Navigating North Star Journeys:

A collaboration between

and

Brain Injury Association of Minnesota

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INTRODUCTION

Navigating North Star Journeys is a collaboration between Tubman and the Brain Injury Association of Minnesota that commenced in November 2009. The three-year project is funded through a grant from the US Department of Justice, Office on Violence Against Women.

Tubman, a multi-service agency with more than 35 years of experience serving individuals and families, is Minnesota's largest provider of domestic violence services. The agency offers a full complement of services such as family violence shelter; transitional housing; legal assistance; mental and chemical health counseling and therapy; in-home transitional support services; parenting, financial literacy, and job seeking education; child care and violence prevention. Tubman strives to eliminate barriers to service and offers a comprehensive network of care to help more than 50,000 adults and children reach their full potential for safe, healthy, stable lives. With a strong focus on research and innovation, building efficiencies and creating partnerships, Tubman is a pioneer in best practice models of family violence prevention and intervention.

The **Brain Injury Association of Minnesota** (BIA), the only state-wide nonprofit dedicated to enhancing the quality of life for Minnesotans affected by brain injury, has been providing services for 26 years to thousands of people. Their goal is to work towards a world where all avoidable brain injuries are prevented, all non-preventable brain injuries are minimized, and all individuals who have experienced brain injury can maximize their quality of life. BIA envisions a world where every brain injury is prevented and where every injury is met with impassioned advocacy, extraordinary services, knowledgeable professionals, and quality choices. BIA strives to educate everyone to recognize brain injury, its causes and effects, and where all individuals living with brain injury are encouraged to realize their full potential and their value to our community.

Both Tubman and the Brain Injury Association of Minnesota strive to provide services, programs, and information to individuals to enhance their lives and help them reach their full potential within their communities. Each organization recognizes that it will take a monumental systematic effort to eradicate brain injuries and domestic violence. Through this grant they are committed to exploring and capitalizing on each other's knowledge and expertise to minimize the effects of brain injury and domestic violence. They will strive to create a model that can be replicated to a wider geographic area and across disability and other social service agencies.

The first phase of the collaboration between Tubman and the Brain Injury Association of Minnesota focuses on building the foundation for the collaboration, identifying the needs of the organization and the individuals it serves, and developing the strategies to address specific needs to narrow gaps in services and programs. The goal of this project is to create a sustainable infrastructure to ensure effective services for people with brain injury and domestic violence in the greater metropolitan Twin Cities area in Minnesota, specifically, Ramsey, Hennepin, and Washington Counties.

INTRODUCTION

The problem.

Violence is a major cause of brain injuries (BI) and repeat injuries can have a cumulative effect and worsen BI. When an individual suffers damage to their brain many issues can arise such as memory loss, inability to problem solve, lack of impulse control, and significant problems with sight, hearing, and movement. Insufficient screening and lack of adequate services can result in victims with BI returning to violent relationships and sustaining additional injuries. Further, they may be in situations where their abuser is also their caregiver which puts them in a problematic situation. Due to increased dependence on partners for financial support and other needs, problems communicating, and other symptoms of their disability, individuals with BI may be at greater risk of sustaining additional injuries, become isolated, or contribute to significant mental health (e.g., depression, anxiety, etc.) or chemical health issues.

Many victims with BI may not seek any type of services because they may not recognize their symptoms as BI, may not identify as a victim of violence, may not be aware of available services, or may be dependent on an abusive partner for basic needs and unable to make decisions. When a victim seeks services, BI symptoms may be confused with crisis reactions and may not be recognized as BI until difficulty concentrating, remembering, or solving problems causes the victim not to follow through on goals. When an individual with BI is not identified as such, critical safety planning, advocacy and support services may be delayed or not provided at all and the victim may return to a violent relationship at increased risk for additional injury. There are a number of tools that can be utilized for people living with the effects of a brain injury such as modifying the environment, using memory aids, utilizing technology, accompaniment to appointments, and other types of supports.

The solution.

Tubman and the Brain Injury Association of Minnesota are committed to creating a screening and assessment process to identify brain injury at the earliest possible point of contact within each organization. Even when shelter residents are eligible for Medical Assistance, there is often a waiting list for a neuro-psychological evaluation, a critical medical diagnostics to determine treatment for a brain injury. It is this diagnostic evaluation that determines specific treatment activities and is also used to determine disability and access to state or federal medical reimbursement funds. One challenge is that an individual may leave a shelter before an evaluation is available and before receiving needed services. Also, this evaluation cannot be the only measurement of assessment for an individual since some people may never get this type of medical evaluation. When an individual comes into a shelter environment there is any opportunity to do a preliminary assessment to determine if there is a likelihood of a brain injury. Knowing this information is the first step in determine what special accommodations may be necessary in helping serve an individual. Currently, the Brain Injury Association utilizes a tool called HELPS which asks a series of questions that can help an employee determine if there is a possibility of a brain injury. Utilizing a proven screening process will help identify a potential brain injury and give employees the opportunity to work with the individual and help them adopt strategies that can make allowances for different learning styles, physical issues, and emotional needs. It is too early to determine if the HELPS tool will be adequate in a shelter environment yet it offers a starting place to think about a process to solicit information. Each person has unique individual needs and a system will need to allow for whatever special accommodation a person presents with when entering a shelter. Persons living with the effects of a brain injury may encounter domestic violence in their lives and need services to address their particular safety concerns in much the same way.

INTRODUCTION

Resource Facilitators at the Brain Injury Association work with individuals over the phone. Because they are not able to meet with individuals face-to-face all of the information they gather is through conversational inquiry. Talking to an individual over the phone that may have a speech, hearing, or cognitive issue makes it challenging to learn as much about the person and their situation. These barriers make it especially difficult in situations of domestic abuse where the abuser may be controlling access to the phone or may be exerting power within the relationship. It will take thoughtful questioning to learn about domestic violence without putting the person in danger. Individuals who do not recognize or do not understand the complexity of the factors and issues surrounding brain injury and domestic still need to be provided available resources and services. Advocates, women's counselors, resource facilitators, therapists, and case managers will encourage individuals to continue receiving advocacy services knowing more about their unique needs. Individuals living with a brain injury and domestic violence need consistent support to work toward the goals they have identified, including accompaniment to appointments, following through on therapy, or other daily living activities. People living with brain injury may need different supports when dealing with domestic violence due to the nature of their particular situation. Individuals who are dependent on their daily care by their intimate partner are considerably more vulnerable to all forms of abuse. Regardless of which organization an individual seeks support, the ability to identify brain injury and domestic violence early in the journey will help ensure safety and stability for individuals.

The second phase of the collaboration will focus on implementation of the identified needs that will bring about strong collaboration between the two agencies. Information gathered from the needs assessment process will help shape a strategic plan that will provide the framework in which to meet the unique needs of individuals at the intersection of brain injury and domestic violence. Specific implementation strategies may include enhancement of policies, practices, and knowledge, creating mechanisms to share resources, and coordinating services to provide the optimal experience for an individual living with the effects of a brain injury and domestic abuse.

VISION STATEMENT

Tubman and the Brain Injury Association of Minnesota envision a model of accessible service that minimizes the effects of domestic violence and brain injury by providing resources within its programs, services, and information that helps individuals understand their options and helps them navigate their choices, free of violence and injury that enhances their life journey.

MISSION STATEMENT

The mission of Navigating North Star Journeys is to enhance Tubman's and the Brain Injury Association of Minnesota's capabilities to provide a holistic response to serve the unique needs of those who have experienced a brain injury and violence within an intimate relationship where a pattern of abusive behaviors occurs. The organizations will create a plan that utilizes the following broad approaches to minimizing the effects of domestic violence and brain injury:

- *Early identification.* The ability for each organization to engage and consult with one another early in an individual's journey to identify their unique needs to serve them accordingly.

- *Barrier-free access.* The ability for individuals served to know, understand, and choose from a broad range of resources available within specific services and programs offered by each organization. This also includes access to information about domestic violence and brain injury prevention and intervention.

- *Individual choice.* Provide individualized services that integrate best-practices surrounding co-occurring conditions.

- *Professional knowledge.* Increase professional knowledge by staff from each agency to ensure cultural competencies to understand and meet the unique needs of the populations it serves.

- *Team-based approach.* Provide a multi-disciplinary approach that captures the collective knowledge of staff from diverse education, experience and skill levels to help people navigate their individual options.

- *Accessibility and safety*. Evolve policies and procedures that promote accessibility and safety for individuals by creating an environment that meets their unique needs.

VALUES AND ASSUMPTIONS

Domestic violence, dating violence, sexual assault, and stalking are leading causes of brain injury which puts an individual at greater risk of being re-victimized. Brain injuries can place an individual in circumstances that may make them more vulnerable to domestic violence. In some cases, an individual with certain types of brain injury may have increased aggressiveness or impulsivity post-injury which may contribute to domestic violence. Further, individuals may depend on others for the daily care and can be vulnerable either physically, cognitively, or emotionally by their caregiver who may also be their intimate partner. Increasing training, screening, and assessment for brain injury and brain injury by both domestic violence service providers and disability service providers can help address the barriers to access and services by identifying the unique needs of these individuals to enhance their lives when faced with life changing events or circumstances. Both organizations recognize that there may currently be gaps in how individuals are served and will look to identify these gaps through a thorough needs assessment which will lead to the development of specific strategies to minimize or eliminate the gaps in services. Tubman and the Brain Injury Association of Minnesota hold the following values important when serving people who face violence and disability in their lives.

VALUES

Core Values:

- **Innovation**. Achieving service delivery excellence through continuous learning, practice, and performance by staff of both organizations that encourages new and innovative approaches to servicing individuals.
- **Choice.** Providing services that meet the individual needs and desires of those who are served that are not limited by prescribed approaches or resources...

- **Strengths-based**. Empowering individuals to advocate for themselves to reach their full potential through their skills, strengths, and talents. Where staff can explore with individuals those positive attributes that support and strengthen their lives.

Values:

- **Social change/activism.** Embracing justice and building strong communities in which people can thrive. Where all individuals can feel safe, be healthy, and be supported in their community.
- **Access to services.** Ensuring that people are aware of services and have access to those services that are physically, culturally, programmatically, and attitudinally appropriate for their particular lifestyle, needs, and desires.

- **Collaboration & cooperation.** Working together as a multi-disciplinary team to serve people while respecting their choices and unique needs that may be different from our own.

- **Person-centered.** Advocating and supporting individuals by understanding their current situation, not judging their choices, and helping them in their journey within their needs, preferences, desired outcomes and expectations.

- **Welcoming.** Providing a physical and emotional environment that is safe and accessible, and where everyone is treated with dignity and respect by each and every employee.

VALUES AND ASSUMPTIONS

ASSUMPTIONS

Members of the project team believe that an individual must feel safe, be free of harm, and be accepted for who they are despite any barriers or limitations in their lives. The team holds the following statements to be true when serving those who have experienced a brain injury and violence within an intimate relationship where a pattern of abusive behaviors occurs. These assumptions will influence how people are served and will guide decisions made during the course of the project and by employee as the project evolves.

1. Both agencies currently offer services and programs that enhance the lives of those they serve which help to keep them safe, healthy, and free of violence.

2. The greater metropolitan Twin Cities area, which has a population of nearly 3 million people in its seven major counties (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington), has very strong communities that provide additional supports that people need in their lives.

3. Both agencies want to offer better and appropriate services to those served to ensure that their needs are being met.

4. We recognize that the premises, programs, attitudes, and cultural beliefs may not meet some individual needs and each agency strives to provide excellent services.

5. We recognize that staff may not have the necessary skills or knowledge to identify co-occurring brain injury and domestic violence, which limits the potential support available when working with people with these complexities.

6. We recognize that not all teams within the organizations have problem-solving abilities, communication skills, or resource knowledge to effectively determine recommendations for people with brain injuries due to violence or for people who have brain injuries and may be vulnerable to domestic violence or may potentially cause domestic violence.

7. We recognize that individuals may be unaware of the broad range of disabilities or domestic violence or underestimate the extent to which these disability issues or domestic violence affect them and this provides additional challenges in identifying and providing services.

8. We recognize that individuals face:
    i. Re-victimization due to their vulnerabilities in certain circumstances. Individuals with brain injury and domestic violence may have certain dependencies in their lives and need different types of supports.
    ii. challenges when presenting with co-occurring conditions which creates complexity in coordinating services between a disability provider and a domestic violence provider.
    iii. significant social, emotional, health, housing, and economic barriers regardless of their specific circumstances or health condition.
    iv. attitudinal, programmatic and cultural barriers to service delivery by employees which may make it difficult to identify appropriate resources to assist individuals.
    v. social stigma and isolation related to identification as an individual with domestic violence and a disability which may create a set of circumstances that make it difficult for a person to reach out for services, or conversely, for an employee to provide services.
    vi. guidelines and processes related to obtaining services through federal, state, and local programs may be challenging for people to understand/navigate when under high stress, have significant health issues, or are cognitively impaired.

MEMBER ORGANIZATIONS

Navigating North Star Journeys: A collaboration between Tubman and the Brain Injury Association of Minnesota

Both Tubman and the Brain Injury Association of Minnesota strive to provide services, programs, and information to individuals to enhance their lives and to help them reach their full potential within their communities. Each organization recognizes that it will take a monumental systematic effort to eradicate brain injuries and domestic violence. For this project and into the future they are committed to exploring and capitalizing on each other's knowledge and expertise to minimize the effects of brain injury and domestic violence and create a model that can be replicated to a wider geographic area and across disability and other social service agencies**.**

Jan Williams, Project Director, was hired to lead the collaborative effort between Tubman and the Brain Injury Association of Minnesota. She is an experienced change leader with abilities in strategy development, project management, strategic communications, and organizational development to drive initiatives that increase stakeholder engagement and enhance organizational performance excellence. Williams holds a bachelor's of science in Communication Studies and Business from the University of Minnesota and is certified as a Professional in Human Resources. Williams has worked in government, higher education, non-profit, and healthcare and has a range of experience working with administrators, employees, boards of directors, and stakeholders. Williams is a Baldrige evaluator with the Minnesota Council for Quality and is driven to enhancing performance excellence so organizations can meet the needs of those they serve with the best possible service or product. Williams has served as a Ramsey County guardian *ad litem* and has volunteered with a variety of community programs that serve families and children.

