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State of Minnesota
HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 3308

03/05/2018 Authored by Kiel, Nornes, Albright, Backer, Poston and others
The bill was read for the first time and referred to the Committee on Health and Human Services Reform

1.1 A bill for an act
1.2 relating to health; providing protections for older adults and vulnerable adults;
1.3 modifying the health care and home care bills of rights; modifying the regulation
1.4 of home care providers; modifying requirements for reporting maltreatment of
1.5 vulnerable adults; establishing working groups; requiring reports; appropriating
1.6 money; amending Minnesota Statutes 2016, sections 144.651, subdivision 20;
1.7 144A.44, subdivision 1; 144A.473, subdivision 2; 144A.474, subdivision 2;
1.8 144A.53, by adding a subdivision; 626.557, subdivisions 9c, 9e, 12b, 17.

1.9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.10 Section 1. Minnesota Statutes 2016, section 144.651, subdivision 20, is amended to read:

1.11 Subd. 20. **Grievances.** Patients and residents shall be encouraged and assisted, throughout
1.12 their stay in a facility or their course of treatment, to understand and exercise their rights
1.13 as patients, residents, and citizens. Patients and residents may voice grievances ~~and~~,
1.14 recommend changes in policies and services to facility staff and others of their choice, and
1.15 otherwise exercise their rights under this section free from restraint, interference, coercion,
1.16 discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure
1.17 of the facility or program, as well as addresses and telephone numbers for the Office of
1.18 Health Facility Complaints and the area nursing home ombudsman pursuant to the Older
1.19 Americans Act, section 307(a)(12) shall be posted in a conspicuous place.

1.20 Every acute care inpatient facility, every residential program as defined in section
1.21 253C.01, every nonacute care facility, and every facility employing more than two people
1.22 that provides outpatient mental health services shall have a written internal grievance
1.23 procedure that, at a minimum, sets forth the process to be followed; specifies time limits,
1.24 including time limits for facility response; provides for the patient or resident to have the
1.25 assistance of an advocate; requires a written response to written grievances; and provides

2.1 for a timely decision by an impartial decision maker if the grievance is not otherwise resolved.
2.2 Compliance by hospitals, residential programs as defined in section 253C.01 which are
2.3 hospital-based primary treatment programs, and outpatient surgery centers with section
2.4 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed
2.5 to be compliance with the requirement for a written internal grievance procedure.

2.6 Sec. 2. Minnesota Statutes 2016, section 144A.44, subdivision 1, is amended to read:

2.7 Subdivision 1. **Statement of rights.** A person who receives home care services has these
2.8 rights:

2.9 (1) the right to receive written information about rights before receiving services,
2.10 including what to do if rights are violated;

2.11 (2) the right to receive care and services according to a suitable and up-to-date plan, and
2.12 subject to accepted health care, medical or nursing standards, to take an active part in
2.13 developing, modifying, and evaluating the plan and services;

2.14 (3) the right to be told before receiving services the type and disciplines of staff who
2.15 will be providing the services, the frequency of visits proposed to be furnished, other choices
2.16 that are available for addressing home care needs, and the potential consequences of refusing
2.17 these services;

2.18 (4) the right to be told in advance of any recommended changes by the provider in the
2.19 service plan and to take an active part in any decisions about changes to the service plan;

2.20 (5) the right to refuse services or treatment;

2.21 (6) the right to know, before receiving services or during the initial visit, any limits to
2.22 the services available from a home care provider;

2.23 (7) the right to be told before services are initiated what the provider charges for the
2.24 services; to what extent payment may be expected from health insurance, public programs,
2.25 or other sources, if known; and what charges the client may be responsible for paying;

2.26 (8) the right to know that there may be other services available in the community,
2.27 including other home care services and providers, and to know where to find information
2.28 about these services;

2.29 (9) the right to choose freely among available providers and to change providers after
2.30 services have begun, within the limits of health insurance, long-term care insurance, medical
2.31 assistance, or other health programs;

3.1 (10) the right to have personal, financial, and medical information kept private, and to
3.2 be advised of the provider's policies and procedures regarding disclosure of such information;

3.3 (11) the right to access the client's own records and written information from those
3.4 records in accordance with sections 144.291 to 144.298;

3.5 (12) the right to be served by people who are properly trained and competent to perform
3.6 their duties;

3.7 (13) the right to be treated with courtesy and respect, and to have the client's property
3.8 treated with respect;

3.9 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation,
3.10 and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment
3.11 of Minors Act;

3.12 (15) the right to reasonable, advance notice of changes in services or charges;

3.13 (16) the right to know the provider's reason for termination of services;

