

# Maltreatment Report

This report combines information about reports and investigation of alleged maltreatment of both vulnerable adults under Minnesota Statutes, section 626.557, and minors under Minnesota Statutes, section 626.556 in Department of Human Services (DHS) licensed programs.

This report covers FY 2011 and FY 2012

Department of Human Services

Office of Inspector General

Licensing Division

April 2013



### **COST OF PREPARING THE REPORT**

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

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

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

It took approximately 40 hours of staff time to prepare the report. Based on an estimate of \$50 per hour for salaries and benefits, staff costs for preparing the report were \$2,000. The cost of printing and distributing 17 copies of the report is minimal. Therefore, the total cost of preparing, printing, and distributing this report is estimated to be \$2,000.

The report will also be available to the public on the Department of Human Services Division of Licensing web site (<http://www.dhs.state.mn.us.licensing/>).

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## **LEGISLATIVE DIRECTIVE**

Minnesota Statutes, section 626.557, requires DHS to annually report to the Legislature and the Governor information about alleged maltreatment in licensed facilities. Minnesota Statutes, section 626.557, subdivision 12b, paragraph (e), states:

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 to statutory time frames;
- (2) Where adequate coverage requires additional appropriations and staffing; and,
- (3) Any other trends that affect the safety of vulnerable adults.

## EXECUTIVE SUMMARY

**Reporting period:** FY 2011 and FY 2012

Although this report specifically addresses fiscal years 2011 and 2012, the charts and graphs generally provide data for five fiscal years in order to show changes occurring over the past five years. For report data prior to FY 2008, see the maltreatment reports from previous years.

**Focus:** The focus of this report is the investigation of maltreatment in the Department of Human Services (DHS) directly licensed programs (approximately 4,000 programs) and adult foster care (approximately 4,750 programs). Adult foster care is licensed by DHS; however, except for investigating maltreatment and issuing licensing sanctions, the monitoring and oversight responsibilities for adult foster care has been delegated to the counties under Minnesota Statutes, section 245A.16.

Data in this report combines information about reports and investigation of alleged maltreatment of both vulnerable adults under Minnesota Statutes, section 626.557 and minors under Minnesota Statutes, section 626.556 in DHS licensed programs.

**Purpose:** This report is issued pursuant to Minnesota Statutes, section 626.557, subdivision 12b, paragraph (e), which directs the Commissioner to report on the following:

- (1) Whether and where backlogs of cases result in a failure to conform to statutory time frames;
- (2) Where adequate coverage requires additional appropriations and staffing; and,
- (3) Any other trends that affect the safety of vulnerable adults.

The report also includes data on the number and type of reports of alleged maltreatment involving licensed facilities reported to DHS, the number of those requiring investigation, and the resolution of those investigations.

### Data Trends

The following chart shows the number of reports received during the last five years. In-office investigation is conducted on reports that require additional information in order to determine whether the report will be assigned for site investigation of maltreatment, assigned for investigation of possible licensing violations, or screened out. An average of 930 reports per year required in-office investigation.

Reports are also received that are outside DHS jurisdiction; these are referred to other agencies with jurisdiction. This report focuses on out-of-office investigations of alleged or suspected maltreatment and reviews of reported deaths of vulnerable of vulnerable adults or children.

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<b>General Data</b>	<b>FY 11</b>	<b>FY 12</b>	<b>5 year average</b>
Reports received	4,486	4,921	4,582
No jurisdiction <sup>1</sup>	234	398	317
In-office investigation	846	912	930
Not assigned for further investigation	2,041	2,309	2,209
Reports referred to other entity	839	847	794
Assigned to DHS licensors – licensing complaint	679	588	636
<b>Data which is focus of the report</b>			
Assigned for out-of-office investigation or death review	953	1,053	958
Maltreatment allegations in reports assigned	1,177	1,247	1,209
Licensing allegations in reports assigned to maltreatment investigators	134	78	145
Investigations of maltreatment	820	649	796
Death reviews	169	156	167 <sup>2</sup>
Total out-of-office maltreatment investigation and death reviews completed	989	805	929
Reports substantiated <sup>3</sup>	218	174	225
Allegations substantiated	274	217	277
Individuals disqualified from direct contact	92	59	76
Reports assigned and pending investigation	379	629	458

Note: This data was included in calculating the average number of investigations which an investigator can complete per year (40 reports).

**Trends Affecting the Safety of Vulnerable Adults:**

- There is an increasing number of reports received for assessment by DHS.
- There is an increasing number of reports received that require in-office investigation.
- There was a significant increase in the number of reports assigned for out-of-office investigation or death review in FY12, an increase of 100 reports (approximately 10 percent).
- The number of completed investigations declined.

<sup>1</sup> Event did not occur in a DHS licensed program.

<sup>2</sup> Based on a four-year average

<sup>3</sup> Substantiated means that it was determined that an event/incident occurred that met a definition of maltreatment.

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- The percent of investigations substantiated and the percent of individuals disqualified for serious and/or recurring maltreatment following investigation remains fairly consistent.
- The overall trend regarding substantiated abuse is generally decreasing, neglect is increasing, and financial exploitation is generally remaining the same.

***Performance Results***

**Statutory requirements:**

- An initial determination of what the response will be to a report must be provided to the reporter of the event within five days;
- An investigation should be completed within 60 days; and,
- If the investigation is not completed within 60 days, notice must be given to the vulnerable adult or the vulnerable adult's legal guardian and the facility as to why the report is not completed. A projected completion date is also required.