Williams offices at both organizations and is afforded many opportunities to interact with the employees. This increased access to staff, processes, and culture has allowed her greater ease in managing the range of activities to bring about the desired sustainable changes that will enhance each organizations reach in the communities it serves. Each organization brings to this unique partnership information and knowledge that will bring about enhance services and programs at the intersection of domestic violence and brain injury. Change happens at all levels of the organization – the individual, the team, and the organization itself – and each organization is committed to exploring each level and enhancing its services and program. The following information outlines specific programs and services that each organization offers:

TUBMAN

History:
Tubman is a multi-service agency with more than 35 years of experience serving individuals and families and is Minnesota's largest provider of domestic violence services. Tubman was formed from the merger of three separate organizations: Chrysalis, A Center for Women, founded in 1974; the Harriet Tubman Women's Center, founded in 1976; and Family Violence Network, founded in 1982.

MEMBER ORGANIZATIONS

The agency offers a full complement of services such as family violence shelter; transitional housing; legal assistance; mental and chemical health counseling and therapy; in-home transitional support services; parenting, financial literacy, and job seeking education; child care and violence prevention. Tubman strives to eliminate barriers to service and offers a comprehensive network of care to help more than 50,000 adults and children reach their full potential for safe, healthy, stable lives. With a strong focus on research and innovation, building efficiencies and creating partnerships, Tubman is a pioneer in best practice models of family violence prevention and intervention.

The mission of Tubman is to promote safe and healthy individuals, families, and communities through evidence-based intervention, prevention, and education.

Goals:

1. Attract people to a continuum of services and engage them in transforming their lives.
2. Motivate the community to act on our shared responsibility for individual and family health and safety.
3. Be recognized as a global research and Learning Institute that shapes the Agency's work and contributes to the work of others.
4. Build and sustain an entrepreneurial organizational culture.
5. Secure a balanced portfolio of financial support including new resource development strategies.

Current Programs and Activities:

Shelter and Residential Services (Crisis Intervention)

Tubman operates three emergency shelters, providing nearly 25 percent of the shelter beds in Minnesota. More than 1,500 women and children are served each year with an average 41 day stay in the shelter. Services include safety planning, housing information and resources, health assessments, counseling, legal services, financial and career information, educational programs, parenting support, family activities, as well as cultural and spiritual support.

Legal Services and Programs (Crisis Intervention)

Legal advocates, staff and volunteer attorneys, and legal interns provide critical legal services to more than 4,500 individuals each year. Attorneys help family violence victims obtain life-saving Orders for Protection, while advocates provide support in criminal court proceedings. Attorney volunteers provide legal representation, advice and information primarily in family law matters, assisting families through difficult life transitions to a safe and stable future.

Transitional Housing and In-Home Support Services (Stability Support)

Eleven affordable housing units are available for families to live up to two years in a supportive environment. Services include locating permanent housing, addressing transportation needs, education, skill building and problem solving, and career and financial planning. In-home services support families in transition and offer similar services.

Counseling and Therapy Services (Stability Support)
Tubman provides direct mental health services for more than 2,000 women, children and families annually. Tubman's Chemical Health program is recognized for its Co-Occurring Disorders (COD), or specialized therapy for those addressing mental health issues and chemical dependency, a diagnosis affecting 52% of chemically dependant women. Our mental health staff helps each client identify his or her strengths and resources, define barriers and develop individual plan for growth. Issues addressed but are not limited to anxiety, depression, abuse, sexuality, parenting, behavioral concerns in children, pregnancy and loss, intimacy, divorce and blended families. Services include:

- Holistic Counseling Program
- Child/adolescent therapy
- Couples therapy
- Play therapy
- Workshops
- Dialectical Behavior therapy
- Individual therapy
- Family therapy
- Group therapy
- Psychiatric assessment & medication
- Chemical Health Assessments
- Trauma-Focused Cognitive Behavioral therapy

Chemical Dependency Treatment (Stability Support)
An outpatient program providing a non-traditional, gender-specific program for women struggling with substance abuse and dependency. Programs include Co-occurring disorders (dual diagnosis of chemical dependency and mental illness), Effecting Positive Change (support services to mothers in recovery), case management, and licensed Rule 25 chemical dependency assessments

Holistic Counseling and Therapeutic Support (Stability Support)
A self-referred and court-ordered family violence program serving domestic violence offenders. Services include a 14-week group curriculum and individual counseling. After a safety assessment, individuals completing treatment may enter into couples counseling.

Youth and Family Services (Stability Support)
Tubman's Youth and Family programs provides direct services to over 1,500 children each year, in shelter and in the community, through approximately 50 programs and support groups. An additional 6,800 receive violence prevention education in area schools. Services include: individual support, safety planning, goal planning, age-specific support groups and recreational activities, respite child care, homework and school transition assistance, dating violence prevention, conflict resolution skills, family activities, and resource referrals.

Community-Based Program for Children and Youth (Stability Support)
A variety of programs address domestic violence in our communities. Programs include Kids in Transition, a program for children who have witnessed domestic violence, grief and loss, and other family changes. Movement for Violence Prevention teaches and refined students' skills to take a stand against relationship violence. Teens have the opportunity to create and share creative communications to support anti-violence through the MyDefinition.org.

MEMBER ORGANIZATIONS

Voices in Prevention (Prevention)
This program works with adolescents in the 7th-12th grades to provide tools to recognize signs of abuse and develop health dating relationships.

Sustainability Services (Comprehensive)
This programming offer a wide range of choices and services to clients seeking to make – and sustain – changes in their lives and is open to the community. The goals of the program include assisting those in crisis to meet their basic needs, supporting those in transition, preventing future crises, and helping maintain client personal stability. Services include: resource counseling and 24-hour crisis line, financial education, career workshops, housing workshops and support groups.

Community Education (Re-Emergence)
Tubman reaches more than 7,000 people annually via presentations at job and educational fairs, faith-based organizations, and other community settings. Professional staff lectures and trains across the nation. In addition, Tubman partners with local television, radio and print media to produce public service campaigns, increasing public awareness of abuse and creating a dialogue around its treatment and prevention. Public information campaigns cover the metro area annually to promote community engagement and changes in thought and action.

Collaborations:
Tubman is deeply committed to building new working relationships, as our many alliances, mergers, and partnerships demonstrate. We depend upon strong collaborations with other social service organizations, businesses, government entities, colleges, universities, and advocacy groups to accomplish our goals while providing the best care to our clients. Through relationships with United Way, various legal services, treatment centers, healthcare facilities, other domestic violence agencies, statewide coalitions, police departments, the courts and other branches of the judicial system, all clients have access to the best resources and assistance they need to make safe, healthy, and positive changes in their lives.

Organization Contact Information:

Tubman
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MEMBER ORGANIZATIONS

Project Team Leadership:

President/Executive Director, Tubman (1989-present) During her tenure, Beverly Dusso has built the agency from two duplexes on Oakland Avenue to a $10 million organization with services throughout the metropolitan area and a national reputation in violence prevention, mental and chemical health services. Prior to joining Tubman, Ms. Dusso led major ballet companies as the General Manager of Miami City, Houston, and Ohio Ballets, and the Minnesota Dance Theater and School. She began her career with an executive internship at Lincoln Center for the Performing Arts.

Ms. Dusso serves on and chaired the Bolz Center for Arts Administration Advisory Board (UW-Madison) and the UW-Madison Business School Advisory Board. She has served as a board member of the United Way of Washington County - East, the Minneapolis United Way, and the Clear Channel Local Community Advisory Board. In the recent past, Dusso co-chaired the Northeast Chapter of the Metropolitan Interfaith Council on Affordable Housing (MICAH), and was past president of the Minneapolis United Way Council of Agency Executives and the St Croix Council of Agency Executives. She received Women Venture's Pioneer Award in 2005, and was named a Woman of Distinction by Century College, Minnesota in 2008.

Director of Residential Programs. Junauld Presley joined the agency in 1995 as manager the Harriet Tubman Women's Shelter. Since that time and after the consolidation with Family Violence Network, she became Director of the agency's three shelters (128 beds), its transitional housing and all in-home residential programs. Prior to this position, she worked in the human service field for 21 years providing chemical dependency case management, and was formerly the Clinical Director of a women's day treatment correctional program.

Ms. Presley holds a bachelor's of Individual Studies in Sociology from the University of Minnesota. She minored in both African American studies and Counseling in the area of chemical dependency and employee assistance. She is a certified Chemical Dependency Counselor Reciprocal and trainer for the Black Children of Alcohol and Drug Addicted Parent Model.

Women's Counselor. Brenda Westbrook began her work at Tubman 13 years ago when she started as a domestic violence advocate at Tubman's Anne Pierce Rogers Shelter. During her time with Tubman she has had a number of responsibilities including: Lead Advocate for Housing, Day-One, and Intern and Volunteers Programs; supervising and training interns, volunteers, and shelter staff; facilitating domestic violence support groups, and co-facilitating Anger Management Groups through Tubman's Holistic Program. She has represented Tubman in several community collaborations including Washington County Housing Collaborative, including participation in the creation of its Continuum of Care and Family Homeless Prevention Program, the St. Paul Area Coalition for the Homeless, and the St. Paul Foundation.

Currently, Ms. Westbrook is responsible for the management of twelve to twenty families and utilizes independent living, goal setting, and safety planning to help individuals navigate stability in their lives. The shelter is one component that women must navigate in their journey to a violence free life and Ms. Westbrook helps individuals with community resources and referrals including housing, financial assistance, child support, medical, furniture, clothing, legal, parenting, employment, and domestic violence waivers. She and her team collaborate and consult on each case to provide services that are unique to the needs of each individual served at their shelter.

Ms. Westbrook attended Century College and her degree in Human Services has provided her with the skills and knowledge to provide direct services to a diverse population of single adults, families, and youth. Westbrook is currently leading activities to transition two shelters into a new location by the end of 2010.

MEMBER ORGANIZATIONS

BRAIN INJURY ASSOCIATION OF MINNESOTA

History:
In 1984, a small group of families and providers came together to advocate for services for persons with brain injury and their families. Today, the Brain Injury Association of Minnesota it is celebrating its twenty-six year as the only statewide nonprofit dedicated to enhancing the quality of life for Minnesotans affected by brain injury. The Brain Injury Association of Minnesota envisions a world where every brain injury is prevented and where every injury is met with impassioned advocacy, extraordinary services, knowledgeable professionals, and quality choices. Headquartered in Minneapolis, the Association serves numerous people throughout the State of Minnesota. The Brain Injury Association's goal is to work towards a world where all avoidable brain injuries are prevented, all non-preventable brain injuries are minimized, and all individuals who have experienced brain injury can maximize their quality of life. We work toward a Minnesota where everyone recognizes brain injury, its causes and effects, and where all individuals living with brain injury are encouraged to realize their full potential and their value to our community.

Current Services and Activities:
Resource Facilitation
Resource Facilitators are available to provide confidential support following a brain injury. Persons with brain injury, their family or friends, and professionals can use this FREE statewide telephone service to answer questions, problem-solve issues, find brain injury support resources, navigate complicated systems and assist with educating family, employers and professionals about living with a brain injury.

Persons affected by brain injury or their families can seek support from the Resource Facilitation service anytime after a brain injury. Many are referred to the service at the point of hospital discharge, but anyone can self-refer or be referred by a professional, such as a social worker, rehabilitation provider, teacher or nurse, at any time.

Participants in Resource Facilitation can receive scheduled calls at regular intervals for up to two years or longer to ensure that their needs are met. Resource Facilitation allows individuals to determine the level of support needed and provides information and support so that each person can actively guide and direct his or her rehabilitation process. Participants can initiate further calls at any time.

Interpretation services are available for non-English speakers. Resource Facilitation does not replace any medical or rehabilitation follow-up that may be needed.

Multicultural Outreach
Multicultural Outreach services broadens awareness of brain injury in racially/ethnically diverse communities and connects underserved communities affected by brain injury to support services. This is achieved by working closely with existing cultural service organizations to provide education and support to professionals, spiritual leaders, elders and community members. The Multicultural Outreach service also assists homeless individuals with brain injury and those affected by domestic violence. Bilingual and culturally-specific staff and interpreters are available.

MEMBER ORGANIZATIONS

Case Management
The Brain Injury Association of Minnesota is contracted by Hennepin and Ramsey counties to provide waivered services. Case Management supports individuals who have a brain injury diagnosis and are eligible for either a Community Alternative for Disabled Individuals (CADI) or Brain Injury (TBI) Waiver. The CADI Waiver provides funding for home and community-based services for people who would otherwise require a level of care provided in a nursing facility while the TBI Waiver provides funding for similar person-centered services for people who have an acquired or traumatic brain injury and can benefit from behavior related services.

Peer/Mentor Support Connection
Peer/Mentor Support Connection is a way to connect individuals who have recently sustained brain injury or their family members (Peers) with trained volunteers who have personally experienced brain injury (Mentors). Today, over thirty individuals are involved in Peer/Mentor Supports and the need for more mentors continues to grow.

Education
Education services offers a variety of education opportunities for persons affected by brain injury and the professionals who support them. Persons affected by brain injury can take advantage of free and low-cost educational opportunities such as Brain Injury Basics I–III classes (An Introduction; Adjustment to Disability; Care giving) at an Annual Family Retreat and a one-day symposium for individuals living with brain injury and their families. Professional development programming is offered through an annual Conference for Professionals in Brain Injury, brain injury trainings and seminars, such as Brain Injury Basics for Professionals, Shaken Baby Syndrome/inflicted Brain injury, Long-Term Care, and Family Violence and Brain Injury.

Public Policy Advocacy
The Public Policy department conducts direct and grassroots advocacy activities to ensure we have sound public policies to meet the needs of people with brain injury and their families. Grassroots advocacy activity is designed to engage people to become more involved in the democratic process of their government. Through encouraging people with brain injury and their loved ones to tell their stories to policymakers and by training individuals in effective advocacy skills we hope to create better state policies to ensure we are meeting the needs of all Minnesotans affected by brain injury. Funding for public policy advocacy is through private dedicated funding.

Speakers Bureau
The Speakers Bureau offers an opportunity for people to raise awareness and educate community members about brain injury through public speaking.