3.14 (17) the right to at least ten days' advance notice of the termination of a service by a
3.15 provider, except in cases where:

3.16 (i) the client engages in conduct that significantly alters the terms of the service plan
3.17 with the home care provider;

3.18 (ii) the client, person who lives with the client, or others create an abusive or unsafe
3.19 work environment for the person providing home care services; or

3.20 (iii) an emergency or a significant change in the client's condition has resulted in service
3.21 needs that exceed the current service plan and that cannot be safely met by the home care
3.22 provider;

3.23 (18) the right to a coordinated transfer when there will be a change in the provider of
3.24 services;

3.25 (19) the right to complain about services that are provided, or fail to be provided, and
3.26 the lack of courtesy or respect to the client or the client's property;

3.27 (20) the right to recommend changes in policies and services to the home care provider,
3.28 provider staff, and others of the person's choice, free from restraint, interference, coercion,
3.29 discrimination, or reprisal, including threat of termination of services;

4.1 ~~(20)~~ (21) the right to know how to contact an individual associated with the home care
4.2 provider who is responsible for handling problems and to have the home care provider
4.3 investigate and attempt to resolve the grievance or complaint;

4.4 ~~(21)~~ (22) the right to know the name and address of the state or county agency to contact
4.5 for additional information or assistance; and

4.6 ~~(22)~~ (23) the right to assert these rights personally, or have them asserted by the client's
4.7 representative or by anyone on behalf of the client, without retaliation.

4.8 Sec. 3. Minnesota Statutes 2016, section 144A.473, subdivision 2, is amended to read:

4.9 Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner shall
4.10 issue a temporary license for either the basic or comprehensive home care level. A temporary
4.11 license is effective for up to one year from the date of issuance, except that a temporary
4.12 license may be extended according to subdivision 3. Temporary licensees must comply with
4.13 sections 144A.43 to 144A.482.

4.14 (b) During the temporary license ~~year~~ period, the commissioner shall survey the temporary
4.15 licensee within 90 days after the commissioner is notified or has evidence that the temporary
4.16 licensee is providing home care services.

4.17 (c) Within five days of beginning the provision of services, the temporary licensee must
4.18 notify the commissioner that it is serving clients. The notification to the commissioner may
4.19 be mailed or e-mailed to the commissioner at the address provided by the commissioner. If
4.20 the temporary licensee does not provide home care services during the temporary license
4.21 ~~year~~ period, then the temporary license expires at the end of the ~~year~~ period and the applicant
4.22 must reapply for a temporary home care license.

4.23 (d) A temporary licensee may request a change in the level of licensure prior to being
4.24 surveyed and granted a license by notifying the commissioner in writing and providing
4.25 additional documentation or materials required to update or complete the changed temporary
4.26 license application. The applicant must pay the difference between the application fees
4.27 when changing from the basic level to the comprehensive level of licensure. No refund will
4.28 be made if the provider chooses to change the license application to the basic level.

4.29 (e) If the temporary licensee notifies the commissioner that the licensee has clients within
4.30 45 days prior to the temporary license expiration, the commissioner may extend the temporary
4.31 license for up to 60 days in order to allow the commissioner to complete the on-site survey
4.32 required under this section and follow-up survey visits.

5.1 Sec. 4. Minnesota Statutes 2016, section 144A.474, subdivision 2, is amended to read:

5.2 Subd. 2. **Types of home care surveys.** (a) "Initial full survey" means the survey of a
5.3 new temporary licensee conducted after the department is notified or has evidence that the
5.4 temporary licensee is providing home care services to determine if the provider is in
5.5 compliance with home care requirements. Initial full surveys must be completed within 14
5.6 months after the department's issuance of a temporary basic or comprehensive license.

5.7 (b) "Change in ownership survey" means a full survey of a new licensee due to a change
5.8 in ownership. Change in ownership surveys must be completed within six months after the
5.9 department's issuance of a new license due to a change in ownership.

5.10 (c) "Core survey" means periodic inspection of home care providers to determine ongoing
5.11 compliance with the home care requirements, focusing on the essential health and safety
5.12 requirements. Core surveys are available to licensed home care providers who have been
5.13 licensed for three years and surveyed at least once in the past three years with the latest
5.14 survey having no widespread violations beyond Level 1 as provided in subdivision 11.
5.15 Providers must also not have had any substantiated licensing complaints, substantiated
5.16 complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors
5.17 Act, or an enforcement action as authorized in section 144A.475 in the past three years.

