DEPARTMENT OF HUMAN SERVICES

LICENSING DIVISION

LEGISLATIVE REPORT

MALTREATMENT REPORT

(Minnesota Statutes, section 626.557, subdivision 12b)

JANUARY 2003

COST OF PREPARING THE REPORT

The cost of preparing this report is provided to comply with the requirements of Minnesota Statutes, section 3.197, which states:

> 3.197 **Required reports**. A report to the legislature must contain, at the beginning of the report, the cost of preparing the report, including any costs incurred by another agency or another level of government.

This report was prepared by staff from the Department of Human Services, Division of Licensing. No outside consultants assisted in the development of this report.

It took approximately 180 hours of staff time to prepare the report. Based on average per hour compensation of staff, including benefits, the staff costs for preparing the report is $5,400.

The cost of printing and distributing 70 copies of the report is estimated to be $81.00.

The total cost of preparing, printing, and distributing this report is $5,481.

LEGISLATIVE DIRECTIVE

Minnesota Statutes, section 626.557, requires DHS to annually report to the Legislature and the Governor information about alleged maltreatment in licensed facilities.

Minnesota Statutes, section 626.557, subdivision 12b, paragraph (e), states:

> ***Summary of reports.*** *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.*

TABLE OF CONTENTS

DEPARTMENT OF HUMAN SERVICES
LEGISLATIVE REPORT
MALTREATMENT

I. EXECUTIVE SUMMARY

The focus of this report is the investigation of maltreatment in the Department of Human Services, Division of Licensing (DHS) directly licensed programs (approximately 3,900 programs) and adult foster care homes (approximately 3,700 homes). Since 1998, DHS has seen an increase in all areas of the work necessary to assess and respond to reports of maltreatment.

Key Data

The report describes, in more detail, the following general trends and information: increases in the number of reports received, assessed, and investigated; relatively consistent percentages of allegations substantiated; information on the effect of maltreatment on vulnerable adults and children; resolution of investigations; and improvements made and planned to increase output.

Numbers of Reports Received

The data shows:

- An increase in the number of reports of suspected maltreatment of vulnerable adults and children received and assessed by DHS each year, from approximately 3000 in FY 98 to almost 4000 in FY 02 (33 percent increase).
- An increase in the number of reports receiving a telephone investigation from 842 in FY 98 to 1449 in FY02 (72 percent).
- An increase in the number of reports assigned for field investigation from 650 in FY01 to 695 in FY 02. The increase of 45 reports from FY01 to FY02 is almost equal to the number of reports that one full-time, experienced investigator can complete in a year.

Serious Issues

The data shows that the effect of alleged maltreatment on the vulnerable adult and/or child victim is often serious. For example, of reports assigned during FY01 and FY 02 there were:

- 51 allegations investigated where a vulnerable adult or child had died;
- 91 allegations where a vulnerable adult or child sustained a serious or life threatening injury; and
- 204 allegations where a vulnerable adult or child was sexually abused.

Number of Investigations Completed

The number of investigations completed by DHS per year over the past 6 years has averaged 570. FY02 had the lowest number of investigations completed (425) due primarily to staffing issues.

Issues Affecting DHS Output

While the 2001 Legislature reviewed the workload and product of this Department function and provided an increased appropriation of $359,000 in FY02 and $277,000 each year thereafter, staffing issues significantly affected the number of investigations that were completed in FY02. These issues included:

- staff turnover;
- a hiring freeze that resulted in unfilled positions;
- a strike by MAPE employees; and
- redirection of staff resources to train new investigators.

Toward the end of FY02 six new positions were created and filled in the Centralized Intake and Investigations Unit, and two positions that had been left vacant due to a hiring freeze were filled.