Public Awareness
The Public Awareness department conducts outreach to increase awareness of brain injury causes and symptoms through media stories, targeted marketing and exhibit attendance. Public Awareness publications are available to help individuals with brain injury and their families become aware of available services, and to reach professionals with information about brain injury. These publications include informational brochures, the quarterly *Mind Matters* magazine, a bi-weekly electronic newsletter, the Brain Injury Association of Minnesota Web site and our Consumer Guide.

MEMBER ORGANIZATIONS

Volunteer

Individuals volunteer a diversity of skills, expertise and time so that the Brain Injury Association of Minnesota can reach more people and better serve those in need. The Volunteer program offers one time or ongoing volunteer opportunities and workplace experience as well as an opportunity for persons with brain injury to socialize and develop individual skills. Volunteers assist with administrative tasks, represent the Brain Injury Association of Minnesota at public events, translate material, and photograph and register participants at events. Individuals can also volunteer through the Speakers Bureau program, allowing them to take their personal story about brain injury and the Association to communities throughout Minnesota.

Organization Contact Information:

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34 – 13th Avenue NE
Minneapolis, MN 55413-1005
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800.669-6442 (toll-free)
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Project Team Leadership:

Executive Director. David King has over 27 years of experience working with non-profit organizations, including the past 15 years as Executive Vice President for Accessibility and Courage Center prior to that. The majority of this time has focused on vocational rehabilitation working with individuals living with brain injuries and other disabilities. He holds a B.S. in Social Work and a Master's degree in Business Administration.

Associate Director of Services. Pete Klinkhammer, BA, SW, CBIS. Mr. Klinkhammer oversees direct services, including Resource Facilitation, Case Management, and Multicultural Outreach. His degree is in Criminal Justice Studies with a minor in Social Work, and he has 24 years of professional experience in social services, including counseling adolescent sexual offenders and County social work in the areas of child and adult protection, homelessness, mental health, chemical dependency, brain injury and other disabilities. He participates in service provision committees through the MN Department of Human Services and provides leadership and training in service provision and best practices.

Resource Facilitation Manager. Christina Kollman, LSW, CBIS, monitors and implements comprehensive proactive consumer-directed support and advocacy for individuals with TBI and their families in all regions of Minnesota. She oversees Resource Facilitation services including data collection, reporting, and outcome management and coordinates and participates in collaborative networks to promote community inclusion of people with brain injury. She supervises and monitors the Education Department and has been with the Association for 8 years.

COMMITMENTS AND CONTRIBUTIONS

Tubman and the Brain Injury Association of Minnesota have worked together over the years to serve individuals. Each year the Brain Injury Association has provided training about brain injury and information about its services and programs to employees of Tubman. Each organization has referred individuals to services and programs offered by the other agency which has been enhanced when an employee was employed at both organizations. Having these opportunities to interface has strengthened relationships across the organizations. Through this project each organization is allowed the time to learn more about each other's operations and to explore way to enhance its services and programs for individuals at the intersection of domestic violence and brain injury. This ability to explore and reflect not only brings about awareness in how each organization operates but more importantly, it allows time to grow ideas and capitalize on each other's strengths. It is through a process that encourages reflection and inquiry that a plan of action can be cultivated to bring about sustainable growth and change to benefit those who are served.

Organizational Roles and Contributions

Tubman and Brain Injury Association of Minnesota are respected social service organizations in the state of Minnesota. Tubman specializes in the field of domestic violence, chemical dependency, and mental health services and provides shelter and transitional housing, mental health/chemical dependency clinical assessment and therapy, sustainability/outreach services, community education, youth and family programming and legal services. The Brain Injury Association of Minnesota is the only state-wide provider of resource facilitation, case management, and multicultural outreach for individuals affected by brain injuries.

Shared Commitments and Contributions

The project partners agree to commit their skills, knowledge, and abilities to ensure a quality collaborative partnership. Each organization is committed to creating an environment where change is embraced to meet the evolving needs of the individuals it serves. Each organization will share best practices, information, tools, and research to advance the knowledge at the intersection of brain injury and violence between individuals within an intimate relationship where a pattern of abusive behaviors occurs.

Project meetings will take place bi-weekly for two hours and will rotate amongst three locations. The host agency will provide a tour of the location and will introduce staff to members of the project team. Each member is committed to the planning and implementation phases and will support and encourage employee's participation at various points in the process.

COMMITMENTS AND CONTRIBUTIONS

Individual roles and contributions

Executive Directors

- Bring relevant information to the collaboration team to enhance its process
- Serve as champions of the project internally and externally with staff and stakeholders
- Serve as the liaison to the organization's board of directors
- Allow time for project activities by dedicating staff time and resources
- Attend quarterly project team meetings and retreats
- Share knowledge and provide feedback to the project team
- Find opportunities to share project progress and success
- Serve as change agents by supporting team's recommendations

Project Team Members

- Contribute to agendas and participate in regular meetings and activities
- Rotate meeting responsibilities (time keeper, participation monitor, note keeper)
- Communicate agency happenings/project progress to staff and stakeholders
- Help employees understand the need to enhance services through strategic change
- Keep staff informed of progress on the collaboration through regular communication
- Encourage staff to participate in project by sharing their expertise
- Keep executive directors informed of team activities
- Advocate for change within organization to enhance service to individuals

Project Director

- Manage day-to-day project activities
- Provide weekly progress reports to program directors and VERA
- Meet regularly with program directors and other project team members
- Office at each location to ensure accessibility to staff
- Participate in staff activities to strengthen relationships
- Communicate regularly with VERA and seek technical assistance when needed
- Meet financial, reporting, and project management expectations of the granting agency (OVW)

Employees

- Provide opportunities to share knowledge and expertise
- Allow team building activities to increase trust and problem solving abilities
- Empower employees to help create change by providing an environment that encourages risk taking an innovative thinking

Board Members

- Provide opportunities to share information and seek input and guidance
- Utilize board committees to increase organization change efforts

Stakeholders

- Allow opportunities for information sharing to increase understanding of needs

DECISION MAKING PROTOCOL

The project team agrees to a consensus model of decision making and is committed to working collaboratively to develop plans of action and make decisions based on the following expectations that utilize the following organizational structure for information sharing, problem solving, and decision making:

Decision Making Authority:

Board of Directors:

- Accountable for organization integrity and service to its stakeholders
- Contributes to the organization's vision, mission, and goals which are determined by the executive director and directors.
- Creates the strategic direction of the organization and will review and provide input into the project's activities when requested by the team.

Executive Directors:

- Assure that there is budget transparency and fiscal accountability within their organizations.
- Creates access to their respective boards of directors and shares any pertinent information to or from the project team.
- Demonstrate accountability to the Office on Violence Against Women in the use of grant funds and oversees progress by the project team.
- Review and sign off on all final OVW deliverables.
- Review and approve any policy or document that substantially alters activities of the organization.

Fiscal Responsibility:

- Tubman Executive Director is responsible for fiscal responsibility of the grant funds and approves any recommendations for changes brought forth by financial staff or project director.
- Tubman chief financial officer is responsible for oversight of financial staff and thus accountable for all financial transactions.
- Tubman financial staff are responsible for quarterly financial reporting to OVW.
- Project Director is responsible for following all Tubman financial accounting procedures.

Program directors:

- Will serve as a conduit between team members, staff and executive director.
- Will approve any policy, procedure, or any course of action that affects employee's time or other resources following agency protocols.
- Will submit quarterly timesheets and prepare financial billing summaries for reimbursement.
- Be aware of expenditures and participate in budget discussions.

Project team members:

- Develop plan and prioritize project activities.
- Fulfill the obligations as stated in the Memo of Understanding with OVW.
- Forwards policies and procedure recommendations to program directors for consideration and approval.
- Abide by agreed upon collaborative charter protocols concerning decision making, confidentiality, conflict and communication for this grant.

DECISION MAKING PROTOCOL

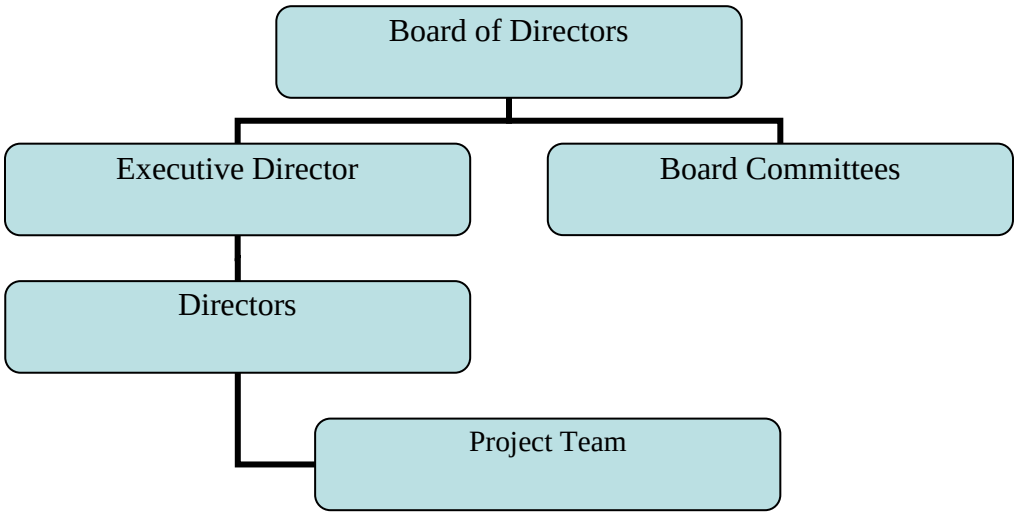
Project director:

- Prepare semi-annual reports with input from team members with timely submission to OVW.
- Submits deliverables created through the work of the project team to OVW.
- Serves as a point of contact for Vera Institute of Justice.
- Oversees budget and seeks financial guidance (as needed) to ensure fiscal accountability of grant funds spent for project activities.
- Media contact for initiative.
- Responsible for coordination of team activities, priorities and timelines.

Working groups and/or staff members:

- Individual staff members may be asked to participate in the needs assessment or to work in groups to enhance the effectiveness of the project. Team program directors will work with any respective program directors to determine appropriate membership to ensure coverage of other duties. The individual working groups will serve in an advisory capacity only by putting forth recommendations or providing their individual opinions.

DECISION MAKING FLOW



DECISION MAKING PROTOCOL

The project team will utilize a consensus decision making process where each member will have an opinion and a voice to be heard but as a whole, the team will reach an agreement that is satisfactory to all members to serve the greater good of the project. The group agrees that each team member will make a good faith effort to come to a consensus when a decision needs to be made. This assumes that everyone supports the decision even if they are not in agreement. All individual opinions will be heard and respected by other members of the team. Team members agree that decision making is a process and not an event and there, will not rush any decision. By utilizing the following process, the team supports each organization's value of including individuals in helping bring about changes that supports their vision and mission.

Consensus Decision Making Process:

Step 1: The project team is comprised of six members: three from Tubman (executive director, program director, and a staff member) and three from the Brain Injury Association (executive director, program director, and a staff member). The executive directors do not attend the bi-weekly project team meetings. It is agreed that of the two remaining members from each organization that at least one member must attend the regular bi-weekly meetings in order to adequately share information and make decisions. Further, it is agreed that all six members of the project team must attend quarterly meeting and Vera-led retreats in order to adequately represent all levels of the organization. Members may elect to conference call into a meeting if there is a barrier to attending the meeting in person.

Step 2: When there is a decision to be made, a team member must clearly state the decision that needs to be made by the team. This can be done in person at a meeting, through an e-mail to the whole team, or via participation through a conference call.

Step 3: Each team member is given the opportunity to express their opinion, seek clarification, or ask questions. Team members can ask for the opportunity to share information and other team members will listen and show respect to the team members speaking.

Step 4: Each member will indicate their support of the decision or conversely, share any reservations they may have concerning the decision. Members may voluntarily share their support or concerns otherwise, the project director will ask each member if they support the decision. If members have concerns then they will be given time to express their opinion.

Step 5: Discussions will be tabled if it becomes apparent that no progress is being made in the decision making process. The issue will be revisited after everyone is given some time to think about the issue. The group will bring the issue up at its next scheduled meeting or at a time that is agreed to by the members of the team. Any team member may contribute new information that they feel is relevant to the discussion at any time. *See conflict resolution agreement if there are differences that need to be resolved.*

Step 6: Action items discussed during meetings will be reviewed at the end of a meeting to ensure follow through on assigned activities. Progress on action items will be revisited at the start of each meeting (if needed).

The project team recognizes that this process is used for making decisions within the scope of this project. Any proposed organizational changes that are identified through the project will be considered recommendations to each organization's executive leadership team for their decision making authority.

Assumptions:

- Each team member makes a good faith effort to come to a consensus when a decision needs to be made; this assumes that everyone supports the decision
- All individual opinions are heard and respected.
- Team members agree that decision making is a process not an event.

CONFLICT RESOLUTION

The project team is committed to resolving any differences or conflicts that may arise throughout the course of the project to ensure that any personality conflicts, communication styles or assumptions do not hamper progress on the project. The following strategies will be utilized to resolve these potential conflicts:

Strategies members will use:

- Direct communication and actively listen to others to encourage two-way communication
- Positive orientation to the issue and to not take things personally or defensively
- Solutions-oriented approach to foster a strengths-based approach to resolving any differences of opinion
- Clear and concise language; utilizing "I" statements and other positive orientation to help articulate the meaning and intention of the communication
- Objectivity by separating the problem (issue) from the person to minimize any personal interferences or bias

Values utilized by team members:

- Respect and trust. Assume the best in each other by giving everyone the benefit of the doubt regarding their motives. Do not blame or assign fault to another person. Utilize the group to share information and grow in knowledge.
- Ownership. Assumes the best of intentions of each person. Each person has the right to their own onion and should feel safe in expressing their opinion(s)
- Good faith effort. Everyone will seek to resolve the issue and not let individual bias, values, or beliefs cloud their judgment about what is best for the team

Process for resolving a conflict:

Step 1: Acknowledge that a conflict exists.

Step 2: Clearly state the issue. Members should remember to ask themselves "how does this relate to the mission?"

Step 3: Give each person an opportunity and time to express themselves without interruption.

Step 4: Each member will evaluate the issue and will seek clarification to any point they do not fully understand.

Step 5: The group will make a decision based on the information they have at hand. Members will agree or agree to disagree yet support the decision.

Step 6: Even if there is not 100% in agreement, other members will be asked to support the ultimate decision.

