OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

Evaluation Report Summary / March 2018

Office of Health Facility Complaints

OHFC has not met its responsibilities to protect vulnerable adults in Minnesota.

Key Facts and Findings:

- The Office of Health Facility Complaints (OHFC) within the Minnesota Department of Health (MDH) investigates allegations of maltreatment by MDH-licensed providers, such as nursing homes and home care providers.
- Between fiscal years 2012 and 2017, the number of allegation reports OHFC received increased by more than 50 percent, reaching 24,100 in Fiscal Year 2017. OHFC triaged for onsite investigation only 5 percent of the reports it received that year.
- OHFC does not have an effective case management system, which has contributed to lost files and poor decisions regarding resource allocation.
- The majority of OHFC staff do not have confidence in OHFC leadership's ability to lead the office.
- OHFC has frequently failed to meet required triage and investigation deadlines.
- OHFC's intake, triage, and investigation processes lack sufficient quality control measures.
- OHFC does not inform vulnerable adults or their family members whether providers have reported suspected maltreatment.
- OHFC posts investigation reports on its website, but the website is incomplete and difficult to navigate.
- OHFC does a poor job managing its data, and MDH does not use available allegation and investigation data to identify trends and inform prevention efforts.
- "Housing with services" establishments—which include assisted living facilities—are not licensed by the state and do not have the same level of oversight as nursing homes or other licensed service providers.

Key Recommendations:

- OHFC should implement an electronic case management system.
- The MDH Commissioner's Office should play a stronger role overseeing OHFC.
- OHFC should incorporate quality control measures into its triage and investigation processes.
- The Legislature should require OHFC to regularly report on its progress in meeting state and federal requirements.
- The Legislature should amend state law to allow OHFC to inform a vulnerable adult and his or her legal representative when a provider has filed a report that involves the vulnerable adult.
- The Legislature should require OHFC to post all investigation reports on its website, and OHFC should improve its website.
- OHFC should better manage its data, and MDH should analyze the data to identify trends and share its findings with providers and other stakeholders.
- The Legislature should establish a work group to examine the state's oversight of senior care providers and housing facilities.

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Report Summary

The Office of Health Facility Complaints (OHFC) in the Minnesota Department of Health (MDH) receives and responds to allegations that MDH-licensed providers—such as nursing homes and home care providers—violated the state's Vulnerable Adults Act.[1] OHFC also responds to allegations about licensing violations.

When OHFC receives an allegation report, staff review it to determine whether OHFC should conduct an onsite investigation. If OHFC staff determine that an investigation is needed, an investigator conducts an investigation and makes a determination about whether maltreatment or licensing violations occurred.

In Fiscal Year 2017, OHFC received about 24,100 reports of alleged maltreatment or licensing violations, an increase of more than 50 percent from Fiscal Year 2012. The number of reports OHFC investigated during this time period also increased by more than 50 percent, reaching about 1,300 in Fiscal Year 2017.

OHFC has been poorly managed.

OHFC's case management system has numerous deficiencies.

OHFC does not have an office-wide system in which its supervisors can monitor the progress of cases or the workload of staff. Office leadership told us that they do not know the current size of investigators' caseloads, and they do not assign cases with respect to investigators' current workload.

Furthermore, although OHFC receives most allegation reports electronically, it prints those reports and conducts its work using paper case files. OHFC's paper-based system has contributed to files being lost or misplaced.

We recommend that OHFC implement an electronic case management system.

High staff turnover, few written policies, and a lack of confidence in senior leadership reflect a dysfunctional office culture.

In fiscal years 2015 and 2017, OHFC's staff turnover exceeded 25 percent. In 2015, for example, 8 of the 32 staff people in OHFC resigned, retired, or transferred to another position within state government. Almost half of OHFC's current staff have been working at the office for less than two years.

Many of OHFC's internal policies are unwritten. For example, OHFC has few written policies to standardize routine investigation tasks, such as who to interview during investigations. Similarly, OHFC does not provide guidelines for investigators about how to investigate common types of incidents, such as when a vulnerable adult with dementia leaves a locked facility unsupervised, or when a vulnerable adult experiences an unexplained injury.

As part of our evaluation, we conducted a survey of all OHFC staff. Staff reported that they are proud of the work they do at OHFC. However, almost 60 percent of survey respondents indicated that they do not have confidence in OHFC senior leadership, and more than 60 percent indicated that OHFC senior leadership does not do a good job of communicating the goals and strategy of the office. Respondents also commented about "disorganization" and "mistrust" in the office.

We recommend that the MDH Commissioner's Office play a stronger role in overseeing OHFC and its work.

Inadequate quality controls have resulted in triage and investigation practices that do not always meet standards.

Neither OHFC leadership nor supervisors regularly audit case files to ensure that

[1] The 1980 Minnesota Legislature created the Vulnerable Adults Act; *Laws of Minnesota* 1980, Chapter 542, codified as *Minnesota Statutes* 2017, 626.557. The act establishes protections for "vulnerable adults," who are individuals age 18 or over and residents of a facility, such as a nursing home; receive certain state-licensed services; or have an infirmity that impairs their ability to protect themselves from maltreatment. The act defines "maltreatment" as abuse, neglect, and financial exploitation.

OHFC has not met required deadlines for triaging or investigating allegations.

triage decisions and investigations meet expectations. Audits conducted by the federal Centers for Medicare and Medicaid Services (CMS) concluded that OHFC did not meet triage standards for the past two years.[2]

As part of our evaluation, we reviewed files of 53 cases that OHFC investigated. We found that OHFC investigators sometimes failed to interview key individuals—including the vulnerable adult. Many of the case files we reviewed did not contain documentation to support information in OHFC's investigation reports.

