Minnesota Department of **Human Services**

Maltreatment Report

Office of the Inspector General

2016

Minnesota Department of **Human Services**

Office of this Inspector General/Licensing Division Report
Maltreatment Report Data for Fiscal Year 2016

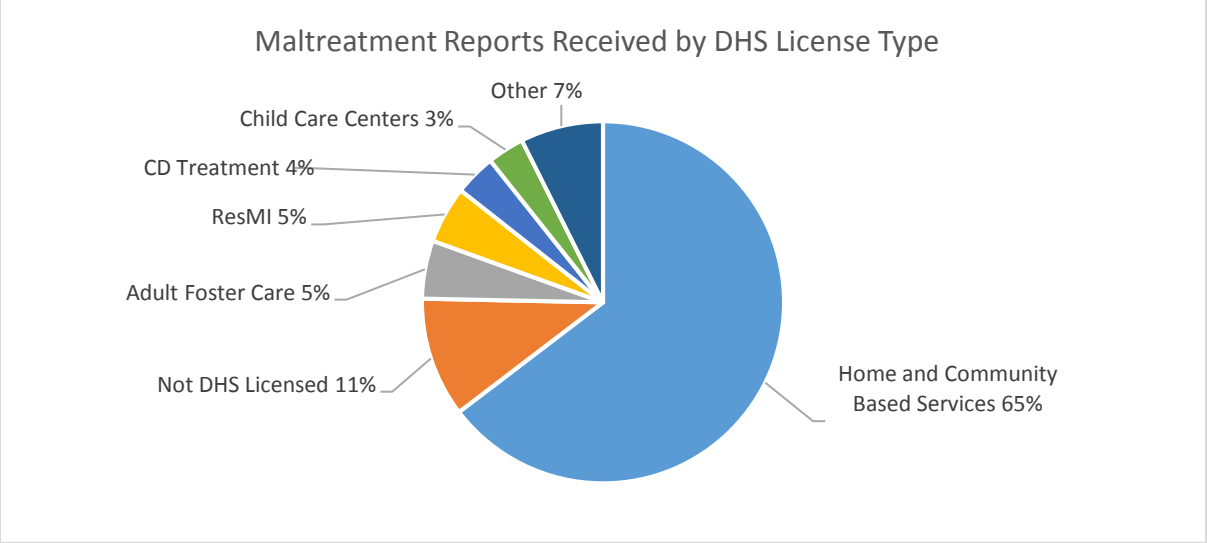
KEY FINDINGS

- Home and community based services (HCBS) is the service area with the highest number of alleged maltreatment reports;
- There has been a significant jump in the number of maltreatment reports received over the last couple years, due in large part to the increased number of home and community based programs and services licensed by DHS with the statutory changes in Minnesota Chapter 245D. The implementation of the Minnesota Adult Abuse Reporting Center (MAARC) was also an important factor in the number of reports received;
- Neglect continues to be the maltreatment category with the largest number of reports, but there has been a notable increase in the number of reports of financial exploitation over the last year as well;
- DHS has a strong record of completing out-of-office investigations on time, with 95-percent completed on time in FY16.

INTRODUCTION

In FY16, the Department of Human Services (DHS), in partnership with counties, licensed 22,041 service providers and monitored and investigated their compliance with Minnesota statutes and rules. Licensed programs serve thousands of people in child care programs, adult day service centers, adult foster homes, and home and community based services programs, as well as residential and outpatient programs for people with chemical dependency and/or mental health conditions. DHS is responsible for completing maltreatment investigations as they relate to 9,009 licensed programs. This includes both DHS directly-licensed and monitored programs (approximately 7,875 licensed programs) and indirectly-licensed adult foster care homes (approximately 1,134 licensed programs). Although DHS delegates authority to the counties to license adult foster care facilities, the Department is responsible for overseeing maltreatment investigations for this service area. Counties provide oversight for the remaining 13,032 licensed programs. The representation of the DHS licensed services with maltreatment alleged is shown in Figure 1.

Figure 1: DHS Licensed Services with Maltreatment Alleged, FY16



As shown in Figure 1, the highest percent of maltreatment reports occurred in Home and Community Based Services (65-percent). Home and Community Based Services include community residential services and day services facilities, which serve 32,000 individuals in more than 1,300 programs. The significant numbers of people served, as well as the intensity of the services provided, provide context for the high percentage of maltreatment reports for that area.

Figure 1 also demonstrates that the second highest percentage of maltreatment reports occurred in Residential Facilities for Adults with Mental Illness (5-percent), followed by Chemical Dependency Treatment (4-percent), and Child Care Centers (3-percent). The "Other" category includes mental health programs, detox programs, and the Minnesota Security Hospital. Of the maltreatment reports received for FY16, 5-percent were from Adult Foster Care programs. Lastly, 11-percent of the reports received by DHS were from the category "Not DHS Licensed." These reports do not fall under the jurisdiction of DHS and are re-referred by DHS to the appropriate office or agency with authority to investigate the claims.

