Evaluation Report of Adult Protective Services Standardized Intake Decision Tool

6/30/2021

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EXECUTIVE SUMMARY

Summary of Engagement

The Minnesota Department of Human Services (DHS) contracted with a consulting company (Consultant, the Consultant) to evaluate the validity of Minnesota's Structured Decision Making® (SDM®) Intake Assessment tool[1]. The SDM® tool is a screening aid used by county adult protective services (APS) units to support objective screening decisions when screening referrals of vulnerable adults (VA) reported for suspected maltreatment. In 2013, Minnesota (MN) Statute 626.557[2] was revised to require county-based lead investigative agencies (LIA) to use a standardized tool provided by DHS.

The tool guides a county APS worker through the process of comparing an incoming referral to Minnesota (MN) Statute 626.5572[3] with the expected outcome of advancing incoming cases that align to statutorily defined parameters for case acceptance for investigation and delivery of protective services.

Research Plan Process

Consultant studied the validity of Minnesota's SDM® Intake Assessment Tool by implementing a multi-step research plan, described below.

Step 1. Data Analysis, including statistical significance and correlations of key SDM® Intake Assessment Tool data components

Step 2. Analysis of equity outcomes for vulnerable adults referred to adult protective services

Step 3. Systems analysis of program-related documents including, but not limited to policies, workflows, procedure manuals, and training materials

Step 4. Stakeholder engagement analysis including focus groups and targeted interviews

Step 5. Identify recommendations and develop preliminary and final reports

Minnesota (MN) Statute 626.5572[4] defines a vulnerable adult as any person 18 years of age or older who possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction that:

- Impairs the individual's ability to provide adequately for the individuals' own care without assistance, including the provision of food, shelter, clothing, heath care, or supervision; and
- Because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to self-protect from maltreatment

[1] Consultant additionally subcontracted with which represents the nation's 56 state and territorial agencies on aging and disabilities and long-term services and supports directors, as a subcontractor to provide subject matter expertise on national Adult Protective Services practices. References to the Consultant team include the contributions of subcontractor.
[2] 2020 Minnesota Statute, 626.557, https://www.revisor.mn.gov/statutes/cite/626.557
[3] 2020 Minnesota Statute, 626.5572, https://www.revisor.mn.gov/statutes/cite/626.5572
[4] 2020 Minnesota Statute, 626.5572, https://www.revisor.mn.gov/statutes/cite/626.5572

Maltreatment categories span physical, emotional, and/or sexual abuse, caregiver neglect, self-neglect, and/or financial exploitation. The screening process is a gateway for promoting –timely and appropriate advancing of suspected cases for investigation and intervention to address the safety of the VA. DHS also aims for APS workers to use person-centered approaches for assessment, safety planning and interventions that connect a VA to services and supports that can mitigate future risk and improve quality of life and long-term community safety.

Minnesota's APS system is a state-supervised, county-administered system. DHS provides oversight and monitoring to 87 counties, each defined as individual LIAs that operate adult protective services. While DHS has implemented mandatory structured decision making tools, current program regulations allow counties to develop county-specific screening policies – termed county prioritization guidelines. These county specific guidelines inform the use of discretionary overrides, giving counties flexibility to tailor their screening approach to programmatic needs within their immediate community.

DHS partnered with the Consultant to analyze data collected via SDM® Intake Assessment tools completed from 2017 - 2020 to evaluate whether the tool produces valid and reliable screening decisions. In addition to data analysis, Consultant performed policy analysis and engaged stakeholders across county APS teams throughout the state to understand how the tool is operationalized today to formulate recommendations that foster valid and reliable screening decisions in the future.

The consultant was also charged to study the equity of outcomes to identify whether APS consistently resulted in equitable linkage of diverse VA's to needed services and supports. Consultant used data that counties input into the state's *Social Services Information System* (SSIS) to evaluate whether services are equitably offered across diverse demographics including age, gender, geography, disability type, race/ethnicity, etc. SSIS is also the system in which the SDM® decision making tool is housed. Consultant developed a research plan explaining all methods deployed in the study, which DHS reviewed and approved in late 2020. Consultant highlighted the research plan process steps above and will explain in further detail in Sections III – VI.

The goals of this evaluation included:

- Confirming if the SDM® Intake Assessment tool results in valid and reliable screening decisions that fosters objectivity, equitable access to services and statewide consistency across counties for vulnerable adults reported as suspected of experiencing maltreatment; and
- Confirming if APS systems in Minnesota result in equitable outcomes through the extension of protective services and person-centered linkage to services and supports for all vulnerable adult citizens.

Findings and Recommendations

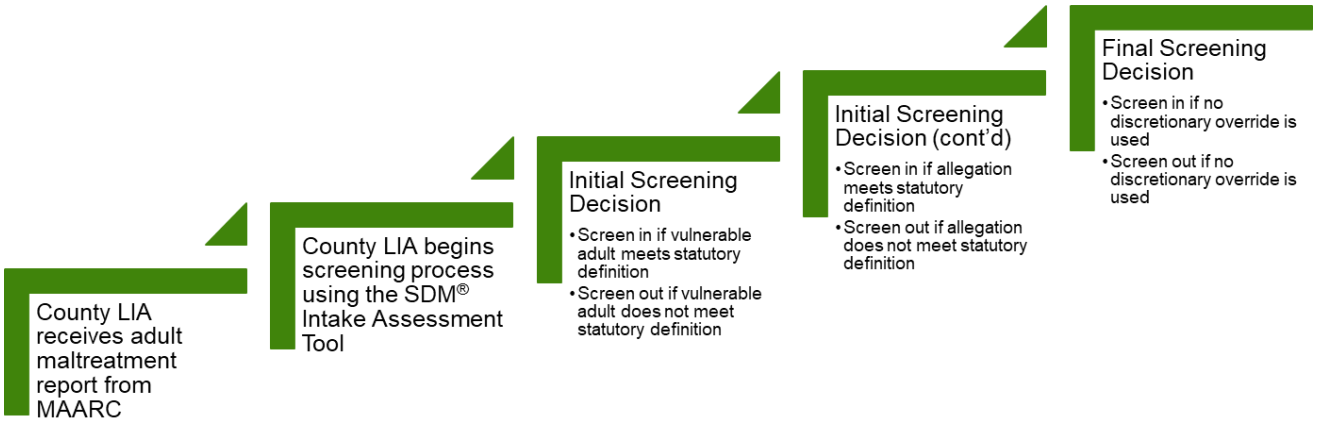
Our post-evaluation findings suggest that there is significant, statewide use of discretionary override among the total sample of SDM® Intake Assessment tool completions analyzed. Over a third (35%) of all incoming APS case referrals are ultimately screened out on the basis of discretionary override. The rate of discretionary override is

applied for a variety of reasons that are difficult to trend due to higher-than-anticipated use of an "other" category that allows the county APS worker to enter a free-text rationale for why APS , the county lead investigative agency (LIA), is electing to screen out the referral, despite the referral meeting the statutory definition for APS eligibility for investigation thus qualifying for an investigation per completed fields within the SDM® tool.

It should be noted that 41% of cases referred to county APS lead investigatory agencies, would be screened out when strictly following the decision-making logic used in the SDM® Intake Assessment tool. When discretionary override is applied the statewide screen-out rate jumps from 41% to 76% of all cases being screened out. Thus, less than one quarter of all cases referred to adult protective services in Minnesota were advanced for investigation during the evaluation period, which is significantly lower than the national average captured in the federal National Adult Maltreatment Reporting System (NAMRS) report – which during the respective time period of this evaluation has increased from a 45.9% screen-in rate to a 62.3% screen-in rate.[5]

Data and free-text entry analysis coupled with qualitative analysis using statewide stakeholder engagement from county APS agencies indicate that many county LIAs are not using the SDM® Intake Assessment tool as designed and as a result, the tool is not the primary driver of screening decisions. The widespread application of discretionary override by APS undermines the validity and reliability of the tool overall. Based on the limited sample size of ultimate screen-ins with an even smaller sample of screen-ins resulting in substantiated cases of maltreatment, Consultant has advised the Department that it would be difficult to measure scientific validity of the SDM® tool until it is being used as designed by county APS agencies. Figure 1 offers a high-level overview of the current intake process flow.

Figure 1. Intake Process Flow



While we were unable to and did not complete a formal validity evaluation, data analysis, review of free text entry and qualitative analysis using stakeholder engagement indicates that state-wide APS inter-rater reliability is low. Outcomes in the data sample studied do not support that all vulnerable Minnesotans have equitable access to APS maltreatment investigation, strengths and needs assessments, safety planning, protective interventions and linkage to services and supports that can prevent future maltreatment and improve a VA's ability to thrive in community.

Findings that lead the consultant to state there are risks to equitable access include:

- Screen-out rates varied considerably by county ranging from 0 – 88% indicating that a VA's county of residence is a significant factor in determining access to services. It is important to note that several of the counties with the highest screen-out rates are in the Minneapolis-St. Paul metro counties where a higher volume of total referrals are made based on higher population density.

- There are statistically significant disparities in screen-out rates when considering screening rates by racial and ethnic group. Racial and ethnic minorities are statistically more likely to be screened out for APS than Caucasians. Whereas statewide screening rates for referrals when the vulnerable adult is Caucasian are roughly 50% screened-in vs. screened-in rates for people who are not Caucasian:

    - 39% of American Indian / Alaskan native persons referred are screened in

    - 32% of Asian persons referred are screened in

    - 30% of Pacific Islander persons referred are screened in

    - 20% of Black or African American persons referred are screened in

Consultant acknowledges that racial and ethnic minorities predominantly reside in metro counties and that metro counties have higher overall screen-out rates. Ultimately, data analysis demonstrated reduced access to APS for racial and ethnic minorities within the two largest counties in the State that would suggest that even in counties with high screen-out rates, there is still statistically significant disparity in screening decisions. The relationship between counties, race, and screen-out rates will be further discussed in Section III of this report. Recommendations support the goal of reducing racial disparities in screen-outs to bolster equity.

- Analysis also indicated variance among access by the vulnerable adult's disability type, with particularly high screen out rates for persons with chemical dependency. Overall screening rates by disability category range from 30 – 50% screen-in, a variance that suggests services are not equitably accessible among all disability types.

While the consultant was charged to measure "equity of outcomes" to measure if interventions are equitably offered to vulnerable adults receiving APS, this analysis could not be performed due to the higher than anticipated screen-out rate and because only 21.8% of VA's who are screened-in for APS have a service intervention documented (a total of 2,142 records) in the SSIS.

Through stakeholder engagement we verified that the broad APS workforce is not using the SDM® Intake Assessment tool as designed. Stakeholder engagement activities also revealed multiple APS program components where policy and/or operational and systems analysis indicated that oversight approaches can be further defined by DHS, as the state administrator, to promote consistency across county administered APS programs. Conversations with stakeholders also indicated strong opportunity to improve consensus, shared vision and understanding among DHS and county agencies around the purpose, guiding principles of APS and expectations for balancing core but competing principles like person-centered care, respecting individual autonomy and rights of adults, while also engaging APS's vulnerable adult clients in the necessary level of protection and intervention.

Post-evaluation recommendations SDM® are listed in Figure 2, including a summary of the recommendation and the intended outcome. Readers should refer to Section VII for further detail. DHS retains sole decision-making authority on whether to proceed with any or all of the post-evaluation recommendations.

Figure 2. Summary of Recommendations

#	Recommendation	Anticipated Outcome
1	Reinforce the intended use of the SDM® Intake Assessment Tool as the primary arbiter of screening decisions by taking steps with county APS agencies to reduce use of discretionary override, including statewide re-training.	Consultant recommends DHS act in partnership with county APS agencies to reduce the volume of discretionary overrides used to screen out referrals. DHS should leverage the SDM® Intake Assessment Tool Outcome as the "source of truth" on when to proceed to investigation and service assessment. Consultant recommends DHS conduct on-going training to reiterate the purpose of the SDM® Intake Assessment Tool and intention of the discretionary override option.
2	Develop guiding principles for APS operation to more specifically define the role of APS in the social services continuum	Consultant recommends DHS develop guiding principles for APS operation. DHS should use continued statewide engagement to more specifically define the role of APS in the social services continuum, define a scale of 'least to most protective,' and offer ongoing guidance and case studies to promote consistency in how APS workers balance person-centeredness and self-determination in protective services provisions. This includes when working with other social services agencies.
3	Conduct cross-model workflow mapping	Consultant recommends that DHS lead county workgroups to perform end-to-end process workflow mapping. The workflow mapping aims to establish appropriate minimum standards and best practice approaches across three emergent operating models used statewide.

#	Recommendation	Anticipated Outcome
4	Assess current Department of Human Services (DHS) technical assistance practices	Consultant recommends an assessment of current DHS technical assistance practices to improve the provision of targeted and proactive feedback to the statewide network and individual counties. By enhancing technical assistance for the decision-making tool data and other measurements, DHS can promote improved consistency across counties and upstream identification of outliers.
5	Implement standardized sharing of best practices among county APS agencies	Consultant recommends that DHS implement a standardized method for performing quarterly statewide calls to share APS-related best practices and share performance findings from recurring data analysis.
6	Modify screening timeframes	Consultant recommends DHS modify the mandatory timeframe for making the intake and initial disposition decision from five (5) business days following the date the agency received referral of the adult maltreatment report to 48 hours following referral. The expedited timeframe would reflect the urgency of extending investigation where appropriate and minimize the volume of telephonic investigative activities during the screening process and intake assessment.
7	Conduct a statewide listening tour to address racial and ethnic inequity in Adult Protective Services	Consultant recommends DHS conduct a statewide listening tour that includes APS workforce and external stakeholders, including representatives of racially and ethnically diverse communities. The tour would aim to gather feedback on barriers to equitable APS approaches and inform future DHS recommendations for mitigating the risk of inequitable access to APS and/or inequitable service provision.
8	Clarify the role and responsibility of case managers when collaborating with an active APS case	Consultant recommends DHS clarify the role and responsibility of active case managers and Adult Protective Services (APS) workers in the intake process for all allegation types.
9	Establish a multidisciplinary workgroup to develop policy / guidance on applying protective services to individuals with chemical dependency	Consultant recommends DHS establish a multidisciplinary workgroup to develop best practice policy or guidance on applying protective services to individuals with chemical disability to promote consistent application of APS for this population.

#	Recommendation	Anticipated Outcome
10	Define a policy for screening referrals where the vulnerable adult is in a hospital or short-term facility	Consultant recommends DHS define a policy for screening referrals where the individual vulnerable adult is in a hospital, short-term / sub-acute, or facility-based setting. Consultant recommends developing this policy to decrease the risk to vulnerable adults being discharged back to the community without a safety plan and/or services in place
11	Limit the ability to use "other" throughout the SDM® Intake Assessment Tool	Consultant recommends DHS limit the ability to use "other" as a discretionary override throughout the SDM® Intake Assessment Tool by offering more discrete data options, based on observed trends in the current screening methods, such as adding character limits to free text boxes, adding additional drop-down options, and/or eliminating the free text option where possible.
12	Implement SSIS functionality to view multiple screens	Consultant recommends DHS implement SSIS functionality to allow the supervisor or designated reviewer the ability to view multiple screens when working in SSIS. This includes adding functionality that would allow a reviewer to read case notes while simultaneously viewing the SDM® Intake Assessment Tool, along with functionality to view the adult maltreatment report while viewing the SDM® Intake Assessment Tool.
13	Implement SSIS functionality for information and referral capture at screening	Consultant recommends DHS add SSIS functionality accessible during the intake screening process that would allow the APS Worker to record any information and referral provided prior to screen out.
14	Implement SSIS functionality requiring APS workers enter interventions at case closure, regardless of determination	Consultant recommends DHS add SSIS functionality that requires the APS Worker to record any targeted interventions and/or direct referral to service providers during the intake screening or investigation process and prior to case closure, regardless of final determination.
15	Conduct future evaluation following implementation of recommendations	Consultant recommends DHS monitor the impact of implementing Recommendations #1 through #14 to identify if statewide screening rates increase to **within 10% of the national average** (or higher) as measured via the NAMRS system. If screening rates do not improve accordingly following operational and policy changes, the State may need to initiate regulatory changes that disallow discretionary overrides of the screening result when using the SDM® Decision

#	Recommendation	Anticipated Outcome
		Making Tool. Consultant also recommends performing a validity study of the tool once there is confidence it is being used as designed.

Report Overview

The consultant assisted Minnesota DHS Aging and Adult Services Division, Adult Protection Unit in evaluating the State's standardized intake tool and determining the extent to which data inputs rendered consistent screening responses and service decisions for vulnerable adults. The scope of work included: developing data analysis methodology; analyzing demographic data; reviewing policy and procedure guidelines; engaging county stakeholders to evaluate APS processes; and recommending courses of action for the State to improve consistency in vulnerable adult outcomes. This final report summarizes the evaluation planning, results, conclusions, and recommendations aimed at improving screening consistency in Minnesota.

The full report contains the following sections:

- ***Section I: Study Purpose and Background*** describes the study objectives, the role of the advisory workgroup in the study, and the study limitations.
- ***Section II: Adult Protective Services Landscape*** provides a summary of the national trends in APS, including an overview of the National Adult Maltreatment and Reporting System (NAMRS) reporting measures and trends, and the evolution of APS in the State of Minnesota.
- ***Section III: Data Analysis – Demographics*** describes Consultant's methodology, observations, and findings based on an analysis of the SDM® Intake Assessment Tool data.
- ***Section IV: Data Analysis – Equity of Outcomes*** describes approach to and analysis of program referrals and service linkages for vulnerable adults.
- ***Section V: Systems and Policy Analysis*** describes Consultant's review of DHS policies, procedures, and training materials, and a selection of county prioritization guidelines, along with observations and findings.
- ***Section VI: Qualitative Analysis – Stakeholder Engagement*** provides approach to and summaries of stakeholder engagement activities, including focus groups and targeted supervisory interviews, along with observations and findings.
- ***Section VII: Recommendations*** summarizes the key findings and corresponding recommendations.

SECTION I: STUDY PURPOSE AND BACKGROUND

Study Objectives

DHS issued a competitive procurement in the Spring of 2020 to procure a contractor to evaluate the validity of the SDM® Intake Assessment Tool. DHS maintains a publicly available Vulnerable Adult Dashboard[6] to publicly share state and county data on the number of reports, the allegations, and the investigation determinations. DHS had analyzed this data and observed a high degree of variability in screen-in and screen-out rates across the state, ranging from 0% case acceptance rate to 100% case acceptance rate, and requested a study to review additional data points, including demographic information and SDM® Intake Tool data, including the use of override, to study the validity of the SDM® Intake Assessment Tool.

DHS was also seeking the contractor to review current policy and operational factors that could be impacting the validity of the SDM® Intake Assessment Tool.

The Consultant team, including our partners from Subcontractor, DHS, and the Advisory Workgroup discussed the definition of both validity and reliability:

- "**Validity** in research refers to how accurately a study answers the study question or the strength of the study conclusions. For outcome measures such as surveys or tests, validity refers to the accuracy of measurement. Here validity refers to how well the assessment tool actually measures the underlying outcome of interest."
- "**Reliability** refers to whether an assessment instrument gives the same results each time it is used in the same setting with the same type of subjects. Reliability essentially means consistent or dependable results. Reliability is a part of the assessment of validity."[7]

Advisory Workgroup

The proposed study design included the support of an advisory workgroup, designed to advise the study process. DHS identified and requested participation from county leads from throughout the State to advise study efforts and offer valuable subject matter expertise throughout this study. The role and purpose of the advisory workgroup was to:

[6] https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/adult-protection/dashboard.jsp

[7] Sullivan G. M. (2011). A primer on the validity of assessment instruments. Journal of graduate medical education, 3(2), 119–120. https://doi.org/10.4300/JGME-D-11-00075.1.

- Inform study methods and provide subject matter expertise to maximize study efforts
- Share subject-matter expertise on the operational realities of APS programs and how those realities impact the study methods
- Discuss preliminary findings and provide input to vet findings via quantitative and qualitative study
- Review post-study recommendations and provide comment

The advisory workgroup was comprised of individuals representing the statewide regions designated by Minnesota Association of County Social Service Administrators (MACSSA), Workgroup participation was offered by invitation and was voluntary. Workgroup members were not reimbursed for their involvement. DHS worked collaboratively with MACSSA to identify APS leaders to serve as participants in the workgroup. Stakeholder input was critical to include throughout the entirety of the study. The study team sought input and feedback throughout the study to vet hypothesis, review data and related observations, and present preliminary recommendations to individuals that are actively conducting and leading the work to further inform data and systems analysis. The workgroup was presented with a charter which defined participatory expectations, which is found in Appendix D.

From December 2020 to May 2021, the Consultant and DHS hosted three workgroup meetings to discuss the following topics:

Figure 3. Advisory Workgroup Meeting Topics

Meeting Date	Meeting Topics
December 2020	• Review study purpose and proposed study design • Gather input on study parameters
March 2021	• Review and discuss data-based findings and process reviews • Request input into stakeholder engagement activities
May 2021	• Review input gleaned through stakeholder engagement activities • Discuss preliminary findings and recommendations

Refer to Appendix C for a listing of advisory workgroup members by MACSSA region.

Evaluation Limitations

The consultant encountered multiple limitations and challenges as the study team attempted to evaluate the validity of the SDM® Intake Assessment Tool. Consultant faced challenges with studying some demographic data (i.e., referral source), the general sample size, and data points related to the equity of outcomes.

Lack of Populated Referral Source

Consultants had planned to study the report referral source to determine if the reporter type (i.e., mandated reporter or non-mandated reporter) or the reporter role (i.e., case manager, family member, etc.) had any impact on the results of the screening decisions. Approximately 30% of all records indicate a referral source, while approximately 70% of the records showing the referral source as blank. Due to the low volume of records that could be analyzed, Consultants did not conduct further data analysis on the referral source. After discussing with DHS, they informed the study team that referral source is not a required field which explains the limited data.

Limited Sample Size

Due to the particularly high volume of screen-outs, the resulting sample size of final screen ins was limited in size. One of the initial study hypotheses was that cases that were ultimately screened in would result in substantiation of the maltreatment allegation reported, therefore confirming the validity of the SDM® Intake Assessment tool. With the limited number of people screened in for APS and then additionally limited vulnerable adults screened in for APS with an allegation that was substantiated it was challenging to confirm this hypothesis. Only 1,104 (11%) of the final screen ins were substantiated, and 30% of the final screen ins remained open

for APS service assessment and investigation and were still pending determination at the time of the data analysis. Intervention data was also incredibly limited due to the DHS policy of not requiring interventions to be recorded in the data system by APS unless the maltreatment allegation was substantiated. The sample size limitations make it challenging to scientifically validate the SDM® Tool at this time.

The Consultant was also unable to evaluate the equity of outcomes because of the limited sample size and because APS workers are only mandated to enter service interventions when an APS allegation is substantiated. Further information regarding equity of outcome study information can be found in Section IV.

Limited National Data for Comparison

The Consultant was unable to compare Minnesota's screen-in and screen-out rates against peer states. Nationally, APS programs often have nuanced policies, definitions, and data collection fields that vary from state-to-state. Additionally, the NAMRS data does not currently collect data points related to the rational for screening decision, which is one of the emergent issues DHS was seeking to understand and trend.

SECTION II: ADULT PROTECTIVE SERVICES LANDSCAPE

Overview of Adult Protective Services

Adult Protective Services is a critical part of the human services continuum, serving some of the community's most vulnerable citizens to identify, address, resolve and prevent future cases of abuse, neglect, and exploitation (A/N/E). The National Center on Elder Abuse estimates that one in ten older Americans are victims of A/N/E, thus risk is widespread in community.[8] APS services were designed to create channels to report and investigate elder abuse.[9] APS are federally mandated programs responsible for responding to reports of abuse, neglect, and exploitation. Nationally, all 56 states and territories operate distinct APS programs.

Adult Protective Services

A social services program provided by state and local governments serving older adults and adults with disabilities who need assistance because of abuse, neglect, self-neglect, or financial exploitation (adult maltreatment). In all states, APS is charged with receiving and responding to reports of adult maltreatment and working closely with clients and a wide variety of allied professionals to maximize client safety and independence.[1]

Source: Adult Protective Services Technical Resource Center (APS TARC)

The United States Department of Health and Human Services (HHS) Administration for Community Living (ACL) provides federal oversight and monitoring of APS agencies across the country.[10] Each of these agencies are responsible to "identify, investigate, resolve and prevent elder abuse." Traditionally, APS services have been heavily oriented towards older adults and reports of elder abuse. However, there is also a population of vulnerable adults over 18 who require investigation and protection due to other criteria, like disabilities. APS agencies and workers collaborate with law enforcement, health care providers and caretakers to prevent, identify and respond to adult abuse.[11] Each APS agency defines APS differently but in general, APS programs were designed to protect against key types of elder abuse:

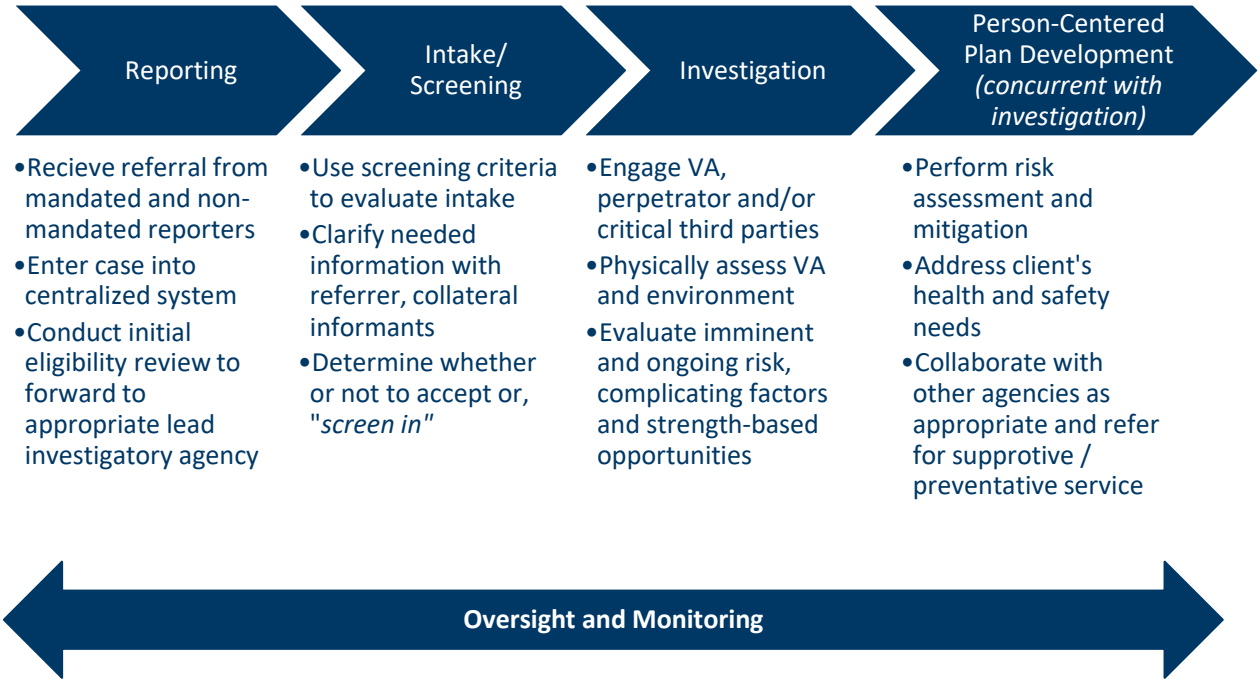
- Physical abuse
- Sexual abuse

[8] Rosay, A. B., & Mulford, C. F. (2017). Prevalence Estimates and Correlates of Elder Abuse in the United States: The National Intimate Partner and Sexual Violence Survey. Journal of Elder Abuse & Neglect, 29(1), 1-14.
[9] US Government Accountability Office, Elder Justice: Goals and Outcome Measures Would Provide DOJ with Clear Direction and a Means to Assess Its Efforts, June 7, 2019. Available online: https://www.gao.gov/products/gao-19-365
[10] The Centers for Medicare and Medicaid Services (CMS) provides oversight and monitoring of elder abuse in nursing homes and assisted living facilities.
[11] United States Government Accountability Office, Elder Abuse. Available online: https://www.gao.gov/elder-abuse.

- Psychological abuse
- Financial exploitation
- Neglect

Each State APS programs individually determines their definition of “adult” and the population that the program will serve. Almost all states serve adults aged 18 years or older with a significant physical and/or mental impairment and are referred to as vulnerable adults. Figure 4 provides a high-level review of the APS process.

