your facility conducts its own investigation?

Never	Sometimes	Usually	Always
_____	_____	_____	_____

9. Does your facility use criteria for determining when it should immediately contact law enforcement for its response to a vulnerable adult complaint?

Yes ____ No ____

If yes, please describe the criteria used. If those criteria are written, please attach a copy.

III. COORDINATION

1. In the last two years, please note which agencies have investigated vulnerable adult reports made by your facility by placing an "X" in the space to the left of each of the agencies below. Please note which agencies most frequently investigated your facility's reports by ranking them 1-3 (with 1 being the most frequent) in the space to the right.

Investigated		Ranking
____	Police	____
____	Sheriff	____
____	Prosecutor's Office	____
____	Office of Health Facility Complaints	____
____	County Adult Protection	____
____	Ombudsman Office	____
____	Department of Human Services Licensing	____
____	Medical Examiner/Coroner's office	____
____	Other, please specify: _____	

2. In your community who has the primary responsibility for investigating vulnerable adult reports made by your facility? Please check one.

____ Police
____ Sheriff
____ Prosecutor's Office
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ No agency
____ Do not know
____ Other, please specify:_____

3. In your community who do you believe should investigate vulnerable adult reports made by your facility? Please check one or more.

____ Police
____ Sheriff
____ Prosecutor's Office
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ Individuals/facilities who provide care to vulnerable adults
____ Other, please specify:_____

4. Why should the agency or agencies you identified in Question 3 be responsible for investigating reports of abuse or neglect of vulnerable adults?

5. What, if any, recommendations would your facility make to improve how agencies coordinate their efforts when responding to vulnerable adult reports?

IV. TRAINING

1. Have personnel from your facility received formal or informal training on any of the following topics relating to the Vulnerable Adult Act?

____ Overview of the Vulnerable Adult Act
____ Reporting requirements of the Vulnerable Adult Act
____ Coordination/working with agencies investigating reports
____ Specialized investigative skills relating to investigations in a health care setting
____ Working with/evaluating vulnerable adult victims as witnesses
____ Other, please specify_____

2. What training on vulnerable adult issues would your facility find useful? Please list below.

V. OTHER CONCERNS ABOUT THE VAA RESPONSE, REPORTING AND PENALTY SYSTEM

1. Our facility's three main problems with how the VAA system works are:

   1.

   2.

   3.

2. The following things work very well within the VAA process:

   1.

   2.

   3.

3. Our facility believes the following things would improve the VAA system:

   1.

   2.

   3.

We welcome any additional input you care to provide about your experience with the VAA system. Please attach additional sheets if there is not sufficient room for your comments on this page.

Please return this survey to:

Thom Campbell
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3843

Agency Name_____
Contact Telephone #_____
Contact Person (optional)_____

VULNERABLE ADULT ACT
REPORTING, RESPONSE AND PENALTY SYSTEM
EVALUATION

This survey seeks to obtain information about and identify improvements for the vulnerable adult response, reporting, and penalty system in Minnesota. A "vulnerable adult report" is a complaint, verbal or written, which claims that a "vulnerable adult" has been the victim of physical, sexual or emotional abuse, financial fraud, or neglect. "Vulnerable adults" are persons 18 years or older who are residents of facilities such as nursing homes, hospitals or intermediate care facilities for the mentally retarded. "Vulnerable adults" are also any persons 18 years or older who would be unable or unlikely to report abuse or neglect because of a mental, physical or emotional impairment, regardless of their residence. For a complete definition, see Minnesota Statute section 626.557.

I. REPORTS

1. Does your agency receive reports (verbal or written) of abuse, neglect or financial fraud of residents in nursing homes or other care facilities?

   Yes ____ No ____

2. Does your agency receive reports (verbal or written) of abuse, neglect or financial fraud of "vulnerable adults" who are not residents of nursing homes or other care facilities?

   Yes ____ No ____

3. Does your agency categorize reports about "vulnerable adults" as defined above separately from other reports?

   Yes ____ No ____

4. If so, how many vulnerable adult reports did your agency receive in

   1991 ____ 1992 ____

5. Please indicate whether your agency received vulnerable adult reports from the following sources by placing an "X" in the space to the left of each of the sources listed below. If you have specific numbers of reports your agency received from each source, please note the number for each of the years 1991 and 1992.

