Testimony
Senate Committee on Health and Welfare

S.40
An act relating to the creation of a Vulnerable Adult Fatality Review Team

Stuart Schurr, Deputy Commissioner
Agency of Human Services
Department of Disabilities, Aging and Independent Living

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Background

The movement across the United States to establish adult fatality review teams, similar to Child Death and Domestic Violence Fatality Review teams, is growing. Although little data exists, adult fatality review teams are seen as adding value to the public good by creating greater collaboration between providers, raising the awareness of the needs of elders in the community and promoting greater interest in advocacy. There is some evidence this can lead to systems improvements that result in improved early identification of high risk elders.

DAIL has been in discussion with the Long Term Care Ombudsman, Jackie Majoros, at least for the past four years about the utility and viability of establishing an adult fatality review team in Vermont. Additional discussions have taken place with staff within the Attorney General's Office and the Office of the Chief Medical Examiner.

Activities and findings to date

- Researched the experience in other states through the use of the National Center for Elder Abuse (NCEA) list serve
    - All respondents found the teams valuable in forging new relationships.
    - Only a couple of respondents were able to describe concrete policy recommendations/initiatives/interventions that emerged from the teams' meetings.

- Most of the teams are led by or operate under the aegis of the Attorney General's office; we believe one may be led by the Long Term Care Ombudsman (New Hampshire)
- Some review teams investigate suicides; some death by law enforcement that involves individuals with mental illness (New Hampshire)

- Spoke/corresponded with members of functioning teams in four states
  - Teams that function best had at least initial funding from grants; some that did not receive continued funding, folded; others continued and rolled the activity into other job duties.

- Compared cost of setting up such teams with respect to materials, time and human resources. Range is no additional FTEs to 1FTE at a cost of $0 to $95K

- Identified standards for adult fatality review teams
  - The American Bar Association produced a manual for states wanting to replicate elder death review teams from the pilots. http://apps.americanbar.org/aging/publications/docs/fatalitymanual.pdf

Specifics in S.40 of concern **as introduced**

- The scope of review has not been defined: How many? Which cases? Etc.
- There are no indicators proposed that would help judge the value of such teams in Vermont.
- The bill leaves it to the team to develop and use "uniform procedures established by the team" despite the availability of best practices.
- The actual resource need has not been acknowledged.
- Who will house the team, coordinate the meetings, prepare the materials, etc. is unclear.
- It is clear that an exemption from the Open Meeting Law is desirable in order to protect confidentiality. It may, however, be worth considering having only a portion of the proceedings (the actual case review) be exempt; it may be helpful to have policy recommendations be discussed openly

Discussion

Both prior to and since testifying on the companion bill, H. 46, in the House Committee on Human Services, DAIL has communicated with the Long-Term Care Ombudsman, the Attorney General's Office and the Office of the Chief Medical Examiner to reach agreement on the language of this bill. Despite our best efforts, we believe there is still work to be done. The overarching message that DAIL wishes to communicate is that while we believe that Vulnerable Adult Fatality Review Teams can be a valuable tool in helping to reduce preventable deaths, we do not believe that the needed resources have been adequately acknowledged or where the focus of the Team needs to be in order have the greatest impact on the number of preventable deaths among vulnerable adults.

1. DAIL supports creating the Vulnerable Adult Fatality Review Team within the Office of the Attorney General, as is the case with the Domestic Violence Fatality Review Commission. Further, as DAIL does not have the human resources necessary to provide leadership or the technical or administrative support and level of membership that has been proposed, DAIL supports providing a single member to the Team; not the three members as proposed in the bill as introduced. **§6961(a)**

2. DAIL supports a more clear articulation of the purposes of the Team as a means to assess the value of the Team. Specifically, DAIL supports the following language:
    a. Aggregating and analyzing the trends and patterns of abuse and neglect- related fatalities of vulnerable adults in Vermont;
    b. Educating the public, service providers and policymakers about the abuse and neglect-related fatalities of vulnerable adults and the strategies for intervention; and
    c. Recommending policies, practices and services to promote interagency collaboration and to improve systemic responses to abuse and neglect of vulnerable adults. **§6961(a)**

3. We have been unable to reach agreement is in the area of deciding which cases should be reviewed. The proposed draft before you provides that the "Team shall establish criteria for selecting specific fatalities for review to ensure the analysis of fatalities occurring in institutional, home and community-based settings." While DAIL believes there is value in reviewing fatalities that occur in hospitals and nursing homes, DAIL believes there is more value in looking at deaths that no one is looking at. As such, DAIL believes that this Team should devote its limited resources to our biggest gap in knowledge, which concerns the prevention of adult fatalities in home and community based settings. Whereas hospitals have morbidity and mortality committees to review deaths in those settings and nursing homes have quality improvement mechanisms in place to address falls and deaths, home- and community-based settings have no such mechanisms, and DAIL believes that the review of deaths in such settings can lead to the greatest impact. **§6962(b)(3)**

4. While DAIL believes that a biennial report to the Governor and General Assembly, which would report on a greater number of reviewed deaths, would more effectively capture trends, system gaps and risk factors, allow the Team to recommend meaningful changes that would likely decrease the number of preventable deaths, and more thoroughly assess the effectiveness of the Team's activities, we support language which requires the inclusion of this information in an annual report if it is available or appropriate. **§6962(c)(1)**

5. In ensuring that the deaths of vulnerable adults are analyzed using uniform procedures established by the Team, DAIL supports language which states that those procedures adhere to the American Bar Association's best practices for fatality review teams. **§6962(a)**

6. While the proceedings and records reviewed by the Team are to be confidential, DAIL proposes that the Team hold an open meeting to publish its reports. **§6963**

7. Finally, upon resolution of the above outstanding issues, DAIL believes that it makes no sense to sunset the act if the Team is demonstrating results. As we offered during our testimony before House Committee on Human Services, the bill could create a three year pilot with performance measures (RBA) to demonstrate: 1.How much? 2. How well? and 3. Is anybody better off? If those results can be demonstrated, DAIL believes that the work of the Team should continue. **Sec. 2**

References

Theresa M. Covington, MPH
Director
National Center for the Review and Prevention of Child Deaths
1115 Massachusetts Avenue, NW
Washington, DC 20005
800-656-2434 (office)
517-927-1527 (cell)
info@childdeathreview.org
www.childdeathreview.org

List of all cities/states who provided input: California, New Hampshire, NYC, Virginia, Georgia, Wyoming, Rochester NY, Iowa, Maine