Legislation will take critical next steps on child care safety, other key licensing issues

Action taken by the Minnesota Department of Human Services, providers, and local partners to address a dramatic increase in the deaths of infants in child care has helped to stall the alarming trend, according to the 2012 annual report on licensing activities by the DHS Office of Inspector General (OIG). Infant deaths occurring in child care settings was one of four "emergent issues" identified in the report released on April 3.

The increase was initially identified in the 2011 annual report, the first released by the newly created OIG. Further analysis showed the number of deaths increased from an average of six per year prior to 2006 to more than 11 in both 2010 and 2011. Within the first four months of 2012, six infant deaths had already been reported. The deaths were predominantly in family child care settings and related to unsafe sleep practices.

The 2012 report (PDF) showed marked improvement in the second half of the year. No infant deaths in child care were reported for 2012 after July. In 2013 one death has been reported. The report said efforts to raise child care providers' awareness of safe sleep practices and stepped-up enforcement of rules appear to have contributed to the drop.

"Every death of a child is tragic, but even more so when it could have been prevented," said Human Services Commissioner Lucinda Jesson. "These results are encouraging, but we must take additional steps to ensure we are doing all that we can to keep children safe."

Gov. Mark Dayton's proposed budget includes measures that will improve safety in child care settings particularly related to safe sleep. They include additional training for child care providers, clarifications of existing requirements and several new requirements related to infant sleeping situations. DHS will put additional compliance information about family child care providers online for the public and parents to help make child care decisions.

Other emergent issues identified in the report:

• **Strengthening standards for methadone clinics**. The report noted an increase in serious licensing violations at methadone clinics. During 2012, DHS revoked one license and issued conditional licenses to two more programs. These three programs serve more than 1,500 clients. Methadone, which is used in the treatment of heroin and prescription opiates, has recently been the center of high profile reports about its abuse. DHS has proposed legislation that would help prevent misuse and strengthen enforcement when abuse occurs.

• **Implementing standards for home and community-based services**. The report details implementation of new standards for home and community-based services, including refining those for providers that had been unlicensed. These critical services allow people at risk of institutionalization to receive services in the community. Legislative proposals require licensure of care services with the goal of serving people in an integrated setting and protecting health, safety and rights.

The new licensure standards will also enhance the program integrity for these services that

are mostly funded through Medicaid.

• **Redesigning background study procedures**. The redesign of Minnesota's background study procedures, which protect Minnesotans receiving care in licensed facilities and homes, will move forward with the award of a $3 million federal grant. This allows work to start on a more comprehensive system to begin next year with personal care assistants and employees who provide long-term care services. It will eventually include fingerprint checks accessing records from all 50 states. Legislative proposals currently under review include expanding studies to the state Predatory Offender Registry and using an electronic system to routinely check for new criminal violations on prior background study recipients.

Jesson created the OIG in 2011 to improve fraud prevention and recovery and to step up regulatory effectiveness. The OIG's Licensing Division licenses about 23,000 programs that provide 17 different types of services to children and vulnerable adults in Minnesota. The Division licenses about 4,000 providers with direct oversight by DHS employees, and it licenses an additional 19,000 providers through partnering with counties and private licensing agencies. The division also is responsible for maltreatment investigations and conducts background studies for people working in these and other programs — 271,476 in 2012.

Beyond spotlighting trends and emerging issues, the report reviews licensing activity for licensed programs, and notes trends relative to maltreatment data and background studies.