Step 7: If commitment cannot be made by a member, then the issue will be tabled for a week and the process will be repeated.

Step 8: If it appears that after repeated attempts to resolve an issue, a program director or the project director may seek advice/counsel from an executive director.

As a last resort, if the issue cannot be resolved by the project team, then the project director will seek mediation assistance with the project associate from the Vera Institute of Justice.

COMMUNICATIONS PLAN

Navigating North Star Journeys recognizes the importance of effective communication in building and sustaining the collaboration. The following communications plan outlines strategies the team believes will effectively communicate information amongst internal and external stakeholders as well as managing media outlets.

A. Internal Communications within the Collaborative

1. **Guidelines:** Team members will use direct and positive communication in its interactions, discussions, and sharing of information. They will strive to respect another member's unique perspective and seek to understand that perspective, especially when it is different. Communication requires two-way communication and therefore, each member supports actively listen and clearly articulating their message. The team believes that the use of "I' statements will minimize any blaming or other ineffectual language. Each member will use a solutions-oriented approach to issues and seek to understand. Conflicts will be addressed directly between two members and likewise, any issue involving the team will be addressed directly in a group meeting.

2. **Confidentiality:** Team members will keep discussions confidential and will share any relevant information back out of the group where input or dissemination of information is necessary to the group's activities. Members will notify their staff, peers, or executive director when there are issues of importance and likewise, will bring to the group any issues that would be relevant to the project. Information concerning individuals served within the two agencies will remain confidential and only general facts on a case will be shared. Only on cases where a release of information has been signed by an individual will specific information be shared amongst agency staff.

3. **Meetings:** Team Members will meet bi-weekly for two hours during the planning phase of the project. The Project Director will facilitate each meeting and each member will assist in the following roles: time keeper, participation monitor, and note keeper (when needed). Additionally, members will provide agenda topics and will fully participate in the meetings. Meeting locations will rotate amongst three sites (Tubman West, Tubman East and Brain Injury Association). The meeting schedule has been set for 2010 and a 2011 schedule will be determined after the needs assessment process.

4. **Mode of communication:** Two forms of communication will be utilized.
    - *E-mail:* The Project Director will be responsible for disseminating meeting agenda, notes, and other relevant information. Group members will "reply to all" individuals when responding to an e-mail to ensure that all members of the team have the same information.

    - *In person*: Team members will communicate in person at meetings and retreats. At least one team member from each organization will be present at the scheduled meetings to represent the interests of that organization.

B. Collaborative Member and Partner Agency Communication

Each member will be responsible for communicating pertinent information about the project to her or his own agency. The Program Directors from each agency will serve as the liaison between the collaboration team and the executive directors. The executive directors will serve as the liaison to their boards of directors. All team members will serve as liaisons to fellow staff members. Information about the collaboration will be shared at staff meetings, board meetings and via e-mail list serve. The Project Director will be responsible for preparing communications and all members of the team will review and approve content before dissemination of information.

C. External Communications

1. **Vera Institute of Justice:** The Project Director is the key contact for the collaboration with the Vera Institute of Justice and will communicate on a bi-weekly basis with its Vera program associate, or more often if needed, for technical assistance. The Vera program associate will participate in collaborative meetings, retreats, or other communications to foster good relationships between the agencies and the VERA Institute of Justice.

2. **Office on Violence Against Women:** The Project Director and the Executive Director of Tubman will be the primary contacts with OVW.

3. **Other stakeholders:** Our project partners will communicate with additional stakeholders in the community as needed to maintain positive relationships and support for the work of the collaboration. A communication team member from each organization and the project director developed talking points that will serve as key messages for talking to external groups or stakeholders. Communication may be fostered via e-mail, Web site, direct mail, in person, or through advertising. Employees from each organization have opportunities to disseminate the talking points through their education program, outreach activities, or during service delivery.

4. **Crisis Communication**: There may be times when something happens within the organizations that is not favorably viewed by members of the public, internal staff, the board of directors, the media, or other external organization or entity. At these times, the executive director from each organization will be alerted to the potential risk to reputation and work with their staff to create a plan of action to address the issue. If there is an issue that crosses both organizations, such as a domestic violence occurrence by a cognitively-impaired individual and the media is interested in a story, the executive directors from each agency will work with their communications staff to craft a communication plan to address their approach in order to clearly state their messages utilizing a united approach. The goal is to minimize risk to each organization, maintain organizational reputation and respect for any individual involved in the situation.

COMMUNICATION PLAN

D. Media Plan

1. **Talking Points:** The talking points for the collaboration were developed by the two agency communication teams to ensure that consistent messages are delivered whenever an opportunity to share information becomes apparent.

   Who: Tubman and the Brain Injury Association of Minnesota are respected social service organizations in the state of Minnesota. Tubman specializes in the field of domestic violence, chemical dependency, and mental health services and provides shelter and transitional housing, mental health/chemical dependency clinical assessment and therapy, sustainability/outreach services and legal services. The Brain Injury Association of Minnesota is the only state provider of resource facilitation, case management, and multicultural outreach to serve individuals affected by brain injuries. Together these two organization can work together to meet the needs of individuals at the intersection of domestic violence and brain injury.

   Where: The goal of this project is to create a sustainable infrastructure to ensure effective services for people with brain injury and domestic violence in the greater metropolitan Twin Cities area in Minnesota, specifically, Ramsey, Hennepin, and Washington Counties.

   When: The Office on Violence Against Women funded a 3-year grant (2009-2012) to provide the necessary resources for Tubman and the Brain Injury Association of Minnesota to collaborate on this project.

   The first phase of the collaboration focuses on building the foundation for the collaboration, identifying the needs of the organization and the individuals it serves, and developing specific strategies to address needs.

   The second phase of the collaboration focuses on implementation of the identified needs that will bring about strong collaboration between the two agencies. Specific activities can include enhancement of policies, practices, and knowledge, creating mechanisms to share resources, and coordinating services to provide the optimal experience for an individual living with the effects of a brain injury and domestic violence.

COMMUNICATION PLAN

What: By increasing screening, assessment, and training for brain injury as a result of domestic violence by service providers and likewise, screening, assessment, and training for domestic violence with individuals living with the effects of brain injury or those at risk of sustaining or perpetrating domestic violence because of their brain injury by disability service providers they can help coordinate efforts to address the barriers to access and services and enhance the lives of people faced with life changing events through coordinated efforts. By closing the gap, each agency will enhance their services and individuals will lead fuller lives.

Why: Domestic violence, dating violence, sexual assault, and stalking are leading causes of circumstances that lead to injuries such as brain injuries (BI). Repeat injuries to the head or lack of oxygen to the brain can have a cumulative effect on an individual and worsen BI. Insufficient screening and lack of adequate services can result in victims with BI returning to violent relationships and sustaining additional injuries.

Brain injuries effect different parts of the brain and this can cause increased dependence on partners for financial support and other physical or emotional needs, problems communicating, and other symptoms of a cognitive disability. This puts individuals with a brain injury at greater risk of becoming victims of domestic violence and in some cases may cause a brain injured person to act out aggressively due to the damage in certain parts of the brain.

How: Tubman and the Brain Injury Association of Minnesota will work to increase their capabilities to provide a holistic response to serve the unique needs of those who have experienced a brain injury and domestic violence.

The first phase of the collaboration will focus on building the foundation for the collaboration by identifying the needs of the organization and the individuals they serve, and developing the strategies to address those specific needs.

The second phase of the collaboration will focus on implementation of the identified needs to bring about strong collaboration between the two agencies. Information gathered from the needs assessment will help shape a strategic plan that may include implementation strategies such as enhancement of policies, practices and knowledge, creating mechanisms to share resources, and coordinating services to provide the optimal experience for an individual living with the effects of brain injury and domestic violence.

The goal of the project is to create a sustainable infrastructure to ensure effective service delivery for people with brain injury and domestic violence.

2. **Media Contacts:** The media contacts for each organization will make the determination on what media opportunities will be pursued based on their available resources and within their agency media policy guidelines. The media contacts will consult with the Project Director prior to initiation of any media opportunity to ensure that opportunity is within the scope the collaboration.

Contact Information:

Jan Williams
Project Director
3111 1st Avenue South
Minneapolis, MN 55407
612.767.6693
E-mail: jwilliams@tubman.org

Mike Stephenson
Media for Tubman
3111 1st Avenue South
Minneapolis, MN 55407
763.242.4748
E-mail: mstephenson@tubman.org

Pat Marciniak
Media for Brain Injury Association
34 – 13th Avenue NE
Suite B0001
Minneapolis, MN 55413-1005
612.877.7900
E-mail: patm@braininjurymn.org

3. **Contact Tracking:** When media contact is made by a partner agency, information regarding the contact and copies of any resulting articles should be sent to the Project Director. A debrief will take place with the Project Director and communications staff to determine the effectiveness of the media opportunity. This information will then be shared with the project team members.

CONFIDENTIALITY PROTOCOL

The project team developed the following protocol for working together as a team and recognizes that each member understands that issues may arise during discussions that may be sensitive due to the nature of the information disclosed. The goal of confidentiality is to create a safe and trusting environment within the team that encourages deep discussion and seeks to understand issues without blame or assumption. It is believed that the following assumptions will minimize any breaches in confidentially and maintain the highest standards of privacy for individuals served by either organization.

The team arrived at the following organizational and individual assumptions based on current practices within each organization. There were many similarities in approaches and policies that support the shared approaches that are defined below.

Organizational Assumptions:

- Representatives from both agencies are responsible for ensuring confidentiality with anything discussed concerning the project, their staff, and the individuals served that others outside the team may find troubling.
- Current policies and procedures for each agency are adhered to in their entirety as they are currently written. Team members will keep an open mind about each other's policies and procedures when issues are raised and not rush to judgment about perceived inadequacies. Any information regarding suggested changes will follow agency protocol for modifications .
- Information that is learned by team members or invited guests in a meeting is considered confidential (client, financial, personnel, and personal). The goal of sharing information is to learn more about each organization's processes, culture, and operations.
    - Client information may require follow up to ensure the safety of an individual served or protect the integrity of the organization.
    - Financial information about the organization will not be disclosed outside of team discussions.
    - Personnel information will be handled on a case-by-case basis by either organization's program director serving on the project team if it is deemed important to be dealt with by themselves. They will review any instances with the team if they believe the matter must be handled by another supervisor within their respective organization.
    - Personal information shared by team members will remain within the team confines and will be protected to maintain trust.

CONFIDENTIALITY PROTOCOL

- The program directors may discuss any concern that is raised in meetings about an employee's behavior or attitude that is relevant to the project. They will share the issue with a supervisor of their organization if it is deemed critical to the functioning of the organization or has an impact on the health or safety of the individual served.
- Permission is sought through a release of information form when sharing information between agencies about any individual served.

Individuals Served Assumptions:

- No personal identifying information is disclosed when discussing a specific case.
- A release of information form/process is used for all consumers/clients/residents interactions between the agencies.
- Each agency adheres to the federal Health Insurance Portability and Protection Act (HIPPA) to ensure confidentiality of health information of those individuals served.

MANDATORY REPORTING

VULNERABLE ADULT

In Minnesota, a vulnerable adult is defined in Minn. Stat. 609.232 to mean any person 18 years of age or older who is: (1) is a resident or inpatient of a facility; (2) receives services at or from a facility required to be licensed to serve adults under sections 245A.01 to 245A.15, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4); (3) receives services from a home care provider required to be licensed under section 144A.46; or from a person or organization that exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651, and 256B.0653 to 256B.0656; or (4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction: (i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and (ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment (Subd. 21)

REPORTING OF MALTREATMENT OF A VULNERABLE ADULT

Tubman and the Brain Injury Association of Minnesota are social service agencies and follow the legislation of Minn. Stat. 626.557 REPORTING OF MALTREATMENT OF VULNERABLE ADULTS when any physical, mental or emotion dysfunction impairs the ability to care for themselves *(see appendix for full description).* Each agency has a designated mandated reporting officer and procedures in place so that employees are aware of their responsibilities. Employee are mandated reporters and receive training from the state of Minnesota on their responsibilities specific to reporting requirements related to suspected vulnerable adult maltreatment. Employees discuss evidence to support their suspicions with the reporting officer of their organization and also utilize team members to seek additional perspectives about their concerns. A staff member will encourage an individual to self report as allowed by statue and offer their support in participating in the reporting.

MANDATED REPORTING

Each employee of Tubman and the Brain Injury Association is considered a mandated reporter under Minn. Stat. 626.557, subd. 1 which states that a mandated reporter is any professional or professional's delegate engage in: social services, law enforcement, education, or care of vulnerable adults. The reporting of maltreatment is described in Minn. Stat. 626.557, Subd. 4 which states that a mandated reporter shall make an oral report to the Common Entry Point system (CEP), a county unit responsible for receiving oral reports of suspected maltreatment twenty-four hours per day, 7 days per week. See MN Department of Human Services Bulletin #08-25-02 http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_141296.pdf Internal reporting of maltreatment is established for both organizations that conform to licensing requirement. The following process outlines their protocol:

MANDATORY REPORTING

Process:

Step 1: When an agency staff member recognizes or becomes aware of circumstances of abuse or maltreatment that endangers an individual or another, they notify their agency's mandated reporting officer of the facts to support the necessity to make a reporting of vulnerability and the process of reporting begins. Employees are allowed by statute to report directly to the Common Entry Point system (CEP) if they so choose.

Step 2: Clients/residents/consumers are encouraged to self-report with or without an agency staff member pursuant to Minn. Stat. 626.557.

Step 3: In cases where Tubman and the Brain Injury Association are working together to benefit a specific individual they will notify the respective agency of the reporting as a professional courtesy.

WORK PLAN

TIMELINE:	ACTIVITIY:
JULY/AUGUST 2010	DEVELOP COLLABORATIVE CHARTER
OCTOBER 2010	SUBMIT COLLABORATIVE CHARTER TO OVW
NOVEMBER 2010	START NEEDS ASSESSMENT PLANNING
JANUARY 2011	SUBMIT NEEDS ASSESMENT PLAN TO OVW
FEBRUARY 2011	CONDUCT NEEDS ASSESSMENT
MARCH 2011	SYNTHESIZE NEEDS ASSESSMENT FINDINGS
APRIL 2011	SUBMIT NEEDS ASSESSMENT FINDINGS TO OVW
MAY 2011	DEVELOP STRATEGIC PLAN
JUNE 2011	SUBMIT STRATEGIC PLAN TO OVW
JULY 2011-JULY 2012	IMPLEMENTATION PHASE ; ACTIVITIES TBD

GLOSSARY OF KEY TERMS

A

Abuser: Someone who carries out the tactics/acts of domestic violence on another person. Also referred to as a batterer, perpetrator or offender.

