

# **Maltreatment Report: Vulnerable Adults in Minnesota Health Care Facilities**

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*Report to the Minnesota Legislature  
summarizing allegations and investigations of  
maltreatment for State Fiscal Year 2012*

**Minnesota Department of Health**

**February 2014**



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# Table of Contents

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I. Executive Summary.....	5
II. Introduction .....	6
A. General.....	6
Mission and Purpose .....	6
Vulnerable Adults Act .....	6
State and Federal Compliance.....	8
B. Allegation Process Overview .....	8
Intake/Triage Process .....	8
III. Maltreatment Data Requirements .....	10
A. Maltreatment Data (Number and Types of Alleged Maltreatment Reports) .....	10
B. Maltreatment Data: Source of Maltreatment Allegation.....	11
C. Maltreatment Data: Type of Alleged Maltreatment by Source.....	13
D. Maltreatment Data: Statutory Time Frames.....	15
E. Maltreatment Data: Where Adequate Coverage Requires Additional Appropriations and Staffing.....	16
IV. General Trends.....	18

# List of Tables and Figures

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Table 1: Total Maltreatment Allegations, Total Onsite Investigations & Outcomes .....	10
Table 2: Maltreatment Complaint Allegations: Total Received & Outcomes of Onsite Investigations .....	11
Table 3: Maltreatment Facility-Reported Allegations: Total Received & Outcomes of Onsite Investigations .....	12
Table 4: Total Maltreatment Complaint/Reports Received, by Provider-Type.....	13
Table 5: Maltreatment Onsite Investigations: Number & Percent Completed Within 60 Days...	16
Figure 1: Maltreatment Complaint Allegations - Number Received & Type of Violation .....	14
Figure 2: Maltreatment Report Allegations - Number Received & Type of Violation .....	15

# I. Executive Summary

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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<sup>1</sup>. 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 contained within those complaints and reports of alleged maltreatment;
- 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 just licensed health care facilities, but also with providers of home care.

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/legislativeverpts.html](http://www.health.state.mn.us/divs/fpc/legislativeverpts.html)

This report was prepared by staff of the Division of Compliance Monitoring. 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 2012 (SFY12), which occurred from July 1, 2011 through June 30, 2012.

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<sup>1</sup> See the Minnesota Department of Human Services for maltreatment data relating to providers licensed by DHS

## **II. Introduction**

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### **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 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 case.”

Maltreatment is defined (under Minnesota Statutes 626.5572) as cases of suspected abuse, neglect, financial exploitation, unexplained injuries, and errors as defined in Minnesota Statute 626.5572, subd. 17(c)(5). 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, just enough evidence to make it more likely than not, that the allegation is true. Although a vulnerable adult or their health care agent can appeal an inconclusive finding, facilities and alleged perpetrators are limited to appealing only substantiated maltreatment determinations.

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;
- **Not substantiated**– An unsubstantiated finding means a preponderance of the evidence shows that an act that meets the definition of maltreatment did not occur; or
- **Inconclusive** – A finding of inconclusive means that there is not a preponderance of evidence to show that maltreatment did or did not occur.

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 certification 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 prevent 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 may 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 prevent recurrence of violations of state and federal regulations that impact the safety and quality of life for vulnerable adults. 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 (reports) 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 conduct an in-office investigation. Gathering of information 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 investigation, the determination is made as to which allegations will be assigned for onsite investigations.

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 beginning 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.

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 2,000 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 home care 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 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. In these cases, an inconclusive or not substantiated finding is appropriate.

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 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

As the above data reflects, the total number of maltreatment allegations received has risen substantially over just a few years. The percent increase of maltreatment allegations between SFY11 and SFY12 was 30%; however, the increase in total maltreatment allegations from SFY10 to SFY11 increased by 255%. This means that over a three year period (SFY10 to SFY12), OHFC has experienced a staggering 362% increase in maltreatment allegations, all of which require in-office investigations.

While the number of total allegations of maltreatment has been increasing, the number of onsite investigations that resulted in substantiated maltreatment findings have been slightly decreasing. Any reduction in substantiated maltreatment is a positive sign of the treatment of vulnerable adults in Minnesota. In SFY10, 31% of alleged maltreatment onsite investigations were found to be substantiated allegations. In SFY11 21% of those investigations were determined as substantiated maltreatment. SYF12 resulted in still thousands more maltreatment allegations than the previous year, and approximately 18% of the allegations that were investigated onsite resulted in substantiated maltreatment findings.

