UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, Guardians and next friends of Bradley J. Jensen, *et al*.,

Plaintiffs,

v.

Minnesota Department of Human Services, an agency of the State of Minnesota, *et al*.,

Defendants.

Civil No. 09-1775 (DWF/FLN)

REPORT TO THE COURT: TIMELINESS OF VULNERABLE ADULT MALTREATMENT INVESTIGATIONS

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March 18, 2014

INTRODUCTION

It is the policy of Minnesota to provide safe environments for vulnerable adults and to provide protective services for vulnerable adults who have been maltreated.[1] State policy is to provide "safe institutional or residential services, community-based services, or living environments" for those who have been maltreated.[2] Generally, there are three kinds of maltreatment: abuse, neglect and financial exploitation.

Reports of maltreatment are investigated. The statute states, "The lead investigative agency shall complete its investigation within 60 calendar days."[3] If the agency "is unable to complete its final disposition within 60 calendar days," a new completion date is set and certain notifications are required "provided that the notification will not endanger the vulnerable adult or hamper the investigation."[4] Dispositions are subject to appeal and review processes.

The Minnesota Vulnerable Adult Act, which governs this process, does not mandate any time limit for issuing the investigation reports and findings. Despite the default statutory 60 day period, investigations have taken many months and even years to complete.

Consistent with DHS' own findings, the Court Monitor finds that completion of investigations of maltreatment is simply taking too long. Investigations related to use of restraints or seclusion, and concomitant injury, have in recent years (and earlier) taken many months, and risk further harm to clients.

DHS responded to the draft of this report with an acknowledgement that "there is much work to do" with regard to streamlining investigations for completion in a timely manner, with thoroughness and without compromising integrity. Appendix B (Memorandum of March 17, 2014 from Deputy Commissioner Anne Barry to Court

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[1] A vulnerable adult can be any person over age 18 who:

- Has a physical, mental or emotional disability that makes it difficult for the person to care for themselves or to protect themselves from maltreatment
- Is in a hospital, nursing home, transitional care unit, assisted living, housing with services, board and care, foster care or other licensed care
- Receives services such as home care, day services, personal care attendant/CPA, employment training, treatment for mental illness, etc.

[2] Minnesota Vulnerable Adult Act, MN Stat. 626.557, subd. 1.

[3] §626.556, subd. 9c(e).

[4] *Id.*

Monitor). DHS accepts one of the three recommendations by the Court Monitor, and requests to discuss the other two recommendations. *See* below at 6-7.

SCOPE OF REPORT

This Report to the Court addresses the delays in completion of maltreatment investigations in which the allegations relate to the use of restraints or seclusion in facilities operated or licensed by the Department of Human Services.

This scope was chosen for several reasons: a) the misuse of restraints and seclusion has been a high profile element of the relief in this litigation; b) injuries can result from restraint and seclusion use; c) restraints and seclusion have been used to control behavior either under a formal treatment plan or in lieu of appropriate non-aversive positive behavior supports.[5]

In addition, because maltreatment involving seclusion or restraints takes place within a care facility, in which staff and clients are in close, often 24/7 contact, and in which modifications to treatment plans and modalities may need to be made quickly, the need for timely completion of maltreatment investigations is accentuated.

FINDINGS

Deficiencies in timeliness of DHS maltreatment investigations is a state-wide issue, as DHS itself has reported. *See* Section A below. The Court Monitor's investigation of timeliness with regard to restraint/seclusion maltreatment allegations has confirmed that serious deficiencies in timeliness of completion of the sub-category of restraint/seclusion maltreatment reports also exists.

A. DHS is Aware of State-wide Deficiencies in Timeliness of Investigations

The Department of Human Services is aware of serious deficiencies in the timeliness of investigations state-wide. Absent urgent action, there is no effective remedy in the works.

FY 2013
Time to Complete Investigations

Average Time = 7 months

65% take longer than 120 days

DHS' Office of Inspector General recently issued its Maltreatment

[5] *See Rule 40 Advisory Committee Recommendations on Best Practices and the Modernization of Rule 40.*

Report: Legislative Report (FY 2013). ("DHS 2013 Report"). The report acknowledges the 60 day requirement and states: *"In FY 2013, it took an average of seven months to complete an investigation."*[6] (emphasis added).

Only 14% of reports are completed within 60 days, with 65% taking longer than 120 days. The DHS 2013 Report displays the timeliness breakout this way:[7]

Total Maltreatment Reports Completed	60 days	90 days	120 days	Over 120 days	Total
FY13	98 (14%)	78 (11%)	69 (10%)	459 (65%)	704
FY12	145 (22%)	78 (12%)	80 (12%)	345 (53%)	648
FY11	191 (23%)	125 (15%)	67(8%)	438 (53%)	822

The Department is walking backwards against a rising escalator, making no progress in improving timeliness. There is no effective remedy in the works. The Inspector General acknowledges the need for additional investigator staffing, improved efficiency and streamlining in its processes, and other improvements. This may take some time; there were 718 new maltreatment reports assigned in FY 13, but there were 628 reports still pending from the prior year.

Untimeliness has increased in each of the most recent fiscal years, as the table above shows. 23% of reports were timely in FY 2011 with just 14% in FY 2013, even though there were significantly fewer maltreatment reports (704 compared to 822).

FY 2013: 718 new reports
628 reports carried over from prior year

The Department is walking backwards against a rising escalator, making no progress in improving timeliness

B. Seclusion/restraint Maltreatment Reports Are Untimely

The Court Monitor reviewed maltreatment reports provided by DHS in response to a request for internal or external reports on seclusion or restraint use within State Operated Services.[8] 53 Maltreatment Investigation reports were provided with a date range from 1998 to 2013.[9]

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[6] DHS 2013 Report at 15.

[7] *Id*.

[8] On October 18, 2013, the Court Monitor requested this information on the use of restraints and seclusion, in a follow-up to an earlier report. *Rationale for Document*

For all cases, the days elapsed from incident date to report date range from 98 days to 1,228 days. Confining our attention to 2011-2013, the days elapsed are (incident date is shown as "month-year:"

INCIDENT DATE	DAYS ELAPSED
Aug-12	**375**
Aug-12	**282**
Jul-12	**128**
Mar-12	**173**
Dec-11	**103**
Nov-11	**169**
Nov-11	**191**
Nov-11	**452**
Oct-11	**122**
Apr-11	**128**
Apr-11	**254**
Apr-11	**410**

The following chart shows the allegations and the facility for each of the above incidents.

Request: Restraint Chair and Seclusion Use at AMRTC and MSH: Phase 1 Review (Oct. 17, 2013) (Dkt. 236).

[9] This Report does not consider the content of the reports. It may be that the reports provided do not comprise the entirety of all such reports for DHS' state operated services. The Court Monitor is relying on DHS for the completeness of the reports provided. In any event, however, it is certain that the referenced reports were issued on the referenced dates, and that delays well beyond the default 60 days are common and virtually universal.