GENERAL OVERVIEW

Maltreatment Definition

The Maltreatment of Minors Act (MOMA), enacted in 1975, and the Vulnerable Adults Act (VAA), enacted in 1980, are state laws meant to protect adults and children particularly vulnerable to maltreatment. Maltreatment, as described in the VAA, is abuse, neglect and/or the financial exploitation of a vulnerable adult. The MOMA characterizes maltreatment as any of the following: physical abuse, neglect, sexual abuse, or mental injury of a child.

Reporting Maltreatment

Maltreatment reports are made by a wide range of sources, including the vulnerable adults themselves, 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.

Maltreatment Investigations

When conducting an investigation, investigators may conduct site visits and extensive interviews, obtain relevant documents, carefully review those documents, and make a determination as to what 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 intensive training period for new investigators and limits the number of investigations each investigator can adequately complete. Based on current caseloads, one investigator completes four investigations per month. Most investigations include a visit to the program; since DHS investigators are based in St. Paul, the investigators must travel to other parts of the state as necessary.

The laws governing maltreatment investigations are complex. DHS is directed to issue extensive notifications of decisions made and actions taken, and the subject or facility determined to be responsible for maltreatment is entitled to initiate an appeal process. In addition, as DHS is required to prohibit individuals found responsible of certain types of maltreatment from providing direct contact services, DHS must be thorough and meet certain standards when determining who is responsible for maltreatment. These requirements can lead to lengthier investigations and more detailed reporting of the decisions.

DEPARTMENT 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. DHS and MDH submitted a joint report to the Legislature and governor in FY2015.

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. This requirement is outlined in Minnesota Statute, Section 626.557, subd. 12b, where it states:

> The commissioners of health and human services shall annually publish on their Web sites 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. On a biennial basis, the commissioners of health and human services shall jointly report the following information to the legislature and the governor:

(1) The number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigations under this section, the resolution of those investigations, and which of the two lead agencies was responsible;
(2) Trends about types of substantiated maltreatment found in the reporting period;
(3) If there are upward trends for types of maltreatment substantiated, recommendations for addressing and responding to them;
(4) Efforts undertaken or recommended to improve the protection of vulnerable adults;
(5) Whether and where backlogs of cases result in a failure to conform with statutory time frames and recommendations for reducing backlogs if applicable;
(6) Recommended changes to statutes affecting the protection of vulnerable adults; and
(7) Any other information that is relevant to the report trends and findings.

THE MALTREATMENT REPORTING AND INVESTIGATION PROCESS

Reports Received

All maltreatment reports received by DHS receive an in-office investigation. An in-office investigation is the process by which additional information is gathered to determine jurisdiction. In-office investigations also determine whether the allegation was reportable and whether additional investigation is needed.

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

- If the event did not occur in a DHS licensed program, the report is closed as **"no jurisdiction"** and referred whenever possible to the correct agency or board that has jurisdiction to investigate the complaint.
- If the alleged event does not meet required criteria outlined in the definition of maltreatment in Minnesota law, and does not represent a possible licensing violation, **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, then the report is assigned for an **out-of-office investigation**.
- If information obtained indicates a possible violation of a licensing standard, and not maltreatment, the report is assigned for **investigation by a licensing unit**.[1] For more data on licensing complaints by service area, see Table 1-A in the Appendix.
- Due to the serious nature of reports involving the death of a child or vulnerable adult, all such reports are immediately assigned for an in-depth, 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 FY12-FY16, including the number of reports related to some of the outcomes described above: in-office investigation, no jurisdiction, licensing investigation, and an out-of-office maltreatment investigation.

[1] The Licensing Division includes four primary licensing units: 1) Chemical Dependency/Mental Health; 2) Home and Community Based Services; 3) Child Care Centers and Adult Day Centers; and 4) Family Systems.

Table 1: Reports Received and Initial Dispositions from FY12-FY16

	FY12	FY13	FY14	FY15	FY16
Reports received, in-office investigation[2]	4,922	5,272	5,403	6,359	7,616
No jurisdiction	401	407	438	552	1,190
Assigned for licensing investigation	603	638	574	752	1,046
Assigned for out-of-office maltreatment investigation	843	683	720	858	817

As shown in Table 1, there was a nearly 20 percent increase between the reports received in FY16, with those received in FY15. One key factor for the increase in reporting was the creation of the new statutory guidelines for home and community based services (HCBS) under Minnesota Chapter 245D in 2014. This statutory change, which went into effect on January 1, 2014, incorporated more services and settings into the licensing process. With these changes, the number of licensed services increased from six to 19 and the number of people served jumped from 12,000 persons to 32,000 persons. In addition, the number of license holders rose from 600 licensees previously licensed under Chapter 245B, to over 1,300. The substantial increase in the number of programs licensed by DHS had a significant impact on the number of reports received.

