Complaint Investigations of Minnesota Health Care Facilities

Report to the Minnesota Legislature explaining the investigative process and summarizing investigations from State Fiscal Year 2009 through State Fiscal Year2011.

Minnesota Department of Health

December 2012

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Purpose of the Report

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. This report includes:

- summary data relating to the number of complaints and facility reported incidents received during state FY09 to state FY11;
- summary data about the nature of the allegations contained within those complaints and reports;
- a description of the Office of Health Facility Complaints (OHFC) investigative process, from the intake function to completion of investigations (including issues relating to the performance of its responsibilities).

The latter category includes information on the ability to conform to statutory requirements, the effectiveness of current staffing and any trends relating to the safety of vulnerable adults. 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 information related OHFC investigations under federal regulations visit www.health.state.mn.us/divs/fpc/legislativerpts.html

The Mission of the Office of Health Facility Complaints

The mission of the Minnesota Department of Health (MDH) is to protect, maintain, and improve the health of all Minnesotans. OHFC achieves this goal through investigations of alleged violations of compliance and application of appropriate state and federal regulations to achieve the best outcome for vulnerable adults. 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 MN Attorney General's Office, and the 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.

The Purpose of OHFC

OHFC was created by the Legislature in 1976 to review allegations that licensed health care facilities were not complying with standards established by statute and MDH 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 is a section within the Compliance Monitoring Division (CM) of MDH designated to investigate complaints and reports of non-compliance that occur in facilities licensed to provide health care services in Minnesota. In addition to OHFC, CM includes a Licensing and Certification (L&C) section which conducts ongoing licensing and inspections of health facilities in Minnesota, including investigations of allegations of non-compliance with federal regulations. Increased collaboration between OHFC and L&C over the past several years has resulted in a more comprehensive approach to provider compliance. 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. Complaints that are triaged at a low risk of harm to vulnerable adults are referred to L&C for investigation as part of their regulation inspections. In addition, complaints related to specialized facility types may be referred to L&C for investigation.

State and federal laws authorize anyone to file a complaint about licensed health care facilities with OHFC, including complaints of maltreatment defined under Minnesota Statutes 626.5572 (VAA), as cases of suspected abuse, neglect, financial exploitation, unexplained injuries, and errors as defined in Minnesota Statutes 626.5572, subd. 17(c)(5). State law also mandates that allegations of maltreatment (facility reports) against a vulnerable adult or a minor be reported by the licensed health care entity to OHFC or the Common Entry Point (CEP).

Complaint Process Overview

Intake/Triage Process

Every complaint and facility 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, CEP, and via the OHFC web based reporting system. The intake unit is responsible for gathering sufficient information to make a determination of which complaints and reports will be assigned onsite investigations. Decisions are 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 as onsite investigations. Timeframes for onsite investigations are also based on the level of harm and may vary from 2 days to the next scheduled annual survey. As previously stated OHFC reviews every complaint but may not investigate every complaint or report under the VAA, if another state or federal regulation may provide better outcomes for vulnerable adults.

Although OHFC understands that all complaints are serious to vulnerable adults and their families, not all complaints are prioritized for further investigation or action by OHFC. A number of complaints and reports received may be closed for a number of reasons including: lack of information, incidents that do not represent violations of regulations, incidents older than one year, insufficient information etc. Some complaints are forwarded to other agencies for further action. These agencies may include the Ombudsman office, the Minnesota Attorney General Office, the Office of Inspector General, the Board of Medical Practice, Board of Nursing or other licensing boards. OHFC does not investigate allegations related to billing issues.

