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DHS-7404A-ENG 01-18

DEPARTMENT OF HUMAN SERVICES

Maltreatment Report

State fiscal year 2017

Office of Inspector General

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Introduction

The Minnesota Department of Human Services (DHS) is required to publish information on its website each year that provides the public with information about the number and type of reports of alleged maltreatment involving programs and facilities licensed by the 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 SFY 2017, July 1, 2016 through June 30, 2017, and will be made available to the public on the DHS web site at https://mn.gov/dhs//. See Minnesota Statutes, section 626.557, subdivision 12b, paragraph (e), for reporting requirements.

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. Programs licensed by DHS serve or have the capacity to serve more than 300,000 individuals 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.

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.

The division investigates allegations of maltreatment of children and vulnerable adults receiving services from DHS licensed providers across more than 8,700 licensed settings. The division receives reports of alleged maltreatment through the Minnesota Adult Abuse Reporting Center (MAARC), and those reported directly to the division. The division's central intake unit assesses both alleged maltreatment and licensing violations. A significant number of maltreatment reports contain multiple allegations of suspected maltreatment.

DHS is required to prioritize reports of alleged maltreatment to determine which ones will receive an out-of-office investigation. To do this, when initial reports are received, each report receives a robust intake, assessment and in-office investigation. Many of the reports do not include adequate information for the division

[1] See Minnesota Statutes, section 626.557.

[2] See Minnesota Statutes, section 626.556.

to determine the harm, or risk of harm, presented to the vulnerable adult or child by the reported events or conditions, or whether the issue reported represents maltreatment or a licensing violation. Therefore, additional information is often obtained during an in-office investigation.

Intake staff complete research using DHS data on the alleged perpetrator, alleged victim, and facility to check for duplicate or similar allegations. The intake process is also the first step in identifying reports that need to be immediately assigned, need coordination with county emergency protection agencies or law enforcement, or need referral to another lead agency. Each report involving the death of a vulnerable adult or child is immediately assigned for initial in-office investigation to determine if it should be assigned for an out-of-office maltreatment investigation.

Once the initial triage has been completed, the intake staff move the reports to the assessor staff for further review. Assessors generally make additional phone calls to gather more information about the incident, the risk of harm to the vulnerable adult, and the actions taken by the facility in response to the incident. If the assessment and in-office investigation shows that there may be maltreatment or a high risk of harm, then that report is immediately assigned for an out-of-office maltreatment investigation. For reports involving possible licensing violations, the report may be assigned to a licensing unit for an out-of-office investigation related to licensing standards instead of, or in addition to, a maltreatment investigation.

Maltreatment data for fiscal years 2016-17

Reports received

Table 1 lists the reports received for state fiscal years 2016 and 2017, including the number of reports received for which DHS determined it did not have jurisdiction. These reports were referred to the correct state or county agency, to law enforcement if not previously referred by the MAARC system, or other appropriate entity.

Table 1: Maltreatment reports received and initial disposition

State fiscal year	2016	2017
Reports received	**7,616**	**8,114**
No jurisdiction and referral	1,191	951

Table 2 lists the number of maltreatment reports received and assessed by DHS staff and the number of reports of violations of licensing rules and standards received and assessed by DHS staff, 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 for state fiscal years 2016 and 2017.

Table 2: Reports received and assigned

State fiscal year	2016	2017
Maltreatment reports	**4,377**	**4,340**
Assigned for an out-of-office maltreatment investigation	817	737
Licensing reports	**3,239**	**3,774**
Assigned for a licensing investigation	1,046	1,227

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. A report may have more than one allegation of maltreatment that is reported. There was a decrease in reports alleging neglect and an increase in reports alleging abuse and financial exploitation in SFY 2017 compared to 2016. Table 3 shows the maltreatment reports received by primary type of maltreatment that was alleged in the report for SFY 2016 and 2017.

Table 3: Type of maltreatment alleged

State fiscal year	2016	2017
Total maltreatment reports received	**4,372**	**4,340**
Neglect	2,993	2,850
Abuse	858	884
Financial exploitation	521	606

Out-of-office maltreatment investigations and outcomes

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. Maltreatment 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. 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.

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, DHS is required to determine who was responsible for maltreatment. If a facility or individual appeals the finding, investigators are also involved in preparing documents and testifying at the appeal hearings. 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.

In state fiscal year 2017, DHS completed 777 out-of-office maltreatment investigations. Of these, 636 investigations involved maltreatment under the Vulnerable Adults Act (VAA) and 141 involved the Maltreatment of Minors Act (MOMA). Table 4 lists the number of maltreatment reports assigned for out-of-office investigation that were completed in SFY16 and SFY17, and of these:

- the number in which maltreatment was substantiated[3]
- the percent with maltreatment substantiated and
- the percent completed within 60 days.

[3] 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.”

Table 4: Maltreatment out-of-office investigation results

State fiscal year	2016	2017
Maltreatment out-of-office investigations completed	**789**	**777**
Number with maltreatment substantiated	268	268
Percent with maltreatment substantiated	34%	35%
Percent completed within 60 days	**95%**	**90%**

When DHS finds that maltreatment has occurred, DHS must also determine whether the facility or individual was responsible, or whether both the facility and the individual were responsible for the maltreatment. When DHS determines that a facility is responsible for maltreatment, the facility is ordered to pay a $1,000 fine. Due to recent legislative changes, starting in SFY 2018, DHS must also issue a fine for $5,000 for serious maltreatment for which a facility is responsible. DHS may also issue correction orders or more serious actions against the license (e.g., conditional terms, revocation) if licensing violations are also identified.

DHS is also required to bar people from providing direct contact services when they are found responsible for certain types of maltreatment; accordingly, 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. 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.

Table 5 lists party responsible for maltreatment reports for which maltreatment was determined, and of these:

- whether the facility or individual was responsible
- whether both the facility and the individual were responsible for the maltreatment
- whether DHS was unable to determine who is responsible for the maltreatment, and
- the number of substantiated reports where at least one person was disqualified from direct contact.

Table 5: Substantiated maltreatment by responsibility

State fiscal year	2016	2017
Total reports substantiated	**268**	**268**
Facility responsible	36	37
Staff responsible	197	201
Both facility and staff responsible	25	19

State fiscal year	2016	2017
Inconclusive responsibility	10	11
Number of substantiated reports with at least one individual disqualified from direct contact	**92**	**98**

Conclusion

Following a continuous improvement project in 2014, the Licensing Division created a robust central intake unit, developed standardized decision-making protocols, and automated many workflows to streamline the review of determinations for out-of-office investigations. These changes have enabled the division to research, triage and assess an increasing number of reports received each year and still complete 90 percent of investigations within the 60-day timeframe required by the Vulnerable Adult Act. With finite number of staff, this robust assessment process helps ensure that incidents with the greatest risk of harm to vulnerable adults and children are prioritized for an out-of-office investigation. The numbers in this report reflect that there has been considerable 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 alleging either maltreatment or licensing violations 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.