Accessible: Easy to approach, enter, operate, participate in, and/or use safely and with dignity by a person with a disability. Areas to consider include attitudinal, programmatic, physical, and cultural.

Accommodation: Modifications or adjustments to a program, service, work environment, or job description that make it easier for a person with a disability to participate in the same manner as other people.

Accountability: The quality or state of being responsible; willing to accept responsibility of one's obligations.

Actualize: To make real; bring into existence.

Acquired Brain Injury: Injury to the brain that occurs after birth and can include anoxia, drug reactions, infection, stroke, trauma and tumors. *See also Brain injury.*

Adult Mental Health Targeted Case Management (MH-TCM): Adult Mental Health Targeted Case Management (MH-TCM) services are Medical Assistance (MA) state plan services. These services assist persons with ongoing assessment, planning, referral, service coordination and monitoring of multiple needs. MH-TCM is provided to adults determined to have a *serious and persistent mental illness (SPMI)*.

Adult Rehabilitative Mental Health Services: Adult Rehabilitative Mental Health Services (ARMHS) also known as the "MA Rehab Option" and Adult Mental Health Crisis Response Services are Medical Assistance (MA) State Plan Mental Health Services.

Adult and Child Foster Care: Individual waiver services provided to persons living in a home licenses as foster care. Foster care services are individualized and based on the individual needs of the person and service rates must be determined accordingly. When planning a child or adult into licensed foster care setting, all federal, state, county and/or licensing agency rules and regulations must be followed.

Adult companion services: Non-medical care, assistance, supervision and socialization provided to a person age 18 years or older in accordance with a therapeutic goal in the plan of care.

Advocate: A volunteer or paid staff person whose job it is to support the victim, help identify options and resources, explain processes, and/or speak on the victim's behalf. The advocate may work in different settings, such as a shelter, hospital, or court, but is not an attorney or mental health therapist.

American with Disabilities Act (ADA): National civil rights legislation passed in 1990. The purpose is to eliminate discrimination on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

Adaptive equipment: Equipment that someone with a disability or functional limitation will use to adapt to the environment in which they live or work. Adaptive equipment could be a wheelchair, cane, electronic equipment, or other assistive devices.

Adult day care: Services provided to persons who are 18 years of age or older that are designed to meet the health and social needs of the person. The plan identifies the needs of the person and is directed toward the achievement of specific outcomes.

Advocacy: Intervening on behalf of, or representing, another person or cause.

American Sign Language (ASL): A manual or visual language in which information is expressed through combinations of handshapes, palm orientations, facial expressions, and movements of the hands, arms, and body. ASL is a complete language with its own grammar and syntax, separate from the English language.

American Sign Language interpreter (ASLI): An individual professionally trained in translating between a spoken language and American Sign Language (ASL). In other words, this person interprets what is being said into ASL for someone who is Deaf or hard of hearing.

Anecdotal evidence: An informal account of something based on stories or experience. The term is often used in contrast to scientific evidence which is a kind of formal research.

Anosognosia: Lack of awareness of deficits.

Anoxia: Stop in oxygen getting to the brain.

Anoxic: Lack of oxygen.

Aphasia: Difficulty understanding speech and/or difficulty expressing thoughts.

Assault: An action, threat or attempt to hurt another individual. It can be physical, verbal, or physical in nature.

Assessment: Process of identifying: a) a person's strengths, preferences, functional skills and need for support and services; b) the extent to which natural supports and informal providers are able to meet the person's need for support and services; and c) the extent to which human services agencies and providers are able to provide or develop needed support or services.

Assisted living: A package of regularly scheduled individualized health-related and supportive services provided to a person residing in a residential center (apartment buildings) or housing with services establishment.

Assisted living plus: A package of regularly scheduled individualized health-related and supportive services provided to a person residing in a residential center (apartment buildings) or housing with services establishment. Must include 24-hour on site supervision in addition to services provided by home care aides, home health aides or residential staff.

Assistive technology devices: As used in the Assistive Devices Supplement to the 1990 NHIS, the operational definition of assistive technology includes devices that enhance the ability of an individual with a disability to engage in major life activities, actions, and tasks. These devices assist people with deficits in physical, medical, or emotional functioning.

Auditory/oral: A communication method used by some Deaf and hard of hearing individuals in which listening is the primary means of understanding language and speech is the primary means of expressing language. In addition to listening (through the use of assistive technology such as hearing aids or cochlear implants), individuals watch the speaker for additional information from speech reading, facial expression, and gesture.

Autonomous decisions: A decision that does not affect the whole group, but only the decision-maker, and can be made by that sole party.

Autonomy: A person's ability to make independent choices; self reliance; control over environment.

B

Barrier: Something that blocks, prevents or hinders movement, action or passage.

Batterer: A person who causes physical or emotional abuse on another.

Behavior Programming: Individually designed strategies to decrease severe maladaptive behaviors that interfere with the ability of a person to remain in the community.

Benchmark: A point of reference from which a measurement can be made; something that serves as a standard for an industry, profession or other group by which other things are measured or judged.

Brain injury: Injury to the brain caused by an external physical force and not of a degenerative or congenital nature. The injury results in an impairment of cognitive abilities or physical functioning. Additional consequences of the injury may include changes in behavior and/or emotional functioning.

Burden of proof: The requirement that both sides in a case provide the required amount of evidence. Includes by preponderance of the evidence, by clear and convincing proof, and by proof beyond a reasonable doubt.

C

CADI (Community Alternatives for Disabled Individuals): MN Stat 256B.49 home and community-based services necessary as an alternative to institutionalization that promote the optimal health, independence, safety and integration of a person who would otherwise require the level of care provide in a nursing facility.

Case management: Waiver case management /service coordination services assist persons on a waiver to access needed waiver and state plan services, as well as needed medical, social, educational, housing and other support services, regardless of the funding source.

Case Management/Service Coordinator: Assists persons on a waiver to access needed waiver and state plan services, as well as needed medical, social, educational and other services, regardless of the funding source.

Case management aide: Assistance to the case manager, in carrying out administrative activities of the case management function.

CDCS (Consumer directed community supports): Service option available under the CAC, CADI, EW, MR/RC, TBI waivers that gives persons more flexibility and responsibility for directing their services and supports, including hiring and managing direct care staff, CDCS may include services, support and/or items currently available through the MA waivers, as well as additional allowable services that provide needed support to persons.

Caregiver: A person who provides direct service care to another, both formally, such as a hired Personal Care Attendant, or informally, such as an unpaid family member or friend. The term is often used to denote a person who specifically provides care for the young, the elderly, or people with disabilities.

Certified Deaf interpreter (CDI): An individual who is Deaf or hard of hearing and is certified by the Registry of Interpreters for the Deaf as an interpreter. In addition to proficient communication skill and interpreter training, the CDI has knowledge and understanding of Deaf culture and community as well as language fluency to help enhance communication.

Close-ended question: Questions that can be answered finitely by either "yes" and "no;" can include presuming, probing, restrictive or leading questions.

Closed captioning: A service that allows for people who can not hear the audio programming portion of a television show or movie, to read it by putting the words on the screen. Closed captioning provides a link to news, entertainment, and information and can also be formatted in different languages. Most TVs can turn on closed captions through the remote control or an on-screen menu.

Cognitive impairment: Difficulty with perception, memory, attention and reasoning skills. Activities of daily living, such as hygiene, eating, household management, community re-integration and many other aspects of day-to-day living are affected by cognitive changes.

Cognitive Remediation Training: Services and interventions specifically designed to improve cognitive functions.

Collaboration: According to the Fieldstone Alliance, collaboration is "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve results they are more likely to achieve together than alone." This relationship includes commitment to mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and awards.

Collective identity: A strong sense of belonging to a group that shares similar experiences or motivations; stronger than community ties or singular identity.

Community stakeholder: A member (or organization) in a particular community that has an interest in the activities of

another organization. The interest may include financial, social interests, partnership, etc.

Competency or capacity: A legal term that basically reflects a mental ability to understand the nature and effect of one's acts.

Confidentiality: The ethical principle and legal right that a professional will hold all information relating to a client in confidence, unless the client gives consent permitting disclosure or unless disclosure is required by the law.

Consensus: General agreement among the members of a group or community, each party of which has an equal right and responsibility to decision-making and follow-up action.

Confidentiality: Basic tenet in health care respecting confidential nature of patient information.

Conservatorship: Court procedure in which a court appoints a person (conservator) to manage another person's assets and estate.

Consumer Choice: Ability to choose supports and services from a range of service options to meet the diverse and personalized needs of a person. The degree to which persons have choice must go beyond the range of service choices and include opportunities for persons to decide when, where, how and who will provide supports and services.

Consumer Directed Community Supports (CDCS): Service option available under the CAC, CADI, DD, EW, TBI waivers that gives persons more flexibility and responsibility for directing their services and supports, including hiring and managing direct care staff. CDCS may include services, support and/or items currently available through the MA waivers, as well as additional allowable services that provide needed support to persons.

Continuum of care: Promotes the role of population health improvement in raising the quality of care, improving health outcomes and reducing preventable health care and injury costs for individuals. It supports "care continuum services" such as health and wellness promotion, disease management, case coordination, violence prevention, community resources by means of advocacy, research and the promotion of best practices.

Control: The ability to block or limit influence.

Core competency: An area of specialized knowledge that is a result of collective efforts of education, technology and work activity.

Co-occurring disorders: Where two or more diagnosis are recognized in an individual (i.e., depression and chemically dependency)

Counseling: A method utilized by a specially-trained individual who utilizes a dynamic, holistic, strengths-based approach to assist clients to increase self-awareness, personal growth and wellness.

Crisis Line: A no cost 24/7 phone service that offers support, information and referrals by staff or volunteers who are trained in domestic violence issues and are knowledgeable about community resources.

Crisis Services: Services that provide specific short-term care and intervention strategies to a person due to the need for relief and support of the caregiver and/or protection of the person or others living with that person. This includes addressing both medical and behavioral needs. For domestic violence these services include safety planning, harm reduction, and outreach.

Cued speech: A communication method used by some Deaf and hard of hearing individuals that is designed to make visually available all the elements needed to understand spoken English. It combines information that can be seen through watching lip movements with information from additional hand shapes and hand positions near the face, used to identify sounds that can't be seen on the lips or that look the same on the lips.

Cultural competency: The ability of certain people of one culture (often a dominant one) to acknowledge and consider the needs and interests of other cultures.

Culture: The values, traditions, norms, customs, arts, history, folklore, and institutions that a group of people, who are unified by race, ethnicity, language, nationality, or religion, share; the way of life shared by the members of a group.

Cyber stalking: Threatening behavior or unwanted advances directed at another using the Internet and other devices or forms of technology. Cyber stalkers target their victims by making threatening or obscene e-mails or text messaging, hiding cameras, spamming, tracking computers and internet activity, tracking movement through GPS in cell phones, and in numerous other ways.

D

Deaf: Individuals with severe to profound hearing loss. The lowercase "d" reflects a physical or audiological perspective. Individuals who identify with and participate in the language, culture and community of Deaf people, based on sign language. The capital "D" reflects this socio-cultural point of view.

Deaf-blind: Individuals who have lost varying degrees of their hearing and sight.

Deafhood: According to Paddy Ladd, who coined the term, Deafhood is "the process of defining the existential state of Deaf 'being-in-the-world.' Deafhood is not seen as a finite state but as a process by which Deaf individuals come to actualize their Deaf identity, positing that those individuals construct that identity around several differently ordered sets of priorities and principles, which are affected by various factors such as nation, era and class."

Deafness: A term that is used to describe hearing loss from a medical perspective.

Democratic decisions: Decisions that are settled by vote and require a majority of voters' support.

Depression: Depression is a common mental disorder marked by sadness, inactivity, difficulty in thinking and concentration, a significant increase or decrease in appetite and time spent sleeping, feelings of dejection and hopelessness, and sometimes suicidal tendencies. It occurs in people of all genders, ages and backgrounds.

Developmental disabilities: According to the CDC, developmental disabilities are a diverse group of severe chronic conditions that are due to mental and/or physical impairments. People with developmental disabilities have problems with major life activities such as language, mobility, learning, self-help, and independent living. Developmental disabilities begin anytime during development up to 22 years of age, and usually last throughout a person's lifetime.

Disability: Inability to engage in substantial gainful activity by reason of any medically determined physical or mental impairment that can be expected to last for a continuous period of not less than 12 months. To be eligible for one of the waiver programs, the Social Security Administration or the State Medical Review Team (SMRT) must certify the person as disabled.

Disability Determination: Person must meet the disability definition from the Social Security Administration to be eligible to receive MA benefits as a disabled person. A person may also be certified disabled by the Social Security Administration or State Medical Review Team (SMRT).

Disclosure: The act of sharing personal information which might, under other circumstances, is kept secret.

Discrimination: The act or practice of categorically judging rather than individually judging a group or idea.

Domestic abuse: Includes: putdowns, keeping a partner from contacting their family or friends, withholding money, stopping a partner from getting or keeping a job, actual or threatened physical harm, sexual assault, stalking, intimidation.

Domestic violence: Behaviors used by one person in a relationship to control the other. Partners may be married or not married; heterosexual, gay, or lesbian; living together, separated, dating and in some cases a personal care attendant.

Dual diagnosis: Used to describe the presence of one or more disorders (or diseases) in addition to a primary disease or disorder such as a person suffering from a mental illness and a substance abuse problem.

E

Ethics: A sense of, or system of, morals and values.

Etiquette: Appropriate conduct or procedure, as required by social or official life.

Empowerment: Refers to increasing the spiritual, political, social, or economic strength of individuals and communities. Developing confidence in one's own capacities.

Emotional dysregulation (**ED**): Used in mental health community to refer to an emotional response that is poorly regulated and does not fall within the conventionally accepted range of emotive response.

F

Family training, education and counseling: Services provided for the person and/or the family as identified in the individual plan of care. CAC waiver has two separate services known as Family Training and Family Counseling. CADI and TBI Waivers have one service known as Family Training and Counseling and Education.