Figure 4. High Level APS Process[12]



APS work is both complex and challenging. A 2019 United States Government Accountability Office (GAO) report highlighted the following functional / operational challenges that many APS programs face:

- Limited workforce and resource availability to match caseloads
- Inability to utilize modern administrative and data reporting systems to track cases and outcomes

[12] NCEA/NAPSA Fact Sheet: Adult Protective Services, https://ncea.acl.gov/NCEA/media/publications/APS-Fact-Sheet.pdf

- Lack of data and measures to assess program effectiveness
- Ever changing abuse tactics that may be national or international in nature (e.g., financial scams)[13]

Individuals who receive an investigation based on a report of alleged A/N/E are known as *clients*, and individuals with one or more substantiated allegations are identified as *victims*. APS clients and victims of A/N/E are diverse, there is no single demographic predictor of who is at-risk and thus can benefit from APS. Key national demographics about clients and victim profiles from HHS Administration for Community Living's *National Adult Maltreatment and Reporting System* (NAMRS)[14] include:

- **Age:** According to NAMRS, over 70% of APS clients and victims are 60 or older. Minnesota aligns mostly with NAMRS data in the older age ranges, with just under 75% of final screen-ins in the 60 and over age bands.
- **Disability Type:** NAMRS data on APS clients and victims shows that the most common disability types are ambulatory, cognitive, and difficulty with independent living. Minnesota categorizes disability types differently, thus this data cannot be compared.
- **Gender:** Nationally, NAMRS reports that 58.3% of clients are women compared to 39.5% of clients who are men. Minnesota data is similar, as 56.8% of initial screen-ins are female vs. 41.8% of initial screen-ins which are male.
- **Race / Ethnicity:** NAMRS data shows that 56.3% of clients are Caucasian, and 12.6% are Black/African American. As might be expected based on the state's general demographics, Minnesota's APS population looks significantly different, with 85.4% of Minnesota's final screen-ins Caucasian and only 6.3% Black/African American. Additionally, 3.3% of Minnesota's final screen-ins are Native American/Alaskan Native, compared to just 0.9% nationally.

Referral and Eligibility Considerations

Adult protection programs vary in design and operation and are often tailored from state-to-state because each state can define eligibility standards, which are often defined in state statute or regulation. Eligibility standards are intended to determine if the adult referred requires protective support due to an age or disability related impairment that hampers his or her ability to evade maltreatment on his or her own. Adult protection is different from child protection in that most children below the age of 18 are considered to require legal protection based on age-related vulnerability. Adults are legally considered self-governing and thus able to self-

[13] US Government Accountability Office, Elder Justice: Goals and Outcome Measures Would Provide DOJ with Clear Direction and a Means to Assess Its Efforts, June 7, 2019. Available online: https://www.gao.gov/products/gao-19-365

[14] https://namrs.acl.gov/

protect unless vulnerable, which introduces the need for more consideration of whether or not to extend protective services. States have flexibility to design APS programs to respond to the unique needs of their constituents and the way in which states design these parameters are often influenced by key partners who also influence factors like legal, criminal and social interventions, including, but not limited to:

- Those the state defines as mandated reporters
- Local and state law enforcement systems
- Local and state judiciary systems and probate courts
- The State's Medicaid program
- The State's aging and disability services network and its providers

The State's interpretation of vulnerability and the degree to which the State enforces various types of maltreatment, applies legal guardianship standards to vulnerable adults and/or prosecutes perpetrators of abuse often influences the operations of the State APS system. Each state develops its own eligibility and intervention criteria to determine who is being protected from which type of abuse. State APS agencies then customize their individual programs according to this APS eligibility and intervention criteria. These program elements are all approved and monitored by the federal government, as appropriate, within the United States ACL.

Eligibility Criteria

- APS programs vary greatly between states with respect to how they define the populations served. Most states include adults (individuals aged 18 years and older) with a disability in this definition. Some states also include all older adults in the population served, regardless of disability status.[15] In Minnesota, individuals are not eligible based on age alone. Instead, APS defines the vulnerable adult population by specific disability factors that place an individual at greater risk for harm.[16]

Intervention Criteria

States sometimes differ in the types of maltreatment that their APS programs address. Almost every APS program investigates the same primary allegations, including neglect, physical abuse, self-neglect, sexual abuse, financial exploitation, and emotional abuse. However, some state APS programs also investigate exploitation (non-specific), abandonment, other exploitation, and, in rare cases, suspicious death. Minnesota APS statutes

[15] NAMRS, 2019 Adult Maltreatment Report. Available online: https://namrs.acl.gov/getattachment/Learning-Resources/Adult-Maltreatment-Reports/2019-Adult-Maltreatment-Report/2019NAMRSReport.pdf.aspx?lang=en-US#page=13

[16] Minnesota Elder Justice Center. Known the Basics. Available online: https://elderjusticemn.org/about-us/know-the-basics/

define maltreatment of vulnerable adults to include abuse (emotional, physical, sexual), neglect, or financial exploitation.[17]

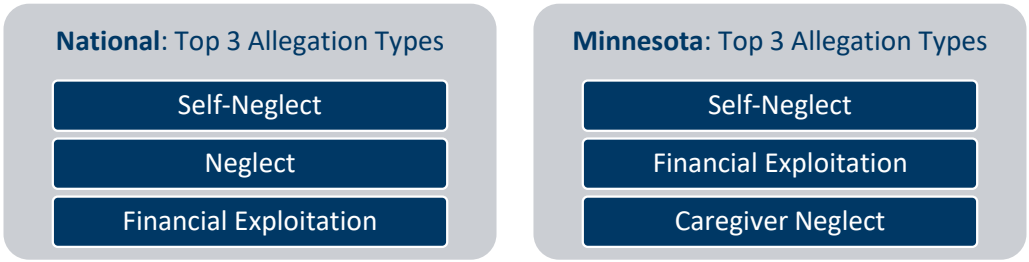
Program Functions

Although specifics vary, most APS programs perform similar basic functions for their populations of interest. Common APS program functions typically match those outlined in the Elder Justice Act and include receiving reports of maltreatment; investigating reports; providing case work; and facilitating protective, emergency, and support services.[18]

Elder Abuse Reporting Trends

Although APS operates differently in each state, most programs follow the same general process for how cases are reported, investigated, and addressed. APS cases initially enter the system through reports of alleged maltreatment. The most common type of reported maltreatment in both Minnesota and NAMRS is self-neglect. Figure 5 compares the top three most common types of reported maltreatment nationally and in Minnesota

Figure 5. Top Three National and Minnesota-Specific Allegation Types



Anyone can report an allegation to APS, but most states require that certain individuals, known as *mandated reporters*, **must** report suspected maltreatment. Fifteen states consider all observers of A/N/E to be mandated reporters, but most designate categories of people (often professionals) who are considered mandated reporters. Minnesota establishes specific professionals as mandated reporters, including those engaged in social services, law enforcement, education, direct care, or licensed health and human services professionals.[19] ADvancing States previously conducted a national survey[20] of APS programs in partnership with the National

[17] Minnesota Legislature. 2020 Minnesota Statutes, Section 626.5572. Available online: https://www.revisor.mn.gov/statutes/cite/626.5572

[18] Congress. Elder Justice Act of 2009 (S.795). Available online: https://www.congress.gov/bill/111th-congress/senate-bill/795/text#toc-idfaf7858e-a993-41e6-b9fe-469057da17ae

[19] Minnesota Department of Human Services. The who, what and where of mandated reporting. Available online: https://registrations.dhs.state.mn.us/webmanrpt/Who_CEP4.html

[20] NASUAD (Subcontractor), NAPSA, and NAPSRC. Adult Protective Services in 2012. Available online: http://www.advancingstates.org/sites/nasuad/files/hcbs/files/218/10851/NASUAD_APS_Report.pdfn

Adult Protective Services Association (NAPSA)[21] and the National Adult Protective Services Association Resource Center (NAPSRC). According to this survey, several states also identify certain financial professionals like bankers as mandated reporters based on the growing issue of financial exploitation.

APS programs can receive maltreatment reports in a variety of ways, including telephone hotlines, in-person report, and web-based reporting via a designated portal. Nationally, most reports are made via telephone hotlines, with increasing numbers of states accepting web-based maltreatment reports. Most APS programs staff phone hotlines at the state level in a centralized model, and about a quarter of states use a combined model run by both state and local entities. Minnesota previously collected reports at the county level but transitioned in 2013 to a centralized model when the Vulnerable Adults Act was amended.[22] In Minnesota, the *Minnesota Adult Abuse Reporting Center* (MAARC) serves as the single statewide entry point operating a central phone hotline for suspected maltreatment reports.[23]

National vs. Minnesota Intake and Screening Trends

Once an APS program receives a report of alleged mistreatment, the intake process is initiated to determine whether to screen in the report for investigation and service assessment. This process is typically guided using an assessment or decision-making tool. Over three quarters of states use one structured tool, including in Minnesota.

States determine whether to accept a cased based on factors including if the report meets the population, setting, and jurisdiction eligibility criteria – this is referred to as being *screened in*. According to NAMRS data, 62.3% of reports nationally were screened in for investigation in FY 2019. Comparatively, Minnesota accepts much fewer reports than average. During the period from September 1, 2018 – September 1, 2020, Minnesota screened in 24% of all maltreatment reports. Thus, Minnesota's screening trends do not presently align with state peers or the evolving national direction of screening rates.

Investigation Trends

Once a case is accepted, the county APS agency initiates the investigation and service assessment. Most APS programs initiate the investigation process within one business/calendar day of receiving a report, and 98% of investigations are initiated within seven days. This aligns with the *National Voluntary Consensus Guidelines* for State APS Systems issued by ACL, which recommends that initiation for non-emergency cases should occur

[21] The National Adult Protective Services Association (NAPSA) is a national association of APS agencies and workers with representation across all fifty states. NAPSA gathers and consolidates best practices to improve APS work.
[22] Minnesota House Research. The Minnesota Vulnerable Adults Act. Available online: https://www.house.leg.state.mn.us/hrd/pubs/vuladult.pdf
[23] Minnesota Department of Human Services. Vulnerable adult protection and elder abuse. Available online: https://mn.gov/dhs/people-we-serve/seniors/services/adult-protection/

within five days of reporting.[24] However, the amount of time until case initiation may vary depending on the case, as many states self-reported in ADvancing States' APS survey[20] that they use a triaging system to risk-categorize cases based on urgency of risk/harm to the adult to tier required response times accordingly.

Per NAPSA's best practices, when investigations related to abuse, neglect or exploitation, a face-to-face investigation should occur.[25] It is not recommended that investigations occur solely via telephone. Many signs of maltreatment or abuse may only be visible via an in-person visit to the vulnerable adult's residence or through in-person interaction with the vulnerable adult. An APS worker on the telephone is unable to confirm that the vulnerable adult or other collateral contact is in a safe space to answer allegation-related questions. An APS worker cannot verify abuse, neglect or exploitation without physical surveillance of the individual being harmed or observing the living / community-based environment in question. In Minnesota, the investigation guidelines are as follows:

1. "Interview the alleged victim;
2. Interview of the reporter and others who may have relevant information;
3. Interview of the alleged perpetrator;
4. Examination of the environment surrounding the alleged incident;
5. Review of pertinent documentation of the alleged incident; and
6. Consultation with professionals"[26]

During the investigation process, programs determine whether the original allegation is valid, or substantiated. Most states (61%), including Minnesota, use a "preponderance of the evidence" as the standard to determine whether a maltreatment allegation is substantiated. The definition of "preponderance of the evidence" is that the evidence shows it is more likely than not that the maltreatment allegation occurred. 15% percent of states do not have a state standard, 13% use "credible reasonable, or probably cause", and 9% use "clear and convincing" as the standard. The average length of investigation until findings is 52.6 days, and about two-thirds of all investigations are completed between 1 and 60 days. This trend aligns with Minnesota's statewide policy that APS investigations should be completed within 60 days.

Person Centered Protective Services Plan Development Trends

[24] Administration for Community Living. National Voluntary Guidelines for State Adult Protective Services Systems. Available online: https://acl.gov/programs/elder-justice/final-voluntary-consensus-guidelines-state-aps-systems
[25] National Adult Protective Services Association, *What is Adult Protective Services.* Available online: https://www.napsa-now.org/get-help/how-aps-helps/.
[26] 2020 Minnesota Statutes: 626.557 Subdivision 10b: https://www.revisor.mn.gov/statutes/cite/626.557

APS programs are evolving similar to broader trends in overall case management programs that serve community-based individuals, to offer individualized, person-centered care with the goal of keeping individuals in community-based settings. While developing care plans, APS workers balance the need to issue appropriate protective services, or interventions to vulnerable adults but also have the legal autonomy to make their own decisions and can deny interventions.

While protective services care plan elements vary across states, the APS worker will typically coordinate with both an adult's formal and informal supports, local law enforcement and the justice system (as needed) and other pertinent members of the individual's person-centered team to identify risks, provide risk management and harm reduction, and address care and safety concerns. Depending on the severity of risk for harm and the VA's degree of vulnerability and ability to self-manage his or her safety, interventions may be more extreme and move to remove the individual from a high-risk setting that poses ongoing risk or harm or death. According to NAPSA guidelines, a primary goal is to develop a plan that will assist the individual to "maintain his or her well-being and independence."[27]

Oversight and Monitoring Trends

National reporting and analysis of elder abuse is evolving and coordinated data is relatively new to APS programs. The *Elder Abuse Prevention and Prosecution Act of 2017* was signed into law to establish national, standardized reporting requirements and build off previously established data reporting efforts. In 2016, the Administration for Community Living launched the National Adult Maltreatment Reporting System (NAMRS) to collect standardized data from state APS programs. NAMRS compiles information submitted by individual APS programs to provide a comprehensive national overview of adult maltreatment. The 2019 NAMRS Adult Maltreatment Report captured data from 100% of state APS programs, demonstrating a national commitment to improved reporting and systemic measurement. Currently, the type and level of data each state provides can vary. States are not mandated to participate in sharing data with NAMRS and there is still a need to standardize data submitted, identify outcomes and quality goals and align data reporting with federal and state regulations.[28]

Despite variances in how states report APS data - NAMRS data is useful in highlighting general APS trends across the country. Of note, the most recent NAMRS data shows that the number of reports, investigations, victims, and clients have all increased each year over the past three years. These data points help demonstrate that adult maltreatment is a growing national issue.

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[27] National Adult Protective Services Association, What is Adult Protective Services. Available online: http://www.napsa-now.org/get-help/

[28] US Government Accountability Office, Elder Justice: Goals and Outcome Measures Would Provide DOJ with Clear Direction and a Means to Assess Its Efforts, June 7, 2019. Available online: https://www.gao.gov/products/gao-19-365

Recent Evolution of APS in Minnesota

Program Administration

Minnesota's APS program is governed by Minnesota Statute 626.557, known as the *Vulnerable Adult Act* (VAA). The VAA was passed in 1980 to:

"*Protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment; to assist in providing safe environments for vulnerable adults; and to provide safe institutional or residential services, community-based services, or living environments for vulnerable adults who have been maltreated […and…] to require the reporting of suspected maltreatment of vulnerable adults, to provide for the voluntary reporting of maltreatment of vulnerable adults, to require the investigation of the reports, and to provide protective and counseling services in appropriate cases*."[29]

The Minnesota Department of Human Services (DHS) oversees the execution of APS within all 87 counties, each designated as LIAs. Many counties operate their APS programs within their county social service agency. There are three agencies in MN that serve multiple counties, and throughout this report are referred to as *collaboratives*. Regardless of the counties' APS structure, DHS is responsible to supervise the statewide APS program and oversee local administration. The Minnesota legislature passed Minnesota Statute 626.557 and the legislature established vulnerable adult reporting requirements by counties to DHS. The statute requires counties to report to DHS reports of vulnerable adults and associated investigations. APS programs are must adhere to Minnesota Statutes. DHS is responsible to provide overarching policy and procedural guidance statewide. Minnesota statute requires that each county APS agency develop its own specific guidelines for prioritizing APS reports for investigation[30] and these specific guidelines must also adhere to the VAA.

Program Operations

Since July 1, 2015, DHS has operated a common entry point to accept all reports of suspected maltreatment of a vulnerable adult. This common entry point (CEP) in Minnesota is the MAARC. The MAARC accepts reports and documents details of the suspected maltreatment in the SSIS. MAARC is responsible to refer the report to a designated lead investigative agency. Minnesota Statute 626.5572 defines the lead investigative agency (LIA) as the primary administrative agency responsible for investigating reports and for the purposes of this study, the LIA is the designated county APS agency.

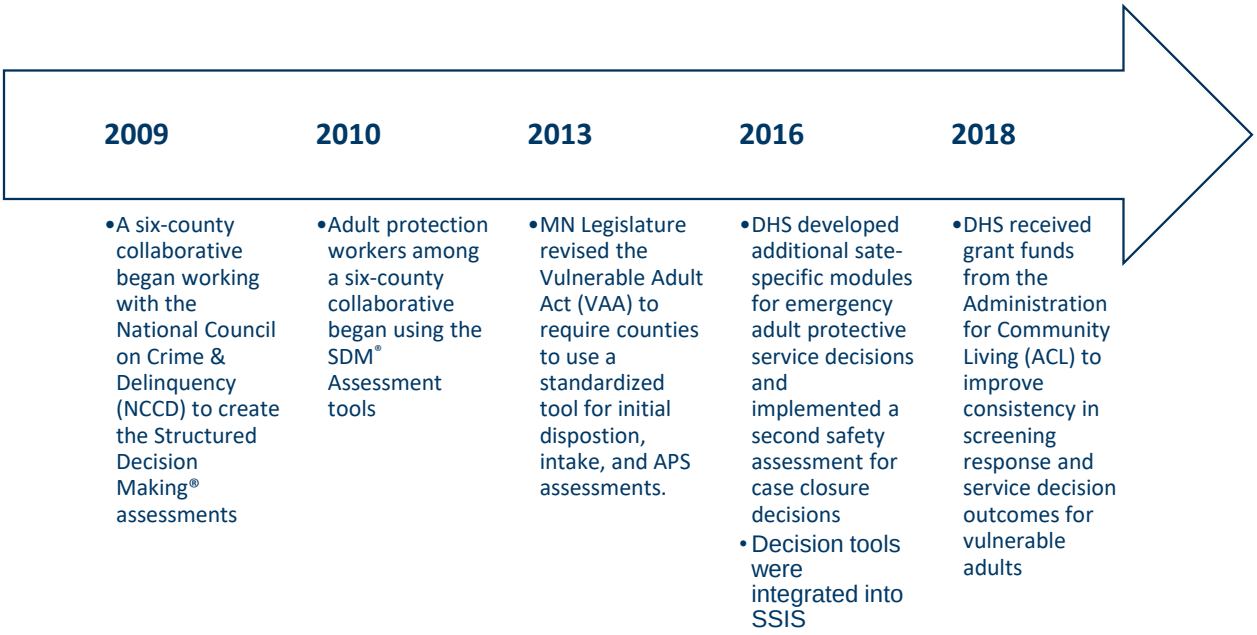
The use of standardized assessment tools has evolved over time in Minnesota. Currently, Minnesota Statute 626.557 requires that DHS has a standardized assessment tool available for county APS agencies deciding whether to investigate an alleged maltreatment report. The current standardized assessment tool in place to aid

[29] 2020 MN Statutes: 626.557: https://www.revisor.mn.gov/statutes/cite/626.557

[30] MN Statute 626.557, Subdivision 9b: https://www.revisor.mn.gov/statutes/cite/626.557

APS in making this initial screening disposition is the Structured Decision Making (SDM®) Intake Assessment Tool. Figure 6 provides a timeline and additional insight into the evolution of standardized decision making tools in MN.

Figure 6. Evolution of MN's Standardized Decision-Making Tools



Future Considerations and the Anticipated Evolution of APS

A driving factor facing aging and disability service systems, including Adult Protective Services programs, is that America is rapidly aging; the United States Census estimates that Americans over 65 will outnumber children by 2034.[31] The growth in the older adult population is part of the reason for an increase in federal funding to adult protection work. An increase in federal funding for APS will likely influence future regulatory and data requirements, which the Consultant anticipates will become more robust to demonstrate program impact and return on federal investment.

The 2021 *Coronavirus Response and Relief Supplemental Appropriations Act* included substantial APS funding, and the *American Rescue Plan Act (ARPA) of 2021* expanded available funding. ARPA clearly states the purpose is to "enhance, improve and expand" APS services, a signal that Congressional intent for the $93,880,000 is to not simply fill budget holes but to further drive program maturation. ACL issued this funding to "help provide meals and other nutrition services, support family caregivers, help older adults connect and engage with others to

[31] Vespa, Jonathan, The United States Census, The U.S. Joins Other Countries with Large Aging Populations, March 13, 2018. Available online: https://www.census.gov/library/stories/2018/03/graying-america.html.

reduce social isolation, re-open senior centers and help residents of nursing homes resolve complains."[32] The State of Minnesota was allocated a total of $2,877,779 for APS from funds appropriated by these Acts. The initial allocation was $1,501,422[33] and an additional $1,376,357[34] was subsequently provided. Funding may be used to support hardware and software purchase, establish new or improving existing process for responding to alleged scams and frauds, expand community outreach, and/or address additional allowable program improvements.

Supplemental funding represents formal recognition by the federal government that resources are needed and overdue to strengthen opportunities for safe, independent living by adults in the community who require protection from abuse, neglect and exploitation. Advocates have long argued for some visible progression towards funding parity with Child Protective Services (CPS). While this enhanced appropriation is much smaller than of the $9.8 billion dollars in annual federal CPS support, APS programs are encouraged to embrace this opportunity to demonstrate value, impact and federal return on investment. This window of opportunity, assuming more federal support to come, could revolutionize the APS program. All stakeholders from the initial intake worker to the final state reporting authority must embrace the importance of accurate and timely data collection, process adherence, reporting, and program operational continuity.

It is imperative that Minnesota and other states maximize current and future opportunities to evaluate existing state practices, improve statewide data collection and reporting to reinforce a stronger foundation and fully leverage anticipated future federal investment.

[32] The Administration for Community Living, 2021 Budget. Available online: https://acl.gov/about-acl/budget.
[33] federalregister.gov/documents/2021/02/01/2021-02091/availability-of-program-application-instructions-for-adult-protective-services-funding
[34] https://www.federalregister.gov/documents/2021/05/28/2021-11343/availability-of-program-application-instructions-for-adult-protective-services-funding

SECTION III: DATA ANALYSIS: DEMOGRAPHICS

Purpose

The first evaluation phase focused on data analysis. Consultant conducted a comprehensive review of APS referral and SDM® Intake Assessment Tool input data to identify variations between counties in operationalizing the screening tool and rendering screening decisions. The goals and anticipated outcomes of conducting the demographic data analysis included:

Goal 1: Consider the factors influencing the decision to accept a maltreatment report for investigation and services and how these factors impact the effectiveness of the SDM® Intake Assessment Tool.

- ✓ *Anticipated Outcome*: Identify the data elements that more frequently correlate to variability among all counties.

Goal 2: Measure the degree of variability in trends across county APS programs and examine whether the SDM® Intake Assessment Tool is contributing to more consistent statewide approaches across counties.

- ✓ *Anticipated Outcome*: Identify trends by county to establish if there are correlations based on where the tool is deployed.

Goal 3: Establish statistically significant variation, determine averages based on a variety of influential factors, and evaluate results by analyzing the confidence interval in which results fall.

- ✓ *Anticipated Outcome*: Determine the factors that may significantly influence variability and may need to be addressed to improve tool validity.

Methodology

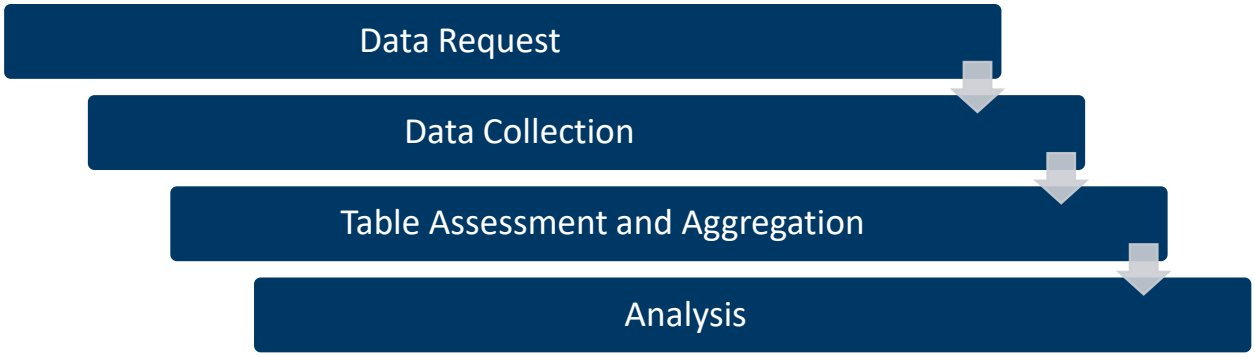
The method to analyze APS referrals and the SDM® Intake Assessment Tool followed a step-by-step process that beginning with a data request to DHS, provided in December 2020. DHS provided the Consultant with 53 tables from their internal SSIS database that were linked together to analyze program information. This was the first time that the data set was analyzed at an in-depth, formal level. Therefore, it was essential to carefully evaluate various tables to accurately link the information for analysis. Due to the complexity of the tables, Consultant built a process map that outlined how each table was connected ultimately creating the final report database for the SDM® Intake Tools. Throughout data analysis, the process map was reviewed with the DHS team to ensure all parties, including DHS subject matter experts on the data tables, agreed to our approach to linking relational datasets to draw analytic conclusions.

The Adult Protection (AP) Report table was at the core of the process, containing the initial adult maltreatment report information. From here key demographic tables, the SDM® intake tool responses, interventions and

determinations were joined to analyze screening outcomes. The study team acknowledges that many tables could have multiple allowable values within a single report, such as having multiple disability types, which was continuously factored into analysis.

Figure 7 represents the data evaluation process. Consultant held ongoing discussion with DHS at each point during the process to determine the best methodology and to confirm understanding of the data. The final analysis was approached in a step-wise fashion. As we discovered information from within the data, we had the ability to pivot and dig deeper into findings.

Figure 7. High Level Data Process



The study period of September 2017 to September 2020 was used based on data accessibility and the state's data destruction policy. This period provided two full years of complete data with additional months in 2017 and 2020. Most outcomes reported were analyzed using 37 months to form the total sample size.

The Consultant, in conjunction with DHS and the Advisory Workgroup, identified demographic fields of interest based on the anticipated impact each component had on driving variability in screening decisions. A listing of these demographic fields is in the Research Study Plan, (*Appendix A*).

Data analysis included calculating initial report counts, initial screening rates (screen-in and screen-out), number of reports overridden to screen out and ultimate screen-in rates for MN maltreatment reports. Consultant assessed the variability in screening rates between MN counties and compared the overall MN screening rates to national averages.

Next, we stratified data on the screening categories to isolate differences and patterns of screening decisions affiliated with key demographic categories. After slicing the data into these individual components, we identified that disability type and race were the two demographic study areas with statistically significant findings, which will be discussed with more detail later in the report.

Our analysis of the data revealed that many APS county agencies frequently use the discretionary override function, at rates higher than expected by DHS. To further understand the frequent use of this field, we analyzed the discretionary override process from both a qualitative and quantitative lens. Analysis examined the

prevalence of each override reason selected by APS workers in the SDM® Tool. Consultant also recorded observations based on review of the SDM® Tool's "Other" free-text comments field to better understand the basis for APS worker screen-outs.

Observations

Initial Reports and Screening Decisions

Consultant calculated the baseline case screen-in rate using the volume of initial reports referred to county LIAs that were the responsibility of the county who had authority to make the subsequent screening decision. During the study period, counties received 40,510 adult maltreatment reports. Figure 8 shows that 59% of these reports were initially screened in using the SDM® Tool with 41% screened out.

Figure 8. Initial Reports and Screening Decisions

Initial Screen-In Results	Count	% of Total Reports
Initial Reports for County	40,510	
Initial Screen-In via SDM® Tool	23,970	59%
Initial Screen-Out	16,540	41%

Following the initial screening, lead investigative agencies have the option to screen out the report via a discretionary override. The number of discretionary overrides determine the final screening rates. As shown in Figure 9, applying the discretionary override function 59% of the initial screen-ins were screened out. As a result of the override function, 24% of the initial reports were ultimately screened in. This is significantly lower than the SDM® Tool's initial screen-in rate of 59% before applying discretionary override.

Based in part on APS county agencies using the override function, 24% of initial reports were ultimately screened in. This rate is significantly lower than the initial screen-in rate of 59% based strictly on information housed in the SDM® Intake Assessment tool.

Figure 9. Final Screening Decisions

Final Screening Decisions	Count	% of Screen-In	% of Total Reports
Override to Screen-Out	14,155	59%	35%
Final Screen-In	9,815	41%	24%

This data suggest that the majority of referrals are screened out through either the initial screening (meaning the individual did not meet the definition of a vulnerable adult or the allegation did not meet the required definition) or as a result of using a discretionary override.

Minnesota's screen-out rate was significantly higher than the national screening rate based on the 2019 NAMRS report. The overall screen-out rate in Minnesota is 75.8%, while the national average during the same period is 37.7%.[15]

We also analyzed screen-in and screen-out rates based on metro counties versus counties throughout the rest of Minnesota, to identify if there is a relationship between more densely populated regions of the state vs. rural regions. This analytic step was important to consider where operational dynamics like higher referral volumes and/or caseload sizes may influence how screening decisions are made. Metro counties include the Minneapolis-St. Paul metropolitan area and include: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties. Figure 10 contains screen-in data comparing the Metro counties rates to non-metro MN counties.