Incident Date	Report Issued Date	Time to Issue Report: DAYS	Facility	Allegation
8/18/12	8/28/13	**375**	MSH	Staff told not to intervene with client who repeatedly engaged in self-injurious behavior resulting in bruised swollen face
8/15/12	5/24/13	**282**	MSH	Client elbow broken during physical restraint
7/21/12	11/26/12	**128**	MSH	Client kept in seclusion, 7 hours. 3 days later [7/24/12] client was dehydrated in restraint
3/28/12	9/17/12	**173**	MSOCS Hennepin	Staff threw client to floor and threatened to kill client
12/14/11	3/26/12	**103**	MSOCS Northland Park	[After release from arm bar restraint] Client was yelled at and screamed at by staff
11/20/11	5/7/12	**169**	MSOCS Hennepin	Staff put client in physical hold on floor and stomped next to client's head, threatened to stomp client if client attempted to hit staff
11/15/11	5/24/12	**191**	MSH	Client left naked an hour in seclusion; left without mattress. Report re-issued 12/13/12.
11/11/11	2/5/13	**452**	MSH	Client placed naked into seclusion. Over 2 hours without gown
10/3/11	2/2/12	**122**	MSOCS Richfield	Client injured when staff held client when client attempted to leave facility
4/27/11	9/2/11	**128**	MSH	Staff tackled client from behind and used excessive force to restrain client

4/26/11	1/5/12	**254**	MSH	Staff antagonized client, resulting in seclusion

CONCLUSION

The Court has a vital and reasonable concern with client safety and with protection of clients from maltreatment. Minnesota statute and DHS policy also express that concern. The longstanding mounting untimeliness is undermining the safety of the beneficiaries of the Court's orders. Public and client confidence in the investigation system is also in jeopardy.

Safety, especially with regard to restraints and seclusion, is a fundamental constitutional concern with regard to individuals in the care of the state for the purposes of care and treatment. *Youngberg. v. Romeo*, 457 U.S. 307 (1982). Safe use and limited use of restraint are covered in the Settlement Agreement and the Comprehensive Plan of Action (with regard to "facilities" defined in the agreement), of restraint.

The *Olmstead Plan* will cover *loci* of care not otherwise defined as "facilities." As the Court Monitor advised the Court, the final *Plan* should address abuse/neglect investigations, as well as use of restraints and seclusion.[10]

The Court Monitor accepts the Minnesota Legislature's outside limit of 60 days for completion of investigations, with the caveat that urgent situations, such as those involving deaths, restraints, seclusion, serious physical injury, deserve consideration for completion well within the 60 day limit. While there may be situations in which it is not possible to complete certain investigations within 60 days, there appears to be no reason for investigations to take hundreds of days.

Delays risk exposure of clients to further harm and danger. For example, if improperly addressed behavioral issues, or failed implementation of care plans, are identified months or years later in an investigation report, the client has been denied the benefit of remediation which might otherwise have taken place sooner.

The DHS Office of Inspector General's FY 2013 Report recognizes the urgency of the situation and discusses efforts to address the need for investigations to be timely and to meet the statutory default where possible. That candor is appreciated and commended.

With respect to investigations of maltreatment of the beneficiaries of the Court's orders in this case, the time lag in many cases is longer than appropriate for

[10] Court Monitor, *Report to the Court: Minnesota's 2013 Olmstead Plan* (Dec. 31, 2013 (Dkt. 263).

individuals living in state-operated facilities and, with regard to the data reviewed here, allegedly maltreated in situations involving restraints or seclusion.

RECOMMENDATIONS

In the draft report provided to the parties, the Court Monitor respectfully recommended:

1. The *Olmstead Plan* sub-cabinet should consider, on an expedited basis, seeking legislation revising the 60 day limit to a shorter time period for urgent situations, such as those involving deaths, restraints, seclusion, serious physical injury, and neglect in residential facilities, and also otherwise limiting the number of permissible extensions of time for other cases. Additional resources should be considered for the DHS OIG as needed to enable these changes.

2. Apart from possible legislation, the DHS Office of Inspector General should internally establish a maximum 30 to 60 day limit for investigation completion for urgent situations, such as those involving deaths, restraints, seclusion, serious physical injury, and neglect in residential facilities.[11]

3. The DHS Office of Inspector General is expected to continue its efforts to facilitate and streamline its processes to ensure complete and accurate reports, issued in a timely fashion.

DHS's responded to recommendations 1 and 2 is that it would like to discuss them during the Court Monitor's visit March 31-April 1, 2014, with the participation of the *Olmstead* Implementation Office. The Department accepts the third recommendation without further comment. *See* Appendix B.

DHS and the Court Monitor agree that the current situation is inadequate. At this time, the Court Monitor recommends that the Court enter the attached proposed order, requiring DHS to advise the Court on its plan and actions to address the situation described in this report. The Court Monitor will follow up with the parties and will update the Court on DHS' actions on this issue.

Dated: March 18, 2014

David Ferleger
Court Monitor

[11] The DHS OIG has an internal one page "draft" list of factors related to prioritization; it is undated, and it does not provide guidance on when the factors may prompt extensions beyond the 60 days, or prompt acceleration of reports for completion within a shorter time period.

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, Guardians and next friends of Bradley J. Jensen, et al.,

Civil No. 09-1775 (DWF/FLN)

Plaintiffs,

ORDER

Minnesota Department of Human Services, an agency of the State of Minnesota, et al.,

Defendants.

AND NOW, this ___ day of March, 2014, upon consideration of the Court Monitor's *Report to the Court: Timeliness of Vulnerable Adult Treatment Investigations* (Dkt. ____), it is hereby ORDERED that the Department of Human Services, within thirty (30) days, shall advise the Court on actions it will take to improve timeliness of maltreatment investigation reports regarding beneficiaries of the orders of this Court, including but not limited to the *Olmstead Plan*. The Court Monitor may thereafter comment or make recommendations regarding the Department of Human Services' submission.

Date: _____

_____
HON. DONOVAN W. FRANK
United States District Judge

APPENDIX A

DAYS ELAPSED BETWEEN INCIDENT & MALTREATMENT INVESTIGATION REPORT Reports Relating to Restraints/Seclusion 1998-2012 (sorted by incident date)

Incident Date	Report Issued Date	Time to Issue Report: **DAYS**	Facility	Allegation
8/18/12	8/28/13	**375**	MSH	Staff told not to intervene with client. Repeatedly engaged in self-injurious behavior resulting in bruised swollen face
8/15/12	5/24/13	**282**	MSH	Client elbow broken during physical restraint
7/21/12	11/26/12	**128**	MSH	Client kept in seclusion, 7 hours. 3 days later [7/24/12] client was dehydrated in restraint
3/28/12	9/17/12	**173**	MSOCS Hennepin	Staff threw client to floor and threatened to kill client
12/14/11	3/26/12	**103**	MSOCS Northland Park	[After release from arm bar restraint] Client was yelled at and screamed by staff
11/20/11	5/7/12	**169**	MSOCS Hennepin	Staff put client in physical hold on floor and stomped next to client's head, threatened to stomp client if client attempted to hit staff
11/15/11	5/24/12	**191**	MSH	Client left naked for an hour in seclusion; left without mattress. Report re-issued 12/13/12.
11/11/11	2/5/13	**452**	MSH	Client placed naked into seclusion. Over 2 hours without gown