We recommend that OHFC incorporate quality control measures and that supervisors regularly review triage decisions and investigation practices.

OHFC did not meet triage and investigation deadlines for a large share of its cases.

Both state law and federal regulations prescribe how quickly OHFC must triage allegation reports. For example, federal regulations require OHFC to triage certain allegation reports within two business days from the date that OHFC received the allegation report. In Fiscal Year 2017, OHFC met this two-day deadline for only 56 percent of investigated reports.

There are also multiple deadlines for conducting and completing investigations. For example, state law requires OHFC to conclude an investigation within 60 days of receiving an allegation report. OHFC concluded investigations within this 60-day timeline for only 12 percent of the cases it investigated in Fiscal Year 2017.

We recommend that the Legislature require OHFC to regularly report on its progress toward meeting these deadlines.

OHFC does not inform vulnerable adults or their legal representatives whether providers have reported suspected maltreatment.

State law protects the identity of those who report allegations. The law states: "The identity of any reporter may not be disclosed."[3] OHFC leadership told us that they consider the name of a healthcare provider to be protected under this law. As a result, if a vulnerable adult or family member asks OHFC whether a provider reported an incident, OHFC will not provide this information.

We heard two key concerns about this issue. First, if a provider informs a vulnerable adult that it has reported suspected maltreatment to OHFC, the vulnerable adult has no way to verify if the provider is telling the truth. Second, even if the provider did report the allegation, the vulnerable adult has no way to verify whether the description of the incident the provider reported matches the vulnerable adult's understanding of the incident.

We recommend that the Legislature revise the law to allow OHFC to inform a vulnerable adult and his or her legal representative when a provider has filed a report that involves the vulnerable adult.

OHFC's website is incomplete and difficult to navigate.

OHFC does not post to its website all of its investigation reports. We estimate that the website may be missing up to 19 percent of reports that, according to OHFC leadership, should be posted. Missing investigation reports limit consumers' ability to learn about the quality of different providers.

OHFC's website is also difficult to navigate. Consumers must sometimes search for a provider using the name and address of a parent company, rather than

[2] CMS regularly audits OHFC's triage decisions. CMS's standard is that OHFC followed federal triage guidelines for at least 90 percent of the cases reviewed. In 2016, 85 percent of the cases reviewed met this standard; in 2015, only 38 percent met this standard.

[3] *Minnesota Statutes* 2017, 626.557, subd. 5(d).

Minnesota has less oversight of housing with services establishments—which include assisted living facilities—than nursing homes and other licensed providers.

the name and street address of the actual facility they are researching.

We recommend that the Legislature require OHFC to post all recent investigation reports on its website. We also recommend that OHFC improve its website.

OHFC does not manage its allegation or investigation data well, and MDH does not use available data to inform prevention efforts.

OHFC does not have documented guidance for how data fields in its database should be used, or even descriptions of the codes used within each field. As a result, staff record information inconsistently in the database. Additionally, OHFC does not collect data necessary to inform and focus prevention activities. For example, to determine whether certain vulnerable adults have a higher risk of experiencing maltreatment, OHFC should collect data about the vulnerable adults involved in alleged maltreatment incidents, such as their diagnoses or disabilities.

Other than presenting high-level trend data in statutorily mandated reports, MDH does not analyze the data that OHFC does collect. Neither MDH nor OHFC shares trend data with providers regarding the allegation reports OHFC receives or the investigations it conducts.

We recommend that OHFC better manage its existing data and collect more complete data. Additionally, we recommend that MDH analyze and share trend data regarding maltreatment allegations and investigations. These data could help providers identify patterns and protect against future incidents.

Minnesota's regulatory structure provides less oversight of "housing with services" establishments, which include assisted living facilities.

Even if OHFC makes needed changes, some vulnerable adults will receive less protection than others due to Minnesota's regulatory structure. Many vulnerable adults in Minnesota live in housing with services establishments, but these facilities are subject to limited state regulatory oversight because they are registered (not licensed) by MDH. Through its investigations and periodic inspections, MDH verifies that *licensed* providers meet certain standards. However, MDH does not have the same oversight of providers or facilities that are merely *registered* with the department, such as assisted living facilities.

We recommend the Legislature establish a work group to examine the state's oversight of senior care providers and housing facilities. The Legislature should holistically examine the state's oversight of these providers and facilities to ensure the state's regulatory approach supports state policy priorities.

Summary of Agency Response

In a letter dated March 1, 2018, Minnesota Department of Health Commissioner Jan Malcolm commented that the "evaluation raises a number of serious and important issues." She noted that, "In recent years, OHFC has not met Minnesotans' reasonable expectations for investigating maltreatment complaints in a timely way. Improving the performance of this office is a top priority and we are committed to rebuilding trust with victims, families and the people of Minnesota." In her letter, the commissioner highlighted her department's Interagency Partnership with the Minnesota Department of Human Services and noted that through the partnership, the department has "started making the changes necessary for OHFC to help prevent vulnerable adult abuse and neglect, respond to abuse complaints in a timely manner, and ultimately, hold accountable those responsible for their failures in care and protection."

The full evaluation report, *Office of Health Facility Complaints*, is available at 651-296-4708 or:
www.auditor.leg.state.mn.us/ped/2018/ohfc.htm