Improvements Made and Planned to Increase Output

During the past year DHS received additional resources, hired 6 additional investigators, and reorganized duties to maximize the effectiveness of the increased resources. Specifically, DHS completed:

- hiring and training of six additional investigators and filling of two positions that had remained open as a result of a hiring freeze;
- centralization of report intake functions and restructuring of related duties within the division;
- development and implementation of technological changes; for example, beginning in September 2002 reports of alleged maltreatment are received electronically from Hennepin County. This increases efficiency by reducing data entry and reduces cost for Hennepin County.

The effective and efficient utilization of resources has positioned DHS well to continue to conduct thorough and objective investigations of reports of alleged maltreatment. However, on-going staff turnover and an on-going hiring freeze may significantly impact DHS's ability to continue progress in this area.

II. INTRODUCTION AND BACKGROUND

The Minnesota Department of Human Services (DHS), in cooperation with counties, licenses approximately 28,000 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 and residential, outpatient, and day training treatment programs for people with chemical dependency, mental illness or developmental disabilities. The focus of this report is the investigation of maltreatment in DHS directly licensed programs (approximately 3,900) and adult foster care homes (approximately 3,700) licensed by DHS which, except for maltreatment investigations, are monitored by counties.

The statutes most relevant to investigating maltreatment are MN Statute 626.557, the Reporting of Maltreatment of Vulnerable Adults Act (VAA), MN Statute 626.556, the Reporting of Maltreatment of Minors Act (MOMA), and Chapter 245A, the Human Service Licensing Act (HSLA). From 1995 to the present there have been significant changes to both the VAA and the MOMA. Some of these changes made DHS the sole agency responsible for investigating reports of maltreatment in DHS directly licensed programs and in adult foster care homes. All adults served in DHS licensed programs, except for outpatient chemical abuse treatment programs, are categorically "vulnerable adults" under the VAA.

Also since 1995, additional statutory changes increased the complexity of investigations by initiating a sophisticated appeal process and requiring extensive notifications of actions taken. Because of HSLA background study requirements that direct DHS to disqualify people from providing direct contact service when they are found responsible for some types of maltreatment, the changes have also addressed standards for determining who is responsible for maltreatment. Today each investigation must determine:

- what actually happened;
- whether the event meets the definition of maltreatment;
- whether an individual or facility was responsible for the occurrence;
- whether the maltreatment was serious and/or recurring; and
- whether action is necessary to reduce the chance of recurrence of the event to protect the health and safety of vulnerable adults and children.

Most investigations include a visit to the program, many interviews, and the review and collection of a variety of documents. The complexity of investigations requires an extensive training period for new investigators and limits the number of investigations each investigator can adequately complete. A trained investigator is expected to complete approximately 50 investigations per year. This includes time in appeals such as assisting in preparation for, and testifying at, administrative hearings.

