Maltreatment Report: Vulnerable Adults in Minnesota Health Care Facilities

Report to the Minnesota Legislature summarizing allegations and investigations of maltreatment for State Fiscal Year 2013.

Minnesota Department of Health

July 2014

Commissioner's Office
625 Robert St. N.
P.O. Box 64975
St. Paul, MN 55164-0975
(651) 201-4989
www.health.state.mn.us

Maltreatment Report: Vulnerable Adults in Minnesota Health Care Facilities

July 2014

For more information, contact:
Office of Health Facility Complaints
Minnesota Department of Health
P.O. Box 64970
St. Paul, MN 55164-0970

Phone: (651) 201-4201
TDD: (651) 201-5797

As requested by Minnesota Statute 3.197: This report cost approximately $3,150.00 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or cassette tape. Printed on recycled paper.

Table of Contents

List of Tables and Figures

I. Executive Summary

Minnesota Statutes, section 626.557, requires the Minnesota Department of Health (MDH) to annually report to the Legislature and the Governor information about alleged maltreatment in licensed health care entities.

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

> Summary of reports. The commissioners of health and human services shall each annually report to the legislature and the governor on the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. The report shall identify:
> (1) whether and where backlogs of cases result in a failure to conform with statutory time frames;
> (2) where adequate coverage requires additional appropriations and staffing; and
> (3) any other trends that affect the safety of vulnerable adults.

To provide context for the information required by the law, this report must address the department's complaint investigation responsibilities relating to health care facilities licensed by MDH[1]. This report includes:

- summary and trend data relating to the number of complaints and facility-reported incidents of alleged maltreatment;
- summary data about the nature of the allegations of alleged maltreatment, as well as with substantiated maltreatment determinations;
- a description of the Office of Health Facility Complaints (OHFC) investigative process, from the intake and triage research to completion of onsite investigations;
- as with previous reports, this report was expanded to include allegations of maltreatment found in not only in licensed health care facilities, but also with providers of home care and assisted living.

While OHFC investigates allegations of maltreatment, a large portion of OHFC's workload is the investigation of alleged violations of compliance at facilities that are federally certified by the Center for Medicare and Medicaid Services (CMS). For other complaint information, including information related to OHFC investigations under federal regulations in nursing homes visit www.health.state.mn.us/divs/fpc/legislativerpts.html

This report was prepared by staff of the Compliance Monitoring Division. This report is the eighth annual report on alleged maltreatment in licensed health care entities, and is based on OHFC program data during State Fiscal Year 2013 (SFY13), which occurred from July 1, 2012 through June 30, 2013.

[1] See the Minnesota Department of Human Services for maltreatment data relating to providers licensed by DHS

II. Introduction

A. General

Mission and Purpose

The mission of the Minnesota Department of Health (MDH) is to protect, maintain, and improve the health of all Minnesotans. The Office of Health Facility Complaints (OHFC) works to investigate alleged violations of compliance with appropriate state and federal regulations to achieve the best outcome for and protection of vulnerable adults.

OHFC is a section within the Compliance Monitoring Division (CM) of MDH, designated to investigate complaints and reports of non-compliance that occur in Minnesota's licensed health care facilities and other licensed health care providers, such as home care. The Office of Health Facility Complaints was created by the Legislature in 1976 to review allegations that licensed health care facilities were not complying with standards established by state statute and rules. With the enactment of the Vulnerable Adults Act (VAA) in 1981, the responsibilities of OHFC were expanded to include investigations into claims of abuse and neglect of residents in licensed health care facilities, and to receive and evaluate incidents reported from facilities that may constitute violations of the VAA.

OHFC works side by side with the Licensing and Certification (L&C) section which conducts ongoing licensing and inspections of health facilities in Minnesota, but also conducts some investigations of allegations of non-compliance with federal certification and state licensing regulations. Complaints that are triaged at a low risk of harm to vulnerable adults are often referred to L&C for investigation as part of their annual compliance surveys. In addition, complaints related to specialized facility types may also be referred to L&C for investigation. The goal of the two sections is to work together to provide increased communication and transparency through ongoing provider education and the consistent application of state and federal regulations. Increased collaboration between OHFC and L&C over the past several years has resulted in a more comprehensive approach to overseeing provider compliance.

Vulnerable Adults Act

As mentioned above, the Vulnerable Adults Act (VAA) was enacted in 1981. Minn. Stat. Sec. 626.557, subd. 1 describes the public policy behind the VAA:

> "The legislature declares that the public policy of this state is 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.

> In addition, it is the policy of this state 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."

Maltreatment is defined (under Minnesota Statutes sec. 626.5572, subd. 15) as incidents of abuse, neglect, and financial exploitation. Unexplained injuries are also reportable if they meet the definition of abuse or neglect under Minnesota Statutes 626.5572, subd. 2 and 7. Accidents (under Minnesota Statutes section 626.5572, subd. 2) are not reportable.

A preponderance of evidence is a legal standard of proof used in maltreatment investigations. In order to substantiate the occurrence of maltreatment, OHFC must have enough evidence from its investigation to support the allegation. **All substantiated or unsubstantiated determinations must be based on a preponderance of evidence which is defined as more than 50% of weighted evidence.** This means that while an act of maltreatment may have occurred, enough evidence must exist to make it more likely than not that the allegation is true.