5.18 (1) The core survey for basic home care providers must review compliance in the
5.19 following areas:

5.20 (i) reporting of maltreatment;

5.21 (ii) orientation to and implementation of the home care bill of rights;

5.22 (iii) statement of home care services;

5.23 (iv) initial evaluation of clients and initiation of services;

5.24 (v) client review and monitoring;

5.25 (vi) service plan implementation and changes to the service plan;

5.26 (vii) client complaint and investigative process;

5.27 (viii) competency of unlicensed personnel; and

5.28 (ix) infection control.

5.29 (2) For comprehensive home care providers, the core survey must include everything
5.30 in the basic core survey plus these areas:

5.31 (i) delegation to unlicensed personnel;

6.1 (ii) assessment, monitoring, and reassessment of clients; and

6.2 (iii) medication, treatment, and therapy management.

6.3 ~~(c)~~ (d) "Full survey" means the periodic inspection of home care providers to determine
6.4 ongoing compliance with the home care requirements that cover the core survey areas and
6.5 all the legal requirements for home care providers. A full survey is conducted for all
6.6 temporary licensees and for providers who do not meet the requirements needed for a core
6.7 survey, and when a surveyor identifies unacceptable client health or safety risks during a
6.8 core survey. A full survey must include all the tasks identified as part of the core survey
6.9 and any additional review deemed necessary by the department, including additional
6.10 observation, interviewing, or records review of additional clients and staff.

6.11 ~~(d)~~ (e) "Follow-up surveys" means surveys conducted to determine if a home care
6.12 provider has corrected deficient issues and systems identified during a core survey, full
6.13 survey, or complaint investigation. Follow-up surveys may be conducted via phone, e-mail,
6.14 fax, mail, or on-site reviews. Follow-up surveys, other than complaint surveys, shall be
6.15 concluded with an exit conference and written information provided on the process for
6.16 requesting a reconsideration of the survey results.

6.17 ~~(e)~~ (f) Upon receiving information alleging that a home care provider has violated or is
6.18 currently violating a requirement of sections 144A.43 to 144A.482, the commissioner shall
6.19 investigate the complaint according to sections 144A.51 to 144A.54.

6.20 Sec. 5. Minnesota Statutes 2016, section 144A.53, is amended by adding a subdivision to
6.21 read:

6.22 Subd. 5. **Safety and quality improvement technical panel.** The director shall establish
6.23 an expert technical panel to examine and make recommendations, on an ongoing basis, on
6.24 how to apply proven safety and quality improvement practices and infrastructure to settings
6.25 and providers that provide long-term services and supports. The technical panel must include
6.26 representation from nonprofit Minnesota-based organizations dedicated to patient safety or
6.27 innovation in health care safety and quality, Department of Health staff with expertise in
6.28 issues related to adverse health events, the University of Minnesota, organizations
6.29 representing long-term care providers and home care providers in Minnesota, national patient
6.30 safety experts, and other experts in the safety and quality improvement field. The technical
6.31 panel shall periodically provide recommendations to the legislature on legislative changes
6.32 needed to promote safety and quality improvement practices in long-term care settings and
6.33 with long-term care providers.

Sec. 6. Minnesota Statutes 2016, section 626.557, subdivision 9c, is amended to read:

Subd. 9c. **Lead investigative agency; notifications, dispositions, determinations.** (a) ~~Upon request of the reporter,~~ The lead investigative agency shall notify the reporter that it has received the report, and provide information on the initial disposition of the report within five business days of receipt of the report, provided that the notification will not endanger the vulnerable adult or hamper the investigation.

(b) Upon conclusion of every investigation it conducts, the lead investigative agency shall make a final disposition as defined in section 626.5572, subdivision 8.

(c) When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead investigative agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

(d) When substantiated maltreatment is determined to have been committed by an individual who is also the facility license holder, both the individual and the facility must be determined responsible for the maltreatment, and both the background study disqualification standards under section 245C.15, subdivision 4, and the licensing actions under section 245A.06 or 245A.07 apply.

(e) The lead investigative agency shall complete its final disposition within 60 calendar days. If the lead investigative agency is unable to complete its final disposition within 60

calendar days, the lead investigative agency shall notify the following persons provided that the notification will not endanger the vulnerable adult or hamper the investigation: (1) the vulnerable adult or the vulnerable adult's guardian or health care agent, when known, if the lead investigative agency knows them to be aware of the investigation; ~~and~~ (2) the facility, where applicable; and (3) the reporter. The notice shall contain the reason for the delay and the projected completion date. If the lead investigative agency is unable to complete its final disposition by a subsequent projected completion date, the lead investigative agency shall again notify the vulnerable adult or the vulnerable adult's guardian or health care agent, when known if the lead investigative agency knows them to be aware of the investigation~~, and~~; the facility, where applicable; and the reporter, of the reason for the delay and the revised projected completion date provided that the notification will not endanger the vulnerable adult or hamper the investigation. The lead investigative agency must notify the health care agent of the vulnerable adult only if the health care agent's authority to make health care decisions for the vulnerable adult is currently effective under section 145C.06 and not suspended under section 524.5-310 and the investigation relates to a duty assigned to the health care agent by the principal. A lead investigative agency's inability to complete the final disposition within 60 calendar days or by any projected completion date does not invalidate the final disposition.