On July 1, 2015, the state implemented the Minnesota Adult Abuse Reporting Center (MAARC), a centralized statewide common entry point. This change also likely impacted the number of reports received. MAARC changed the reporting of maltreatment from a county-based local system, to a single state-wide common entry point operated under the Commissioner of Human Services. The center provides a web-based reporting system, and a single toll-free number, available 24 hours a day, seven days a week for mandated reporters. Other states that implemented this type of simpler reporting process also experienced an increase in the number of reports. While MAARC has increased the number of reports, the number of reports with no jurisdiction has also increased 115 percent since MAARC's implementation, indicating that not all reports may be routed to the correct lead investigative agency.

Reports Assigned to an Out-Of-Office Investigation

If information obtained from the in-office investigation appears to meet the statutory definition of maltreatment, and indicates harm, or a high risk of harm, to the vulnerable adults or child affected, the report is assigned for out-of-office investigation. Currently, each investigation must determine:

- What occurred and whether the event met the definition of maltreatment;
- Whether it was an individual, a facility, or both that 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; and
- Whether further action is required by DHS related to the facility or the individual.

[2] The number of reports received includes both licensing and maltreatment reports.

DHS issues a written public investigative memorandum (also referred to as a report) for each out-of-office investigation it completes. These documents are available on the DHS Licensing Lookup website by searching the license holder name or the license number of the DHS licensed program involved in the investigation. Statutory requirements provide the option of an appeals process and requiring extensive notifications of decisions made and actions taken. Due to the fact that statutory background study requirements mandate 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.

Determinations

Investigations under the Maltreatment of Minors Act (MOMA) can result in a decision of *maltreatment determined*, *maltreatment not determined, or non-maltreatment mistake*. Investigations under the Vulnerable Adults Act (VAA) can result in a disposition that the report was an *error in the provision of therapeutic conduct, substantiated, inconclusive, or false*. 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 finding of "false" under the VAA and "maltreatment not determined" under MOMA are both represented in the category of "not substantiated."

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 number of reports that were inconclusive (VAA); and
- The percent of reports with maltreatment substantiated

Even as the number of investigations have fluctuated between FY12-FY16, the percentage of substantiated reports has remained relatively consistent.

Table 2: DHS Maltreatment Out-of-Office Investigations Completed & Outcomes, FY12-FY16

	FY12	**FY13**	**FY14**	**FY15**	**FY16**
Total Completed	612	673	996[3]	1,078	789
Substantiated	174	192	384	349	268
Not Substantiated	216	217	217	244	203
Inconclusive	222	264	395	485	318
Substantiated %	28%	29%	39%	32%	34%

Disqualifications

Table 3 provides an overview of the number of individuals disqualified from direct contact based on a determination of serious or recurring maltreatment over the last five years as a result of DHS' investigations. An individual found responsible for serious or recurring maltreatment is

[3] The total number of DHS investigations completed increased substantially from FY12-FY15. This rise is due in part to changes in DHS Licensing's business process that resulted in the elimination of the backlog of investigations during FY14 and FY15. With the elimination of the backlog, the number of completed investigations decreased. Specifically, the number of maltreatment investigations completed decreased by 27 percent between 2015 and 2016.

disqualified for seven years under Minnesota Statutes, chapter 245C, the Human Services Background Study Act. However, in some of the most extreme cases, a disqualification could be permanent. A license holder found responsible for maltreatment is subject to appropriate licensing sanction under Minnesota Statutes, chapter 245A, the Human Services Licensing Act. As shown by Table 3, there were 92 individuals disqualified from providing services in FY16.

Table 3: Number of Individuals Disqualified Due to Serious or Recurring Maltreatment, FY12-FY16

	FY12	FY13	FY14	FY15	FY16
Number of Individuals Disqualified	57	54	116	96	92

Maltreatment Reports Received by Type

Maltreatment is defined as the abuse or neglect of a vulnerable adult or a child, or the financial exploitation of a vulnerable adult. Table 4 shows the type of maltreatment that DHS substantiated and the percent change from the previous year. As Table 4 demonstrates, neglect continues to be the largest category of maltreatment reports received. The numbers also show that there have been significant changes in the number of reports over the last five years, with reports of neglect increasing by 38 percent, reports of abuse increasing by 26 percent, and reports of financial exploitation increasing by 58 percent.

