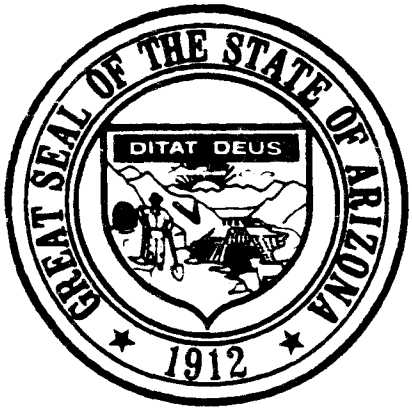

PERFORMANCE AUDIT

DEPARTMENT OF ECONOMIC SECURITY

Division of Developmental Disabilities

Report to the Arizona Legislature
By the Auditor General
March 1993
93-2

STATE OF ARIZONA

DOUGLAS R. NORTON, CPA
AUDITOR GENERAL

OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
DEPUTY AUDITOR GENERAL

March 30, 1993

Members of the Arizona Legislature

The Honorable Fife Symington, Governor

Mr. Charles E. Cowan, Director
Department of Economic Security

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Department of Economic Security, Division of Developmental Disabilities. This report is in response to a December 13, 1991, resolution of the Joint Legislative Oversight Committee.

This is the second in a series of reports to be issued on the Department of Economic Security. We found the Division of Developmental Disabilities has made significant improvements in its fiscal and program management. Our report offers additional recommendations to strengthen client assessment, case management, facility licensing, contract management, and protection of clients.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on March 31, 1993.

Sincerely,

Douglas R. Norton
Auditor General

2700 NORTH CENTRAL AVENUE ▪ SUITE 700 ▪ PHOENIX, ARIZONA 85004 ▪ (602) 255-4385 ▪ FAX (602) 255-1251

SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Economic Security, Division of Developmental Disabilities pursuant to a December 13, 1991 resolution of the Joint Legislative Oversight Committee. This performance audit, the second in a series on the Department of Economic Security (DES), was conducted as part of the Sunset Review set forth in Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957.

The Division of Developmental Disabilities (DDD) provides services and programs to individuals with developmental disabilities and to their families. Individuals with severe, chronic disabilities caused by mental retardation, cerebral palsy, epilepsy, or autism may qualify for Division services. Approximately 11,400 clients are currently participating in the Division's service system. To the extent possible, services are provided at home or in community-based settings rather than in institutions. Both State and Federal monies (received through the Title XIX-funded Arizona Long-Term Care System) support Division programs.

The Division Needs To More Adequately Implement Its Policies For Assessing And Planning Individual Client Services (See pages 9 through 15)

Consultants hired to assist us in evaluating the Division's services concluded that the assessment and service planning process was not functioning properly. Due in large part to poor case management, the Division has not conducted all necessary assessments for some individuals, a process vitally important for both understanding clients' abilities and meeting their individual needs. In 18 of the 30 case files reviewed by the consultants, additional assessments were needed but had not been conducted. For example, a young man living at home had difficulty communicating, and was experiencing medical problems, including seizures. Despite these problems and the challenges his behavior presented to his family, case records indicated he had not received a neurological examination, nor had his communication, psychological, vocational, or educational needs been assessed.

The Division's Case Management System Cannot Effectively Service Clients
(See pages 17 through 25)

Although good case management is crucial to the success of its service system, the Division's case management system is overburdened and unable to perform effectively. Both clients and case managers expressed significant dissatisfaction with the current system. Families reported that case managers are often inexperienced, poorly trained, difficult to contact, and have little knowledge of clients. Case managers we surveyed complained that because of excessive demands and high case loads, they are often unable to effectively service their clients. Some case managers told us they see clients as infrequently as once a year.

Due in part to Federal funding requirements, case managers are buried in paperwork. We identified over 100 forms and reports that case managers at any given time are responsible for. These paperwork requirements can be streamlined to allow case managers more time with clients.

In addition, case manager case loads should be reduced. Case managers average 47 cases each, with some having case loads of 70 clients or more. However, experts in the field and practices in other states suggest that case loads should average about 30 cases per worker. High case loads make it difficult for case managers to adequately fulfill all assigned responsibilities, and also contribute to high turnover, which further weakens the Division's case management system.

The Division Can Improve Its System For Investigating Client Abuse And Neglect
(See pages 27 through 33)

The Division's system for investigating allegations of client abuse and neglect can be strengthened. The Division's clients are particularly vulnerable due to their disabilities and must rely on the Division's incident reporting system for protection. However, this system exhibits several weaknesses. Some incidents that warrant investigation are not reported or are reported too late. Reported incidents are not always investigated adequately or by the appropriate authorities. Finally, response to some incidents has not been adequate.

The Division is taking several steps to improve its reporting and investigations system. For example, a new policy with investigation guidelines has been developed, and a new computer tracking system is being piloted. The Division should also consider strengthening Central Office oversight over incidents of a more serious nature, reassigning the staff to the oversight function, and improving staff training.

Licensing Inspections Need To Be More Timely And Enforcement Should Be Strengthened
(See pages 35 through 42)

Several operational deficiencies within the Division's licensing function need to be addressed. The Division is routinely late in conducting both initial inspections and its relicensing inspections. In addition, six-month monitoring visits have not been timely, and follow-up actions in response to violations have been inadequate. As a result, licensing inspections have identified numerous repeat violations at some facilities. For example, six inspections since 1986 at one group home found numerous health and safety hazards, many of which were repeat violations from previous inspections. Three inspections found that toxic substances were not properly locked up.

The Division Needs To Continue And Extend Efforts To Strengthen Its Contracting Process
(See pages 43 through 50)

The Division should continue efforts to improve its contracting process. Since most of the Division's services are contracted out to private providers, a sound procurement process is vital. The Division has strengthened the Central Office's role in negotiating and overseeing contracts; however, we found that more oversight over district procurement practices is needed. A limited review of contract files disclosed several weaknesses, such as limited review of provider financial information and questionable evaluations of provider proposals.

Inadequate review of provider financial information and insufficient auditing have been particularly costly to the Division and its clients. A recent set of nine financial reviews ordered by the Division's assistant director identified over $2.1 million in questionable or

excessive costs that had not been previously identified. For example, auditors found several instances in which compensation paid to executive staff was excessive. The president of one provider agency received over $417,000 in bonuses between June 1990 and June 1991.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Economic Security, Division of Developmental Disabilities, pursuant to a December 13, 1991 resolution of the Joint Legislative Oversight Committee. This performance audit, the second in a series on the Department of Economic Security, was conducted as part of the Sunset Review set forth in Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957.

Background

The Division of Developmental Disabilities is one of nine divisions within DES. The Division's purpose is to provide services and programs to individuals with developmental disabilities and to their families. Approximately 11,400 persons with developmental disabilities are currently receiving services through the Division. As defined in statute (A.R.S. §36-551), developmental disability means either

> ...a strongly demonstrated potential that a child under the age of six years is developmentally disabled or will become developmentally disabled as determined by a test performed pursuant to A.R.S. §36-694 or by other appropriate tests, or a severe chronic disability which: (a) is attributable to mental retardation, cerebral palsy, epilepsy, or autism, (b) is manifest before age eighteen, (c) is likely to continue indefinitely, (d) results in substantial functional limitation in three or more of the following areas of major life activity (self-care, learning, mobility, receptive/expressive language, self-direction, economic self-sufficiency, or capacity for independent living), (e) reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary or generic care, treatment, or other services which are of lifelong or extended duration.

Division philosophy focuses on providing services to meet an individual's needs at home or in other community-based settings rather than in institutions. To accomplish its mission, the Division directly provides, and also contracts with, individuals and agencies. Services are provided

to eligible individuals based on the person's needs, State and Federal guidelines, and available funding. Examples of services provided include:

Case management	Acute care
Residential room and board	Personal care
Foster care for children	Respite care
Early intervention for children	Day care
Recreation/socialization programs	Homemaker
Vocational-related assistance	Home health aide
Non-emergency transportation	Therapies
Habilitation	Physician visits/nursing

The State's ability to provide services for persons with developmental disabilities was greatly expanded with the implementation of the Federal Medicaid (Title XIX) program in Arizona. Until 1989, essentially all services provided to individuals by DDD were funded solely with State appropriations. In late 1988, DDD entered into an agreement with the Arizona Health Care Cost Containment System (AHCCCS) to provide both acute and long-term care to persons with developmental disabilities. For this to occur, AHCCCS negotiated with the Federal Health Care Financing Administration (HCFA) for a five-year demonstration (research) project to allow the State to provide long-term care, medical services, and case management to AHCCCS-eligible developmentally disabled persons. The program is referred to as the Arizona Long-Term Care System (ALTCS) and is funded by Federal Medicaid monies and matching State appropriations. Individuals who are eligible for services through the Division may also be eligible for services through ALTCS if they are determined to be at risk of institutionalization. ALTCS provides both acute medical services and medically necessary home- and community-based services. As a result of new Federal funding, approximately 6,000 more persons are receiving some services.

Organization And Staffing

Headed by an assistant director, the Division is composed of six regional districts, approximately 46 local offices, and a Central Office located in Phoenix. Services are coordinated through, and in some areas directly provided by, DDD staff located in the districts (e.g., State-operated group homes). Each district has a district program manager, area program

managers, case managers, and various other program and operations staff. The Central Office provides for administration, business operations, program functions (directs the Title XIX Long Term-Care and State-funded programs and manages compliance with Federal funding and program requirements), and managed care operations (directs the administration of all medical and long-term care services with an emphasis on cost containment). In total, the Division has an authorized full-time employee staffing level of 1,468 for Fiscal Year 1992-93 (see Tables 1 and 2, pages 4 and 5).

Funding

Funding is provided primarily through State appropriations and Title XIX of the Social Security Act (Medicaid). With the implementation of the ALTCS program, the Federal government funds approximately 62 percent of the expenses for persons qualifying for that program, with the State paying the balance. As a result of this new program, developmental disability resources were split into two program budgets. Clients eligible for Federal assistance are primarily funded from the Long-Term Care System budget program (see Table 1, page 4). All other clients receiving assistance are funded through the 100 percent "State-funded" program, referred to as Developmental Disabilities program budget (see Table 2, page 5). For Fiscal Year 1992-93, DDD's total budget is over $184 million.