The following data documents the number of complaints/reports that are assigned for onsite investigation:

	Complaints/Reports **Triaged**	Complaints/Reports **Investigated**	Final Determination **Substantiated**	Final Determination **Not Substantiated**	Final Determination **Inconclusive**
SFY 09	10,215	1026	266	439	321
SFY 10	11,603	1094	275	558	261
SFY 11	12,262	1023	226	616	181

Number and Types of Alleged Maltreatment Reports

There are more than 2,000 licensed health care entities in the state. Licensed health care entities include nursing homes, hospitals, boarding care homes, supervised living facilities, home care agencies and other providers, including assisted living home care providers, hospice programs, hospice residences, facilities and free standing outpatient surgical facilities. The licensure laws contained in Minnesota Statutes Chapters 144 and 144A detail the department's responsibilities in this area. Many of these licensed health care entities are also federally certified for purposes of participation in the Medicare and Medicaid programs.

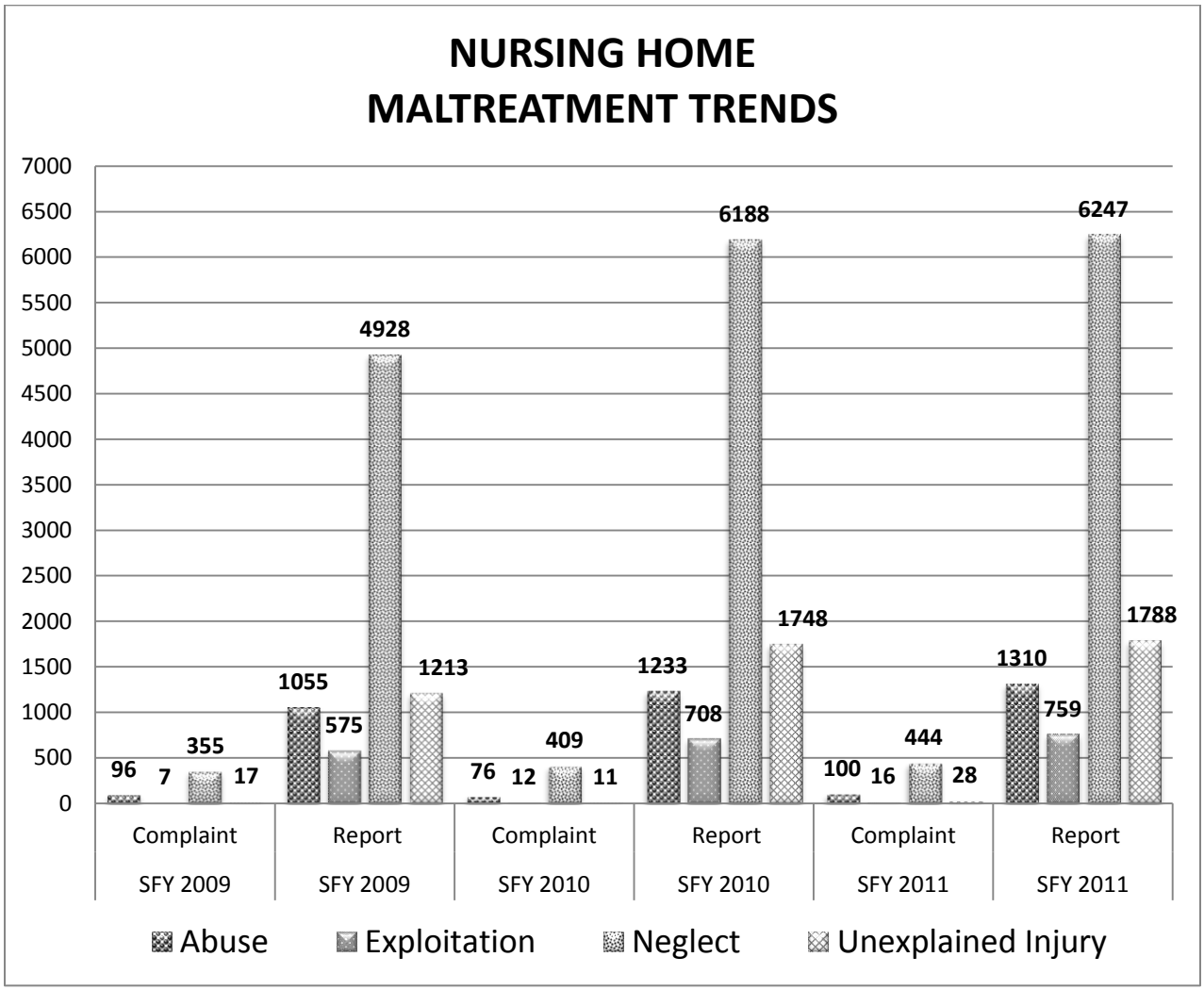
The number of complaints and reports and the types of alleged maltreatment involving licensed facilities may vary according to the facility type as reflected in the following data:

