MGS Webinar: Elder Abuse Prevention in Minnesota- Next Steps

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Summary of Take-away Lessons

- We have more in common in terms of overall goal(s) than we do differences in details: no tolerance for maltreatment and responding with prevention, transparency and accountability;
- All stakeholders have played a role leading up to the consumer report and proposed legislation; and all can play a role in improvements to older adult/vulnerable adult protection;
- There are broader consequences that need to be considered when larger systems changes are proposed-hopefully interim task force(s) will give us time to identify and address—if not legislatively mandated then stakeholders should set up their own process;
- It is important to accurately analyze and share data;
- Change doesn't have to wait for legislation to pass-while we all want legislation to pass this year we can take action regardless;
- Broader external trends need to be identified and addressed such as serious workforce shortages, law enforcement and professional licensing practices that put vulnerable adults at risk, and increased mental health/behavioral health in older adults;
- Current actions do not addresses some of the "other prevention options" contained in the OLA report such as addressing workforce challenges and evaluation of information available to consumers;
- We can all do better!

Post-Session Action and Emerging Practice(s)

Identified Task Forces/Reports

- OHFC Provider Education
- OHFC Reports/Publications
- Dementia Care Certification
- Assisted Living Licensing
- Assisted Living Report Card Working Group
- Safety and Quality Improvement Technical Panel

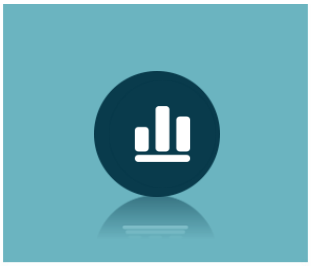
Quality Improvement Focused on Prevention, Transparency and Accountability

- Data Analysis and Reporting—identification of trends and root causes of maltreatment
- Development of Provider Training and Tools
- Framing the discussions for the "next generation" of assisted living

Sampling of Proactive Work

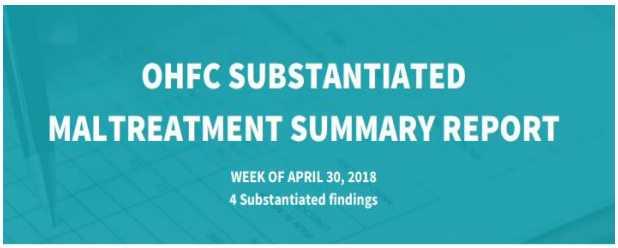
- Ongoing review of OHFC reports;
- Ongoing review of SNF/NF and Home Care Survey results;
- Development of training tools and resources in response to findings;
- Identification of data needs for quality improvement and prevention strategies;
- Quality Council and Workforce Council strategic work such as research projects with U of MN; and
- Regional conversations with our senior housing and home care members.

Why OHFC Data Matters



- Numbers of reports aren't reflective of prevalence of maltreatment but the reports contain valuable information that can be helpful in training, prevention, and improving quality of care—our Quality/Regulatory Council wants data for training and tools:
  - Identification of medication diversion trends—how meds are being diverted and who is most at risk;
  - Identification of equipment malfunction and/or misuse where all providers need to get the information;
  - Identification of clinical training needs;
  - Identification of reporting trends—numbers, correlations, staffing, settings;
  - Development of correlations reports looking at types of settings, staffing, quality metrics, etc.

Care Providers of Minnesota Weekly Updates



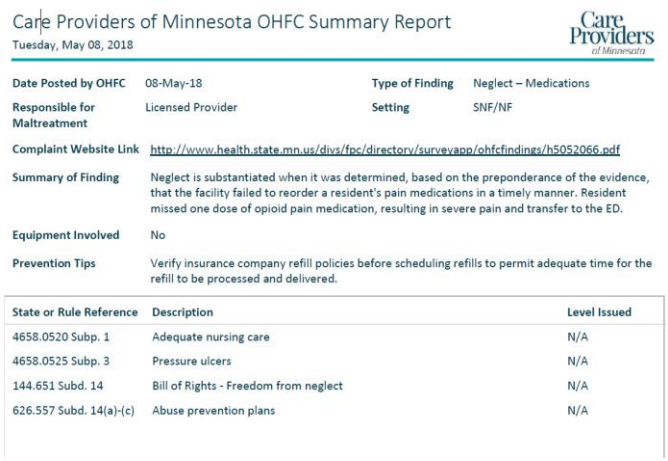
2	Maltreatment findings in Home Care provided in a HWS/ AL setting
2	Maltreatment findings in an SNF/NF setting

1	Maltreatment findings against staff
3	Maltreatment findings against the licensed provider
0	Maltreatment Findings against both staff and the licensed provider

1	Exploitation/Theft (debit card and cash)
3	Neglect (healthcare)
0	Abuse

10	Unsubstantiated findings also posted this week
6	Inconclusive findings also posted this week

Care Providers of Minnesota Weekly Updates-Example



Care Providers of Minnesota OHFC Summary Report
Tuesday, May 08, 2018

Care Providers of Minnesota

Date Posted by OHFC	08-May-18	**Type of Finding**	Neglect – Medications
Responsible for Maltreatment	Licensed Provider	**Setting**	SNF/NF
Complaint Website Link	http://www.health.state.mn.us/divs/fpc/directory/surveyapp/ohfcfindings/h5052066.pdf		
Summary of Finding	Neglect is substantiated when it was determined, based on the preponderance of the evidence, that the facility failed to reorder a resident's pain medications in a timely manner. Resident missed one dose of opioid pain medication, resulting in severe pain and transfer to the ED.		
Equipment Involved	No		
Prevention Tips	Verify insurance company refill policies before scheduling refills to permit adequate time for the refill to be processed and delivered.		

State or Rule Reference	Description	Level Issued
4658.0520 Subp. 1	Adequate nursing care	N/A
4658.0525 Subp. 3	Pressure ulcers	N/A
144.651 Subd. 14	Bill of Rights - Freedom from neglect	N/A
626.557 Subd. 14(a)-(c)	Abuse prevention plans	N/A

Other Prevention Options-Opportunities

Workforce-related Issues

- Delayed responses from state agencies/licensing boards on identified employees with history of medication diversion/theft;
- Lack of law enforcement resources to file charges against thefts by employees—they can move on to the next setting;
- Accountability of unlicensed personnel;
- Training gaps — behavior health, drug diversions, equipment, technologies;
- Analysis of implications of reporting structure on staff recruitment and retention;
- With low unemployment we also need improved training on "red flags"!

Broader Issues

- Mental Health treatment and crisis services availability;
- Access to engaged guardians;
- Expanded utilization of ombudsman services;
- Functional consumer information;
- Accountability for mandated reports and timelines;

Contact Information

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