III. CURRENT STATUS AND TRENDS

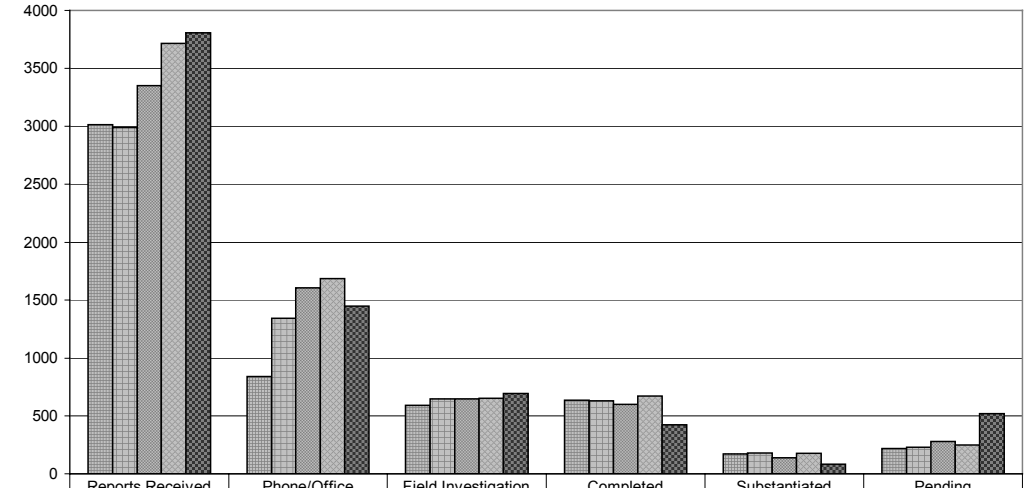
A. Reports assessed

The number of reports of suspected maltreatment of vulnerable adults and children received by DHS each year has increased from approximately 3000 in FY 98 to almost 4000 in FY 02 (33 percent increase). Reporters of maltreatment include county staff members, family members of vulnerable adults and children, staff members of licensed programs, other professionals working with people receiving services, and community persons.

Following are trends identified in recent data:

- The number of reports receiving a **phone investigation** increased from 842 in FY 98 to 1449 in FY02 (72 percent).
- The number of reports **assigned** for maltreatment field investigations was consistent in FY's 99, 00, and 01, approximately 650, and then increased in FY02 to 695. The increase of 45 reports from FY01 to FY02 almost equals the number of reports that one full-time, experienced investigator can complete in a year.
- The number of reports completed per year over the past 6 years has averaged 570. FY02 had the lowest number of reports completed (425) due primarily to staffing issues. The staffing issues included staff turnover, a hiring freeze that resulted in unfilled positions, a strike by MAPE employees, and redirection of some staff resources to train new investigators. See Figure 1 for an overview of reports received, reports receiving office or field investigations, reports substantiated, and reports pending.

Figure 1 Maltreatment and Abuse Reports and Investigations by Fiscal Years



	Reports Received	Phone/Office	Field Investigation	Completed	Substantiated	Pending
FY 98	3015	842	590	635	173	220
FY 99	2988	1343	646	631	181	232
FY 00	3350	1606	645	602	138	281
FY 01	3715	1686	652	671	177	252
FY 02	3807	1449	695	425	84	520

B. Effect of Alleged Maltreatment on the Victim

The Department tracks the effect of alleged maltreatment on the vulnerable adult or child victim by using the statutory definitions of maltreatment. Each report may include more than one allegation (average of 1.6 allegations per report). This means that there can be more than one effect on the vulnerable adult or child victim on each report assigned for field investigation. For example, it may be alleged that a vulnerable adult was both financially exploited and physically abused.

Reports of maltreatment that were assigned for field investigation in FY 01 and FY02 alleged the following effect on the alleged victim:

- 51 alleged that maltreatment preceded or caused a vulnerable person's death (FY01 24; FY02 27)
- 91 alleged that the victim sustained a serious or life threatening injury (FY01 59; FY02 32)
- 204 alleged that the victim was sexually abused (FY01 90; FY02 114)
- 720 alleged that the victim suffered physical pain or emotional distress (FY01 383; FY02 337)
- 145 alleged that the victim sustained a moderate injury (FY01 84; FY02 61)
- 443 alleged that the victim was exposed to threat or danger in (FY01 161; FY02 282)
- 164 alleged that the victim sustained a minor injury (FY01 123; FY02 41)
- 365 alleged that the victim was financially exploited (FY01 161; FY02 204)
- 15 allegations had an unknown impact (FY01 12; FY02 3)

Investigations completed in FY01 and FY02 where DHS substantiated that maltreatment occurred showed the following effects on the vulnerable adult or child victim of the maltreatment:

- 7 investigations determined that maltreatment preceded or caused a vulnerable person's death (FY01 3; FY02 4)
- 13 investigations determined that the victim sustained a serious or life threatening injury (FY01 12; FY02 1)
- 40 investigations determined that the victim was sexually abused (FY01 20; FY02 20)
- 87 investigations determined that the victim suffered physical pain or emotional distress (FY01 48; FY02 39)
- 35 investigations determined that the victim sustained a moderate injury (FY01 26; FY02 9)
- 75 investigations determined that the victim was exposed to threat or danger (FY01 31; FY02 44)
- 23 investigations determined that the victim sustained a minor injury (FY01 13; FY02 10)
- 185 investigations determined that the victim was financially exploited (FY01 105; FY02 80) See Figure 3 on the next page for FY 2001/2002 data.