TABLE 1

DEPARTMENT OF ECONOMIC SECURITY
LONG-TERM CARE SYSTEM BUDGET (ALTCS)
STATEMENT OF FTEs AND ACTUAL AND BUDGETED EXPENDITURES
FISCAL YEARS 1990-91, 1991-92, AND 1992-93
(unaudited)

	1990-91 (Actual)	1991-92 (Actual)	1992-93 (Approved)
FTE Positions	773	898	979
EXPENDITURES			
Operating:			
Personal Services	$ 16,295,600	$ 19,543,200	$ 21,142,100
Employee Related	4,250,300	5,322,400	5,827,200
All Other Operating	4,473,500	5,304,000	5,129,200
OPERATING SUBTOTAL	25,019,400	30,169,600	32,098,500
Special Line Items:			
Acute Care	15,959,600	19,014,700	20,489,500
Fee for Service	2,801,300	4,950,200	5,434,300
Foster Care	6,970,700	8,165,400	7,946,600
Purchase of Care	64,222,100	73,287,900	76,306,000
Stipends & Allowances	205,400	205,400	205,400
SPECIAL LINE ITEM SUBTOTAL	90,159,100	105,623,600	110,381,800
TOTAL(a)	$115,178,500	$135,793,200	$142,480,300

(a) Of these total expenditures, amounts funded by Title XIX (and to a significantly lesser extent, other funding sources) and State appropriations totaled the following:

	FY 1990-91 (Actual)	FY 1991-92 (Actual)	FY 1992-93 (Approved)
State Appropriations	$ 45,954,900	$ 57,025,900	$ 56,186,900
Title XIX & Other	69,223,600	78,767,300	86,293,400
	$115,178,500	$135,793,200	$142,480,300

Source: Department of Economic Security, Office of Budget, Financial Management and Control System Reports for Fiscal Years 1990-91 and 1991-92 and the State of Arizona, Appropriations Report for Fiscal Year 1992-93.

TABLE 2

DEPARTMENT OF ECONOMIC SECURITY
DEVELOPMENTAL DISABILITIES BUDGET (STATE FUNDED ONLY)
STATEMENT OF FTEs AND ACTUAL AND BUDGETED EXPENDITURES
FISCAL YEARS 1990-91, 1991-92, AND 1992-93
(unaudited)

	1990-91 (Actual)	1991-92 (Actual)	1992-93 (Approved)
FTE Positions	702	545	489
EXPENDITURES			
Operating:			
Personal Services	$ 14,237,100	$ 11,650,600	$ 10,600,700
Employee Related	3,713,900	3,259,600	2,923,600
All Other Operating	3,397,200	2,535,200	2,115,800
OPERATING SUBTOTAL	21,348,200	17,445,400	15,640,100
Special Line Item:			
ASH Community Placement	108,000	91,300	118,300
Assistance to Families	463,200	463,200	463,200
Foster Care	3,643,100	3,138,700	3,638,400
Housekeeping Payments	204,800	169,700	197,400
Out-of-District Placement	181,900	736,800	219,100
Purchase of Care	20,223,600	19,268,000	21,073,700
Stipends and Allowances	10,400	10,400	10,400
Voc Rehab Contracts	123,500	208,500	217,900
SPECIAL LINE ITEM SUBTOTAL	25,513,400	23,568,900	25,901,200
TOTAL	$ 46,861,600	$ 41,014,300	$ 41,541,300

Source: Department of Economic Security, Office of Budget, Financial Management and Control System Reports for Fiscal Years 1990-91 and 1991-92 and the State of Arizona, Appropriations Report for Fiscal Year 1992-93.

Audit Scope

In late 1991 when this audit was authorized and initiated, there were numerous legislative concerns about the Division's operations. However, during our audit, a new assistant director was appointed who has aggressively pursued changes in both fiscal and programmatic areas.

Throughout this report, our findings and recommendations acknowledge and build upon the many changes that have been spearheaded by the assistant director.

Our report presents findings and recommendations in five areas:

- The extent to which individual needs are being adequately assessed and services properly planned
- The need for changes in the Division's case management system to better enable case managers to provide effective case management to clients
- The adequacy of the Division's system of investigating client abuse and neglect
- The efficiency and effectiveness of the Division's licensing process
- The need for DDD to continue and expand its efforts at improving its contracting process

To help us determine how well DDD has assisted persons with developmental disabilities, we contracted with the consulting firm of Conroy & Feinstein Associates (CFA) of Wynnewood, Pennsylvania, noted experts in the field of developmental disabilities. We asked them to assess the Division's performance in three main areas: (1) determination of eligibility for services and assessment of individual needs, (2) efforts at planning appropriate services for meeting identified needs, and (3) ability to secure adequate and quality services. The consultant's research consisted mainly of completing in-person surveys with clients and their families/caregivers, and phone interviews with case managers for 219 randomly selected persons; conducting 30 detailed case file reviews; clinically analyzing 10 cases; holding focus group meetings with Division administrators and case managers, family members, and services providers; and reviewing and evaluating DDD policies and procedures. Due to funding limitations, only ALTCS-eligible consumers were studied; those eligible for State-funded services only were not.

Finding I summarizes their conclusions regarding the Division's performance in assessing needs and planning services for individuals. A summary of the consultant's conclusions regarding the overall quality and availability of services can be found on page 51.

The audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the Director and staff of the Arizona Department of Economic Security, and the Assistant Director and staff of the Division of Developmental Disabilities for their cooperation and assistance during the audit.

FINDING I

THE DIVISION NEEDS TO MORE ADEQUATELY IMPLEMENT ITS POLICIES FOR ASSESSING AND PLANNING INDIVIDUAL CLIENT SERVICES

The Division is not consistently following established procedures in assessing needs and planning individual client services. Our consultants found that appropriate client assessments are not always completed prior to the development of written service plans required for all clients. In addition, planning meetings are not always appropriately conducted and monitoring and adjustment of plans is sometimes lacking. While Division policies and procedures for assessing client needs and developing plans were found to be state of the art by our consultants, they are not being consistently followed by Division case managers.

The Service Planning Process

All services provided to Division clients are developed and authorized through a formal planning process. This process begins after clients are determined eligible for Division services. First, client needs are assessed by case managers and, as appropriate, by outside professional specialists. After assessments are completed, an interdisciplinary team meets, often with clients and family members participating, to formally plan client goals and services. Additional assessments may be requested by the team. A written Individual Program Plan (IPP) is prepared following these meetings. Plans are updated annually, or more frequently if necessary. For example, a formal review of service plans for most Title XIX clients must take place every 90 days. These reviews can result in changes or modifications to the client's IPP.

All Necessary Assessments Are Not Being Done

Our consultants found that all assessments that should be completed on some clients are not being done prior to the IPP meetings. General assessments of client functioning that are routinely done for all clients

are not always completed by the time the team meets, and some special assessments needed are not being done at all. As a result, many of the services and goals established at the IPP meetings are not based on formal, documented assessments of client needs.

Types of assessments - The first critical step in assisting a person with developmental disabilities in obtaining needed services and supports involves the assessment of the person's abilities and disabilities, and strengths and weaknesses. Assessment results are crucial to developing appropriate plans to assist individuals in achieving more independence and a better quality of life. Two primary categories of assessments are typically administered:

- General functional ability - The Division uses an assessment package, the Inventory for Client and Agency Planning (ICAP) to evaluate the client's overall functional level. The ICAP is generally completed on an annual basis by the Division's case managers with the assistance of individuals who know the client well. ICAP results provide a basic overview of functional abilities in such areas as eating, dressing, and grooming. Results also help identify levels of supervision the client may require, challenging behaviors (such as aggressiveness), and the need for additional assessments, services, and supports. According to our consultants, the Division's ICAP is a valid and appropriate package for use in assessing general functional abilities, and is especially appropriate for adults. It is not necessarily appropriate, however, for assessing the abilities and needs of infants and young children.(1)

- Special assessments - Additional assessments may be required to determine an individual's special needs. For example, the ICAP cannot reveal the extent to which a client may need physical or occupational therapy. Separate assessments by appropriate professionals need to be administered, and are essential to developing a comprehensive understanding of individual abilities and needs. Typically, these additional assessments are requested by case managers.

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(1) The consultants found 6 children, ages 5 years and younger, for whom an ICAP was inappropriately administered by the Division. Because of this, the consultants recommended alternative assessments more appropriate for young children, such as the Denver Developmental Screening Instrument, the Slosson Intelligence Test, and the Bayley Scales of Infant Development. According to the Division, however, all of its districts have been utilizing various standardized and nationally recognized assessments for young children for several years, such as the Denver and the Bayley.

ICAPs not timely - Although the ICAP is a valid and appropriate instrument, it is not always administrated in a timely manner. Our consultants found that, in some cases, the ICAP was not completed until after the IPP team had met. When this occurs, important information which should be considered by the team in developing goals is not available since a service plan has not been completed. The team needs ICAP results to help its members understand an individual's functional needs. It is unlikely this information would be available elsewhere.

Special assessments - Moreover, the Division has not ensured that all necessary additional assessments of individuals have been conducted. Our consultants felt that additional assessments were necessary for 18 of the 30 individuals whose Division maintained case files they reviewed. While the consultants realize that all types of assessments are not always necessary, some circumstances dictate that formal assessments be conducted. For example, some files contained a reference that a particular service, such as physical therapy, was needed; however, there was no indication that an assessment was done. The consultants further commented that the failure to conduct necessary assessments is unacceptable and inconsistent with practices in other states that they have reviewed. In these states, they found that the assessment process was clear, routine, and "practically never misses any important area." In Pennsylvania, for example, formal written plans cannot be developed without evidence that all essential assessments have been conducted.

Because assessments were not always done, some clients have not received services and supports they may need.(1) For example:

- A medically fragile 2-year-old girl had worn hearing aids for a period of time. According to the consultant's review of her case file, her hearing was somehow determined adequate for speech, and the hearing aids were discontinued. However, a speech evaluation was not completed until over one year after the decision was made to discontinue use of the hearing aids.

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(1) The case examples cited here are based on the consultant's review of Division case files, client visits, and case manager interviews. The consultants strongly believe that all important information about a client should be documented in Division records and available to the case manager, who is responsible for the clients' day-to-day support.