10/3/11	2/2/12	**122**	MSOCS Richfield	Client injured when staff held client when client attempted to leave facility
4/27/11	9/2/11	**128**	MSH	Staff tackled client from behind and used excessive force to restrain client
4/26/11	1/5/12	**254**	MSH	Staff antagonized client, resulting in seclusion
4/10/11	5/24/12	**410**	MSH	Day after restraint, client had visible injuries. Medically fragile client was not to have been restrained
10/15/10	12/22/11	**433**	MSH	Client's plan stated, "avoid a prone position." Information regarding prone restraint. While being physically escorted to a seclusion room following restraint, staff pushed client's head into door 3 times making door bounce.
9/22/10	5/25/11	**245**	MSH	When client was allowed out of protective isolation room, staff put handcuffs on tightly, injuring client. Same staff spit in client's food. Date: prior to 9/22/10.
9/21/10	12/22/11	**457**	MSH	Staff took client's mattress away and client had to sleep on concrete slab for 25 nights. Date: prior to 9/21/10. [other allegations also]
3/22/10	12/20/10	**273**	MSH	Staff emotionally abused client, resulting in restraint. Separate incident: emotional abuse during transport to hospital. Date: prior to 3/22/10.
1/13/10	4/15/11	**457**	MSOS West Concord	During a restraint on 1/13/10, staff choked client

1/4/10	11/30/10	**330**	MSOCS Rochester	Staff dragged client from bathroom to van
12/31/09	5/27/10	**147**	MSOCS Eden Prairie	While restrained by 4 staff, client stopped breathing. Taken to hospital, died 8 days later.
12/22/09	8/24/10	**245**	METO	Following manual restraint, client had fractured arm
11/25/09	1/21/10	**57**	MSOCS Pine City	During restraint, client sustained fractured elbow
6/30/09	3/25/11	**633**	MSOCS Richfield	Staff restrained client with insuffient reason, resulting in client injuries
5/13/09	1/14/10	**246**	MSOCS Eden Prairie	Staff unnecessarily restrained client
5/4/09	6/29/09	**56**	MSOCS Straight River	Client sustained bruises during restraint
12/19/08	2/17/09	**60**	MSH	Staff punched client in nose and swore at him during physical restraint
12/3/08	4/17/09	**135**	METO	Client placed in time out room naked and in handcuffs. [Also, 10/17/08 incident]. *Licensing violation not determined
6/2/08	8/8/08	**67**	MSOCS Valley Enterprises	Staff held client on floor and toes touched client's buttocks. Report received 6/2/08.
5/14/08	10/28/08	**167**	MSOCS Cannon River	Scratches found on client after physical restraint
11/15/07	8/21/08	**280**	MSOCS Dodge County	2 staff put client in physical restraint, resulting in injury
7/7/06	2/27/07	**235**	MSH	Client and staff struggled, leading to client being placed in seclusion and subsequently dying

4/3/06	6/2/06	**60**	MSH	Staff hit client over head with flashlight while client was in handcuffs
1/17/06	8/22/06	**217**	EMSOCS Austin	Client restrained by staff sustained spiral fracture of humerus
11/10/05	5/16/06	**187**	MSOCS Cannon River	Staff put client into prone hold
1/10/05	8/22/06	**589**	MSH	Client did not receive adequate supervision and died while in protective isolation
9/9/04	9/29/05	**385**	MSOCS Cannon River	2 staff physically abused client during restraint (bang head on floor, slapped face, pulled hair)
8/12/04	6/29/05	**321**	METO	Excessive force during restraint
7/22/04	8/31/05	**405**	METO	Staff grabbed, choked client, placed in restraints
5/14/04	4/26/05	**347**	MSOCS Duluth Airpark	During restraint, staff stuffed pull-tabs in client's mouth; excessive force used to restrain
5/9/04	11/2/06	**907**	METO	Staff made degrading statements to client, resulted in restraint
5/2/04	3/29/07	**1,061**	MSH	While implementing restraint, staff kicked or kneed client in back. Separate incident: staff rubbed client's face into carpet during restraint. [Also a 2/29/04 incident]
3/3/04	8/27/04	**177**	METO	Staffed rubbed client face into carpet during restraint
9/26/03	11/26/03	**61**	AMRTC Detox	Staff threw client into "quiet room," handcuffed
4/29/03	7/28/06	**1,186**	MSOCS Straight River	Client observed naked from chest to thighs in bed, appeared unable to get up. [had been restrained]

12/14/02	10/6/04	**662**	METO	Staff pulled client hair and used physical force during physical restraint
5/22/02	10/31/02	**162**	METO	Staff pulled client hair, pulled head back during hold
2/15/02	6/4/04	**840**	MSOCS Cannon River	Staff used excessive force during restraint
9/10/01	1/29/03	**506**	MSH	Staff pushed client to floor and placed staff's knee on client neck
2/5/01	3/20/03	**773**	EMSOCS Austin	Client experienced emotional distress in support plan implementation. Another occasion: unexplained bruises. Prior date: 12/22/00.
11/3/99	10/31/02	**1,093**	MSH	During restraint, staff carried client to seclusion in carrying blanket. On arrival, at seclusion room, client was not breathing. Client died
9/1/99	12/30/99	**120**	MSOCS Fairbault Regional	At community event, staff unnecessarily and roughly restrained client
2/25/99	3/29/00	**398**	MSOCS Eden Prairie	Staff caused bruises and scratches to client during restraint
1/11/99	5/23/02	**1,228**	MSH	Client died in seclusion. Client had head injury and was deceased for some time when found even though staff were required to perform 15 minute checks
7/11/98	10/12/98	**93**	Cambridge RTC	Staff grabbed client by hair, slammed client to floor

APPENDIX B

Minnesota Department of **Human Services**

Memo

DATE: March 17, 2014

TO: David Ferleger, Esq
Court Monitor
Jensen Settlement Agreement [Court File No.: 09-CV-01775 DWF/FLN]

FROM: Anne Barry,
Deputy Commissioner
Minnesota Department of Human Services

SUBJECT: Re: Draft Report to the Court: Timeliness of Vulnerable Adult Maltreatment Determinations

Dear Mr. Ferleger:

Thank you for your proposed recommendations in the above-noted draft report to the Court and an opportunity to comment.

In your draft report, you recommend the following:

1. The Olmstead Plan sub-cabinet should consider on an expedited basis seeking legislation revising the 60 day limit to a shorter time period for urgent situations, such as those involving deaths, restraints, seclusion, serious physical injury, and neglect in residential facilities, and also otherwise limiting the number of permissible extensions of time for other cases. Additional resources should be considered for the DHS OIG as needed to enable these changes.

2. Apart from possible legislation, the DHS Office of Inspector General should internally establish a Maximum 30 to 60 day limit for investigation completion for urgent situations, such as those involving deaths, restraints, seclusion, serious physical injury, and neglect in residential facilities.

3. The DHS Office of Inspector General is expected to continue its efforts to facilitate and streamline its Processes to ensure complete and accurate reports, issued in a timely fashion.

The Department accepts Recommendation No. 3 and, acknowledging Recommendation Nos. 1 & 2, would like to discuss the recommendations during your visit to Minnesota at the end of March, early April. The Olmstead Plan Sub-Cabinet, through its Olmstead Implementation Office, would also like to join the discussion. While the Sub-Cabinet is taking steps that indirectly relate to the recommendations -- among other things, adopting an Olmstead Quality Improvement Plan including policies and procedures that establish best practice in the prevention of abuse and neglect of persons with disabilities

- the Sub-Cabinet and Department believe that the Department is better situated to address operational issues related to the timing and completion of maltreatment investigations for urgent situations.