Figure 2 Maltreatment Allegations by Effect on Victim (FY 01 & 02)

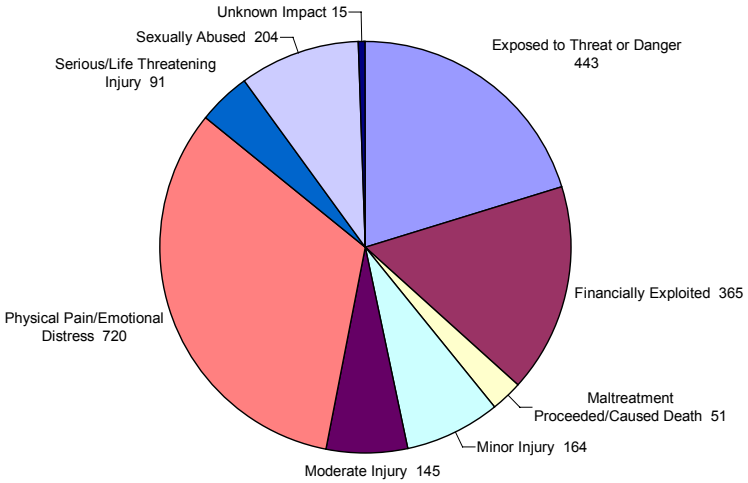
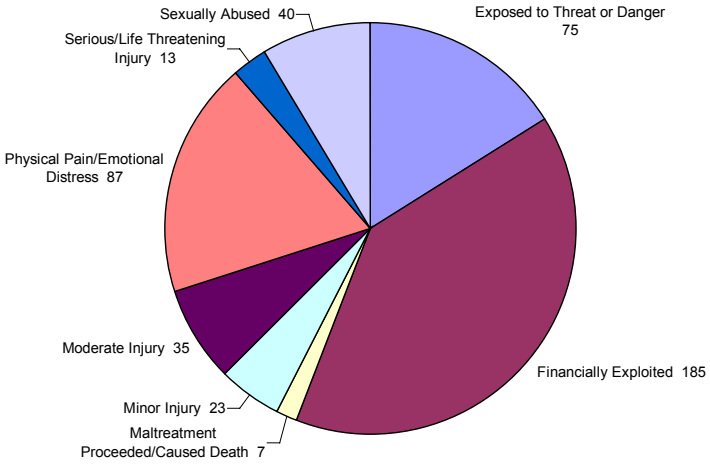


Figure 3 Maltreatment Substantiated by Effect on Victim (FY 01 & 02)

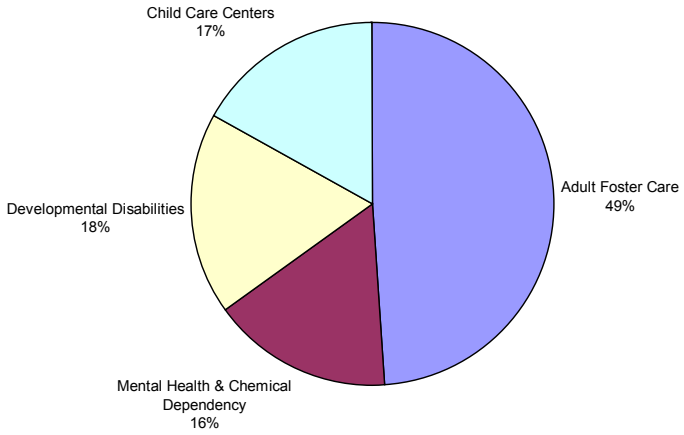


C. Type of program/vulnerability of victim

The data shows:

