

VAA Stakeholder Reform Group

Categories and Issues Modified and Developed after the April 18, 2008 Meeting
Prepared for the VAA Stakeholders by Kevin Hansen and Alicia Jaworski

Issues	Statute
1) Education and Training	
a) Educating PCAs on care issues, tailoring presentations to accommodate the various sub-groups and cultures within the PCA profession (perhaps adding a VAA component to the training)	
b) Educating law enforcement about building strong case for the prosecuting attorney to proceed upon in court in VA case	Minn. Stat. § 62
c) Educating various organizations/departments on how to conduct effective and thorough investigations into an alleged incident by looking closely at language of Subdivision 9e(b)	Minn. Stat. § 62
d) Increasing annual trainings under Subdivision 9e from 1 per year to 3 by including Departments of Health, Human Services, and Public Safety	Minn. Stat. § 62
e) Looking at asking for actual trainers from the state for educating organizations	
f) Modifying the CEP Training (see meeting notes from April 2008)	
g) Allowing other courses (i.e. from trade associations) to train individuals and help with the training requirements mandated by statute, provided that the programs are pre-approved by the necessary agency (MDH/DHS collaboration)	
h) Clarifying who "others" are who need to be educated and trained (perhaps define in § 626.5572 instead, pull it out entirely, or give it meaning in this section)	Minn. Stat. § 626

2) Protections (Prevent Injury/Maintain Autonomy)

<p>a) Providing method for release of information that caregiver or office can get on behalf of an incapacitated individual</p>	
<p>b) Addressing issue where caregiver, guardian, or POA is perpetrator (compelling accountings, improve tracking methods of individuals or agencies working with a VA, removing a PCA's license number, provide/perform background checks, and maintain investigation to its conclusion even after employment is terminated)</p>	
<p>c) Providing awareness for "wandering elders" similar to Amber Alert or Code Adam (possibly creating an exception to the requirement to wait for 24 hours when the missing individual is a VA or has dementia or another mental incapacity)</p>	
<p>d) Determining ways to identify and protect the "unbefriended" or "invisible"</p>	
<p>e) Making a way for APS or another agency to be able to apply for an Order for Protection or a Hardship Waiver on behalf of an individual instead of just that individual being able to or his/her guardian doing it</p>	<p>Order for Protection 518B.01 subd. 4; Minn. Stat. § 256</p>
<p>f) Creating expungement rights for a perpetrator to get off a central registry of information (due process consideration that other states include in statutes)</p>	
<p>g) Increasing the appeal rights for victims (perpetrators have a lot, currently)</p>	

3) Increased Scope of Statutes

<p>a) Allowing recovery of funds through statutes - making provisions for criminal punishment as well as creating civil form of action for individual against perpetrators by using age categories to allow an agency to seek higher penalties (currently a bill on hold in committee about financial exploitation and fiduciaries)</p>	
<p>b) Strengthening the current VA review panel or consider its elimination</p>	<p>Minn. Stat. § 62</p>
<p>c) Coordinating domestic violence statutes with elder abuse concerns</p>	<p>Minn. Sta</p>
<p>d) Consider use of Revenue Recapture Act, when a person with substitute-decision making power over a vulnerable adult improperly uses funds, to withhold a tax refund (transfer money to MA program or care facility) or preventing an inheritance when someone financially exploits/abuses a family member</p>	
<p>e) Expanding language of statutes from care provider focus to community focus</p>	
<p>f) Coordinating Federal and State laws to minimize conflict and clarify liability and penalties for each division</p>	
<p>g) Requiring notification to APS or relevant office after an emergency guardianship or conservatorship has been obtained to allow investigation by APS</p>	<p>Minn. Stat. §</p>
<p>h) Mandating background checks on any individual who provides care or acts in a substitute-decision making capacity for another (POA, guardian, PCA, etc.)</p>	
<p>i) Making financial institutions and their employees mandated reporters</p>	
<p>j) Providing for a means to freeze a VA's assets while an investigation or proceeding is going on so the VA has something left over after a disposition has been reached (something similar to a TRO or HRO)</p>	

4) Reporting

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

5) Definitions

<p>a) Redefining "facility" (who qualifies as such a designation, what that facility is obligated to do, etc.) with consideration of new CMS requirements</p>	<p>Minn. Stat. § 62</p>
<p>b) Creating definitions of "informal caregiver" and legal implications of such status</p>	
<p>c) Defining situations where it is appropriate for a lead agency to be delegated</p>	<p>Minn. Stat. § 626.1</p>
<p>d) Re-examining definition of self-neglect and consider capacity implications (making decisions without the capacity to understand the consequences of such, looking at how other states define self-neglect and how the Federal definition works)</p>	
<p>e) Considering implications of centralized reporting system and central registry</p>	
<p>f) Considering adding stronger language to requiring Common Entry Points to take all calls received by counties</p>	
<p>g) Reviewing maltreatment concerns: excluding perpetrators from providing care, consequences for a perpetrator (especially those who are a licensed individual), and re-examining the language of "serious or recurring"</p>	
<p>h) Clarifying what events SHOULD be reported and what MUST be reported; using language and requirements to minimize over-reporting</p>	<p>Minn. Stat. § 62</p>
<p>i) Looking at language: patient vs. inpatient vs. client vs. someone who is receiving care and/or services from another (what's best to use or include all of it)</p>	

6) Investigations

<p>a) Clarifying how an investigation is conducted by looking at either updating Protective Services Rules or bringing investigation requirements into VAA</p>	<p>Protective Service</p>
<p>b) Strengthening requirements on banks for disclosure of financial records that will assist in vulnerable adult maltreatment investigations (mandated reporters)</p>	
<p>c) Creating a mechanism for an outside group (APS, AG's Office, etc.) to access records</p>	
<p>c) Enacting a "yellow flag" system for an individual who is currently under investigation but the investigation has not been resolved (prevent the moving around of perpetrators and not violating due process rights)</p>	
<p>d) Examining ways to prioritize investigations (currently, when an employee is fired, the investigation gets a lower priority by DHS; looking at how priorities are set)</p>	
<p>e) Setting a system of best practices (only one agency has a defined process)</p>	

7) CMS Considerations

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| a) Examining the duplicative reporting structure currently in place to the CEP (state requirement to do so) and MDH (Federal requirement to do so) ... is this a problem | |
| b) Looking at the state vs. the Federal definitions: setting requirements, modifying the state definitions to fit within the Federal definitions and then move a step further to meet the specific needs we identify | |
| c) CEP cannot REQUIRE a written report to be made to them, but they certainly can accept one if the reporter submits information in this fashion; does this help with concerns revolving around reporting (changing ways to report) | |
| d) Weighing the pros and cons of pulling nursing homes/SNF's out of the VAA (looking at the downsides of this, including no centralized data collection system) | |