- A young man living with his family has difficulty communicating and presents behavioral problems that are challenging to them. He also experiences medical problems, including seizures. Although he receives some services, the consultants found no current neurological assessments or physician's notes in the Division's case file. In addition, he has not had his communication, psychological, vocational, or educational needs assessed. The consultants concluded that the young man has not received comprehensive functional assessments in all needed areas, and when assessments have been completed, they have not been conducted in a timely or coordinated manner.

Plans not supported - Because all necessary assessments are not always done prior to the IPP meeting, goals have been established and services authorized that are not based on an assessed need. This can result in the delivery of costly services that may be unnecessary or excessive.

During their review of case files, our consultants found no evidence of an assessed need for approximately 43 percent of goals contained in planning documents. During the IPP meetings, goals are established for clients, such as learning how to eat or dress, or increasing social interaction. Services are then developed to help meet these goals. However, our consultants often could not determine how or why many goals were set. They stress that accurately determining a client's needs is paramount for ensuring an effective and efficient service system.

Procedures For Conducting Planning Meetings Are Not Always Followed

Some planning meetings are not conducted according to established procedures, and follow up between annual planning meetings is sometimes lacking. Teams do not always include all appropriate individuals who should be involved and some critical information, in addition to assessment results, is lacking when the IPP team meets. Monitoring of client progress is also weak in some cases and plan revisions are not always made when appropriate.

Team composition - According to our consultants, professional personnel and others who should be involved in the IPP team meeting are often left out. In fact, in their review of 30 case files, the consultants found only one case in which there was a properly constituted interdisciplinary

team present during the client's annual IPP review. In most cases the teams consisted of the client, case manager, and family members. In a few cases, residential and day program providers were involved. However, the consultants believe that residential and day program representatives should be more involved in the planning process. Furthermore, if important assessments will not be available for the planning meeting, various other professionals who interact with the client should at least be available, given the complex needs of many individuals who have developmental disabilities. According to the consultants, these individuals, including medical specialists, physical and occupational therapists, teachers, and speech/language professionals, were rarely involved in planning in the cases they reviewed.

Information lacking - In addition to assessment results, other critical information is also not available when some IPP teams meet. In their case file review, the consultants found that medical records, laboratory test results, and client plans developed by other agencies were sometimes lacking. They noted that this makes it impossible for appropriate planning to occur.

The consultants also did not find any comprehensive IPPs that encompassed assessment results from other agencies working with the client, especially for clients over five years of age. For example, local school districts develop Individual Educational Plans (IEPs) for developmentally disabled youth who reside in their districts. In addition, adult clients may have an employment-related plan developed through the DES, Division of Vocational Rehabilitation (DVR). When plans are not integrated, the result is often poor coordination of service delivery and inconsistency in efforts to address service needs.

Monitoring and plan adjustment - The consultants also identified weaknesses in the monitoring of client progress and adjusting of client plans. Although the ICAPs are completed, results are not used to benchmark functional abilities and measure progress over time. According to the consultants, ICAPs appear to be completed "simply because they are required," and are often forgotten once completed.

In addition, teams often do not reconvene when appropriate to adjust client plans. Plans may need to change between annual IPP meetings if no progress is being made, or if new problems or other needs arise. For example, in one case reviewed, an individual had experienced 14 behavioral episodes between July and October 1992. The team did not meet to examine the possible causes for the increased number of behavioral incidents nor to discuss a plan of action. The consultants felt that the client would have benefited greatly had the IPP team reconvened to address the client's problems. In only one of 30 cases reviewed did the IPP team reconvene between annual meetings.

Breakdowns Occur Within The Case Management System

Weaknesses in the Division's case management system appear to be the principal cause of problems with the assessment and planning process. The consultants found Division policies and procedures were appropriate. However, because of poor communication and lack of training, case managers were not uniformly following these policies and procedures in the field. For example, the consultants learned that assessments were often not requested because the case manager believed the assessments were not eligible for Title XIX funding. In fact, one case manager admitted that none of the 44 clients in the case manager's case load has had any assessments other than the ICAP. The case manager saw no point in requesting assessments that would not be funded. Division administrators explained, however, that such assessments could be funded with Title XIX monies. Our consultants concluded that Division policies have not been fully explained to case managers, and as a result are simply not being consistently followed.

Finding II (page 17) addresses in more detail other problems, such as excessive paperwork, high case loads, and staff turnover, which may also adversely impact the Division's ability to adequately assess needs and create effective service plans.

RECOMMENDATIONS

1. The Division should adequately train case managers and others involved in the assessment process in proper procedures for conducting assessments, and should instill a clear understanding of the importance of full and consistent implementation of its policies and procedures.

2. The Division should ensure that a more appropriate tool is consistently used for assessing the functional abilities of young children.

3. The Division should ensure that comprehensive assessment information is available to planning teams when goals are set and services are authorized.

4. The Division should ensure that case managers involve all appropriate personnel in the IPP planning process.

5. To strengthen its planning ability, the Division should take steps to ensure that all information essential to the planning process, such as medical examination and laboratory test results, assessments, and information prepared by other agencies, is contained in client case files.

6. In cases involving multiple agencies, the Division should attempt to develop integrated plans that are comprehensive and consistent with plans developed by these other agencies.

FINDING II

THE DIVISION'S CASE MANAGEMENT SYSTEM CANNOT EFFECTIVELY SERVICE CLIENTS

The Division's case management system is overburdened and poorly administered. This is particularly disturbing because case management is a critical element in the system that delivers services to persons with developmental disabilities. However, excessive paperwork, high case loads, and other factors make it difficult for DDD's case managers to carry out their responsibilities. Although the Division recognizes that problems exist and some improvements are planned, further efforts are needed.

Case Management Is Essential, But Inadequate At DDD

Quality case management is important to successful client development, yet the case management system at DDD is lacking. Case managers perform many important functions, and fostering strong personal relationships through frequent contact with clients and their families is among the most crucial. However, both DDD case managers and clients feel that DDD's case management is not responsive to clients' needs.

Good case management is necessary - DDD's case managers are the key contact within the system for persons wanting to access services. Specifically, case managers are responsible for determining whether a person is eligible for Division-funded services, and if so, ensuring necessary assessments are conducted to determine the individual's needs. For example, the case manager may need to address issues such as which type of residential placement would most benefit a client, which therapies are needed, and which programs could assist the individual in developing new skills and abilities. Case managers also determine whether the client's family has any special needs. Based on these assessments, the case manager, along with others involved with the client, plans and coordinates the delivery of services through a network

of providers. The case manager also monitors services received by the client and assesses the client's progress in achieving goals.

In addition to accurately assessing a person's needs and coordinating services, case managers need to develop close personal relationships with clients and their families. Building such a relationship is often accomplished by frequently visiting and talking with clients and their families. By doing this, case managers can increase their opportunities for ensuring the client's needs have been accurately determined and that services are reaching and benefiting the client. Furthermore, many persons with developmental disabilities have severe physical limitations. Some clients are non-verbal, or cannot walk or even stand. Others may be dependent on ventilators for breathing. Many clients are also vulnerable to such things as self-inflicted injury, physical neglect or abuse, or exploitation. Frequent case manager contact with clients helps to ensure their safety and may help reduce crisis situations.

Effective case management hampered - Although case management is vitally important to successful client development, neither case managers nor clients are satisfied with the current system. We surveyed, by mail, all 246 case managers employed by DDD during July 1992; 130 responded to our survey. Those who responded estimated they currently spend about ten percent of their time in direct contact with clients, but felt, on average, that they should spend nearly one-quarter of their time in this manner. Many reported that excessive demands on their time have greatly impacted their ability to know their clients and perform their jobs effectively. Several case managers we spoke with see some of their clients as little as once a year.

Families of persons with developmental disabilities have also expressed dissatisfaction with the case management services their family members are receiving. More than two dozen parents voiced their concerns during a Joint Legislative Committee hearing in November 1991. Some parents stated that case managers are generally inexperienced, poorly trained, difficult to contact, and have little knowledge of the individual for whom they are coordinating services. Parents questioned whether case

managers were properly prepared to identify and meet the needs of their children. In addition, some family members surveyed by our consultants, or who contacted Auditor General staff directly during the audit, also expressed their unhappiness with DDD's case management system. Problems they noted include high case manager turnover, lack of case management services, and unknowledgeable and uninformed case managers.

Various Factors Hamper DDD's Ability To Provide Good Case Management

Several aspects of DDD's current system have rendered case managers unable to provide clients with quality case management. Excessive paperwork requirements demand much of the case managers' time. Adding to this is high client-to-case manager ratios. High turnover and poor training also make it difficult, if not impossible, for case managers to fulfill their responsibilities.

Considerable paperwork required - Case managers responding to our survey noted that a reduction in paperwork would be the one change that would most improve their jobs. In some cases, the problem is that case managers have to complete various types of reviews and complete paperwork on those reviews too often, while in other instances, the paperwork they complete is often duplicative.

We identified over 100 forms and reports which case managers may have to fill out, depending on Division requirements and client needs. Some of these forms, and the type and amount of information contained within them may not be necessary, at least to some degree. Recently, for instance, two internal studies both concluded that the forms and paperwork required for most case management functions contain duplicative information and that the tasks expected of case managers are excessive and redundant. Both reports recommended that procedures and paperwork need to be simplified. Consultants hired by the Auditor General also noted that case managers seem to be burdened with an inordinate amount of paperwork. They recommend that duplicative tasks be reduced, and that case aides or other staff be responsible for some of the paperwork.

To illustrate one impact of high paperwork requirements, we found that while accompanying a case manager to a group home where several of her clients lived, she spent only a few minutes with each of her clients during the 2-and 1/2-hour visit. She spent the remaining time soliciting information from the group home administrator and completing paperwork.

High case loads - Case managers have difficulty finding enough time to adequately service all clients on their case loads. We found that in June 1992, DDD case managers were assigned an average of 47 clients each, with some having upwards of 70 clients or more. High case loads can limit a case manager's ability to perform effectively, as well as his or her opportunity to visit clients and personally monitor their progress. It has also forced some case managers into "prioritizing" individuals in their case loads, causing a disparity in the equitable provision of case management among clients.

Nearly everyone involved with case management at DDD agrees that case loads are too high. Case managers and case manager supervisors we surveyed indicated that the average case load size should be reduced to a maximum of 33 clients.