It is the State of Minnesota's and the Department's interest to protect the health, safety, rights, and well-being of the Minnesotans we serve. The Department strives to complete investigations in a timely manner, especially those where death, serious physical injury, and neglect that pose a threat to the individual's well-being are alleged. As we continue efforts to streamline processes to ensure investigations are thorough and timely without compromising integrity, we realize there is much work to do. We appreciate your review and suggestions and hope you will accept our invitation to discuss this important issue and next steps during your up-coming visit to Minnesota.

Cc: Shamus O'Meara, Attorney for Plaintiffs
Colleen Wieck, Executive Director for the Governor's Council on Developmental Disabilities
Roberta Opheim, Ombudsman for Mental Health and Developmental Disabilities
Steven Alpert, Assistant Attorney General
Scott Ikeda, Assistant Attorney General
Aaron Winter, Assistant Attorney General
Gregory Gray, DHS Chief Compliance Officer
Amy Akbay, DHS Chief General Counsel
Jerry Kerber, Inspector General, Office of the Inspector General
Christina Baltes, Jensen Compliance Officer

Attachment: 2013 Legislative Report on Alleged Maltreatment

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 FY13

Department of Human Services

Office of Inspector General

Licensing Division

Legislative Report

Minnesota Department of **Human Services**

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, Licensing Division 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.

DHS OIG-Licensing Division
FY 13 Maltreatment Report

EXECUTIVE SUMMARY

The Department of Human Services (DHS), in partnership with counties, licenses approximately 22,500 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 service centers, day training and habilitation programs, as well as residential and outpatient programs for people with chemical dependency, mental illness or developmental disabilities. DHS is responsible for completing maltreatment investigations when they relate to approximately 8,755 licensed settings, consisting of DHS directly-licensed and monitored programs (approximately 4,034 licensed programs) and adult foster care homes (approximately 4,721 licensed programs).

Focus: The focus of this report is the investigation of maltreatment in the Department of Human Services (DHS) directly licensed programs (4,034 programs) and adult foster care (4,721 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 is delegated to the counties under Minnesota Statutes, section 245A.16.

Data in this report combines information about reports and investigations 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.

Although this report specifically addresses fiscal year (FY) 2013, some of the charts and graphs contained in this report provide data for six fiscal years in order to show changes occurring over this time period. Please refer to maltreatment reports from previous years for report data prior to FY08.

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 three 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.[1]

Reports Received and Outcome

General Data	FY11	FY12	FY13	Percent change from FY12
Reports received	4,486	4,922	5,273	7%
No jurisdiction[2]	234	400	405	1%
In-office investigation only	846	916	829	-9%
Not assigned for further investigation	2,041	2,309	2,698	17%
Reports referred to other entity	903	952	987	4%
Assigned to DHS licensors – licensing complaint	679	589	662	12%
Reports assigned for out-of-office maltreatment investigation	785	880	718	-18%
Total maltreatment allegations in reports assigned (one report or investigation often involves more than one allegation)	1,034	1,126	906	-20%
Investigations of maltreatment completed	821	648	704	9%
Reports substantiated[3]	218	174	192	10%
Allegations substantiated	274	217	235	8%
Individuals disqualified from direct contact	92	57	54	-5%
Maltreatment investigations remaining open on June 30 of fiscal year.	379	628	601	-4%

[1] Reports that are screened out are referred to another agency with jurisdiction to follow up on the issue; they may have been adequately resolved with no harm experienced and minimal risk of harm to any person receiving services; they may represent a concern that is neither a licensing violation nor possible maltreatment; or they are determined to represent such an overall minimal risk of harm that they do not warrant a full 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. The maltreatment investigation unit of DHS also investigates deaths that occur in licensed programs for which the reporter did not suggest maltreatment. The death investigations are included where specified, but they are not reflected in the total maltreatment investigations data.

[2] Event did not occur in a DHS licensed program.

[3] Substantiated means that it was determined by a preponderance of the evidence that an event/incident occurred that met a definition of maltreatment.

Trends in maltreatment reports and investigations

- The number of reports received for assessment by DHS is increasing.
- In FY13, 18% fewer reports were assigned for maltreatment investigation.
- From FY12 to FY13, the number of maltreatment allegations decreased by 20% in the reports assigned. (Each report can have more than one allegation.)
- The number of maltreatment investigations completed increased by 9% between FY 12 and FY 13.
- The number of maltreatment investigations remaining open at the end of the fiscal year decreased by 4% from FY12 to FY13.
- In FY 13, 66% of substantiated maltreatment involved neglect, 17% involved abuse and 17% involved financial exploitation. These findings are identical to those reported for FY 12.

Performance Results

Statutory requirements and outcomes:

- Notice to the reporter of the initial determination of a report is required within five days. In 100% of the cases, the initial determination was provided to the reporter in five days.
- Completion of the investigation is required within 60 days. If an investigation is not completed within 60 days, a notice is required to be given to the vulnerable adult or the vulnerable adult's legal guardian and the facility of why the report is not completed along with a projected completion date. In FY 13, the percent of reports completed within 60 days was 14%. In 100% of the cases where investigations were not completed within 60 days, the required notice was provided to the vulnerable adult or the vulnerable adult's legal guardian and the facility.

Maltreatment Investigations Pending:

- Reports pending at the end of FY12: 628
- Reports pending at the end of FY13: 601

Adequacy of Staff Resources

- If staffing levels had been at full complement for the entire year, it is estimated that about 850 maltreatment investigations could have been completed in FY13, compared to the 704 investigations actually completed. Due to normally occurring turnover, there were as many as five vacancies at one time for a portion of the year.

- With 718 new maltreatment investigations assigned for FY13, resources would appear to be adequate to meet the demand. However, 628 maltreatment investigations pending from the previous fiscal year also needed to be completed.

- To become current with investigations, the Department would have had to complete 1,235 maltreatment investigations, including 628 pending from FY12 and 607 from the first 10 months of FY13.

- Filling all vacant positions and hiring additional maltreatment investigators with 2013 legislative appropriations is expected to greatly improve the more timely completion of investigations.

- The additional resources are also designed to address the increasing number of maltreatment investigation cases expected from the licensure of additional Home and Community Based Services under the new Minnesota Statutes, chapter 245D, that becomes effective January 1, 2014. Six months of this additional work will be addressed in the FY14 Maltreatment Report.

While 2013 legislation will significantly help address resource issues, finding greater efficiencies will continue to be a priority in the OIG. To this end, a recent restructuring in the Licensing Division provided separation of complaint/intake and assessment functions from maltreatment investigator functions (similar to the Minnesota Department of Health's Office of Health Facility Complaints), and a project to thoughtfully review the current maltreatment investigation process will be initiated. Additionally, a pilot project is underway that modifies 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 is now used. This change is expected to provide some workload relief that should assist in addressing the timeliness and backlog issues.

Expanded Prevention Efforts

- The 2013 Legislature adopted multiple improvements to regulatory standards, the OIG's authority to monitor and investigate services and billing, and appropriated over 40 new positions to expand the effectiveness in carrying out these functions.

In conclusion, the 2013 Legislative session can be viewed as very significant for the OIG and for people receiving services from licensed programs because it provided notable increases in maltreatment investigation resources, enhancement and clarification of service delivery standards, and increased resources for enforcement of compliance with Minnesota laws and rules. As a result of these changes, DHS OIG expects improved protections of the health, safety, and rights of clients. It is hoped these changes will help curb the trend of increasing reports of alleged maltreatment and the number of investigations pending completion.