**Completed Investigations:**

- In FY 2011, the percent of reports completed within 60 days was 36 percent.
- In FY 2012, the percent of reports completed within 60 days was 25 percent.

**Reports Pending:**

- Reports pending at the end of FY 2011: 379
- Reports pending at the end of FY 2012: 629 (includes one death review)

**Where Adequate Coverage Requires Additional Appropriations and Staffing:**

- When staffing levels are at full complement, it is anticipated that approximately 840 to 900 maltreatment investigations and death reviews can be completed per year.
- The high completion rate in FY 2011 was due, in large part, to overtime hours worked by maltreatment investigators.
- The decrease in the number of investigations completed in FY 2012 was due in part to the three-week state shut down.

## I. INTRODUCTION AND BACKGROUND

The Department of Human Services (DHS), in partnership with counties, licenses approximately 23,000 service providers and monitors and investigates their compliance with Minnesota laws and rules. The purpose of licensing is to protect the health, safety, rights and well-being of those receiving services by requiring that providers meet minimum standards of care and physical environment. Licensed programs serve thousands of people in child care centers, adolescent group homes, adult day care centers, day training and habilitation programs, as well as residential and outpatient programs for people with chemical dependency, mental illness or developmental disabilities. The focus of this report is the investigation of maltreatment in DHS directly licensed and monitored programs (approximately 4,000 licensed programs) and in adult foster care homes (approximately 4,750 licensed programs). Except for investigating maltreatment and issuing licensing sanctions, the monitoring and oversight responsibilities for adult foster care has been delegated to the counties under Minnesota Statutes, section 245A.16.

Data in this report covers the five-year period from FY2008 to FY2012 and combines information about reports and investigation of alleged maltreatment and death reviews of both vulnerable adults under Minnesota Statutes, section 626.557 and minors under Minnesota Statutes, section 626.556 in DHS licensed programs.

The statutes most relevant to the investigation of maltreatment are:

- Minnesota Statutes, section 626.557, the Reporting of Maltreatment of Vulnerable Adults Act (VAA)
- Minnesota Statutes, section 626.556, the Reporting of Maltreatment of Minors Act (MOMA)
- Minnesota Statutes, Chapter 245A, the Human Services Licensing Act (HSLA)
- Minnesota Statutes, Chapter 245C, the Human Services Background Study Act.

From 1995 to the present, there have been significant changes to both the VAA and the MOMA. One such change made DHS the sole agency responsible for investigating reports of maltreatment in DHS directly licensed programs and in adult foster care homes.

Except for adults in outpatient chemical dependency treatment programs and adults in DHS' two sexual psychopathic personality treatment programs, all adults served in DHS licensed programs are categorically "vulnerable adults" under the VAA.

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Over time, statutory changes have increased the complexity of maltreatment investigations by initiating an appeal process and requiring extensive notifications of decisions made and actions taken. Because statutory background study requirements direct DHS to disqualify people from providing direct contact service when they are found responsible for serious or recurring maltreatment, the changes have also addressed standards for determining who was responsible for maltreatment. Today, each investigation must determine:

- What actually occurred;
- Whether the event met the definition of maltreatment;
- Whether an individual or facility was responsible for substantiated maltreatment;
- Whether the maltreatment committed by an individual was serious and/or recurring;
- Whether action was necessary to reduce the likelihood of recurrence of the event to protect the health and safety of vulnerable adults and children; and,
- Whether further action is required by DHS related to the facility or the individual alleged perpetrator.

The complexity of investigations requires an extensive training period for new investigators and limits the number of investigations each investigator can adequately complete. Most investigations include a visit to the program; since DHS investigators are based in St. Paul, the investigator must travel to other parts of the state as necessary.

Investigators are required to conduct numerous interviews, obtain pertinent documents, carefully review the documents, and make a determination as to what actually occurred. After a maltreatment determination is made, investigators are also involved in preparing documents for the appeal and testifying at the appeal hearings. In addition to the out-of-office investigation duties, maltreatment investigators also complete in-office investigations and assess initial reports received. A trained investigator can complete approximately 40 investigations per year.

It is worth noting that for home and community-based services for people with disabilities, the costs to the division for investigating alleged or suspected maltreatment far outweigh the costs of routine monitoring under the current licensing statute. As new licensing fees are calculated for regulated services, the actual costs for investigating alleged maltreatment are about twice the cost for the routine licensing activities. Therefore, legislative proposals for changes must be increasingly focused on overall program integrity and compliance with regulations.

## **II. CURRENT STATUS AND TRENDS**

### **A. Reports investigated**

Reports of maltreatment are received from county staff members, family members of vulnerable adults and children, staff members of licensed programs, other professionals working with people receiving services, and community persons. It is required by statute that all deaths of vulnerable adults and children in licensed services be reported by the program serving the individual.

The number of reports of suspected maltreatment of vulnerable adults and children received by DHS has generally increased over time.

When initial reports are received, many of the reports do not include adequate information for DHS to determine the harm, or risk of harm, presented to the vulnerable adult or child by the reported events or conditions, or whether the issue reported represents maltreatment or a licensing violation. These reports are assigned for in-office investigation. If information obtained from the in-office investigation indicates harm, or a high risk of harm, to the vulnerable adults or children affected, and the incident appears to meet the statutory definition of maltreatment, then the report is assigned for out-of-office investigation. Each report begins with research of DHS data to determine if there is any history available on the vulnerable adult or child, the facility, or the staff person involved.