Case managers average about 50 percent more clients than experts say should be assigned to their case loads. Our consultants explained that current best practice dictates that one case manager be involved in supporting about 30 individuals. We also spoke with several other consultants who specialize in the field. They told us that a case load size of 20 to 30 is generally reasonable to ensure quality case management. In addition, Michigan and New Hampshire, two states identified to us as having model DD programs, reported average case load sizes of 24 and 25 clients, respectively, per case manager.

Because of system requirements and the complicated needs of many individuals with developmental disabilities, a reasonable case load size is crucial. Effectively servicing even one client can take a considerable amount of time and effort. To illustrate this point, case managers are required to ensure that, for many clients, written plans outlining the client's services are reviewed quarterly and that other,

more formal reviews occur once or twice a year. This process alone can necessitate discussions with parents, guardians, and others involved with the individual, and arranging and preparing for meetings with medical specialists, therapists, and other professionals. The case manager must also document the results both manually and on the Division's computer system. If changes in services or other supports are determined to be needed, the case manager is then responsible for coordinating these changes for the client. In addition, case managers with clients in foster care must prepare a variety of reports for the foster care review board and the courts, as well as participate in court hearings. Also absorbing part of a typical case manager's work week is travel time to and from client planning meetings, meetings with providers, and visits with clients.

The Division has realized its need for more case managers in an effort to handle both new client growth and reduce high case loads. Division officials told us they have requested additional case manager positions in recent years. Although some case manager and related support positions were added as a result of these requests, mostly for servicing Long-Term Care System (ALTCS) clients, DDD management acknowledges more case managers are needed to allow for manageable case loads.

While it is clear that smaller case loads should be the norm at DDD, various factors, such as client type and the intensity of the person's needs, would need to be considered to most effectively determine appropriate case loads for individual case managers.

Other factors also impact - Case manager knowledge of clients and their ability to ensure client needs are met is further impacted by high turnover and inadequate training.

- **Turnover** - Although we were unable to accurately calculate DDD's turnover rate for case managers, Central Office case management staff estimate it to be between 25 and 35 percent, approximately double the average turnover rate for several states identified as having model DD programs and significantly greater than the 10 percent turnover rate for case managers employed by Child Protective Services. High turnover negatively impacts case management in several ways. According to experts in the field of developmental disabilities, the case manager's value grows with experience, often taking years for the case manager to develop necessary skills. We found, however, that more than 50 percent of DDD's case managers have worked in the Division fewer than two years.

Turnover also reduces the client's opportunities to develop a continuing relationship with his or her case manager. Turnover also adds to already high case loads for remaining case management staff, including case manager supervisors. Finally, training and recruitment activities are costly.

According to case managers and supervisors we surveyed, as well as some we interviewed, the high rate of turnover among DDD case managers is due in large part to relatively low salaries. Currently, DDD's entry-level case manager earns an annual salary of $17,755. The base salary for case managers working for Maricopa County Long-term Care is about 25 percent more, while case managers in Child Protective Services earn about 20 percent more and those contracting with the Office for the Seriously Mentally Ill earn nearly 10 percent more. According to a Division representative, in an effort to make its case managers' salaries more competitive, DDD contacted the Department of Administration to conduct a Classification Maintenance Review (a position/salary reclassification analysis) for Fiscal Year 1992-93. However, DOA declined to perform such a review because the Division had no funding allocation identified to support any resulting reclassification. Still, the Division should continue its efforts to improve case manager salaries, when possible to do so.

- **Training** - DDD is not providing case managers with adequate training. According to the results of our case manager survey, 40 percent of the case managers responded that DDD training was insufficient and nearly 20 percent believe it has not been beneficial. Further, according to a recent study commissioned by the Division, consultants found that only 12 of 181 case managers included in the analysis have had training on all topics necessary to perform their jobs effectively. We also found that DDD has failed to provide training to new case managers on a timely basis.

The training program is not sufficiently standardized or properly monitored. The absence of written standards or guidelines on how to develop a training course has resulted in more than 100 different training packages in use statewide. Also, the adequacy of case manager training is affected by poor monitoring. For example, though DDD spent more than $130,000 for the development of a competency-based training system in 1990, which was designed to guarantee case managers received appropriate training and periodic monitoring by Central Office, it never fully implemented the system.

During their review, our consultants also expressed concern about case manager training. They concluded that DDD's training curriculum has not been implemented. As a result, and as evidenced through the records review and other work they performed, they feel strongly that key areas of competence have not been clearly achieved.

Changes Are Needed

Much needs to be done to develop an effective case management system. DDD is taking some steps to improve the system, such as strengthening Central Office's role and redesigning the case manager training program. However, a number of critical issues, including case load size, have yet to be addressed in any significant way.

DDD working toward improvement - DDD management recognizes that deficiencies exist and appears to be committed to improving its case management system. Recently, the assistant director selected a group of DDD managers and staff to analyze the Division's operations and practices in the wake of considerable criticism from clients and their families, legislators, and staff. Case management was one of the five functional areas studied by the group. The group identified a number of inefficiencies within the case management system. Management is now deciding what actions to take to create a stronger case management system statewide.

The Division is also beginning to address the issue of excessive paperwork. For instance, DDD has identified about 20 processes and corresponding forms it believes could either be consolidated or eliminated entirely, such as consolidation of the Individual Program Plan (IPP) document with the Service Plan. The assistant director has also obtained AHCCCS' approval to complete formal reviews for some clients less frequently than is currently the case.

DDD is also in the process of developing a stronger and more uniform training program. The Division recently hired a consulting group to work with Division staff in assessing the Division's training programs, especially as they relate to case managers. As a result, DDD is

developing guidelines for training new case managers that combine formal classroom training with supervised on-the-job training. Classroom training is expected to emphasize basic case management functions as well as specialty areas, such as mental health and medical needs assessments.

More changes will be needed - Although DDD is trying to effect some changes, more changes will be needed. For example, even after the proposed changes, case managers will continue to be overburdened by excessive and duplicative paperwork.

Once case manager paperwork requirements have been minimized, the Division needs to develop a policy on case load size. DDD should assess case manager duties to determine the time case managers need to fulfill each of their tasks. DDD will then need to establish a plan, which could include reorganizing or redeploying existing staff. Only after these steps have been taken should the Division consider requesting more case manager positions from the Legislature.

Due to budget constraints, State funds may not be immediately available to hire additional case managers. However, if DDD wants to improve the quality of its case management services, case load sizes will have to be reduced. The problems of turnover and low salaries will also need to be addressed. Until Division case managers are paid similarly to case managers in other Arizona agencies, high turnover will continue.

RECOMMENDATIONS

1. DDD should continue its effort to further reduce excessive paperwork requirements and related tasks.

2. Once paperwork requirements are adequately addressed, DDD should analyze remaining case manager activities and develop an appropriate case manager-to-client ratio.

3. DDD should analyze the relationship between high turnover among case managers and such issues as low salaries. DDD may want to request the Department of Administration to study restructuring the salary classification for its case managers, when budgetary guidelines and funding make it possible to do so.

4. DDD should continue to revise its case manager training program to ensure case managers have the skills they need. Specifically, DDD should develop a training curriculum for new and experienced case managers, properly standardize and monitor case manager training, and provide training to new case managers on a timely basis.

FINDING III

THE DIVISION CAN IMPROVE ITS SYSTEM FOR INVESTIGATING CLIENT ABUSE AND NEGLECT

The Division's system for reporting, investigating, and acting upon incidents of client abuse and neglect can be strengthened. Many people who rely on DDD for services must also rely on DDD to protect them, as they cannot protect themselves. However, DDD does not always conduct adequate investigations into allegations of abuse and neglect or take appropriate action to safeguard clients. Several factors contribute to this failure. Although DDD has recently taken some steps to address the problem, further action must occur.

Reports, Investigation Required For Protection Of Vulnerable Clients

The physical and mental limitations that make people eligible for DDD services also make them particularly vulnerable to abuse and neglect. Many clients cannot speak, so cannot protest or tell others when they are mistreated. Others have physical impairments that prevent them from defending themselves or running away. Some lack the ability to recognize abusive situations. Furthermore, DDD clients cannot simply find a new home, a new job, or a new school if they become victims, but must depend on others to help them change their circumstances.

Whenever client abuse or neglect is observed, alleged, or suspected, DDD division management must be notified by means of an Unusual Incident Report (UIR). Licensing regulations (R6-6-1601) require contract agency employees to report to DDD via the observing employee's supervisor. The Division's policies and procedures require DDD employees to verbally inform a supervisor immediately upon learning about the problem from the agency, a client, the public, or by their own observation, and to prepare a written UIR within 24 hours. Investigation of a UIR is mandatory in

all cases of client abuse and neglect.[1] UIRs and investigation reports alert management to problems, provide a written history for spotting trends, and supply information needed to determine actions to correct problems and prevent their recurrence.

The Division Has Not Adequately Resolved Some Incidents

Our review of over 100 UIRs[2] and other records revealed several weaknesses in the Division's system for protecting clients. Some incidents did not result in UIRs, some UIRs were slowly or inadequately investigated or were inappropriately turned over to provider agencies for investigation, and some investigations did not lead to appropriate action. In at least two cases, complainants were identified to the subjects of the complaints, in violation of regulations. Of the 19 cases we chose for review of district records, 6 were investigated by the provider instead of by DDD, and 5 were not investigated at all. We found investigation start and completion dates for 13 of the 19 cases; investigations started up to 47 days after the incident was reported (average 8 days), and the investigations took from 1 to 107 days to complete (average 24 days).

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(1) Other examples of unusual incidents include client death, medication errors, missing clients, theft of client property, serious client illness or injury, community disturbances involving clients, non-routine damage to State and provider property, and community complaints regarding residential settings. Currently, DDD has about 450 to 500 UIRs per month. DDD management estimates approximately ten percent of these UIRs are serious.

(2) We reviewed 103 UIRs at Central Office, based on a judgmental sample of incidents listed in the Central Office database for January and one-half of February 1992. The incidents selected involved community complaints, client neglect or abuse or death, unexplained injury, theft or misuse of client money, or medication errors, and appeared to be potentially serious and/or preventable. When the Central Office files contained additional UIRs for the same clients noted in the judgmental sample, we reviewed those UIRs as well.

Although we cannot project how frequently they occur, the serious nature of the problems we discovered, as illustrated by the following case examples, make clear the need to improve DDD's system for responding to incidents of abuse and neglect.

