

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-fourth Legislature - First Regular Session

HOUSE AD HOC COMMITTEE ON ABUSE AND NEGLECT OF VULNERABLE
ADULTS

Report of Interim Meeting
Tuesday, November 12, 2019
House Hearing Room 1 -- 1:30 P.M.

MINUTES RECEIVED
CHIEF CLERK'S OFFICE

11-14-19

Convened 01:31 P.M.

Recessed

Reconvened

Adjourned 03:21 P.M.

Members Present

Representative Longdon, Chairman
Representative Dunn, Vice-Chairman
Dr. Christ
Ms. Kennedy
Ms. Knupp
Ms. McFadden
Ms. Ortiz
Ms. Reed
Mr. Rico
Ms. Snyder
Mr. Trailor

Members Absent

Ms. Collins
Ms. Kader

Agenda

Original Agenda – Attachment 1

Request to Speak

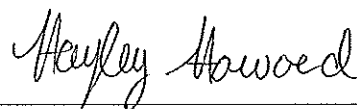
Report – Attachment 2

Committee Attendance

Report – Attachment 3

Review and Discussion

<u>Name</u>	<u>Organization</u>	<u>Attachments (Handouts)</u>
Jennifer Longdon	House of Representatives	4



Hayley Howard, Committee Secretary
November 14, 2019

(Original attachments on file in the Office of the Chief Clerk; video archives available at <http://www.azleg.gov>)

Interim agendas can be obtained via the Internet at <http://www.azleg.gov/Interim-Committees>

ARIZONA STATE SENATE

INTERIM MEETING NOTICE OPEN TO THE PUBLIC

HOUSE AD HOC COMMITTEE ON ABUSE AND NEGLECT OF VULNERABLE ADULTS

Date: Tuesday, November 12, 2019

Time: 1:30 P.M.

Place: HHR 1

AGENDA

1. Call to Order
2. Review and Discussion of Potential Committee Recommendations
3. Public Testimony
4. Adjourn

Members:

Representative Jennifer Longdon, Chair
 Representative Timothy M. Dunn, Vice Chair
 Colby Bowers – designee for Dr. Cara Christ
 Sherri Collins
 Sarah Kader
 Dana Kennedy
 Cheryl Knupp

Erica McFadden
 Elizabeth Ortiz
 April Reed
 Jose de Jesus V Rico
 Jami Snyder
 Molly McCarthy

* The committee may go into an executive session to receive testimony or documents pursuant to House Rules.

11/07/19
JY

People with disabilities may request reasonable accommodations such as interpreters, alternative formats, or assistance with physical accessibility. If you require accommodations, please contact the Chief Clerk's Office at (602) 926-3032 or through Arizona Relay Service 7-1-1.

Information Registered on the Request to Speak System

House Ad Hoc Committee on Abuse and Neglect of Vulnerable Adults (11/12/2019)

3, Public Testimony

Support:

Betty McEntire, AZ Commission For The Deaf And Hard Of Hearing; Sienna Hart, representing self; Karen Dana, representing self; Tonia Rokeby, representing self

All Comments:

Tonia Rokeby, Self: requested for co-worker that will do a manual request upon arrival.

PLEASE COMPLETE THIS FORM FOR THE PUBLIC RECORD



HOUSE OF REPRESENTATIVES

Please PRINT Clearly

Committee on Ad Hoc Committee on Abuse & Neglect of Vulnerable Adults Bill Number _____

Date 11/12/19 Support Oppose Neutral

Name Laura Hartgroves Need to Speak? Yes No

Representing _____ Are you a registered lobbyist? no

Complete Address 9

E-mail Address laura.hartgroves@steward.org Phone Number 928-310-4346

Comments: _____

FIVE-MINUTE SPEAKING LIMIT

PLEASE COMPLETE THIS FORM FOR THE PUBLIC RECORD



HOUSE OF REPRESENTATIVES

Please PRINT Clearly

Committee on House Ad Hoc Committee on Abuse & Neglect of Vulnerable Adults Bill Number _____

Date 11/12 Support Oppose Neutral

Name Christine Scianna Need to Speak? Yes No

Representing Self Are you a registered lobbyist? _____

Complete Address 5928 W. Coster Ln Surprise, AZ 85379

E-mail Address cmwebster3153@gmail.com Phone Number _____

Comments: Daughter has autism, she was abused in a group home.