If an onsite investigation of maltreatment is conducted, the state VAA allows for one of the three following determinations:

- ***Substantiated*** – A substantiated finding means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred;

- ***False*** – "False" means a preponderance of the evidence shows that an act that meets the definition of maltreatment did not occur; or,

- ***Inconclusive*** – An inconclusive determination means that there is not a preponderance of evidence to show that maltreatment did or did not occur.

A vulnerable adult or their health care agent can appeal an inconclusive finding; however, facilities and alleged perpetrators are limited to appealing only substantiated maltreatment determinations.

State and federal laws authorize anyone to file a complaint about licensed health care facilities with OHFC, including complaints of alleged maltreatment. The complaint process must ensure that a person who has filed the complaint in good faith about the quality of care or other issues relating to a licensed or certified health care facility is not retaliated against for making the complaint. The complaint resolution process must include procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received; procedures to determine the likely severity of a complaint and for the investigation of the complaint; and procedures to ensure that the identity of the complainant will be kept confidential.

State law also mandates that licensed health care entities report all allegations of maltreatment (facility reports) against a vulnerable adult or a minor. In accordance with Minnesota Statutes, section 626.557, subdivision 9, "each county board shall designate a common entry point for

reports of suspected maltreatment." While the Vulnerable Adults Act requires all facilities to report to the common entry point, some complaints/reports of maltreatment are also received by OHFC because they include allegations of non-compliance with federal or state licensing regulations.

All allegations of maltreatment that originated from licensed health care providers are reflected in this report as facility-reported incidents (or reports), and maltreatment allegations originating from any other source will be referenced in this report as complaints.

State and Federal Compliance

It is important to note that when a complaint is received, OHFC may issue federal deficiencies and/or state correction orders which require the facility/provider to take corrective action. This may occur whether or not maltreatment is found to be substantiated under the Vulnerable Adults Act. Application of appropriate regulations is an important part of OHFC's focus to deter recurrence of future incidents that may result in harm to vulnerable persons residing in licensed health facilities in Minnesota. Facilities receiving state or federal violations are required to take corrective actions within a prescribed timeframe. Compliance will be verified during an onsite post corrective review. Continued non-compliance can result in money penalties, licensing sanctions as well as denial of Medicare/Medicaid payments for new admissions.

Protection of vulnerable adults in Minnesota is a collaborative effort with many agencies playing a different, yet important, enforcement role in the process. OHFC's role is to identify violations of state and federal regulations that impact the safety and quality of life for vulnerable adults and to deter recurrence of the violations. Law enforcement agencies provide justice to victims of maltreatment and protection of the public through criminal charges, while private civil attorneys work with vulnerable adults to seek compensation through the Minnesota Court System. In addition, the Minnesota Attorney General's Office, and the Minnesota Department of Human Services (DHS) Office of Inspector General work together with OHFC on fraud issues related to Medicaid Fraud. The Ombudsman Offices provide additional resources and assistance to OHFC in the area of patient rights. By working together, these agencies cast a wide net of enforcement services available to vulnerable adults living in Minnesota health facilities.

B. Allegation Process Overview

Intake/Triage Process

Every complaint and facility-reported incident (report) received by OHFC is reviewed and triaged according to state and federal protocols to determine what further action should be taken. The intake unit receives complaints and reports through a variety of sources including: email, fax, letters, phone calls, the common entry point, and via the OHFC web-based reporting system.

Once a complaint or report is received, the intake and triage unit is responsible for gathering sufficient information to make a triage determination. This gathering of information or "in-

office investigation" is for triage purposes and often includes the following: phone calls made to the facility, the complainant, or the police; medical records may be requested; and/or other types of additional information may be requested. Once sufficient information is received, the triage unit conducts an in-office investigation of the additional information collected. Depending on the allegation and the amount of information needed to make a decision, this internal review may take days to fully conduct. At the conclusion of the in-office gathering of information, the determination is made as to what further action is appropriate.

Therefore, it is important to note that "in-office investigations" are conducted on every allegation of maltreatment. Even if an onsite investigation isn't conducted, thorough in-office investigating and gathering of information occurs before this determination can be made. The determination to conduct an onsite investigation is based on a number of factors including:

- seriousness of the harm;
- previous complaint and survey results;
- previous reporting history;
- date of last onsite licensing inspection; and,
- whether the facility has appropriately addressed and corrected the alleged violations.

OHFC's response to these complaints and reports is based on the level of harm and/or potential harm to vulnerable adults who reside in Minnesota health care facilities. The highest priority complaints and reports are assigned for onsite investigations. Timeframes for initiating onsite investigations may vary from two days to the next scheduled annual survey, depending on the level of harm involved with the allegation. OHFC reviews every allegation, and the determination may be made that the complaint or report will not be investigated under the VAA if another state or federal regulation may provide better outcomes for the affected vulnerable adults.

Although OHFC understands that all complaints are serious to vulnerable adults and their families, not all allegations are prioritized for further onsite investigation by OHFC. Complaints and reports that received in-office investigations may be closed without an onsite investigation for a number of reasons. The most common reasons include:

- insufficient information to support a maltreatment finding;
- incidents that do not represent substantial violations of regulations;
- no jurisdiction, and;
- incidents older than one year where supporting evidence is no longer available.

In addition, some complaints are forwarded to other agencies for further action. These agencies may include the Office of Ombudsman, the Minnesota Attorney General Office, the Office of Inspector General, the Board of Medical Practice, the Board of Nursing or other licensing boards. OHFC does not investigate billing disputes between consumers and providers. Complaints related to Medicare/Medicaid fraud will be forwarded to the appropriate agency.