Figure 10. Comparing Screen-In Rates Among Metro Counties vs. Non-Metro Counties

County Designation	Total Initially Screened-In via SDM® Tool	% of Total Initially Screened-In Reports via SDM® Tool	Total Reports Overridden via Discretionary Override	% of Reports Overridden via Discretionary Override
Metro Counties	15,147	63.2%	11,042	73%
All Other	8,823	36.8%	3,113	35%

County Designation	Total Initially Screened-In via SDM® Tool	% of Total Initially Screened-In Reports via SDM® Tool	Total Reports Overridden via Discretionary Override	% of Reports Overridden via Discretionary Override
Total	**23,970**		**14,155**	**59%**

This data shows that these ten metro counties account for roughly 63.2% of reports initially screened-in using the SDM® Intake Assessment Tool within the state. This volume was expected because the metro counties have a larger population and therefore receive a higher volume of reports. However, the Metro counties use discretionary override to screen out reports at a much higher rate of 73% compared to all other counties that screen out at 35%. It is important to note that overall low screen-in rates are not exclusive to the metro counties, as there are non-metro counties with high screen out rates as well. Moreover, some metro counties have lower use of discretionary override, as demonstrated in Figure 11, which contains screen-in rates comparing the top 10 most populated counties by population size.[35]

[35] Minnesota State Demographic Center, Annual Estimates of Minnesota and its 87 counties' population and households, 2019: https://mn.gov/admin/demography/news/media-releases/?id=36-250801#:~:text=%5B1%5D%20The%207-county,Bureau%20consists%20of%2016%20counties

Figure 11. Comparing Screen-In Rates Among the Top 10 Most Populated Counties in Minnesota

#	County	Total Population in 2019[35]	Total Number of Reports	Total Initially Screened-In via SDM® Tool	% Initial Screen-In of Total Reports via SDM® Tool	Total Reports Overridden via Discretionary Override	% of Reports Overridden via Discretionary Override
1	Hennepin	1,279,981	10,432	10,026	96%	8,525	85%
2	Ramsey	558,248	4,438	1,916	43%	1,268	66%
3	Dakota	433,302	2,453	1,060	43%	200	19%
4	Anoka	362,648	2,480	1,511	61%	937	62%
5	Washington	262,748	1,159	344	30%	34	10%
6	St. Louis	199,661	1,814	369	20%	119	32%
7	Olmsted	160,431	843	290	34%	111	38%
8	Stearns	160,211	933	643	69%	345	54%
9	Scott	148,458	525	159	30%	30	19%
10	Wright	138,531	867	678	78%	224	33%

This data shows a wide range in screen-in rates by county with wide variance among the most populated counties in the state. For instance:

- Hennepin County screened in 96% of initial reports when using the SDM® Intake Assessment Tool their initial. In comparison, neighboring Ramsey and Dakota counties are initially screening in 43% of their APS referrals via the SDM® Intake Assessment Tool. St. Louis county is only screening in 1 in 5 (20%) of its reports based on outcomes within the tool.
- Hennepin county eventually screened out 8,525 reports via discretionary override, representing 85% of the initial screened in reports. Additionally, Ramsey, Anoka and Steams county each apply discretionary overrides to over 50% of their initial screen-ins. Meanwhile, Scott, Dakota and Washington county overrides less than 20% of their cases.
- The table shows that across the 10 counties the range of override to screen out ranges from 85% to 19% suggesting wide variability in the use of the override function.

Statewide variability in screening rates that is driven by discretionary overrides that are subjectively applied beyond the fields of the decision-making tool hampers equitable access to APS based on county of residence.

Selected Demographic Findings

After linking and analyzing demographic data, the Consultant determined there fairly consistent trends in screening decisions across most demographic study areas, including reports by allegation type, age band, gender, and ethnicity However, there was significant variation observed related to disability type and race. For demographics where we did not observe significant variations, MN data largely aligned with national data trends captured in the 2019 National Adult Maltreatment Reporting System (NAMRS) report. Findings related to these demographic study areas can be found in Appendix B.

While other demographic study areas are associated with relatively consistent screening decisions, the Consultant identified areas of significant variance related to disability type and race.

Reports by Disability Type

The Consultant analyzed reports by disability type, acknowledging that reports may include more than one disability, to examine variations in screening decisions for disability type of the individual referred.

The disability type is entered into the standard intake form and includes information gathered from the individual reporting the alleged maltreatment. Disability types include:

- Chemical abuse
- Developmental disability

- Frailty of aging
- Impaired memory
- Impaired reasoning or judgment
- Mental / emotional impairment
- Physical impairment
- Traumatic brain injury

Figure 12 lists the total number of reports, screen-ins, overrides, and screening rates by disability type. Figures 13 and 14 depict the screening decisions by disability type in graphical form.

Figure 12. APS Screening Decisions by Disability Type Reported for the Person

Disability Type	Total Number of Reports	Total Initially Screened-In via SDM® Tool	% of Total Reports Initially Screened In via SDM® Tool	Total Reports Overridden via Discretionary Override	# of Final Reports Screened In	% of Reports Overridden to Screen-Out	% Final Screen-In's
	A	B	C	D	E	F = D / B	G = E / B
Physical	19,110	11,918	62%	6,883	5,035	58%	42%
Mental	17,677	10,521	60%	6,568	3,953	62%	38%
Impaired reasoning or judgment	16,237	10,087	62%	5,705	4,382	57%	43%
Impaired memory	11,571	7,362	64%	3,811	3,551	52%	48%
Frailty of aging	11,809	7,301	62%	3,659	3,642	50%	50%
Chemical	5,408	3,185	59%	2,223	962	70%	30%
Developmentally disabled	4,253	2,659	63%	1,570	1,089	59%	41%
Traumatic brain injury	3,008	1,899	63%	1,196	703	63%	37%

Disability Type	Total Number of Reports	Total Initially Screened-In via SDM® Tool	% of Total Reports Initially Screened In via SDM® Tool	Total Reports Overridden via Discretionary Override	# of Final Reports Screened In	% of Reports Overridden to Screen-Out	% Final Screen-In's
Total Population	**89,073**	**54,932**	**62%**	**31,615**	**23,317**	**58%**	**42%**

**Types of disabilities are not mutually exclusive. Therefore, a person who is the subject of a single report can have multiple disabilities.*

Figure 13. APS Screening Decision Trends by Disability Type Reported for the Person

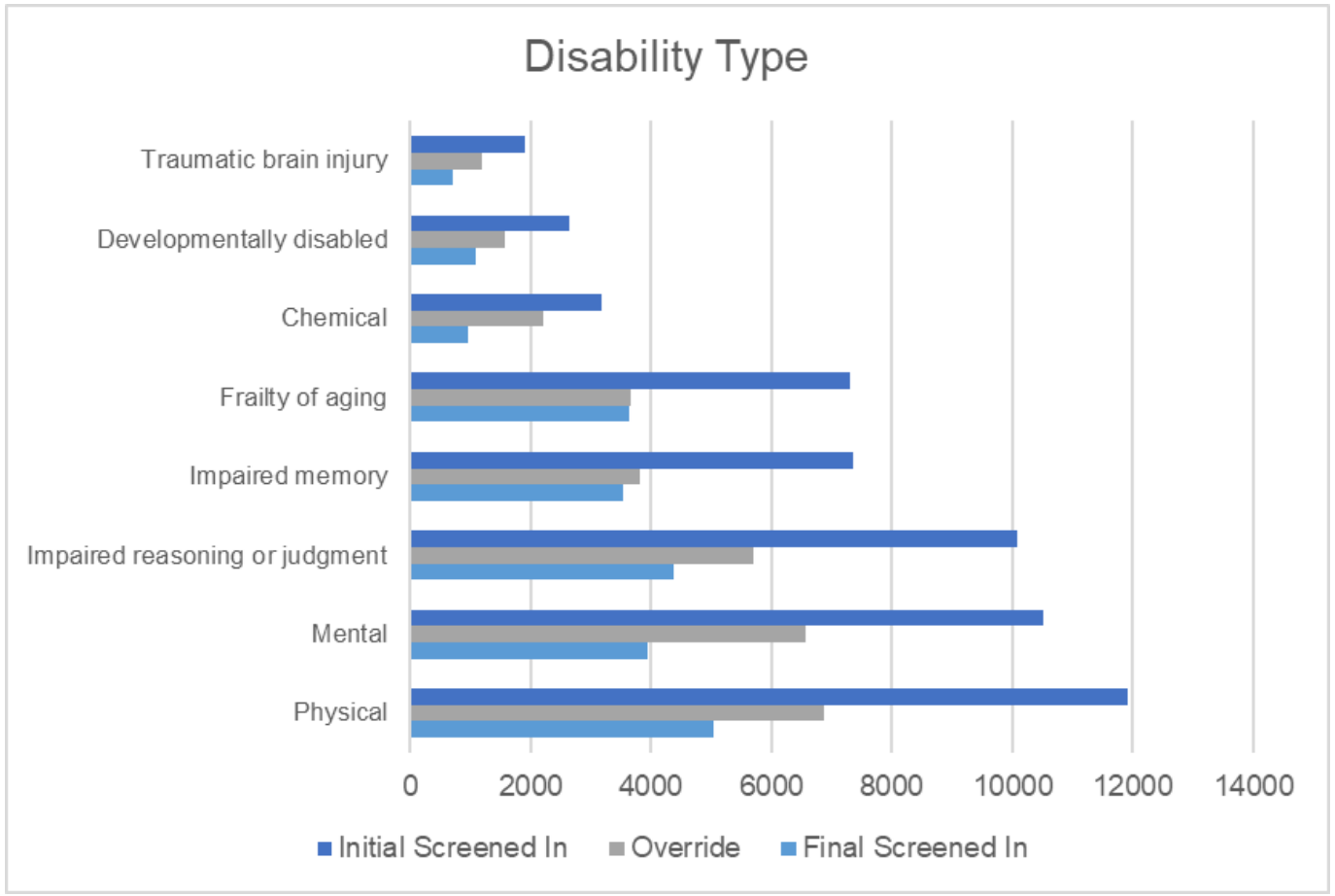
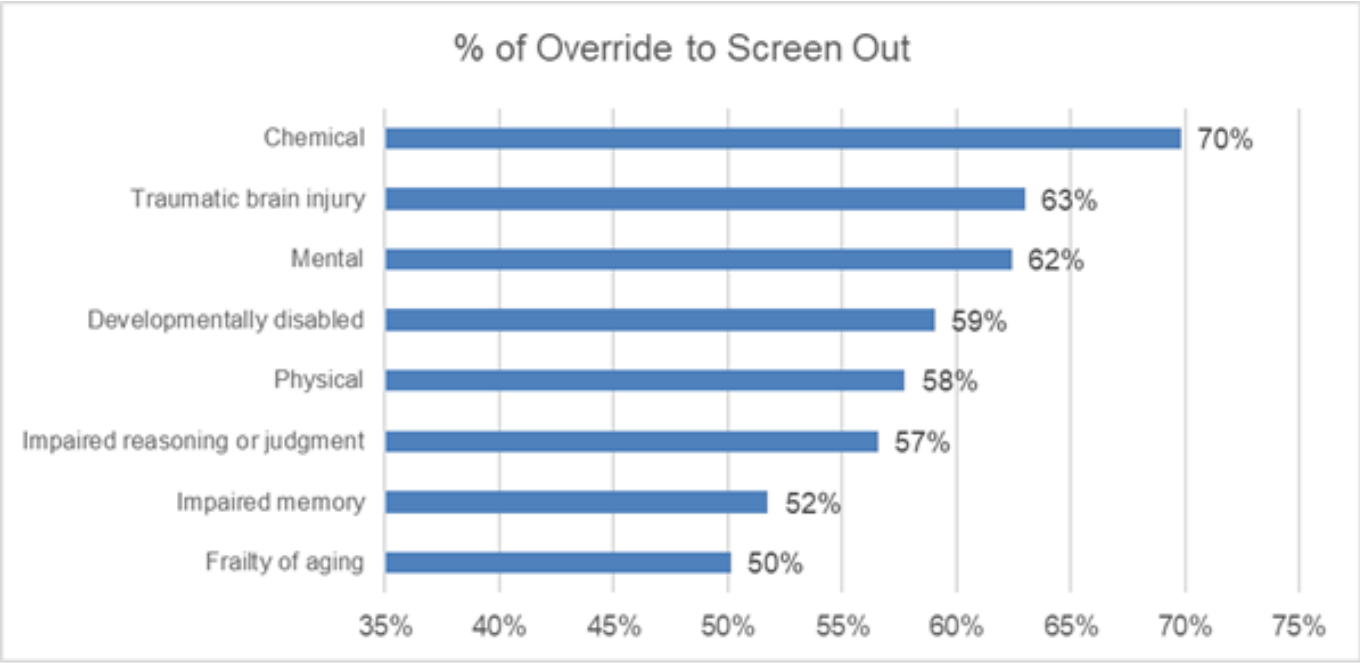


Figure 14. APS Override to Screen Out Rates by Disability Type Reported for the Person



Data reflects that initial screen-in rates vary across people with different types of disability. The initial screen-in rates, or reports that were screened in using the SDM® Intake Assessment tool, prior to applying any discretionary overrides, ranged from 64% to 59% across all types of disability. It is important to note that disability types are not mutually exclusive and a single report can identify that the individual has multiple disability types that apply.

The Consultant analyzed the final screen-in rates and found the rate of discretionary override to screen-out was highest for people reported as having a chemical disability at 70%. Data showed the screen-out rate for people with traumatic brain injury and mental disability were above the total population screen-out rate at 63% and 62% respectively. Persons listed as having "frailty of aging were most frequently screened in, suggesting risk that the system may be biased toward disability and/or A/N/E connected to aging or physical disability.

At DHS' request, the Consultant further explored the association between a person reported as having a chemical disability and the person's age to obtain additional insight into the reason for the high chemical disability screen-out rate. Figure 15 contains the chemical disability reports broken down by age bands.

Figure 15. APS Screening Decisions for Persons Reported as Experiencing Chemical Disability by Age Band

Age Band	Total Number of Reports	Total Initially Screened-In via SDM® Tool	Total Referrals Overridden via Discretionary Override	Final Number of Reports Screened In	% of Reports Overridden to Screen-Out	% of Reports with Final Screen-In's
	A	B	C	D	E = C / B	F = D / B
18-29	524	296	223	73	75%	25%
30-39	621	316	255	61	81%	19%
40-49	589	341	265	76	78%	22%
50-59	1,177	672	463	209	69%	31%
60-69	1,461	927	619	308	67%	33%
70-74	440	281	167	114	59%	41%
75-84	380	248	153	95	62%	38%

Age Band	Total Number of Reports	Total Initially Screened-In via SDM® Tool	Total Referrals Overridden via Discretionary Override	Final Number of Reports Screened In	% of Reports Overridden to Screen-Out	% of Reports with Final Screen-In's
85+	56	33	21	12	64%	36%
Total	**5,248**	**3,114**	**2,166**	**948**	**70%**	**30%**

Analysis showed that following the initial screen-in based on the SDM® Intake Assessment Tool, individuals aged 18-40 with a disability type of chemical are screened out through discretionary override at higher rates than other age bands. Individuals aged 18-40 are discretionarily screened out 78-81% of the time whereas all other age bands are discretionarily screened out between 59-69% of the time. Consultant noted the high chemical disability screen-out rate, including the impact to individuals aged 18-40, as consideration for further discussion during stakeholder engagement activities (See Section VII).

Reports by Race / Ethnicity

Reports were analyzed by race / ethnicity of the person referred to determine whether there were significant variations in screening decisions associated with the race / ethnicity of the person being screened. It should be noted that APS workers do not populate the “race” field in report referred electronically through SSIS, as this field is documented in the adult maltreatment report at the time of the initial referral based on information provided by the reporter. Figures 16 and 17 depict the break-down of adult maltreatment reports by race, including the number of people initially screened in using the decision logic in the SDM® Intake Assessment Tool, and the people subsequently screened out by APS using the discretionary override option in the tool. Figures 18 and 19 depict the break-down of adult maltreatment reports by Hispanic code indicator.

Figure 16. APS Screening Decisions by Race Reported for the Person

Race / Ethnicity	Total Number of Reports	Reports Initially Screened-In via SDM® Tool	Reports Overridden to Screen-Out via Discretionary Override	Final Number of Screen-Ins	% of Referrals Overridden to Screen-Out	% of Final Screen-Ins	% of Total Reports That Were Final Screen-Ins	% of Total Population Served with Final Screen-Ins	% of Race in Statewide Population Mix*
	A	B	C	D	E = C / B	F = D / B	G = D / A	H = D / 9,815	I
Caucasian	31,849	18,469	10,078	8,391	55%	45%	26%	86%	83.8%
Black or African American	4,152	3,069	2,452	617	80%	20%	15%	6%	7.0%
American Indian/Alaskan Native	1,480	839	514	325	61%	39%	22%	3%	1.4%
Hispanic Origin**	909	486	287	199	59%	41%	22%	2%	5.6%
Asian	635	394	266	128	68%	32%	20%	1%	5.2%
Pacific Islander	71	43	30	13	70%	30%	18%	.01%	0.1%
Unknown	2,204	1,076	755	321	70%	30%	15%	3%	N/A
Declined	119	80	60	20	75%	25%	17%	.02%	N/A

Race / Ethnicity	Total Number of Reports	Reports Initially Screened-In via SDM® Tool	Reports Overridden to Screen-Out via Discretionary Override	Final Number of Screen-Ins	% of Referrals Overridden to Screen-Out	% of Final Screen-Ins	% of Total Reports That Were Final Screen-Ins	% of Total Population Served with Final Screen-Ins	% of Race in Statewide Population Mix*
Total	40,510	23,970	14,155	9,815	59%	41%	100%		

* Population Mix is derived from Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for Minnesota: As of July 1, 2019 (SC-EST2019-SR11H-27)
Source: U.S. Census Bureau, Population Division
Release Date: June 2020
**The Hispanic Origin indicator reported in an independent data table / source from race, therefore individuals reported as of Hispanic origin are also represented in the Caucasian race category and not included in the total count at the bottom of Figure 16.

Figure 17. APS Screening Decisions by Race Reported for the Person

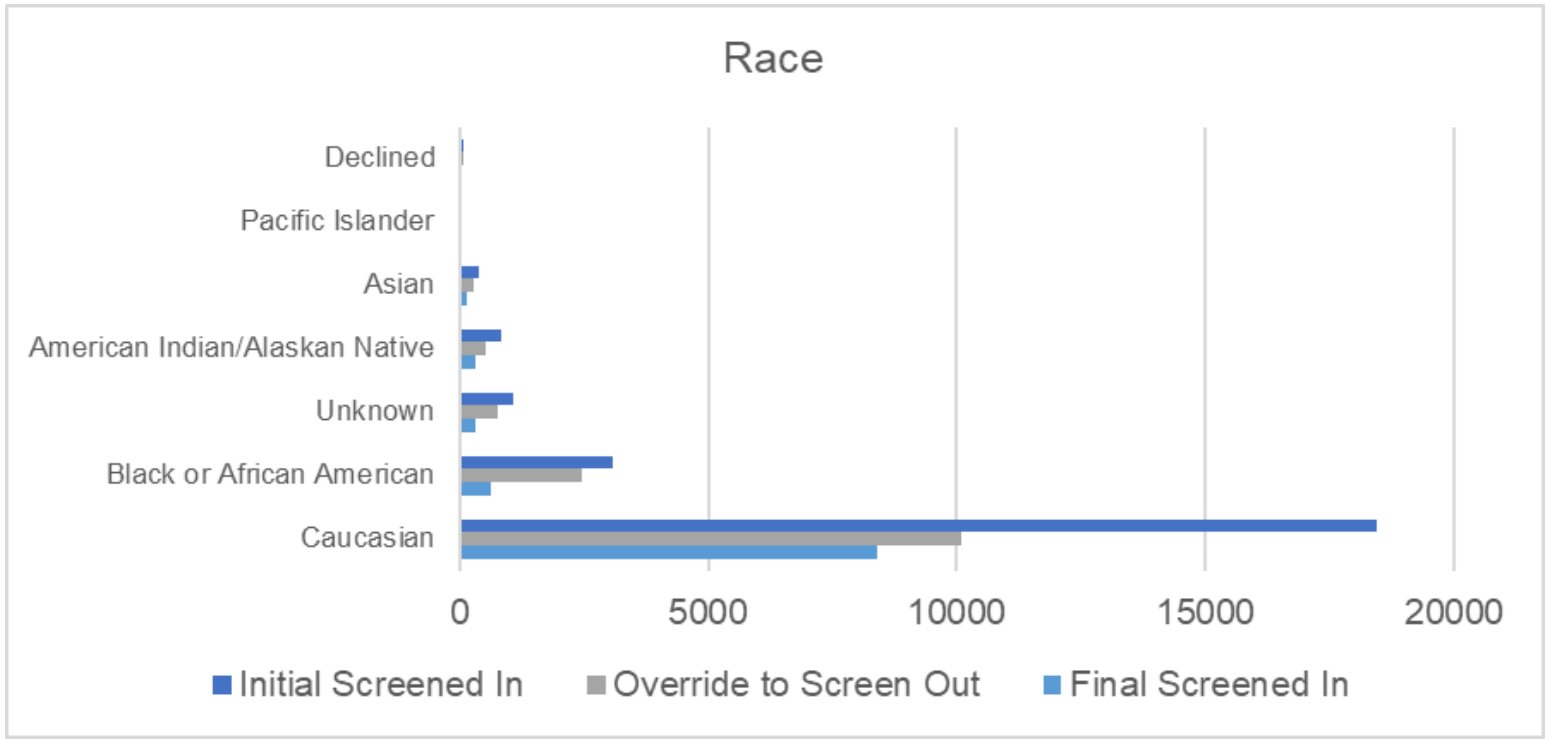
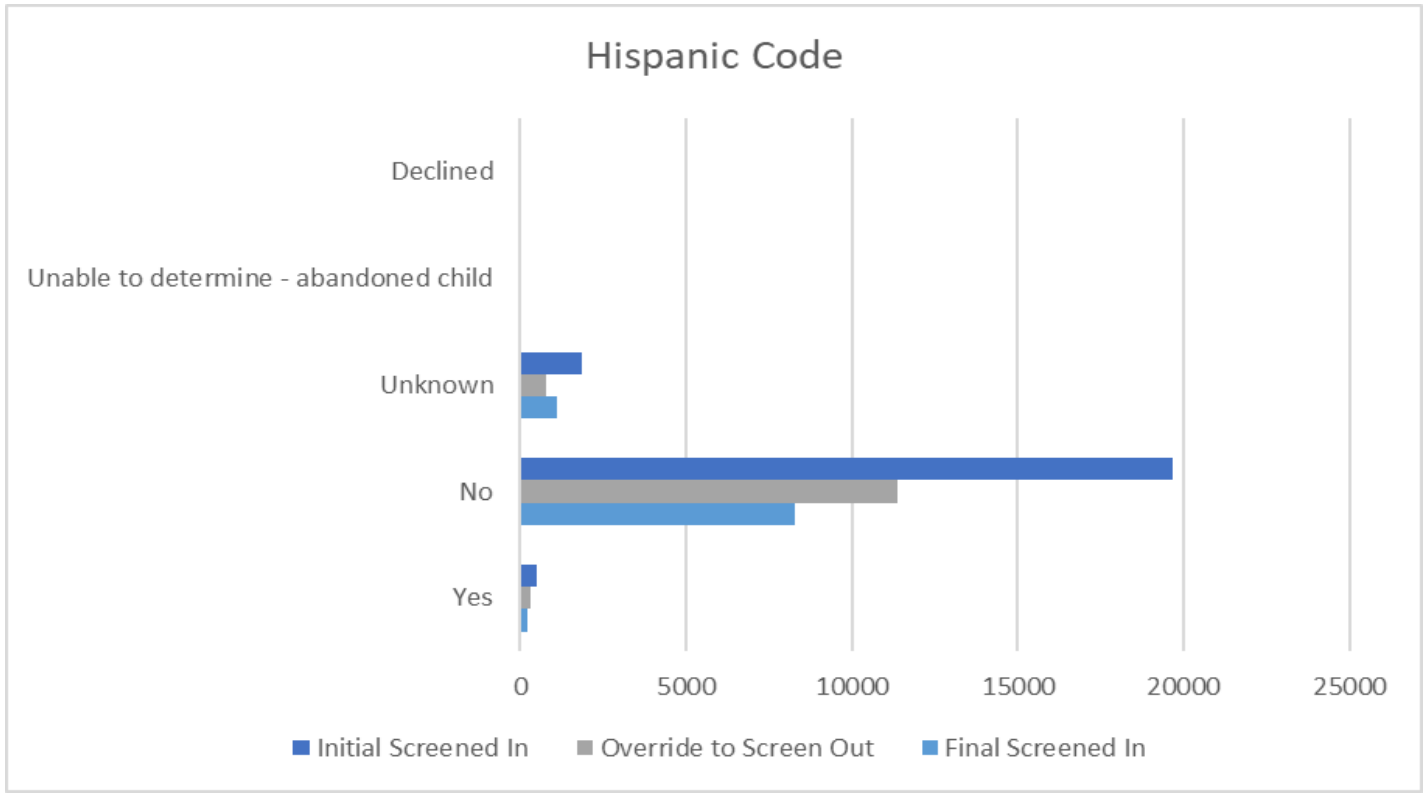


Figure 18. APS Screening Decisions by Ethnic Indicator (Hispanic Code) Reported for the Person

Hispanic Code	Number of Initial Reports	Reports Initially Screened-In Using the SDM® Tool	% of Total Initial Screened-In Using the SDM® Tool	Total Reports Overridden via Discretionary Override to Screen-Out	% of Reports Overridden to Screen-Out	Final Number Screened-In	% of Final Screen-In's
Yes	909	486	53%	287	59%	199	41%
No	32,808	19,670	60%	11,375	58%	8,295	42%
Unknown	3,224	1,860	58%	758	41%	1,102	59%
Unable to determine - abandoned child	2	-	0%	-	0%	-	0%
Declined	3	3	100%	1	33%	2	67%
Total	**36,946***	**21,533**	**60%**	**12,134**	**56%**	**9,399**	**44%**

***Total reported of 36,946 is less than the 40,510 total reports Consultant analyzed because 3,564 records' Hispanic Code was blank.

Figure 19. APS Reports by Ethnicity Indicator (Hispanic Code) Reported for the Person



The results in Figures 16 and 17 show that screen-out rates are higher among racial and ethnic minorities compared to vulnerable adults referred to APS who are Caucasian. Compared to the overall screen out rate of 59%, the following racial minorities had higher screen-out rates because of discretionary overrides:

- **Black or African American**: 80% of initially screened in reports are overridden and the overall representation of the population is lower than the population prevalence in the statewide population mix.
- **Hispanic:** 59% of initially screened in reports are overridden and the prevalence of cases in the APS case mix is lower than the statewide population prevalence**.**
- **Pacific Islander**[36]: 70% of initially screened in reports are overridden with a small total population prevalence and case prevalence.
- **Asian**: 68% of initially screened in reports are overridden, and the prevalence of cases in the APS case mix is lower than the statewide population prevalence.
- **American Indian/Alaska Native**: 61% of initially screened in reports are overridden while the total volume of persons served is slightly higher within the national case mix vs. prevalence within the statewide population mix.

The Consultant conducted additional evaluation to understand if there was a relationship between minority populations and high screen-out rates within two highly populated counties with a significant representation of minorities (Hennepin and Ramsey counties) to detect if significant variance existed *within* the county's screening trends, acknowledging high overall screen-out trends that could skew statewide outcomes for race / ethnicity. We focused on comparing Black / African American vs. Caucasian screening trends to compare the highest and lowest races screened out to identify if there was a significant variation.

Figure 20 shows an analytic comparison of Caucasian referrals and Black / African American referrals in Hennepin and Ramsey counties versus all other counties combined.

[36] The Pacific Islander population had a notably low volume of reports: 71 total initial reports, 43 initially screened in, 30 overridden to screen out, and 13 ultimately screened in.

Figure 20. Race Analysis by County Reported Comparing Screening Rates for Caucasian Individuals vs. Black or African American Individuals

Caucasian					
County Name	**Reports Initially Screened-In via SDM® Tool**	**% of Total Initial Screened-In Using the SDM® Tool**	**Total Reports Overridden via Discretionary Override**	**% of Initially Screened-In Reports Overridden via Discretionary Override**	**Counties' % of Total Overridden Reports**
Hennepin/Ramsey	7,922	42.9%	6,354	80%	63%
All Other	10,544	57.1%	3,723	35%	37%
Total	**18,466**		**10,077**	**55%**	
Black or African American					
County Name	**Reports Initially Screened-In via SDM® Tool**	**% of Total Initial Screened-In Using the SDM® Tool**	**Total Reports Overridden via Discretionary Override**	**% of Initially Screened-In Reports Overridden via Discretionary Override**	**Counties' % of Total Overridden Reports**
Hennepin/Ramsey	2,620	85.4%	2,249	85.8%	92%
All Other	449	14.6%	203	45.2%	8%
Total	**3,069**		**2,452**	**79.9%**	

The Consultant determined that 85.4% of adult maltreatment reports for Black or African American vulnerable adults fell within Hennepin and Ramsey counties. When reviewing Hennepin and Ramsey counties specifically, the two counties override 80% of initially screened in referrals for Caucasians and 85.8% of initially screened in referrals for Black or African Americans. We then performed a *chi-square test* on the screen-out rates in Hennepin and Ramsey counties to test the statistical significance of the nearly 6% difference in screen-out rates between Caucasians and Black or African Americans. The test found that the differences are still statistically

significant, meaning there is a significant correlation between the race of the person (specifically whether the person is Caucasian or Black/African American) and rate of screen out. Chi-squared tests showed statistically significant variation both statewide and within Hennepin and Ramsey counties, suggesting a correlation beyond mere chance. Analytic outcomes lead the Consultant to comfortably conclude that there is disparity in screening outcomes by race / ethnicity both within a sample of counties with a high overall screen-out rates and across all counties regardless of overall screening rate.