FIVE-MINUTE SPEAKING LIMIT

ARIZONA STATE LEGISLATURE
Fifty-fourth Legislature - First Regular Session

COMMITTEE ATTENDANCE RECORD

HOUSE AD HOC STUDY COMMITTEE ON ABUSE AND NEGLECT OF
VULNERABLE ADULTS

CHAIRMAN: Jennifer Longdon VICE-CHAIRMAN: Timothy M. Dunn

DATE	11/12/19	/19	/19	/19	/19
CONVENED	1:30 pm	m	m	m	m
RECESSED					
RECONVENED					
ADJOURNED	3:21 pm				
MEMBERS					
Colby Bower- Designee for Dr. Cara Christ	✓				
Sherri Collins					
Sarah Kader					
Dana Kennedy	✓				
Cheryl Knupp	✓				
Erica McFadden	✓				
Elizabeth Ortiz	✓				
April Reed	✓				
Jose de Jesus V Rico	✓				
Jami Snyder	✓				
Molly McCarthy- Designee for DES	✓				
Dunn, Vice-Chairman	✓				
Longdon, Chairman	✓				

✓ Present --- Absent exc Excused

Recommendations and Notes from Ad Hoc Committee Members

April Reed- Ability360

Below are some of my thoughts and recommendations from the AD Hoc Committee meetings:

- Require trauma-informed training for providers, consumers, and families to ensure that all know how to recognize the signs of abuse and neglect.
 - After an investigation, develop policies and procedures that ensure appropriate trauma counseling referrals are made for the vulnerable adult.
- Adult Protective Services intake does not ask about disability or health conditions and thus does not inquire about accommodations needed to participate in the intake.
- Education to providers on the ADA requirements to provide accommodations to people with disabilities.
 - Address through training the attitudinal barriers that exist on providing the accommodations. Specifically, address intake procedures that have prevented the Deaf community from receiving sign language interpreters.
- Caregiver Workforce shortage and challenges in recruiting qualified caregivers.
 - Address funding to increase caregiver pay
- Group Homes
 - Creation of entity who will have the responsibility to monitor and visit group homes. Entity will also have the ability to receive, investigate, and intervene on resident complaints or incidents of abuse or neglect similar to the authority the AAA Ombudsmen program has in SNFs and Assisted Living Centers.
 - *Searchable records* available to the public who are looking for group homes monitoring records or ADHS site visits records. Right now families and advocates struggle to find group home records on monitoring reports and thus struggle to make an educated decision on the quality of a group home services.

Elizabeth Ortiz- APAAC

Below please see my recommendation for a number of changes at several stages:

1. New staff for residential facilities
 - a. What is the proper ratio of staff to residents
 - b. What is the fair market rate of pay and how do we get the funding to pay it
 - c. What security measures are being taken to screen applicants
 - i. Fingerprint clearance – additional funding is required to continue to address the issues surrounding incomplete/missing criminal history information
 - d. What initial training is needed
 - i. Who does the training
 - ii. Who pays for it
2. Incoming residents
 - a. Assessment of needs & proper placement
 - b. Information to resident and their family regarding rights and how to file complaint/appeal
3. Residential facilities
 - a. Centralization of responsibility to monitor/audit facility
 - b. Expanded ongoing training for staff
 - c. Continued security assessment of staff (e.g. create ongoing reporting notice if staff gets criminal conviction after being hired)
 - d. Creation of documentation and security processes that will assist in oversight and also assist law enforcement if necessary

4. Group homes
 - a. Create system for oversight
5. Law Enforcement
 - a. Expansion of investigative/interviewing techniques when interacting with vulnerable adults
 - b. Develop communication protocols between law enforcement and APS
6. APS
 - a. Determine staffing levels necessary to meet needs
 - b. What is fair market rate of pay and how do get the funding
 - c. Expanding Initial and ongoing training for staff
 - d. Increasing the accessibility of APS (e.g. expanding hot line hours)

Dana Kennedy- AARP of AZ

- Detecting and preventing elder abuse requires increasing awareness. The general public, and health professionals all must be made aware of the signs of abuse. In-home services, such as Meals on Wheels or home health care, play significant roles in preventing and addressing abuse of frail older adults. A broad range of protective services are needed to help prevent and stop abuse, ranging from simple assistance with household chores to outright guardianship. Other examples include community-based programs that provide services such as counseling, information and referrals, and personal money management.
- Enhancing legal protections against elder abuse could help prevent it. It would also allow victims to seek restitution. State laws typically offer victims a range of remedial services. Statutes also impose criminal penalties for various forms of elder abuse.