III. Maltreatment Data Requirements

There are more than 2,600 health care entities licensed by the Minnesota Department of Health (MDH). Licensed health care entities include nursing homes, hospitals, boarding care homes, supervised living facilities, home care providers, assisted living providers, hospice programs, hospice residences, and free standing outpatient surgical facilities. The licensure laws contained in Minnesota Statutes Chapters 144 and 144A detail the department's authority and responsibilities in this area. Many of these licensed health care entities are also federally certified for purposes of participation in the Medicare and/or Medicaid programs.

While the Office of Health Facility Complaints (OHFC) investigates other complaints, the data in this report is specific to complaints and facility-reported incidents of alleged maltreatment occurring in facilities that are licensed by MDH.

A. Maltreatment Data (Number and Types of Alleged Maltreatment Reports)

As mentioned earlier, internal research and reviews are conducted on every incoming allegation of maltreatment. This triage and in-office investigation process involves gathering and review of information from an array of sources (refer to the Intake/Triage Process in the previous section). Once OHFC has made the determination to conduct an onsite investigation of a complaint or report of alleged maltreatment, OHFC has three determination options: substantiated, false (OHFC uses the federal terminology of not substantiated), or inconclusive. All substantiated or unsubstantiated determinations must be based on a preponderance of evidence which is defined as more than 50% of weighted evidence. **This means that although a maltreatment complaint may have merit and the incident may have occurred, there may not be sufficient relevant evidence to support a substantiated finding of non-compliance or "fault."**

In addition, not all complaints or facility-reported incidents meet the definition of maltreatment under Minnesota Statutes, section 626.5572. Although the evidence may confirm the incidents occurred, it may not constitute a finding of maltreatment under Minnesota Statutes, section 626.5572, subd. 15.

The following data represents the number of allegations of maltreatment triaged which received an in-office investigation, the total number that were assigned for onsite investigation, and the outcome of those onsite investigations. These totals include both complaints and facility-reported incidents of alleged or possible maltreatment.

Table 1: Total Maltreatment Allegations, Total Onsite Investigations & Outcomes

	Total In-Office Investigations	Total Investigated Onsite	Investigated Onsite: Substantiated	Investigated Onsite: Not Substantiated	Investigated Onsite: Inconclusive
SFY10	3,608	591	186	181	224
SFY11	12,823	852	174	438	240
SFY12	16,667	760	139	392	229
SFY13	20,882	581	119	308	154

While OHFC conducted 24% fewer onsite maltreatment investigations compared to the previous fiscal year, this may be reflective of a more effective in-office triage process. Since a preponderance of evidence (more than 50% of weighted evidence) is required in order to make a determination of maltreatment, OHFC has improved its in-office investigation accuracy in determining if enough evidence existed to merit an onsite investigation that could result in either a substantiated or not-substantiated conclusion status.

The percent change of onsite investigations resulting in an "Inconclusive" status decreased by 33% when comparing SFY13 to the previous fiscal year.

- Percent change of onsite investigations: -24%
- Percent change of Inconclusive determinations: -33%

Fewer investigations resulting in an "Inconclusive" status also supports a recent trend among lead agencies to consider an investigation to be either substantiated or not substantiated, limiting the use of inconclusive findings to circumstances where parties provide conflicting evidence (he said/she said) to support a finding that the incident did or did not occur.

Another factor to note about SFY13 was that the percentage of onsite investigations resulting in substantiated maltreatment findings slightly increased in SFY13 compared to the prior year: SFY13 saw 20% of onsite investigations reaching a substantiated determination, compared to the 18% in SFY12 (an increase of 11%).

B. Maltreatment Data: Source of Maltreatment Allegation

The information in this section is a break down of the total SFY13 information located in Table 1, but is separated by whether the allegation of maltreatment was received as a complaint or whether the allegation was received as a facility-reported incident. As noted above, the data in this section continues to reflect a decline of onsite investigations, as well as a simultaneous decline in investigations resulting with inconclusive determinations.

Table 2 represents the total number of maltreatment allegations that were received as complaints, the total number of those that were assigned for onsite investigation, and the outcome of those onsite investigations.

Table 2: Maltreatment Complaint Allegations: Total Received & Outcomes of Onsite Investigations

	Total In-Office Investigations: Complaints	Total Complaints Investigated Onsite	Investigated Onsite: Substantiated	Investigated Onsite: Not Substantiated	Investigated Onsite: Inconclusive
SFY10	493	360	76	135	149
SFY11	1,137	515	68	318	129
SFY12	1,223	436	61	254	121
SFY13	1,345	380	47	242	91

The below table depicts the number of possible allegations of maltreatment that originated from licensed health care providers (facility-reported incidents or "reports"). Included is the total number of maltreatment allegations that were received as reports, the total number of those that were assigned for onsite investigation, and the outcome of the onsite investigations.

Table 3: Maltreatment Facility-Reported Allegations: Total Received & Outcomes of Onsite Investigations

	Total In-Office Investigations: Reports	Total Reports Investigated Onsite	Investigated Onsite: Substantiated	Investigated Onsite: Not Substantiated	Investigated Onsite: Inconclusive
SFY10	3,115	231	110	46	75
SFY11	11,686	335	106	120	111
SFY12	15,444	324	78	138	108
SFY13	19,537	201	72	66	63

Over a four year period (SFY10 to SFY13), the total facility-reported incidents of maltreatment received increased by 527%. There are two main reasons attributable to this skyrocketing trend:

1. The complexity and differences between required state and federal reporting. In an attempt to avoid deficiencies/citations related to "non-reporting", some facilities choose to report all incidents, even if they don't meet the requirements of reporting.

