Minnesota Department of **Human Services**

Maltreatment Report

Office of the Inspector General

2014

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Minnesota Department of Human Services

Office of this Inspector General/Licensing Division Report
Maltreatment Report Data for Fiscal Year 2014

INTRODUCTION

The Department of Human Services (DHS), in partnership with counties, licenses approximately 22,500 service providers and monitors and investigates their compliance with Minnesota laws and rules. The purpose of licensing is to protect the health, safety, rights and well-being of those receiving services by requiring that providers meet minimum standards of care and physical environment. Licensed programs serve thousands of people in child care centers, adolescent group homes, adult day service centers, day training and habilitation programs, as well as residential and outpatient programs for people with chemical dependency, mental illness or developmental disabilities. DHS is responsible for completing maltreatment investigations as they relate to approximately 9,000 licensed settings. These settings consist of approximately 4,249 programs that are monitored by DHS licensing staff, and another 4,693 providers that are monitored by county licensing staff. The county monitored programs include 1,307 adult foster care homes and 3,386 community residential settings that prior to July 1, 2014, were licensed as adult foster care homes.

GENERAL OVERVIEW

Maltreatment means the abuse or neglect of a vulnerable adult or a child, or the financial exploitation of a vulnerable adult. Reports of maltreatment are received from vulnerable adults, county staff members, family members of vulnerable adults and children, staff members of licensed programs, other professionals working with people receiving services, and community members. State statute also requires that all deaths of vulnerable adults and children in licensed services be reported by the program serving the individual.

Since 1995, additional statutory changes in two important areas have increased the complexity of maltreatment investigations: allowing the subject or facility to initiate an appeal process and requiring DHS to issue extensive notifications of decisions made and actions taken. In addition, because DHS is required to bar people from providing direct contact services when they are found responsible for certain types of maltreatment, the Legislature has enacted more exact standards that DHS must apply when determining who is responsible for maltreatment. All of these changes have resulted in lengthier investigations and more detailed reports that provide a thorough explanation for the decision.

Investigators are required to conduct numerous interviews and site visits, obtain pertinent documents, carefully review the documents, and make a determination as to what actually occurred. If a facility or individual appeals the finding, investigators are also involved in preparing documents and testifying at the appeal hearings. The complexity of investigations requires an extensive training period for new investigators and limits the number of investigations each investigator can adequately complete. Most investigations include a visit to the program; since DHS investigators are based in St. Paul, the investigator must travel to other parts of the state as necessary.

MALTREATMENT REPORTING REQUIREMENTS

Historically, both the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH) were required to submit an annual report to the legislature and the governor that detailed maltreatment investigation work completed by each agency. In 2014, the Legislature eliminated the requirement for individual reports from each agency. Instead, on a biennial basis, the Commissioners of Health and Human Services must provide a joint report to the legislature and the governor about maltreatment reports, investigations, outcomes, trends and recommendations for improving the protection of vulnerable adults. Because each agency provided a detailed report to the legislature and governor for FY 2013 trends and outcomes, the first joint report between DHS and MDH will be prepared later next year using data from FY 2014-15.

In addition to the joint biennial report, both agencies are also required to publish information on their websites each year that provides the public with information about the number and type of reports of alleged maltreatment involving programs and facilities licensed by each agency, the number of those that required investigation, and the resolution of those investigations. The required information is summarized below and includes reports received by DHS that alleged maltreatment of both vulnerable adults[1] and minors[2] in DHS-licensed programs. This information covers FY 2014 and will be made available to the public on the Department of Human Services, Licensing Division web site at http://www.dhs.state.mn.us/

See Minnesota Statutes, section 626.557, subdivision 12b, paragraph (e), for reporting requirements.

[1] See Minnesota Statutes, section 626.557.
[2] See Minnesota Statutes, section 626.556.

Maltreatment Data for Fiscal Year 2014 and Five Year Comparison

1. REPORTS RECEIVED

When an initial report is received, research of DHS data is conducted to locate any history available on the vulnerable adult, the child, the facility, or the staff person involved in the report. Many reports do not include adequate information for DHS to determine the harm, or risk of harm, presented to the vulnerable adult or child by the reported event or condition, or to determine whether the issue reported represents maltreatment or a licensing violation. Therefore, additional information is obtained during an in-office investigation.

