



Elder Abuse Prevention and Vulnerable Adult Protection in Minnesota - Legislative Updates & Next Steps

Marie Dotseth, Assistant Commissioner
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Overview

- Leading up to the 2019 Session – Where We’ve Been
 - MDH improvements to date – Where we are
- Protecting Vulnerable Adults: Regulatory Reforms & MDH Operational Improvements
- Timeline and Next Steps

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Where we've been

- **2017**
 - Increasing number of reports, backlogs, media attention, Commissioner resignation
 - Governor Dayton Consumer Coalition Report
- **2018**
 - Legislative Session: High level legislation without significant detail, little agreement, disappointment
 - OLA Audit Report
 - Fall, Commissioner convenes informal working groups
 - Licensure Approaches for Assisted Living Facilities
 - Assisted Living Report Card
 - Certification of Dementia Care Units
 - Consumer Rights
 - Electronic Monitoring in Care Facilities
 - Prevention Strategies to Improve Quality and Safety

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Where We've Been

OLA Report detailed failures in OHFC complaint process and diagnosed causes

- Delays in investigations and missed statutory timelines
- Lack of communication to families and providers
- Paper based system
- Staffing, management and morale concerns
- In all, 23 recommendations for OHFC



2017 Backlog

- Triage Backlog of 2300 cases – **CLEARED** on February 28, 2018
- Investigation Backlog of 1800 cases – **CLEARED** on August 8, 2018

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Key Areas of Improvement at MDH

- **Improved workflows and management**

- Standard Investigator Protocol
- Updating and upgrading training for all staff
- Improved ability to determine jurisdiction (MDH, DHS, or County) on the initial screening
- Paperless document management system
- Internal audits and checks

- **Improved communication with complainants and family**

- Timely and empathetic response to frustrated callers.
- Letters from OHFC were updated to be in plain language
- Include direct contact information for OHFC staff

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Key Areas of Improvement at MDH

- **Updated and improved**

- Public Report
- Dashboard

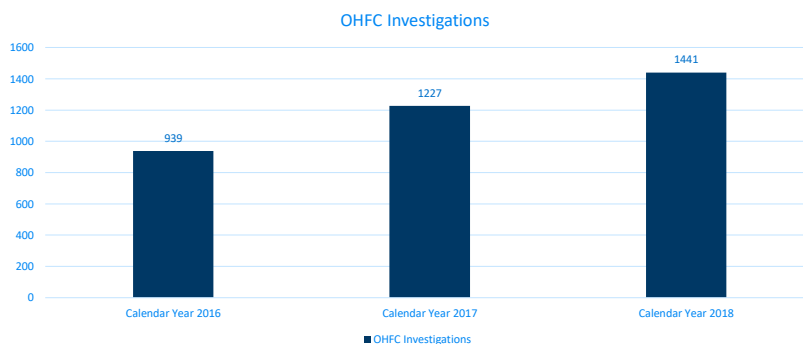
The screenshot displays two web pages from the Minnesota Department of Health (MDH). The top page is the 'Office of Health Facility Complaints Investigative Public Report' form, which includes fields for Report #, Date Concluded, Date of Visit, Name, Address, and County of Facility Investigated, and Name, Address, and County of Housing with Services Registration. The bottom page is the 'Vulnerable Adult Protection Dashboard', which features a navigation menu, a sidebar with links like 'Health Regulation - Facilities and Professions', and a main content area showing a 'NUMBER OF REPORTS RECEIVED FOR THE WEEK OF 12/24/2018' with a value of 345. Below this is a 'WEEKLY REPORT TOTALS' line chart showing data from 09/10 to 12/24.

Date	Reports
09/10	405
09/17	476
09/24	482
10/01	453
10/08	501
10/15	448
10/22	396
10/29	423
11/05	448
11/12	409
11/19	386
11/26	331
12/03	408
12/10	395
12/17	471
12/24	345

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More completed OHFC Investigations



6/7/2019

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Where We've Been

Fall 2018 Informal Working Groups – Built understanding and trust

Sample conclusions from the working groups:

- Assisted living service and housing regulation should be combined into one license
- Consumers should retain the ability to grow and age in place where possible, which includes the ability to bring in added services to their place of residence
- People living with dementia should not be required to live in dementia care settings, however additional certification or licensure for specialized dementia care settings
- Electronic monitoring devices should be permitted, resident rights protected and the process for placing devices should be clarified
- We should better educate consumers about their rights, better enforce those rights, and strengthen rights in key areas
- A report card is needed and should be pursued as part of a multi-pronged effort to encourage and reward quality
- Quality and patient safety information is transparent and easy to understand for residents, families, and providers and is fair/just and promotes accountability across all settings

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Protect Vulnerable Adults—MDH Operational Improvements in 2019 Legislation

- Increase regulatory capacity by fully funding the state match requirement
- Increase capacity for Home Care surveys
- Create a modern, centralized framework for case management
- Improved data analysis, reporting and community engagement



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Protect Vulnerable Adults— Regulatory Reform, Licensure and Other Consumer Protections

- **Licensing Framework:**
 - Assisted Living Facility: A facility providing sleeping accommodations and assisted living services to one or more adults must apply for an assisted living license.
 - Assisted Living Services: consist of basic and comprehensive services from Chapter 144A as well as supportive services.
 - Two Categories of Licensure: The assisted living license is a single, integrated license incorporating both housing and assisted living services.
- **Assisted Living Facility Service Requirements**
 - Additional Requirements for Assisted Living Facilities with Dementia Care License
- **Physical Plant and Life Safety Code Requirements**
- **Resident Rights and Facility Responsibilities**
- **Surveys, Investigations, and Enforcement**

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Additional Consumer Protections

- Retaliation Prohibited
 - Effective August 1, 2019 for HWS and Nursing Homes.
August 1, 2021 for new Assisted Living License
- Termination Protections and Appeal Rights, Effective August 1, 2021
- Electronic Monitoring Effective January 1, 2020
- “I’m Okay” Check Services, Effective August 1, 2021

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Timeline & Next Steps



Next for MDH:

- Begin Rules
- Implement Operational Improvements- Case management, increased survey capacity, data analytics, website
- Work with Ombudsman & Stakeholders on Electronic Monitoring form
- Continue Stakeholder Engagement – informal and formal rules process

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Signed,

Cheryl Hennen
State Ombudsman for
Long-Term Care



Kristine Sundberg, President
Elder Voice Family Advocates



Beth McMullen, Vice President
Alzheimer's Association



Jean Peters RN, CNP, Vice President
Elder Voice Family Advocates



Amanda Vickstrom
Minnesota Elder Justice Center



Gayle Kvenvold
LeadingAge Minnesota



Ron Elwood, Supervising Attorney
Legal Services Advocacy Project



Patti Cullen, President/CEO
Care Providers of Minnesota



Will Phillips, AARP MN
State Director



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Thank you

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