(f) Within ten calendar days of completing the final disposition, the lead investigative agency shall provide a copy of the public investigation memorandum under subdivision 12b, paragraph (b), clause (1), when required to be completed under this section, to the following persons: (1) the vulnerable adult, or the vulnerable adult's guardian or health care agent, if known, unless the lead investigative agency knows that the notification would endanger the well-being of the vulnerable adult; (2) the reporter, ~~if the reporter requested notification when making the report,~~ provided this notification would not endanger the well-being of the vulnerable adult; (3) the alleged perpetrator, if known; (4) the facility; and (5) the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities, as appropriate.

(g) If, as a result of a reconsideration, review, or hearing, the lead investigative agency changes the final disposition, or if a final disposition is changed on appeal, the lead investigative agency shall notify the parties specified in paragraph (f).

(h) The lead investigative agency shall notify the vulnerable adult who is the subject of the report or the vulnerable adult's guardian or health care agent, if known, and any person or facility determined to have maltreated a vulnerable adult, of their appeal or review rights under this section or section 256.021.

9.1 (i) The lead investigative agency shall routinely provide investigation memoranda for
9.2 substantiated reports to the appropriate licensing boards. These reports must include the
9.3 names of substantiated perpetrators. The lead investigative agency may not provide
9.4 investigative memoranda for inconclusive or false reports to the appropriate licensing boards
9.5 unless the lead investigative agency's investigation gives reason to believe that there may
9.6 have been a violation of the applicable professional practice laws. If the investigation
9.7 memorandum is provided to a licensing board, the subject of the investigation memorandum
9.8 shall be notified and receive a summary of the investigative findings.

9.9 (j) In order to avoid duplication, licensing boards shall consider the findings of the lead
9.10 investigative agency in their investigations if they choose to investigate. This does not
9.11 preclude licensing boards from considering other information.

9.12 (k) The lead investigative agency must provide to the commissioner of human services
9.13 its final dispositions, including the names of all substantiated perpetrators. The commissioner
9.14 of human services shall establish records to retain the names of substantiated perpetrators.

9.15 Sec. 7. Minnesota Statutes 2016, section 626.557, subdivision 9e, is amended to read:

9.16 Subd. 9e. **Education requirements.** (a) The commissioners of health, human services,
9.17 and public safety shall cooperate in the development of a joint program for education of
9.18 lead investigative agency investigators in the appropriate techniques for investigation of
9.19 complaints of maltreatment. This program must be developed by July 1, 1996. The program
9.20 must include but need not be limited to the following areas: (1) information collection and
9.21 preservation; (2) analysis of facts; (3) levels of evidence; (4) conclusions based on evidence;
9.22 (5) interviewing skills, including specialized training to interview people with unique needs;
9.23 (6) report writing; (7) coordination and referral to other necessary agencies such as law
9.24 enforcement and judicial agencies; (8) human relations and cultural diversity; (9) the
9.25 dynamics of adult abuse and neglect within family systems and the appropriate methods
9.26 for interviewing relatives in the course of the assessment or investigation; (10) the protective
9.27 social services that are available to protect alleged victims from further abuse, neglect, or
9.28 financial exploitation; (11) the methods by which lead investigative agency investigators
9.29 and law enforcement workers cooperate in conducting assessments and investigations in
9.30 order to avoid duplication of efforts; and (12) data practices laws and procedures, including
9.31 provisions for sharing data.

9.32 (b) The commissioner of human services shall conduct an outreach campaign to promote
9.33 the common entry point for reporting vulnerable adult maltreatment. This campaign shall
9.34 use the Internet and other means of communication.

10.1 (c) The commissioners of health, human services, and public safety shall offer at least
10.2 annual education to others on the requirements of this section, on how this section is
10.3 implemented, and investigation techniques.

10.4 (d) The commissioner of human services, in coordination with the commissioner of
10.5 public safety shall provide training for the common entry point staff as required in this
10.6 subdivision and the program courses described in this subdivision, at least four times per
10.7 year. At a minimum, the training shall be held twice annually in the seven-county
10.8 metropolitan area and twice annually outside the seven-county metropolitan area. The
10.9 commissioners shall give priority in the program areas cited in paragraph (a) to persons
10.10 currently performing assessments and investigations pursuant to this section.