Each report involving the death of a vulnerable adult or child is immediately assigned for initial investigation.

For reports involving systemic licensing issues, the report may be assigned to a licensing unit for an out-of-office investigation related to licensing standards instead of, or in addition to, a maltreatment investigation.

The number of assigned and completed investigations in this report refers only to reports assigned for maltreatment out-of-office investigations and in-office death reviews. An investigation is considered completed when the investigation memorandum required in statute is written and all required notices of the findings have been issued. (This report does not address the resolution of reports assigned for investigation of alleged licensing violations with no allegation of maltreatment.)

- The number of reports receiving an in-office investigation has averaged 930 for the last five years.
- In FY 2011, 4,486 reports were received for assessment.

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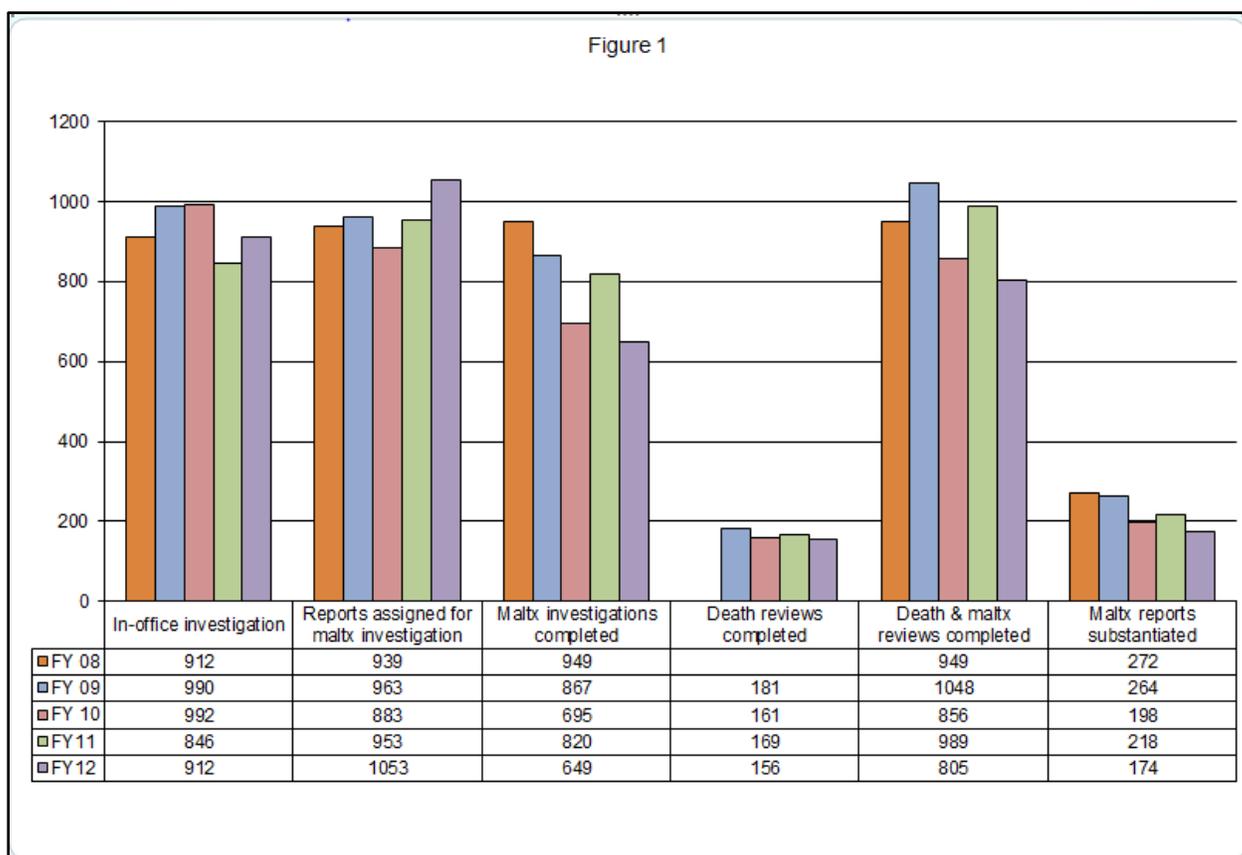
- In FY 2012, 4,921 reports were received for assessment. Historically, the percent assigned for out-of-office investigation has ranged from 19 to 21 percent.
- In FY 2012, 1,053 maltreatment reports were assigned for out-of-office maltreatment investigation or death review, an increase of 100 investigations over FY 2011.
- The 953 reports assigned for out-of-office maltreatment investigation or death review in FY 2011 included 1,177 allegations of maltreatment and 134 allegations of licensing violations (1.4 allegations per report).
- The 1,053 reports assigned for out-of-office investigation in FY 2012 included 1,247 allegations of maltreatment and 78 allegations of licensing violations (1.3 allegations per report.)<sup>4</sup>
- In FY 2011, 989 investigations were completed. In 218 of the reports, maltreatment was substantiated, approximately 27 percent of the reports investigated (after deducting the death reviews). Ninety-two individuals were disqualified from providing direct contact services in licensed programs due to serious or recurring maltreatment.
- In FY 2012, 805 investigations were completed. In 174 of the reports, maltreatment was substantiated, representing approximately 27 percent of the reports investigated (after deducting the death reviews). Fifty-nine individuals were disqualified from providing direct contact services in licensed programs due to serious or recurring maltreatment.
- The number of pending investigations is increasing. At end of FY 2011, there were 379 reports pending (none of the reports pending was a death review). At the end of FY 2012, there were 629 (one of the reports pending was a death review).
- The trend of increasing reports received and assigned for investigation from outside of the metro area appears to have stabilized. In FY 2011 and FY 2012, approximately 55% of reports assigned were outside the metro area and 45% were in the metro area.