## B. Maltreatment Data: Source of Maltreatment Allegation

The following two charts break down the information in the first chart by whether the allegation of maltreatment was received as a complaint or whether the allegation was received as a facility-reported incident.

The data below represents the number of allegations of maltreatment that originated as a complaint (i.e. not originated from a facility self-report). Included is 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

The next table depicts the number of 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

Over a three year period (SFY10 to SFY12), the total facility-reported incidents of maltreatment received increased by 396%. It is believed that part of the reason is due to the complexity between required state and federal reporting; some facilities choose to report all incidents, even if they don’t meet the requirements of reporting.

Another reason this substantial increase may have occurred has to do with an emerging trend MDH identified in SFY12 related to the increased issuance of citations related to reporting (F225 and F226). It is believed that nursing facilities began reporting everything in an attempt to avoid any citations/deficiencies during a complaint investigation and/or survey related to failure to report.

Since this “over reporting” puts a strain on the workload of OHFC and the common entry points, the emerging trend was shared with providers during a statewide call. The Licensing & Certification Program and the Office of Health Facility Complaints then worked together as a team in order to address any consistency and accuracy issues of these particular tags and shared with providers the additional guidance CMS had issued regarding these deficiencies that relate to reporting.

### Source of Maltreatment Allegation by Provider-type

Tables 2 and 3 above separated complaints from facility-reported incidents, which showed that facility-reported incidents make up the majority of the total maltreatment allegations received (93%). In order to provide further background on the source of maltreatment allegations, Table 4 below again separates the total number of complaints/reports received in SFY12 by the same two categories of complaints and facility-reported incidents. Then 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
Nursing Home	283	588	516
Hospital	13	18	19
Home Health	168	419	538
Other Licensed Entities	29	112	150
<b>Total Complaints Received</b>	<b>493</b>	<b>1,137</b>	<b>1,223</b>
Facility Reported Incidents	SFY 10	SFY 11	SFY 12
Nursing Home	2,679	10,152	13,546
Hospital	37	101	140
Home Health	239	874	1,113
Other Licensed Entities	160	559	645
<b>Total Facility Reports Received</b>	<b>3,115</b>	<b>11,686</b>	<b>15,444</b>
<b>Grand Total</b>	<b>3,608</b>	<b>12,823</b>	<b>16,667</b>

Nursing homes are by far the largest source of allegations of maltreatment. Eighty-four percent (14,062) of all complaints/reports of alleged maltreatment received in SFY12 related to nursing homes, and 96% of those allegations were initiated by the providers themselves as facility-reported incidents (please see previous page for possible reasons for increased nursing home reporting in SFY12).