I. INTRODUCTION AND BACKGROUND

The Department of Human Services (DHS), in partnership with counties, licenses approximately 22,500 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 service centers, day training and habilitation programs, as well as residential and outpatient programs for people with chemical dependency, mental illness or developmental disabilities. DHS is responsible for completing maltreatment investigations as they relate to approximately 8,755 licensed settings, consisting of DHS directly-licensed and monitored programs (approximately 4,034 licensed programs) and adult foster care homes (approximately 4,721 licensed programs). Except for investigating maltreatment and issuing licensing sanctions, monitoring and oversight responsibilities for adult foster care is delegated to the counties under Minnesota Statutes, section 245A.16.

Data in this report covers the six-year period from FY2008 to FY2013 and combines information about reports and investigations 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.

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 solely 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 the Minnesota Sex Offender Program, all adults served in DHS licensed programs are categorically "vulnerable adults" under the VAA.

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, the facility, or both were responsible for substantiated maltreatment;
- Whether the maltreatment committed by an individual was serious and/or recurring;
- Whether the facility took action 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 and site visits, obtain pertinent documents, carefully review the documents, and make a determination as to what actually occurred. If a facility or individual appeals the finding, investigators are also involved in preparing documents and testifying at the appeal hearings.

A trained investigator can annually complete approximately 40 out-of-office maltreatment investigations, including the investigation of some possible licensing violations related to the maltreatment investigation and some non-maltreatment-related death review investigations.

II. CURRENT STATUS AND TRENDS

A. Reports investigated

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

When initial reports are received, each report receives an in-office investigation. 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. 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, the report is then assigned for out-of-office investigation. Each investigation 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. If the initial investigation shows that there may be maltreatment, that report is immediately assigned for an out-of-office maltreatment investigation.

For reports involving possible licensing violations, 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.

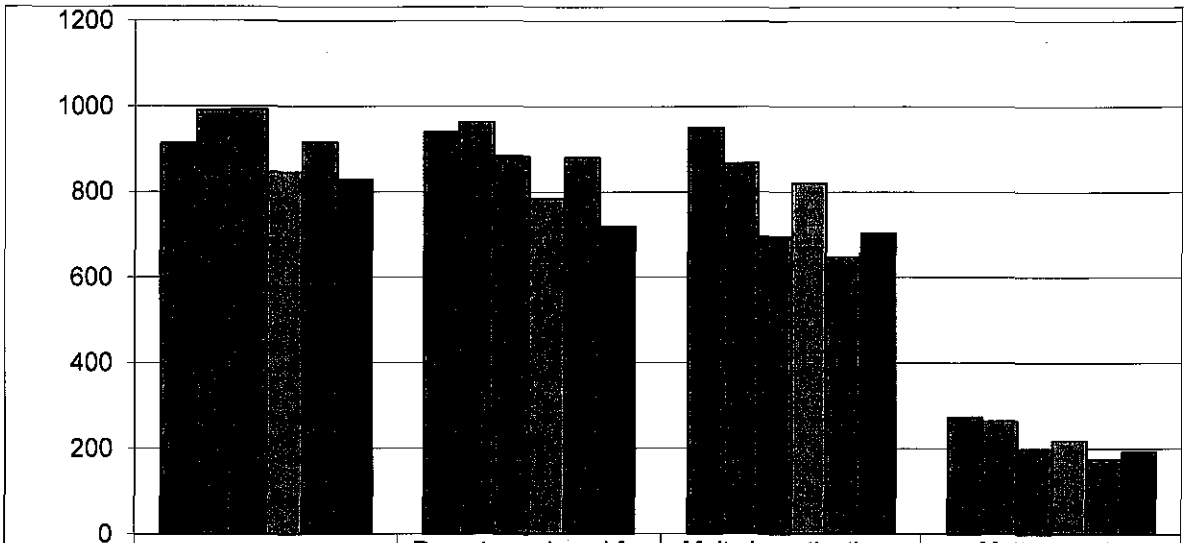
An investigation is considered completed when the investigation memorandum required in statute is written and all required notices of the findings have been issued.[4]

- In FY13, 5,273 reports were received for assessment.
- The 718 reports assigned for out-of-office maltreatment investigation in FY13 included 906 allegations of maltreatment, for an average of 1.4 allegations per report.
- In FY13, 156 non-maltreatment death reviews were completed.
- Fifty-four individuals were found to be responsible for serious or recurring maltreatment and were disqualified from providing direct contact services according the Human Services Background Study Act (Minn. Stat., chapter 245C).
- The number of investigations pending at the end of the fiscal year decreased by 4% from FY12 to FY13. At the end of FY12, there were 628 pending investigations; at the end of FY13, there were 601 pending investigations.
- The trend of increasing reports received and assigned for investigation from outside of the metro area appears to have stabilized. In the last three fiscal years, approximately 55% of reports assigned were outside the metro area and 45% were in the metro area. (This data is not shown on charts.)

[4] This report does not address the resolution of reports where no allegation of maltreatment was investigated.

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

Figure 1



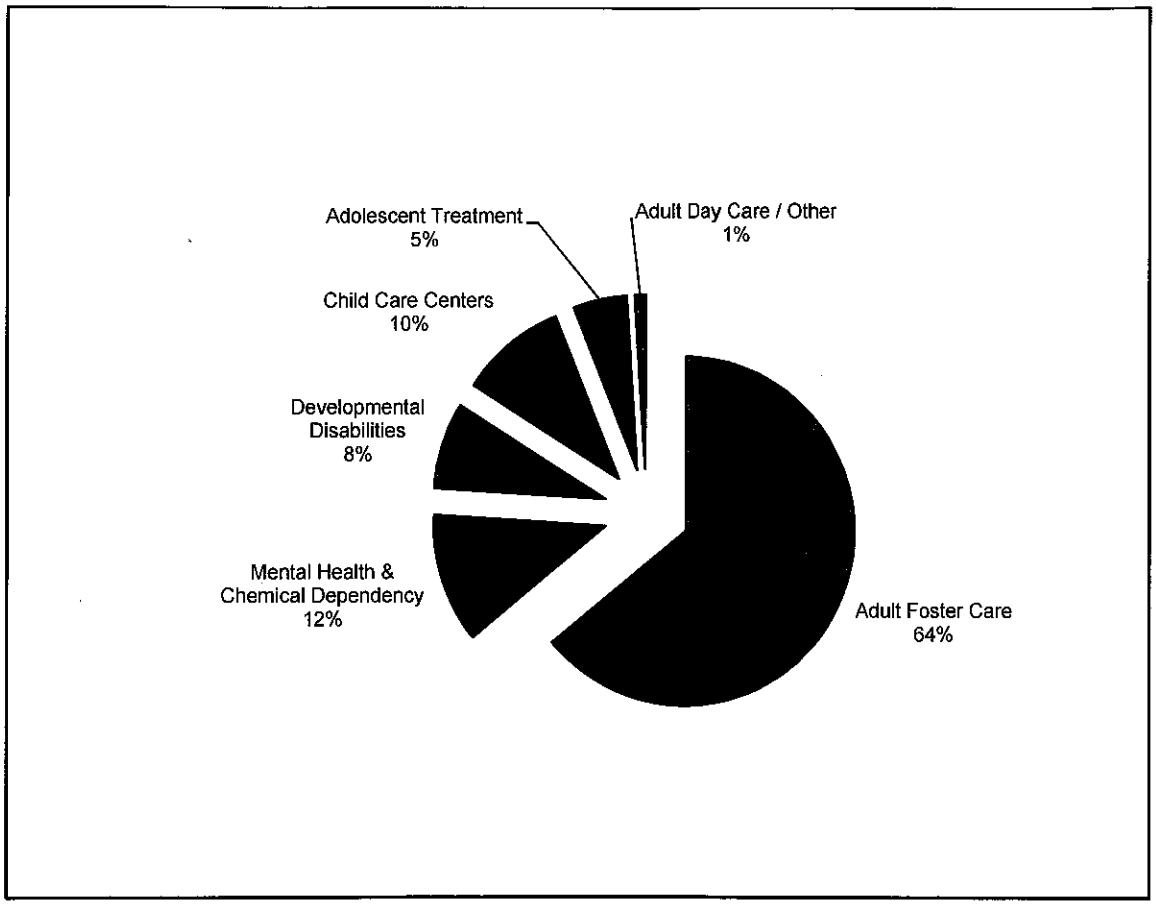
	In-office investigation	Reports assigned for maltx investigation	Maltx investigations completed	Maltx reports substantiated
FY 08	912	939	949	272
FY 09	990	963	867	264
FY 10	992	883	694	198
FY11	846	785	821	218
FY12	916	880	648	174
FY 13	829	718	704	192