Explore Mandatory Reporting Statute to:

- Impose Civil Penalty on the *individual* failing to report, (See, interesting rationale for going the civil route at <http://publish.illinois.edu/elderlawjournal/files/2017/07/Bernal.pdf>) *OR*
- Impose stricter criminal penalty (as in NY/felony)

Impose Civil Penalty on *the institution* with a number of potentially escalating remedies which could include:

- (a) Revoke the facility's license and/or contract with the state to provide services;
 - (b) Deny payment;
 - (c) Assess and collect a civil monetary penalty with interest from the facility owner and/or facility administrator;
 - (d) Appoint temporary management;
 - (e) Close the facility and/or transfer residents to another certified facility;
 - (f) Direct a plan of correction;
 - (g) Assign monitors to the facility; or
 - (h) Reduce the licensed bed capacity.
- Require facilities to train all staff and contractors with potential for resident access and test on mandatory reporting. Mandate continuing education on same.
 - Strengthen Criminal Background Checks to ensure coverage of all employees and contractors with direct access; Create a system to automatically alert facilities of new arrests (or even convictions) at the state and federal level.
 - Strengthen penalties for facilities that fail to follow statutory or regulatory guidelines. Ensure that remedies are swiftly and consistently imposed.
 - Pass Virtual Visitation Legislation requiring nursing homes to inform residents and their families of their right to utilize technology in their rooms to monitor their care and facilitate communication with family members. This was just recently passed in Louisiana.

- Facilitate family involvement in nursing home care planning. Strengthen Criminal Background Checks to ensure coverage of all employees and contractors with direct access; Create a system to automatically alert facilities of new arrests (or even convictions) at the state and federal level.
- Strengthen penalties for facilities that fail to follow statutory or regulatory guidelines. Ensure that remedies are swiftly and consistently imposed.
- Pass Virtual Visitation Legislation requiring nursing homes to inform residents and their families of their right to utilize technology in their rooms to monitor their care and facilitate communication with family members. This was just recently passed in Louisiana.
- Facilitate family involvement in nursing home care planning.
- Strengthen nursing home family council requirements. Ensure that groups of family members can organize a group and meet without nursing home staff, to discuss concerns and make recommendations to the nursing facility for action.
- Fully fund agencies responsible for investigating abuse and neglect and ensure that they have the capacity to respond appropriately and follow-up.
- Implement and fund strong and *independent* LTSS ombudsman programs that go beyond federal requirements and include an adequate number of ombudsmen.
- Provide adequate funding to permit Ombudsmen to visit all facilities including group homes.
- Ensure that complaints and reports of nursing home abuse are fully investigated by those with skills, training and capacity to do so, and that cases of nursing home sexual abuse are handled by those with expertise in that area.
- Look at model legislation from other states and introduce a package of bills to address the changes we can make.
- Develop a work group to explore best practice models to recruit, train and mentor paid caregivers.

Cheryl Knupp-Beatitudes

I would like to see about an expanded role for Area Agency on Aging. There are areas in need that do not fit the Older American's Act such as those that need assistance in group homes or even independent living.

Additionally, I would propose there be a registry created for certified caregivers and a regulatory board that holds them accountable like there is for Nurses, Certified Nursing Assistants, Nursing Home Administrators as well as Assisted Living Managers.

JJ Rico- ACDL

Abuse and Neglect Ad Hoc Committee - ACDL Priorities .

1) Fund Arizona Revised Statute 36-592 for DD Group Home Monitoring

36-592(B)- The department shall maintain a system of independent oversight of licensing. The department may contract with third parties to perform services in connection with oversight and licensing. The department may not contract with the same third party for both oversight and licensure under this subsection.