   OHFC staff do not know if an incident is reportable until it is triaged (the "in-office investigation" is completed). Therefore, the reporting of all incidents, including "non-reportable" incidents, puts a strain on the workload of OHFC and the common entry points.

2. The other primary reason is because all incoming facility-reported incidents from nursing homes are initially coded as maltreatment allegations.

The current practice of coding all incoming facility-reported incidents from nursing homes as potential maltreatment allegations is a large contributor to the significant increase of total facility-reported allegations. The total facility-reported incidents of potential maltreatment received by OHFC increased by 527% from SFY10 to SFY13; but approximately 87% of these total allegations were incidents reported by nursing facilities.

OFHC is currently exploring ways to potentially modify its coding of facility reports received from nursing facilities. While many provider-initiated reports from nursing facilities may still be a potential violation of the Vulnerable Adults Act, many allegations may instead be initially coded as a possible violation of state or federal regulations. It is OHFC's goal to code data to assure it provides an acute picture of maltreatment allegations. Any changing in coding facility-reported incidents from nursing homes would not be implemented until SFY15.

Source of Maltreatment Allegation by Provider-type

In order to provide further background on the source of maltreatment allegations, Table 4 below again separates the total number of allegations by the same two categories of complaints and facility-reported incidents. Within each of these categories, the totals are broken down again to reflect the number received for each by provider-type.

Table 4: Total Maltreatment Complaint/Reports Received, by Provider-Type

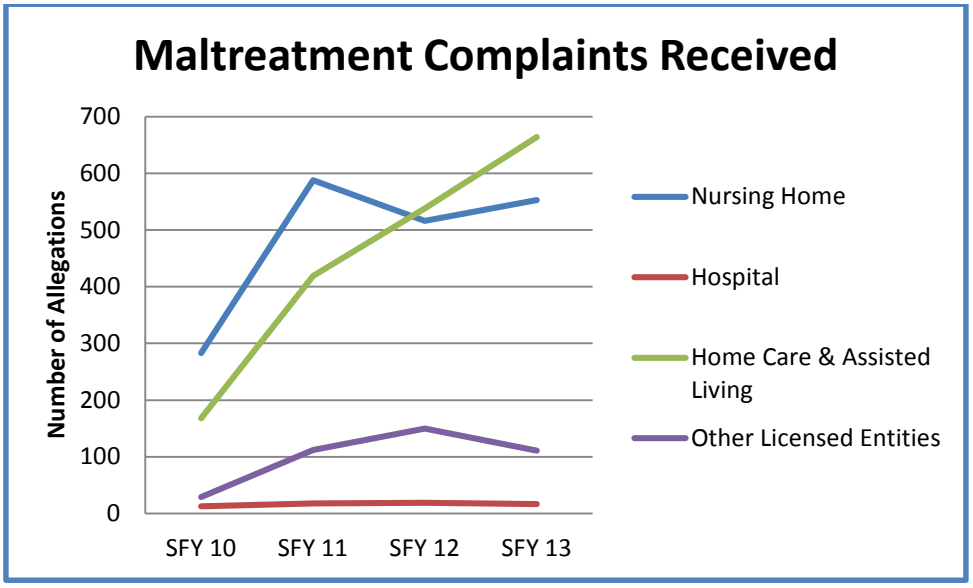
Complaints	SFY 10	SFY 11	SFY 12	SFY 13
Nursing Home	283	588	516	553
Hospital	13	18	19	17
Home Care and Assisted Living	168	419	538	664
Other Licensed Entities	29	112	150	111
Total Complaints Received	**493**	**1,137**	**1,223**	**1,345**
Facility Reported Incidents	**SFY 10**	**SFY 11**	**SFY 12**	**SFY 13**
Nursing Home	2,679	10,152	13,546	16,784
Hospital	37	101	140	161
Home Care and Assisted Living	239	874	1,113	1,730
Other Licensed Entities	160	559	645	862
Total Facility Reports Received	**3,115**	**11,686**	**15,444**	**19,537**
Grand Total	**3,608**	**12,823**	**16,667**	**20,882**

Hospital complaints and reports have remained fairly consistent over the past 4 years and do not represent a large portion of VAA cases investigated by OHFC. Unlike nursing homes, hospitals have a separate system of reporting adverse events to MDH that is outside the VAA reporting requirements. Since the VAA does not include penalties for maltreatment findings, most hospital investigations are conducted under the federal regulations as directed by CMS. Penalties associated with federal non-compliance include fines, denial of Medicare/Medicaid payments, and other remedies which offer incentive for compliance.

Table 4 also illustrates the large majority of allegations attributed to facility-reported incidents from nursing homes, as well as increases in maltreatment allegations received as complaints. Since SFY 10, the total maltreatment allegations received as complaints have increased by 173%.

The two most significant increases in maltreatment-related complaints have been seen in nursing homes and with home care and assisted living providers. Complaints of maltreatment relating to each of those provider-types have increased by 95% and 295% respectively over four years. Figure 1 below represents the increases of complaint allegations received for each provider-type.