		1991	1992
____	Police	____	____
____	Sheriff	____	____
____	Prosecutor's Office	____	____
____	Office of Health Facility Complaints	____	____
____	County Adult Protection	____	____
____	Facilities (nursing homes, hospitals, etc.)	____	____
____	Residents of Facilities	____	____
____	Family Members of Vulnerable Adults	____	____
____	Consumer Groups	____	____
____	Ombudsman's Office	____	____
____	Department of Human Services Licensing	____	____
____	Medical Examiner/Coroner's Office	____	____
____	Other, please specify: _____		

6. When your agency receives vulnerable adult reports, does it refer those reports to another agency?

Yes ____ No ____

6a. If yes, please indicate to which agency or agencies you refer those reports by placing an "X" in the space to the left of the sources listed below. If you have specific numbers of reports referred by your agency to other agencies, please note the number for each of the years 1991 and 1992.

		1991	1992
____	Police	____	____
____	Sheriff	____	____
____	Prosecutor's Office	____	____
____	Office of Health Facility Complaints	____	____
____	County Adult Protection	____	____
____	Department of Human Services Licensing	____	____
____	Other, please specify: _____		

7. If a vulnerable adult report is substantiated by your agency, does your agency refer that report to another agency?

Yes ____ No ____

7a. If yes, please indicate to which agency or agencies you refer those substantiated complaints by placing an "X" in the space to the left of the agencies listed below. If you have specific numbers of reports referred by your agency to other agencies, please note the number for each of the years 1991 and 1992.

		1991	1992
____	Police	____	____
____	Sheriff	____	____
____	Prosecutor's Office	____	____
____	Office of Health Facility Complaints	____	____
____	County Adult Protection	____	____
____	Department of Human Services Licensing	____	____
____	Other, please specify: _____		

8. What changes, if any, would your agency recommend in the VAA (Vulnerable Adult Act) reporting system?

II. PROCEDURE FOR RESPONSE

1. Do you have person(s) designated to <u>receive/screen</u> the vulnerable adult report?

   Yes ____ No ____

   Number of full-time equivalent staff positions_____
   Position title_____

2. Does your agency use specific criteria (for example: personnel resources, seriousness of injury, credibility of reporter, etc.) to evaluate a vulnerable adult report to determine your agency's response?

   Yes ____ No ____

   If yes, please list those criteria or attach any written materials which contain those criteria.

3. Does your agency have criteria for determining whether it should immediately refer a vulnerable adult complaint to law enforcement for their response?

Yes ____ No ____

If yes, please describe the criteria used. If these criteria are written, please attach a copy.

4. Does your agency have staff who are specifically assigned to respond to reports involving abuse, neglect or financial fraud of vulnerable adults?

Yes ____ No ____

Number of full-time equivalent staff positions_____
Position title_____

5. For those cases where your agency did **not** take action on a vulnerable adult complaint, please place an "X" next to the top three reasons identified below which most often contributed to that decision.

____ Lack of evidence
____ Victim viewed as unreliable witness
____ Evidence was too old (stale)
____ Age of victim
____ Offense considered too minor to pursue
____ Another agency already involved in investigation
____ Another agency viewed as responsible for investigation
____ Lack of witness cooperation
____ Lack of cooperation from facility
____ Lack of available resources to respond
____ Lack of medical expertise to evaluate/assist
____ Other, please specify:_____

III. COORDINATION

1. Does your agency have written procedures for coordinating responses to vulnerable adult complaints with other agencies?

   Yes ____ No ____

   If yes, please attach your written policies.

2. Has your agency <u>received</u> written procedures for coordinating responses to vulnerable adult complaints from any other agencies? (Other agencies may include the Office of Health Facility Complaints, the Department of Human Services Licensing, County Adult Protection, etc.)

   Yes ____ No ____

   If yes, please indicate which agency/agencies have provided its written procedures to your agency.

   ____ Police
   ____ Sheriff
   ____ Office of Health Facility Complaints
   ____ County Adult Protection
   ____ Department of Human Services Licensing
   ____ Other, please specify: _____

3. Does your agency work together with any other agencies to coordinate the response to vulnerable adult reports?

Never	Sometimes	Usually	Always
_____	_____	_____	_____

In the last two years, please note which agencies your agency has worked with to coordinate a response to a vulnerable adult report by placing an "X" in the space to the left of each of the agencies below. Please note which agencies your agency most frequently coordinated with by ranking them 1-3 (with 1 being the most frequent) in the space to the right.