- In FY 02 approximately two of every three reports assigned for field investigation involved a vulnerable adult and approximately one of every three reports involved a child.
- Figure 2 shows that in FY02 the number of reports assigned for field investigation in child care centers, programs serving persons with developmental disabilities, and programs serving persons with mental illness and chemical dependency are very similar at 17, 18, and 16 percent of the total respectively.
- There has been a gradual increase in the percentage of reports assigned that occurred in adult foster care homes and a gradual decline in the percent that occurred in residential institutions for persons with developmental disabilities. This is consistent with the trend of people increasingly choosing to live in smaller community-based homes and consistent with the continuously increasing number of adult foster care licensed programs. On July 1, 1996 there were 2,585 licensed adult foster care programs, and by July 1, 2002 the number of programs was 3,698; an increase of 43 percent. Many of the licensed foster care providers are also directly licensed by DHS to provide waiver services to persons with developmental disabilities. During the same period the number of licenses to providers of waiver services to people with developmental disabilities has increased from 533 to 818; an increase of 54%. This is significant for workload issues because it may be determined that the report received does not represent maltreatment, but still needs to be investigated to determine if there are licensing violations. See Figure 4 below for FY 2002 data.

Figure 4 Type of Programs Where Victim of Reports Assigned for Investigation Received Service (FY 02)



IV. RESOLUTION OF INVESTIGATIONS:

A. Determinations

Under the maltreatment reporting and investigations statutes, and under the licensing statutes, various types of resolutions are possible at different stages of the investigation. These include an initial determination, a determination of whether maltreatment occurred, and a determination as to whether action is necessary to decrease the risk of recurrence of maltreatment.

1. Initial Determinations

The initial resolution of investigations includes one of the following three determinations: no jurisdiction because the event did not occur in a DHS licensed program; or further investigation is not necessary because the event does not meet a statutory definition of maltreatment and does not represent a possible licensing violation; or the report is assigned for further investigation.

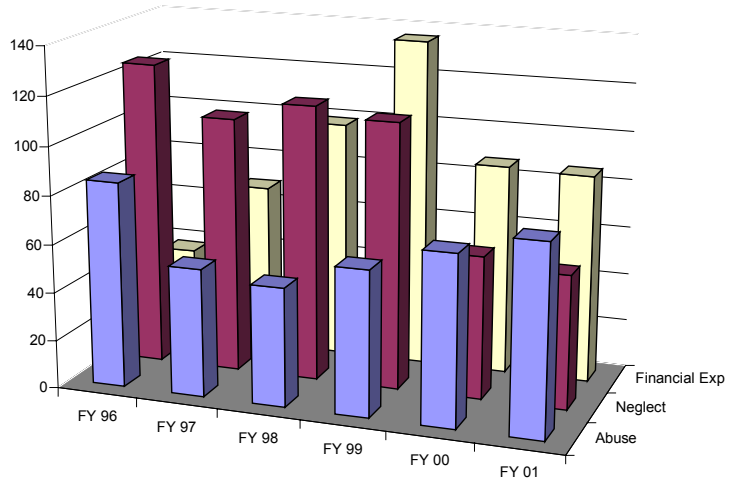
2. Did Maltreatment Occur

As stated earlier, each report assigned for further investigation will result in a determination of whether or not maltreatment occurred. If maltreatment occurred there is a determination of whether an individual(s) or facility was responsible for the maltreatment, whether the maltreatment is serious and/or recurring, and whether any action is necessary to reduce the risk of recurrence. The determinations of whether or not maltreatment of children occurred include: "maltreatment determined" or "maltreatment not determined." Determinations for vulnerable adult maltreatment include: "substantiated," "inconclusive," "false," or "no determination will be made."