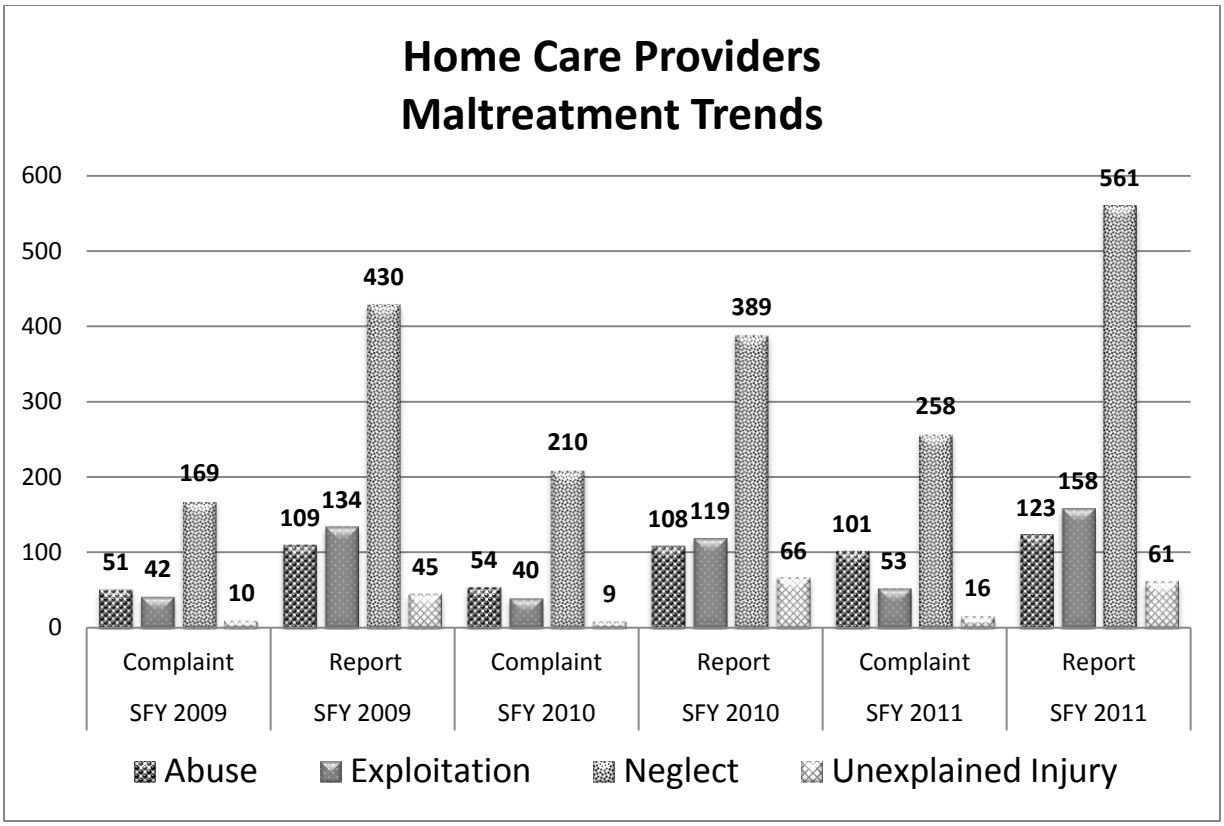
Complaints Received	**SFY 09**	**SFY 10**	**SFY 11**
Nursing Home	883	830	843
Hospital	292	303	294
Home Health	653	460	738
Other Licensed Entities	208	351	219
***Total Complaints Received**	**2036**	**1944**	**2094**
Facility Reported Incidents	**SFY 09**	**SFY 10**	**SFY 11**
Nursing Home	6750	8333	8669
Hospital	85	102	96
Home Health	595	377	803
Other Licensed Entities	725	847	600
***Total Facility Reports Received**	**8155**	**9659**	**10168**
****Grand Total**	**10191**	**11603**	**12262**