Coordinated With		Ranking
____	Police	____
____	Sheriff	____
____	Prosecutor's Office	____
____	Office of Health Facility Complaints	____
____	County Adult Protection	____
____	Ombudsman Office	____
____	Department of Human Services Licensing	____
____	Medical Examiner/Coroner's office	____
____	Other, please specify: _____	

4. If your agency has contacted a facility which provides care to a vulnerable adult during the course of your investigation, did that facility provide all relevant information and assistance necessary to complete your investigation?

Never	Sometimes	Usually	Always	Did Not Contact Facility
_____	_____	_____	_____	_____

5. In your community who has the primary responsibility for investigating vulnerable adult reports? Please check one.

____ Police
____ Sheriff
____ Prosecutor's Office
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ No agency
____ Do not know
____ Other, please specify:_____

6. In your community who do you believe <u>should</u> investigate vulnerable adult reports? Please check <u>one or more</u>.

____ Police
____ Sheriff
____ Prosecutor's Office
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ Individuals/facilities who provide care to vulnerable adults
____ Other, please specify:_____

7. Why should the agency or agencies you identified in Question 6 be responsible for investigating reports of abuse or neglect or financial fraud of vulnerable adults?

8. What, if any, recommendations would your agency make to improve how agencies coordinate their efforts when responding to vulnerable adult reports?

IV. TRAINING

1. Have personnel from your agency received formal or informal training on any of the following topics relating to the Vulnerable Adult Act?

____ Overview of the Vulnerable Adult Act
____ Reporting requirements of the Vulnerable Adult Act
____ Coordination/working with other agencies
____ Specialized investigative skills relating to investigations in a health care setting
____ Working with/evaluating vulnerable adult victims as witnesses
____ Other, please specify:_____
_____

2. What training on vulnerable adult issues would your agency find useful? Please list below.

V. OTHER CONCERNS ABOUT THE VAA RESPONSE, REPORTING AND PENALTY SYSTEM

1. Our agency's three main problems with how the VAA system works are:

   1.

   2.

   3.

2. The following things work very well within the VAA process:

   1.

   2.

   3.

3. Our agency believes the following things would improve the VAA system:

1.

2.

3.

We welcome any additional input you care to provide about your experience with the VAA system. Please attach additional sheets if there is not sufficient room for your comments on this page.

Please return this survey to:

Thom Campbell
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3843

Agency Name _____
Contact Telephone#_____
Contact Person (optional)_____

VULNERABLE ADULT ACT
REPORTING, RESPONSE AND PENALTY SYSTEM
EVALUATION

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I. REPORTS

1. Does your agency receive reports (verbal or written) of abuse, neglect or financial fraud of residents in nursing homes or other care facilities?

   Yes ____ No ____

2. Does your agency receive reports (verbal or written) of abuse, neglect or financial fraud of "vulnerable adults" who are not residents of nursing homes or other care facilities?

   Yes ____ No ____

3. Does your agency categorize reports about "vulnerable adults" as defined above separately from other reports?

   Yes ____ No ____

4. If so, how many vulnerable adult reports did your agency receive in

   1991 ____ 1992 ____

5. Please indicate whether your agency received vulnerable adult reports from the following sources by placing an "X" in the space to the left of each of the sources listed below. If you have specific numbers of reports your agency received from each source, please note the number for each of the years 1991 and 1992.

		1991	1992
____	Other Law Enforcement Agencies	____	____
____	Prosecutor's Office	____	____
____	Office of Health Facility Complaints	____	____
____	County Adult Protection	____	____
____	Facilities (nursing homes, hospitals, etc.)	____	____
____	Residents of Facilities	____	____
____	Family Members of Vulnerable Adults	____	____
____	Consumer Groups	____	____
____	Ombudsman's Office	____	____
____	Department of Human Services Licensing	____	____
____	Medical Examiner/Coroner's Office	____	____
____	Other, please specify: _____		

6. When your agency receives vulnerable adult reports, does it refer those reports to another agency?

Yes ____ No ____

6a. If yes, please indicate to which agency or agencies you refer those reports by placing an "X" in the space to the left of the sources listed below. If you have specific numbers of reports referred by your agency to other agencies, please note the number for each of the years 1991 and 1992.