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<sup>4</sup> When all of the people receiving services are alleged to be subjects of the maltreatment, this is counted as one allegation. When a report includes alleged maltreatment and licensing violations the report is assigned for maltreatment out-of-office investigation.

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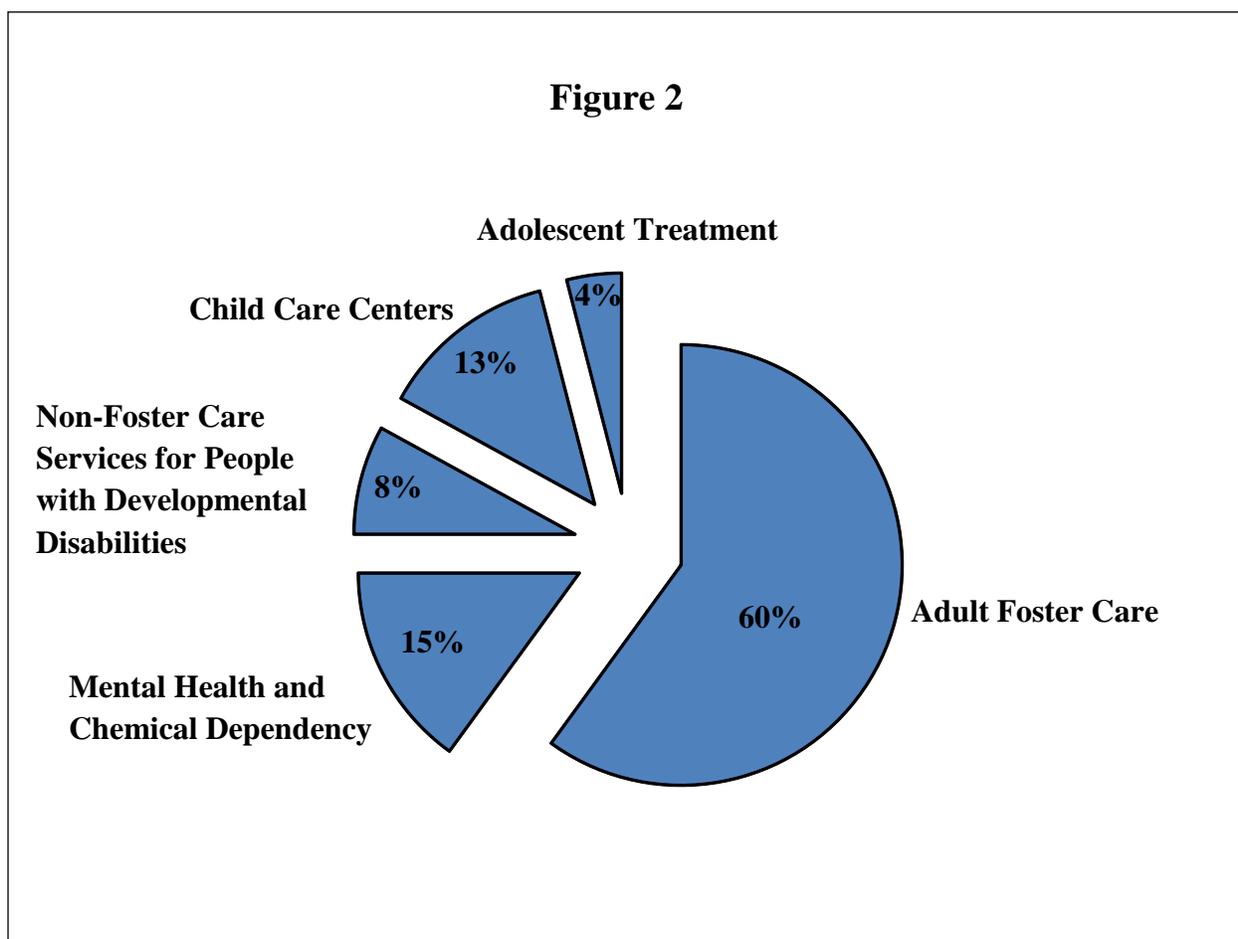
**Figure 1** depicts an overview of reports received, reports resulting in in-office or out-of-office investigations, reports completed, and reports substantiated.



**B. Type of program/vulnerability of victim**

In FY 2011, 86 percent of reports assigned for out-of-office maltreatment investigation involved a vulnerable adult and 14 percent involved a child. In FY 2012, 84 percent of reports assigned for out-of-office investigation involved a vulnerable adult and 16 percent involved a child.

**Figure 2** shows the types of programs where victims of reports assigned for out-of-office maltreatment investigation received services in FY12.