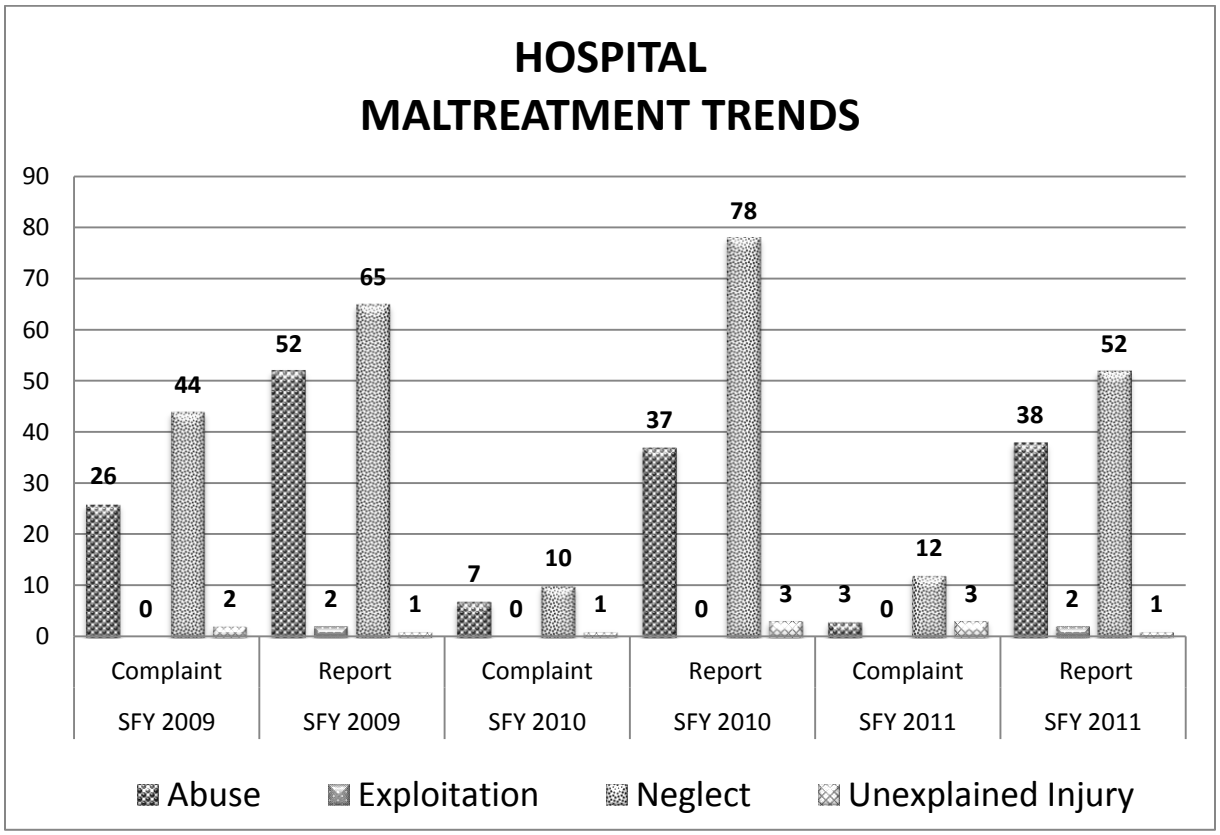
Investigation and Resolution of Complaints