2) Create a registry of care providers who have had an allegation of abuse of a person with a disability substantiated against them.

Abuse is defined as an act that results in serious emotional or physical injury.

3) Require that Arizona representatives attend a training similar to Project FIND (Forensic Interviewing Individuals with Disabilities) - Advanced Forensic Interview Certificate Four Day Training

Following attendance, implement similar training and certificate program in Arizona.

Erica McFadden- AZ Developmental Disabilities Planning Council

1. Because the quality of APS' investigations increases the likelihood of APS cases being substantiated, require specific training, by statute, for APS investigators (like they do for DCS investigators and as established in Colorado for its APS). Include stronger minimum requirements for APS staffing in statute. For example, require at least a high school degree for call center staff.
2. Require annual checks of the central and APS registries for any organization that serves vulnerable adults and children, including senior living residences, such as apartment or private group homes. Currently, it's only one time, which does not address any new substantiations that may occur.
3. Require annual duty to report training, that includes recognizing and reporting abuse, for everyone obligated to report. Currently, this training is not required legislatively. *Include senior living management, or those who interact daily with senior residents*, in this requirement. People don't necessarily know to whom and how to report.
4. Elevate penalties for failing to report so it's equitable and ensure there is a method for enforcing these penalties. Move failing to report sexual assault of a vulnerable adult from a class 1 misdemeanor to class 6 felony, equivalent with similar statute for reporting child abuse.
5. Create a community advisory committee for APS in statute that meets at least quarterly so that the community could work with APS to address issues and outcomes, increase transparency and help build trust. (Note: This was similarly set up legislatively for DCS. That group, however, was dissolved and brought in-house. There may need to be something in statutory language to prevent that from happening if this option is included in legislative recommendations.)
6. Not many understand what APS actually does when they investigate a case or the outcomes of those investigations, as few outcomes are reported. Legislatively require APS to collect and report data that highlights case information including disability type, APS actions taken and referrals made, number of repeat cases/victims, number of repeat perpetrators identified in cases with different victims, number of perpetrators who are vulnerable adults in verified cases of maltreatment, reasons why cases are closed, and why cases were not investigated and classified as I&R. This data is crucial to identify trends related to vulnerable adult abuse in Arizona. Require a report to the legislature each year to assess these outcomes and detect trends.
7. Strengthen monitoring, enforcement, and penalties for non-compliance around health and safety of children or vulnerable adults for any organization that serves children or vulnerable adults and contracts with ADHS, AHCCCS, or DES/DDD. (All of the current strategies utilized need to be re-reviewed.)
8. Currently, there are posting requirements by Executive Order on how to report abuse, neglect, or exploitation for organizations that serve vulnerable adults and contract with ADHS, AHCCCS, or DES. Require it in legislation. Include anti-retaliation language in the posting language so staff and the victims themselves, are not afraid to report due to retaliation.
9. Require DDD group homes to be monitored at least annually by an independent third party in statute.
10. Begin a cross-departmental task force or a legislative ad-hoc or study committee that, with self-advocates, identifies methods or models to address serious staffing challenges and its impact to quality care. Require a deadline for a report with recommendations to be made to the legislature.
11. Require that school-aged children and vulnerable adults are notified at least annually on what abuse is and how to report it by agencies/organizations/schools that are serving them, in a manner that is appropriate to the individual.
12. Require that for a vulnerable adult where: any maltreatment reports are made by that vulnerable adult that involve a perpetrator; or there is a verified or a substantiated report of maltreatment; that the vulnerable adult always is given the option AND has access to receiving trauma-informed counseling in a manner that is accessible to the vulnerable adult.

Kyle Sawyer Legislative Liaison - AHCCS

- Training of providers - The State must ensure that caregivers have full access to consistent, comprehensive training related to detecting and reporting abuse and neglect. This includes caregivers in ICF, group home and in-home settings.
- Trauma informed care - The state should bolster its efforts to advance a trauma-informed framework focused on understanding, recognizing, and responding to the effects of all types of trauma.
- Accommodations - The State must ensure the provision of necessary accommodations, allowing individuals with varying needs to effectively report incidents and obtain needed services following an incident.