### III. RESOLUTION OF INVESTIGATIONS

**Determinations:** Under the maltreatment reporting and investigations statutes, the licensing statute, and the background study statute, various types of resolutions are possible at different stages of the investigation. These include an initial determination, a determination of whether maltreatment occurred, and a determination as to whether action is necessary to decrease the risk of recurrence of maltreatment, and what that action should be.

#### A. Initial Determinations

After an initial investigation to obtain information regarding the vulnerable adult or child, the facility, and the staff person(s) involved, one of five possible determinations is made:

- No jurisdiction because the event did not occur in a DHS licensed program.
- No further investigation is necessary because the event does not meet a statutory definition of maltreatment and does not represent a possible licensing violation.
- In some limited cases, further investigation is not necessary because of low risk (the vulnerable adult or child was not physically injured and risk of injury is low because the facility took action to reduce the risk of recurrence).
- The report is assigned for licensing out-of-office investigation.
- The report is assigned for maltreatment out-of-office investigation.

Due to the seriousness of reports involving the death of a child or vulnerable adult, all such reports are immediately assigned to a senior investigator for an in-office investigation. If resulting information indicates possible maltreatment, the report is assigned for an out-of-office investigation.

#### B. Did Maltreatment Occur?

Each report assigned for out-of-office investigation will result in a determination of whether or not maltreatment occurred. If maltreatment occurred, a determination is made as to whether:

- An individual(s) or facility was responsible for the maltreatment.
- The maltreatment was serious and/or recurring if an individual was responsible for the maltreatment.
- Any action is appropriate to reduce the risk of recurrence, including:
  - Disqualification of an individual (when an individual is found responsible for substantiated maltreatment); or,

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- Issuance of a fine issued to the facility (when the facility is determined to be responsible for substantiated maltreatment).

Investigations of alleged maltreatment of a child can result in conclusion of:

- “Maltreatment determined” or
- “Maltreatment not determined”

Investigations of alleged maltreatment of a vulnerable adult can result in findings that the report was:

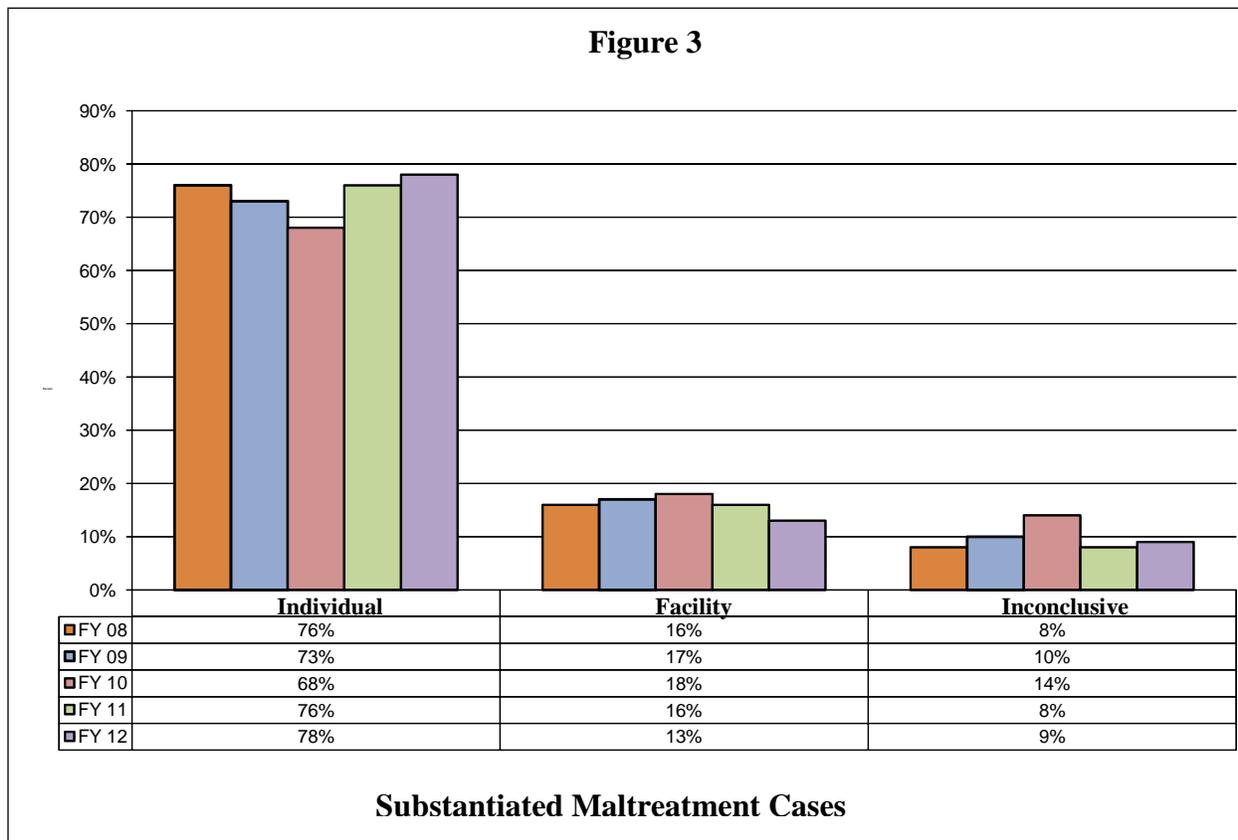
- Substantiated
- Inconclusive
- False
- No determination will be made

For the sake of tables in this report, the terms “determined” and “substantiated” are both represented as “substantiated.”