		1991	1992
____	Other Law Enforcement Agency	____	____
____	Prosecutor's Office	____	____
____	Office of Health Facility Complaints	____	____
____	County Adult Protection	____	____
____	Department of Human Services Licensing	____	____
____	Other, please specify: _____		

7. If your agency has probable cause to believe a vulnerable adult report is true (or is "substantiated"), does your agency refer that report to another agency?

Yes ____ No ____

7a. If yes, please indicate to which agency or agencies you refer those substantiated complaints by placing an "X" in the space to the left of the agencies listed below. If you have specific numbers of reports referred by your agency to other agencies, please note the number for each of the years 1991 and 1992.

		1991	1992
____	Other Law Enforcement Agency	____	____
____	Prosecutor's Office	____	____
____	Office of Health Facility Complaints	____	____
____	County Adult Protection	____	____
____	Department of Human Services Licensing	____	____
____	Other, please specify: _____		

8. What changes, if any, would your agency recommend in the VAA (Vulnerable Adult Act) reporting system?

II. PROCEDURE FOR RESPONSE

1. Do you have person(s) designated to receive/screen the vulnerable adult report?

Yes ____ No ____

Number of full-time equivalent staff positions_____
Position title_____

2. Does your agency use specific criteria (for example: personnel resources, seriousness of injury, credibility of reporter, etc.) to evaluate a vulnerable adult report to determine your agency's response?

Yes ____ No ____

If yes, please list those criteria or attach any written materials which contain those criteria.

3. Does your agency have staff who are specifically assigned to <u>respond</u> to reports involving abuse, neglect or financial fraud of vulnerable adults?

Yes ____ No ____

Number of full-time equivalent staff positions_____
Position title_____

4. For those cases where your agency did **<u>not</u>** take action on a vulnerable adult complaint, please place an "X" next to the top three reasons identified below which most often contributed to that decision.

____ Lack of evidence
____ Victim viewed as unreliable witness
____ Evidence was too old (stale)
____ Age of victim
____ Offense considered too minor to pursue
____ Another agency already involved in investigation
____ Another agency viewed as responsible for investigation
____ Lack of witness cooperation
____ Lack of cooperation from facility
____ Lack of available resources to respond
____ Lack of medical expertise to evaluate/assist
____ Other, please specify:_____

III. COORDINATION

1. Does your agency have written procedures for coordinating responses to vulnerable adult complaints with other agencies?

Yes ____ No ____

If yes, please attach your written policies.

2. Has your agency <u>received</u> written procedures for coordinating responses to vulnerable adult complaints from any other agencies? (Other agencies may include the Office of Health Facility Complaints, the Department of Human Services Licensing, County Adult Protection, etc.)

Yes ____ No ____

If yes, please indicate which agency/agencies have provided its written procedures to your agency.

____ Other Law Enforcement Agencies
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ Other, please specify: _____

3. Does your agency work together with any other agencies to coordinate the response to vulnerable adult reports?

Never	Sometimes	Usually	Always
_____	_____	_____	_____

In the last two years, please note which agencies your agency has worked with to coordinate a response to a vulnerable adult report by placing an "X" in the space to the left of each of the applicable agencies below. Please note which agencies your agency most frequently coordinated with by ranking them 1-3 (with 1 being the most frequent) in the space to the right.

Coordinated With	Ranking
____ Other Law Enforcement Agencies	____
____ Prosecutor's Office	____
____ Office of Health Facility Complaints	____
____ County Adult Protection	____
____ Ombudsman Office	____
____ Department of Human Services Licensing	____
____ Medical Examiner/Coroner's office	____
____ Other, please specify: _____	

4. If your agency has contacted a facility which provides care to a vulnerable adult during the course of your investigation, did that facility provide all relevant information and assistance necessary to complete your investigation?

Never	Sometimes	Usually	Always	Did Not Contact Facility
_____	_____	_____	_____	_____

5. In your community who has the primary responsibility for investigating vulnerable adult reports? Please check one.

____ Police
____ Sheriff
____ Prosecutor's Office
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ No agency
____ Do not know
____ Other, please specify:_____

6. In your community who do you believe should investigate vulnerable adult reports? Please check one or more.

____ Police
____ Sheriff
____ Prosecutor's Office
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ Individuals/facilities who provide care to vulnerable adults
____ Other, please specify:_____

7. Why should the agency or agencies you identified in Question 6 be responsible for investigating reports of abuse or neglect or financial fraud of vulnerable adults?

8. What, if any, recommendations would your agency make to improve how agencies coordinate their efforts when responding to vulnerable adult reports?