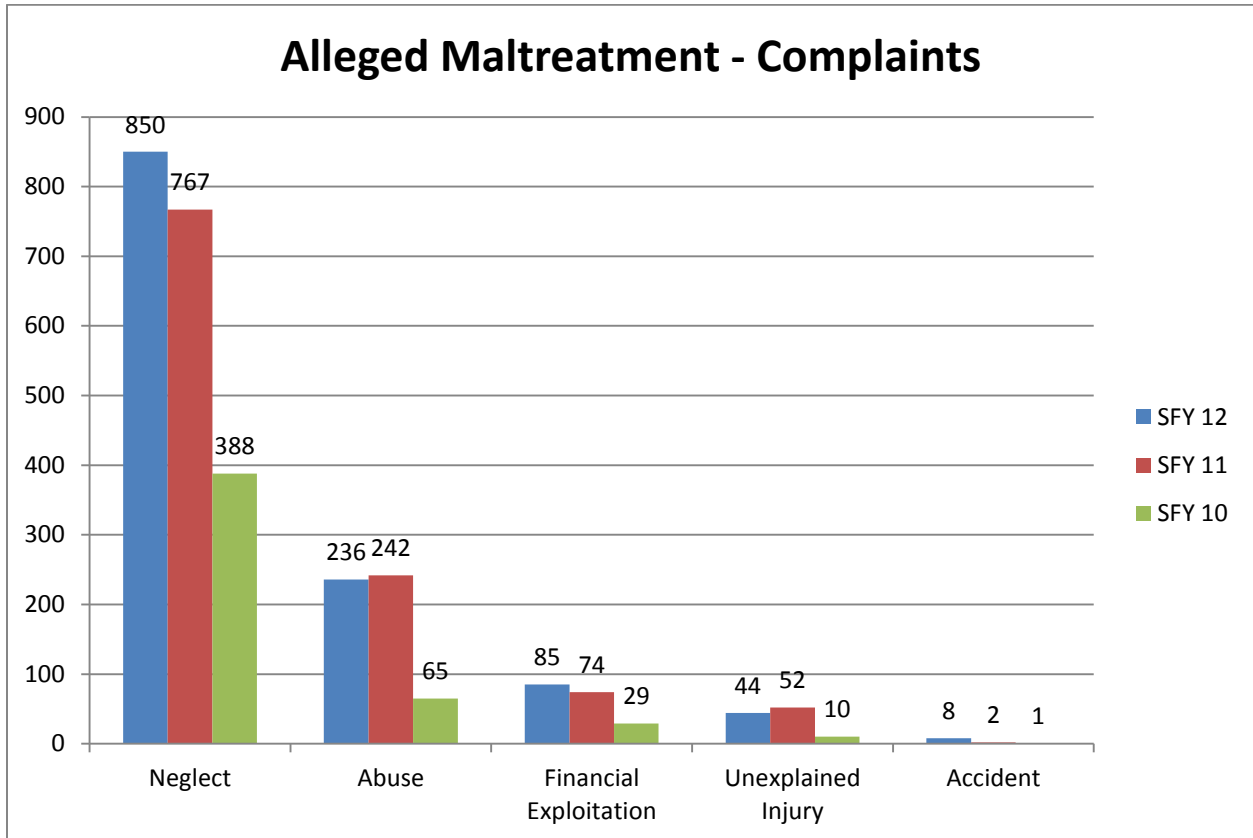
The data in Table 4 above also reflects a trend of increasing complaints and reports of allegations of maltreatment with home health providers. In fact, in SFY12 more complaints of alleged maltreatment were related to home care than to nursing homes. From SFY10 to SFY12, there has been a 220% increase in complaints related to allegations of maltreatment with home health providers, and a 366% increase in “provider-initiated” reports of maltreatment with home health providers. Since the number of home health providers in Minnesota only increased by 4% from SFY10 to SFY12, we can attribute much of the substantial increase in maltreatment allegations to home care providers gaining a better understanding of reporting requirements.

### **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.

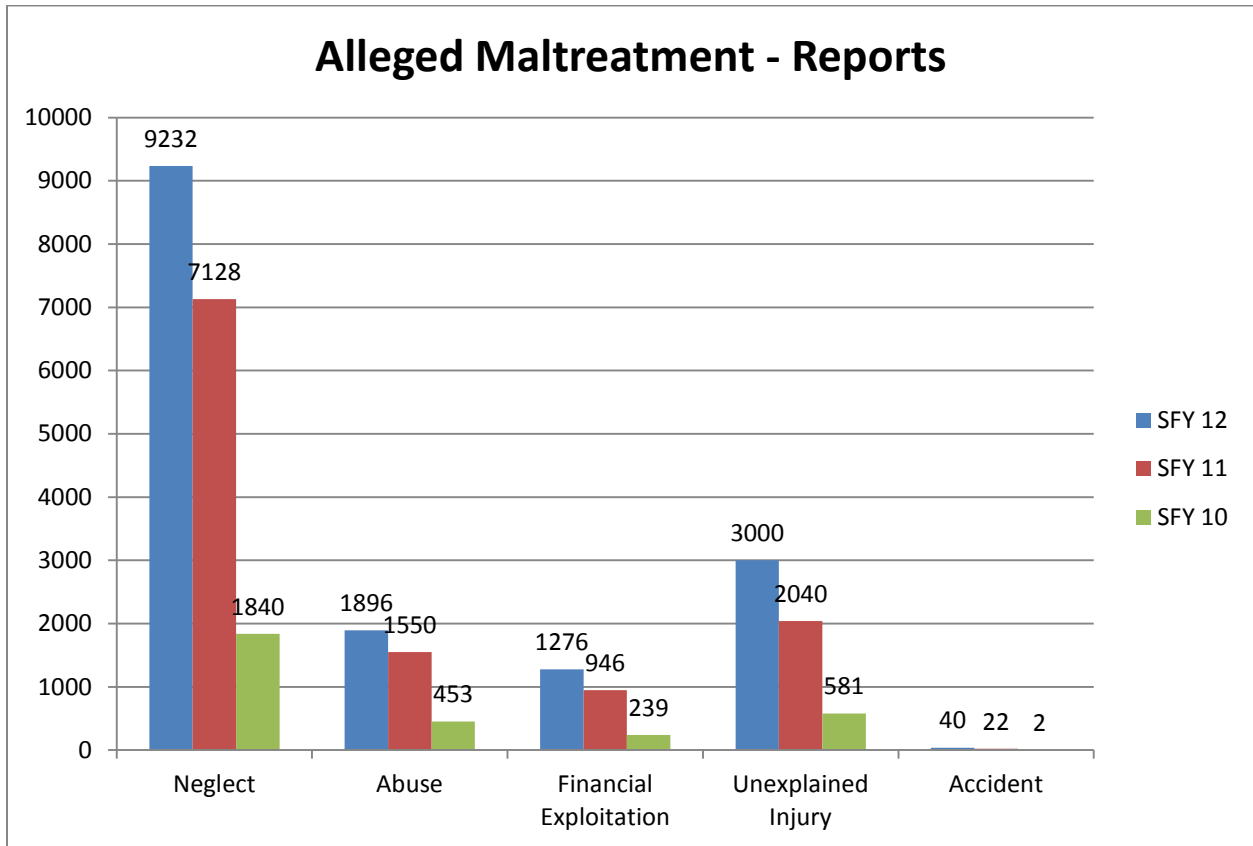
Note this information represents **allegations** of maltreatment and not final maltreatment determinations resulting from onsite investigations.