A review of **substantiated reports and allegations** shows the following:

- The percent of reports substantiated has remained relatively stable; averaging 26 percent until FY02 when the percent of substantiated reports declined to 20 percent. It is possible that this decline is related to the smaller number of investigations completed and may increase as the pending investigations are completed. See Figure 1 on page 8.
- For approximately one quarter of substantiated findings a facility was responsible for the maltreatment and for approximately three fourths an individual was responsible.
- Over the past six fiscal years: substantiation of abuse remained relatively consistent; substantiation of neglect declined (this corresponds with a change in the statute excluding some events from the definition of neglect); and substantiation of financial exploitation increased, peaking in FY99, and then decreasing in FY01 and 02. See Figure 5 on the next page.
- For FY00 and FY01 substantiated maltreatment findings averaged 34 percent abuse, 26 percent neglect, and 40 percent financial exploitation.

Figure 5 VAA and MOMA Allegations Completed and Substantiated



	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01
Abuse	85	53	49	60	70	78
Neglect	126	106	114	110	59	55
Financial Exp	38	69	99	136	87	86

3. Was Action Necessary to Decrease Risk of Recurrence

The focus of this section is on the resolution of reports assigned for further investigation where DHS determined that maltreatment occurred and investigations where there was a determination that some type of action was necessary to reduce the risk of recurrence. Possible actions taken to reduce the risk of recurrence of maltreatment are authorized under Chapter 245A and include: disqualification of an individual from the provision of direct care to persons served in programs licensed by DHS, the Department of Health, the Department of Corrections, and Personal Care Provider Organizations; issuance of a citation(s) ordering a facility to correct a licensing violation; or a negative licensing action (fine, conditional license, suspension or revocation of license).

The following **actions** have been **taken by DHS** following maltreatment investigations:

- Since 1998 investigations have resulted in an average of 65 persons per year being disqualified from direct contact with persons served by licensed programs.
- During FY01 and FY02 there were 18 negative licensing actions that involved maltreatment investigations.
- During FY01 and FY02 150 citations for rule violations were issued following maltreatment investigations.

B. Appeals

Every decision regarding maltreatment and every decision regarding consequences for maltreatment made by DHS following completion of an investigation is subject to review and appeal. A vulnerable adult, a vulnerable adult's or child's designee, a substantiated individual perpetrator, or a substantiated facility may ask for reconsideration of the determination of whether maltreatment occurred. The Division of Licensing responds to each request for reconsideration received. If, after this administrative reconsideration, DHS does not change the finding, the substantiated perpetrator may request an Administrative Hearing. This Administrative Hearing is available to substantiated perpetrators only, whether they are individuals or facilities. The victim, victim's designees, or a child's parent or guardian may request review by a maltreatment review panel. The maltreatment review panel may make recommendations to the investigation agency.

The following **appeals** have been conducted following maltreatment determinations:

FY	Reports completed/findings	Reconside r-ations.	Changed findings	Hearings	Changed findings
98	635 *	68	2	8	2
99	631 1033	54	2	22	9
00	602 1122	48	4	13	5
01	671 1226	67	3	7	1
02	425 692	54	1	6	2
Ttl	2964 4073	291	12	56	19

*Figure not available

These figures show that:

- 11 percent of investigations were appealed through reconsideration
- 4 percent of administrative reconsiderations resulted in a changed finding
- 19 percent of investigations that were appealed through reconsideration went on to a fair hearing.
- 34 percent of hearings resulted in a changed finding
- Overall 12 percent of appeals changed the determination as a result of either administrative reconsiderations or fair hearings.

It is likely that some of the decrease in the number of hearings occurring in FY02 is due to the lower number of investigations completed, and it is likely that the number of hearings will increase in FY03 as more investigations are completed.

During FY 02 there were also four DHS investigations reviewed by the Vulnerable Adult Maltreatment Review Panel and one DHS case reviewed by the Maltreatment of Minors Review Panel. No recommendations were made as a result of these reviews.