IV. TRAINING

1. Have personnel from your agency received formal or informal training on any of the following topics relating to the Vulnerable Adult Act?

____ Overview of the Vulnerable Adult Act
____ Reporting requirements of the Vulnerable Adult Act
____ Coordination/working with other agencies
____ Specialized investigative skills relating to investigations in a health care setting
____ Working with/evaluating vulnerable adult victims as witnesses
____ Other, please specify: _____
_____

2. What training on vulnerable adult issues would your agency find useful? Please list below.

V. OTHER CONCERNS ABOUT THE VAA RESPONSE, REPORTING AND PENALTY SYSTEM

1. Our agency's three main problems with how the VAA system works are:

1.

2.

3.

2. The following things work very well within the VAA process:

1.

2.

3.

3. Our agency believes the following things would improve the VAA system:

1.

2.

3.

We welcome any additional input you care to provide about your experience with the VAA system. Please attach additional sheets if there is not sufficient room for your comments on this page.

Please return this survey to:

Mamie Segall
Assistant Attorney General
Medicaid Fraud Division
1400 NCL Tower
445 Minnesota Street
St. Paul, MN 55101

Agency Name_____
Contact Telephone #_____
Contact Person (optional)_____

VULNERABLE ADULT ACT
REPORTING, RESPONSE AND PENALTY SYSTEM
EVALUATION

This survey seeks to obtain information about and identify improvements for the vulnerable adult response, reporting, and penalty system in Minnesota. A "vulnerable adult report" is a complaint, verbal or written, which claims that a "vulnerable adult" has been the victim of physical, sexual or emotional abuse, financial fraud, or neglect. "Vulnerable adults" are persons 18 years or older who are residents of facilities such as nursing homes, hospitals or intermediate care facilities for the mentally retarded. "Vulnerable adults" are also any persons 18 years or older who would be unable or unlikely to report abuse or neglect because of a mental, physical or emotional impairment, regardless of their residence. For a complete definition, see Minnesota Statute section 626.557.

I. REPORTS

1. Does your office receive complaints/reports (verbal or written) of abuse, neglect or financial fraud of residents in nursing homes or other care facilities?

   Yes ____ No ____

2. Does your office receive complaints/reports (verbal or written) of abuse, neglect or financial fraud of "vulnerable adults" who are not residents of nursing homes or other care facilities?

   Yes ____ No ____

3. Does your office categorize reports about "vulnerable adults" as defined above separately from other reports?

   Yes ____ No ____

4. If so, how many vulnerable adult reports did your office receive in

   1991 ____ 1992 ____

5. When you receive an initial report of abuse/neglect of a vulnerable adult, what agency do you refer the report to for further investigation?

____ Police
____ Sheriff
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ Other, please specify: _____

6. In your community who has the primary responsibility for investigating vulnerable adult reports? Please check one.

____ Police
____ Sheriff
____ Prosecutor's Office
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ No agency
____ Do not know
____ Other, please specify: _____

7. In your community who do you believe should investigate vulnerable adult reports? Please check one or more.

____ Police
____ Sheriff
____ Prosecutor's Office
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ Individuals/facilities who provide care to vulnerable adults
____ Other, please specify: _____

8. What changes, if any, would your office recommend in the VAA (Vulnerable Adult Act) reporting system?

II. REFERRALS FOR PROSECUTION

All of the following questions relate to case referrals which another agency has investigated and has presented to your office for a charging decision.

1. How many vulnerable adult case referrals did your office receive in the following years:

____ 1991 ____ 1992

2. Please indicate whether your office received vulnerable adult case referrals from the following sources by placing an "X" to the left of each source listed below. If you have specific numbers of reports your office received from each source, please note the number for 1991 and 1992.

		1991	1992
____	Police	____	____
____	Sheriff	____	____
____	Office of Health Facility Complaints	____	____
____	Ombudsman's Office	____	____
____	Department of Human Services Licensing	____	____
____	Medical Examiner/Coroner's Office	____	____
____	Other, please specify: _____		

3. For those cases where prosecution was declined, please indicate the reason(s) for declining prosecution by placing an "X" next to the three reasons identified below which most often contributed to that decision.