**Figure 1: Maltreatment Complaint Allegations - Number Received & Type of Violation**



Neglect is by far the most common type of allegation of maltreatment received as a complaint, with abuse being the second most common. In SFY12, 70% of all complaint maltreatment allegations were related to neglect, 19% of complaint allegations were related to abuse, 7% related to financial exploitation, 4% 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 15% from SFY11 to SFY12. The number of maltreatment complaint allegations of abuse also slightly decreased in SFY12 compared to the previous year.

**Figure 2: Maltreatment Report Allegations - Number Received & Type of 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 (60%) in SFY12. Unexplained injury is the second most common at 19% and abuse comprised 12% 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. In every category of maltreatment, allegations that were facility-reported incidents increased from SFY11 to SFY12.

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: 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). A 2011 change in 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 with 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 2011 federal imposition of this strict two day investigation requirement, OHFC’s backlog has continued to decrease over the past three years, going from 16% completed within 60 days in SFY10, 18% completed within 60 days in SFY11, and 30% completed within 60 days in SFY12. This reflects a 52% improvement between SFY11 and SFY12 in the number of onsite investigations completed within 60 days.

**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	764	231	70%	30%

## **E. Maltreatment Data: Where Adequate Coverage Requires Additional Appropriations and Staffing**

Though OHFC has continued to improve on the number of onsite investigations completed within 60 days, the goal for even better timely completion rates remains a focus. The stringent time requirements, travel demands, and the general stress that is involved in this kind of 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. For example, the state shutdown in July 2011 impacted the timeframes to complete investigation and resulted in a significant backlog of cases that needed to be completed. 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; continued streamlining of the public case report; identification of IT enhancements allowing the transfer of information between federal and state data bases reducing the need for double entry; increased education and communication with providers through quarterly calls, video conferences, and subgroup meetings to clarify and streamline reporting requirements and processes; collaboration with DHS to develop increased consistency of the background study process; increase OHFC efficiency through staff retention by increasing the option of telecommuting for OHFC investigators; and increasing the number of staff in MDH district offices to reduce the amount of travel for OHFC investigators. 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

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- The total number of maltreatment allegations received has risen substantially over just a few years. Over a three year period (SFY10 to SFY12), OHFC has experienced a 362% increase in maltreatment allegations (all which require in-office investigations). The percent increase of maltreatment allegations between SFY11 and SFY12 was 30%.
- Reporting of alleged maltreatment relating to home health providers continues to rise substantially. The increase of allegations of maltreatment relating to home health providers is deriving from both complaints and from facility-reported incidents. From SFY10 to SFY12, OHFC has seen an overall increase of 306% of alleged maltreatment relating to home health providers. This increase does not match the growth of home health providers (which was only 4% 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.
- 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 Center 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. The hope is that a single common entry point would limit the number of incidents that are not reportable under the state and/or federal regulations.
- Hospital complaints and reports have remained fairly consistent over the past 3 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.
- Financial Exploitation continues to be an area of concern with related allegations from SFY10 to SFY12 increasing by 408%. Oftentimes the perpetrator in these cases uses the vulnerable adult's money to make payments on personal accounts. Financial exploitation includes drug diversions when the medication belong to a resident is used for another person's benefit. The maltreatment report reflecting SFY13 data will include drug diversion as its own category.