While we cannot confirm a causal relationship our evaluation findings merit further investigation and proactive steps to promote systemic equity, which is included in post-study recommendations. All counties should take steps to explore and further understand the risk for racial and ethnic inequity in APS and understand that this observation is a statewide trend spanning multiple racial and ethnic minorities that could pose risk to equitable service access and delivery.

Discretionary Override Findings

A significant number of referrals are screened out by county APS agencies who apply a discretionary override. The MN APS Policy and Procedure Manual provides a listing of discretionary override options and includes brief definitions. The SDM® Intake Assessment Tool also includes a place for the worker to select discretionary override – "other". This option allows the worker to provide a free-text explanation of the reason the referral is being screened out. For all discretionary override options, the county APS agency must identify the override in their county-specific prioritization guidelines.

Discretionary override definitions include[37]:

- **Self-Neglect**: Can be resolved through case management or current services: Select 'Yes" if self-neglect can be resolved through case management or current services. This override must be identified in county's written prioritization guidelines.
- **Financial exploitation loss less than county guidelines**: Select 'Yes' if financial exploitation loss is less than the amount identified in county's written prioritization guidelines.
- **VA deceased at time of report**: Select 'Yes' if VA deceased at the time of the report. This override must be identified in county's written prioritization guidelines.
- **VA incarcerated at time of report**: Select 'Yes' if VA incarcerated. This override must be identified in county's written prioritization guidelines.

[37] Adult Protection Structured Decision Making and Standardized Tools Guidelines and Procedures Manual

- **No benefit to VA from adult protective services or investigation**: Select 'Yes' if no benefit to VA from adult protective services or investigation because maltreatment has been resolved with minimal risk of repeat maltreatment and/or no protection to this VA or other VA's from investigation or alleged perpetrator. This override must be identified in county's written prioritization guidelines.
- **Other**: (examples which county provides in text box)

The override to screen out breakdown is in Figure 21. APS workers can select more than one override type. Data shows the "other" drop down option was selected 53% of the time, with self-neglect selected 25% of the time.

Figure 21. Override to Screen-Out Breakdown Reported for the Person

Override to Screen-Out Breakdown	Count of Reports Overridden to Screen-Out	% of Count
Self-Neglect	3,968	25%
Financial Exploitation	119	1%
VA Deceased	107	1%
VA not in MN	71	0%
VA Incarcerated	32	0%
No Benefit	3,066	19%
Other	8,419	53%
Total	**15,782**	**100%**

Analyzing Discretionary Override – "Other" Data

With over 8,000 referrals screened out using the discretionary override – "other" drop down option, the study team further reviewed the free-text comments to establish common patterns and further analyze the free-text information entered into the SDM® Intake Assessment Tool. The data suggests a higher than anticipated use of override – "other" (53% of all discretionary overrides). Due to the "other" option allowing the worker to enter free-text comments, it was difficult to precisely track and analyze the rationale that caused the worker to select

"other" as the override reason. This free form text area was used in a case note fashion that even though provides good documentation within each county it creates challenges from a data analytics perspective to identify the reason the tool policy to screen-in was overridden by APS to screen out the person referred.

To trend free text field entries, the Consultant used the sequence below to analyze the high volume of discretionary override – "other" free text comments:

1. Consultant assembled and scanned a representative sample of 15% of the discretionary override – "other" free-text comments entered in the SDM® Intake Assessment Tool, resulting in a scan of approximately 1,200 records.
2. During the scan, Consultant captured key words and phrases that appeared within multiple comments.
3. Consultant used these key words and phrases to search the entire override- other free form text field to determine the frequency of use. This search relied on workers spelling words correctly, and as a result, there may have been some comments not correctly categorized due to mis-spelled words.
4. Consultant placed the key words and phrases into "categories" for additional analysis.
5. Consultant reviewed the comments within each category to gather observations. Team observations were used to further inform the systems analysis and stakeholder engagement phases of the project.

The above methodology resulted in 11 distinct categories that were each associated with several search terms (Figure 22).

Figure 22. Discretionary Override Reported for the Person – "Other" Categorization of Search Terms

Category	Search Term(s) Used
Bounce	• Bounce[38]
Case Management	• Case management • Case manager • CM

[38] Bounce means the referral was returned to the centralized reporting center for referral to DHS-Office of Inspector General (OIG) or Minnesota Department of Health (MDH) as county APS was not the LIA with jurisdiction to respond.

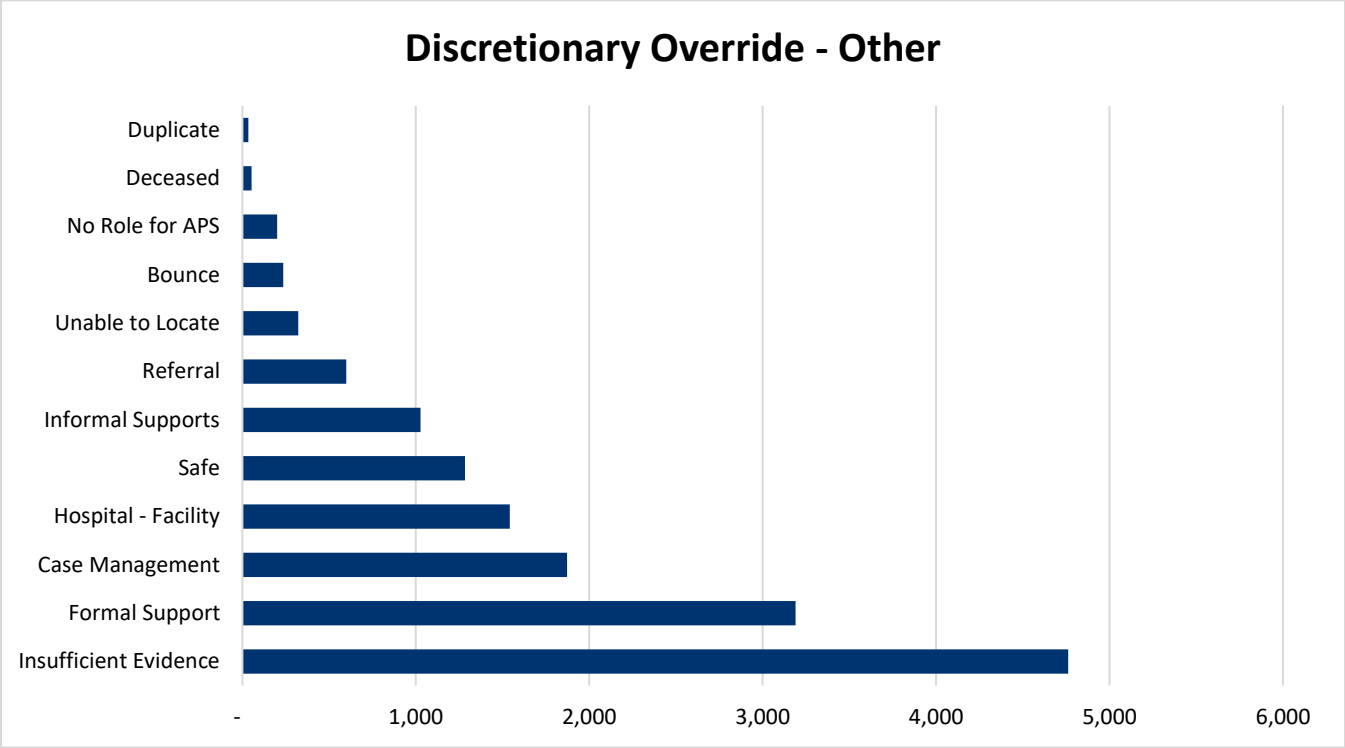
Category	Search Term(s) Used
Deceased	• Deceased • Passed away
Duplicate	• Duplicate
Formal Support	• Formal support
Hospital – Facility	• Facility • Hospital • TCU* - *Transitional care unit*
Informal Support	• Informal support
Insufficient Evidence	• Insufficient evidence • Harm
No Role for APS	• No role for APS
Referral	• Referral • Refer
Safe	• Safe
Unable to locate	• Unable to locate • Whereabout

Using the search terms in Figure 22, the Consultant was able to categorize 84.8% of the 8,419 individual comments reviewed and placed flagged records into at least one of the twelve categories listed above. Figure 23 contains the count of comments within each category. Many comments fit into more than one category, with 7.8% (647 records) falling into at least four of the twelve categories.

Figure 23. Discretionary Override Reported for the Person – "Other"

Discretionary Override - Other	Count	% of Override - Other
Insufficient Evidence	4,762	56.6%
Formal Support	3,190	37.9%
Case Management	1,873	22.2%
Hospital - Facility	1,542	18.3%
Safe	1,284	15.2%
Informal Supports	1,027	12.2%
Referral	599	7.1%
Unable to Locate	322	3.8%
Bounce	236	2.8%
No Role for APS	200	2.4%
Deceased	53	0.6%
Duplicate	34	0.4%

Figure 24. Discretionary Override Reported for the Person – Other Categorization



The Consultant then reviewed a selection of comments within each of the designated "other" categories to attempt to gather additional understanding of the APS worker's rationale for screening out a report. This analysis led the study team to identify several important observations, including:

- Documentation suggests that investigatory activities are taking place during the intake / screening process with a high use of "insufficient evidence" as the basis for not screening a case in for investigation.
- If APS workers are making decisions on the vulnerable adult's safety without obtaining firsthand knowledge or completing field visits to confirm the vulnerable adult's condition, this raises a concern as the APS worker is unable to obtain firsthand knowledge of the vulnerable adult's current situation or needs.
- Workers heavily rely on formal and informal supports, including hospital discharge planners to address and resolve the vulnerable adult's safety needs

A lack of evidence is contrary to the basis for why a county APS program should advance a case to investigation – as the investigation phase is when evidence can and should be gathered to assess VA risk and safety.

Additional observations and example free text entries for each major category of the discretionary override "other" data are below in Figure 25. Consultants selected the example free text entries directly from text entered into the SDM® Intake Assessment Tool with all personally identifiable and sensitive information removed, including examples from the top six categories listed above in Figure 24.

Figure 25. Discretionary Override Reported for the Person – "Other" Observations and Example Free Text Entries

Category	Observations	Example Free Text Entries
Insufficient Evidence: 56.2%	• APS workers may be using the assessment tool for investigatory activities. • The intake / screening process is telephonic, but the narrative reflects investigative conclusions without observing the vulnerable adult.	*"Risk vs harm"* *"There is insufficient evidence of harm. The building social worker has been alerted to the concerns in the report putting her in a position to assist VA in obtaining any desired services."* *"There is no indication that VA has been harmed by alleged caregiver neglect. Case manager is involved and will be discussing concerns with VA and family."* *"Unknown whether VA authorized transactions or not, no harm to VA as she was being cared for."* *"Unclear if W.H. is a caregiver, insufficient evidence of maltreatment / harm, resources provided."*
Formal Support: 37.9%	• Some "formal support" comments present as valid reasons to screen out. • There is potential over-assumption that formal supports are sufficient to remediate maltreatment and/or lack of appreciation that formal supports may be contributing to the alleged maltreatment. • Some comments indicate observed risks which may warrant further APS investigation as opposed to a rational for screening the report out.	*"There is risk, but maltreatment will be reduced or eliminated by supports and services. Writer spoke with, Service Planner. Service Planner states that he is working with VA to get some form of income and find new housing. There are formal supports in place."* *"Case will be closed at Intake. There is risk, but maltreatment will be reduced or eliminated by supports and services. Writer spoke with P.T. with X Residence. P.T. states that a police report has been filed and it is unknown who stole and crashed VA's car. P.T. states that VA has insurance and is filing an*

Category	Observations	Example Free Text Entries
	• Consultant observed that "formal or informal supports are in place for the immediate protection of the VA" is a discretionary override option for the Emergency Adult Protective Services (EPS) intake tool. It appears this EPS option is also being used as an override for the intake assessment tool through comment via the discretionary override – other selections.	*insurance claim to get the car repaired. There are formal supports in place."* *"No evidence to support allegation of financial exploitation or any related financial crimes against VA - formal supports in place"* *"This report is closing in Intake. VA continues to reside in the residence with her daughter-in-law. Police were not involved in the reported incident and the VA did not require medical attention to the bruise sustained to her leg. There are formal supports in place to assist the VA. The vulnerable adult is supported by an ILS worker who has attempted to mediate the situation with the VA's adult daughter-in-law. The VA's ILS worker has also assisted the VA in obtaining a new debit card so that no one else including her daughter-in-law will have access to her account…"* *"Bruising appears to be a result of careless or rough administration of insulin, possibly also helping with transfers. There are formal supports in place at this time to reduce the risk of maltreatment, and a new MAARC report will be made if conditions deteriorate."*
Case Management: 22.2%	• SDM® and Standardized Tools Guidelines defines the following override option: "Self-Neglect can be resolved through case management / current services." This is not consistently leveraged as a dropdown option.	*"Open to MH case management and case manager will follow up."* *"The allegations for self-neglect do not meet the MN statute description, VA can request new PCA workers. VA has been in contact with case manager and does not have concerns regarding PCAs."*

Category	Observations	Example Free Text Entries
		"VA met previous case manager to discuss waiver services." *"It was suggested by staff to block caller from VA's phone. Actions can also be resolved through case manager or current services."* *"Issues have been resolved through the help of law enforcement and CD case manager. EBT and cash card fraud have been reported."*
Hospital / Facility: 18.3%	• Hospitalization at the point of intake is being used to justify case non-acceptance when hospitalization or facility placement may not be a permanent safety arrangement. • Deferral to "safe" discharge planning may not guarantee the VA's safety or address the abuse allegations.	*"VA hospitalized at the time of report; reportedly was again hospitalized shortly after initial discussion with reporter, but no update."* *"Facility will assess him for a higher level of care."* *"VA is hospitalized - 72 hour hold and statement expected."* *"VA was taken into the ER and admitted to the hospital."* *"VA is currently safe and in the hospital."* *"VA in ICU, and family is working with Hospital and SW to plan for safe discharge."*
Safe: 15.2%	• Comments suggest the intake worker may be conducting the Initial Safety Assessment concurrently with the Intake Assessment Tool. • Observation aligns with stakeholder feedback during the first advisory workgroup meeting indicating that there may be	*"VA is safe and caregivers, grandson and fiancé taking precautionary measures to keep VA and VA's spouse safe."* *"VA is in safe environment and is choosing to make poor decisions."* *"Family has safety plan in place."*

Category	Observations	Example Free Text Entries
	instances when APS workers are completing investigative activities during the intake / screening process.	*"The injury to the VA was accidental and a safety plan and corrective action has been developed."*
Informal Support: 12.2%	• All comments referencing "informal support" also fell into at least one other category. • Comments indicate reliance on the informal support system prior to the investigative process. • "Formal or informal supports are in place for the immediate protection of the VA" is a discretionary override drop down option for the EPS Intake Tool. It appears it is also being used as an override for the Intake Assessment Tool.	*"The family VA is living with will call the police if AP shows up. The family is in process of helping VA obtain an OFP. The family went to social security and switched representative payees to protect VA's social security funds. Informal supports in place, formal supports are in process."* *"There is an informal support system to reduce maltreatment. VA's daughter is aware of the concerns regarding her living environment. A home care agency is in contact with VA regarding home cleaning services."* *"Information indicates that there was no maltreatment, report had incorrect facts. There are formal and informal supports in place."*

Overall, the “other” field in the discretionary override form was used more often than anticipated by the study team; the APS worker selected “other” in over half of the reports screened out by discretionary override in the study. It appears that the use of “other” as a discretionary override field option contributes to the disproportionately high screen-out rate for MN maltreatment reports. Text analysis from the use of the “other” field also reflects that preliminary investigatory activities are occurring during the screening process. For example, one comment suggests that the vulnerable adult’s injuries were “accidental and do not warrant follow-up”. Conclusions on the determination for maltreatment allegations should be made after the APS worker completes an investigation and not during a telephonic intake screening.

SECTION IV: DATA ANALYSIS: EQUITY OF OUTCOMES

Purpose

The study team was tasked with evaluating the equity of APS outcomes for vulnerable adults referred to APS. The objective was to analyze the referral and SDM® Intake Assessment Tool data to establish the extent to which individuals referred to APS are equitably linked to necessary services and supports and to identify any trends that can be addressed to promote equitable access for vulnerable adults to adult protective services.

Methodology

The study design for the equity of outcomes analysis included a simple cross-sectional study testing the below hypothesis:

- Standardized tool guidance supports equity in service outcomes for vulnerable adults accepted by APS for investigation and service response for reports of suspected abuse, neglect, and exploitation.

DHS provided APS service and intervention data captured within SSIS for the time period from 9/1/2017-9/1/2020. Consultant planned to analyze each APS report in a three-step approach:

1. Analyze reports by county demographics, including age, race, gender, disability, and geographic location;
2. Compare service outcomes between vulnerable adults enrolled in medical assistance programs and services and those who are not to determine the impact of participation in DHS programs and services; and
3. Use case demographic and eligibility information to determine if APS-accepted individuals who are eligible for but not accessing Medicaid are experiencing access gaps

Final Case Determinations

Of the 40,510 adult maltreatment reports received by the county APS agency, approximately 3% resulted in substantiated allegation during the study period (9/1/2017-9/1/2020). See Figure 26 for the determination code breakdown for all SDM® Intake Assessment Tools processed by county APS agencies.

Figure 26. Determination Code as Reported for the Person – All SDM® Intake Assessment Tools

All SDM® Intake Tools		
Determination Code	**Count of SDM® Intake Tool**	**% of Total**
No Determination Available	33,536	83%
False	2,780	7%
Inconclusive	1,501	4%
No determination - investigation not possible	790	2%
No determination - not a vulnerable adult	787	2%
Substantiated	1,116	3%
Total	**40,510**	**100%**

The Consultant reviewed the determination codes for all adult maltreatment reports that were ultimately screened in. The purpose of reviewing this data was to determine the number of screened-in reports that resulted in a substantiated allegation, to aid in determining the validity of the SDM® Intake Assessment Tool. This analysis was hampered by the higher than anticipated percentage of records that had no determination available (30%) and the low percentage of substantiated reports (11%). Figure 27 contains the ultimate screen-ins by determination code.

Figure 27. Ultimate Screen-In Determination Codes as Reported for the Person

Determination Code	Intake Tools	% of Total Ultimate Screen-Ins
No Determination Available	2,936	30%
False	2,743	28%
Inconclusive	1,483	15%

Determination Code	Intake Tools	% of Total Ultimate Screen-Ins
No determination - investigation not possible	773	8%
No determination - not a vulnerable adult	776	8%
Substantiated	1,104	11%
Total	**9,815**	**100%**

Medicaid Indicator

The Consultant compared final determinations between vulnerable adults enrolled in medical assistance programs and services and those who were not enrolled in medical assistance programs but saw no significant difference between these two populations. Figure 28 contains a summary of final determinations by Medicaid indicator.

Due to the low volume of substantiated investigations, combined with the high volume of missing determinations, the Consultant was unable to further analyze whether or not individuals who are eligible for but are not accessing Medicaid are experiencing access gaps.

Figure 28. Investigation Determination by Medicaid Indicator as Reported for the Person

Determination by Medicaid Indicator	Ultimate Screen-Ins	% of Initial Screen-Ins via SDM® Tool
Not Medicaid	**7,007**	
Missing	2,129	30%
False	1,943	28%
Inconclusive	1,012	14%
No determination - investigation not possible	536	8%

Determination by Medicaid Indicator	Ultimate Screen-Ins	% of Initial Screen-Ins via SDM® Tool
No determination - not a vulnerable adult	658	9%
Substantiated	729	10%
Medicaid	**2,808**	
Missing	807	29%
False	800	28%
Inconclusive	471	17%
No determination - investigation not possible	237	8%
No determination - not a vulnerable adult	118	4%
Substantiated	375	13%
Total	**9,815**	

Observations

While the study team was able to analyze data and review trends for medical assistance program enrollment groups and ultimate screen in determinations, the Consultant was unable to comprehensively study the equity of outcomes as originally intended due to multiple factors:

- The low percentage of overall screen ins provided a statistically small sample size to analyze.
- Only a small proportion of the screened in cases were associated with an intervention; only 21.82% of screened in cases, or 2,142 total records, had an intervention attached to the report.
- Low intervention rates may be exacerbated by the observation that APS workers do not consistently enter interventions into SSIS unless the final determination is substantiated. Although workers can enter

interventions for false or inconclusive, the system does not prompt them to do so and there are no policies or procedures currently in place that required this information to be entered.

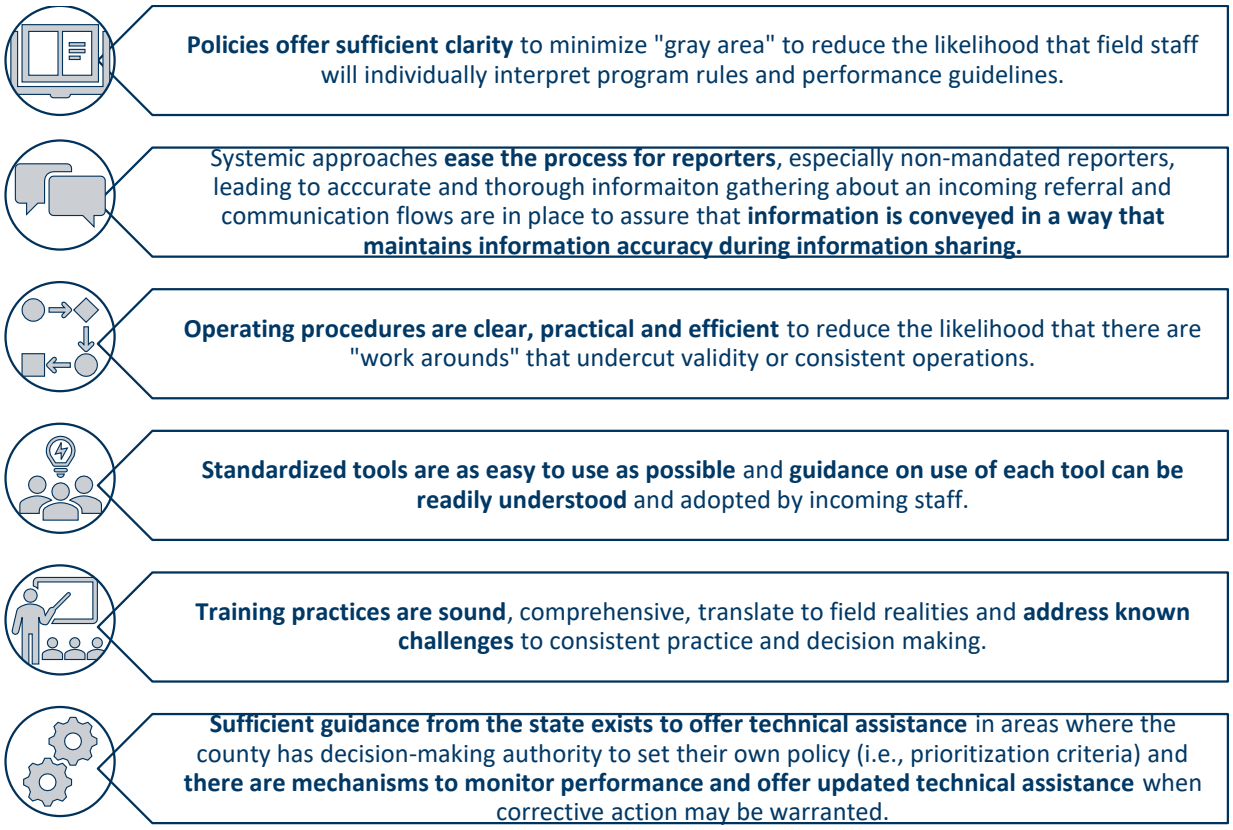
SECTION VI: SYSTEMS AND POLICY ANALYSIS

Purpose

Data alone cannot provide total insight into APS operations, it is necessary to consider other influencers that govern a program's operations including regulation, policy, operating procedures, formal guidance, training materials and other tools commonly leveraged across the delivery system. Consultant's systems and policy analysis included a desk review of the tools, associated training, workforce guidance and policies and procedures that guide MN's APS program operations. This analysis was pertinent to understand current APS environment, including the APS intake process and to determine if systems and policy guidance is clear and consistent across all materials. The Consultant also used this analysis to help interpret data analysis, develop stakeholder engagement follow-up questions and to fully inform our recommendations.

Consultant's desk review focused on analyzing and recording our findings related to factors that, when addressed, promote operational consistency using standardized tools and methodologies. These factors are listed in Figure 29.

Figure 29. Review Factors that Improve Operational Consistency



In addition to the tools and systems implemented by DHS, MN Statute 626.557, Subd. 10b, allows each lead investigative agency the authority to implement its own agency-specific guidelines for prioritizing reports for investigation. This guidance is commonly referred to as *county prioritization guidelines*. Another purpose of the agency-specific guidelines scan was to gather additional understanding of the differences between county practices which might be impacting the overall consistency between intake decisions and service outcomes across the state.

Methodology

DHS Policies, Procedures, and Training

The Consultant accessed publicly available policies, procedures, and training materials via the DHS Adult Protection website. Consultant submitted a document request to DHS to confirm the list of public documents and requested that DHS submit any additional policy, training, or other relevant materials for Consultant to review. A complete listing of all Consultant-reviewed DHS documents is available in Appendix E. During the December 2020 Advisory Workgroup meeting, the Consultant presented the list of anticipated desk review materials. Workgroup members confirmed Consultant had a comprehensive list of relevant and appropriate materials.

The Consultant initiated this phase of analysis by comparing each policy, procedure, and training document to MN Statutes 626.55729, 626,557139, and 626.557217 to confirm policies aligned with APS related statutes and found none of the DHS materials to be out of compliance with the statute. Each document reviewed cited all relevant statute and policy and included hyperlinks to the online statute. While Consultant reviewed all materials provided, only those that contain pertinent policy and procedure information related to the study are referenced in the summary findings table.

Observations

DHS Policies, Procedures, and Training

Consultant's review of DHS policies, procedures, and training found that materials consistently reference MN Statutes 626.557 (Reporting of Maltreatment of Vulnerable Adults) and 626.5572 (Definitions). Policy manuals, including the Minnesota Adult Protection Service Policy and Procedures Manual and the Minnesota Adult Protection Structured Decision Making and Standardized Tools Guidelines and Procedures Manual, along with the APS Foundations Online Trainings (Sessions # 1 - # 3) contain hyperlinks to the MN statutes and hyperlinks to the policy manuals, resulting in consistent messaging throughout the DHS published policy, procedure, and training material.

[39] 2020 MN Statutes, 626.5571: https://www.revisor.mn.gov/statutes/cite/626.5571

When it comes to the interpretation of the statutes and additional explanation of the APS intake process, the Consultant observed that the intake process is not always fully explained in the reviewed policies, procedures, and training materials. The materials contain information that can be subject to individual interpretation. For example, the Minnesota Adult Protection Structured Decision Making® and Standardized Tools Guidelines and Procedures Manual[40] and Minnesota Adult Protection Policy and Procedure Manual42 advise APS uses professional judgement and knowledge based on experience working with the referred vulnerable adult in conjunction with the SDM® Intake Assessment Tool to make screening decisions, without clarity on how professional judgment or knowledge of the vulnerable adult should be documented. Any document that is open to individual interpretation poses risk for subjectivity and inconsistency in respond which undermines statewide consistency, reliability and consequently the equity of high quality APS for all statewide VA.

Figure 30 contains an additional summary of Consultant's review findings of DHS' policies and procedures, specific to reviewing for factors that improve operational consistency. The Consultant focused the below findings on the Minnesota Adult Protection Service Policy and Procedures Manual and the Minnesota Adult Protection Structured Decision Making and Standardized Tools Guidelines and Procedures Manual, and the APS Foundations Online Trainings (Sessions # 1 - # 3) as these materials are cited most often as the primary sources of policy and instruction outside of the MN Statutes.