____ Lack of evidence
____ Family refused to cooperate with prosecution
____ Victim refused to cooperate with prosecution
____ Victim was not viewed as a reliable witness
____ Criminal intent could not be established
____ Evidence too old (stale)
____ Offender left jurisdiction
____ Offense considered too minor to prosecute
____ Event occurred in another jurisdiction
____ Flawed or inadequate investigation
____ Lack of medical expertise to evaluate/assist
____ Other (please specify) _____

III. TRAINING

1. Have personnel from your office received formal or informal training on any of the following topics relating to the Vulnerable Adult Act?

____ Overview of Vulnerable Adult Act
____ Reporting requirements of the Vulnerable Adult Act
____ Coordination/working with other agencies
____ Specialized investigative skills relating to investigations in a health care setting
____ Working with/evaluating vulnerable adult victims as witnesses
____ Other, please specify:_____
_____

2. What training on vulnerable adult issues would your office find useful? Please list below.

IV. OTHER CONCERNS ABOUT THE VAA RESPONSE, REPORTING AND PENALTY SYSTEM

1. Our office's three main problems with how the VAA system works are:

1.

2.

3.

2. The following things work very well within the VAA process:

1.

2.

3.

3. Our office believes the following things would improve the VAA system:

1.

2.

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We welcome any additional input you care to provide about your experience with the VAA system. Please attach additional sheets if there is not sufficient room for your comments on this page.

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Mamie Segall
Assistant Attorney General
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Organization Name_____
Contact Telephone #_____
Contact Person (optional)_____

VULNERABLE ADULT ACT
REPORTING, RESPONSE AND PENALTY SYSTEM
EVALUATION

This survey seeks to obtain information about and identify improvements for the vulnerable adult response, reporting, and penalty system in Minnesota. A "vulnerable adult report" is a complaint, verbal or written, which claims that a "vulnerable adult" has been the victim of physical, sexual or emotional abuse, financial fraud, or neglect. "Vulnerable adults" are persons 18 years or older who are residents of facilities such as nursing homes, hospitals or intermediate care facilities for the mentally retarded. "Vulnerable adults" are also any persons 18 years or older who would be unable or unlikely to report abuse or neglect because of a mental, physical or emotional impairment, regardless of their residence. For a complete definition, see Minnesota Statute section 626.557.

I. REPORTS

1. Does your organization receive reports (verbal or written) of abuse, neglect or financial fraud of residents in nursing homes or other care facilities?

   Yes ____ No ____

2. Does your organization receive reports (verbal or written) of abuse, neglect or financial fraud of "vulnerable adults" who are not residents of nursing homes or other care facilities?

   Yes ____ No ____

3. Does your organization categorize reports about "vulnerable adults" as defined above separately from other reports?

   Yes ____ No ____

4. If so, how many vulnerable adult reports did your organization receive in

   1991 ____ 1992 ____

5. Please indicate whether your organization received vulnerable adult reports from the following sources by placing an "X" in the space to the left of each of the sources listed below. If you have specific numbers of reports your agency received from each source, please note the number for each of the years 1991 and 1992.

		1991	1992
____	Police	____	____
____	Sheriff	____	____
____	Prosecutor's Office	____	____
____	Office of Health Facility Complaints	____	____
____	County Adult Protection	____	____
____	Facilities (nursing homes, hospitals, etc.)	____	____
____	Residents of Facilities	____	____
____	Family Members of Vulnerable Adults	____	____
____	Consumer Groups	____	____
____	Ombudsman's Office	____	____
____	Department of Human Services Licensing	____	____
____	Medical Examiner/Coroner's Office	____	____
____	Other, please specify: _____		

6. When your organization receives vulnerable adult reports, does it refer those reports to another agency?

Yes ____ No ____

6a. If yes, please indicate to which agency or agencies you refer those reports by placing an "X" in the space to the left of the agencies listed below. If you have specific numbers of reports referred by your organization to other agencies, please note the number for each of the years 1991 and 1992.

		1991	1992
____	Police	____	____
____	Sheriff	____	____
____	Prosecutor's Office	____	____
____	Office of Health Facility Complaints	____	____
____	County Adult Protection	____	____
____	Department of Human Services Licensing	____	____
____	Other, please specify: _____		

7. What changes, if any, would your organization recommend in the VAA (Vulnerable Adult Act) reporting system?

II. PROCEDURE FOR RESPONSE

1. Do you have person(s) designated to receive/screen the vulnerable adult report?

   Yes ____ No ____

   Number of full-time equivalent staff positions_____
   Position title_____

2. Does your organization use specific criteria (for example: personnel resources, seriousness of injury, credibility of reporter, etc.) to evaluate a vulnerable adult report to determine your organization's response?