Flashback: The vivid reoccurrence of a past, usually traumatic, incident in the mind.

Framework: Basic, conceptual structure; a structural plan or formula.

G

Goal: The end towards which effort is directed.

Guardianship: Court-ordered or confirmed protective arrangement whereby an interested person or party is nominated and appointed as a guardian for an incapacitated person for the purpose of managing the personal care and affairs of a person.

H

Hard of hearing: Individuals who experience hearing loss from a physical or audiological perspective. An individual who is hard of hearing may primarily use spoken language (their residual hearing and speech) to communicate.

Harm reduction: Refers to a range of public health policies designed to reduce the harmful consequences associated with recreational drug use and other high risk activities. The objective is to provide services that help individuals manage their addictions and health without abstinence being the only measure of success.

Hearing: Individuals who are not deaf and who come from the dominant American culture.

Hemiparesis: Weakness on one side of body.

Hydrocephalus: Excess cerebrospinal fluid.

I

Incidence: The number of new cases of a disease or other condition occurring in a population during a defined time interval.

Inclusion: When persons with disabilities are not only in the same place as persons without disabilities but also participate in the same activities at the same time

Independent living skills: Services that develop and maintain the community living skills and community integration of a person. Independent livings skills must be provided in: person's home and/or community settings typically used by the general public.

Independent living skills – TBI therapies: Specified in the individual plan of care that have specific therapeutic goals and outcomes established and are not merely diversional in nature. Independent living skills – TBI (ILS-TBI) therapies may be provided in the home of the person or in the community.

Informed Choice: Voluntary decision, made by a person (consumer) or the person's (consumer's) legal representative, after becoming familiarized with alternatives to:
• Select from a number of feasible alternatives
• Select an alternative that may be developed in the future
• Refuse any or all alternatives

Informed decision: A decision based on relevant and sufficient information.

Instant messenger: A free online service that lets you communicate over your computer or PDA in real time. Using certain features you can see when people are available to "talk" with you. There are various kinds of IM services.

Institutionalization: The act of placing someone in the care of an institution, care facility, or other agency that will be responsible for full care of a person. Historically, many people with disabilities were institutionalized against their will.

Intake Process: An initial assessment of needed services and a process used to collect demographic information on an individual served**.**

Interactive: Involving the actions or responses of users.

J

Jurisdiction: The territorial range of a law, authority, or certain kinds of control; the right to interpret legal rights and interpret the law.

K

Kinesthesia: A sense mediated by receptors located in muscles, tendons, and joints and simulated by bodily movements and tensions that regulate a person's perception of space and movement.

L

Late-deafened: Individuals, who grow up hearing or hard of hearing and, either suddenly or gradually, experience a profound loss of hearing later in life.

Least restrictive environment: As part of the Individuals with Disabilities Act, this is one of the six principles that govern the education of students with disabilities which states that a student who has a disability should have the opportunity to be educated with non-disabled peers, to the greatest extent possible.

Legal guardian: Person with legal authority and duty to act on behalf of the ward as a substitute decision-maker to care for personal and property interests of another person.

Linguist: A person who specializes in languages.

M

Mainstream: To incorporate into the majority or general group.

Mandatory reporter: A professional who is required by law to make a report to federal, state, or local agencies when abuse, neglect or violence have occurred. Oftentimes, such reporters include health care workers, welfare workers, teachers or social workers, residential service workers, and law enforcement personnel. Laws vary by state.

Mandatory reporting: All states have mandatory reporting laws, and although the specifics may vary among states, these laws require that certain professional groups report certain cases of abuse and/or neglect to law enforcement, social services and/or other regulatory agencies.

Manually Coded English (MCE): A term used to describe a visual (signed) form of the English language. While this system may use American Sign Language (ASL) signs as a base, they follow the grammar and syntax of English.

Mediation: An act in which a neutral third party sits down with the parties in conflict to look for mutually acceptable solutions.

Memory problems: Considered the most disabling consequence of brain injury, impaired memory affects a person's ability to learn, retain, and use new information and may significantly affect a person's ability to live independently.

Mental health: Describes a level of cognitive or emotion well-being or the absence of a mental disorder. According to the World Health Organization mental health is defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"

Mental illness: Psychological or behavioral pattern associated with distress or disability that occurs in an individual and is not a part of normal development or culture. Mental disorders are conceptualized as disorders of brain circuits likely caused by developmental processes shaped by a complex interplay of genetics and experience

Methodology: A particular set of procedures or analyses employed by a discipline.

Mild brain injury: Characteristics include: loss of consciousness for less than 30 minutes (or no loss); Glasgow Coma Scale of 13-15; post-traumatic amnesia for less than 24 hours; temporary or permanently altered mental or neurological state; post concussion symptoms.

Minnesota Disability Health Options Program (MnDHO): Health care program for people with physical disabilities who are eligible for Medical Assistance (MA). People who are eligible for both MA and Medicare may also enroll. People with physical disabilities can choose to join MnDHO or stay in their current MA program. MnDHO is a flexible, person-centered service delivery model providing specialized services and coordination of care across acute and long-term care, including nursing home and home and community-based waiver services.

Minority: The smaller in number of two groups constituting a whole; a group having less than the number of votes necessary for control; a part of the population differing from others in some characteristics and often subjected to differential treatment.

Mission: A pre-established and often self-imposed objective or purpose.

Moderate brain injury: Characteristics include: coma more than 20-30 min., but less than 24 hours; Glasgow Coma Scale of 9-12; possible skull fractures with bruising and bleeding; signs on EEF, CAT or MRI scans; some long term problems in one or more areas.

Modifications and Adaptations: Physical adaptations to the person's home and/or vehicle

N

Neglect: A passive form of abuse in which a person is responsible to provide care for another who is unable to care for oneself, but fails to provide adequate care to meet the person's needs. Includes: failing to provide sufficient supervision, nourishment, medical care or other needs for which the individual is helpless to provide for him or her self.

Negotiate: A dialogue intended to resolve disputes, to produce an agreement about a course of action, or to agree on an outcome that satisfies various interests.

O

Objective: Something towards which effort is directed; an aim, goal or end of action; a strategic position to be attained.

Omission: Failure to do something one can and ought to do.

Open-ended question: Questions that will solicit additional information from the inquirer; broad in nature and requiring more than a one or two word answer.

Oppression: The exercise of authority or power in a burdensome, cruel, or unjust manner. It can also be defined as an act or instance of oppressing, the state of being oppressed, and the feeling of being heavily burdened, mentally or physically, by troubles, adverse conditions, and anxiety.

Order for Protection: A legal process that limits the contact an offender can have with a victim (and/or their children and pets) of domestic violence, harassment, stalking or sexual assault. Referred to as restraining order in many states.

Outcome: Benefit of services or supports as defined by the individual recipient of service.

P

Pager: An electronic device used to contact people via a paging network. It pre-dates mobile phone technology, and today has mostly been replaced by PDAs and other text-messaging equipment.

Person-Centered Services: The system of providers and services to meet the needs of the client.

Perpetrator: A person who executes criminal behavior such as sexual assault, rape, and assault

Physical disability: The World Health Organization defines as follows: "Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives."

Posttraumatic Stress Disorder (PTSD): A complex health condition that can develop in any person in response to a traumatic experience that causes a person to feel intense fear, horror or a sense of helplessness. PTSD can cause severe problems at home or at work.

Post-concussion symptoms: May or may not persist and include: headache, dizziness, vomiting, sleep disturbance, memory problems, changes in personality, irritability, depression, changes in personality, difficulty in problem solving, diminished attention span.

Power of attorney: Authorization to act on someone else's behalf in a legal or business matter.

Prevalence: A measure of a condition in a population at a given point in time.

Privilege: Special entitlement or immunity granted by a government or other authority to a restricted group, either by birth or on a conditional basis.

Protocol: A code prescribing strict adherence to correct etiquette and precedence; a set of conventions governing the treatment and formatting of data or other information.

Psychotherapy: An intentional interpersonal relationship used by trained psychotherapists to aid a client/patient in problems of living where the aim is to increase the individual's sense of their own well being.

Q

R

Rape Trauma Syndrome (RTS): The emotional response to the extreme stress experienced by the survivor of sexual assault. RTS is a response to the profound fear of death that almost all survivors experience during an assault.

Referral: The act, action, or instance of sending or directing to treatment or assistance of some kind.

Residential Care: Supportive and health supervision services provided in a licensed residential setting as identified in an Individual Service Plan.

Respite: Services provided to persons unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Revictimization: a pattern wherein the victim of abuse and/or crime has a statistically higher tendency to be victimized again, either shortly thereafter or much later in adulthood in the case of abuse as a child. Revictimization in the short term is often the result of risk factors that were already present, which were not changed or mitigated after the first victimization; sometimes the victim cannot control these factors.

S

Safety Plan: Identifies specific strategies and resources to help individuals try to protect themselves before, during, or after a dangerous situations. Safety plans are customized to an individual's or family's situation, and usually address things like securing documents and other necessary items, building support systems, and identifying places to go in a time of crisis.

Screen: To examine methodically in order to make a separation into different groups or acceptance; to test or examine for the presence of something.

Self-determination: Free choice of one's own acts without external compulsion.

Self-sufficiency: A state of not requiring any outside aid, support, or interaction, for survival; it is therefore a type of personal or collective autonomy

Sexual abuse: the forcing of undesired sexual behavior by one person upon another, when that force is immediate, short duration, or infrequent, it is called sexual assault.

Sexual harassment: A form of sex discrimination. According to the Equal Employment Opportunity Commission, unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitutes sexual harassment when submission to or rejection of this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance or creates an intimidating, hostile or offensive work environment.

Shelter: A place where individuals and their children can live in a safe and support environment for a short period of time, usually during a crisis, free of charge. This gives families time to determine their options.

Shock: The impact or effect of a violent or jarring experience. A state of being depressed, disturbed, or scared.

Socio-economic status: Of, relating to, or involving a combination of social and economic factors.

Social change: Alterations in basic structures of a social group or society.

Specialized supplies and equipment: devices, controls or medical appliances specified in the plan of care that enable the person to increase their ability to: perform activities of daily living; to perceive, control or interact with their environment or communicate with others.

Stalker: Someone who obsessively pursues another person. People who execute stalking behavior and break stalker laws.

Stalking: Refers to unwanted, obsessive attention by individuals (and sometimes groups of people) to others. Stalking behaviors are related to harassment and intimidation.

Stakeholder: One that has an interest in and connection to the outcome of a certain gain or loss.

Strengths-based practice: A social work practice theory that emphasizes people's self determination, strengths, talents, and skills. Strengths based practice is client led, with a focus on future outcomes and strengths that the people bring to a problem or crisis

Structured day program: Service designed for persons who may benefit from continued rehabilitation and community integration directed at the development and maintenance of community living skills. Structured day program services take place in a non-residential setting separate from the home of the person and must include intensive therapeutic interventions.

Strategy: A long term plan of action designed to achieve a particular goal, as differentiated by certain tactics or actions.

Substance abuse: Refers to a maladaptive pattern of use of a substance that is not considered dependent.

Substance dependence: Can be diagnosed with physiological dependence, evidence of tolerance or withdrawal, or without physiological dependence.

Support Groups: Groups offer a mean of sharing confidential conversations with other in similar situations and receive emotional support from others. Groups are facilitated by trained staff or volunteers.

Survey: A written set of questions used to collect information from a defined group of individuals.

Survivor: A person who has continued to live, prosper or remain functional after a traumatic event; considered an empowering term. To be healed and strong.

Sustainability: The capacity to endure, maintain, support.

T

Tactic: A method or device for accomplishing an end.

TBI Model Systems: Research centers involved in prospective, longitudinal multi-center efforts to examine the course of recovery and outcomes following TBI.

Telecommunication relay services: A telephone service that allows persons with hearing or speech disabilities to place and receive telephone calls by using operators to facilitate conversations over the phone through a typewriter or computer.

Teletypwriter (TTY): A device that allows people who are deaf, hard of hearing or have speech difficulties use the telephone to communicate, by typing messages back and forth to one another. The messages get sent over the phone line, and other person's responses can be read on the TTY's text display.

Template: Something that serves as or establishes a pattern.

Therapist: A person with special skills obtained through education, training and experience in one or more areas of mental health.

Timeframe: A period of time, especially with respect to certain actions or project's completion.

Trauma: An altered sense of self resulting from severe mental or emotional stress or physical injury.

Trauma informed care: An environment that is intended to be more supportive, comprehensively integrated, and empowering for trauma survivors.

Traumatic Brain injury (TBI) Waiver: Home and community - based services necessary as an alternative to institutionalization that promote the optimal health, independence, safety and integration of an eligible person and who would otherwise require the level of care provided in a specialized nursing facility or neurobehavioral hospital.

Transitional Services: Covers items, expenses and related support that are necessary and reasonable for a person to transition to their own home from one of the following settings: adult foster care homes, family and group family foster care, hospitals, intensive rehabilitation treatment and rule 36 settings, intermediate care facilities, nursing facilities, domestic violence shelter and transitional housing.

Treatment: Process of modifying or altering something such as using a form of therapy to remedy a health problem.

U

Undue burden: An accommodation that is unduly costly, extensive, substantial or disruptive, or would fundamentally alter the nature or operation of an organization or program.

Universal Design: A framework for the design of places, things, information, communication and policy to be usable by the widest range of people operating in the widest range of situations without special or separate design. Most simply, Universal Design is human-centered design of everything with everyone in mind.

V

Victim: A person against whom a crime is committed; most often used as a legal term, but also used in some organizations when discussing women or survivors who come in for services.

Victim blaming: Holds that the victim of a crime, accident or any type of abusive maltreatment to be entirely or partially responsible for the unfortunate incident that has occurred in their life. It is also about blaming individuals for their personal distress or for social difficulties, rather than the other parties involved or the overarching social system in place.

Victim/survivor: A phrase that recognizes two perspectives on the experiences of people who have experienced domestic violence, sexual assault, and stalking. While some agencies might refer to someone as a victim, others prefer to use 'survivor.

Video Relay Service (VRS): A free service for Deaf and hard of hearing individuals that enables anyone to conduct video relay calls with family, friends or business associates through an interpreter via a high-speed Internet connection and a video relay solution (or VRS call option).