Figure 30. Summary of DHS Policy and Procedure Review Findings

Document Name and Type	Findings
APS Foundations Online Training Module – Sessions # 1, 2, 3	**Use of the SDM® Intake Assessment Tool** • The APS Foundations Online **Training** Module, Session 2 script **instructs** APS workers that "tool completion includes following the policy guidance in the tool to determine if the person is a vulnerable adult and the incident alleged is maltreatment." It is unclear if the speaker's notes are shared with APS workers, but it would be beneficial to include this instruction on any worker takeaway materials. **Timeframes** • There is an **opportunity to clarify** the intake timeframes in the training module. Manuals, statute, and training material indicate the initial disposition is required within 5 business days, level 1 response time is 24

[40] Minnesota Adult Protection Structured Decision Making® and Standardized Tools Guidelines and Procedures Manual, Revised 9/2018, accessed via: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6762A-ENG

Document Name and Type	Findings
	hours and level 2 response time is up to 72 hours, however it is unclear when the 24-hour or 72-hour timeframe is initiated.
Minnesota Adult Protection Service Policy and Procedure Manual	**Use of the SDM® Intake Assessment Tool** • The definition of "assess" reads: To initiate intake using information in the MAARC report, other information from the reporter, and information known to the county or available within SSIS to prioritize county EPS or county APS intake response. Manual **lacks clarity** on what might be considered "information known to the county." Information known to the county can include historical knowledge such as past APS referrals or investigations. • Manual states: "relevant history with the agency, including prior accepted and screened out reports of maltreatment are considered during intake." Manual **lacks guidance** on how the relevant history is considered or additional clarity on how agency history impacts intake screening decisions. • Manual states: Intake decisions should be consistent with the most protective response when screening information to establish vulnerable adult status is inconsistent or unavailable. Manual should include **additional clarity**, especially for a new staff person that may not understand what is meant by "most protective response." **Discretionary Override** • APS policy and procedure manual does not reference or define the purpose of the discretionary override function during the intake assessment process resulting in **unclear operating procedures** in regard to making screening decisions. • Manual **lacks direction** on best practices or instruction on how APS workers should handle intakes in which there is an active case manager assigned and/or the vulnerable adult is hospitalized or in a short-term facility.
Minnesota Adult Protection Structured Decision Making® and Standardized Tools Guidelines and Procedures Manual	**Use of the SDM® Intake Assessment Tool**

Document Name and Type	Findings
	• Manual **does not provide guidance** or best practices on the types of information to include in any "other" free-text boxes, including discretionary override. **Discretionary Override** • The discretionary override definitions **are succinct and consistent** with the definitions housed directly within the SDM® Intake Assessment Tool. The manual also **clearly specifics** that any discretionary overrides must be included in the respective county prioritization guidelines. • The manual contains **no guidance** to APS workers on what type of information to include as a rationale for "other". The manual defers to the county prioritization guidelines, but **does not provide parameters** such as examples of the type of information DHS intended for this free-text box to capture.

County Prioritization Guidelines

The Consultant reviewed intake disposition data for all counties and requested and reviewed county prioritization guidelines for a sample of fifteen (15) county APS agencies. The fifteen (15) APS agencies were selected based on a number of factors, including screen-out rates, racial / ethnic diversity, and location (at least one county from each MACSSA region41). DHS approved the selected sample and approved contact with each agency's APS program director.

The Consultant received responses from thirteen (13) of the fifteen (15) counties selected. Consultant submitted additional reminder outreach emails to the remaining two counties, but these counties were unresponsive. Figure 31 below contains the screen-out rate and volume of individual APS referrals screened during the study period for each of the counties that submitted their county prioritization guideline.

Figure 31. County Prioritization Guideline Submissions by Individual Screen Out Rate and Referral Volume

#	Screen-Out Rate	Volume of Individual APS Referrals Screened*
1	88%	Under 500

#	Screen-Out Rate	Volume of Individual APS Referrals Screened*
2	85%	Over 3,001
3	61%	Under 500
4	54%	501-1,500
5	38%	501-1,500
6	36%	Under 500
7	35%	Under 500
8	35%	501-1,500
9	32%	1,501-3,000
10	21%	Under 500
11	17%	Under 500
12	10%	501-1,500
13	0%	Under 500

*Date range of data analyzed: 9/1/2017 – 9/1/2020

Findings Related to County Prioritization Guidelines

Although the standardized SDM® Intake Assessment tool is mandatory and thus commonly used, differences between county prioritization guidelines and intake processes are a likely factor driving inconsistencies in screening responses and service outcomes. Each of the county prioritization guidelines reviewed cite MN Statutes 626.557 and 626.5572 as guiding the county's APS program. One county responded to Consultant's

request for their county prioritization guidelines and indicated they use DHS's Structured Decision Making® and Standardized Tools Guidelines and Procedures Manual.

The Consultant reviewed the county prioritization guidelines and identified common topic areas that multiple counties address. Figure 32 contains the county prioritization guideline topic area, number of counties that include at least one guideline in the topic area, and example guidelines. As indicated in the summary table, some counties use unique screening criteria to either screen in or screen out referrals, and this variation can result in inconsistent interpretations across the state, resulting in potentially inconsistent service outcomes.

Figure 32. Summary of County Prioritization Guideline Review Findings

Topic	# of Counties Including the Topic Within Their Guidelines (Out of 13)	Example Guidelines

Case Management (excluding Self-Neglect)	5	• If a county case manager is in place, they may be contacted to screen the adult maltreatment report. Screening will be used to determine if the CM will work with the client on the allegations or if there is a need for an investigation.
		• If the Vulnerable Adult receives ongoing case management services:
		  ○ All other [excluding self-neglect] maltreatment allegations will be considered for adult protective services and investigation via this screening protocol
		  ○ Investigations will be coordinated with the current case manager

Death of the Vulnerable Adult	6	• Reports made regarding alleged maltreatment of a vulnerable adult who is deceased will be responded to on a case-by-case basis in consultation with the Sheriff's Department and the County Attorney. • County will not investigate vulnerable adult reports involving alleged victims that are deceased unless the report indicates there may be other possible victims. • Discretionary override to screen out if the vulnerable adult is deceased at the time of the report
Financial Exploitation	7	• Screen out if financial exploitation alleging a VA's financial representative has not paid a bill, without any other information indicating the misuse of funds for the AP's personal gain/profit or advantage. • Screen in if Financial Exploitation:

Topic	# of Counties Including the Topic Within Their Guidelines (Out of 13)	Example Guidelines
		○ The amount of the alleged loss of funds will adversely deprive the vulnerable adult ○ Vulnerable adult has a personal needs allowance with a loss of more than $20.00 ○ Vulnerable adult living independently with a loss of more than $100.00 • Financial exploitation must be in amounts exceeding $500
Formal / Informal Supports	3	• Screen in if the vulnerable adult has no support person who is able to assist the vulnerable adult to remedy the situation. • Screen in if the vulnerable adult has supports but is declining the support person's intervention.
Self-Neglect	6	• Self-neglect allegations will be screened out if the allegation is an unintentional isolated incident and no other indications of the vulnerable adult's capacity to make decisions is in question and/or no other co-occurring self-neglecting behaviors are also identified. • Discretionary override to screen out if self-neglect can be resolved through case management or current services
Sexual Assault	2	• All allegations of sexual assault will also follow the SAIC protocol regarding victims' rights • Discretion to screen out will be used with criminal sex allegations and theft of narcotics. These reports will be referred to the local Law Enforcement for criminal proceedings.

Topic	# of Counties Including the Topic Within Their Guidelines (Out of 13)	Example Guidelines
Vulnerable Adult Considerations / Definitions	5	• If mental capacity is unknown, the report can be screened in at the screening team's discretion, to assess the vulnerable adult's mental capacity. If the vulnerable adult is determined to have the mental capacity to make their own decisions, services will be offered, and the adult protection assessment will be closed. • Adult protection cannot provide services to vulnerable adults who have capacity and refuse further intervention. • A domestic violence incident is not generally considered maltreatment under the Vulnerable Adults Act unless the victim meets the definition of a vulnerable adult.

SECTION VII: QUALITATIVE ANALYSIS – STAKEHOLDER ENGAGEMENT

Purpose

The Consultant engaged county stakeholders to gather additional input on the SDM® Intake Assessment Tool. This input was intended to supplement the data-driven findings with operational realities obtained directly from statewide APS leaders and workers. The study team gathered feedback on:

- County intake processes and operations
- County prioritization guidelines
- County-specific workflows
- Operational realities / challenges
- Observations and lessons learned using the SDM® Intake Assessment Tool

We also sought feedback on specific findings following data analysis, specifically:

- Higher than anticipated screen-out rate
- Higher than anticipated use of discretionary override – other
- Themes we observed when analyzing the free text discretionary override – other comment fields
- High screen out rate for individuals with chemical disability
- Disproportionate screen-out rate for racial / ethnic minorities

Stakeholder Focus Groups

Methodology

The Consultant facilitated six focus groups throughout April 20, 2021 – April 25, 2021. Sessions were ninety (90) minutes long and staffed by a meeting facilitator, designated note-taker and one DHS representative. Between 6-13 APS workers (depending on the region and invitation response rate) attended each session. Due to public health related restrictions, focus group sessions were conducted virtually using Microsoft Teams as an interactive video-conferencing platform. Participants were encouraged to keep their cameras on to promote maximum interaction and engagement, although in some instances participants with internet connectivity issues or who joined by telephone participated in voice-only format. Session facilitators led introductions and

consciously aimed to elicit direct feedback and promote participation among all attendees, and the remote format was largely successful in driving the level of interaction and cross-agency input desired.

Focus groups were established based on the Minnesota Association of County Social Service Administration's (MACSSA) designated regions.[41] Consultant obtained a listing of lead investigative agency supervisor names and contact information. We emailed invitations to each supervisor, requesting that the APS county agency send 1-2 workers to their region-specific focus group. Non-responsive supervisors were sent a follow-up communication. Consultant sent all invited participants a formal meeting invitation and a listing of potential focus group questions, so that the participants could come prepared to engage and speak about the relevant topics. A list of these questions can be found in Appendix G.

The Consultant established the following focus group goals:

- Obtain input on the SDM® Intake Assessment Tool from APS workers across all regions of Minnesota
- Promote cross-county interaction to share collective interpretations of SDM® Intake Assessment Tool use and overall APS system performance with each other and DHS
- Understand what operational considerations and challenges may impede system performance today

A total of fifty-two (52) APS workers representing forty-one (41) counties and three collaboratives participated in the focus groups

Focus Group Themes

Stakeholders were engaged, open, and collaborative during focus group meetings. Stakeholders advised that they appreciated the opportunity to share insights into both the SDM® Intake Assessment Tool and the general APS process. A Consultant captured detailed notes and summarized notes into the key themes listed in Figure 33. We used feedback gleaned during the focus groups to inform many of the study recommendations. Stakeholder insights aided in our understanding of current field dynamics, including how the SDM® Intake Assessment Tool is used in practice.

[41] Minnesota Association of Social Service Agencies (MACSSA) Regional Map, accessed online: http://cms5.revize.com/revize/macssa/Documents/MACSSA_Regions.pdf

Figure 33. Focus Group Themes

Topic	Themes
Adult Protective Services Purpose	• Provide assessment and promote the safety of vulnerable adults • Honor the vulnerable adult's right to self-determination • Educate and partner with community members and other social service agencies on the role of adult protective services
General SDM® Intake Assessment Tool Feedback	Stakeholder perceptions of the purpose of the SDM® Intake Assessment include: • Tool is a place to document the screening decision, but the tool does not drive the decision. Many stakeholders report they have already made the screening decision before opening the tool in SSIS. • A standardized location in SSIS where the screening decision and rationale is documented. • A location to store adult maltreatment related definitions for easier access during the intake process. Stakeholders reported the below feedback regarding usability of the SDM® Intake Assessment Tool: • Frustrated that workers cannot view the adult maltreatment report at the same time they are completing the SDM® Intake Assessment Tool. • Some stakeholders wished there was more space in the tool to document case notes and rationale, instead of having to enter the case notes into a separate location in SSIS.
County Intake Screening Methods	Stakeholders shared multiple approaches to how their county makes screening decisions. Approaches include: • Team approach – designated agency staff meet on at a regularly scheduled time to review all reports and make collective decision on whether or not to screen in our screen out the report. Some stakeholders reported meeting three times per week and others meeting daily.

Topic	Themes
	• Clearly designated intake role versus investigator role – intake staff exclusively process incoming adult maltreatment reports. Intake staff do not complete APS investigations. • Some agencies have one worker that handles all components of the APS end-to-end process. Typically, this approach is used in smaller counties where the staffing resources are more limited and/or are shared with other programs beyond APS.
Discretionary Overrides	Stakeholders reported the following common reasons for discretionary override decisions: • The vulnerable adult already has an active case manager assigned. • The vulnerable adult is in the hospital at the time the report is made. • The agency does not see any role for APS. The below reasons for discretionary override were not widely utilized approaches, but were shared by more than one stakeholder: • Intake provides the opportunity to contact multiple individuals at the time of screening, including the reporter and other collateral contacts such as family members, formal supports (home health workers, discharge planners), and active case managers to gather information to supplement the adult maltreatment report. Agencies that make this level of outreach during intake reported they are able to screen out more reports using the discretionary override option because, based on telephonic outreach, the worker does not feel the vulnerable adult will benefit from APS. • Intake is used to connect the vulnerable adult to referrals and services during the screening period (five (5) business days) to avoid accepting the case for investigation. Stakeholders cited the intrusive nature of an APS investigation and the desire to protect the vulnerable adult from APS "showing up on their doorstep" as rationale for these discretionary overrides.
Role of Active Case Managers	Stakeholders reported inconsistent and varied approaches to collaborating with active case managers during the end-to-end APS process. Various approaches include: • Collaborating with the case manager immediately upon starting the screening process to determine what actions or interventions the case manager has tried. This

Topic	Themes
	helps the APS worker to decide whether or not APS will have a role in working with the vulnerable adult. • Screen out and defer to the active case manager, because they consider APS the service of last resort and prefer to maintain a person's right to self-determination. • APS workers expressed frustration with some case managers because there is a mis-interpretation that APS workers have mor authority and service options at their disposal than they actually do.
Chemical Dependency Related Reports	All stakeholders cited challenges in addressing adult maltreatment reports for individuals with chemical dependency. Challenges include: • Difficult to determine if the individual meets the definition of vulnerable adult. For example, the individual may meet the definition when intoxicated, but not when sober. • Agencies receive multiple reports related to chemical dependency, but there are blurred lines regarding the role the agency should take. • Individuals have a right to self-determination and can choose to use or mis-use alcohol or drugs.
Racial / Ethnic Disparities	Consultant discussed the high screen-out rates for racial / ethnic minorities and asked for feedback and possible insight into understanding this data. Stakeholders shared the following: • Many variables could be impacting these numbers and further research may be needed. Many stakeholders were surprised and saddened by the data, and recognized the need for increased cultural sensitivity, along with more open conversations to address unconscious bias. There are likely cultural considerations to be mindful of, especially in APS cases where law enforcement may become involved. Family dynamics in some racial and ethnic groups may also contribute to higher screen-out rates.
Role of APS when the Vulnerable Adult is Hospitalized	Stakeholders reported inconsistent approaches to screening individuals that are hospitalized or in short-term facilities. Approaches include: • Relying on the hospital being fully responsible for making a safe discharge plan and putting services in place for the vulnerable adult.

Topic	Themes
	• County prioritization guidelines that necessitate screening out if the vulnerable adult is in the hospital at the time of the report. • Tendency to screen out because it is unclear if the individual meets the definition of vulnerable adult as a result of the hospitalization.
Interventions Post-Determination	SSIS requires APS workers enter an intervention for substantiated cases. We asked stakeholders if they document interventions for cases with a final determination of inconclusive or false. Stakeholders reported the following: • APS workers arrange for and connect vulnerable adults with multiple services and referrals, including when the allegation is determined to be false or inconclusive. • Workers report that due to the volume of documentation already required, workers do not consistently enter interventions into the designated intervention tab in SSIS, however do include provided services and interventions in the case notes.
SSIS Feedback	We asked stakeholders for input on usability of SSIS and received the following feedback: • Stakeholders would like to be able to view the adult maltreatment report at the same time they are completing the SDM® Intake Assessment Tool.
DHS Collaboration and Training	We asked stakeholders to share ideas related to APS training, including DHS support and collaboration. Stakeholders shared: • Increased community training, specifically to the medical community and mandated reporters, on the role of APS. • Increased collaboration with DHS. Stakeholders ask questions, but are often referred back to the regulations and policies. Many workers are seeking a more collaborative approach, where cases can be discussed and DHS can work with the agency to interpret how the statutes and policies apply in unique situations. • Better understanding of statistical information. Stakeholders lacked knowledge of why DHS was collecting data and the purpose the data collection serves.

Targeted Stakeholder Interviews

Consultants also conducted ten targeted interviews, which were held from April 20, 2021 – May 3, 2021. Each interview was scheduled for sixty (60) minutes. To promote transparency DHS elected not to attend the targeted

interviews so that interviewees felt comfortable to share their thoughts openly and directly. Each interview was conducted by two members of the Consultant study team. Interviewees were informed that the information provided would be de-identified and shared with DHS in summary format via the final study report.

Interviewees were selected based on a number of factors, including:

- Regional Representation (i.e., Metro versus Rural; geographical regions)
- County prioritization guideline follow-up
- Racial / ethnic diversity
- Override percentage
- Total volume of incoming screenings

Figure 34 lists interviewee profiles by override screen-out rate and volume of individual APS referrals screened, and shows that the study team endeavored to obtain diverse perspectives based on operating trends and realities among county APS agencies:

Figure 34. County Interviewee Profiles

County / Interviewee	Override Screen-Out Rate	Volume of Individual APS Referrals Screened*
1	88%	Under 500
2	85%	3,001 and above
3	66%	3,001 and above
4	54%	501-1,500
5	54%	501-1,500
6	50%	Under 500
7	32%	1,501-3,000

County / Interviewee	Override Screen-Out Rate	Volume of Individual APS Referrals Screened*
8	21%	1,501-3,000
9	19%	501-1,500
10	0%	Under 500

The Consultant obtained a listing of lead investigative agency supervisor names and contact information and scheduled formal meetings with each selected county. Due to public health related restrictions, targeted interviews were conducted virtually using Microsoft Teams as an interactive video-conferencing platform. Interviewees were provided interview questions in advance so that the interviewees could come prepared to engage and speak about the relevant topics. A list of these questions can be found in Appendix F.

A total of 12 APS supervisors representing nine (9) counties and one (1) collaborative participated in a targeted interview

The Consultant established the following targeted interview goals:

- Obtain input from APS supervisors with a focus on outliers or counties with observed variance to conduct exploration
- Discuss practical and remedial considerations that could drive reductions in variability and study recommendations
- Ask questions targeted for supervisory input related to staffing, training, team oversight perspectives, and the role of the supervisor review and discretion in the APS process

Targeted Interview Themes

Consultants asked the interviewees a combination of some of the same / similar focus group questions, and new questions related to operations and supervisory perspectives. Interviewee questions are listed in Appendix F and relevant interview themes are listed in Figure 35.

The supervisors' responses to questions related to the below topic areas aligned with the focus group responses:

- County intake screening methods
- Discretionary override reasons and rationales
- The role of active case managers
- The role of APS when the vulnerable adult is hospitalized

Figure 35. Interview Themes

Topic	Themes
Adult Protective Services Purpose	Supervisors agreed with the APS purpose themes shared during the stakeholder focus groups with the below additional comments: • One of the purposes of APS is to investigate maltreatment and connect individuals with necessary services to preserve the vulnerable adult's safety. • One supervisor highlighted that the most important role of APS is the vulnerable adult's outcome following APS's involvement. This includes honoring and respecting the vulnerable adult's right to self-determination but not at the sacrifice of the individual's safety.
General SDM® Intake Assessment Tool Feedback	**SDM® Intake Assessment Tool Useability** • Some supervisors expressed frustration that they are not able to view the case notes while the SDM® Intake Assessment Tool is open. This is challenging when supervisors conduct a supervisory review, because they are not able to compare the information in the tool to the rationale and documentation entered in the case note. **Screening Timeframes** Consultant asked interviewees to provide an estimate of how long it takes to complete the screening process and the activities that occur during the time the referral is pending the initial disposition. • The majority of supervisors report making the initial determination within two (2) days of receiving the report. • Other supervisors use the full five business days allowed to complete the initial disposition. Intake activities that occur during these five days include: ○ Attempts to refer for services and/or resolve the allegation in lieu of screening in for investigation.

Topic	Themes
	○ Contacting the reporter and other collateral contacts such as law enforcement, hospital discharge planners, case managers, and family members to gather additional information and detail regarding the allegation and the vulnerable adult's current situation.
Statewide Consistency	• Supervisors agree that having a consistent set of screening standards is important to promote overall statewide consistency in APS. • It may be difficult to achieve statewide consistency for the following reasons: ○ Each county can develop their own specific county prioritization guidelines. ○ Dynamics, such as staffing levels, referral volume and available resources, in urban or "Metro" areas of the state are different than rural parts of the state.
Diversity Initiatives	• Nearly all supervisors report increased focus on diversity initiatives and cultural sensitivity trainings, with staff being required to complete annual cultural competency training. • One county shared it has a diversity committee dedicated to diverse hiring practices and addressing racial inequity.
Discretionary Override	• All supervisors reported that they approve 100% of the discretionary overrides in their respective agency. Supervisors review that the tool was completed correctly and that there is a valid rationale in either the tool or the case notes.
DHS Collaboration	• Many interviewees are hesitant to reach out to DHS for technical support for the following reasons: ○ While interviewees recognize DHS cannot make screening decisions on behalf of the county, they would like additional opportunities to talk about APS best practices, statewide trends, and interpreting statutes and policies. ○ DHS responses feel scripted, and often refer the lead investigative agency back to the statute or policy manual. Interviewees were frustrated, stating that they are aware of statutes and are reaching out to DHS because the question or scenario requires a higher level of interpretation and conversation.

Observations

The Consultant applied the feedback and insights obtained during the focus groups and targeted interviews to drive many of our recommendations (Section VIII). Upon speaking with stakeholders, it appears that in many cases, that the SDM® Intake Assessment Tool is not being operationalized as it was originally intended – as the primary "source of truth" in making screening decisions. The APS workers we spoke with reported that they largely use the tool as a method of documenting the adult maltreatment report initial disposition, instead of using the screening tool to aid in making the initial disposition. Although it is not the intent of DHS that the tool replaces professional judgement[42], one of the objectives of the SDM® Intake Assessment Tool is to promote statewide consistent and equitable intake decisions and service outcomes regardless of the vulnerable adult's location in Minnesota.

[42] Minnesota Adult Protection Policy and Procedure Manual, Revised 9/2018

SECTION VIII: RECOMMENDATIONS

The Consultant's post-study recommendations are intended to help DHS reinforce the intended use of the SDM® tool and collaborate with counties to develop courses of action that promote equitable service outcomes for Minnesota's vulnerable adults. While the Consultant shared preliminary findings with DHS and welcomed feedback, all recommendations were developed based on independent analysis and should be considered independent conclusions subject to application at the discretion of DHS.

Each of the 15 recommendations are drafted to meet the following study goals:

1. Maximize the positive impact of the APS program statewide
2. Improve data collection practices to:
    a. Quantify the impact of APS programs on those served
    b. Drive data-informed oversight and quality improvement
3. Promote person-centered approaches
4. Promote equitable, individualized approaches to vulnerable adults
5. Assist counties in navigating case-specific "gray area" while following regulatory requirements, policies, and best practices
6. Balance work demands with resource realities to drive performance using practicality

Recommendations

Recommendation #1: Reinforce the Intended Use of the SDM® Intake Assessment Tool as the Primary Arbiter of Screening Decisions by Taking Steps with county APS agencies to Reduce Use of Discretionary Override including statewide re-training.

Consultant recommends DHS take actions in partnership with statewide county APS agencies to reduce the volume of discretionary overrides used to screen out referrals. DHS should leverage the SDM® Intake Assessment Tool Outcome as the "source of truth" on when to proceed to investigation and service assessment. Consultant recommends DHS conduct on-going training to reiterate the purpose of the SDM® Intake Assessment Tool and intention of the discretionary override option.

- **Data analysis** indicated MN's screen-out rate of 75.8% is significantly higher than the national screen-out rate of 37.7% based on the 2019 NAMRS report. Discretionary overrides are used to justify 35% of the 75.8% of statewide cases screened-out. These data points demonstrate that discretion is commonly used instead

of the SDM® Intake Screening Tool to make screening decisions. This adds subjectivity risks and removes inter-rater reliability.

- **Data analysis** suggested there is a statistically significant risk of inequitable application of APS services to all citizens throughout the State by geography, race, and other demographic factors.

- **Systems and policy analysis** showed that the Minnesota Adult Protection Structured Decision Making® and Standardized Tools Guidelines and Procedures Manual does not provide sufficient clarity or guidance on when it is most appropriate to use the discretionary override "other" drop down option, nor does it provide clarity on the type of information APS workers should include within the free-text comment box.

- **Qualitative analysis - stakeholder engagement** indicated the SDM® Intake Assessment Tool is not consistently used to determine screening decisions. Instead, in many cases, counties use the tool to document their screening decision after the decision has already been made based on factors not within the tool itself.

Recommendation #2: Develop Guiding Principles for APS Operation to More Specifically Define the Role of Adult Protective Services in the Social Services Continuum

Consultant recommends DHS develop guiding principles for APS operation. DHS should use continued statewide engagement to more specifically define the role of APS in the social services continuum, define a scale of 'least to most protective,' and offer ongoing guidance and case studies to promote consistency in how APS workers balance person-centeredness and self-determination in protective services provisions. This includes when working with other social services agencies.

- **Qualitative analysis - stakeholder engagement** revealed inconsistent approaches amongst APS workers when balancing between principles of protection, person-centeredness, and maintaining the right of adults to personal autonomy and self-preservation. A lack of consensus on best practices for leading and lagging principles and how to manage the complexities of balancing principles based on emerging case specifics - lead to disparate approaches across different counties. Where some counties are more closely aligned to DHS' emphasis on person-centeredness and individualized protective service delivery, other counties suggested they currently place more emphasis on self-preservation or struggle to move past historic positioning of APS within their county's social services continuum as an enforcement-driven involuntary service model.

- **Qualitative analysis - stakeholder engagement** and **systems analysis** identified that county stakeholders are not fully aligned with DHS on how to balance a person-centered response with traditional protective services. MN's APS Foundations Training highlights a "focus on person-centered and least-restrictive interventions and solutions to challenges reported to adult protection." However, some stakeholders cited self-determination as a reason to screen out before an investigation could occur and the individual was offered choices or engaged in safety planning and service interventions that APS can offer.

Recommendation #3: Conduct Cross-Model Workflow Mapping

Consultant recommends that DHS lead county workgroups to perform end-to-end process workflow mapping. The workflow mapping aims to establish appropriate minimum standards and best practice approaches across three emergent operating models used statewide that can anchor future training and technical assistance.

- **Qualitative analysis - stakeholder engagement** identified three operating models in practice, including:
    - An individual APS operator completes the end-to-end APS process, including intake, initial disposition, investigation, and making final determinations. Often, this individual APS operator is also responsible for other programs within their respective county.
    - The county's intake function is segmented and separate from the investigative function.
    - The county employs a team-based approach to full operations where the entire APS team, and in some instances, a cross-disciplinary team, discusses the referral and makes the screening decision as a group.
- Through **systems and policy analysis***,* Consultant observed that DHS guidance is not customized to address how applying regulations and policy might vary across these different operating models.
- **Qualitative analysis - stakeholder engagement** indicated that collaboration between DHS and MN counties to develop end-to-end workflow mapping will ultimately result in consensus and clarity. This will accommodate the variation in county size, refine DHS technical assistance, and promote consistent practices across all county operating models.

Recommendation #4: Assess Current Department of Human Services (DHS) Technical Assistance Practices

Consultant recommends an assessment of current DHS technical assistance practices to improve the provision of targeted and proactive feedback to the statewide network and individual counties. By enhancing technical assistance for the decision-making tool data and other measurements, DHS can promote improved consistency across counties and upstream identification of outliers.

- **Data analysis** indicated significant inconsistency in screen-out rates across Minnesota counties. Two counties had screen-out rates of 88% and 86%, respectively. The remainder of the county screen-out rates ranged from 0% - 66%. Consultant did not observe patterns that were solely attributable to the size or location of the county.
- **Qualitative analysis - stakeholder engagement** demonstrated a need for stakeholders to have better understanding of how data entered into the SDM® Intake Assessment Tool and SSIS is being used to measure performance. Stakeholders did not express clear understanding of how SDM® tool input data is currently leveraged and how it aids DHS in conducting oversight. Technical assistance could be used to promote sound adoption of tools and data entry practices.

- **Stakeholder engagement** showed inconsistency in responses to whether the SDM® Intake Assessment Tool offers value; some focus group participants and APS supervisors found the tool valuable for training new staff members and for keeping statute definitions in one place, while other focus group participants and APS supervisors felt the tool was an additional piece of documentation and did not add value to the intake process.

Recommendation #5: Implement Standardized Sharing of Best Practices Among County APS Agencies

Consultant recommends that DHS implement a standardized method for quarterly statewide calls to review APS-related best practices and share performance findings from recurring data analysis.

- **Systems and policy analysis** showed DHS policy and procedure consistently cite MN statutes. However, stakeholder engagement revealed that the APS network is seeking additional case collaboration to interpret these statutes and policies.

- **Qualitative analysis - stakeholder engagement** indicated multiple stakeholders would like a more collaborative partnership with DHS. We also found that stakeholders would like a place for the APS network to share best practices and ideas with DHS and other lead investigative agencies, both within and outside their respective regions.

Recommendation #6: Modify Screening Timeframes

Consultant recommends DHS modify the mandatory timeframe for deciding the intake and initial disposition from 5 business days following the date the county APS agency is assigned referral of the adult maltreatment report to 48 hours following referral. The adjusted timeframe reflects the urgent nature that often applies to initiating investigation when needed. This recommendation, if implemented will also minimize the volume of telephonic investigative activities that can occur during the screening process.

- **Data analysis**, specifically analysis of the discretionary override "other" free-text entries, revealed that investigative activities are conducted via telephone without contacting the vulnerable adult. Conducting telephonic investigative activities raises safety concerns because workers cannot directly confirm the vulnerable adult's situation or status.

- **Systems and policy analysis** involving MN Statute 626.557 clearly communicated the 5 business day timeframe for making the intake and initial disposition decision, as did the Minnesota Adult Protection Policy and Procedure Manual. However, it is unclear when the response priority timeframe of 24 hours for a level 1 priority response or 48 hours for level 2 response starts. The lack of clarity in timeframe requirements can result in critical delays assessing the vulnerable adult.