In general, in-office investigations result in the following outcomes:

- If the event did not occur in a DHS licensed program, the report would be closed as "no jurisdiction" and referred whenever possible to the correct agency or board that has jurisdiction to investigate the complaint.
- If the event does not meet a statutory definition of maltreatment and does not represent a possible licensing violation, no further investigation is necessary and the report is closed.
- If information obtained from the in-office investigation indicates harm, or a high risk of harm, to the vulnerable adults or child affected, and the incident appears to meet the statutory definition of maltreatment, the report is then assigned for out-of-office investigation.
- If information obtained indicates a possible violation of a licensing standard, the report is then assigned for investigation by a licensing unit.
- Due to the seriousness of reports involving the death of a child or vulnerable adult, all such reports are immediately assigned to a senior investigator for an in-office investigation. If resulting information indicates possible maltreatment, the report is assigned for an out-of-office maltreatment investigation.

Table 1 lists the reports received for each of the last five fiscal years, including the number of reports where DHS did not have jurisdiction, the number assigned to maltreatment investigators for an out-of-office investigation, and the number assigned to DHS licensors for an investigation related to licensing standards.

Table 1

	FY 10	FY 11	FY 12	FY 13	FY 14
Reports received, in-office investigation	4,703	4,721	5,323	5,679	5,840
No jurisdiction	266	235	401	407	438
Assigned for out-of-office maltreatment investigation	710	785	880	718	735
Assigned for licensing investigation	537	679	591	666	596

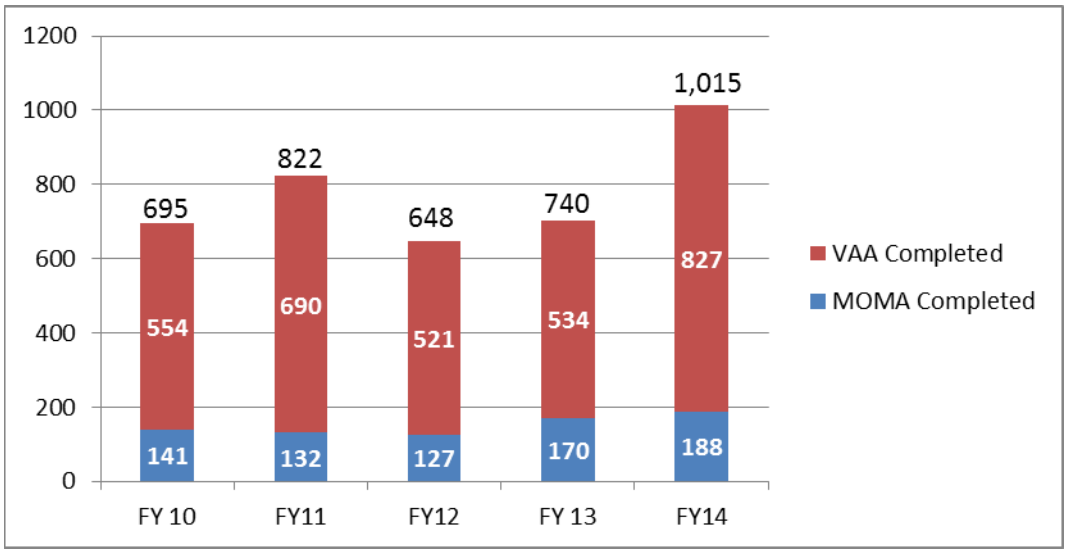
2. COMPLETED REPORTS

If information obtained from the in-office investigation indicates harm, or a high risk of harm, to the vulnerable adults or child affected, and the incident appears to meet the statutory definition of maltreatment, the report is then assigned for out-of-office investigation. Over time, statutory changes have increased the complexity of maltreatment investigations by providing an appeal process and requiring extensive notifications of decisions made and actions taken. Because statutory background study requirements require DHS to disqualify people from providing direct contact service when they are found responsible for serious or recurring maltreatment, the changes have also addressed standards for determining who was responsible for maltreatment. Today, each investigation must determine:

- What actually occurred and whether the event met the definition of maltreatment;
- Whether an individual, the facility, or both were responsible for maltreatment;
- Whether the maltreatment committed by an individual was serious and/or recurring, which would result in being disqualified from direct contact services;
- Whether the facility took action necessary to reduce the likelihood of recurrence of the event to protect the health and safety of vulnerable adults and children; and
- Whether further action is required by DHS related to the facility or the individual alleged perpetrator.

Figure 1 shows the total number of maltreatment reports completed by DHS for each of the last five fiscal years and the number that involved maltreatment under the Vulnerable Adults Act (VAA) and Maltreatment of Minors Act (MOMA).