Figure 1: Number of Maltreatment Allegations Received as Complaints



Just as we saw in SFY12, more complaints of alleged maltreatment were related to home care than to nursing homes in SFY13. Over four years, there has been a 295% increase in complaints related to allegations of maltreatment with home care and assisted living providers. Almost half of the home care and assisted living maltreatment complaints in SFY13 were related to allegations of neglect (48%).

Of the maltreatment allegations relating to home care and assisted living providers that received an onsite investigation, 21% resulted in substantiated maltreatment findings. Therefore, despite increases in complaints relating to home care and assisted living providers, the rate of substantiated findings remains similar to the overall rate of substantiated maltreatment findings for all provider-types (which was 20% in SFY13).

In addition to increases in complaints, we are seeing dramatic rises in "provider-initiated" reports of maltreatment with home care and assisted living providers. Since SFY10, there has been a 624% "provider-initiated" increase in allegations of maltreatment with home care and assisted living providers. More than half of these reports of alleged maltreatment were related to neglect (60%).

It is important to note that these increases in maltreatment-related complaints and provider-initiated reports are not related to simultaneous increase in number of providers. During the same span of time, the number of home care and assisted living providers only increased by 12%.

Since the number of home health providers in Minnesota only increased by 12% from SFY10 to SFY13, we can attribute much of the substantial increase in provider-initiated reports of maltreatment to home care & assisted living providers gaining a better understanding of reporting requirements.

New Home Care Regulation

In response to the increasing consumer use of home care and assisted living, new legislation was passed in 2013 that enhances the requirements and oversight of home care and assisted living providers. Some of the 2013 regulation changes that enhance the home care and assisted living program are:

- Changes to the licensing application requirements to ensure that new applicants are ready to provide safe and appropriate care to clients
- Increased frequency of inspection of providers to at least once every three years
- A new process for imposing fines based on scope and severity of violations
- Providers must keep copy on record of action taken to correct violations
- Required annual training: all staff that perform direct home care services must complete at least 8 hours of annual training with each year of employment, which includes reviewing the providers' policies and procedures
- Required emergency preparedness and disaster planning: a written plan of action must be developed to facilitate the management of client's care and services in the event of a natural disaster or other emergency
- A new requirement for quality management activity: includes evaluating quality of care and other issues that may have occurred.

Quality management activity means evaluating the quality of care by periodically reviewing client services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to clients.

It is MDH's goal that the new requirements will have a positive impact on the quality of care received by consumers of home care and assisted living providers. The new home care

regulations are effective for new providers as of January 1, 2014, and current providers will begin to convert to the new requirements between July 1, 2014 and June 30, 2015.

The Home Care and Assisted Living Program (HCALP) is also significantly increasing their number of home care surveyors. OHFC will also be adding at least two additional investigators who will only investigate reports and complaints related to home care and assisted living providers. Increasing staff in both programs will increase the ability for effective collaboration between HCALP and OHFC, and result in a more comprehensive approach to home care regulations.

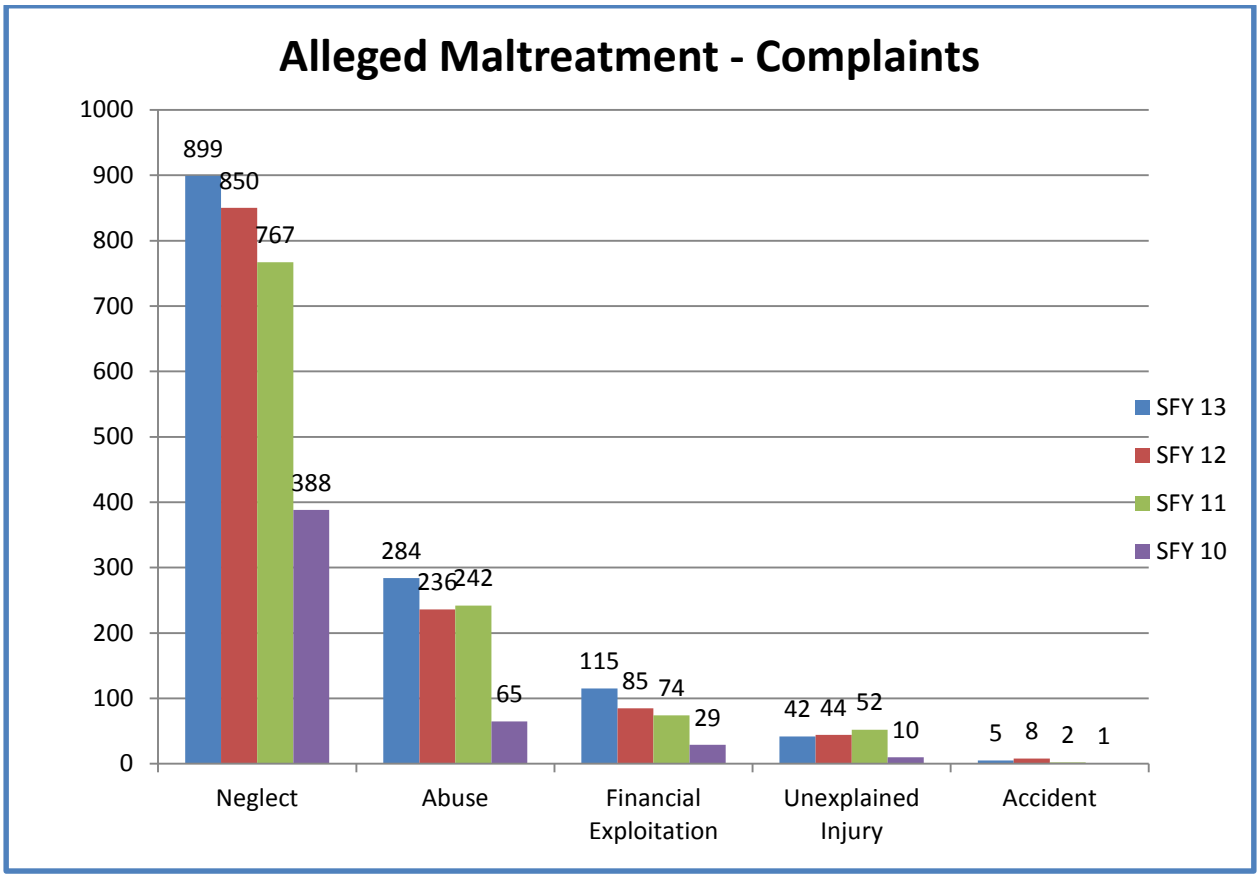
C. Maltreatment Data: Type of Alleged Maltreatment by Source