Colby Bower- AZDHS

1. I'm still unclear of the population we are talking about. I know its "vulnerable adults," and that has a specific definition in statute. But this committee has discussed much larger populations, including those with disabilities and children. I understand this is meant to see the "system" as a whole, but it makes it difficult for me to understand or identify what problem we are trying to address. For example, we have discussed the lack of interpreters, domestic violence, the challenges of the disability community in various settings, the child safety system, DD group homes, and ICF-IID facilities. While there can be vulnerable adults in these settings, it makes it hard to come up with a plan and a set of recommendations. I'll be interested to see where this goes and look forward to the discussion.
2. However, I am grateful for the broad discussion because, like many others, it does demonstrate the difficulty in the average person's ability to navigate it given their own situation. As a citizen, the various moving pieces must be nearly impossible to grasp.

Sherri Collins- AZ Commission for the Deaf and the Hard of Hearing

1. After hearing all the presentations - how to navigate the system is still confusing.
2. What are the standards/procedures to ensure deaf, hard of hearing and deafblind are receiving appropriate assessment and communication accommodations? Still get the "round around" and no one can really answer.
3. Where/what is the check and balances on the oversight of service delivery.

Sarah Kader- AZ Statewide Independent Living Council

- Increased pay for care-workers
- Training on signs of abuse/neglect for compliance officers that go into facilities
- Add checklist regarding abuse/neglect to licensure requirements
- Training for peace officers on how to spot abuse/neglect and how to respond to calls about abuse/neglect
- Education and resources in the community regarding abuse/neglect (for families, individuals who have disabilities, teachers, social workers, etc)
- APS should be 24/7
- Increased reporting requirements
- Make unlawful policies that disincentivize reporting
- Expand ombudsman office to include monitoring of DDD group homes

Jami Snyder- Director – AHCCS

- Training of providers - The State must ensure that caregivers have full access to consistent, comprehensive training related to detecting and reporting abuse and neglect. This includes caregivers in ICF, group home and in-home settings.

-Trauma informed care - The state should bolster its efforts to advance a trauma-informed framework focused on understanding, recognizing, and responding to the effects of all types of trauma.

Accommodations - The State must ensure the provision of necessary accommodations, allowing individuals with varying needs to effectively report incidents and obtain needed

Kathy Ber- Legislative Director- AZ DES

APS Powers and Duties/Scope

Based on Committee discussion, there seems to be an interest in increasing the scope of what APS has authority to investigate. The Department recommends that the Committee review the APS powers and duties statutes (A.R.S. § 46-452).

The Committee should also review the definitions that provide the scope for APS investigative authority (A.R.S. § 46-451):

Vulnerable Adult – A.R.S. § 46-451(A)(10)

- "Vulnerable adult" means an individual who is eighteen years of age or older and who is unable to protect himself from abuse, neglect or exploitation by others because of a physical or mental impairment. Vulnerable adult includes an incapacitated person as defined in section 14-5101.

Incapacitated Person – A.R.S. § 14-5101(3)

- "Incapacitated person" means any person who is impaired by reason of mental illness, mental deficiency, mental disorder, physical illness or disability, chronic use of drugs, chronic intoxication or other cause, except minority, to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person. In cases of limited guardianship only, a person is not deemed an incapacitated person for purposes of voting if the person files a petition and has a hearing and the judge determines by clear and convincing evidence that the person retains sufficient understanding to exercise the right to vote pursuant to section 14-5304.02.

Abuse – A.R.S. § 46-451(A)(1)

- "Abuse" means:
 - (a) Intentional infliction of physical harm.
 - (b) Injury caused by negligent acts or omissions.
 - (c) Unreasonable confinement.
 - (d) Sexual abuse or sexual assault.

Exploitation – A.R.S. § 46-451(A)(5)

- "Exploitation" means the illegal or improper use of a vulnerable adult or the vulnerable adult's resources for another's profit or advantage.