- **Police were called repeatedly for runaway client, no UIRs written** - One client had many incidents but no UIRs until Child Protective Services got involved. The police called CPS to report that the client was running away from his group home one to two times a day, and police had been called eight times in a two-year period to help find him. Police records showed the client had broken his arm in a fall during one incident, and another time he returned to the home with a bicycle of unknown origin. Group home staff notified DDD via incident reports or phone calls to the case manager.

  These incidents clearly signal a problem at the group home that needed resolution. In addition, they should have been considered in making license renewal decisions. Without UIRs, however, those who make the decisions and resolve the problems do not learn about the incidents.

- **Group home management implicated in allegations but DDD did not investigate** - A former employee of a group home made several allegations regarding abuse and neglect of clients at the home. The nature of some of the allegations implicated management of the contract agency that operated the home. However, instead of beginning an independent investigation, the DDD district wrote to the agency to request investigation. In this letter, the district identified the complainant by name and enclosed a copy of the UIR, although Rule R-6-6-120 prohibits disclosure of the complainant without his or her written permission. A brief investigation by the agency director confirmed that at least some of the allegations were true. Furthermore, the agency director's response revealed that he had previous knowledge of some of the incidents but had not reported them to DDD. The district chose to take no action on this matter, stating that the agency had adequately addressed the problem when the agency director counseled the home supervisor to follow the rules.

Several Factors Contribute To Failures

DDD's UIR system has several weaknesses that prevent it from effectively protecting clients. Although Central Office oversight of UIRs is important for several reasons, DDD's decentralized system fails to keep Central Office informed. In addition, we found DDD files regarding UIRs to be incomplete, making it less likely that a case manager or other DDD employee will identify and resolve an ongoing problem. Furthermore, the

Central Office unit responsible for UIRs is inadequately staffed to handle the high volume of incidents. Finally, few DDD staff have any training in investigative methods.

Central Office receives inadequate information for effective oversight - Central oversight and tracking of UIRs is necessary for several reasons, but DDD's Central Office does not receive the information it needs. Central oversight permits licensing inspectors to consider UIRs in making license renewal decisions, discloses patterns of injury, abuse, and neglect, and facilitates sharing of solutions to complex problems. At DDD, however, although policy requires districts to send a copy of all UIRs and investigation reports to Central Office, we found the Central Office files to be so incomplete as to be unusable. Virtually all non-death investigation reports were missing, and DDD staff told us some UIRs were never sent to Central Office.

Files are incomplete - We also found that district files did not maintain UIR information and references in a consistent manner. In some cases, UIRs and related information were scattered haphazardly among other documents in client files. Many case note references to incidents were not supported by a copy of a UIR or a cross-reference to other files. Without the important information contained in UIRs and investigation reports accessible to case managers, it is hard to imagine how they can make critical decisions about clients' needs. Licensing files also lack complete information about UIRs, and the Department of Health Services' recent audit report on DDD licensing criticized the Division's failure to keep adequate UIR information in those files.

Central Office staff insufficient - At its Central Office of Compliance Review, DDD lacks adequate staff to effectively manage UIRs. The office has only one administrative assistant and one-half of one manager's time to monitor, review, file, and track all the Division's UIRs, and to handle any incidents and investigations that are too sensitive to be left up to the district. With 450 to 500 UIRs every month, this is clearly an impossible task.

Staff who conduct investigations lack training - DDD's district offices handle most UIR investigations. Most districts, however, do not have staff who specialize in investigations, or who have received any training in investigation methods. In a January 1991, report evaluating DDD's Quality Assurance System, the Human Services Research Institute (HSRI) stated that "There is unanimity among key informants that UIR investigations are of poor quality and are conducted by poorly trained or untrained personnel." Although HSRI expected improvement after DDD completed some planned training sessions and hired full-time investigators in two districts, we found that only one of the districts had hired investigators and the planned training had been canceled due to lack of funds. The problems noted in that two-year-old report have still not been addressed. Only a few Division staff have received investigative training, and they are concentrated in District 2 (Pima County) because one of their employees attended a week-long session out of state and returned to share what she learned with the district's staff.

Division Is Trying To Improve But Needs To Do More

DDD is taking some steps to remediate its UIR handling system, but additional steps are needed. Other government entities have processes that DDD could adopt to improve its ability to respond to incidents of abuse and neglect.

DDD's recent efforts for improving its performance include:

- A new and clearer UIR policy, currently in draft form, that includes guidelines for investigations;
- A new computer tracking system, currently in the pilot stage, that will provide more complete information about each UIR so patterns can be identified;
- Review of every abuse and neglect UIR by the Assistant Director of DDD, to give him a better feel for the problems and to identify areas where top-level management can make system-wide improvements; and
- Planning to coordinate investigative training with the assistance of the Attorney General and DES's Office of Internal Affairs, at some time after the new tracking system is fully implemented.

In addition, District 2, headquartered in Tucson, has implemented some innovative techniques to improve its quality assurance as a whole, including UIRs. Its unique Quality Advocacy Unit reviews the program manager's recommendations, oversees investigations conducted by others, and conducts investigations into serious incidents. The District's Human Rights Committee has also taken an active role in ensuring adequate follow up on UIRs. As noted earlier, District 2 has some staff who have received training regarding investigative methods.

DDD could adopt some techniques used by other government entities that manage UIRs differently:

- In Connecticut, abuse, neglect, and serious injury are treated separately from minor incidents. Eighteen liaisons statewide conduct investigations and maintain daily communication with Central Office regarding serious incidents, while minor incidents are handled at the local level. Separating the types of incidents this way could reduce the burden on Central Office staff.
- Maricopa County has 14 investigators who specialize in various incident types.
- Arizona State Hospital uses a duplicate-style UIR form. The person who fills it out gives one copy to his or her supervisor, and gives the other directly to the hospital's Quality Assurance Office. This ensures that Central Office is informed more quickly, and also prevents any censoring of the report before it reaches Central Office.

Adopting these methods of separating serious from minor incidents, using staff who have been specially trained in investigation techniques, and using control techniques to improve reporting could strengthen DDD's ability to effectively investigate, monitor, and respond to client abuse and neglect.

RECOMMENDATIONS

1. DDD should improve the quality of its investigations by:

    - Giving priority to developing comprehensive investigation training and providing it to all staff who conduct investigations of client abuse and neglect;

- Considering using staff who report directly to the Central Office of Compliance Review to conduct all investigations into serious incidents; and

- Investigating all abuse and neglect incidents directly instead of requesting provider agencies to conduct investigations.

2. DDD should more effectively address reported problems by:

   - Analyzing and distributing information from the new computer tracking system to improve problem solving and trend identification; and

   - Maintaining complete records of reported incidents and investigations in files accessible to licensing staff and case managers, and noting cross-references to those files in the appropriate licensing and client files.

3. DDD should improve Central Office oversight of serious incidents by:

   - Enforcing its requirement that districts submit information about incidents and investigative reports to Central Office. DDD may consider using two-part forms where one copy goes directly to Central Office while the other goes through supervisory channels.

   - Considering establishing a two-tier system, where serious incidents such as abuse and neglect are handled separately from minor incidents

   - Increasing the number of Central Office staff assigned to duties associated with the tracking and monitoring of client abuse and neglect reports

FINDING IV

LICENSING INSPECTIONS NEED TO BE MORE TIMELY AND ENFORCEMENT SHOULD BE STRENGTHENED

Action needs to be taken to improve the current licensing process so that it more adequately safeguards the clients' health, safety, and fair treatment. The Division has not conducted timely licensing inspections and repeat violations have not been effectively addressed. In addition, the licensing process is cumbersome and disorganized and has not been implemented uniformly throughout the State.

The licensing process is important in protecting client health and safety rights, and ensuring client programs are properly developed and implemented. The vulnerable nature and medical problems of many DDD clients mandates the use of the licensing process. Residential facilities are not just places to live, but important components of client habilitation programs.

DDD licenses residential facilities under contract with the Division, and also certifies intermediate care facilities for the mentally retarded (ICF/MRs) and State-operated group homes.(1) Facilities satisfactorily passing an inspection receive a one-year regular license or certificate, which indicates the facility's compliance with licensing standards. This inspection, conducted by Central Office licensing staff, should occur before the expiration of the current regular license or certificate so the facility can correct violations and have the corrections verified by district monitoring staff before the license or certificate expires. Midyear monitoring visits by district monitors are expected to ensure ongoing compliance with standards. According to Division information, in Fiscal Year 1991-92, 364 privately operated group homes, 25 State-operated group homes (SOGHs), and 14 ICF/MRs were operating under DDD licenses and certificates.

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(1) DDD does not license facilities which only provide residential services to private-pay clients.

The Division's Licensing Process Has Been Inconsistent And Inefficient

The licensing process has not been consistently and efficiently administered by DDD. DDD has routinely failed to inspect, initially license, and relicense residential facilities in a consistent and timely manner. Also, DDD failed to effectively follow up on licensing violations, resulting in repeat violations among licensees and allowing underlying problems to go unchecked.

DDD is routinely late in inspecting, initially licensing, and relicensing residential facilities - Our review of 50 randomly selected licensing files found that DDD routinely failed to inspect, initially license, and relicense facilities until months after a facility had opened or the current license had expired.[1] Further, to cover inspection and licensing delays, DDD inappropriately issued provisional licenses and backdated both regular and provisional licenses. A review of both State-operated and contracted group homes indicated that DDD, on average:

- Issued a 6-month provisional license[2] 32 days after the regular license expired, backdated to the expiration date of the regular license (obscuring the 32-day period of operating without a license)
- Inspected group homes 87 days after the regular license expired or 55 days after provisional license had been issued
- Issued an inspection report 35 days after the inspection had been completed or 122 days after the regular license had expired
- Issued a regular license 31 days after the provisional license had expired or 213 days after the previous regular license had expired, backdated to show the expiration date of the provisional license (again, disguising a 31-day period of operation without any type of license)

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(1) We reviewed information contained in licensing files for inspections conducted during the time period of January 1990 through April 1992.

(2) Issuing provisional licenses to group homes to compensate for delays in the inspection process is inappropriate because, by definition, a provisional license permits a facility to operate while correcting deficiencies after a licensing inspection has been completed. However, DDD issued at least one inappropriate provisional license to each contracted group home in our sample.