B. Type of programs

In FY13, 85% of reports assigned for out-of-office maltreatment investigation involved a vulnerable adult and 15% involved a child.

Figure 2 shows the types of programs where victims of reports assigned for out-of-office maltreatment investigation received services in FY13.

Figure 2



III. RESOLUTION OF INVESTIGATIONS

Under the maltreatment reporting and investigations statutes, the background study statute, and the licensing statute, various types of resolutions to decrease the likelihood of recurrence are possible depending on the outcome of the investigation. These include:

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 six 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 out-of-office maltreatment investigation.

- The report is assigned for out-of-office investigation of possible licensing standards violations only.

- The report is assigned for out-of-office maltreatment investigation with the additional investigation of a possible violation of one or more licensing standards.

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 maltreatment investigation.

B. Findings of Maltreatment

A determination is made as to whether maltreatment occurred and, if so, whether an individual, provider/employer, or both were responsible for the maltreatment under Minnesota Statutes, section 626.556 and 626.557, the Reporting of Maltreatment of Minors Act and the Reporting of Maltreatment of Vulnerable Adults Act.

Investigations of alleged maltreatment of a child can result in a disposition of:
- Maltreatment determined, or
- Maltreatment not determined

Investigations of alleged maltreatment of a vulnerable adult can result in a disposition that the report was:
- Substantiated,
- Inconclusive,
- False, or
- No determination will be made

For the purposes of tables in this report, the term "maltreatment determined" is synonymous with "substantiated."

- An individual found responsible for serious or recurring maltreatment is disqualified for seven years under Minnesota Statutes, chapter 245C, the Human Services Background Study Act; and

- A license holder found responsible for maltreatment is subject to appropriate licensing sanction under Minnesota Statutes, chapter 245A, the Human Services Licensing Act.

- Between FY08 and FY13, the average percent of assigned out-of-office maltreatment investigations resulting in substantiated maltreatment has remained approximately the same at 27%. (Refer to Figure 1 for numbers of cases)

- IN FY13, 66% of the substantiated maltreatment was neglect, 17% was abuse, and 17% was financial exploitation – the same percentages as FY12. (Refer to figure 3)

- In FY13, 704 maltreatment investigations were completed. Maltreatment was substantiated in 192 investigations or approximately 27% of the maltreatment investigations. Of these investigations:

    - 66% determined that one or more individuals were responsible for maltreatment, and not the facility;

    - 14% determined that only the facility was responsible for maltreatment, and not an individual;

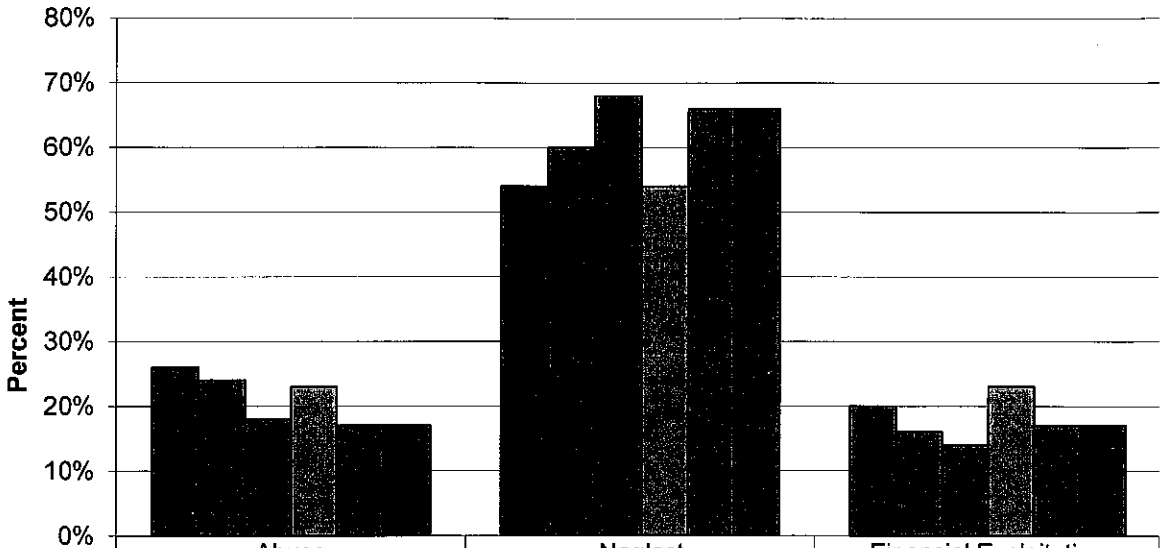
    - 6% determined that both the facility and one or more individuals were responsible for the maltreatment; and

    - 15% could not determine by a preponderance of evidence that either the facility or an individual was responsible for the maltreatment.

    (Refer to figure 4)

Figure 3 shows the type of maltreatment that was substantiated. The overall trend has been of decreasing abuse, increasing neglect and fairly consistent findings of financial exploitation. (Financial exploitation pertains to vulnerable adults only.)