Figure 1



3. OUTCOME OF COMPLETED REPORTS

For allegations of maltreatment that are assigned for an out-of-office investigation, a determination is made as to whether maltreatment occurred and, if so, whether an individual, provider/facility, or both were responsible for the maltreatment. DHS issues a written public investigative memorandum (also referred to a report) for each out-of-office investigation it completes. These documents are available on the DHS Licensing Information Lookup web site by searching the license holder name or the license number of the DHS-licensed facility involved in the investigation.

Investigations under the Maltreatment of Minors Act (MOMA) can result in a disposition of *maltreatment determined* or *maltreatment not determined*. Investigations under the Vulnerable Adults Act (VAA) can result in a disposition that the report was *substantiated, inconclusive, false,* or *no determination will be made*. Because the two statutes use different terms, this report will use the terms "substantiated" and "not substantiated" when referring to a determinations by DHS whether maltreatment occurred. The findings of "inconclusive" and "false" under the VAA are both represented in the category of "not substantiated."

An individual found responsible for serious or recurring maltreatment is disqualified for seven years under Minnesota Statutes, chapter 245C, the Human Services Background Study Act. A license holder found responsible for maltreatment is subject to appropriate licensing sanction under Minnesota Statutes, chapter 245A, the Human Services Licensing Act.

Table 2 lists the number of maltreatment reports assigned for out-of-office investigation that were completed in each of the last five fiscal years, and of these:

- the number of reports in which maltreatment was not substantiated
- the number in which maltreatment was substantiated;
- the percent of reports with maltreatment substantiated, and
- the number of individuals disqualified from direct contact based on a determination of serious or recurring maltreatment.

Table 2

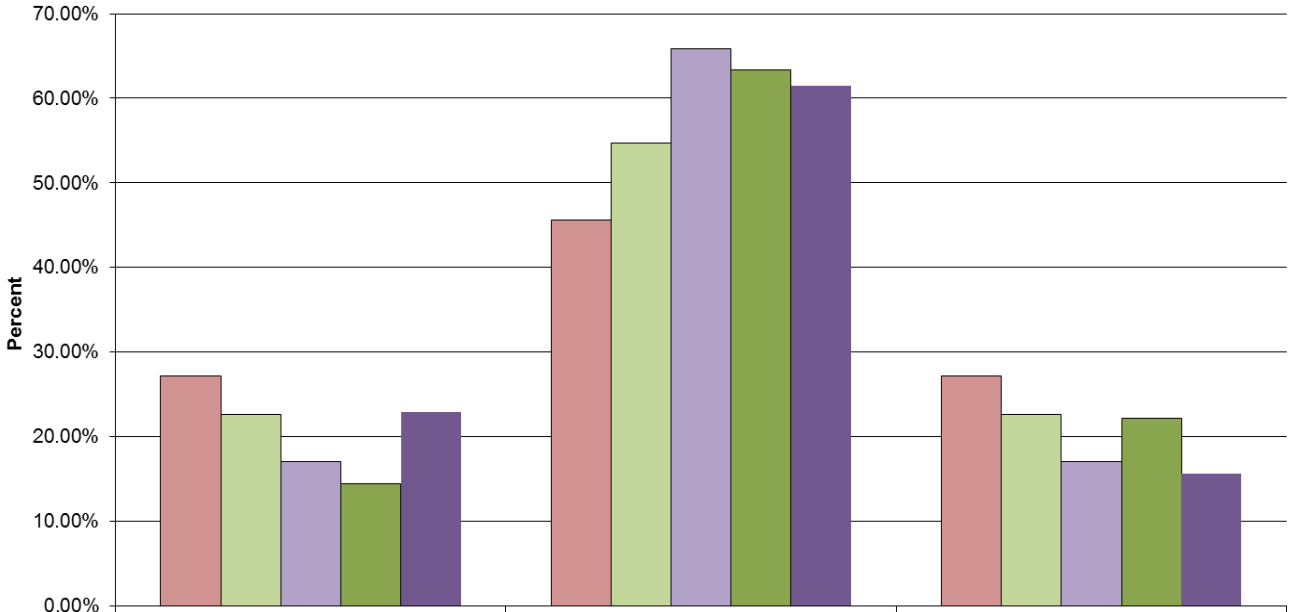
	FY 10	FY 11	FY 12	FY 13	FY 14
Maltreatment reports completed	695	822	648	704	1,015
-Reports with maltreatment not substantiated	497	604	474	512	631
-Reports with maltreatment substantiated	198	218	174	192	384
-Percent substantiated	28.5%	26.5%	26.9%	27.3%	37.8%
-Number of individuals disqualified	57	90	57	54	121

4. MALTREATMENT DETERMINATION BY TYPE

Maltreatment means the abuse or neglect of a vulnerable adult or a child, or the financial exploitation of a vulnerable adult. Figure 2 shows the type of maltreatment that DHS

substantiated and the percentage of each type. The overall trend has been of decreasing abuse, increasing neglect and fairly consistent findings of financial exploitation. (Financial exploitation pertains to vulnerable adults only.) The jump in abuse determinations for FY14 is most likely attributable to the significant work done to complete the backlogged investigations that had grown in FY12 and FY13, as shown in the next section.