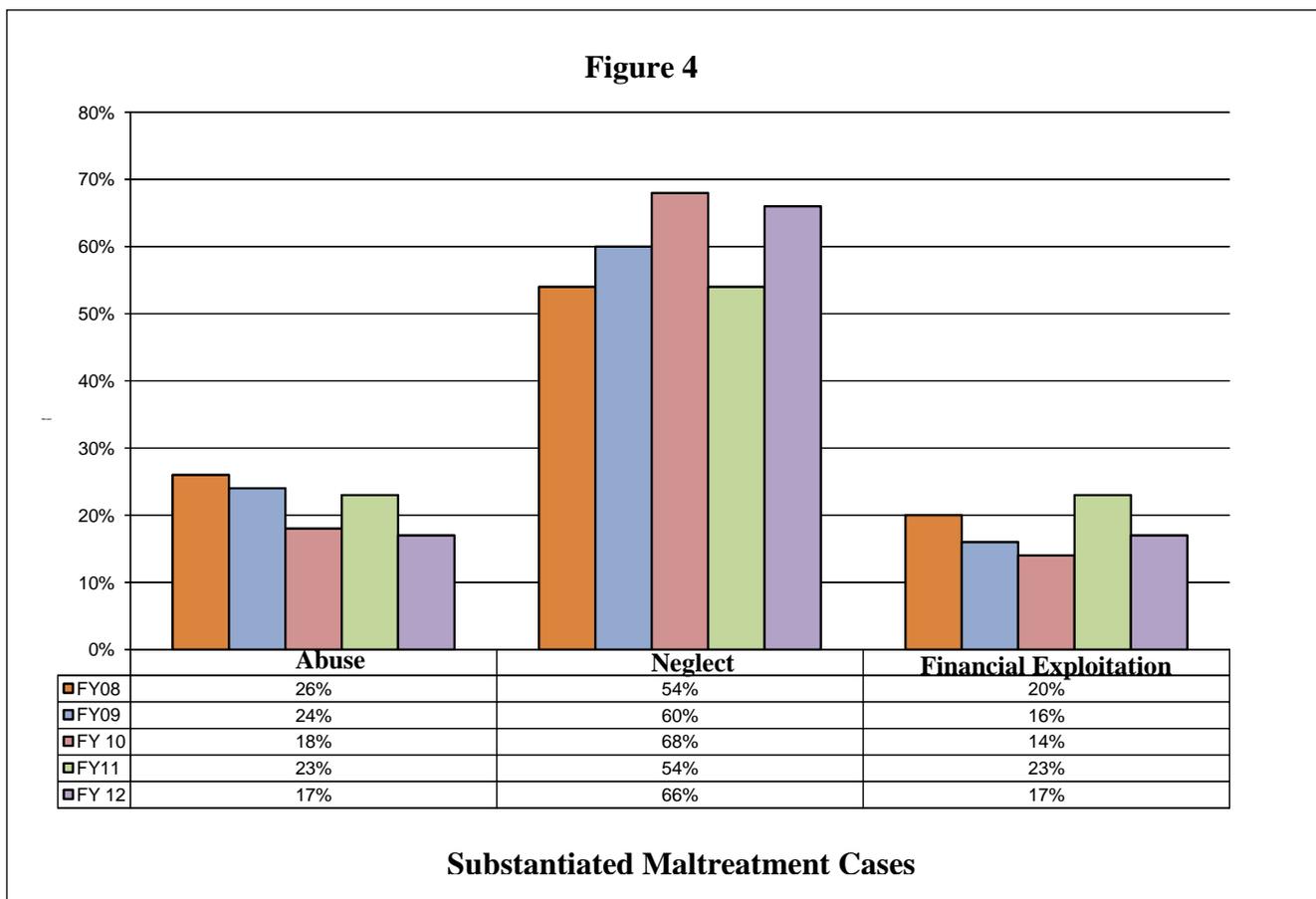
Between FY 2008 and FY 2012, the average percent of assigned out-of-office investigation reports that were substantiated decreased modestly each year from a high of 27% in FY 2008 to 21% in 2012.

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**Figure 3** For investigations that resulted in substantiated maltreatment during FY2008 through FY2012, this chart shows the percentage of cases committed by an individual, a facility, or where there was a finding of inconclusive responsibility.



**Figure 4** shows the type of maltreatment that was substantiated. The overall trend is one of decreasing abuse, increasing neglect and fairly consistent findings of financial exploitation (vulnerable adults only).