- Allowed new group homes to operate for up to three months under a provisional license and without the benefit of an initial inspection

- Failed to inspect State-operated facilities annually as required by statute. In two cases reviewed, the last inspection conducted previous to 1992 was in 1987. Further, when State-operated facilities were inspected, the inspection process was not often completed since reports were not issued, corrective action plans were not required, and follow-up visits were not performed.

Finally, DDD failed to conduct monitoring visits on a consistent and timely basis. Although the Arizona Administrative Code (R6-6-107) requires DDD to conduct a monitoring visit no more than 6 months after the previous licensing inspection, DDD files lacked documentation of these visits for 45 percent of the cases reviewed. In addition, for the monitoring visits that did occur, our review showed that these visits took place, on average, 7 months after the previous inspection.

DDD appears to be addressing some of these issues. According to the licensing manager, the unit is now conducting inspections of new group homes prior to allowing clients to be placed in these settings. He also told us that all State-operated group homes have been inspected as of early November 1992.

DDD fails to effectively follow up on licensing violations - Our review of the 50 licensing files found that 29 licensees were cited for the same violation during two or more inspections or monitoring visits.[1] Some repeated the same violation as many as four times, and several had repeat citations for up to eight standards. This history of repeated violations suggests that problems associated with licensees are not being addressed. The following examples illustrate the problem of repeat violations.

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(1) Our review focused on approximately 113 of 320 total licensing standards used by DDD in conducting inspections. These 113 mandatory licensing standards are those deemed most critical by DDD for ensuring the health, safety, and proper treatment of clients in residential facilities.

- Example 1 - This group home received its first formal inspection in 1986. DDD has inspected this home 7 times since its opening, discovering from 6 to 23 violations of mandatory standards during each inspection, including:

  - Six inspections found the premises to be unclean with numerous health and safety hazards. Three inspections found that toxic substances were not locked up. It was also noted during three inspections that various items in the house did not work, such as the swamp cooler and lighting.

  - Four inspections found fire drills not conducted as required. Two inspections discovered that fire inspections by the appropriate fire authority had not been conducted and one inspection noted that fire extinguishers had not been serviced.

  - Five inspections found that client medication treatment plans were improperly maintained or could not be located, or that the medication log was incorrect, or not properly signed or initialled.

  - Six inspections found that documentation verifying formal first aid, CPR, and additional staff training was not on file for different employees in each inspection.

  - Fingerprint clearances were not on file for eight employees across two inspections.

- Example 2 - This group home opened in 1986 and received its first regular license on January 1, 1987. DDD has inspected the home seven times since its opening, discovering up to ten violations of mandatory standards during each inspection, including:

  - Three inspections found that fire drills were not conducted as required, especially during the night when clients are asleep. Two inspections discovered that fire inspections by the appropriate fire authority had not been conducted and a separate inspection noted that fire extinguishers had not been serviced.

  - Three inspections found that toxic substances were not properly locked in storage.

  - Documentation verifying formal first aid and CPR training was not on file for different employees during two inspections.

  - Fingerprint clearances were not on file for four employees across two inspections.

There are several reasons why DDD follow up is inadequate, leading to frequent cases of repeat violations among licensees. First, DDD did not require corrective action plans (CAPs) for approximately one-half of the

inspections we reviewed, even though licensing procedures require a CAP. DDD waived this requirement when its inspections were too late to enable licensees to prepare a CAP and make necessary corrections before expiration of the provisional license.

Second, DDD does not always conduct the required follow-up visits to ensure required corrections are implemented. Files lacked documentation of these visits in 18 percent of the cases reviewed which required follow up.

Finally, DDD addresses specific incidents rather than the systemic problem that created the incident, thus treating the symptoms of the problem rather than the problem itself. The Department of Health Services, in its report on a recent audit of DDD licensing, stated that "CAP's addressed only specific instances or examples. There was no indication of how the facility would correct systematic problems."

DDD recently took license revocation action against four group homes known to have multiple repeat violations in critical areas. However, the high number of licensees with repeat violations indicates that DDD should strengthen its efforts in this area.

Licensing Process Could Be Streamlined And Administered More Consistently

In addition to being inefficient, the licensing process is cumbersome, disorganized, and lacks statewide uniformity. First, many licensing standards are vague and subject to interpretation. Second, the licensing process is not uniformly administered, resulting in a fragmented approach to inspection and monitoring. Third, staff turnover and lack of training leads to timeliness problems and inconsistent application of standards. The Division should streamline and consolidate its licensing standards and process.

Licensing standards are vague and subjective - The licensing standards DDD has used are vague and subject to interpretation, which has contributed to the lack of understanding among group home providers and licensing inspectors of what is expected for compliance. A task force

led by the Human Services Research Institute (HSRI), which is studying and making recommendations to the Governor's Council on Developmental Disabilities regarding DDD's licensing standards and process, noted the subjectiveness in the licensing process. The task force, which includes representatives of providers, clients, and division staff, recommends reducing licensing standards to an essential core of standards which lend themselves to only "yes" or "no" interpretations. The task force further recommends simplifying the licensing process by limiting it to basic health and safety standards only.

We witnessed the vagueness and subjectivity of licensing standards while observing a training exercise at a statewide licensing meeting, in which inspectors and monitors were asked to identify which standards were violated in scenarios based on actual events. For each scenario, licensing staff and monitors identified several different standards which they thought were violated and applied to each scenario.

All were correct. A DDD licensing supervisor agreed that the division's current approach to licensing is based on subjective interpretations of standards, not objective application of clear standards. Also, nearly one-half of the respondents to our survey of group home providers[1] reported that licensing standards are open to interpretation and that licensing standards have been applied differently to their own settings in different locations. Other providers told us that some of their homes had been rated out of compliance for standards which were not applied to those same homes in prior years.

The vagueness of DDD's licensing standards may be addressed, to some extent, as a result of recent legislation. House Bill 2487, which became law on October 1, 1992, established a committee to examine all Federal and State statutes, rules, and standards relating to the licensure of community residential settings in order to determine their effectiveness

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(1) Auditor General staff surveyed all 38 group home provider agencies by mail. Thirty-three provider agencies (86.8 percent) responded to the survey.

in protecting the clients' health, welfare, and safety. A report is due from the committee by October 31, 1993 and during this examination period, DDD licensing is restricted to using only those standards that appear in statutes and rules for licensure of group homes. DDD licensing spent the month of October 1992 revising their licensing process to reflect this bill's intent. However, DDD licensing management feels the standards identified in the statutes and rules are even more vague than the previous standards, and further revisions are needed to compile an adequate and appropriate set of licensing standards.

Licensing process is not uniformly administered - The licensing process has not been uniformly administered, resulting in a fragmented approach to inspection and monitoring. DDD's licensing inspectors report to a centralized licensing section; but until recently, monitors, who are district employees, reported to district management with the licensing section having no clear authority over them. However, in late 1992, licensing reached an agreement with district management regarding the use of staff for monitoring. In most districts, monitors will continue to report to district management and have other responsibilities besides monitoring, but licensing expects to have a more active role in how monitors utilize their time. District 1 (Maricopa County) monitors will now report directly to licensing and are considered full-time monitors. These changes, if properly implemented, could help strengthen the inspection and monitoring functions.

Still, district monitors do not have clear guidelines to follow or definitions of their licensing responsibilities.

Staff turnover and lack of training contributes to DDD's licensing problems - Staff turnover and lack of staff training contributes to the timeliness problems and inconsistent application and interpretation of standards. Staff turnover probably has the greatest impact on the timely completion of inspections. According to the licensing manager, the turnover rate for licensing inspectors was about 17 percent during calendar year 1992, and 33 percent during 1991.

Limited training for new licensing inspectors and monitors contributes to inconsistencies and delays. The majority of training for licensing inspectors is on the job, as new staff accompany experienced staff on inspections. Training for district monitors is virtually nonexistent. Although licensing management has encouraged monitors to attend the training sessions that are conducted for licensing inspectors, and to accompany inspectors on inspections, monitors' other duties, assigned by districts, have left little time to take advantage of these opportunities.

RECOMMENDATION

The Division should improve its licensing process by:

- Conducting inspections and monitoring visits in a timely manner;
- Discontinuing the improper use of provisional licenses;
- Modifying and consolidating the licensing standards so they are properly and consistently interpreted and applied by licensing staff and understood by licensees;
- Changing the licensing process and procedures to ensure that underlying systemic problems that prevent compliance with licensing standards are properly addressed and corrected;
- Evaluating the effectiveness of placing District 1 monitors under Central Office licensing authority, and if successful, expanding this practice statewide; and
- Providing training to the licensing inspectors and district monitors.

FINDING V

THE DIVISION NEEDS TO CONTINUE AND EXTEND EFFORTS TO STRENGTHEN ITS CONTRACTING PROCESS

The Division has taken significant steps to improve its contracting process, but more can be done to ensure that sound procurement practices are followed statewide. The Division's Central Office has not effectively overseen and controlled district contracting practices which, at times, have been weak and deficient. For example, rate negotiations have been poorly handled by some districts, resulting in significant overpayments to some contractors. The Division has strengthened the Central Office's role in negotiating contractor rates, but more can be done to enhance the Central Office's oversight and support role.

Most Division Services Are Contracted Out

Good procurement practices and procedures are important to the Division because it expends a significant amount of funds for the purchase of care. According to the Division's Business Operations Manager, the Division spent over $150 million on contracted services. Furthermore, the Division accounts for the most procurement activity among the DES divisions, awarding about 800 contracts and almost 500 individual service agreements annually. Contractors provide a variety of services, including room and board, day treatment and training, therapy, home health services, and respite care.

Current structure - Responsibility for contracting is shared by the Division's Central Office and the districts. The Central Office has a contracts management unit staffed by five employees: the unit manager, two contracts specialists, and two clerical staff. The Central Office is responsible for developing and updating policies and procedures, and preparing the Division's annual solicitation for services (a comprehensive request for proposals which is issued annually to all

providers statewide). In addition, the unit is responsible for processing contracts after they are negotiated and submitted for approval by the districts. Although the Central Office played a more significant role this year negotiating provider contracts, in the past the districts have reviewed and evaluated proposals submitted for most services, negotiated rates, and selected providers in their regions. Contracts specialists in the districts work with other employees temporarily assigned to review proposals and select providers.