Videophone: A videophone is a type of technology that allows Deaf people to use their computer or TV, with a camera and a high speed connection to see each other and communicate directly in ASL.

Violence Against Women Act (VAWA): A law passed by U.S. Congress in 1994 and again in 2005. The legislation strengthens law enforcement's response to domestic violence, strengthens services to victims, promotes education about domestic violence, and provides immigration relief for victims (self-petitioning for immigration status and cancellation of deportation). VAWA also provides that domestic violence offenses and violations of protective orders are deportable offenses.

Vision statement: A statement giving broad, aspirational image of the future that an organization is aiming to achieve.

Voice Carry-Over (VCO): A tool for people who are Deaf or hard of hearing but who wish to use their own voice and speak directly to the other party. In response, the relay operator types what is said by the other party and the VCO user reads it on TTY text display.

Vulnerable Adult: *See appendix for full description*

W

Waiver Services Programs: Programs that have received federal approval for expanded coverage for services not usually covered under MA. Minnesota offers the following waivers:

- Community Alternative Care (CAC) Waiver for chronically ill persons
- Community Alternatives for Disabled Individuals (CADI) Waiver
- Domestic Violence (DV) Waver
- Elderly Waiver (EW) Waiver
- Persons with Developmental Disability (DD) or Related Condition Waiver
- Traumatic Brain injury (TBI) Waiver

White cane: A mobility tool that can assist someone who is blind in travel. It can be used to feel for objects or obstacles, as an alert to other people, or to offer physical stability to the user.

Women's Counselor: An individual who provides support for women in shelter through the following activities: 1) goal and safety planning, 2) case management, and 3) support group facilitation, 4) skill building and information sharing. Additionally, program services include: 1) providing emotional support, 2) connecting residents to resources, 3) managing crisis phone calls/situation, and 4) working with community service providers.

Work plan: A detailed, written plan detailing the work that a group or team will accomplish, including an outline of duties, supervisors, checks and balances, resources, and a time frame.

X
Y
Z

The terms included in this glossary were compiled from a number of sources. Disability and planning terms: Accessing Safety Initiative, www.accessingsafety.org, Brain Injury Association, www.braininjury.org, Minnesota Department of Health, www.health.state.mn.us, and individual staff from the Brain Injury Association and Tubman.

Appendix

HIPPA (Federal Health Insurance Portability and Protection Act)
These federal regulations were established to create uniform standards for electronic health care transactions (EDI), establish security protections for data that is electronically stored and transmitted (Security), and set forth privacy rights for individuals regarding their personally identifiable health information (Privacy). Tubman and the Brain Injury Association of Minnesota follow these regulations and have policies and procedures in place for staff to adhere to the regulations. Releases of information are utilized by both organizations when working with other providers to coordinate resources to benefit consumer, residents, and clients.

AMERICAN DISABILITY ACT (ADA)
Tubman and the Brain Injury Association of Minnesota are aware of the federal American Disabilities Act that serves to prevent discrimination against individuals with disabilities and have adopted practices based on their interpretation of the Act. Staff utilize resource information from the Minnesota State Council on Disability (www.disability.state.mn.us/) developed specifically for lawmakers, agencies, non-profits, businesses and individuals with disabilities and the Minnesota Disability Law Center (http://www.mylegalaid.org/) which offers support in understanding specific ADA interpretations and applications.

Individuals with mental and physical disabilities are served through a variety of programs and services offered by Tubman and the Brain Injury Association of Minnesota. Individuals with a mental disability are limited to learning, remembering, and concentrating because of a physical, mental, or emotional condition. Individuals with a physical disability are limited to walking, climbing stairs, reaching, lifting or carrying items. Both organizations strive to meet the special needs of individuals with these disabilities.

The World Health Organization (WHO) defines disability as a contextual variable, dynamic over time and in relation to circumstances. One is more or less disabled based on the interaction between the person and the individual, institutional and social environments. WHO moved to an international classification system, the International Classification of Functioning, Disability and Health (ICF 2001) which emphasizes functional status over diagnosis. The system eliminates explicitly or implicitly distinctions between health conditions that are 'mental' or 'physical' and acknowledges the prevalence of disability corresponding to social and economic status. They support Universal Design as an international priority for reducing the experience of disability and enhancing everyone's experience and performance.

626.557 REPORTING OF MALTREATMENT OF VULNERABLE ADULTS.

Subdivision 1. **Public policy.** The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment; to assist in providing safe environments for vulnerable adults; and to provide safe institutional or residential services, community-based services, or living environments for vulnerable adults who have been maltreated.

In addition, it is the policy of this state to require the reporting of suspected maltreatment of vulnerable adults, to provide for the voluntary reporting of maltreatment of vulnerable adults, to require the investigation of the reports, and to provide protective and counseling services in appropriate cases.

Subd. 2. [Repealed, 1995 c 229 art 1 s 24]

Subd. 3. **Timing of report.** (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.

Subd. 3a. **Report not required.** The following events are not required to be reported under this section:

(1) A circumstance where federal law specifically prohibits a person from disclosing patient identifying information in connection with a report of suspected maltreatment, unless the vulnerable adult, or the vulnerable adult's guardian, conservator, or legal representative, has consented to disclosure in a manner which conforms to federal requirements. Facilities whose patients or residents are covered by such a federal law shall seek consent to the disclosure of suspected maltreatment from each patient or resident, or a guardian, conservator, or legal representative, upon the patient's or resident's admission to the facility. Persons who are prohibited by federal law from reporting an incident of suspected maltreatment shall immediately seek consent to make a report.

(2) Verbal or physical aggression occurring between patients, residents, or clients of a facility, or self-abusive behavior by these persons does not constitute abuse unless the behavior causes serious harm. The operator of the facility or a designee shall record incidents of aggression and self-abusive behavior to facilitate review by licensing agencies and county and local welfare agencies.

(3) Accidents as defined in section 626.5572, subdivision 3.
(4) Events occurring in a facility that result from an individual's error in the provision of therapeutic conduct to a vulnerable adult, as provided in section 626.5572, subdivision 17, paragraph (c), clause (4).
(5) Nothing in this section shall be construed to require a report of financial exploitation, as defined in section 626.5572, subdivision 9, solely on the basis of the transfer of money or property by gift or as compensation for services rendered.
Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, to the extent necessary to comply with this subdivision.
(b) A boarding care home that is licensed under sections 144.50 to 144.58 and certified under Title 19 of the Social Security Act, a nursing home that is licensed under section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under Code of Federal Regulations, title 42, section 482.66, may submit a report electronically to the common entry point instead of submitting an oral report. The report may be a duplicate of the initial report the facility submits electronically to the commissioner of health to comply with the reporting requirements under Code of Federal Regulations, title 42, section 483.13. The commissioner of health may modify these reporting requirements to include items required under paragraph (a) that are not currently included in the electronic reporting form.
Subd. 4a. **Internal reporting of maltreatment.** (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section.
(b) A facility with an internal reporting procedure that receives an internal report by a mandated reporter shall give the mandated reporter a written notice stating whether the facility has reported the incident to the common entry point. The written notice must be provided within two working days and in a manner that protects the confidentiality of the reporter.
(c) The written response to the mandated reporter shall note that if the mandated reporter is not satisfied with the action taken by the facility on whether to report the incident to the common entry point, then the mandated reporter may report externally.
(d) A facility may not prohibit a mandated reporter from reporting externally, and a facility is prohibited from retaliating against a mandated reporter who reports an incident to the common entry point in good faith. The written notice by the facility must inform the mandated reporter of this protection from retaliatory measures by the facility against the mandated reporter for reporting externally.
Subd. 5. **Immunity; protection for reporters.** (a) A person who makes a good faith report is immune from any civil or criminal liability that might otherwise result from making the report, or from participating in the investigation, or for failure to comply fully with the reporting obligation under section 609.234 or 626.557, subdivision 7.
(b) A person employed by a lead agency or a state licensing agency who is conducting or supervising an investigation or enforcing the law in compliance with this section or any related rule or provision of law is immune from any civil or criminal liability that might otherwise result from the person's actions, if the person is acting in good faith and exercising due care.

(c) A person who knows or has reason to know a report has been made to a common entry point and who in good faith participates in an investigation of alleged maltreatment is immune from civil or criminal liability that otherwise might result from making the report, or from failure to comply with the reporting obligation or from participating in the investigation.
(d) The identity of any reporter may not be disclosed, except as provided in subdivision 12b.
(e) For purposes of this subdivision, "person" includes a natural person or any form of a business or legal entity.
Subd. 5a. **Financial institution cooperation.** Financial institutions shall cooperate with a lead agency, law enforcement, or prosecuting authority that is investigating maltreatment of a vulnerable adult and comply with reasonable requests for the production of financial records as authorized under section 13A.02, subdivision 1. Financial institutions are immune from any civil or criminal liability that might otherwise result from complying with this subdivision.
Subd. 6. **Falsified reports.** A person or facility who intentionally makes a false report under the provisions of this section shall be liable in a civil suit for any actual damages suffered by the reported facility, person or persons and for punitive damages up to $10,000 and attorney fees.
Subd. 7. **Failure to report.** A mandated reporter who negligently or intentionally fails to report is liable for damages caused by the failure. Nothing in this subdivision imposes vicarious liability for the acts or omissions of others.
Subd. 8. **Evidence not privileged.** No evidence regarding the maltreatment of the vulnerable adult shall be excluded in any proceeding arising out of the alleged maltreatment on the grounds of lack of competency under section 595.02.
Subd. 9. **Common entry point designation.** (a) Each county board shall designate a common entry point for reports of suspected maltreatment. Two or more county boards may jointly designate a single common entry point. The common entry point is the unit responsible for receiving the report of suspected maltreatment under this section.
(b) The common entry point must be available 24 hours per day to take calls from reporters of suspected maltreatment. The common entry point shall use a standard intake form that includes:
(1) the time and date of the report;
(2) the name, address, and telephone number of the person reporting;
(3) the time, date, and location of the incident;
(4) the names of the persons involved, including but not limited to, perpetrators, alleged victims, and witnesses;
(5) whether there was a risk of imminent danger to the alleged victim;
(6) a description of the suspected maltreatment;
(7) the disability, if any, of the alleged victim;
(8) the relationship of the alleged perpetrator to the alleged victim;
(9) whether a facility was involved and, if so, which agency licenses the facility;
(10) any action taken by the common entry point;
(11) whether law enforcement has been notified;
(12) whether the reporter wishes to receive notification of the initial and final reports; and
(13) if the report is from a facility with an internal reporting procedure, the name, mailing address, and telephone number of the person who initiated the report internally.
(c) The common entry point is not required to complete each item on the form prior to dispatching the report to the appropriate investigative agency.
(d) The common entry point shall immediately report to a law enforcement agency any incident in which there is reason to believe a crime has been committed.
(e) If a report is initially made to a law enforcement agency or a lead agency, those agencies shall take the report on the appropriate common entry point intake forms and immediately forward a copy to the common entry point.
(f) The common entry point staff must receive training on how to screen and dispatch reports efficiently and in accordance with this section.
(g) When a centralized database is available, the common entry point has access to the centralized database and must log the reports in on the database.

Subd. 9a. **Evaluation and referral of reports made to common entry point unit.** The common entry point must screen the reports of alleged or suspected maltreatment for immediate risk and make all necessary referrals as follows:
(1) if the common entry point determines that there is an immediate need for adult protective services, the common entry point agency shall immediately notify the appropriate county agency;
(2) if the report contains suspected criminal activity against a vulnerable adult, the common entry point shall immediately notify the appropriate law enforcement agency;
(3) if the report references alleged or suspected maltreatment and there is no immediate need for adult protective services, the common entry point shall notify the appropriate lead agency as soon as possible, but in any event no longer than two working days;
(4) if the report does not reference alleged or suspected maltreatment, the common entry point may determine whether the information will be referred; and
(5) if the report contains information about a suspicious death, the common entry point shall immediately notify the appropriate law enforcement agencies, the local medical examiner, and the ombudsman established under section 245.92. Law enforcement agencies shall coordinate with the local medical examiner and the ombudsman as provided by law.
Subd. 9b. **Response to reports.** Law enforcement is the primary agency to conduct investigations of any incident in which there is reason to believe a crime has been committed. Law enforcement shall initiate a response immediately. If the common entry point notified a county agency for adult protective services, law enforcement shall cooperate with that county agency when both agencies are involved and shall exchange data to the extent authorized in subdivision 12b, paragraph (g). County adult protection shall initiate a response immediately. Each lead agency shall complete the investigative process for reports within its jurisdiction. A lead agency, county, adult protective agency, licensed facility, or law enforcement agency shall cooperate in coordinating its investigation with other agencies and may assist another agency upon request within the limits of its resources and expertise and shall exchange data to the extent authorized in subdivision 12b, paragraph (g). The lead agency shall obtain the results of any investigation conducted by law enforcement officials. The lead agency has the right to enter facilities and inspect and copy records as part of investigations. The lead agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. Each lead agency shall develop guidelines for prioritizing reports for investigation.
Subd. 9c. **Lead agency; notifications, dispositions, determinations.** (a) Upon request of the reporter, the lead 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 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 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 agency shall complete its final disposition within 60 calendar days. If the lead agency is unable to complete its final disposition within 60 calendar days, the lead 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 legal guardian, when known, if the lead agency knows them to be aware of the investigation; and (2) the facility, where applicable. The notice shall contain the reason for the delay and the projected completion date. If the lead agency is unable to complete its final disposition by a subsequent projected completion date, the lead agency shall again notify the vulnerable adult or the vulnerable adult's legal guardian, when known if the lead agency knows them to be aware of the investigation, and the facility, where applicable, 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. A lead 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 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 legal guardian, if known unless the lead 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) The lead agency shall notify the vulnerable adult who is the subject of the report or the vulnerable adult's legal guardian, 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.
(h) The lead agency shall routinely provide investigation memoranda for substantiated reports to the appropriate licensing boards. These reports must include the names of substantiated perpetrators. The lead agency may not provide investigative memoranda for inconclusive or false reports to the appropriate licensing boards unless the lead agency's investigation gives reason to believe that there may have been a violation of the applicable professional practice laws. If the investigation memorandum is provided to a licensing board, the subject of the investigation memorandum shall be notified and receive a summary of the investigative findings.
(i) In order to avoid duplication, licensing boards shall consider the findings of the lead agency in their investigations if they choose to investigate. This does not preclude licensing boards from considering other information.
(j) The lead agency must provide to the commissioner of human services its final dispositions, including the names of all substantiated perpetrators. The commissioner of human services shall establish records to retain the names of substantiated perpetrators.
Subd. 9d. **Administrative reconsideration; review panel.** (a) Except as provided under paragraph (e), any individual or facility which a lead agency determines has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead agency's determination, who contests the lead agency's final disposition of an allegation of maltreatment, may request the lead agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's legal guardian. If mailed, the request for

reconsideration must be postmarked and sent to the lead agency within 15 calendar days of the individual's or facility's receipt of the final disposition. If the request for reconsideration is made by personal service, it must be received by the lead agency within 15 calendar days of the individual's or facility's receipt of the final disposition. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted in writing within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the lead agency within 30 calendar days of the individual's receipt of the notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the lead agency within 30 calendar days after the individual's receipt of the notice of disqualification.