Figure 2



	Abuse	Neglect	Financial Exploitation
FY 10	27.20%	45.61%	27.20%
FY11	22.63%	54.74%	22.63%
FY 12	17.05%	65.90%	17.05%
FY 13	14.47%	63.40%	22.13%
FY 14	22.95%	61.48%	15.57%

- The type of maltreatment most often found to have occurred is neglect.
- The percent of maltreatment determined due to abuse or financial exploitation can vary significantly from year to year.

5. RECENT EFFORTS TO INCREASE TIMELINESS OF MALTREATMENT REPORT COMPLETION

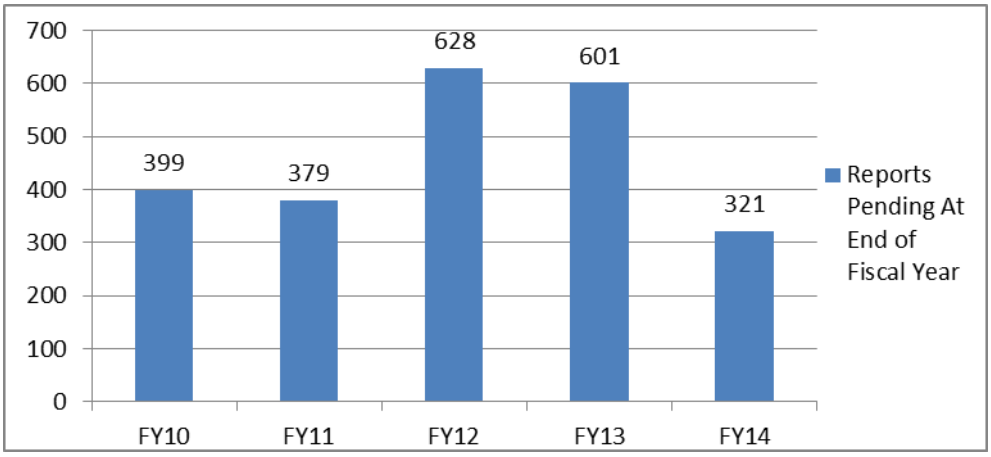
While staff strive to complete timely investigations, maintaining the integrity of the investigative work is paramount both to protect the health, safety and well-being of children and vulnerable adults and because significant licensing actions that affect individuals and facilities are often taken at the conclusion of the investigation. The challenge has been to balance the need for quick turnaround of these cases against increasingly complex maltreatment laws and high standards of quality and integrity.

In the its FY13 legislative report, DHS identified actions it would take to enhance efficiency and increase timeliness of completing reports, including:

- Centralized report assessment functions and restructured intake and assessment duties (originally two full time staff dedicated to this; currently five).
- Implementing a pilot project to abbreviate the investigation memoranda written for reports that result in a finding of false, inconclusive, or maltreatment not determined.
- Increased the focus on triaging new reports in order to resolve more cases at the point of assessment.
- Developed specialty teams to ensure that investigators with the greatest experience in a particular service area were assigned to investigate in those facilities. (Previously, all investigators conducted investigations of reports in all service areas.)

During FY14, DHS operationalized these changes and continued its efforts to increase the timeliness of completing maltreatment reports and made a concerted effort to reduce the number of reports pending more than 60 days. Through the authorization of overtime and broader use of the abbreviated investigation memorandum, the number of reports open decreased from 601 to 321 at the conclusion of FY14. Figure 3 shows the number of reports assigned for out-of-office investigation that were pending at the end of the fiscal year for the period 2011 through 2014.

Figure 3



Finally, in the Spring of 2014, the Division instituted a Continuous Improvement Project to identify additional strategies to increase the timeliness of investigations and to reduce the pending backlog of cases. The goal of this effort is to develop a comprehensive set of steps that staff will take to improve timeliness of maltreatment reports assigned for investigation after June 30, 2014. Investigations assigned after July 1, 2014, will be subject to new processes identified by the Continuous Improvement Project and evaluated for compliance with the 60-day time period set forth in statute.