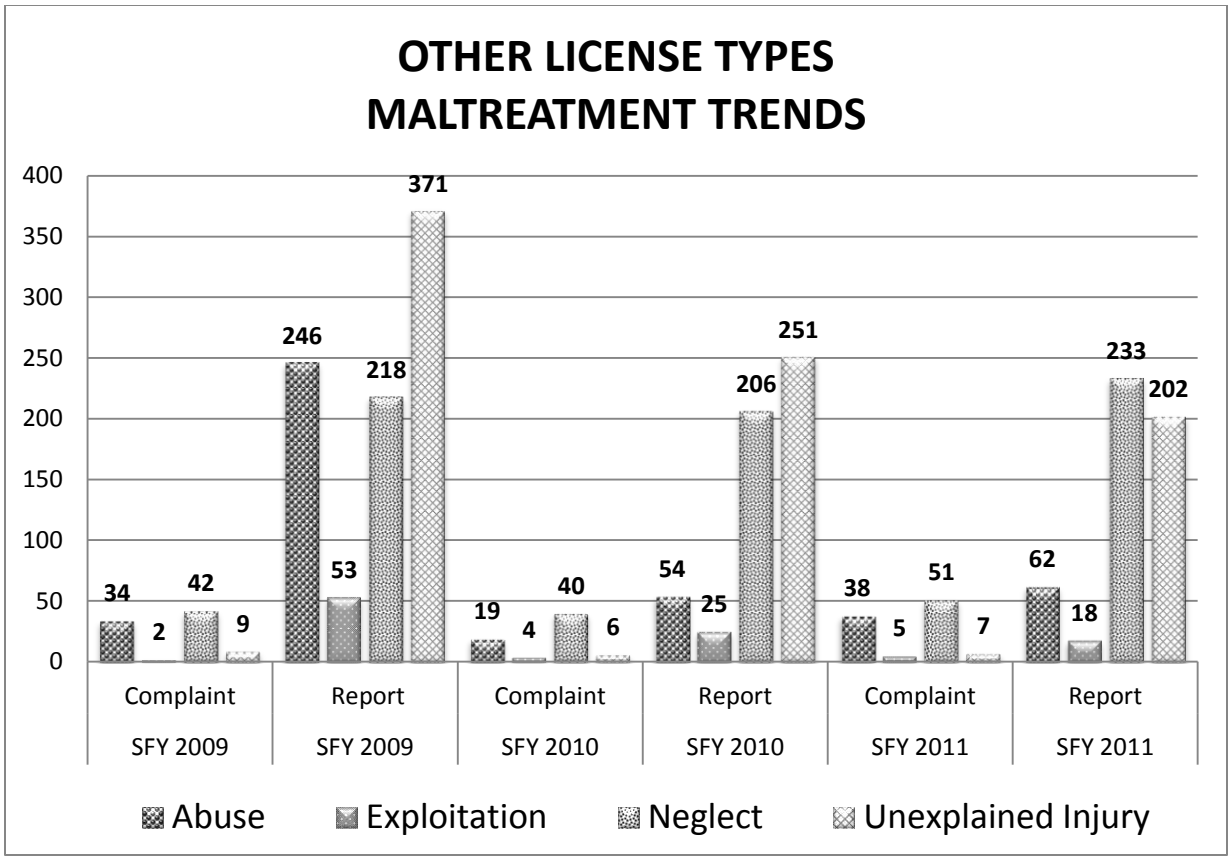
Under Minnesota Statutes, section 626.5572, subdivision 8, OHFC has 3 determination choices for maltreatment investigations conducted under this statute: substantiated, false (OHFC uses the federal terminology of not substantiated), or inconclusive. All determinations must be based on a preponderance of evidence which is defined as more than 50% of weighted evidence. This means that although a 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 meet the definition of maltreatment under Minnesota Statutes, section 626.5572. In these cases, an inconclusive or not substantiated finding is appropriate.