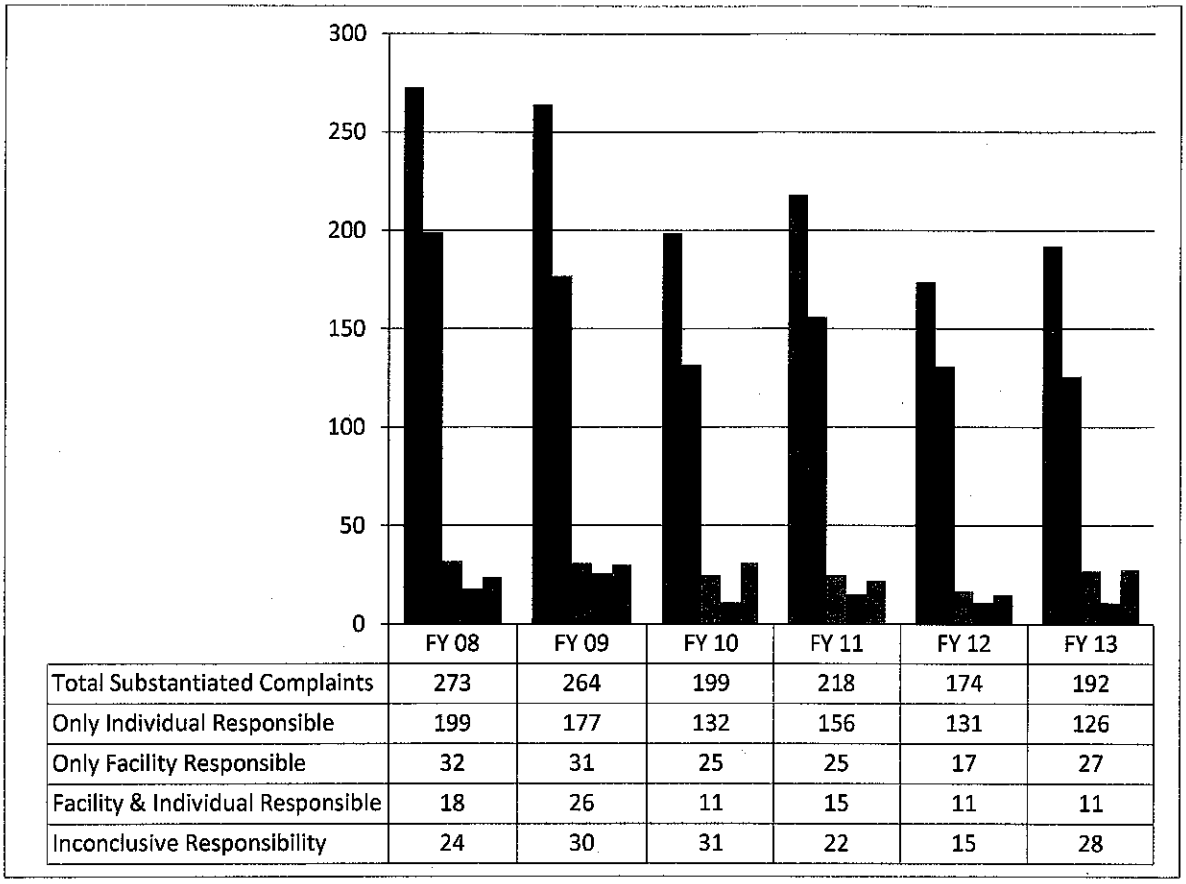
Figure 3



	Abuse	Neglect	Financial Exploitation
FY08	26%	54%	20%
FY09	24%	60%	16%
FY 10	18%	68%	14%
FY11	23%	54%	23%
FY 12	17%	66%	17%
FY 13	17%	66%	17%

Figure 4 shows who was determined responsible for maltreatment when maltreatment was substantiated.

Figure 4

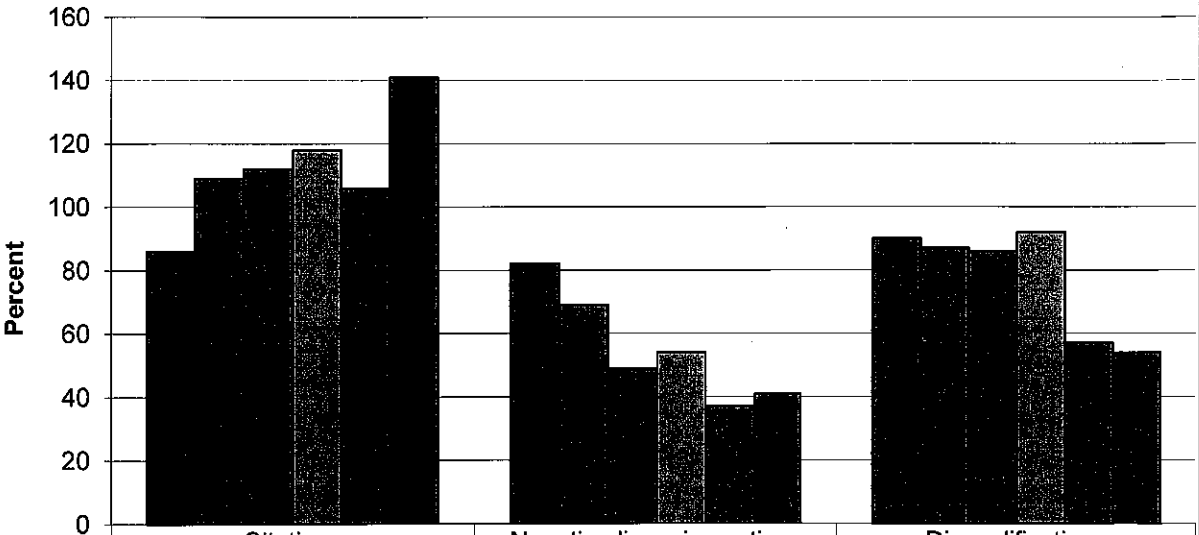


	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13
Total Substantiated Complaints	273	264	199	218	174	192
Only Individual Responsible	199	177	132	156	131	126
Only Facility Responsible	32	31	25	25	17	27
Facility & Individual Responsible	18	26	11	15	11	11
Inconclusive Responsibility	24	30	31	22	15	28

C. Action Taken by DHS

Figure 5 illustrates actions taken by DHS following substantiated maltreatment.

Figure 5



	Citations	Negative licensing actions	Disqualifications
FY08	86	82	90
FY09	109	69	87
FY 10	112	49	86
FY 11	118	54	92
FY12	106	37	57
FY 13	141	41	54

IV. Compliance with Statutory Time Frames

Statutory requirements and outcome

- Notice to the reporter of the initial determination of a report is required within five days. In 100% of the cases, the initial determination was provided to the reporter in five days.

- Completion of the investigation is required within 60 days. If an investigation is not completed within 60 days, a notice is required to be provided to the vulnerable adult or the vulnerable adult's legal guardian and the facility of why the report is not completed along with a projected completion date. In FY 13, reports completed within 60 days totaled 14%. In 100% of the cases where investigations were not

completed within 60 days, the required notice was provided to the vulnerable adult or the vulnerable adult's legal guardian and the facility.

- In FY13, it took an average of seven months to complete an investigation.[5]

Note: Until the older outstanding investigations are all completed, the reported average number completed within 60 days will decrease, and the reported average length of time to complete investigations will increase.

Figure 6 illustrates the number and percentage of investigations completed within specified time frames.

Figure 6

Total Maltreatment Reports Completed	60 days	90 days	120 days	Over 120 days	Total
FY12	145 (22%)	78 (12%)	80 (12%)	345 (53%)	648

Pending reports:

- There were 601 reports pending at the end of FY13. This is a 4% decrease from the end of FY12's 628. (See page 2)

V. Additional Resources and Expanded Prevention Efforts

The Department strives to complete the complex work of investigating alleged or suspected maltreatment within the statutory timelines and in a manner that upholds the highest standards for quality.