V. WHETHER AND WHERE BACKLOGS OF CASES RESULT IN A FAILURE TO CONFORM WITH STATUTORY TIME FRAMES

DHS continues to meet statutory timelines in assessing reports of alleged maltreatment within 24 hours, determining an initial disposition within five days, and providing notification of the initial disposition to reporters of alleged maltreatment within five days.

Although the VAA has required that investigations be completed within 60 days (VAA) since 1995, DHS has not been able to meet this timeline for all investigations. In FY02 investigations were completed within the following timelines:

- 14% of investigations were completed within 60 days;
- 23% were completed between 61 and 120 days; and
- 62% were completed in more than 120 days.

The average number of days to complete reports has been increasing since FY99. In FY02 the average length of time to complete vulnerable adult maltreatment investigations was 7.2 months; the average for maltreatment of minors investigations was 6.3 months. These averages will continue to increase as some of the oldest outstanding reports continue to be completed. There has been progress in this area, for example in May 2002 there were 54 pending investigations that had been assigned for investigation in calendar year 2000; on January 15, 2003, all of those investigations were completed.

.

The number of pending investigations decreased to 220 in FY98, but since then they dramatically increased to 520 in FY02. This increase corresponds with the previously mentioned staff turnover, high number of reports received and assigned, a strike, and a hiring freeze (resulting in unfilled positions). Based on maintaining 15 active investigator positions and each investigator maintaining a caseload of 15 to 20 open investigations, 225 – 300 pending investigations is reasonable.

The 2001 Legislature reviewed the workload and product of this Department function and provided an increased appropriation of $359,000 in FY02 and $277,000 each year thereafter. The state employee strike and various hiring freezes interfered with immediate use of these additional resources. Toward the end of FY02 six new positions were created and filled in the Centralized Intake and Investigations Unit, and two positions that had been left vacant due to a hiring freeze were filled.

Barring unforeseen budget reductions, DHS is now positioned to complete maltreatment investigations at approximately the same rate as new reports needing investigations are received. The backlog of reports currently under investigation will provide an ongoing challenge that will be dealt with through increased efficiencies in investigative activities and through increased use of technology whenever and wherever possible.

VI. WHERE ADEQUATE COVERAGE REQUIRES ADDITIONAL APPROPRIATIONS AND STAFFING

During the past year the Department completed significant work that will maximize the utilization of the increased resources received in FY01. This work included the centralization of report intake functions, restructuring of duties within the division, and the hiring of additional investigators. This centralized intake unit will eventually receive, process, assess, and assign all reports of alleged maltreatment and licensing violations received by the DHS. Milestones include:

- Many computer system improvements have been made to enhance and standardize data collection for managing workflow and for performance reporting.
- Beginning in September 2002 reports of alleged maltreatment are received electronically from Hennepin County. This increased efficiency by reducing data entry.
- An automatic call distribution (ACD) phone system was installed in July 2002. This improves customer service because callers are able to immediately reach a live person to report their concern about the service being provided to someone about whom they care. The phone system also increases efficiency and effectiveness by reducing the number of persons responsible for these calls from approximately 20 staff persons to four staff persons.
- Modifications to the Licensing Information System are underway that are necessary to maximize DHS' ability to collect information and identify patterns of information in reports received, and to centralize the intake process.
- Effective in December 2002 all reports received by DHS are investigated according to standardized criteria based on the potential risk of harm to vulnerable adults or children, and reports with the highest risk of harm are assigned for field investigation first.
- Additional counties are being approached as candidates for sending their maltreatment reports to DHS electronically. This will continue to enhance the efficiency of the centralized intake process.

The restructuring, hiring, and training of staff persons, and progress towards the most effective and efficient utilization of resources have positioned DHS well to continue to conduct thorough and objective investigations of reports of alleged maltreatment received and to reduce the time necessary to complete field investigations. However, on-going staff turnover and possible hiring freezes will significantly impact DHS ability to continue progress in this area.