10.11 (e) The commissioner of public safety shall notify in writing law enforcement personnel
10.12 of any new requirements under this section. The commissioner of public safety shall conduct
10.13 regional training for law enforcement personnel regarding their responsibility under this
10.14 section.

10.15 (f) Each lead investigative agency investigator must complete the education program
10.16 specified by this subdivision within the first 12 months of work as a lead investigative
10.17 agency investigator.

10.18 A lead investigative agency investigator employed when these requirements take effect
10.19 must complete the program within the first year after training is available or as soon as
10.20 training is available.

10.21 All lead investigative agency investigators having responsibility for investigation duties
10.22 under this section must receive a minimum of eight hours of continuing education or
10.23 in-service training each year specific to their duties under this section.

10.24 (g) The commissioners of health and human services shall develop and maintain written
10.25 guidance materials for facilities that explain and illustrate the reporting requirements under
10.26 this section, and the reporting requirements under Code of Federal Regulations, title 42,
10.27 section 483.12(c) for facilities subject to those requirements.

10.28 Sec. 8. Minnesota Statutes 2016, section 626.557, subdivision 12b, is amended to read:

10.29 Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a
10.30 lead investigative agency, the county social service agency shall maintain appropriate
10.31 records. Data collected by the county social service agency under this section are welfare
10.32 data under section 13.46. Notwithstanding section 13.46, subdivision 1, paragraph (a), data
10.33 under this paragraph that are inactive investigative data on an individual who is a vendor

11.1 of services are private data on individuals, as defined in section 13.02. The identity of the
11.2 reporter may only be disclosed as provided in paragraph (c).

11.3 Data maintained by the common entry point are confidential data on individuals or
11.4 protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the
11.5 common entry point shall maintain data for three calendar years after date of receipt and
11.6 then destroy the data unless otherwise directed by federal requirements.

11.7 (b) The commissioners of health and human services shall prepare an investigation
11.8 memorandum for each report alleging maltreatment investigated under this section. County
11.9 social service agencies must maintain private data on individuals but are not required to
11.10 prepare an investigation memorandum. During an investigation by the commissioner of
11.11 health or the commissioner of human services, data collected under this section are
11.12 confidential data on individuals or protected nonpublic data as defined in section 13.02.
11.13 Upon completion of the investigation, the data are classified as provided in clauses (1) to
11.14 (3) and paragraph (c).

11.15 (1) The investigation memorandum must contain the following data, which are public:

11.16 (i) the name of the facility investigated;

11.17 (ii) a statement of the nature of the alleged maltreatment;

11.18 (iii) pertinent information obtained from medical or other records reviewed;

11.19 (iv) the identity of the investigator;

11.20 (v) a summary of the investigation's findings;

11.21 (vi) statement of whether the report was found to be substantiated, inconclusive, false,
11.22 or that no determination will be made;

11.23 (vii) a statement of any action taken by the facility;

11.24 (viii) a statement of any action taken by the lead investigative agency; and

11.25 (ix) when a lead investigative agency's determination has substantiated maltreatment, a
11.26 statement of whether an individual, individuals, or a facility were responsible for the
11.27 substantiated maltreatment, if known.

11.28 The investigation memorandum must be written in a manner which protects the identity
11.29 of the reporter and of the vulnerable adult and may not contain the names or, to the extent
11.30 possible, data on individuals or private data listed in clause (2).

12.1 (2) Data on individuals collected and maintained in the investigation memorandum are
12.2 private data, including:

12.3 (i) the name of the vulnerable adult;

12.4 (ii) the identity of the individual alleged to be the perpetrator;

12.5 (iii) the identity of the individual substantiated as the perpetrator; and

12.6 (iv) the identity of all individuals interviewed as part of the investigation.

12.7 (3) Other data on individuals maintained as part of an investigation under this section
12.8 are private data on individuals upon completion of the investigation.

12.9 (c) After the assessment or investigation is completed, the name of the reporter must be
12.10 confidential. The subject of the report may compel disclosure of the name of the reporter
12.11 only with the consent of the reporter or upon a written finding by a court that the report was
12.12 false and there is evidence that the report was made in bad faith. This subdivision does not
12.13 alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except
12.14 that where the identity of the reporter is relevant to a criminal prosecution, the district court
12.15 shall do an in-camera review prior to determining whether to order disclosure of the identity
12.16 of the reporter.