The Vulnerable Adults Act requires the reporting of neglect, abuse, financial exploitation and resident to resident altercations that result in harm. Depending on the specifics of the allegation, resident to resident altercations that result in harm have been categorized as either neglect or abuse. The next two figures represent allegations of maltreatment based on the type of alleged violation. The first chart represents complaint allegations while the second chart documents facility self-reports.

As mentioned earlier, unexplained injuries are only reportable incidents under the VAA if they meet the definition of abuse or neglect. Accidents are also not reportable; however, OHFC utilizes an intake code only for the purpose of tracking accidents. Since OHFC receives complaints and reports relating to these two types of (non-reportable) allegations, they have been classified as their own categories for allegation coding purposes in this section only. If the accident or unexplained injury was a reportable incident, it is because the incident really met the definition of either abuse or neglect, and the outcome of these investigations would be coded as either neglect or abuse.

Note this information represents **allegations** of maltreatment and not final maltreatment determinations resulting from onsite investigations.

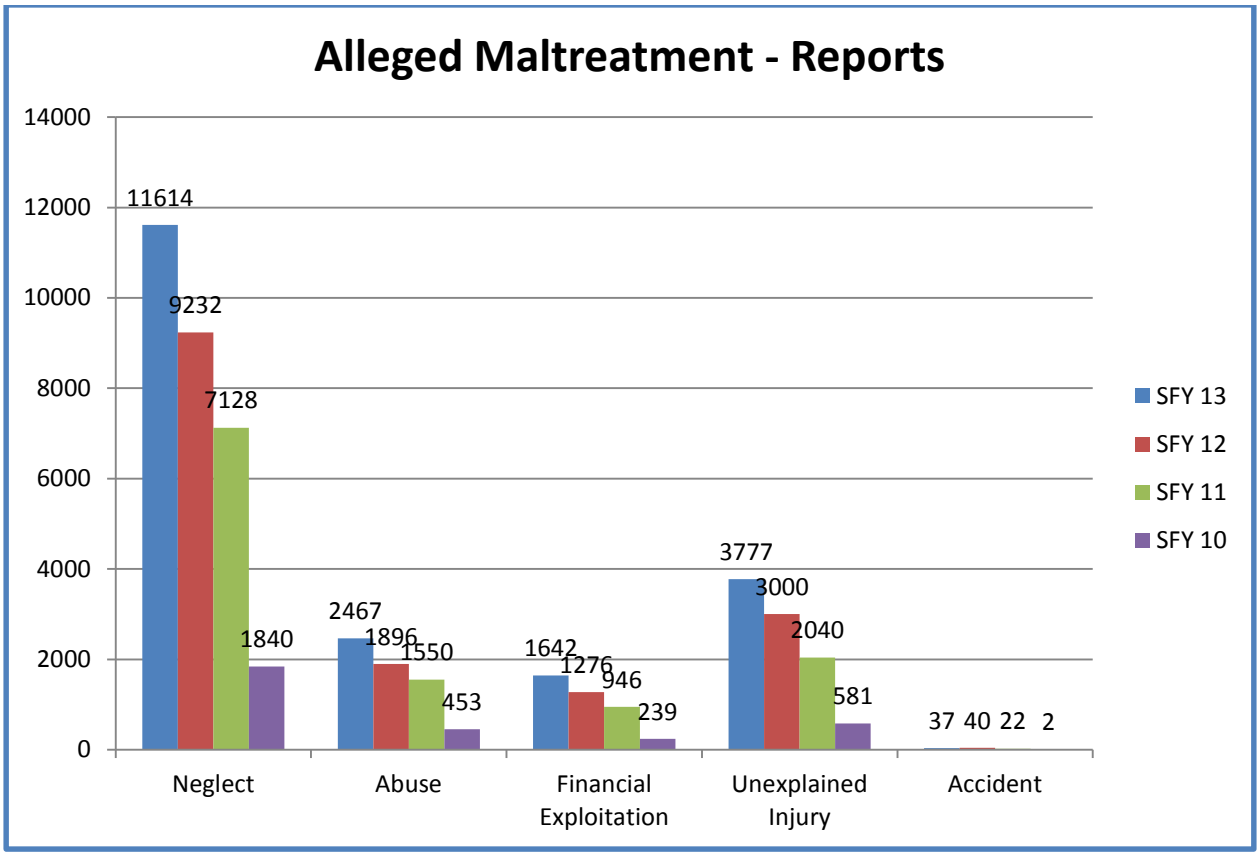
Figure 2: Maltreatment Complaint Allegations - Number Received & Type of Alleged Violation



Neglect continues to be the most common type of allegation of maltreatment received as a complaint, with abuse being the second most common. In SFY13, 67% of all complaint maltreatment allegations were related to neglect, 21% of complaint allegations were related to abuse, 9% related to financial exploitation, 3% related to unexplained injury, and less than 1% were related to an accident.