The average number of complaints/reports assigned since 2009 is approximately 1042 per year. This has remained fairly constant over the past three years with approximately 24% cases resulting in a substantiated maltreatment finding. As noted in the following data, there has been a decline in inconclusive findings and an increase in the number of investigations that result in a not substantiated determination. This data 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. 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.




Home Care Providers
Maltreatment Trends
600
500
400
300
200
100
0
51
42
169
10
109
134
430
45
54
40
210
9
108
119
389
66
101
53
258
16
123
158
561
61
Complaint SFY 2009
Report SFY 2009
Complaint SFY 2010
Report SFY 2010
Complaint SFY 2011
Report SFY 2011
Abuse
Exploitation
Neglect
Unexplained Injury


HOSPITAL
MALTREATMENT TRENDS
90
80
70
60
50
40
30
20
10
0
26
0
44
2
52
2
65
1
7
0
10
1
37
0
78
3
3
0
12
3
38
2
52
1
Complaint SFY 2009
Report SFY 2009
Complaint SFY 2010
Report SFY 2010
Complaint SFY 2011
Report SFY 2011
Abuse
Exploitation
Neglect
Unexplained Injury



Compliance:

It is important to note that even if maltreatment is not substantiated under the VAA, OHFC may issue federal deficiencies and/or state orders which require the facility to take corrective action. 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 through the facility's plan of correction or during an onsite post corrective review. Continued non-compliance can result in money penalties, licensing sanctions as well as denial of Medicare/Medicaid payments.

Statutory Time Frames

OHFC's goal is to provide timely intervention on high priority complaints to mitigate the possibility of harm to residents. 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 previous assigned complaints. This requirement continues to impact investigator's caseloads and cause delays in meeting the 60 day timeframe under the VAA.

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 an investigation receive letters at 60 days informing them that the investigation is ongoing.

Where Adequate Coverage Requires Additional Appropriations and Staffing

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 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 piloting 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.

However, even with increased efficiencies, sufficient resources are always a factor in meeting statutory requirements. OHFC lost two experienced investigators as a result of the state shutdown in 2011. The shutdown also resulted in at least two weeks of backlogged investigations which affected OHFC workloads until the end of 2011.

However, even with the above referenced barriers, OHFC's backlog has continued to decrease over the past three years, going from 15% completed within 60 days in 2009 to 22% completed within 60 days in 2011. OHFC currently has 17 investigators on staff in different stages of training. If the number of OHFC investigators remains consistent over the next year, the number of maltreatment investigations completed in 60 days should increase resulting in a decreased backlog.

	OVER 60 DAYS	TOTAL	PERCENT OVER 60 DAYS	PERCENT ONTIME
SFY2011	555	705	78%	22%
SFY2010	411	500	82%	18%
SFY2009	207	242	85%	15%

General Trends

- The number of facility reports continues to increase across nursing home facilities that report to OHFC via the federal web base reporting system. The intake unit has identified a significant number of these reports are not reportable under state and federal regulations, resulting in a drain of resources at OHFC and the CEP. OHFC is currently working with a number of stakeholders to implement a single common entry point that would process reports from all facility types in Minnesota. The goal of this group is to develop a system that lessens the reporting burdens of facilities, reduces duplication of services, provides better customer service to complainants, as well as creates a system that allows consistent tracking data related to complaints and reports in Minnesota. The task for this project will be the development of a system that meets the reporting requirements for both state and 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 and denial of Medicare/Medicaid payments, which offer the best incentive for compliance.

- Home Health facility reports have increased significantly in 2011. Increased provider education through video conferences and quarterly provider calls has increased provider awareness related to reportable incidents under VAA. Increased collaboration between the home care unit (HCALP) and OHFC has resulted in a more comprehensive approach to regulation, sharing resources to provide better coverage of this facility type.

- Financial Exploitation continues to be an area of concern with an increase in the number of cases received and investigated by OHFC. Anecdotal data suggests that the increase in financial exploitation cases coincides with the current economic downturn. Oftentimes the perpetrator in these cases uses the vulnerable adult's money to make payments on personal accounts.