Central Office Role Has Been Limited

The Division needs to strengthen the Central Office's support and oversight role to ensure that districts follow proper procurement procedures uniformly and consistently. In a limited review of district contract records, we found several problems, such as poor or nonexistent documentation, inadequate evaluations of proposals, and superficial analysis of financial information submitted by providers.

The role of the Division's contracts management unit has primarily been limited to a support function -- it is neither structured nor equipped to oversee and control district procurement practices. The Division's Central Office contracts manager stated that she does not review district contracting practices. Although it desires to provide more oversight, the Central Office is not set up to take on this responsibility easily.

First, the contracts manager does not have direct authority over district personnel involved in the contracting process. These personnel, like the contracts manager, report directly to the Division's business operations manager or to the district program managers. Second, the Central Office does not have adequate staff to review district procedures. According to the contracts manager, her two contracts specialists are too busy preparing the annual solicitation and processing the approximately 800 contracts awarded annually to take on additional tasks. Finally, contract records that would require review are maintained in the districts, further inhibiting the unit's ability to examine district practices.

While the Central Office maintains copies of current contracts, time logs, and related correspondence, other documentation important to the procurement process, such as provider proposals, proposal evaluation forms, and negotiation notes are maintained by the districts.

District problems - More oversight over district practices is needed to ensure that proper procurement procedures are consistently and uniformly followed. We conducted a limited review of 11 provider contract files, examining both Central Office and district records available at the time of our audit.(1) We reviewed both the contract award (which may have occurred in Fiscal Year 1990-91 or 1991-92) as well as any subsequent renewals or amendments to the contract. While the results of this review are not necessarily indicative of a widespread problem, weaknesses we identified indicate a need for more extensive oversight over district contracting practices.

The problems we identified also suggest that the Central Office needs to provide more effective technical support to district personnel. Training of district personnel has been limited, and policies and procedures have not been updated and compiled into an easily accessible and useful manual.

The following are problems we identified that collectively can undermine the integrity, fairness, and competitiveness of the procurement process. These problems could also result in costly administrative or legal challenges to the Division's procurement decisions.

- Limited review of financial information - Some contract files showed little analysis and use of financial information submitted by providers. In several cases, there was no evidence of any systematic or detailed review of agency budgets. Rates for some contracts appear to have been derived by dividing the provider's proposed budget by the number of total client units, suggesting that the provider's proposed budget was accepted without detailed review. In three cases, rates accepted and contained in final contracts were actually higher than rates originally proposed by the

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(1) Our initial, exploratory sample of contracts was selected to represent a diversity of services across districts. It also included two contracts to one provider awarded by a unit in the Central Office. We intended to eventually review a larger sample of contracts; however, the Division was slow in assembling and sometimes unable to make available to us complete records for the initial sample within our audit time frame. Therefore, we were unable to expand our sample size.

providers without justification as to why. In some cases, while there was documentation that costs were discussed in negotiating sessions with providers, there was little evidence that detailed review of costs was conducted or that costs and budget information was independently verified.

- Questionable evaluations - Some proposal evaluations were poorly done. In one case, different evaluators applied criteria inconsistently, resulting in discrepancies in point deductions. In other cases, evaluators rated one service proposed by the provider, then copied the evaluation and used it for all other services proposed. (Large provider agencies typically offer a variety of services, all of which are required to be evaluated independently.) We also examined evaluation forms which had more than one rating number circled for the same evaluation item, illegible entries, and mathematical errors.

- Noncompliance with procedures - District practices did not always comply with the Division's policies and procedures governing the contracting process. In one case, proposals were received and accepted up to seven days after the publicly noticed submittal deadline. There was no documentation that the deadline had been extended. In two other cases contracts were awarded to providers that did not appear to receive the highest ratings.

- Inadequate and incomplete documentation - Several files lacked important documentation. For example, two files had no documentation of the evaluation of the provider's proposal. Four contracts contained no documented justification for contract rate increases that were granted through contract amendments.

Weak Financial Review And Oversight Has Been Costly

Inadequate review of some provider budgets and costs has been costly to the Division and the clients it serves. A recent series of financial audits of major provider agencies disclosed that some providers have been overpaid and spent service dollars in questionable ways.

Recent audits ordered - In May 1992, the Division hired an independent accounting firm, KPMG Peat Marwick, to conduct a financial review of service providers. The financial reviews, initiated by the Division's Assistant Director, were intended to examine provider expenditures and to

determine the reasonableness and allowability of costs. Service providers selected for review were those receiving the largest amounts of funding from the Division.

At the same time the Division was procuring an independent firm to review providers, the DES Office of Internal Audit completed a similar review of another major service provider. This audit was ordered after a letter alleging questionable financial practices was received from the Regional Office of the Inspector General of the U.S. Department of Health and Human Services. The independent financial reviews conducted by the KPMG and the Department's internal audit were the first such in-depth financial examinations ever conducted involving Division service providers.

Significant amounts questioned - The independent financial reviews and the DES internal audit identified a total of over $2.1 million in questioned and/or excessive costs for eight of the nine providers examined. For two providers, total amounts questioned and/or determined to be excessive exceeded $500,000. Examples of costs questioned or determined excessive included the following:

- $417,566 in bonuses paid in three installments from June 1990 to June 1991 to the president of the agency. The bonuses were paid in addition to the president's salary of $44,000. Funds were also used to pay for the president's athletic club membership and for his monthly child care expenses.
- $40,867 in contributions and entertainment expenses spent by the same provider. Entertainment expenses included charges for food and beverages, lodging for management retreats, and floral arrangements for various occasions.
- $347,506 paid in compensation in 1991 to another provider.
- $186,013 in excessive professional fees paid by the same provider for accounting services.
- A $35,000 bonus paid to the executive director of an agency, a $32,000 bonus paid to the assistant director of the entity, and a $5,000 bonus paid to a former office manager in 1991 and 1992. The assistant director's bonus nearly doubled her base salary.

The nature and amount of the questioned and/or excessive costs demonstrate a clear need for a detailed, substantive, and meaningful review of provider budgets and financial information. Financial statement information reviewed by the independent auditors showed that one provider realized net earnings of almost $1.3 million in Fiscal Year 1990-91. The provider had received about $9.6 million in service funds from the Division. In another case, the independent auditors found a mathematical error of over $10,000 in computing the provider's service budget for professional specialty services. In an attempt to verify average hourly costs, the firm also found discrepancies between actual average costs and hourly costs utilized by the provider in its proposal. For example, for personal care services, costs proposed were 38 cents per hour higher than the average hourly costs calculated by the firm.

The Division Needs To Continue Its Efforts To Strengthen The Contracting Process

The Division has taken significant steps to address weaknesses in the contracting process. These efforts need to be expanded to ensure that district contracting practices are appropriate and properly documented and that provider agencies are adequately monitored.

Efforts to improve - The Division took several actions in Fiscal Year 1991-92 to strengthen the Central Office's role in the contracting process. First, the Central Office led negotiations (with the assistance of several district staff) of the 38 largest value contracts, those representing $700,000 or more. These 38 contracts represent about two-thirds of the Division's total dollars spent on purchase of care. An outside firm was hired to assist the Central Office in its negotiations. More detailed financial and budgetary information was requested from the provider agencies, and more emphasis was placed on in-depth review of provider costs. As a result of this effort, the Division estimates it saved approximately $5 million in contractor costs for Fiscal Year 1992-93.

Second, as noted earlier, the Division hired an independent accounting firm to conduct a financial review of eight providers. The Division is currently pursuing recovery of questioned or excessive costs identified

by the financial reviews. In addition, a financial settlement was reached with the provider audited by the Department's Office of Internal Audit. This settlement has resulted in a payback to the State of an undisclosed portion[1] of the over $500,000 in costs questioned by the internal audit.

The Division has initiated other efforts as well. For example, it has promulgated directives to promote more consistent procedures for negotiating contracts in the districts. It is also streamlining the provider payment system by developing "blended rates" for contractors that operate multiple programs, for example, group homes, at different sites. This would reduce the number of individual rates that have to be negotiated with each provider.

Additional steps needed - The Division needs to continue and expand its efforts. First, as noted earlier, it needs to update procedures and its contracts manual for district personnel. The Central Office developed a "Guide to Contracting" in April 1991. According to the Division's contracts manager, the Guide is still in effect but needs to be updated and reformatted for easier future revisions. In addition, numerous directives have been issued to the districts, on an ad hoc basis, by the Division director and the Department's Contracts Management Section. Directives are not compiled into a manual to allow for easy access and reference.

In addition, more training needs to be offered. Some staff told us they had no previous experience handling contracts and felt ill-prepared to take on the contracting responsibilities they were assigned. The districts utilize program personnel to help in the contracting process, but little training has been offered to them. These personnel specialize in service delivery, not fiscal control and accountability. The contracts manager provided some training in 1992 to about 40 personnel, but not all staff involved in contracting attended. Moreover, the

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(1) Under the terms of the settlement, both parties agreed not to disclose details of the settlement. According to the Assistant Attorney General who handled the matter, this was done, in part, to protect the State's position in possible settlements with other providers.

training focused strictly on the negotiation process. No comprehensive training has been provided.

Monitoring of contractors also needs to be strengthened. Currently, financial monitoring is performed on a very limited basis. Contractors receiving over $50,000 annually file quarterly financial reports with the Central Office, but little is done with these reports. Until this past year, there has been little auditing of providers, nor have the districts focused on financial accountability. Further, district contract monitors focus primarily on programmatic rather than financial issues.

Finally, to strengthen accountability, the Division needs to continue its efforts to clarify responsibility and authority on contracting matters. As noted earlier, for example, the contracts manager had overall responsibility for the division's contracting process, but had no line authority over the numerous District personnel involved in the contracting process. This made it difficult for her to ensure and enforce statewide compliance with the Division's contracting policies and procedures.

RECOMMENDATIONS

1. The Division should continue its efforts to strengthen the Central Office's role in the contracting process.

2. To supplement its current efforts, the Division should also consider:

    - Compiling a policies and procedures manual on contracting for District personnel,
    - Providing more extensive training to district staff on contracting policies and procedures,
    - Strengthening financial monitoring of contractors,
    - Clarifying responsibility and authority shared between the Central Office and the districts,
    - Reviewing district contracting practices on a regular basis to ensure compliance with Division procedures, and
    - Ensuring that documentation of the contracts process is adequate and consistently maintained.