Table 4: DHS Maltreatment Reports Received by Type, FY12-FY16

Type of Report	FY12	FY13	FY14	FY15	FY16
Neglect	2,170	2,277	2,115	2,092	2,993
Abuse	683	731	632	802	858
Financial Exploitation	330	317	308	355	521
Total	3,183	3,325	3,055	3,249	4,373[4]
Total Percent Change from the Previous Year	23%	4%	-8%	6%	35%

RECENT EFFORTS TO INCREASE TIMELINESS OF MALTREATMENT REPORT COMPLETION

While completing investigations in a timely manner is a high priority for DHS, the agency also understands the critical importance of ensuring those investigations are comprehensive and fair. Maintaining the integrity of those investigations is essential for protecting the health, safety, and well-being of children and vulnerable adults. The challenge has been to balance the need for quick turnaround of these cases against increasingly complex maltreatment laws and high quality standards.

In 2013, in order to improve efficiency and timeliness in report completion, DHS identified actions to address these areas, including:

- Centralizing report assessment functions and restructured intake and assessment duties (originally two full time staff dedicated to this; currently five);

[4] One report had no listed type.

- Increasing the focus on triaging new reports in order to resolve more cases at the point of assessment;
- Creating a paper-less process which streamlined the investigation and review process.

In FY14, DHS made these changes and continued its work to improve the timeliness of report completion. In addition, DHS made a concerted effort to reduce the number of reports pending more than 60 days. Through the authorization of overtime, the backlog of reports was eliminated as a result of the continuous improvement project, and the number of out-of-office investigations completed within 60 days went from 98 in FY14 to 777 in FY15. The investigations that are not completed in the 60 day timeframe are generally cases that are more complicated and therefore require a higher level of review. As Table 5 shows, the percent of maltreatment investigations completed on time has continued to improve significantly over the last five years.

Table 5: DHS Maltreatment Out-of-Office Investigations Completed Within 60 Days, FY12-FY16

	FY12	**FY13**	**FY14**	**FY15**	**FY16**
Total Out-of-Office Investigations Completed	612	673	996	1,078	789
Total Out-of-Office Investigations Completed Within 60 Days	100	62	98	777	750
Percent Over 60 Days	84%	91%	90%	28%	5%
Percent On Time	16%	9%	10%	72%	95%

Conclusion

The numbers in this report reflect that there has been considerable recent progress in the Department's processing of maltreatment investigation reports. This progress would suggest that the intake, assessment, investigation, and review processes DHS implemented recently have been effective. While these improvements are significant, the increased volume in reports resulting from the new HCBS programs licensed by DHS, as well as from MAARC, indicate that there will likely be a large volume of work for the foreseeable future. The Licensing Division intends to continue to use and improve its existing processes to meet these challenges.

Appendix – Number and Percent of Maltreatment Reports and Licensing Complaints Received by Service Class, FY16

Table 1-A: Number and Percent of Maltreatment Reports and Licensing Complaints Received by Service Class, FY16

Service Class	Number/Percent of Maltreatment Reports	Number/Percent of Licensing Complaints
DHS Directly Licensed Programs		
Adult Day Care Services	84 (1.9%)	17 (0.5%)
Chemical Dependency Treatment	161 (3.7%)	205 (6.3%)
Child Care Center	144 (3.3%)	768 (23.7%)
Children's Residential Facilities	123 (2.8%)	114 (3.5%)
Children's Residential Facilities—Out of State	2 (0.0%)	0 (0.0%)
Detox Services	20 (0.5%)	23 (0.7%)
Home and Community Based Services	2,829 (64.7%)	1,795 (55.5%)
Independent Living Assistance for Youth	0 (0.0%)	0 (0.0%)
Mental Health Center/Clinic	11 (0.3%)	9 (0.3%)
Psychopathic Personality	31 (0.7%)	3 (0.1%)
Residential Facilities for Adults with Mental Illness	222 (5.1%)	89 (2.8%)
Residential Program for Services for Physically Disabled	7 (0.2%)	1 (0.0%
Indirectly Licensed Programs[5]		
Adult Foster Care	226 (5.2%)	130 (4.0%)
Child Care-Placing Agency	1 (0.0%)	5 (0.2%)
Child Foster Care	39 (0.9%)	22 (0.7%)
Family Adult Day Services	0 (0.0%)	1 (0.0%)
Family Child Care	4 (0.1%)	2 (0.1%)
Not DHS Licensed	469 (10.7%)	51 (1.6%)
Total	4,373 (100.0%)	3,235 (100.0%)

[5] Reports received that are "Indirectly Licensed" or "Not DHS-Licensed" are referred to the appropriate jurisdiction.