- **Qualitative analysis - stakeholder engagement** revealed multiple stakeholders focus on contacting the reporter and confirming collateral input from multiple sources during the intake assessment rather than screening in the referral for investigation to obtain firsthand insight by observation, assessment, and communication with the vulnerable adult.

- During **stakeholder engagement**, the majority of stakeholders reported making screening decisions within approximately two days, suggesting it is feasible to make screening decisions in the recommended 48 hour timeframe.

Recommendation #7: Conduct a Statewide Listening Tour to Address Racial and Ethnic Inequity in Adult Protective Services

Consultant recommends DHS conduct a statewide listening tour that includes APS workforce and an array of external stakeholders, including representatives of racially and ethnically diverse communities, service providers and persons served in the community. The tour would aim to gather feedback on barriers to equitable APS approaches and inform future DHS recommendations for mitigating the risk of inequitable access to APS and/or inequitable service provision. The ultimate outcome would be a series of informed steps that can be taken systemically to foster equitable and culturally competent APS across Minnesota's diverse populations and communities.

- **Data analysis** indicated persons referred to APS who are racial minorities are more likely to be screened out at statistically significant rates through the use of discretionary overrides. This data is not sufficient to determine causality and/or inform improved approaches to best support underserved minorities.

- **Qualitative analysis - stakeholder engagement** demonstrated use of multi-disciplinary adult protection teams and cited the importance of lead investigative agencies providing community partnership and education. Supportive services providers, referring parties, and other influencers need to develop a holistic understanding of culturally competent APS delivery.

- Many **stakeholders** reported it is imperative to address unconscious bias and other factors that impact APS's role in working with racial and ethnic minorities. Stakeholders and DHS were both concerned by the data related to racial disparities in screening decisions and indicated a shared desire to reduce those disparities.

- **Stakeholders** also indicated cultural factors and fear of external interventions used in APS including law enforcement involvement, receipt of formal services and/or engagement with government agencies impact population perspectives on whether APS is a helpful vs. harmful service. Understanding strategies that can best inform APS workers and support program operations so that diverse segments of community see the value and are willing to refer to / engage with APS when appropriate, will help extend protection to vulnerable adults in a culturally competent, individualized and equitable manner.

Recommendation #8: Clarify the Role and Responsibility of Case Managers When Collaborating with an Active APS Case.

Consultant recommends DHS clarify the role and responsibility of active case managers and Adult Protective Services (APS) workers in the intake and investigatory process for all allegation types. This should be done both for allegation type, as the role of the case manager in addressing confirmed maltreatment varies based on their purview (e.g. a case manager can more directly address self-neglect than financial exploitation). Additionally,

there are multiple case management programs in Minnesota that APS workers may interface with across cases, each with different limits and services they coordinate. Further guidance by case management source/program will better define how to maximize partnership.

- **Data analysis** indicated approximately 25% of discretionary override screen-outs fall under the discretionary override "self-neglect" drop-down. This override option is selected when intake determines a referral can be resolved through case management or current services. Approximately 22.2% of discretionary override "other" screen-outs include a rationale of referring or assigning to an active case manager.

- **Systems and policy analysis**, which included review of the Minnesota Adult Protection Structured Decision Making and Standardized Tools Guidelines and Procedures Manual and the Minnesota Adult Protection Policy and Procedure Manual, showed that manuals fail to clearly distinguish between the roles and responsibilities of active case managers and APS workers. Consultant observed an opportunity for DHS to better inform best practice approaches to partnering and teaming in risk assessment, intervention, and planning for difficult-to-engage vulnerable adults.

- **Systems and policy analysis** review of county prioritization guidelines indicated inconsistent approaches to screening out referrals when there is a case manager actively working with the vulnerable adult. For example, some lead investigative agency guidelines instruct workers to screen out all referrals where a case manager is actively working with the vulnerable adult, regardless of the allegation type, while other guidelines instruct workers to only screen out self-neglect allegations where a case manager is actively working with the vulnerable adult.

- **Qualitative analysis - stakeholder engagement** revealed that stakeholders report inconsistent approaches to screening out referrals when a case manager is actively working with the vulnerable adult. For example, some lead investigative agencies screen out all self-neglect referrals where a case manager is in place, while others evaluate the case manager's role in the self-neglect allegation on a case-by-case basis.

Recommendation #9: Establish a Multidisciplinary Workgroup to Develop Policy / Guidance on Applying Protective Services to Individuals with Chemical Dependency

Consultant recommends DHS establish a multidisciplinary workgroup to develop best practice policy or guidance on applying protective services to individuals with chemical disability to promote consistent application of APS for this population.

- **Data analysis** indicated approximately 70% of referrals with identified chemical disability are screened out through discretionary override. This is significantly higher than screen outs among other disability types.

- During **stakeholder engagement**, stakeholders:

    - Reported challenges in determining if the VA referred meets the regulatory definition of a vulnerable adult based on sporadic or event-based vulnerability, including temporary periods of diminished capacity as a result of substance misuse.

- Emphasized an individual's right to self-determination. Unless there are signs of diminished capacity, lead investigative agencies tend to screen out individuals because they do not recognize a role for APS.
- Reported they are increasingly teaming with chemical dependency professionals and services, which could serve as a source of improved statewide practice.

- **Systems and policy analysis** revealed a lack of targeted guidance or policy for how APS workers should screen individuals with a chemical dependency and how to determine if the individuals with chemical dependency meets the definition of a vulnerable adult.

Recommendation #10: Define a Policy for Screening Referrals Where the Vulnerable Adult is in a Hospital or Short-Term Facility

Consultant recommends DHS define a policy for screening referrals where the individual vulnerable adult is in a hospital, short-term / sub-acute, or facility-based setting. Consultant recommends developing this policy to decrease the risk to vulnerable adults being discharged back to the community without a safety plan and/or timely APS follow-up.

- **Data analysis**, specifically analysis of the discretionary override "other" field, indicated a reliance on hospital discharge planners to address the vulnerable adult's safety needs. When APS entered rationale that the vulnerable adult was safe and would receive a safe discharge, they did not document how APS services could be leveraged.

- During **stakeholder engagement**, Consultant observed a lack of APS network understanding of what constitutes a "safe discharge" in an acute care setting and how to address community-based risks and alleged maltreatment.

- **Systems and policy analysis** showed a lack of clear guidance or policy for APS workers to follow when they screen referrals where the vulnerable adult is in a hospital or short-term facility.

Recommendation #11: Limit the Ability to Use "Other" Throughout the SDM® Intake Assessment Tool

Consultant recommends DHS limit the ability to use "other" as a discretionary override throughout the SDM® Intake Assessment Tool by offering more discrete data options, based on observed trends in the current screening methods, such as adding character limits to free text boxes, adding additional drop-down categories, and/or eliminating the free text option where possible.

- **Data analysis**, specifically discretionary override – other analysis, indicates case note style entries when APS workers select the "other" option and enter a free text rationale and reason for why the adult maltreatment report was screened out. Free text fields are difficult for DHS to analyze and track trending reasons for screen out.

- **Systems and policy analysis** revealed a lack of targeted guidance on the types of information DHS expects to see in the SDM® Intake Assessment Tool free text boxes.

Recommendation #12: Implement SSIS Functionality to View Multiple Screens

Consultant recommends DHS implement SSIS functionality to allow the supervisor or designated reviewer the ability to view multiple screens when working in SSIS. This includes adding functionality that would allow a reviewer to read case notes while simultaneously viewing the SDM® Intake Assessment Tool, along with functionality to view the adult maltreatment report while viewing and finalizing results of the SDM® Intake Assessment Tool.

- During **qualitative analysis – stakeholder engagement**:
    - Supervisors indicated that they need to review the case notes and SDM® Intake Assessment Tool simultaneously, but current functionality does not allow for this. Improved functionality is likely to reduce "free text" entry which is currently used to aid supervisory review. This should promote improved accuracy in data entry.
    - APS workers requested that the adult maltreatment report be visible while viewing the SDM® Intake Assessment Tool to allow them to review the details of the report while affirming the screening status of the referral.

Recommendation #13: Implement SSIS Functionality for Information and Referral Capture at Screening

Consultant recommends DHS add SSIS functionality accessible during the intake screening process that would allow the APS Worker to record any service information and/or referrals provided prior to screen out. Implementing this recommendation would help to better capture the full impact of APS in linking VA referred to services and supports in the community that can improve their safety, quality of life and meet community-based needs identified by the referring party or during the screening review.

- **Qualitative analysis – stakeholder engagement** revealed that stakeholders provide referrals or service applications to individuals during the intake screening process for referrals that are subsequently screened out. The SDM® Intake Assessment Tool does not provide a location to capture referrals supplied at intake. Stakeholders document referrals in case notes, making it nearly impossible for DHS to track.
- **Data analysis** – equity of outcomes was impossible to study comprehensively because stakeholders currently enter information and referral in case notes, which is difficult for DHS to track.

Recommendation #14: Implement SSIS Functionality Requiring APS Workers Enter Interventions at Case Closure, Regardless of Determination

Consultant recommends DHS add SSIS functionality that requires the APS Worker to record any targeted interventions and/or direct referral to service providers during the intake screening or investigation process and

prior to case closure, regardless of final determination. Implementing this recommendation would help to better measure the full impact of APS in linking those VA screened-in for investigation to services and supports in the community that can improve their safety, quality of life and meet community-based needs identified during the investigation process – even if maltreatment is not confirmed.

- **Systems and policy analysis** confirmed that SSIS requires workers enter an intervention for all substantiated cases. **Data analysis** showed that during the review period, 11% of reports ultimately screened in were substantiated and 30% had no recorded determination available.
    - **Data analysis** – equity of outcomes is not currently possible because interventions are only required for entry in the SSIS interventions tab for substantiated reports. Approximately 22% of ultimately screened in reports include a documented intervention.
- During **qualitative analysis – stakeholder engagement**, stakeholders indicated they do not consistently complete the intervention tab for false or inconclusive reports; however, they often provide service referrals in false or inconclusive investigations.

Recommendation #15: Conduct Future Evaluation Following Implementation of Recommendations

Consultant recommends DHS monitor the impact of implementing Recommendations #1 through #14 to identify if statewide screening rates increase to within 10% of the national average (or higher) as measured via the NAMRS system. If screening rates do not improve accordingly following operational and policy changes, the State may need to initiate regulatory changes that disallow discretionary overrides of the screening result when using the SDM® Decision Making Tool. Consultant also recommends performing a validity study of the tool once there is confidence it is being used as designed.

When implementing these recommendations, Consultant suggests DHS start with a collaborative approach, using a combination of policy, programmatic and consensus-building actions to build a shared understanding of expected and best practices to improve accurate use of the SDM® tool and resulting screening rates.

Ultimately, given that the MN screen-out rates are much higher than the national average when discretionary override is applied, discretionary decisions may pose risk to objective and equitable decision making when screening incoming APS cases.

APPENDIX A: RESEARCH STUDY PLAN

Submitted to DHS on 12/9/2020

Overview

This research plan outlines the Consultant's approach to evaluate the Adult Protective Services (APS) Structured Decision Making® (SDM®) Intake Assessment Tool. The SDM® Intake Assessment Tool is currently being used by county agencies to screen reports of vulnerable adults alleged to have been maltreated.

This research plan details the anticipated methods, risks, and outputs for:

- **Data analysis**, including statistical significance and correlations of key SDM® Intake Assessment Tool data components
- **Analysis of equity outcomes** for vulnerable adults referred to APS
- **Systems analysis** of program-related documents including, but not limited to:
    - Policies
    - Workflows
    - Procedure Manuals
    - Trainings
- **Stakeholder Engagement analysis** including interviews and other modalities

Post-study recommendations are intended to support the Department of Human Services' (DHS) goal of reinforcing that current intake tools drive sound decision-making and consistency. Sound and consistent approaches to program decision-making should assure that vulnerable adults referred to APS for alleged abuse, neglect and/or exploitation (ANE) receive equitable access to APS investigation and supports to address confirmed incidents of ANE and abate future incidents.

The Consultant will deliver findings from each element of the research plan along with a final summary in a formal study report. We anticipate delivering a preliminary draft report for review by DHS in May 2021. We will also share a summary of findings and post-study recommendations with an advisory study workgroup of APS representatives throughout the state to promote stakeholder inclusion and advisement throughout the study process. A final report will be submitted to DHS in June 2021.

The research plan below details the following steps:

- **Step 1:** Perform Quantitative Analysis
- **Step 2:** Analyze Equity Outcomes
- **Step 3**: Conduct Systems Analysis of Workflows, Guidance, Policies, and Trainings
- **Step 4**: Conduct Stakeholder Engagement Activities
- **Step 5:** Identify Recommendations and Develop Draft and Final Study Report

> **Objective:** Analyze referral and SDM® Intake Assessment Tool input data to identify statistically significant correlations that will evaluate the validity of the tool, including identifying any variations that suggest opportunities exist to enhance the tool's validity when used during the case acceptance decision-making process.

Step 1: Perform Quantitative Analysis

The Consultant will conduct a comprehensive review and analysis of APS reports, SDM® Intake Assessment Tool fields, determinations, services offered and demographic and SDM® Intake Assessment Tool data. This review will identify any variances that suggest components of the tool that may need to be improved to promote sound and reliable tool application. Findings will also provide initial insights into variables that could be influencing validity that can be addressed through additional state-level guidance and quality assurance.

We anticipate reviewing the following data elements from the SDM® Intake Assessment Tool to inform the analysis:

- Referral information:
    - Age
    - Race / Ethnicity
    - Gender
    - Disability status / type
    - Geographic location of vulnerable adult
    - Geographic location of alleged perpetrator
    - Type of maltreatment allegation
- Tool usage information:
    - SDM® Intake Assessment Tool fields

- Association of the override option with screening determinations and service outcomes
- County-specific inputs within decision making fields
- Final intake screening decisions
- Categorical referring party
- Case closure / outcomes

The purpose of reviewing the above data collection is to:

- Analyze for variances in data entry and decision making into the SDM® Intake Assessment Tool and if those differences correlate to referral details at a rate significant enough to suggest a pattern of inconsistent application of SDM® based on referral details.
- Identify correlations between county specific intake patterns, screening decisions, and service outcomes
- Determine if the tool guidance results in valid screening decisions based on determination outcomes and service interventions

Figure 1 below describes various analyses and associated tasks that the Consultant will pursue to complete Step One of this study.

Figure 1. Step One Research Elements

Research Activities	1. **Analyze data and provide the statistical significance and correlations of key data components.** Consultant will: a. Gather SDM® Intake Assessment Tool data and information from publicly available data as well as via specific data requests from DHS; b. Analyze the current demographics, policies, and other metrics which may be impacting the consistency of intake screening decisions; c. Conduct multivariate regression modeling to further evaluate the influences of key components and influence of variables on the outcomes; d. Summarize observations with a "report card" style finding that includes a series of tables, charts, maps, and additional visualizations to demonstrate correlational findings between counties; and e. Present findings to DHS team.
Anticipated Timing	December 2020 – February 2021
Involved Parties and Roles	**Consultant:** Review and analyze data; develop summaries of findings. **DHS:** Provide accurate and complete data
Resulting Deliverables	1. **Data analysis and visualizations**: to objectively and transparently share data analysis details in tables and map findings at the county level to depict statewide trends. 2. **Summary findings**: to share with DHS (and in the study report) macro-level findings across broader data analytics and potential indicators to study.

Step 2: Analyze Equity Outcomes

The Consultant will use information learned during Step 1 to analyze the equity of service outcomes for vulnerable adults. Our goal in this step is evaluate the extent to which throughout the delivery system, individuals referred to APS are equitably linked to services and supports that can assist them. In order to further

examine and analyze current service outcomes, we will review both publicly available information as well as DHS provided data.

Figure 2 below describes various analyses and associated tasks that the Consultant will pursue to complete Step Two of this study.

Figure 2. Step Two Research Elements

Research Activities	**1. Analyze equity in outcomes for vulnerable adults.** Consultant will: a. Review and analyze APS reports (captured within SSIS) by county demographics, including age, race, gender, disability and geographic location; b. Review the vulnerable adult's status in medical assistance programs and services to compare service outcomes and determine the impact of participation in DHS programs and services on outcomes; and c. Analyze case demographic information and eligibility data to determine if access gaps exist for APS-accepted individuals who demonstrate eligibility for services but are not accessing Medicaid.
Anticipated Timing	February 2021 – March 2021
Involved Parties and Roles	**Consultant:** Review and analyze outcome data; develop summaries of findings **DHS:** Provide accurate and complete data
Resulting Deliverables	**1. Data analysis and visualizations**: to share outcome information and analysis as well as map equity outcome findings at the county level to depict statewide trends **2. Summary of findings**: to share findings with DHS, include in the final report as an appendix and provide recommendations to DHS to aid in determining the equity of outcomes for vulnerable adults, including those not participating in a medical assistance program or service through DHS

Step 3: Conduct Systems Analysis of Workflows, Guidance, Policies, and Trainings

The Consultant will conduct a comprehensive desk review of SDM® Intake Assessment Tool related workflows, guidance, policies, and trainings to review for operational consistency among the tools and resources currently in use. Our desk review will focus on analyzing and reviewing for the following factors that, when addressed, promote operational consistency:

- Policies offer sufficient clarity to minimize "gray-area"
- Information is conveyed in a way that maintains information accuracy during information sharing
- Operating procedures are clear, practical, and efficient
- Standardized tools and guidance on the use of each tool can be readily understood
- Training practices are sound and address known challenges to consistent practice and decision-making
- Mechanisms are in place to monitor performance and offer technical assistance when needed

Outside of the SDM® Intake Assessment Tool, lead investigative agencies currently develop their own prioritization guidelines, intake processes, and inputs. The Consultant will review differences between these prioritization guidelines to evaluate if this is a contributing factor to observed patterns in decision-making and/or service outcomes. Consultant will review a representative sample of county policies and will work with DHS to confirm the sampling is sufficiently representative of all Minnesota counties.

Figure 3 below describes various analyses and associated tasks that the Consultant will pursue to complete Step Three of this study.

Figure 3. Step Three Research Elements

Research Activities	**1. Conduct systems analysis of workflows, guidance, policies, and trainings.** Consultant will: a. Perform a desk review of Social Service Information System (SSIS) workflows and APS standardized tool-related training materials, manuals, and guidance from DHS and a representative sample of counties; b. Draft summary and analysis of findings; and c. Present findings to DHS team.
Anticipated Timing	December 2020 – February 2021
Involved Parties and Roles	**Consultant:** Review and analyze documents; develop summary of findings. **County Agencies:** Fulfill any requests for county-specific documents, as necessary **DHS:** Provide relevant materials for review; provide communication materials for counties selected to share prioritization guidelines
Resulting Deliverables	**1. Summary of findings:** to include within the final report appendix. Summary will include a visual depiction of the degree to which workflows, guidance, policies, and trainings are clear and consistent; identify and recommend suggested material modifications and next steps

Step 4: Conduct Stakeholder Engagement Activities

In this step, the Consultant will engage county stakeholders to gather additional input on the SDM® Intake Assessment Tool, how processes are impacted by the operating environment and solicit feedback on how to continue improving systems and approaches. Along with findings from quantitative analysis conducted within Step One, stakeholder input will further inform post-evaluation recommendations on steps that DHS can take to enhance tool validity and reliability. Step Four includes options for stakeholder engagement modalities. The preferred stakeholder engagement option will be determined once data analysis has been performed and the nature of focus topics is clear. Options will be selected based on which engagement method is most likely to maximize stakeholder candor and constructive feedback.

Consultant proposes to discuss the following items in meetings with stakeholders:

- County intake processes and operations
- County prioritization guideline analysis
- County-specific workflows
- County staffing resources
- Operational realities / challenges
- Observations and lessons learned using the SDM® Intake Assessment Tool

Figure 4 below describes the various strategies the Consultant will pursue to obtain comprehensive and accurate stakeholder input for this evaluation.

Figure 4. Step Four Research Elements

Research Activities	**1. Conduct stakeholder interviews**. Consultant will: a) Establish interviewees with DHS team, including up to ten targeted APS supervisors / workers; b) Prepare meeting materials and coordinate meeting scheduling and logistics; c) Conduct Interviews; and d) Compile post-interview notes and prepare summary of interview themes *1. [OPTION 1 of 2]* **Perform a series of interactive focus groups.** *Recommended option if data analysis reflects wide range of disparities across counties.* Consultant will: a. Prepare focus group materials and coordinate logistics; b. Host six, 90-minute focus groups, each with 8-10 attendees, including APS workers, supervisors, county administrators, and DHS representatives; and

	c. Review session transcripts to establish themes and findings. 2. *[OPTION 2 of 2]* **Design and deploy a web-based survey.** *Recommended if data analysis reflects potential operational concerns or non-compliance with state trainings and guidance.* Consultant will: a. Develop survey tool questions and confirm question with APS Study Advisory Workgroup; b. Design questions in Qualtrics platform for dissemination; c. Develop and release survey tool link with a briefing memorandum articulating the survey goals, objectives and instructions; d. Hold open survey period with periodic completion prompts via email blast; and e. Close survey tool and analyze findings.
Anticipated Timing	March 2021 – May 2021
Involved Parties and Roles	**Consultant:** Prepare interview questions, agendas, and other meeting materials; facilitate meetings and summarize proceedings. **DHS:** Secure meeting times and locations; identify stakeholder participants; review and approve Consultant-prepared materials; identify providers for site visits and coordinate logistics **Stakeholders:** Provide input
Resulting Deliverables	**1. Stakeholder Interviews** a. Interview communication and schedule b. Interview template c. Interview facilitation

	d. Post-interview summary of findings **2. Focus Groups** a. Focus group invitation and statement of purpose b. Focus group meeting agenda/discussion guide c. Session facilitation d. Post-meeting transcript and summary of findings **3. Web-Based Surveys** a. Full list of survey questions with multiple choice options (as applicable) b. Survey briefing memorandum c. Qualtrics Survey weblink d. Draft of reminder emails e. Summary of post-survey findings (to be included within the final report) with raw data table

Step 5: Identify Recommendations and Develop Draft and Final Study Report

The Consultant will report study outcomes and findings from Steps One – Four and will use these findings to inform recommendations for program optimization, which will be included in a final evaluation report to DHS. To allow DHS input into the report contents before finalization, we will share our preliminary recommendations with DHS by submitting a draft report for departmental review and comment. We will also present a summary of our findings and proposed recommendations to the study advisory panel in May 2021 to obtain stakeholder input before delivering a final report.

Figure 5 below describes the individual tasks associated with identifying recommendations and developing the draft and final study reports.

Figure 5. Step Five Research Elements

Research Activities	**1. Identify recommendations**. Consultant will:

	a. Collect findings from both quantitative and qualitative study pertaining to validity and consistency in use of the standardized APS intake decision making tool including: i. Statistical significance and correlations observed within data analysis; ii. Workflow differences observed via systems analysis that may drive variability that undermines tool validity; iii. Practical and operational observations identified during county agency/stakeholder engagement activities that could introduce variability that undermines tool validity; and b. Identify recommendations that would enhance the SDM® Intake Assessment Tool's validity and consistent use, including but not limited to policy, training, and technical recommendations. **2. Develop draft report.** Consultant will: a. Summarize research and analytic methodology; b. Describe challenges encountered during the evaluation process and how they were addressed; c. Share findings and recommendations; and d. Include appendices with detailed study findings and/or pertinent stakeholder engagement materials. **3. Review draft report** with both DHS and the stakeholder workgroup and incorporate remaining feedback prior to finalizing. **4. Finalize report and share with DHS.**
Estimated Timing	May 2021 – June 2021
Involved Parties and Roles	**Consultant:** Develop preliminary recommendations; develop draft and final reports **DHS:** Provide feedback **Stakeholders:** Provide feedback

Resulting Deliverables	1. **Draft report:** to present analyses and findings to DHS and stakeholders for review and input prior to finalizing report 2. **Final report:** to document findings, DHS and stakeholder input, and share recommendations 3. **Presentation materials:** to summarize the final report and highlight key finding takeaways

Advisory Study Workgroup

Consultant and DHS will seek additional input from an Advisory Study Workgroup to support strategic and effective stakeholder involvement in the study. The Advisory Study Workgroup is slated to meet three times throughout the study and will provide input into many of the study elements. Figure 6 contains the proposed meeting dates and topics.

Figure 6. Proposed Advisory Meeting Dates and Topics

Meeting Schedule *(Anticipated)*	Meeting Topics
December 2020	• Review study purpose and proposed design • Discuss and gather input on proposed study parameters
March 2021	• Review and discuss data-based findings and process reviews • Discuss and obtain input on stakeholder engagement exercises
May 2021	• Review preliminary findings and recommendations • Obtain input to finalize the recommendations included in the report

The Advisory Study Workgroup will be comprised of County APS leadership and will represent each of the 12 Minnesota Association of County Social Service Administrators (MACSSA) regions. Refer to Appendix A for a copy of the Advisory Study Workgroup Charter, which further details the roles and responsibilities of advisory study workgroup members.

Potential Risks and Challenges

Figure 7 below highlights potential risks and challenges to the study and corresponding mitigation plans the Consultant will pursue for each risk.

Figure 7. Potential Risks and Challenges

Potential Risks	**1. Data requests.** Data obtained should be free of data integrity challenges including: inaccuracy, gaps in data, or contain duplicate or invalid data. Observed data integrity issues may delay data analysis (Step One) and achievement of later project milestones. a. Consultant will follow a comprehensive, standard process to request specific, detailed data from DHS. 2. The **COVID-19 public health emergency** may continue to necessitate remote stakeholder engagement methods due to existing restrictions on in-person meetings. **3. Advisory workgroup and focus groups:** Workgroups **/ f**ocus groups should ideally provide representative insights that span the full stakeholder network. Failure to achieve this may impact the qualitative information received to perform the study. a. Consultant will use stakeholder input to supplement data-driven findings from analysis, rather than using qualitative data to solely inform findings and recommendations. b. Consultant will conduct stakeholder engagement using additional methods, including distributing web-based surveys and conducting interviews. c. Consultant will draft a charter outlining rules for workgroup participation to help structure discussion and optimize stakeholder feedback. d. Consultant may also hold follow-up conversations with stakeholders to confirm feedback. e. The COVID-19 public health emergency may continue to necessitate remote engagement methods due to existing restrictions on in-person meetings.

	4. Stakeholder interviews: Scheduling will require flexibility to accommodate schedules of interviewees. If selected interviewees are uncomfortable with answering questions posed, that could impede the accuracy of information received. a. Consultant will remain flexible with meeting format / platform and will assure anonymity and confidentiality.

We will work closely with DHS to track these and other emergent risks or challenges and advise DHS on potential strategies and risk mitigation steps to promote a sound study process and outcomes.