(b) Except as provided under paragraphs (e) and (f), if the lead agency denies the request or fails to act upon the request within 15 working days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045, may submit to the commissioner of human services a written request for a hearing under that statute. The vulnerable adult, or an interested person acting on behalf of the vulnerable adult, may request a review by the Vulnerable Adult Maltreatment Review Panel under section 256.021 if the lead agency denies the request or fails to act upon the request, or if the vulnerable adult or interested person contests a reconsidered disposition. The lead agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the lead agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered disposition. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the lead agency changes the final disposition, it shall notify the parties specified in subdivision 9c, paragraph (d).

(d) For purposes of this subdivision, "interested person acting on behalf of the vulnerable adult" means a person designated in writing by the vulnerable adult to act on behalf of the vulnerable adult, or a legal guardian or conservator or other legal representative, a proxy or health care agent appointed under chapter 145B or 145C, or an individual who is related to the vulnerable adult, as defined in section 245A.02, subdivision 13.

(e) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied or if the disqualification is not set aside under sections 245C.21 to 245C.27, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, the scope of the contested case hearing must include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing must not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination under this subdivision, and reconsideration of a disqualification under section 245C.22, must not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section

245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;
(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and
(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction.
Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.
If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.
(g) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August 1, 2001, that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.
(1) For purposes of compliance with the data destruction schedule under subdivision 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.
(2) For purposes of any background studies under chapter 245C, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under chapter 245C that was based on this determination of maltreatment shall be rescinded, and for future background studies under chapter 245C the commissioner must not use the previous determination of substantiated maltreatment as a basis for disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245C.31.
Subd. 9e. **Education requirements.** (a) The commissioners of health, human services, and public safety shall cooperate in the development of a joint program for education of lead agency investigators in the appropriate techniques for investigation of complaints of maltreatment. This program must be developed by July 1, 1996. The program must include but need not be limited to the following areas: (1) information collection and preservation; (2) analysis of facts; (3) levels of evidence; (4) conclusions based on evidence; (5) interviewing skills, including specialized training to interview people with unique needs; (6) report writing; (7) coordination and referral to other necessary agencies such as law enforcement and judicial agencies; (8) human relations and cultural diversity; (9) the dynamics of adult abuse and neglect within family systems and the appropriate methods for interviewing relatives in the course of the assessment or investigation; (10) the protective social services that are available to protect alleged victims from further abuse, neglect, or financial exploitation; (11) the methods by which lead agency investigators and law enforcement workers cooperate in conducting assessments and investigations in order to avoid duplication of efforts; and (12) data practices laws and procedures, including provisions for sharing data.
(b) The commissioners of health, human services, and public safety shall offer at least annual

education to others on the requirements of this section, on how this section is implemented, and investigation techniques.
(c) The commissioner of human services, in coordination with the commissioner of public safety shall provide training for the common entry point staff as required in this subdivision and the program courses described in this subdivision, at least four times per year. At a minimum, the training shall be held twice annually in the seven-county metropolitan area and twice annually outside the seven-county metropolitan area. The commissioners shall give priority in the program areas cited in paragraph (a) to persons currently performing assessments and investigations pursuant to this section.
(d) The commissioner of public safety shall notify in writing law enforcement personnel of any new requirements under this section. The commissioner of public safety shall conduct regional training for law enforcement personnel regarding their responsibility under this section.
(e) Each lead agency investigator must complete the education program specified by this subdivision within the first 12 months of work as a lead agency investigator.
A lead agency investigator employed when these requirements take effect must complete the program within the first year after training is available or as soon as training is available.
All lead agency investigators having responsibility for investigation duties under this section must receive a minimum of eight hours of continuing education or in-service training each year specific to their duties under this section.
Subd. 10. **Duties of county social service agency.** (a) Upon receipt of a report from the common entry point staff, the county social service agency shall immediately assess and offer emergency and continuing protective social services for purposes of preventing further maltreatment and for safeguarding the welfare of the maltreated vulnerable adult. In cases of suspected sexual abuse, the county social service agency shall immediately arrange for and make available to the vulnerable adult appropriate medical examination and treatment. When necessary in order to protect the vulnerable adult from further harm, the county social service agency shall seek authority to remove the vulnerable adult from the situation in which the maltreatment occurred. The county social service agency may also investigate to determine whether the conditions which resulted in the reported maltreatment place other vulnerable adults in jeopardy of being maltreated and offer protective social services that are called for by its determination.
(b) County social service agencies may enter facilities and inspect and copy records as part of an investigation. The county social service agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. The inquiry is not limited to the written records of the facility, but may include every other available source of information.
(c) When necessary in order to protect a vulnerable adult from serious harm, the county social service agency shall immediately intervene on behalf of that adult to help the family, vulnerable adult, or other interested person by seeking any of the following:
(1) a restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to section 518B.01;
(2) the appointment of a guardian or conservator pursuant to sections 524.5-101 to 524.5-502, or guardianship or conservatorship pursuant to chapter 252A;
(3) replacement of a guardian or conservator suspected of maltreatment and appointment of a suitable person as guardian or conservator, pursuant to sections 524.5-101 to 524.5-502; or
(4) a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under chapter 609.
The expenses of legal intervention must be paid by the county in the case of indigent persons, under section 524.5-502 and chapter 563.
In proceedings under sections 524.5-101 to 524.5-502, if a suitable relative or other person is not available to petition for guardianship or conservatorship, a county employee shall present the petition with representation by the county attorney. The county shall contract with or arrange for a suitable person or organization to provide ongoing guardianship services. If the county presents evidence to the court exercising probate jurisdiction that it has made a diligent effort and

no other suitable person can be found, a county employee may serve as guardian or conservator. The county shall not retaliate against the employee for any action taken on behalf of the ward or protected person even if the action is adverse to the county's interest. Any person retaliated against in violation of this subdivision shall have a cause of action against the county and shall be entitled to reasonable attorney fees and costs of the action if the action is upheld by the court.
Subd. 10a. [Repealed, 1995 c 229 art 1 s 24]
Subd. 10b. **Investigations; guidelines.** Each lead agency shall develop guidelines for prioritizing reports for investigation. When investigating a report, the lead agency shall conduct the following activities, as appropriate:
(1) interview of the alleged victim;
(2) interview of the reporter and others who may have relevant information;
(3) interview of the alleged perpetrator;
(4) examination of the environment surrounding the alleged incident;
(5) review of pertinent documentation of the alleged incident; and
(6) consultation with professionals.
Subd. 11. [Repealed, 1995 c 229 art 1 s 24]
Subd. 11a. [Repealed, 1995 c 229 art 1 s 24]
Subd. 12. [Repealed, 1995 c 229 art 1 s 24]
Subd. 12a. [Repealed, 1983 c 273 s 8]
Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a lead agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section are welfare data under section 13.46. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph (c).
Data maintained by the common entry point are confidential data on individuals or protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the common entry point shall maintain data for three calendar years after date of receipt and then destroy the data unless otherwise directed by federal requirements.
(b) The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County social service agencies must maintain private data on individuals but are not required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02. Upon completion of the investigation, the data are classified as provided in clauses (1) to (3) and paragraph (c).
(1) The investigation memorandum must contain the following data, which are public:
(i) the name of the facility investigated;
(ii) a statement of the nature of the alleged maltreatment;
(iii) pertinent information obtained from medical or other records reviewed;
(iv) the identity of the investigator;
(v) a summary of the investigation's findings;
(vi) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;
(vii) a statement of any action taken by the facility;
(viii) a statement of any action taken by the lead agency; and
(ix) when a lead agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.
The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data listed in clause (2).

(2) Data on individuals collected and maintained in the investigation memorandum are private data, including:
(i) the name of the vulnerable adult;
(ii) the identity of the individual alleged to be the perpetrator;
(iii) the identity of the individual substantiated as the perpetrator; and
(iv) the identity of all individuals interviewed as part of the investigation.
(3) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.
(c) After the assessment or investigation is completed, the name of the reporter must be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.
(d) Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be maintained under the following schedule and then destroyed unless otherwise directed by federal requirements:
(1) data from reports determined to be false, maintained for three years after the finding was made;
(2) data from reports determined to be inconclusive, maintained for four years after the finding was made;
(3) data from reports determined to be substantiated, maintained for seven years after the finding was made; and
(4) data from reports which were not investigated by a lead agency and for which there is no final disposition, maintained for three years from the date of the report.
(e) The commissioners of health and human services shall each annually report to the legislature and the governor on the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. The report shall identify:
(1) whether and where backlogs of cases result in a failure to conform with statutory time frames;
(2) where adequate coverage requires additional appropriations and staffing; and
(3) any other trends that affect the safety of vulnerable adults.
(f) Each lead agency must have a record retention policy.
(g) Lead 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 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. Upon completion of the review, not public data received by the review panel must be returned to the lead agency.
(h) Each lead agency shall keep records of the length of time it takes to complete its investigations.
(i) A lead agency may notify other affected parties and their authorized representative if the 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.
(j) Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead agency may not provide any notice

unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.
Subd. 13. [Repealed, 1995 c 229 art 1 s 24]
Subd. 14. **Abuse prevention plans.** (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.
(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.
(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.
Subd. 15. [Repealed, 1995 c 229 art 1 s 24]
Subd. 16. **Implementation authority.** (a) By September 1, 1995, the attorney general and the commissioners of health and human services, in coordination with representatives of other entities that receive or investigate maltreatment reports, shall develop the common report form described in subdivision 9. The form may be used by mandated reporters, county social service agencies, law enforcement entities, licensing agencies, or ombudsman offices.
(b) The commissioners of health and human services shall as soon as possible promulgate rules necessary to implement the requirements of this section.
(c) By December 31, 1995, the commissioners of health, human services, and public safety shall develop criteria for the design of a statewide database utilizing data collected on the common intake form of the common entry point. The statewide database must be accessible to all entities required to conduct investigations under this section, and must be accessible to ombudsman and advocacy programs.
(d) By September 1, 1995, each lead agency shall develop the guidelines required in subdivision 9b.
Subd. 17. **Retaliation prohibited.** (a) A facility or person shall not retaliate against any person who reports in good faith suspected maltreatment pursuant to this section, or against a vulnerable adult with respect to whom a report is made, because of the report.
(b) In addition to any remedies allowed under sections 181.931 to 181.935, any facility or person which retaliates against any person because of a report of suspected maltreatment is liable to that person for actual damages, punitive damages up to $10,000, and attorney fees.
(c) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of a report, is retaliatory. For purposes of this clause, the term "adverse action" refers to action taken by a facility or person involved in a report against the person making the report or the person with respect to whom the report was made because of the report, and includes, but is not limited to:
(1) discharge or transfer from the facility;
(2) discharge from or termination of employment;
(3) demotion or reduction in remuneration for services;

(4) restriction or prohibition of access to the facility or its residents; or
(5) any restriction of rights set forth in section 144.651.
Subd. 18. **Outreach.** The commissioner of human services shall maintain an aggressive program to educate those required to report, as well as the general public, about the requirements of this section using a variety of media. The commissioner of human services shall print and make available the form developed under subdivision 9.
Subd. 19. [Repealed, 1995 c 229 art 1 s 24]
Subd. 20. **Cause of action for financial exploitation; damages.** (a) A vulnerable adult who is a victim of financial exploitation has a cause of action against a person who committed the financial exploitation. In an action under this subdivision, the vulnerable adult is entitled to recover damages equal to three times the amount of compensatory damages or $10,000, whichever is greater.
(b) In addition to damages under paragraph (a), the vulnerable adult is entitled to recover reasonable attorney fees and costs, including reasonable fees for the services of a guardian or conservator or guardian ad litem incurred in connection with a claim under this subdivision.
(c) An action may be brought under this subdivision regardless of whether there has been a report or final disposition under this section or a criminal complaint or conviction related to the financial exploitation.
History: *1980 c 542 s 1; 1981 c 311 s 39; 1982 c 393 s 3,4; 1982 c 424 s 130; 1982 c 545 s 24; 1982 c 636 s 5,6; 1983 c 273 s 1-7; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1985 c 150 s 1-6; 1985 c 293 s 6,7; 1Sp1985 c 14 art 9 s 75; 1986 c 444; 1987 c 110 s 3; 1987 c 211 s 2; 1987 c 352 s 11; 1987 c 378 s 17; 1987 c 384 art 2 s 1; 1988 c 543 s 13; 1989 c 209 art 2 s 1; 1991 c 181 s 2; 1994 c 483 s 1; 1994 c 636 art 2 s 60-62; 1Sp1994 c 1 art 2 s 34; 1995 c 189 s 8; 1995 c 229 art 1 s 1-21; 1996 c 277 s 1; 1996 c 305 art 2 s 66; 2000 c 465 s 3-5; 1Sp2001 c 9 art 5 s 31; art 14 s 30,31; 2002 c 289 s 4; 2002 c 375 art 1 s 22,23; 2002 c 379 art 1 s 113; 2003 c 15 art 1 s 33; 2004 c 146 art 3 s 45; 2004 c 288 art 1 s 80; 2005 c 56 s 1; 2005 c 98 art 2 s 17; 2005 c 136 art 5 s 5; 1Sp2005 c 4 art 1 s 55,56; 2006 c 253 s 21; 2007 c 112 s 55,56; 2007 c 147 art 7 s 75; art 10 s 15; 2009 c 119 s 11-16; 2009 c 142 art 2 s 46,47; 2009 c 159 s 107*