**C. Was Action Necessary to Decrease the Risk of Recurrence?**

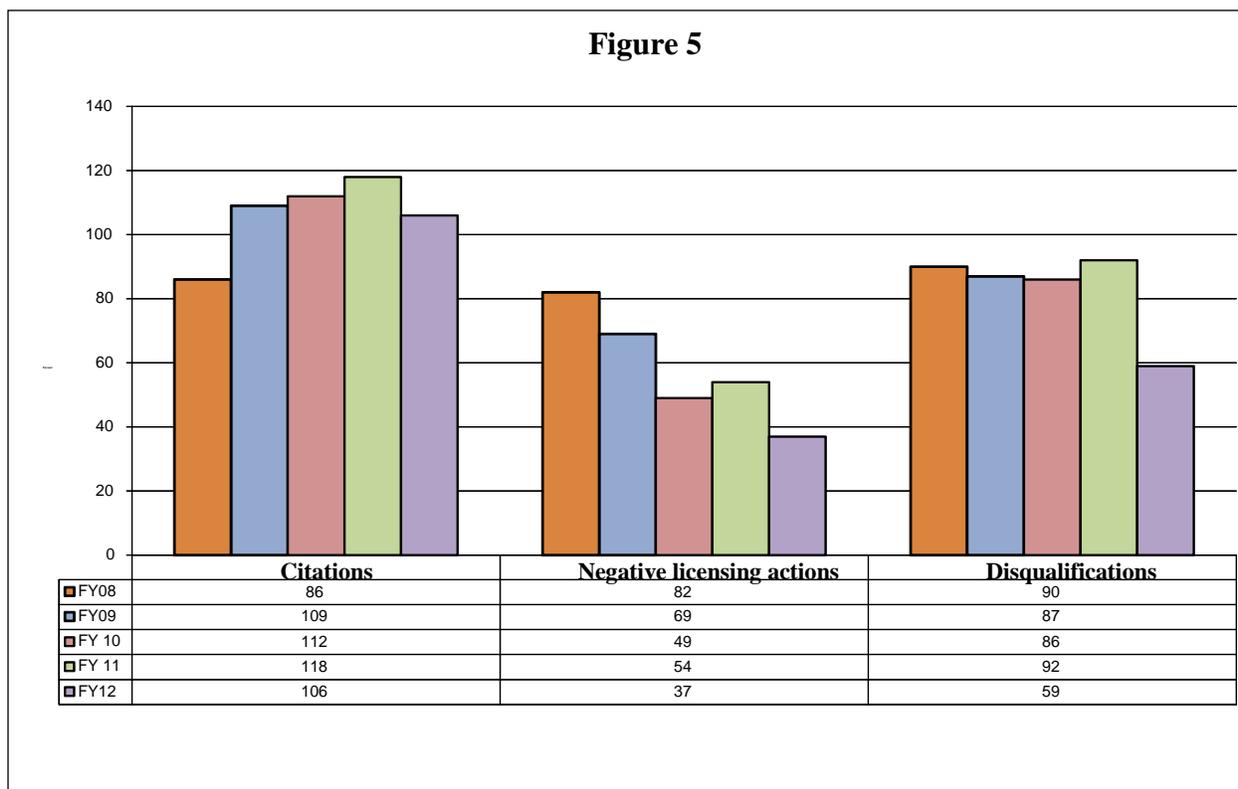
This section focuses on the resolution of reports assigned for out-of-office maltreatment investigation for which DHS determined that maltreatment occurred, and a determination was made that action was necessary to reduce the risk of recurrence. Possible actions taken by DHS to reduce the risk of recurrence of maltreatment are authorized under Minnesota Statutes, Chapters 245A and 245C, and include:

- Disqualification of an individual from providing direct care to persons served in programs licensed by DHS, the Department of Health, the Department of Corrections, and Personal Care Provider organizations

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- Issuance of a citation(s) ordering a facility to correct a licensing violation
- Issuance of a negative licensing action (such as a fine, conditional license, suspension, or revocation of a license).

**Figure 5** illustrates actions taken by DHS following substantiated maltreatment.



**IV. Whether and Where the Numbers of Pending Cases Result in Failure to Conform to Statutory Time Frames**

Statutory requirements include:

- Notice to the reporter of the initial determination of a report within five days
- Completion of the investigation within 60 days
- If the investigation is not completed within 60 days, notice to the vulnerable adult or the vulnerable adult’s legal guardian and the facility of why the report is not completed and a projected completion date.

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- In FY 2011, the percent of reports completed within 60 days was 36%.
- In FY 2012, the percent of reports completed within 60 days was 25%.

**Pending reports:**

- There were 379 reports pending at the end of FY 2011.
- There were 629 reports pending at the end of FY 2012.

The average number of months necessary to complete investigations (approximately four-to-five months) has remained approximately the same in FYs 2011 and 2012.

**V. A Plan to Address Resource Needs**

The Licensing Division has completed significant work to maximize its use of resources, including the centralization of report intake functions and the restructuring of duties within the division. This centralized intake unit now receives, processes, assesses and assigns all reports received by the Licensing Division. To prevent investigation duplication across agencies for reports involving the Minnesota Security Hospital and the Minnesota Sex Offender Program, the Licensing Division receives all reports.

The Licensing Division conducts an initial investigation and determines whether the Licensing Division will investigate alleged maltreatment or a possible licensing violation. Notification of the report, initial investigation information, and whether the Licensing Division will be investigating is then provided to the Minnesota Department of Health's Office of Health Facility Complaints and the Ombudsman for Mental Health and Developmental Disabilities.

In addition, the Licensing Division receives all reports of maltreatment of a vulnerable adult electronically from county common entry points where all reports alleging maltreatment of a vulnerable adult are required to be made under law.

Each report received is prioritized for investigation according to standardized criteria based on the potential risk of harm to vulnerable adults or children. Reports with the greatest harm, and/or highest risk of harm, are prioritized for out-of-office investigation.