It should be noted that the number of complaints related to alleged unexplained injuries was reduced by 19% from SFY11 to SFY13. Also from SFY11 to SFY13, allegations related to financial exploitation increased by 145%.

Figure 3: Maltreatment Report Allegations - Number Received & Type of Alleged Violation



The data in Figure 2 depicts allegations of maltreatment that were received as facility-reported incidents. While neglect is still the majority of alleged maltreatment, it makes up a little under two-thirds of the types of facility-reported alleged maltreatment (59%) in SFY13. Unexplained injury is the second most common at 19% and abuse comprised 13% of facility-reported allegations of maltreatment. Eight percent of facility-reported incidents were related to financial exploitation, and less than 1% were related to an accident.

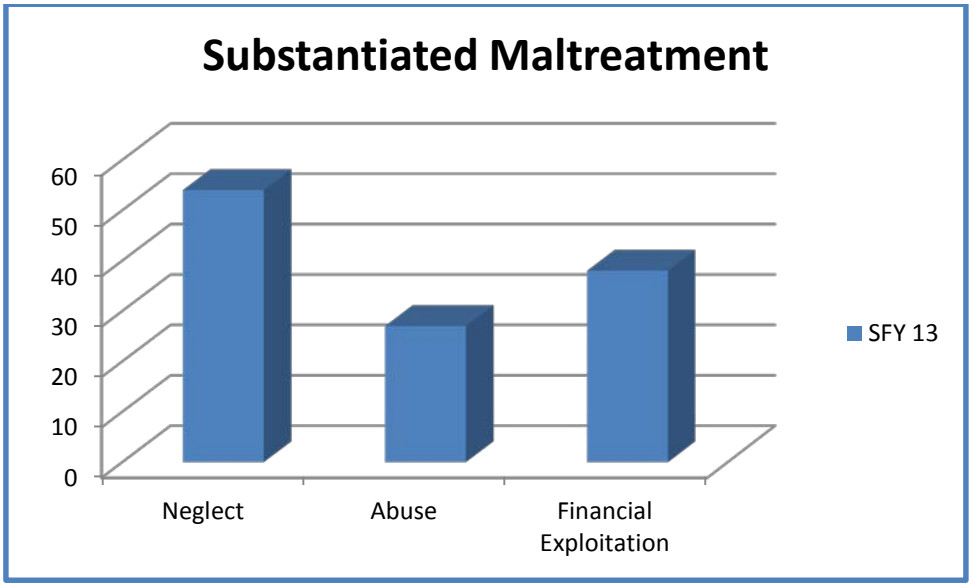
As reflected in the previous two charts, neglect is consistently the most common type of allegation of maltreatment received, regardless of whether the allegation of maltreatment was received as a complaint or as a facility-reported incident.

D. Maltreatment Data: Substantiated Maltreatment Findings

Whereas Figures 2 & 3 in the previous section represented allegations of maltreatment, Figure 4 below reflects the distribution of final maltreatment determinations resulting from the SFY13 onsite investigations.

Note that under state law, maltreatment is defined as neglect, abuse or financial exploitation. Although allegations of unexplained injuries and accidents may be reportable to OHFC, a maltreatment determination may only be determined if the accident or unexplained injury meets the definition of either abuse or neglect.

Figure 4: Final Maltreatment Determinations From Onsite Investigations



Neglect and financial exploitation were the largest sources of maltreatment allegations, and these two categories remain as the two largest categories of substantiated maltreatment determinations. In SFY13, neglect accounted for 45% of all substantiated onsite investigations, and financial exploitation accounted for 32% of all substantiated onsite investigations.

E. Maltreatment Data: Statutory Time Frames

It is one of OHFC's goals to provide timely intervention on high priority complaints to mitigate the possibility of harm to residents (note that harm and/or potential harm is one of the triggers for an onsite investigation). Since 2011, a change to the federal triage protocols increased the number of complaints and reports that must be investigated within 2 days. As a result, OHFC investigators are oftentimes dispatched to different facilities before they have had time to complete previously assigned complaints. This requirement continues to impact investigator's caseloads and cause delays in meeting the VAA requirement that maltreatment investigations be completed within 60 days.

Although OHFC conducts the initial onsite investigation in a timely manner, the conducting of interviews, requesting additional records, as well as the completion of the required public report may fall outside the 60 day timeframe. All parties involved in a maltreatment investigation receive letters at 60 days informing them that the investigation is ongoing.

Despite the strict two day federal investigation requirement, OHFC's backlog has continued to decrease over the past four years. In SFY13, 40% of maltreatment investigations were completed within 60 days, which reflects a 33% improvement between SFY12 and SFY13 and a 150% improvement since SFY10.