With 704 maltreatment investigations completed in FY13, and 718 new maltreatment investigations assigned for FY13, the resources for completing this work would appear to be close to adequate to meet the demand. However, in years with inadequate resources, the Department fell behind in completing maltreatment investigations resulting in 628 maltreatment investigations pending from the previous fiscal year that also needed to be completed in FY13. Both the ongoing new maltreatment reports received daily by the Department and a significant number of older open investigations must be considered when addressing current resource issues.

[5] Investigators handle a number of investigations at any one time.

Renewed interest in this activity by the Administration and the Legislature has resulted in a significant improvement in resources, and in future years, work output in this area is expected to show a substantial increase.

The number of investigations completed in FY13 should have included the number of maltreatment investigations pending at the end of FY12 (628), plus the first 10 months of new investigations - 607 - assigned in FY13, for a total of 1,235 maltreatment investigations. Due to a shortage of resources necessary to complete the remaining 531 maltreatment investigations, 704 of the 1,235 investigations were actually completed. At 40 investigations per investigator per year, this represents the work of approximately 13 investigators. During FY13, maltreatment investigator turnovers occurred and for significant portions of the year there were as many as five vacant positions. At the time of this writing, all five of those vacancies have been filled and an additional supervisor and seven maltreatment investigator positions appropriated by the 2013 Legislature have also been filled. The new resources are expected to significantly help complete the open investigations and then support significant progress toward the ongoing completion of the newly-received maltreatment investigations within the 60-day timeline.

While the Department would like to see more investigations completed annually, maintaining the integrity of the investigative work is paramount. Because significant licensing actions affect both individuals and facilities, it is critical that investigations are thorough and complete.

In response to the ongoing investigations resource issue, the DHS Office of Inspector General (OIG) developed several 2013 legislative proposals. These proposals were designed not only to provide additional maltreatment investigation resources, but because the investigation of reported incidents is costly and always takes place in response to an incident, the proposals included multiple approaches that ultimately are intended to reduce incidents. The proposals are designed to positively impact on the quality of services and the overall accountability of providers of services so as to continue this year's decrease in the number of reports assigned for out-of-office investigations and in the number of allegations of possible maltreatment in those reports.

The 2013 proposals were broad ranging across service types, and they addressed not only updating and clarifying licensing standards to be monitored by licensing staff, but also provided increased accountability related to public funding. With the new OIG structure, the increasing ties between public funding and licensing compliance will only increase as the Department becomes more effective in funding only services that consistently meet the minimal licensing standards.

The following proposals were advanced in the 2013 legislative session and adopted into law.

1. **Home and Community-Based Services:** The expansion of licensure of Home and Community-Based Services standards, under Minnesota Statutes, chapter 245D, requires the licensure of some additional services previously not licensed. The new legislation

also makes regulatory changes to some currently licensed services for people with developmental disabilities. One very significant new requirement relates to the license holder's expanded duties related to program management and oversight that includes evaluation of the program quality and program improvement for services, and identifying specific individuals within the organization who are charged with these important responsibilities.

Many of the services affected by the changes are provided in adult foster care settings that in FY13 account for 64% of maltreatment investigations referenced in this report (Figure 2). The changes also affect 8% of the services represented in Figure 2 related to non-foster care services for people with developmental disabilities. The new licensing and service standards that take effect January 1, 2014, were passed by both the 2012 and 2013 Legislatures, and they will add nine additional FTEs for the Licensing Division in FY14 and an additional six FTEs in FY15. Of these new positions, eight in FY14 and one additional in FY15 are dedicated to be maltreatment investigation-related positions. With these new positions will come additional maltreatment investigation responsibilities; however with a total of 25 maltreatment investigators at the end of the second year of the biennium, resources should more closely match the workload.

2. **Child Care:** Changes in child care licensing aimed at preventing deaths in child care settings were passed in the 2013 legislative session. 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. Five licensing positions will be added over the biennium and an additional training position related to this initiative was funded for the DHS Children and Family Services Administration. As stated earlier, 15% of the maltreatment investigations were assigned in children's programs. Additional safety standards and monitoring are intended to have a positive effect on care provided to children, and a decrease on the need for maltreatment investigations.

3. **Child Care Fraud:** The Legislature also approved establishing a team of child care provider fraud investigators to work with child care assistance program staff, licensing staff, as well as law enforcement personnel in various government entities, to increase accountability related to the Child Care Assistance Program. Six fraud investigative staff and two licensors are being added over the biennium to focus oversight and investigation attention on noncompliant child care providers.

4. **Pre- and Post-Enrollment Inspections:** The federal Affordable Care Act made numerous changes to the state's Medical Assistance (MA) program to fight fraud, waste and abuse. One proposal required that some high- and moderate-risk Medical Assistance reimbursed providers be screened before and after they are enrolled in Minnesota's Medical Assistance reimbursement system to ensure that they are qualified to perform services under state and federal requirements, and eligible to participate in health care programs. As a result of 2013 legislation, six OIG staff will be added to conduct out-of-office visits on these providers before and after they enroll for reimbursement with Medical Assistance funds.

5. **Medicaid Provider Fraud Investigations:** Other 2013 legislation expanded the capacity of the Surveillance and Integrity Review System (SIRS) unit within the OIG to increase the number of fraud investigations related to Medical Assistance reimbursed providers. Previously, 10 investigators were responsible for covering more than 78 different provider types and more than 154,000 enrolled health care providers who are being paid $8.6 billion a year from Minnesota Health Care Programs. With the addition of six investigators in the next fiscal year, more providers will be investigated who have shown significant noncompliance with regulatory requirements and who have been identified as having fraud indicators.

6. **Background Studies:** Additional resources were also appropriated to the Background Study Division to both expand the scope of background studies and to increase efficiency in completing the studies. To keep people who receive care as safe as possible, new authority gives the Background Study Division access to Minnesota's Predatory Offender Registry as part of every background study and the authority to receive new criminal offense information from the Minnesota Court Information System through the development of an electronic notification system currently under development.

7. **Opioid Addiction Treatment Programs:** The 2013 Legislature adopted a significant expansion of licensing standards that significantly increase the direction to and accountability of opioid addiction treatment programs throughout the state, and additional internal resources for the Licensing Division to enhance program monitoring and oversight. One of the important new standards requires the provider to maintain an active quality assurance program that monitors and improves client services and treatment outcomes.

While eight of more than 40 new Office of Inspector General positions are directly related to investigation of reported maltreatment (seven maltreatment investigators and one supervisor), the entire, strengthened OIG will seek greater provider accountability and improved services across programs regulated by the Licensing Division.

The 2013 legislation will significantly help address resource issues, yet finding greater efficiencies will continue to be a priority in the OIG. The Licensing Division will review the current maltreatment investigation process and carefully review 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. A pilot project is underway that modifies the current public investigation memorandum for investigations that results in a finding of false, inconclusive, or maltreatment not determined, and for those findings, an abbreviated report is now used. This change is expected to provide some workload relief in addressing the timeliness and backlog issues.

In conclusion, the 2013 Legislative session can be viewed as significant for OIG because it provided notable increases in maltreatment investigation resources, enhancement and

clarification of service delivery standards, and increased resources for monitoring, investigating and enforcement of compliance with Minnesota laws and rules designed to assure proper care in safe environments. As a result of these changes, DHS OIG expects improved protections of the health, safety and rights of clients. It is hoped these changes will curb the trend of increasing reports of alleged maltreatment and decrease the number of investigations pending completion.