At full complement of 21 investigators, the Licensing Division can be expected to complete approximately 840 investigations per year. Although the performance standard that investigators complete 40 out-of-office investigations per year has not changed, the number of reports received and assigned is increasing.

The Department of Human Services is concerned about the increasing number of pending investigations. While the Department would like to see more investigations completed annually, it is more concerned about maintaining the integrity of the investigative work.

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Due to the significant actions taken that affect both individuals and facilities, it is critical that investigations are thorough and complete.

After careful consideration about how to address the investigations resource issue, the DHS Office of Inspector General has developed several 2013 legislative proposals. The proposals are designed to provide some additional maltreatment investigation resources, but they are also designed to improve regulatory compliance through increased oversight and investigation of financial integrity related to public funding. If the adherence to regulations is enhanced, the hope is that the rate of alleged maltreatment could perhaps decrease. The following are summaries of the proposals.

1. The expansion of licensure of home and community-based services standards, under Minnesota Statutes, chapter 245D is being proposed by the Department in the Governor's budget bill to require the licensure of some additional services that are currently not licensed. This proposal also makes changes to some licensed services for people with developmental disabilities. Many of the services affected by the changes are provided in the adult foster care settings that account for 60% of maltreatment investigations referenced in this report as shown in Figure 2, and changes also affect the 8% of the services represented in Figure 2 related to non-foster care services for people with developmental disabilities. Some of the new licensing and service standards were passed by the 2012 Legislature but will not be effective until July 1, 2013. The new licensing and services standards, with the necessary licensing fees to support the oversight and maltreatment investigations, are before the 2013 Legislature. This legislative proposal seeks nine additional FTEs for the licensing division in FY14 and an additional 12 FTEs in FY15. Of those new positions, eight and nine, respectively, are proposed maltreatment investigator positions. With these new positions will come additional maltreatment investigation responsibilities, but with the total of 30 maltreatment investigators at the end of the second year of the biennium, the resources should more closely match the workload.
2. Changes in child care licensing are being proposed in the 2013 Legislative Session aimed at preventing deaths in child care settings. The changes are intended to strengthen child care licensing, improve the quality and consistency of licensing oversight, improve safe sleep practices, improve and subsidize training for providers, and increase public awareness. This proposal calls for funding an additional six licensing positions over the biennium.
3. DHS is also proposing to establish a team of child care provider fraud investigators to work with child care assistance program and licensing staff, as well as law enforcement, at various government entities to conduct investigations. The proposal calls for adding six fraud investigators and two licensors over the biennium who will be able to focus attention on noncompliant providers.
4. The federal Affordable Care Act made numerous changes to the Medical Assistance (MA) program to fight fraud, waste and abuse. One proposal requires that MA providers be screened to ensure that they are qualified to perform services under state and federal

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requirements, and eligible to participate in health care programs. This proposal would add six OIG staff to conduct out-of-office visits to some providers before and after they enroll for reimbursement with Medical Assistance funds.

5. Another 2013 legislative proposal will expand the capacity of the Surveillance and Integrity Review System (SIRS) unit within the OIG in order to increase fraud investigations. Currently, there are 10 investigators responsible for covering over 78 different provider types and over 154,000 enrolled health care providers who are being paid \$8.6 billion a year from Minnesota Health Care Programs. The addition of six additional investigators in the next fiscal year will help considerably in investigating providers who have shown significant noncompliance with regulatory requirements and who have been identified as having fraud indicators.

While eight of the Office of Inspector General's total 35 new positions planned and requested of the 2013 Legislature for the 2014 fiscal year are directly maltreatment investigator positions, all of the expansion seeks to achieve additional provider accountability across the programs regulated by the Licensing Division. The enhanced pre- and post-enrollment inspections of some Medical Assistance reimbursed providers, with increased resources to investigate billing anomalies in Medicaid funded services and childcare assistance funded services, the increased resources for addressing high risk child care providers, and the overall increase in licensing and monitoring of home and community-based services, will hopefully assist providers in maintaining compliance and ideally decrease the number of complaints that need investigation as possible maltreatment.

Another option to address the number of pending cases is a pilot project currently underway to modify the current public investigation memorandum for investigations that results in a finding of false, inconclusive, or maltreatment not determined. For those findings an abbreviated report will be used. This might provide some workload relief but will not fully address the issue.

Along with the issue of resources is the question of how those resources are used and whether greater efficiencies can be achieved. When resources are scarce, it is difficult to commit staff to activities not directly related to the immediate mission. However, finding greater efficiencies should be a priority. Over the next year, the Licensing Division will explore conducting a LEAN-type project to review the maltreatment investigation process from start to finish (from intake to the filing of investigation records) to determine whether additional efficiencies can be realized. This would involve a careful review of all aspects of the process ranging from the guidelines used to determine what needs to be investigated to a review of statutory requirements under Minnesota Statutes, sections 626.556 and 626.557.

Following the 2013 Legislative session, a careful review of any increased appropriation of resources will take place and the Department will begin planning for the next legislative session that may include additional proposals directly related to investigations of maltreatment.

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In conclusion, along with some increases in maltreatment investigation resources, the proposed enhancement of oversight of DHS licensed service providers, and increased enforcement of compliance with Minnesota laws and rules is expected to improve protections of the health, safety and rights of clients and help curb the trend of increasing reports of alleged maltreatment and the number of investigations pending completion.