Table 5: Maltreatment Onsite Investigations: Number & Percent Completed Within 60 Days

	Total Onsite Investigations	Total Onsite Investigations Completed Within 60 days	Percent Over 60 Days	Percent On time
SFY 10	591	97	84%	16%
SFY 11	852	152	82%	18%
SFY 12	760	231	70%	30%
SFY 13	581	234	60%	40%

In SFY13, the average time investigators spent on onsite maltreatment investigations was 22.3 hours. This time includes investigator preparation, travel, onsite time, and documentation. It should be noted that this average does not include the in-office investigation/triage time or supervisory review time.

F. Maltreatment Data: Where Adequate Coverage Requires Additional Appropriations and Staffing

OHFC has continued to focus on improving the number of onsite investigations completed within 60 days, and the improving trends are reflecting such efforts. However, staff retention/turnover always plays a large role in OHFC's ability to meet various state and federal timeframe requirements. Stringent time requirements, travel demands, and the general stress that is involved in this kind of investigatory work affects the amount of staff turnover OHFC experiences. Adequate staffing is a constant focus of OHFC, but losing trained staff inevitably adds stress to the program simply due to the amount of training required to be an investigator. It is at least one full year before an investigator is fully trained, so a substantial amount of time and resources are invested in each OHFC investigator.

In addition to sufficient resources, there are always other factors in meeting statutory requirements. OHFC has developed and initiated a number of changes to increase the efficiency and the effectiveness of the investigation unit. These changes include:

- the separation of the intake and triage functions to better handle the increased number of complaints/reports and provide improved customer service;
- identification of IT enhancements that will allow the transfer of information between federal and state databases reducing the need for double entry;
- increased education and communication with providers through quarterly calls, through participation and collaboration with the Licensing & Certification program,
- regular trainings, presentations, video conferences, and subgroup meetings with providers to clarify and streamline reporting requirements and processes;
- collaboration with the Department of Human Services to develop increased efficiency of the background study process;
- increase OHFC staff satisfaction and retention by increasing the option of telecommuting for investigators, and;
- increasing the number of staff in MDH district offices to reduce the amount of travel for OHFC investigators.

Another attempt to increase the efficiency of OHFC relates to the development of a single common entry point. As identified earlier, the number of facility reports continues to increase across nursing home facilities that report to OHFC via the federal web based reporting system. The intake unit has identified a significant number of these reports which are not reportable under state and federal regulations, resulting in a drain of resources at OHFC and the Common Entry Point. The Department of Human Services (DHS) received funds to establish a single common entry point in Minnesota. OHFC is working with DHS and the Centers for Medicare/Medicaid Services (CMS) to determine if a web system can be developed that still meets the requirements of nursing home reporting under federal regulations.

Each of these changes has been initiated to reduce the number of hours required to complete an investigation.

OHFC recognizes that improvements could still be made and continues to address issues, such as staffing, in an effort to keep pace with the increasing number of allegations and to strive for greater compliance with statutory time-frames.

IV. General Trends

- Since SFY10, the total maltreatment allegations received as complaints have increased by 173%. The most significant increases in maltreatment-related complaints have been seen in nursing homes, and especially with home care and assisted living providers. Complaints of maltreatment relating to each of those provider-types have increased by 95% and 295% respectively over four years.

- In addition to allegations received as complaints, there have also been dramatic rises in "provider-initiated" reports of maltreatment with home care and assisted living providers. From SFY10 to SFY13, there has been a 624% "provider-initiated" increase related to allegations of maltreatment with home care and assisted living providers. This increase does not match the growth of home health providers (which was only 12% during the same time period), so increase in alleged maltreatment is likely related to both providers gaining a better understanding of reporting requirements, and an increase in consumers using home health services.

- In 2013, new home care legislation passed that changes the way MDH licenses home care providers. As part of this legislation change, OHFC will be increasing the number of investigators for state only facilities by at least two additional home care investigators. This will result in a total of three investigators dedicated to conducting solely home care and assisted living investigations.

- Financial Exploitation continues to be an area of concern with related allegations from SFY10 to SFY13 increasing by 556%. Investigations in the area of financial exploitation also currently include drug diversions, which occurs when the medication belonging to a resident is used for another person's benefit. The drugs are considered property of the vulnerable adult, as financial exploitation includes willful use, withholding, or disposing of funds or property of a vulnerable adult.

  In 2013, OHFC made a change to the maltreatment coding to allow the tracking of allegations of maltreatment that specifically relate to drug diversions. This distinction will provide data that enables OHFC to track allegations and trends of diversion of pharmaceutical drugs by health care professionals. Since all allegations relating to drug diversion are currently being coded as financial exploitation, there will appear to be a decrease in allegations and maltreatment findings of financial exploitation due to drug diversion being "pulled out" into its own category starting in SFY14.

- Neglect continues to be the largest source of both allegations and substantiated onsite investigations of maltreatment. In SFY13, 60% of all maltreatment allegations related to neglect, and 45% of all onsite investigations substantiated neglect.

- The Department of Health (MDH) and the Department of Human Services (DHS) proposed legislation in 2014 that would combine the required maltreatment data from

both agencies. The purpose of the proposal was to combine the information in one report to provide the legislature and consumers a more comprehensive picture of maltreatment incidents in Minnesota. This legislation also proposes to change the legislative report timeline from annually to once every two years to allow a deeper analysis of trends between the two agencies. Both agencies would be required to report maltreatment statistics annually on their website for interested parties.