APPENDIX B. DATA FINDINGS

Figure 1. Initial Reports and Screening Decisions

Initial Screen-In Results	Count	% of Total Reports
Initial Reports for County	40,510	
Initial Screened In via SDM® Tool	23,970	59%
Initial Screened Out	16,540	41%

Figure 2. Final Screening Decisions

Initial Screen-In Results	Count	% of Initial Screen-Ins	% of Total Reports
Override to Screen-Out	14,155	59%	35%
Final Screen-In	9,815	41%	24%
Duplicate Identified	1,010	7%	2%

Figure 3. Screen-In Rates Among Counties Per 1,000 Residents

(Sorted by 2019 Population from Lowest to Highest Population)

County Name	Initial Reports	Initial Screen-Ins via SDM® Tool	Total Reports Overridden via Discretionary Override	Population in 2019	Total Initial Reports Per 1,000 Residents	Total Initial Screen-In's Per 1,000 Residents	Total Overrides Per 1,000	% of Reports Overridden via Discretionary Override
	A	B	C	D	E = (A/D)*1000	F = (B/D)*1000	G = (C/D)*1000	H = G/F
Traverse	43	29	7	3,263	13.18	8.89	2.15	24%
Lake of the Woods	15	13	3	3,798	3.95	3.42	0.79	23%
Red Lake	8	3	1	4,030	1.99	0.74	0.25	33%
Kittson	9	4	-	4,299	2.09	0.93	-	0%
Big Stone	50	36	12	4,993	10.01	7.21	2.40	33%
Cook	32	29	6	5,462	5.86	5.31	1.10	21%
Mahnomen	43	31	13	5,529	7.78	5.61	2.35	42%

County Name	Initial Reports	Initial Screen-Ins via SDM® Tool	Total Reports Overridden via Discretionary Override	Population in 2019	Total Initial Reports Per 1,000 Residents	Total Initial Screen-In's Per 1,000 Residents	Total Overrides Per 1,000	% of Reports Overridden via Discretionary Override
	A	B	C	D	E = (A/D)*1000	F = (B/D)*1000	G = (C/D)*1000	H = G/F
Grant	86	56	17	5,967	14.41	9.38	2.85	31%
Wilkin	33	15	5	6,226	5.30	2.41	0.80	33%
Norman	45	12	1	6,367	7.07	1.88	0.16	8%
Lac qui Parle	45	32	7	6,629	6.79	4.83	1.06	22%
Clearwater	71	51	3	8,808	8.06	5.79	0.34	6%
Marshall	27	19	9	9,342	2.89	2.03	0.96	47%
Swift	71	48	6	9,367	7.58	5.12	0.64	13%
Yellow Medicine	86	59	8	9,729	8.84	6.06	0.82	14%

County Name	Initial Reports	Initial Screen-Ins via SDM® Tool	Total Reports Overridden via Discretionary Override	Population in 2019	Total Initial Reports Per 1,000 Residents	Total Initial Screen-In's Per 1,000 Residents	Total Overrides Per 1,000	% of Reports Overridden via Discretionary Override
	A	B	C	D	E = (A/D)*1000	F = (B/D)*1000	G = (C/D)*1000	H = G/F
Stevens	53	38	8	9,766	5.43	3.89	0.82	21%
Lake	8	3	-	10,632	0.75	0.28	-	0%
Watonwan	54	39	7	10,923	4.94	3.57	0.64	16%
Pope	90	49	11	11,139	8.08	4.40	0.99	22%
Chippewa	85	67	24	11,858	7.17	5.65	2.02	36%
Koochiching	95	11	4	12,430	7.64	0.88	0.32	36%
Wadena	212	90	-	13,744	15.42	6.55	-	0%
Pennington	48	21	1	14,355	3.34	1.46	0.07	5%

County Name	Initial Reports	Initial Screen-Ins via SDM® Tool	Total Reports Overridden via Discretionary Override	Population in 2019	Total Initial Reports Per 1,000 Residents	Total Initial Screen-In's Per 1,000 Residents	Total Overrides Per 1,000	% of Reports Overridden via Discretionary Override
	A	B	C	D	E = (A/D)*1000	F = (B/D)*1000	G = (C/D)*1000	H = G/F
Renville	127	42	15	14,588	8.71	2.88	1.03	36%
Sibley	66	37	17	14,899	4.43	2.48	1.14	46%
Roseau	31	13	4	15,242	2.03	0.85	0.26	31%
Aitkin	176	115	37	15,870	11.09	7.25	2.33	32%
Kanabec	127	54	16	16,310	7.79	3.31	0.98	30%
Houston	106	23	-	18,626	5.69	1.23	-	0%
Fillmore	132	50	12	21,060	6.27	2.37	0.57	24%
DVHHS	114	72	33	21,074	5.41	3.42	1.57	46%

County Name	Initial Reports	Initial Screen-Ins via SDM® Tool	Total Reports Overridden via Discretionary Override	Population in 2019	Total Initial Reports Per 1,000 Residents	Total Initial Screen-In's Per 1,000 Residents	Total Overrides Per 1,000	% of Reports Overridden via Discretionary Override
	A	B	C	D	E = (A/D)*1000	F = (B/D)*1000	G = (C/D)*1000	H = G/F
Hubbard	143	126	57	21,494	6.65	5.86	2.65	45%
Wabasha	165	70	-	21,614	7.63	3.24	-	0%
Nobles	86	31	18	21,976	3.91	1.41	0.82	58%
Meeker	196	56	13	23,256	8.43	2.41	0.56	23%
Todd	193	101	35	24,665	7.82	4.09	1.42	35%
Brown	150	64	34	25,119	5.97	2.55	1.35	53%
Mille Lacs	295	65	35	26,227	11.25	2.48	1.33	55%
LeSueur	159	40	6	28,894	5.50	1.38	0.21	15%

County Name	Initial Reports	Initial Screen-Ins via SDM® Tool	Total Reports Overridden via Discretionary Override	Population in 2019	Total Initial Reports Per 1,000 Residents	Total Initial Screen-In's Per 1,000 Residents	Total Overrides Per 1,000	% of Reports Overridden via Discretionary Override
	A	B	C	D	E = (A/D)*1000	F = (B/D)*1000	G = (C/D)*1000	H = G/F
Pine	329	147	32	29,526	11.14	4.98	1.08	22%
Cass	394	198	67	29,754	13.24	6.65	2.25	34%
Freeborn	276	147	51	30,364	9.09	4.84	1.68	35%
Polk	277	122	75	31,524	8.79	3.87	2.38	61%
Faribault/Martin	319	229	111	33,332	9.57	6.87	3.33	48%
Morrison	273	62	8	33,368	8.18	1.86	0.24	13%
Nicollet	243	93	33	34,323	7.08	2.71	0.96	35%
Becker	303	161	142	34,545	8.77	4.66	4.11	88%

County Name	Initial Reports	Initial Screen-Ins via SDM® Tool	Total Reports Overridden via Discretionary Override	Population in 2019	Total Initial Reports Per 1,000 Residents	Total Initial Screen-In's Per 1,000 Residents	Total Overrides Per 1,000	% of Reports Overridden via Discretionary Override
	A	B	C	D	E = (A/D)*1000	F = (B/D)*1000	G = (C/D)*1000	H = G/F
Carlton	359	123	21	35,935	9.99	3.42	0.58	17%
McLeod	270	144	70	35,963	7.51	4.00	1.95	49%
Douglas	338	124	48	38,220	8.84	3.24	1.26	39%
Mower	421	193	57	40,124	10.49	4.81	1.42	30%
Isanti	290	144	81	40,566	7.15	3.55	2.00	56%
Benton	297	167	55	40,895	7.26	4.08	1.34	33%
Kandiyohi	331	159	33	43,193	7.66	3.68	0.76	21%
Itasca	362	98	22	45,203	8.01	2.17	0.49	22%

County Name	Initial Reports	Initial Screen-Ins via SDM® Tool	Total Reports Overridden via Discretionary Override	Population in 2019	Total Initial Reports Per 1,000 Residents	Total Initial Screen-In's Per 1,000 Residents	Total Overrides Per 1,000	% of Reports Overridden via Discretionary Override
	A	B	C	D	E = (A/D)*1000	F = (B/D)*1000	G = (C/D)*1000	H = G/F
Goodhue	270	61	19	46,449	5.81	1.31	0.41	31%
Beltrami	443	231	39	47,184	9.39	4.90	0.83	17%
Winona	310	84	27	50,830	6.10	1.65	0.53	32%
Chisago	461	204	54	56,613	8.14	3.60	0.95	26%
Otter Tail	557	391	174	58,734	9.48	6.66	2.96	45%
Clay	562	359	161	64,591	8.70	5.56	2.49	45%
Crow Wing	578	171	93	65,274	8.85	2.62	1.42	54%
Rice	334	208	53	66,853	5.00	3.11	0.79	25%

County Name	Initial Reports	Initial Screen-Ins via SDM® Tool	Total Reports Overridden via Discretionary Override	Population in 2019	Total Initial Reports Per 1,000 Residents	Total Initial Screen-In's Per 1,000 Residents	Total Overrides Per 1,000	% of Reports Overridden via Discretionary Override
	A	B	C	D	E = (A/D)*1000	F = (B/D)*1000	G = (C/D)*1000	H = G/F
Blue Earth	486	182	59	68,583	7.09	2.65	0.86	32%
SWHHS	562	241	85	73,200	7.68	3.29	1.16	35%
MNPrairie	504	274	136	76,703	6.57	3.57	1.77	50%
Sherburne	540	412	23	97,520	5.54	4.22	0.24	6%
Carver	302	131	48	107,179	2.82	1.22	0.45	37%
Wright	867	678	224	138,531	6.26	4.89	1.62	33%
Scott	525	159	30	148,458	3.54	1.07	0.20	19%
Stearns	933	643	345	160,211	5.82	4.01	2.15	54%

County Name	Initial Reports	Initial Screen-Ins via SDM® Tool	Total Reports Overridden via Discretionary Override	Population in 2019	Total Initial Reports Per 1,000 Residents	Total Initial Screen-In's Per 1,000 Residents	Total Overrides Per 1,000	% of Reports Overridden via Discretionary Override
	A	B	C	D	E = (A/D)*1000	F = (B/D)*1000	G = (C/D)*1000	H = G/F
Olmsted	843	290	111	160,431	5.25	1.81	0.69	38%
St. Louis	1,814	369	119	199,661	9.09	1.85	0.60	32%
Washington	1,159	344	34	262,748	4.41	1.31	0.13	10%
Anoka	2,480	1,511	937	362,648	6.84	4.17	2.58	62%
Dakota	2,453	1,060	200	433,302	5.66	2.45	0.46	19%
Ramsey	4,438	1,916	1,268	558,248	7.95	3.43	2.27	66%
Hennepin	10,432	10,026	8,525	1,279,981	8.15	7.83	6.66	85%

Demographics

Figure 4. APS Screening Decisions by Abuse Type Reported for the Person

Abuse Type	Total Initially Screened In via SDM® Tool	Number of Total Reports Overridden to Screen-Out	Number of Final Screen-Ins	% of Total Reports Overridden to Screen-Out	% of Final Screen-Ins	% of Total Initially Screened In via SDM® Tool
	A	B	C	D = B / A	E = C / A	
Self-Neglect	11,164	7,081	4,083	63%	37%	38%
Financial Exploitation	6,698	3,245	3,453	48%	52%	23%
Caregiver Neglect	4,652	2,619	2,033	56%	44%	16%
Emotional Abuse	3,774	2,305	1,469	61%	39%	13%
Physical Abuse	2,543	1,578	965	62%	38%	9%
Sexual Abuse	927	570	357	61%	39%	3%
Total Screened In	**29,758**	**17,398**	**12,360**	**58%**	**42%**	**100%**
Total Reported	**40,510**					

Figure 5. APS Screening Decision Trends by Abuse Type Reported for the Person

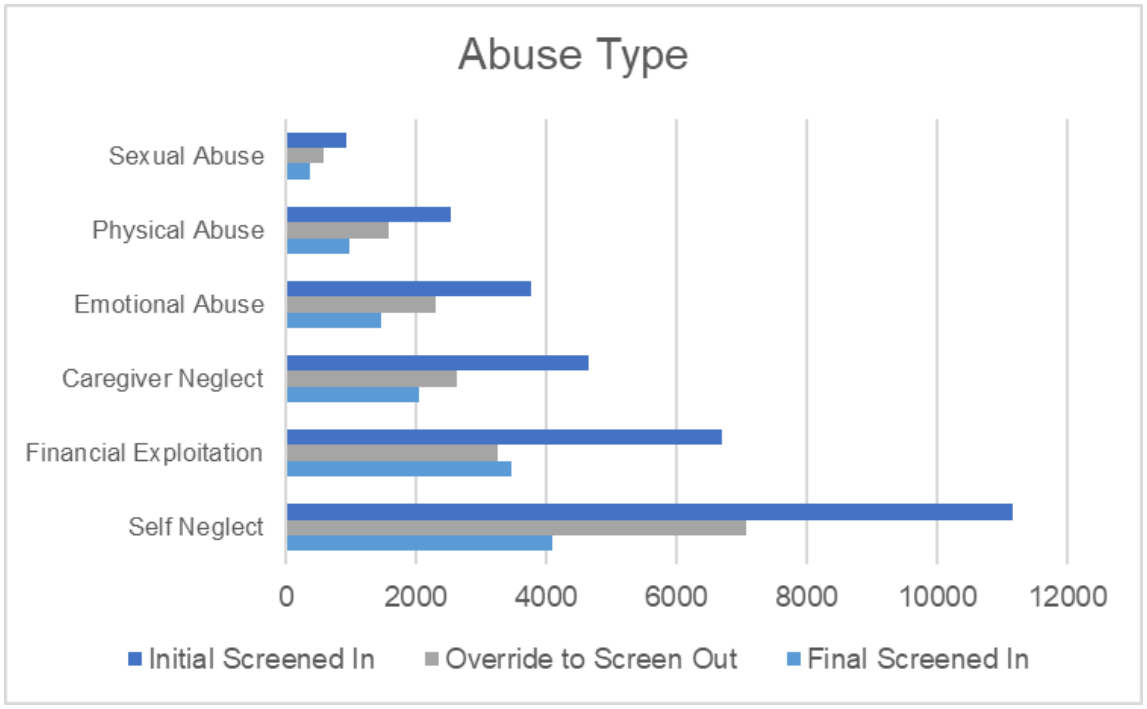


Figure 6. APS Screening Decisions by Disability Type Reported for the Person

Disability Type	Number of Initial Reports	Total Initially Screened-In via SDM® Tool	Total Reports Overridden via Discretionary Override	# of Final Reports Screened In	% of Reports Overridden to Screen-Out	% of Final Screen-In's
	A	B	C	D	E = C / B	F = D / B
Physical	19,110	11,918	6,883	5,035	58%	42%
Mental	17,677	10,521	6,568	3,953	62%	38%
Impaired reasoning or judgment	16,237	10,087	5,705	4,382	57%	43%
Impaired memory	11,571	7,362	3,811	3,551	52%	48%
Frailty of aging	11,809	7,301	3,659	3,642	50%	50%
Chemical	5,408	3,185	2,223	962	70%	30%
Developmentally disabled	4,253	2,659	1,570	1,089	59%	41%
Traumatic brain injury	3,008	1,899	1,196	703	63%	37%

Disability Type	Number of Initial Reports	Total Initially Screened-In via SDM® Tool	Total Reports Overridden via Discretionary Override	# of Final Reports Screened In	% of Reports Overridden to Screen-Out	% of Final Screen-In's
	A	B	C	D	E = C / B	F = D / B
Total	**89,073**	**54,932**	**31,615**	**23,317**	**58%**	**42%**

**Types of disability are not mutually exclusive. One report could have multiple types of suspected abuse.*

Figure 7. APS Screening Decision Trends by Disability Type Reported for the Person

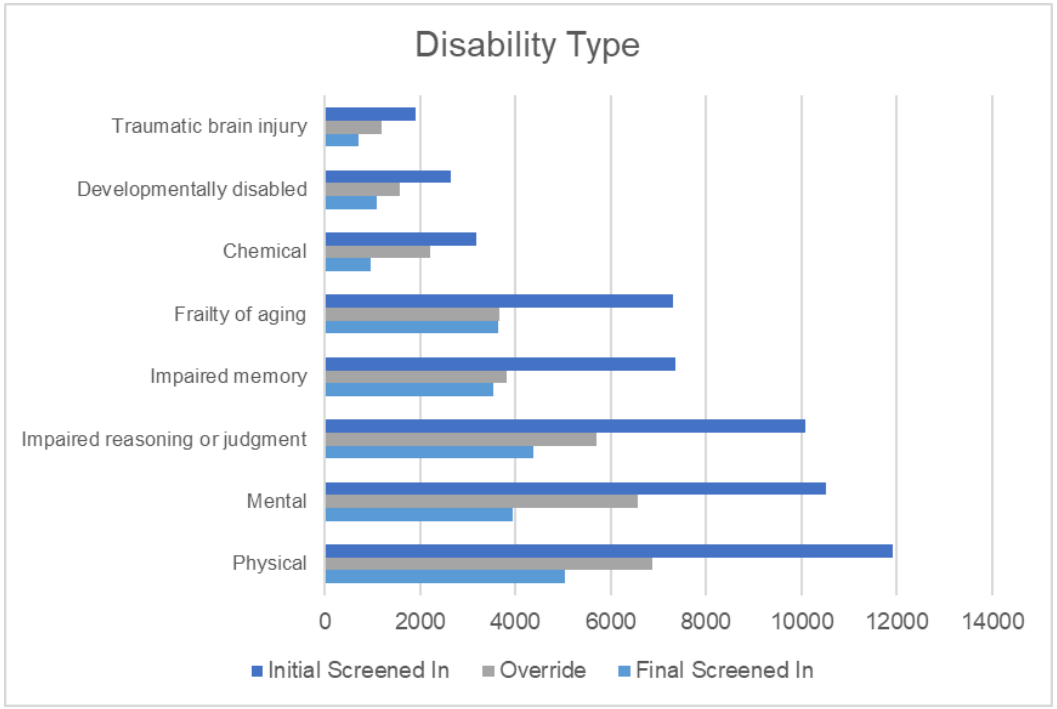


Figure 8. APS Screening Decisions for Persons Reported as Experiencing Chemical Disability by Age Band

Age Bands	Total Number of Reports	Total Initially Screened-In via SDM® Tool	Total Referrals Overridden via Discretionary Override	Final Number of Reports Screened In	% of Reports Overridden to Screen-Out	% of Reports with Final Screen-In's	% Of Total Initial Screened-In Reports
	A	B	C	D	E = C / B	F = D / B	G
18-29	524	296	223	73	75%	25%	14%
30-39	621	316	255	61	81%	19%	21%
40-49	589	341	265	76	78%	22%	20%
50-59	1,177	672	463	209	69%	31%	22%
60-69	1,461	927	619	308	67%	33%	20%
70-74	440	281	167	114	59%	41%	11%
75-84	380	248	153	95	62%	38%	5%
85+	56	33	21	12	64%	36%	1%

Age Bands	Total Number of Reports	Total Initially Screened-In via SDM® Tool	Total Referrals Overridden via Discretionary Override	Final Number of Reports Screened In	% of Reports Overridden to Screen-Out	% of Reports with Final Screen-In's	% Of Total Initial Screened-In Reports
	A	B	C	D	E = C / B	F = D / B	G
Total	**5,248**	**3,114**	**2,166**	**948**	**70%**	**30%**	**14%**

**Total referenced in column G is related to aggregate age band table.*

Figure 9. APS Screening Decisions by Age Band Reported for the Person

Age Bands	Total Number of Reports	# Initially Screened In via SDM® Tool	% of Reports Initially Screened-In via SDM® Tool	# Overridden to Screen-Out via Discretionary Override	Final # Screened In	% of Initial Screen-Ins Overridden to Screen-Outs	% of Initial Screen-Ins That Were Final Screen-Ins
	A	B	C	D	E	F = D / B	G = E / B
18-29	3,553	2,071	9%	1,231	840	59%	41%
30-39	2,739	1,520	7%	1,076	444	71%	29%
40-49	2,883	1,685	7%	1,217	468	72%	28%
50-59	5,322	3,046	13%	2,047	999	67%	33%

Age Bands	Total Number of Reports	# Initially Screened In via SDM® Tool	% of Reports Initially Screened-In via SDM® Tool	# Overridden to Screen-Out via Discretionary Override	Final # Screened In	% of Initial Screen-Ins Overridden to Screen-Outs	% of Initial Screen-Ins That Were Final Screen-Ins
	A	B	C	D	E	F = D / B	G = E / B
60-69	7,676	4,661	21%	2,970	1,691	64%	36%
70-74	4,023	2,492	11%	1,381	1,111	55%	45%
75-84	7,202	4,517	20%	2,169	2,348	48%	52%
85+	4,467	2,683	12%	1,281	1,402	48%	52%
Total	**37,865**	**22,675**	**100%**	**13,372**	**9,303**	**59%**	**41%**

** Claims that had missing or invalid ages were omitted.*

Figure 10. APS Screening Decision Trends by Age Band Reported for the Person

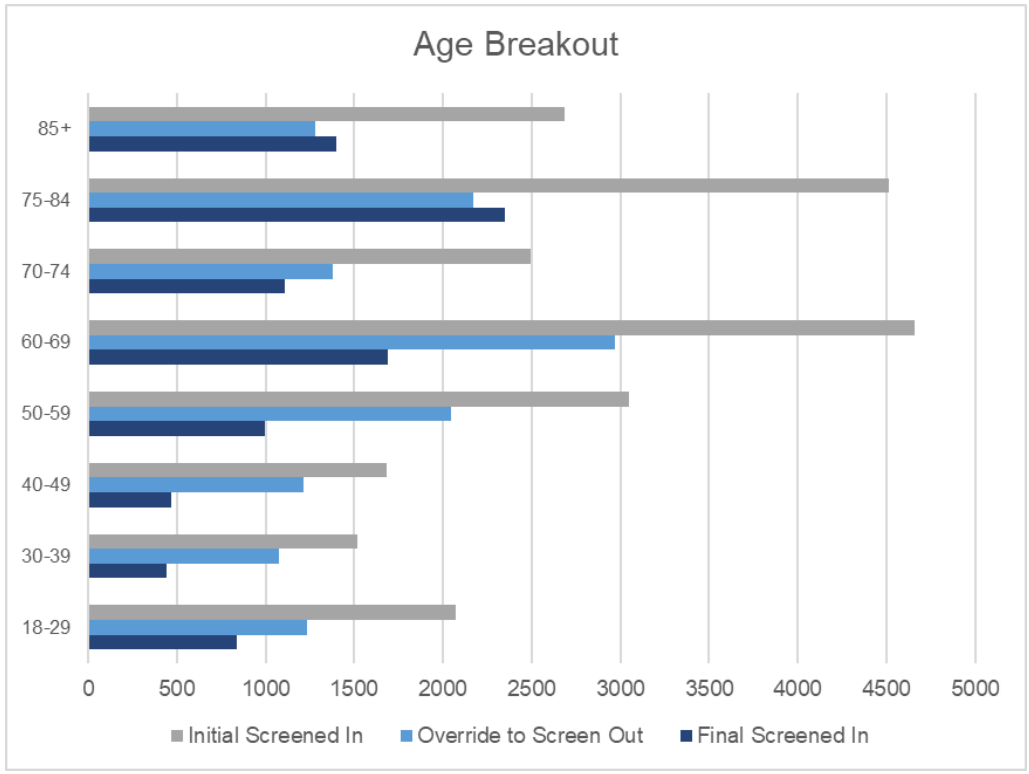


Figure 11. APS Screening Decisions by Gender Reported for the Person

Gender	Total Number of Reports	# Initially Screened In via SDM® Tool	# Overridden to Screen-Out via Discretionary Override	Final # Screened In	% of Initial Screen-Ins Overridden to Screen-Outs	% of Final Screen-Ins	% of Total Initially Screened In
	A	B	C	D	E = C / B	F = D / B	
Male	16,929	10,028	5,955	4,073	59%	41%	42%
Female	22,890	13,610	7,985	5,625	59%	41%	57%
Unknown	45	13	10	3	77%	23%	0%
Blank	646	319	205	114	64%	36%	1%
Total	**40,510**	**23,970**	**14,155**	**9,815**	**59%**	**41%**	**100%**

Figure 12. APS Screening Decisions by Race Reported for the Person

Race	Total Number of Reports	# Initially Screened In via SDM® Tool	# Overridden to Screen-Out via Discretionary Override	Final # Screened In	% of Initial Screen-Ins Overridden to Screen-Outs	% of Final Screen-Ins	% of Total Initially Screened In	Population Mix*
	A	B	C	D	E = C / B	F = D / B	G	H
Caucasian	31,849	18,469	10,078	8,391	55%	45%	77%	83.8%
Black or African American	4,152	3,069	2,452	617	80%	20%	13%	7.0%
Unknown	2,204	1,076	755	321	70%	30%	4%	N/A
American Indian / Alaskan Native	1,480	839	514	325	61%	39%	4%	1.4%
Asian	635	394	266	128	68%	32%	2%	5.2%
Pacific Islander	71	43	30	13	70%	30%	0%	0.1%
Declined	119	80	60	20	75%	25%	0%	N/A

Race	Total Number of Reports	# Initially Screened In via SDM® Tool	# Overridden to Screen-Out via Discretionary Override	Final # Screened In	% of Initial Screen-Ins Overridden to Screen-Outs	% of Final Screen-Ins	% of Total Initially Screened In	Population Mix*
	A	B	C	D	E = C / B	F = D / B	G	H
Total	**40,510**	**23,970**	**14,155**	**9,815**	**59%**	**41%**	**100%**	

* Population Mix is derived from Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for Minnesota: As of July 1, 2019 (SC-EST2019-SR11H-27)
Source: U.S. Census Bureau, Population Division
Release Date: June 2020

Figure 13. APS Screening Decision Trends by Race Reported for the Person

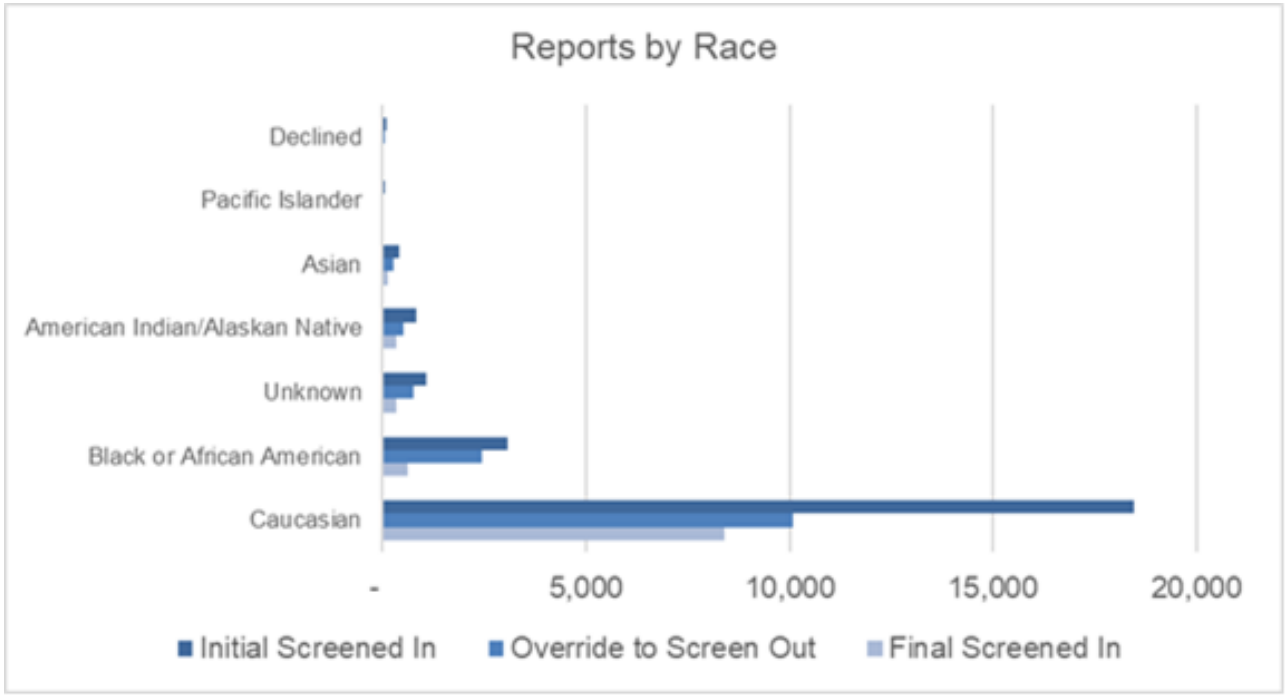
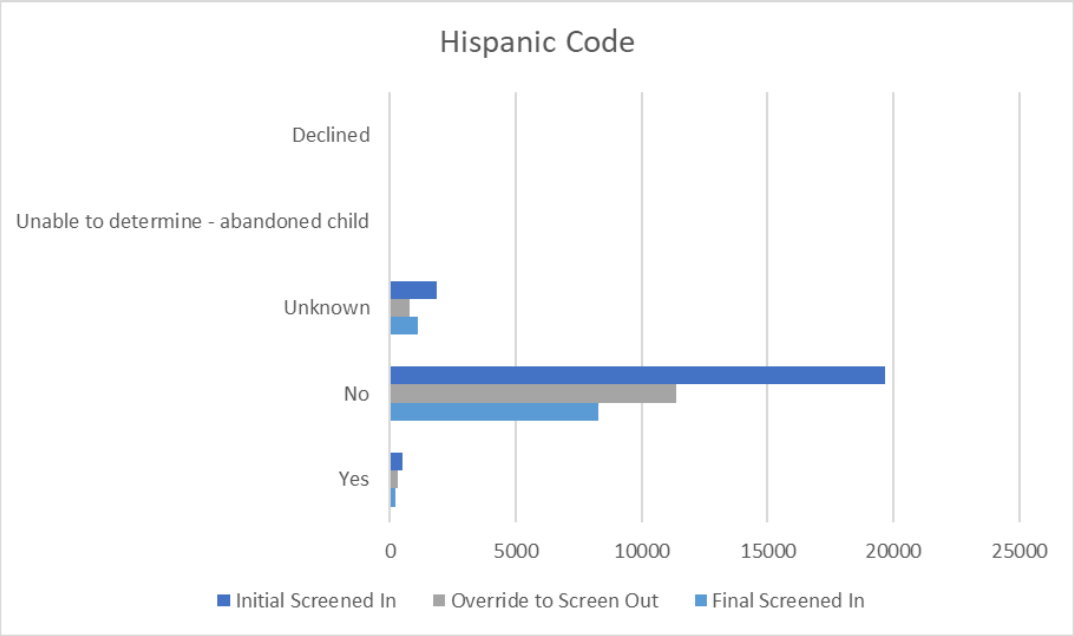


Figure 14. APS Screening Decisions by Hispanic Code Reported for the Person

Hispanic Code	Total Number of Reports	# Initially Screened In via SDM® Tool	% of Total - Initial Screened In	Override to Screen-Out	Final Screened In	% of Override to Screen-Out	% of Final Screen-Ins
Yes	909	486	53%	287	199	59%	41%
No	32,808	19,670	60%	11,375	8,295	58%	42%
Unknown	3,224	1,860	58%	758	1,102	41%	59%
Unable to determine - abandoned child	2	-	0%	-	-	0%	0%
Declined	3	3	100%	1	2	33%	67%
Total	**36,946**	**21,533**	**60%**	**12,134**	**9,399**	**56%**	**44%**

Figure 15. APS Screening Decision Trends by Hispanic Code Reported for the Person



Medicaid Enrollment

Figure 16. Screening Decisions by Medicaid Indicator Reported for the Person

Medicaid Indicator	Total Intakes	Initial Screen In	Initial Screen In % of Total Intakes	Override	Ultimate Screen In	Override % of Screen In	Ultimate Screen In % of Initial Screen In
Not Medicaid	26,956	15,689	58%	8,682	7,007	55%	45%
Medicaid	13,554	8,281	61%	5,473	2,808	66%	34%
Total	**40,510**	**23,970**	**59%**	**14,155**	**9,815**	**59%**	**41%**