12.17 (d) Notwithstanding section 138.163, data maintained under this section by the
12.18 commissioners of health and human services must be maintained under the following
12.19 schedule and then destroyed unless otherwise directed by federal requirements:

12.20 (1) data from reports determined to be false, maintained for three years after the finding
12.21 was made;

12.22 (2) data from reports determined to be inconclusive, maintained for four years after the
12.23 finding was made;

12.24 (3) data from reports determined to be substantiated, maintained for seven years after
12.25 the finding was made; and

12.26 (4) data from reports which were not investigated by a lead investigative agency and for
12.27 which there is no final disposition, maintained for three years from the date of the report.

12.28 (e) The commissioners of health and human services shall annually publish on their Web
12.29 sites the number and type of reports of alleged maltreatment involving licensed facilities
12.30 reported under this section, the number of those requiring investigation under this section,
12.31 and the resolution of those investigations. On a biennial basis, the commissioners of health

and human services shall jointly report the following information to the legislature and the governor:

(1) the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigations under this section, the resolution of those investigations, and which of the two lead agencies was responsible;

(2) trends about types of substantiated maltreatment found in the reporting period;

(3) ~~if there are upward trends for types of maltreatment substantiated,~~ recommendations for preventing, addressing, and responding to ~~them~~ substantiated maltreatment;

(4) efforts undertaken or recommended to improve the protection of vulnerable adults;

(5) whether and where backlogs of cases result in a failure to conform with statutory time frames and recommendations for reducing backlogs if applicable;

(6) recommended changes to statutes affecting the protection of vulnerable adults; and

(7) any other information that is relevant to the report trends and findings.

(f) Each lead investigative agency must have a record retention policy.

(g) Lead investigative agencies, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, if the agency or authority requesting the data determines that the data are pertinent and necessary to the requesting agency in initiating, furthering, or completing an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. The lead investigative agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Notwithstanding section 138.17, upon completion of the review, not public data received by the review panel must be destroyed.

(h) Each lead investigative agency shall keep records of the length of time it takes to complete its investigations.

(i) A lead investigative agency may notify other affected parties and their authorized representative if the lead investigative agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

14.1 (j) Under any notification provision of this section, where federal law specifically
14.2 prohibits the disclosure of patient identifying information, a lead investigative agency may
14.3 not provide any notice unless the vulnerable adult has consented to disclosure in a manner
14.4 which conforms to federal requirements.

14.5 Sec. 9. Minnesota Statutes 2016, section 626.557, subdivision 17, is amended to read:

14.6 Subd. 17. **Retaliation prohibited.** (a) A facility or person shall not retaliate against any
14.7 person who reports in good faith suspected maltreatment pursuant to this section, or against
14.8 a vulnerable adult with respect to whom a report is made, because of the report.

14.9 (b) In addition to any remedies allowed under sections 181.931 to 181.935, any facility
14.10 or person which retaliates against any person because of a report of suspected maltreatment
14.11 is liable to that person for actual damages, punitive damages up to $10,000, and attorney
14.12 fees.

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

14.18 (1) discharge or transfer from the facility;

14.19 (2) discharge from or termination of employment;

14.20 (3) demotion or reduction in remuneration for services;

14.21 (4) restriction or prohibition of access to the facility or its residents; or

14.22 (5) any restriction of rights set forth in section 144.651, 144A.44, or 144A.441.

14.23 Sec. 10. **REPORT; SAFETY AND QUALITY IMPROVEMENT PRACTICES.**

14.24 By January 15, 2019, the safety and quality improvement technical panel established
14.25 under Minnesota Statutes, section 144A.53, subdivision 5, shall provide recommendations
14.26 to the legislature on legislative changes needed to promote safety and quality improvement
14.27 practices in long-term care settings and with long-term care providers. The recommendations
14.28 must address:

14.29 (1) how to implement a system for adverse health events reporting, learning, and
14.30 prevention in long-term care settings and with long-term care providers; and

15.1 (2) interim actions to improve systems for the timely analysis of reports and complaints
15.2 submitted to the Office of Health Facility Complaints to identify common themes and key
15.3 prevention opportunities, and to disseminate key findings to providers across the state for
15.4 the purposes of shared learning and prevention.

15.5 Sec. 11. **ASSISTED LIVING AND DEMENTIA CARE LICENSING WORKING**
15.6 **GROUP.**

15.7 Subdivision 1. **Establishment; membership.** (a) An assisted living and dementia care
15.8 licensing working group is established.

15.9 (b) The commissioner of health shall appoint the following members of the working
15.10 group:

15.11 (1) four providers from the senior housing with services profession;

15.12 (2) two persons who reside in senior housing with services establishments, or family
15.13 members of persons who reside in senior housing with services establishments;

15.14 (3) one representative from the Home Care and Assisted Living Advisory Council;

15.15 (4) one representative of a health plan company;

15.16 (5) one representative from Care Providers of Minnesota;

15.17 (6) one representative from LeadingAge Minnesota;

15.18 (7) one representative from the Alzheimer's Association;

15.19 (8) one representative from the area agencies on aging;

15.20 (9) one federal compliance official; and

15.21 (10) one representative from the Minnesota Home Care Association.