Financial Exploitation – A.R.S. § 46-471(3)

- "Financial exploitation" means either of the following:
 - (a) The wrongful or unauthorized taking, withholding, appropriating or use of money, assets or property of an eligible adult.
 - (b) Any act or omission taken by a person, including through the use of a power of attorney, guardianship or conservatorship of an eligible adult, to either:
 - (i) Obtain control through deception, intimidation or undue influence over the eligible adult's money, assets or property to deprive the eligible adult of the ownership, use, benefit or possession of the eligible adult's money, assets or property.
 - (ii) Convert money, assets or property of the eligible adult to deprive the eligible adult of the ownership, use, benefit or possession of the eligible adult's money, assets or property.

Neglect – A.R.S. § 46-451(A)(7)

- "Neglect" means the deprivation of food, water, medication, medical services, shelter, supervision, cooling, heating or other services necessary to maintain a vulnerable adult's minimum physical or mental health.

Self-Neglect – Not defined in state law

- "An adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including— (A) obtaining essential food, clothing, shelter, and medical care; (B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or (C) managing one's own financial affairs."

Elder Justice Act (Patient Protection and Affordable Care Act - Public Law 111-148)

Emotional Abuse - A.R.S § 13-3623(F) (3)

- "Emotional abuse" means a pattern of ridiculing or demeaning a vulnerable adult, making derogatory remarks to a vulnerable adult, verbally harassing a vulnerable adult or threatening to inflict physical or emotional harm on a vulnerable adult.
- Based on the present definition of abuse, **APS does not have authority to investigate and substantiate allegations of emotional abuse** and the reporting source is advised that APS is unable to investigate allegations of emotional abuse in Title 46.

Caregiver – Not defined in state law

- ➤ The term "Caregiver" is not defined in Arizona state statute, but 39 other states have a definition of "Caregiver" or "Caretaker". Ohio defines a "Caretaker" as: "the person assuming the responsibility for the care of an adult on a voluntary basis, by

contract, through receipt of payment for care, as a result of a family relationship, or by order of a court of competent jurisdiction.

- Develop a public awareness campaign around the role of APS with information related to what their official powers and duties are, along with common public misconceptions. Similar to the Governor's Executive Order Task Force on the Abuse and Neglect of Vulnerable Adults recommendation, community stakeholders and state agencies should collaborate to disseminate this information. The flow chart developed by the Executive Order Task Force that details reporting and investigation processes for all types of abuse, neglect, and exploitation concerns, incidents, and allegations can be used along with the materials already being used by the Department on social media.

Vulnerability Statements

- APS investigators have difficulty obtaining statements of vulnerability during an APS investigation. These statements are used as part of the substantiation process and in making referrals to public fiduciaries and the courts to determine vulnerable adult capacity in guardianship/conservatorship proceedings.
- APS investigates cases involving vulnerable adult abuse, neglect or exploitation. If APS cannot establish the adult is vulnerable, they are not able to substantiate. Vulnerability needs to be determined by a health care professional who can evaluate the adult's capacity for decision making, diagnosis, etc. Many vulnerable adults do not seek regular medical care or lack access to medical care, so APS is unable to proceed with finding an adult vulnerable and proposing substantiation of abuse, neglect or exploitation.
- The Department recommends that the Committee explore opportunities for an on-call health care professional, such as through a mobile unit, who can go to the vulnerable adult with APS investigators to conduct those assessments. While the adult will still have the right to refuse the medical evaluation it is likely that the adult will be more likely to participate if the health care professional is with the APS investigator and travels to the individual.

Forensic Interviewing

- The access point to forensic interviewing for APS investigators is typically through local law enforcement. When law enforcement determines that they are no longer going to move forward with a criminal investigation, APS investigators lose that access to the forensic interview process.
- Another challenge with an adult population is getting them to travel to another location. Unlike children, adults have the right and ability to refuse to participate in the investigative process with APS.
- The Department recommends that the Committee explore opportunities for APS to access forensic interviewers, possibly as part of a mobile unit that goes out with investigators. Having access to a mobile forensic interview process would strengthen the investigative process, enhance the potential of substantiation and preserve evidence for any potential criminal investigation.

Representative Jennifer Longdon

Who is the watchdog? Who is responsible for vigorously monitoring facilities and are they appropriately staffed/resourced?

How do we address the impermeability of "the system?" How do agencies communicate with each other and how do they hand off folks who contact them. Arizonans need a seamless system.