Figure 17. Determination Data by Individual Medicaid Enrollment Reported for the Person

Determination by Medicaid Indicator	Ultimate Screen In	% of Initial Screen In
Not Medicaid	**7,007**	
Missing	2,129	30%
False	1,943	28%
Inconclusive	1,012	14%
No determination - investigation not possible	536	8%
No determination - not a vulnerable adult	658	9%
Substantiated	729	10%
Medicaid	**2,808**	
Missing	807	29%
False	800	28%
Inconclusive	471	17%
No determination - investigation not possible	237	8%
No determination - not a vulnerable adult	118	4%
Substantiated	375	13%
Total	**9,815**	

Figure 18. Intervention for Substantiated Cases by Individual Medicaid Enrollment *(Sorted by Count of Reports)*

Type of Intervention	Not Medicaid	% of Non-Medicaid	Medicaid	% of Medicaid	Grand Total
Grand Total	**1,216**		**598**		**1,814**
Guardian/conservator appointment or replacement	126	10%	67	11%	**193**
Other	123	10%	58	10%	**181**
Move or relocation of the VA	125	10%	43	7%	**168**
Case management/Care Coordination	68	6%	43	7%	**111**
Support system for VA engaged (family, responsible party, other)	77	6%	23	4%	**100**
Representative Payee appointed or modified	36	3%	55	9%	**91**
Home or community based services	66	5%	24	4%	**90**
Law enforcement	54	4%	30	5%	**84**
Caregiver education or support	51	4%	24	4%	**75**
Medical evaluation or care	44	4%	12	2%	**56**
MN Choices Assessment/Long Term Care Consultation (LTCC)	38	3%	12	2%	**50**
Financial management assistance	22	2%	24	4%	**46**

Type of Intervention	Not Medicaid	% of Non-Medicaid	Medicaid	% of Medicaid	Grand Total
Commitment	28	2%	12	2%	**40**
Medical Assistance (MA) application	28	2%	12	2%	**40**
Mental health evaluation or services	24	2%	16	3%	**40**
Criminal conviction of perpetrator	20	2%	17	3%	**37**
Multidisciplinary adult protection team review	28	2%	8	1%	**36**
Power of Attorney or trust completed or modified	25	2%	10	2%	**35**
No intervention - refused services	24	2%	10	2%	**34**
Health and welfare check	28	2%	4	1%	**32**
Chemical dependency assessment/treatment	21	2%	9	2%	**30**
Restraining order for removal of the perpetrator	15	1%	11	2%	**26**
Move or relocation of the perpetrator	10	1%	12	2%	**22**
Housing clean-up or repair	15	1%	6	1%	**21**
Legal advice, counsel or representation	13	1%	7	1%	**20**
No intervention - died	12	1%	5	1%	**17**
Domestic abuse services	6	0%	8	1%	**14**

Type of Intervention	Not Medicaid	% of Non-Medicaid	Medicaid	% of Medicaid	Grand Total
Economic assistance	9	1%	5	1%	**14**
VAs assets or property recovered or returned	10	1%	4	1%	**14**
Family counseling or mediation	11	1%	2	0%	**13**
Hold Order	8	1%	2	0%	**10**
Victim services	5	0%	5	1%	**10**
Emergency hold	6	0%	2	0%	**8**
Housing code inspection	7	1%		0%	**7**
Transportation	5	0%	2	0%	**7**
Economic assistance	4	0%	2	0%	**6**
Emergency Assistance	6	0%		0%	**6**
Sought legal authority to remove the vulnerable adult	2	0%	4	1%	**6**
Not Specified	2	0%	3	1%	**5**
Health Care Directive completed or modified	5	0%		0%	**5**
Medical Assistance hardship waiver	3	0%	1	0%	**4**
Ombudsman	2	0%	2	0%	**4**

Type of Intervention	Not Medicaid	% of Non-Medicaid	Medicaid	% of Medicaid	Grand Total
Gambling addiction treatment		0%	2	0%	**2**
Animal Control	1	0%		0%	**1**
Needed intervention or referral not available in service area	1	0%		0%	**1**
Office of the Inspector General	1	0%		0%	**1**
Tribal agency for social services	1	0%		0%	**1**

Determinations / Interventions

Figure 19. Determination by Race Reported for the Person

Determination	American Indian / Alaskan Native	American Indian / Alaskan Native (% of Total)	Asian	Asian (% of Total)	Black or African American	Black or African American % of Total	Caucasian	Caucasian (% of Total)	Pacific Islander	Pacific Islander (% of Total)	Grand Total
No determination available	99	30%	38	30%	219	35%	2,431	29%	3	23%	**2,936**
False	84	26%	39	30%	132	21%	2,428	29%	3	23%	**2,743**
Inconclusive	46	14%	26	20%	130	21%	1,245	15%		0%	**1,483**
No determination - investigation not possible	41	13%	8	6%	57	9%	623	7%	3	23%	**773**
No determination - not a vulnerable adult	12	4%	9	7%	33	5%	674	8%	1	8%	**776**

Determination	American Indian / Alaskan Native	American Indian / Alaskan Native (% of Total)	Asian	Asian (% of Total)	Black or African American	Black or African American % of Total	Caucasian	Caucasian (% of Total)	Pacific Islander	Pacific Islander (% of Total)	Grand Total
Substantiated	43	13%	8	6%	46	7%	990	12%	3	23%	**1,104**
Grand Total	**325**	**100%**	**128**	**100%**	**617**	**100%**	**8,391**	**100%**	**13**	**100%**	**9,815**

Figure 20. Interventions for Substantiated Cases by Abuse Type Reported for the Person

Intervention Name	Total	Self-Neglect	Caregiver Neglect	Emotional Abuse	Physical Abuse	Sexual Abuse	Financial Exploitation
Grand Total	**1,812**	**854**	**178**	**154**	**136**	**70**	**635**
Guardian/conservator appointment or replacement	**193**	12%	18%	7%	5%	1%	10%
Other	**181**	7%	10%	12%	10%	9%	12%
Move or relocation of the VA	**167**	13%	13%	10%	9%	4%	3%
Case management/Care Coordination	**111**	7%	4%	6%	7%	4%	6%

Intervention Name	Total	Self-Neglect	Caregiver Neglect	Emotional Abuse	Physical Abuse	Sexual Abuse	Financial Exploitation
Support system for VA engaged (family, responsible party, other)	**100**	5%	4%	8%	7%	16%	6%
Representative Payee appointed or modified	**91**	2%	4%	1%	0%	0%	12%
Home or community-based services	**90**	7%	6%	3%	4%	1%	3%
Law enforcement	**84**	1%	4%	8%	5%	14%	9%
Caregiver education or support	**75**	4%	6%	3%	5%	3%	4%
Medical evaluation or care	**56**	5%	2%	3%	1%	0%	1%
MN Choices Assessment/Long Term Care Consultation (LTCC)	**50**	4%	3%	1%	4%	0%	1%
Financial management assistance	**46**	1%	1%	1%	0%	0%	6%
Commitment	**40**	4%	2%	1%	1%	1%	0%
Medical Assistance (MA) application	**40**	3%	4%	1%	1%	0%	2%
Mental health evaluation or services	**40**	3%	1%	3%	1%	7%	1%

Intervention Name	Total	Self-Neglect	Caregiver Neglect	Emotional Abuse	Physical Abuse	Sexual Abuse	Financial Exploitation
Criminal conviction of perpetrator	**37**	0%	1%	1%	4%	10%	4%
Multidisciplinary adult protection team review	**36**	2%	2%	3%	2%	3%	3%
Power of Attorney or trust completed or modified	**35**	1%	2%	1%	0%	0%	3%
No intervention - refused services	**34**	3%	2%	1%	1%	1%	1%
Health and welfare check	**32**	3%	2%	3%	1%	0%	0%
Chemical dependency assessment/treatment	**30**	3%	0%	0%	1%	0%	0%
Restraining order for removal of the perpetrator	**26**	0%	1%	5%	7%	7%	2%
Housing clean-up or repair	**21**	2%	0%	0%	0%	0%	0%
Move or relocation of the perpetrator	**21**	0%	1%	6%	8%	4%	1%
Legal advice, counsel or representation	**20**	1%	1%	2%	1%	1%	2%
No intervention - died	**17**	1%	3%	1%	0%	0%	1%

Intervention Name	Total	Self-Neglect	Caregiver Neglect	Emotional Abuse	Physical Abuse	Sexual Abuse	Financial Exploitation
Domestic abuse services	**14**	0%	0%	5%	7%	3%	0%
Economic assistance	**14**	1%	1%	1%	1%	0%	1%
VAs assets or property recovered or returned	**14**	0%	1%	1%	0%	0%	2%
Family counseling or mediation	**13**	1%	1%	1%	1%	1%	0%
Hold Order	**10**	1%	0%	0%	0%	0%	0%
Victim services	**10**	0%	0%	1%	3%	4%	0%
Emergency hold	**8**	1%	0%	1%	1%	0%	0%
Housing code inspection	**7**	1%	1%	0%	0%	0%	0%
Transportation	**7**	0%	0%	0%	0%	1%	0%
Economic assistance	**6**	0%	1%	0%	1%	0%	0%
Emergency Assistance	**6**	1%	0%	0%	0%	0%	0%
Sought legal authority to remove the vulnerable adult	**6**	1%	0%	0%	0%	0%	0%

Intervention Name	Total	Self-Neglect	Caregiver Neglect	Emotional Abuse	Physical Abuse	Sexual Abuse	Financial Exploitation
Not Specified	**5**	0%	0%	0%	0%	1%	0%
Health Care Directive completed or modified	**5**	0%	1%	1%	1%	0%	0%
Medical Assistance hardship waiver	**4**	0%	0%	0%	0%	0%	0%
Ombudsman	**4**	0%	0%	1%	0%	0%	0%
Gambling addiction treatment	**2**	0%	1%	0%	0%	0%	0%
Animal Control	**1**	0%	0%	0%	0%	0%	0%
Needed intervention or referral not available in service area	**1**	0%	1%	0%	0%	0%	0%
Office of the Inspector General	**1**	0%	0%	0%	0%	0%	0%
Tribal agency for social services	**1**	0%	0%	0%	0%	0%	0%

APPENDIX C. ADVISORY WORKGROUP MEMBER BY MACCSA REGION

Figure 1 below lists the advisory workgroup members identified by the Minnesota Association of County Social Service Administrators (MACSSA) region the workgroup member represented along with the counties included in each region.

Figure 1. Advisory Workgroup Members

Member Number	MACSSA Region	Counties Included in Region*
1	1	Kittson, Marshall, Norman, Pennington, Polk, Red Lake, Roseau
2	2	Beltrami, Clearwater, Hubbard, Lake of the Woods, Mahnomen
3	4	Becker, Clay, Douglas, Grant, Pope, Otter Tail, Stevens, Traverse, Wilkin
4	5	Cass, Crow Wing, Morrison, Todd, Wadena
5	6	Big Stone, Chippewa, Kandiyohi, Lac qui Parle, McLeod, Meeker, Renville, Swift, Yellow Medicine
6	6	Big Stone, Chippewa, Kandiyohi, Lac qui Parle, McLeod, Meeker, Renville, Swift, Yellow Medicine
7	7	Benton, Chisago, Isanti, Kanabec, Mille Lacs, Pine, Sherburne, Stearns, Wright
8	8	Cottonwood, Jackson, Lincoln, Lyon, Murray, Nobles, Pipestone, Redwood, Rock

Member Number	MACSSA Region	Counties Included in Region*
9	9	Blue Earth, Brown, Faribault, Freeborn, Le Sueur, Martin, Nicollet, Sibley, Waseca, Watonwan
10	10	Dodge, Fillmore, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Winona
11	11	Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington

APPENDIX D. ADVISORY WORKGROUP CHARTER

MN APS Advisory Workgroup Charter (issued 12/16/2020)

Background and Relevance

In October 2020, the Minnesota Department of Human Services (DHS) kicked off an evaluation of the validity of Minnesota's Adult Protection Structured Decision Making® (SDM®) Intake Assessment Tool. The evaluation will encompass the tool and impacts of other inputs on the tool's results, including but not limited to, report fields, intake activity, resources, training, policy, and county prioritization guidelines. Study efforts are expected to lead to recommendations that promote consistency in APS practice regarding intake and service decisions for improved outcomes for vulnerable adults regardless of the person's location in Minnesota. A final study report will be developed to share the study's findings and recommendations.

DHS has partnered with a Consultant and its teaming partner Subcontractor to evaluate the validity of the SDM® Intake Assessment Tool and reinforce that the tool drives sound decision-making for case acceptance. This Advisory Study Workgroup will provide subject matter expertise and offer input to inform evaluation efforts to promote holistic consideration and maximize transparency throughout the study process

Workgroup Composition

The Advisory Study Workgroup includes a panel of county APS program representatives who each will bring insights on using the APS SDM® Intake tool, program operations, and policy guidance. Workgroup members were recommended by Minnesota Association of County Social Service Administrators (MACSSA) and include regional representation to promote diverse inputs from programs throughout the State.

Workgroup Member Expectations

DHS considers input from the Advisory Study Workgroup a critical component of evaluating the validity of the SDM® Intake Assessment Tool. As a workgroup member, your transparent sharing of methods and regional dynamics will assist the study team in understanding current practices and aid in developing recommendations for improving consistency in the equity of outcomes for vulnerable adults across all of Minnesota.

Participation in the Advisory Study Workgroup is voluntary. To maximize the Advisory Study Workgroup meeting time, DHS asks that members review the following expectations.

Members of the Advisory Study Workgroup:

1. **Should aim to participate in all three workgroup meetings**. Due to the COVID-19 pandemic, Advisory Study Workgroup meetings will be held virtually, until further notice. Access to virtual meetings will be provided to members within each meeting invitation.

2. **Are asked to come prepared for the Workgroup meeting** by reviewing any information or materials provided by DHS before the meeting. DHS will disseminate materials at least two (2) business days in advance of a workgroup session to provide sufficient time for review and consideration by all workgroup members.

3. **Should openly share their constructive thoughts and ideas** during group discussions and encourage other members to share their experiences and insights to foster an engaging and welcoming conversation. DHS anticipates that we may not all agree or may have conflicting inputs – that opens the door to productive conversation and we encourage all members to keep an open mind.

4. **Are encouraged to think both locally and systemically** to offer insights based on your specific experience coupled with thoughts and input you have about the broader Minnesota APS system. Input based on what you are hearing from colleagues and from other county teams could be useful.

5. **Are asked not to prematurely share information about study findings** before the issuance of the final evaluation report. Advisory workgroup members will likely be provided preliminary findings that are subject to additional study or confirmation. Prematurely sharing a preliminary finding could result in stakeholder misinformation or confusion.

DHS anticipates each meeting will last approximately ninety minutes and will be led by a DHS staff member who will co-present with the Consultant study team. Advance notice of meeting logistics (e.g., date, time, final meeting topic(s) and virtual meeting access) will be provided at least two business days prior to the meeting date.

Meeting Schedule and Topics for the Advisory Study Workgroup

DHS anticipates that the Advisory Study Workgroup will convene on three separate occasions in December 2020, March 2021, and May 2021. Figure 1 below shows tentative Advisory Study Workgroup meeting dates and associated discussion topics.

Figure 1. Advisory Study Workgroup Meeting Schedule and Topics (Tentative and Subject to Change at DHS' discretion)

Meeting Schedule	Meeting Topics
December 2020	- Review study purpose and proposed design - Gather input on study parameters
March 2021	- Review and discuss data-based findings and process reviews

Meeting Schedule	Meeting Topics
	- Request input for stakeholder engagement exercises
May 2021	- Review preliminary findings and recommendations - Obtain input to finalize recommendations included in the final report

Additional Stakeholder Input

DHS will seek additional feedback from all APS stakeholders throughout the study, including through stakeholder interviews, focus groups, and web-based surveys. Stakeholders can also contact Melissa Vongsy, Program Consultant, DHS, Adult Protection at melissa.vongsy@state.mn.us.

APPENDIX E. SYSTEMS AND POLICY ANALYSIS SUMMARY

The following table contains the list of documents Consultant reviewed as part of the systems analysis:

Document Name	Document Type	Reference
Addendum to "The Vulnerable Adult Act and Adult Protective Services in Minnesota: Stakeholder Insights"	VAA Redesign Materials	Accessed via MN-DHS Vulnerable Adult Act (VAA) Redesign webpage
Adult Protection Investigation Determinations Video Conference	MN - APS 'Other Training'	Accessed via MN-DHS Adult protection: policies and procedures webpage
Adult Protection Service Cycle and Time Frames	Job Aid	Provided by DHS
APS Foundations Online Session 1	Training PowerPoint	Provided by DHS
APS Foundations Online Session 2	Training PowerPoint	Provided by DHS
APS Foundations Online Session 3	Training PowerPoint	Provided by DHS
APS Foundations Session 4 Handout	Training Handout	Provided by DHS
Best Practices in Data - SDM for Minnesota APS	Webinar Recording	Provided by DHS

Document Name	Document Type	Reference
Minnesota Adult Abuse Reporting Center (MAARC) Mandated Reporter Guide	Training Guide	Accessed via MN-DHS Adult protection: policies and procedures webpage
Minnesota Adult Protection Policy and Procedure Manual - Revised September 2018	Policy / Procedure Manual	Accessed via MN-DHS Adult protection: policies and procedures webpage
Minnesota Adult Protection Structured Decision Making and Standardized Tools Guidelines and Procedures Manual	Policy / Procedure Manual	Accessed via SSIS Adult Protection Worker Training Webpage
MN SDM® Strengths and Needs Profile	SDM® Report	Provided by DHS
MN Statute 626.557	Minnesota Statute	https://www.revisor.mn.gov/statutes/cite/626.557
MN Statute 626.5571	Minnesota Statute	https://www.revisor.mn.gov/statutes/cite/626.5571
MN Statute 626.5572	Minnesota Statute	https://www.revisor.mn.gov/statutes/cite/626.5572
One Year Post SDM® Tool Implementation: County Adult Protective Services Survey	SDM® Report	Provided by DHS

Document Name	Document Type	Reference
PSC Report: The Vulnerable Adult Act and Adult Protective Services in Minnesota	VAA Redesign Materials	Accessed via MN-DHS Vulnerable Adult Act (VAA) Redesign webpage
SDM® - Q1 Screening Result Stats	Data / Stats	Provided by DHS
SDM® Guidelines and Procedure Manual (Updated November 2012)	Policy / Procedure Manual	Provided by DHS
SDM® Report Tables Jan-June 2014	Data / Stats	Provided by DHS
SDM® Report Tables PPT	Data / Stats	Provided by DHS
SSIS Adult Maltreatment Module 2020_Final	SSIS Training Module	Accessed via SSIS Adult Protection Worker Training Webpage
SSIS Adult Protection eLearning Suite Full Playlist	Training Recordings	Provided by DHS
SSIS Adult Protection FAQ	SSIS Frequently Asked Questions	Accessed via SSIS Adult Protection Worker Training Webpage
SSIS Alerts, Reminders and User Reminders	SSIS Training Module	Accessed via SSIS Adult Protection Worker Training Webpage
Structured Decision Making System in Adult Protective	SDM® Report	Provided by DHS

Document Name	Document Type	Reference
Services; Report for Minnesota Counties 1/1/2014-6/30/2014		
Structured Decision-Making System in Adult Protective Services; Report for Minnesota Counties 1/1/2014-6/30/2014	SDM® Report	Provided by DHS
Using SDM® Data in APS	Webinar PPT	Provided by DHS
Vulnerable Adult Mandated Reporter Training	Training Module	Accessed via MN-DHS Home-Aging webpage

APPENDIX F. TARGETED INTERVIEW QUESTIONS

#	Interview Questions
Role and General SDM® Intake Assessment Tool Questions	
1	What is your role and what are your duties within <Agency / County>'s APS program?
2	What is your understanding of the role of Adult Protective Services – who do you serve and what service does APS provide?
3	How does the SDM® Intake Assessment Tool fit into the end-to-end protective service processes?
4	What value do you think the tool adds to the process, if any?
5	What are your thoughts regarding statewide consistency when it comes to using the SDM® tool to drive screening decisions? Do you think that consistency across all counties is valuable to system performance, or do you think has minimal impact?
6	Do you think there is duplication or extraneous elements of the current processes defined by DHS? What changes might you recommend to better streamline?
7	What is the role of the supervisor in reviewing and approving completed SDM® tools and the inputs? What types of information or detail do you look for when reviewing? - Do you ever review and question the decision or reject an outcome? If so, what are some of the reasons you have done that?
8	DHS policy requires the intake tool be completed within 5 business days, with follow-up for screened in reports either 24 hours or 72 hours. What is the average number of days your agency completes the tool? - Does your team use the full 5 business days to complete the tool? Would you maintain or change that standard? - If so, what types of information is the worker gathering during the timeframe and from whom?
Staffing	
9	How many APS staff members do you have, on average? What's a typical APS caseload ratio in your county (with or without other case types)? - Does your agency have separate intake workers vs. investigators, or do your APS workers serve both functions? - If the roles are separate, can you tell us about how the communication between intake and investigation works?

#	Interview Questions
Role and General SDM® Intake Assessment Tool Questions	
10	What is your agency's supervisor to APS worker ratio?
11	Do your APS workers serve clients in other programs, or are they dedicated fully to APS functions? - If your APS workers serve multiple programs, can you estimate what percentage of time they spend on APS versus other programs? - Do you think that working multiple functions at once impacts case worker performance? Why or why not?
12	What is your APS staff turnover rate? Do you think that worker turnover impacts the use of any of the standardized APS tools, including the intake assessment tool?
County-Specific Questions	
Questions will be based on either county prioritization guidelines or other patterns that we have observed specific to the county.	
13	What quality assurance activities does your agency perform for: - Intake screening decisions? - Interventions?
14	Does your county use a multidisciplinary adult protection team? If so, can you describe the details of the team (i.e., how often the team meets, the role of the team in the intake process, etc.)?
15	How does your agency use DHS as a resource for policy questions? How often does your agency use DHS as a resource for policy and case consultation? - Is there something DHS needs to do different / better as a monitoring agency to help you do your best work?
Training / Technical Assistance	
16	What are the current training requirements for your APS intake workers and investigators? - What are your training practices for onboarding a new employee vs. recurring training? - What kind of supervisory oversight occurs to reinforce training on use of the SDM® and other tools?
17	Are your APS workers required to complete any unconscious bias / cultural sensitivity trainings? If so, how often are these trainings required?

#	Interview Questions
Role and General SDM® Intake Assessment Tool Questions	
18	What has your experience been with DHS training? What have your staff shared with you regarding the effectiveness of DHS training, including SSIS training?
Discretionary Overrides	
19	What is your understanding of the purpose of the override function?
20	Can you tell us your agency's policy for screening in or screening out vulnerable adults when the individual has a case manager, care coordinator, or discharge planner? - Does your county handle this differently for self-neglect versus other allegation types?
21	What communication channels are in place, if any, between the APS intake worker and case managers, care coordinators, or discharge planners when the APS worker screens the referral out because a case manager is already in place?
22	What considerations does your county have when an individual that is "known to the agency" is referred for an APS allegation? Does your agency handle these referrals differently than referrals for individuals that are new to the agency?
Additional Information	
23	Do you have any additional recommendations or thoughts you'd like to share with us today regarding the APS program and the Intake Assessment Tool?

APPENDIX G. FOCUS GROUP QUESTIONS

#	Focus Group Questions
Topic: General SDM® Intake Assessment Tool Questions	
1	What is your understanding of the role of Adult Protective Services? - What is the role of Adult Protective Services – who do you serve and what service does APS provide? - What are the desired outcomes? - Is the system on track to fulfill this role?
2	What is the purpose of the SDM® Intake Assessment Tool? - How does the SDM® Intake Assessment Tool fit into end-to-end protective service processes? - What value do you think the tool adds to the process, if any? - Do you think there's duplication or extraneous elements of the current processes defined by DHS? How do you manage that?
3	Do you find the tool user friendly? Why or why not?
4	If you could make a change to the SDM® Intake Assessment Tool, what would you suggest? - If you could make a change to any state statutes or definitions, what would you suggest?
5	Do you typically complete other SDM® or standardized tools, such as the Initial Safety Assessment, at the same time you complete the SDM® Intake Assessment Tool?
6	How does caseload, workload and / or operational pressures influence how you use the SDM® Intake Assessment Tool?
7	Do you think implicit bias could be affecting the structured decision-making process? - What actions would you recommend to reduce bias among users?
Topic: Discretionary Overrides	
8	What is your understanding of the purpose of the override function?
9	Override reason: *No benefit from APS:* In what types of circumstances is this option used? How is "no benefit" determined at intake? - What do you think the best practice is?
10	*Formal and informal supports*: - Are there any follow-up actions that you take when a vulnerable adult is screened out due to having formal / informal supports in place?

#	Focus Group Questions
	- How do you confirm that the formal / informal supports are willing and able to assist and support the vulnerable adult during the intake process? - How do you confirm whether or not the formal / informal support is not also an alleged perpetrator during the intake process?
11	How do you handle the intake process when the vulnerable adult has a case manager, care coordinator, and/or discharge planner in place and the allegation is self-neglect? What do you think the best practice is?
12	How do you handle the intake process when the vulnerable adult has a case manager, care coordinator, and/or discharge planner in place and the allegation did NOT involve self-neglect? What do you think the best practice is?
13	What is your understanding of how to handle an intake / complete the SDM® Intake Assessment Tool when the vulnerable adult is currently in the hospital or in short-term rehabilitation?
14	Our data analysis indicates approximately 70% of individuals who were identified as having a "chemical" disability at the point of initial screen-in, are screened out with a discretionary override. Does this percentage surprise you / do you think this is problematic? What do you think could be causing that observation. What would you recommend to reduce this variance?
15	Our data analysis indicates that persons referred who are white/Caucasian are statistically more likely to be discretionarily screened out at significantly lower rates than racial/ethnic minorities. While 55% of white persons referred initially screened in were ultimately screened out, this number jumps to 61% among Native Americans, 70% among Asian/Pacific Islanders and 80% among African Americans. What do you think could be causing that observation. What would you recommend to reduce this variance?
16	We observed a high volume of "case note" style entries. What do you think is driving that trend, and what ideas do you have on how to separate the intake process from investigation?
Topic: SDM® Intake Assessment Tool Training and Policies	
17	If you could make any modifications to your county prioritization guidelines, what would you suggest? - Who has influence over your county prioritization guidelines outside of your department, if anyone?
18	DHS policy cites the definition of assess as: *To initiate intake using information in the MAARC report, other information from the reporter, and information known to the county or available within SSIS to prioritize county EPS or LIA intake response. (another part of the manual states it this way: Relevant history with the agency, including prior accepted and screened out reports of maltreatment are considered during intake.)* - What sorts of "relevant history" or "known information" do you (or your county) consider when completing the SDM® Intake Assessment Tool? - What are the local guidelines surrounding how "information known to the county" is applied or included in the SDM® Intake Assessment Tool?

#	Focus Group Questions
19	*Timeframes*: DHS policy requires the SDM® Intake Assessment Tool be completed as soon as possible when the information is received, but no later than one business day from receiving the report from MAARC or request from another county APS agency. The intake decision is completed no later than 5 business days from receiving the report. SDM® Intake results in a decision to open or not open the MAARC referral for investigation and APS and how quickly to initiate APS; 24 or 72 hours. - What is the average length of time it takes to complete the tool? - Do you keep the tool open as you gather information from reporters and others with knowledge of the situation or vulnerable adult?
20	Policy states that intake decisions should be consistent with the most protective response when screening information to establish vulnerable adult status is inconsistent or unavailable. - What factors do you consider when evaluating the "most protective response"? - How does your (your agency's) history of working with the vulnerable adult impact what you consider the most protective response?
21	*Contacting the reporter*: DHS policy indicates contacting the reporter, as needed, during the intake process to gather additional information. - How often would you say you contact the reporter when completing the SDM® Intake Assessment Tool? - What types of information do you typically seek from the reporter?
22	*SSIS*: What is your experience with entering information into the intake assessment tool in SSIS? - Do you find SSIS to be intuitive? - Do you experience any challenges when completing the tool in SSIS? - If you could change anything in SSIS when it comes to APS, what would you change?
23	How could DHS or your agency improve training, operational guidance, workflows, etc. to make it easier to use the SDM® Intake Assessment Tool?
Topic: Closing the APS Investigation	
24	Upon submitting a final determination, what is your understanding of when interventions should be documented in the system? - What role does the Strengths and Needs Assessment play in determining interventions? - What role does the Safety Planning / Safety Assessment play in determining interventions?
25	For cases that are either inconclusive or false, do you document an intervention in the system? Why or why not?
26	How often do you provide interventions to vulnerable adults, even in situations when the determination is something other than substantiated?

#	Focus Group Questions
Topic: Macro Understanding and DHS Collaboration	
27	Do you think you have a good understanding of how state-level data is used to advocate for APS programs and resourcing?
28	Do you think you have a good understanding of federal trends in adult protective services?
29	What is your understanding of how the state uses data to inform quality assurance initiatives and outcomes?
30	What training and technical assistance would you like in the future from DHS to help you do your best work?
31	What are your thoughts on the value of consistent approaches across the State related to: - Screen-in and screen-out rates? - Service decisions and interventions?