15.22 (c) The following individuals shall also be members of the working group:

15.23 (1) the commissioner of health or a designee;

15.24 (2) the commissioner of human services or a designee;

15.25 (3) the ombudsman for long-term care or a designee; and

15.26 (4) one member of the Minnesota Board of Aging, selected by the board.

15.27 (d) The appointing authorities under this subdivision must complete their appointments
15.28 no later than July 1, 2018.

16.1 Subd. 2. **Duties; recommendations.** The assisted living and dementia care licensing
16.2 working group shall consider and make recommendations on a new regulatory framework
16.3 for assisted living and dementia care. In developing the licensing framework, the working
16.4 group must address at least the following:

16.5 (1) the appropriate level of regulation, including licensure, registration, or certification;

16.6 (2) coordination of care;

16.7 (3) the scope of care to be provided, and limits on acuity levels of residents;

16.8 (4) consumer rights;

16.9 (5) staff training and qualifications;

16.10 (6) options for the engagement of seniors and their families;

16.11 (7) notices and financial requirements; and

16.12 (8) compliance with federal Medicaid waiver requirements for home and
16.13 community-based services settings.

16.14 Subd. 3. **Meetings.** The commissioner of health or a designee shall convene the first
16.15 meeting of the working group no later than August 1, 2018. The members of the working
16.16 group shall elect a chair from among the group's members at the first meeting, and the
16.17 commissioner of health or a designee shall serve as the working group's chair until a chair
16.18 is elected. Meetings of the working group shall be open to the public.

16.19 Subd. 4. **Compensation.** Members of the working group shall serve without compensation
16.20 or reimbursement for expenses.

16.21 Subd. 5. **Administrative support.** The commissioner of health shall provide
16.22 administrative support for the working group and arrange meeting space.

16.23 Subd. 6. **Report.** By January 15, 2019, the working group must submit a report with
16.24 findings, recommendations, and draft legislation to the chairs and ranking minority members
16.25 of the legislative committees with jurisdiction over health and human services policy and
16.26 finance.

16.27 Subd. 7. **Expiration.** The working group expires January 16, 2019, or the day after the
16.28 working group submits the report required under subdivision 6, whichever is earlier.

16.29 **EFFECTIVE DATE.** This section is effective the day following final enactment.

17.1 Sec. 12. **DEMENTIA CARE CERTIFICATION WORKING GROUP.**

17.2 Subdivision 1. **Establishment; membership.** (a) A dementia care certification working
17.3 group is established.

17.4 (b) The commissioner of health shall appoint the following members of the working
17.5 group:

17.6 (1) one caregiver of a person who has been diagnosed with Alzheimer's disease or other
17.7 dementia;

17.8 (2) two providers from the senior housing with services profession;

17.9 (3) two geriatricians, one of whom serves a diverse or underserved community;

17.10 (4) one psychologist who specializes in dementia care;

17.11 (5) one representative of the Alzheimer's Association;

17.12 (6) one representative from Care Providers of Minnesota;

17.13 (7) one representative from LeadingAge Minnesota; and

17.14 (8) one representative from the Minnesota Home Care Association.

17.15 (c) The following individuals shall also be members of the working group:

17.16 (1) the commissioner of health or a designee;

17.17 (2) the commissioner of human services or a designee;

17.18 (3) the ombudsman for long-term care or a designee;

17.19 (4) one member of the Minnesota Board on Aging, selected by the board; and

17.20 (5) the executive director of the Minnesota Board on Aging, who shall serve as a
17.21 nonvoting member of the working group.

17.22 (d) The appointing authorities under this subdivision must complete their appointments
17.23 no later than July 1, 2018.

17.24 Subd. 2. **Duties; recommendations.** The dementia care certification working group
17.25 shall consider and make recommendations regarding the certification of providers offering
17.26 dementia care services to clients diagnosed with Alzheimer's disease or other dementias.
17.27 The working group must:

17.28 (1) develop standards in the following areas that nursing homes, boarding care homes,
17.29 and housing with services establishments that offer care for clients diagnosed with
17.30 Alzheimer's disease or other dementias must meet in order to obtain dementia care

18.1 certification: staffing, egress control, access to secured outdoor spaces, specialized therapeutic
18.2 activities, and specialized life enrichment programming;

18.3 (2) develop requirements for disclosing dementia care certification standards to
18.4 consumers; and

18.5 (3) develop mechanisms for enforcing dementia care certification standards.