   Yes ____ No ____

   If yes, please list those criteria or attach any written materials which contain those criteria.

3. Does your organization use criteria for determining when it should immediately refer a vulnerable adult complaint to law enforcement for their response?

   Yes ____ No ____

   If yes, please describe the criteria used. If these criteria are written, please attach a copy.

4. Does your organization have staff who are specifically assigned to respond to reports involving abuse, neglect or financial fraud of vulnerable adults?

Yes ____ No ____

Number of full-time equivalent staff positions_____
Position title_____

5. For those cases where your organization did **not** take action on a vulnerable adult complaint, please place an "X" next to the top three reasons identified below which most often contributed to that decision.

____ Lack of evidence
____ Victim viewed as unreliable witness
____ Evidence was too old (stale)
____ Age of victim
____ Offense considered too minor to pursue
____ Another agency already involved in investigation
____ Another agency viewed as responsible for investigation
____ Lack of witness cooperation
____ Lack of cooperation from facility
____ Lack of available resources to respond
____ Lack of medical expertise to evaluate/assist
____ Other, please specify:_____

III. COORDINATION

1. Does your organization have written procedures for coordinating responses to vulnerable adult complaints with other agencies?

Yes ____ No ____

If yes, please attach your written policies.

2. Has your organization received written procedures for coordinating responses to vulnerable adult complaints from any other agencies? (Other agencies may include the Office of Health Facility Complaints, the Department of Human Services Licensing, County Adult Protection, etc.)

Yes ____ No ____

If yes, please indicate which agency/agencies have provided its written procedures to your organization.

____ Law Enforcement Agencies
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ Other, please specify: _____

3. Does your organization work together with any other agencies to coordinate the response to vulnerable adult reports?

Never	Sometimes	Usually	Always
_____	_____	_____	_____

In the last two years, please note which agencies your organization has worked with to coordinate a response to a vulnerable adult report by placing an "X" in the space to the left of each of the applicable agencies below. Please note which agencies your organization most frequently coordinated with by ranking them 1-3 (with 1 being the most frequent) in the space to the right.

Coordinated With	Ranking
____ Police	____
____ Sheriff	____
____ Prosecutor's Office	____
____ Office of Health Facility Complaints	____
____ County Adult Protection	____
____ Ombudsman Office	____
____ Department of Human Services Licensing	____
____ Medical Examiner/Coroner's office	____
____ Other, please specify: _____	

4. If your organization has contacted a facility which provides care to a vulnerable adult during the course of your investigation, did that facility provide all relevant information and assistance necessary to complete your investigation?

Never	Sometimes	Usually	Always	Did Not Contact Facility
_____	_____	_____	_____	_____

5. In your community who has the primary responsibility for investigating vulnerable adult reports? Please check one.

____ Police
____ Sheriff
____ Prosecutor's Office
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ No agency
____ Do not know
____ Other, please specify:_____

6. In your community who do you believe <u>should</u> investigate vulnerable adult reports? Please check <u>one or more</u>.

____ Police
____ Sheriff
____ Prosecutor's Office
____ Office of Health Facility Complaints
____ County Adult Protection
____ Department of Human Services Licensing
____ Individuals/facilities who provide care to vulnerable adults
____ Other, please specify:_____

7. Why should the agency or agencies you identified in Question 6 be responsible for investigating reports of abuse or neglect or financial fraud of vulnerable adults?

8. What, if any, recommendations would your organization make to improve how agencies coordinate their efforts when responding to vulnerable adult reports?

IV. TRAINING

1. Have personnel from your organization received formal or informal training on any of the following topics relating to the Vulnerable Adult Act?

____ Overview of the Vulnerable Adult Act
____ Reporting requirements of the Vulnerable Adult Act
____ Coordination/working with other agencies
____ Specialized investigative skills relating to investigations in a health care setting
____ Working with/evaluating vulnerable adult victims as witnesses
____ Other, please specify:_____
_____

2. What training on vulnerable adult issues would your organization find useful? Please list below.

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3. Our organization believes the following things would improve the VAA system:

1.

2.

3.

We welcome any additional input you care to provide about your experience with the VAA system. Please attach additional sheets if there is not sufficient room for your comments on this page.

Please return this survey to:

Iris Freeman
Alliance for Health Care Consumers
5609 Lyndale Avenue South
Minneapolis, MN 55419