18.6 Subd. 3. **Meetings.** The commissioner of health or a designee shall convene the first
18.7 meeting of the working group no later than August 1, 2018. The members of the working
18.8 group shall elect a chair from among the group's members at the first meeting, and the
18.9 commissioner of health or a designee shall serve as the working group's chair until a chair
18.10 is elected. Meetings of the working group shall be open to the public.

18.11 Subd. 4. **Compensation.** Members of the working group shall serve without compensation
18.12 or reimbursement for expenses.

18.13 Subd. 5. **Administrative support.** The commissioner of health shall provide
18.14 administrative support for the working group and arrange meeting space.

18.15 Subd. 6. **Report.** By January 15, 2019, the working group must submit a report with
18.16 findings, recommendations, and draft legislation to the chairs and ranking minority members
18.17 of the legislative committees with jurisdiction over health and human services policy and
18.18 finance.

18.19 Subd. 7. **Expiration.** The working group expires January 16, 2019, or the day after the
18.20 working group submits the report required under subdivision 6, whichever is earlier.

18.21 **EFFECTIVE DATE.** This section is effective the day following final enactment.

18.22 Sec. 13. **ASSISTED LIVING REPORT CARD WORKING GROUP.**

18.23 Subdivision 1. **Establishment; membership.** (a) An assisted living report card working
18.24 group, tasked with researching and making recommendations on the development of an
18.25 assisted living report card, is established.

18.26 (b) The commissioner of human services shall appoint the following members of the
18.27 working group:

18.28 (1) two persons who reside in senior housing with services establishments;

18.29 (2) four representatives of the senior housing with services profession;

18.30 (3) two family members of persons who reside in senior housing with services
18.31 establishments;

19.1 (4) a representative from the Home Care and Assisted Living Advisory Council;

19.2 (5) a representative from the University of Minnesota with expertise in data and analytics;

19.3 (6) a representative from Care Providers of Minnesota; and

19.4 (7) a representative from LeadingAge Minnesota.

19.5 (c) The following individuals shall also be appointed to the working group:

19.6 (1) the commissioner of human services or a designee;

19.7 (2) the commissioner of health or a designee;

19.8 (3) the ombudsman for long-term care or a designee;

19.9 (4) one member of the Minnesota Board on Aging, selected by the board; and

19.10 (5) the executive director of the Minnesota Board on Aging who shall serve on the
19.11 working group as a nonvoting member.

19.12 (d) The appointing authorities under this subdivision must complete their appointments
19.13 no later than July 1, 2018.

19.14 Subd. 2. **Duties.** The assisted living report card working group shall consider and make
19.15 recommendations on the development of an assisted living report card. The quality metrics
19.16 considered shall include, but are not limited to:

19.17 (1) an annual customer satisfaction survey measure using the CoreQ questions for assisted
19.18 living residents and family members;

19.19 (2) a measure utilizing level 3 or 4 citations from Department of Health home care survey
19.20 findings and substantiated Office of Health Facility Complaints findings against a home
19.21 care provider;

19.22 (3) a home care staff retention measure; and

19.23 (4) a measure that scores a provider's staff according to their level of training and
19.24 education.

19.25 Subd. 3. **Meetings.** The commissioner of human services or a designee shall convene
19.26 the first meeting of the working group no later than August 1, 2018. The members of the
19.27 working group shall elect a chair from among the group's members at the first meeting, and
19.28 the commissioner of human services or a designee shall serve as the working group's chair
19.29 until a chair is elected. Meetings of the working group shall be open to the public.

20.1 Subd. 4. **Compensation.** Members of the working group shall serve without compensation
20.2 or reimbursement for expenses.

20.3 Subd. 5. **Administrative support.** The commissioner of human services shall provide
20.4 administrative support for the working group and arrange meeting space.

20.5 Subd. 6. **Report.** By January 15, 2019, the working group must submit a report with
20.6 findings, recommendations, and draft legislation to the chairs and ranking minority members
20.7 of the legislative committees with jurisdiction over health and human services policy and
20.8 finance.

20.9 Subd. 7. **Expiration.** The working group expires January 16, 2019, or the day after the
20.10 working group submits the report required in subdivision 6, whichever is earlier.

20.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

20.12 Sec. 14. **APPROPRIATIONS.**

20.13 (a) $....... in fiscal year 2019 is appropriated from the general fund to the commissioner
20.14 of health for purposes of the dementia care certification working group and the assisted
20.15 living and dementia care licensing working group.

20.16 (b) $....... in fiscal year 2019 is appropriated from the general fund to the commissioner
20.17 of human services for purposes of the assisted living report card working group.