OTHER PERTINENT INFORMATION

During the course of the audit, we developed information regarding the adequacy and availability of services provided by the Division.

People with developmental disabilities do not always receive adequate and sufficient services. Overall, our consultants described services provided by the ALTCS program as "borderline acceptable" when compared to other states' programs (see the Introduction and Background, page 6, for information on our consultants.) The consultants base their conclusion, in part, on survey and interview results. Specifically, individuals receiving services, and those persons providing direct care to individuals (including families and service providers), reported that about 25 percent of all services being received were, on average, of less than sufficient quality or that individuals were not receiving enough of a certain service to meet their needs. They rated occupational therapy, recreational therapy, speech therapy, and physical therapy as being most inadequate. Division case managers reported about 19 percent of all services currently provided to those same clients to be less than fully sufficient. Case managers rated community skills training and recreation therapy the lowest.[1] Table 3, page 52 lists those service categories with the lowest sufficiency ratings as identified by both groups.

While interview and survey results revealed concerns over the adequacy of services received by some individuals, evidence gleaned from file reviews suggests that some clients are making developmental progress with services currently received.

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(1) Due to problems in the needs assessment process, service planning process, and process of monitoring progress toward achieving goals currently in place within the Division, the consultants cautioned that service sufficiency ratings as reported may be artificially high.

TABLE 3

SUFFICIENCY RATINGS OF CURRENTLY DELIVERED SERVICES REPORTED BY CLIENTS, FAMILIES, SERVICE PROVIDERS AND CASE MANAGERS (FOR SERVICES RATED LEAST SUFFICIENT)

Service	Percent Of Clients, Families, And Service Providers Rating Service Sufficient
Occupational Therapy	60.5%
Recreational Therapy	63.6%
Speech Therapy	64.6%
Physical Therapy	64.9%
Psychotherapy	70.2%
Cognitive	73.9%
Community Skills	74.0%
Medical	74.3%
Case Management	75.3%
Behavior Modification	79.7%

	Percent Of Case Managers Rating Service Sufficient
Community Skills	68.4%
Recreation Therapy	68.5%
Physical Therapy	73.3%
Occupational Therapy	75.6%
Behavior Modification	75.8%

Source: Auditor General summary of information contained in the consultant's final report to the Auditor General, dated November 1992.

In addition to problems with the quality and level of services actually being received, some services are simply not available when needed. Research we conducted revealed that demand for certain services cannot be met because of the scarcity of some services. Survey and interview information we developed indicated that gaps exist in services needed for both Title XIX eligible and non-Title XIX eligible persons (State-funded only). Moreover, services are generally less available for the non-Title XIX recipients, due largely to a lack of State funding. In total, for all clients, the results of various surveys and interviews we conducted indicates that placement in Intermediate Care Facilities, peer self-help assistance, and special therapies (physical, occupational, and speech) are generally unavailable for many clients. Foster homes (especially culturally appropriate homes), employment-related services, and individual provider services, such as respite and personal care, were also described as being difficult to obtain.

In a similar vein, our consultants were told during a focus group that due to a dearth of therapists in districts other than Districts 2 (Pima County) and 4 (Yuma, La Paz, and Mohave counties), therapy services were rarely, if ever, prescribed even when it would have been appropriate to do so.

Reasons for lack of availability have been described as including: a lack of providers for some services, particularly therapies; lack of State funding (for example, to pay for services Title XIX does not pay for and for development of new residential facilities); lack of Division staff time to recruit individual providers; limitations resulting from income requirements for foster homes; provider difficulties in contracting, billing, and receiving payment from the State, and low pay rates.

To improve availability in these and other areas, those we interviewed or who responded to our surveys made several suggestions, including: (1) consideration of a voucher system for paying individual providers and therapists, which would be expected to increase the number of those providing services and lessen payment problems, and (2) more aggressive efforts by the Division in recruiting individual providers, therapists, and foster homes.

The consultants concluded that the service system lacks innovation, creativity, and effective case management. Other than some creative foster care situations, for example, CFA found little evidence of supported living arrangements or supervised apartments. In terms of day program options, the consultants queried the focus groups about the apparent lack of supported employment options, such as job coaches and sheltered workshops, and were told by case managers that this service was not fundable through Title XIX. The consultants explained, however, that many other states have found creative ways to facilitate supported employment opportunities. Case management, described by the consultants as a critically important service, was found to be ineffective in many cases. Their research found case managers often lacking the necessary competence and ability to perform good case management due to a variety of factors, including inadequate training, high case loads, and too much paperwork (see Finding II, page 17, for additional information on case management.)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
1717 W. Jefferson - P.O. Box 6123 - Phoenix, AZ 85005

Fife Symington
Governor

Charles E. Cowan
Director

MAR 2 6 1993

Mr. Douglas R. Norton, CPA
Auditor General
Office of the Auditor General
2700 N. Central Avenue, Suite 700
Phoenix, Arizona 85004

Dear Mr. Norton:

Thank you for the opportunity to review the Auditor General's Office performance audit on the Division of Developmental Disabilities (DDD).

We have enclosed three copies of our response to the Auditor General's report. In many cases, the response updates information provided in your office's report. We are pleased to have this opportunity to respond and appreciate, as well, the courtesy consistently displayed by your staff in the course of their review.

We believe that the recommendations contained in this report are consistent with the direction that DDD has embarked upon under new leadership. In our response, we demonstrate how the DDD has already begun implementation of many of those recommendations.

If you have any questions or need additional information, please call me.

Sincerely,

Charles E. Cowan

CEC:mo

Enclosure

c:
Sam Thurmond

DIVISION OF DEVELOPMENTAL DISABILITIES

RESPONSE
TO AUDITOR GENERAL'S REPORT DRAFT

Before responding to specific items in the Auditor General's draft report, we want to establish the context in which this information, and the Division of Developmental Disabilities (DDD), must be viewed.

Arizona's Long Term Care System (ALTCS) Title XIX program is unique in the United States and meaningful comparisons with other State programs are difficult.

The Auditor General's report drew upon the analysis of an independent consultant firm, Conroy and Feinstein (CFA). Much of CFA's conclusions are subjective and derived from perceptions at the "front line", that is, case managers and families. These perceptions are valuable, but this population has not felt the impact of the changes which have been instituted in Central Office and which have not yet been fully implemented Statewide.

The DDD recognizes and acknowledges many of the difficulties with this program. The problems are of a long standing nature. The DDD went through a major expansion in December 1988 when the DDD became the only agency in the United States to start both a Long Term and an Acute Care system on the same day. The ALTCS (Title XIX) program increased not only the DDD's client population dramatically but added to the DDD's reporting responsibilities.

Under the current Assistant Director, who has been in charge of the DDD for one year, a series of principal changes have been instituted to address the problems identified in the Auditor General's report. The DDD had already identified many of these same problems in its General Systems Design analysis, and has developed - and in a number of cases executed - plans to address them in a consistent and uniform manner while abiding by budgetary restrictions. The DDD has created systems, procedures, and training to resolve the problems, and is now reaching a stage where these changes are beginning to become evident. Two very obvious examples are the creation of the Statewide Policy and Procedures Manual, which, when published, will be available to case management, and the case manager training program (described by CFA as "state of the art"), which is being implemented in March 1993.

We appreciate the recognition which the report gave to the leadership of the current Assistant Director in pursuing changes in both fiscal and programmatic areas. The Division is confident that future audits will show the culmination of those changes and the resolution of many of the problems identified in the Auditor General's report.

The Division Needs to More Adequately Implement its Policies for Assessing and Planning Individual Client Services

All Necessary Assessments Are Not Being Done

This section of the report contains many statements that can be characterized as subjective.

The finding that all necessary assessments are not being done is based upon conclusions reported by CFA. CFA examined case records and determined that, on the average, 31.9 percent of these cases showed "no evidence that assessment was performed" DDD questions whether this means that no assessments were performed or that an assessment which CFA felt should have been performed was not. The DDD and ALTCS policy calls for assessments only in areas that are considered appropriate for the client and the client's diagnosis.

Evidence that the CFA assessment findings may not be accurate is indicated by family and consumer input. CFA asked families and consumers if they thought the Individual Program Plan (IPP) goals were appropriate. Of respondents, 85.9 percent reported that goals were appropriate, 8.8 percent reported that goals were partially appropriate, and 5.3 percent reported that goals were not appropriate (see pp 46 of the CFA report). Fully 94.7 percent of the respondents believed that the IPPs contained appropriate or partially appropriate goals. Clearly, the DDD is perceived to be addressing the right goals by the families and consumers.

This is not to say, however, that DDD does not need to make improvements in this area. The DDD has launched a number of initiatives that will bring about improvements. Some of these are:

1. The new Individual Service and Program Plan (ISPP) format and training for case managers and provider staff. The ISPP combines the previously used Individual Program Plan (IPP) and the Service Plan. The format of the ISPP specifically requires documentation of all needed assessments and provides a check list for the team members to ensure that no area of assessment is overlooked.

2. The Case Management core curriculum addresses the importance of comprehensive assessments. The utility of this training is acknowledged by CFA when they point out that "the case manager training materials are definitely state of the art; if this training were fully implemented, Arizona's problems with the assessment process would diminish sharply." (pp 40).

3. The DDD case management training and ISPP format emphasize the "person centered planning" approach which is cited by CFA as a current best practice in the field.

4. Training in person centered planning has been provided in four of the six districts since 1990 through a contract with Patterson and Associates. Patterson and Associates is now working with all districts through its Statewide contract with the DDD.

5. The Individualized Family Service Plans (IFSP) approach is cited by CFA as a example of a well integrated assessment and planning approach. The IFSP is being field tested in two DDD districts before Statewide application is approved. The DDD should be implementing this Statewide in FY 94.

ICAPs Not Done Timely

The new ISPP policy and training will address this issue.

Procedures for Conducting Planning Meetings Are Not Always Followed

The Auditor General's report (pp. 12) summarizes the CFA opinion that, "professional personnel and others who should be involved in the IPP team meetings are often left out" and "...only one case in which there was a properly constituted interdisciplinary team present during the clients' annual IPP review". It is neither cost efficient nor necessary for all professional personnel to be included in all ISPP (formerly IPP) meetings. As a practical matter, physicians and therapists are not able to attend such meetings. It is sufficient in most cases for their assessments and recommendations to be available for the team meeting.

It is appropriate to involve medical specialists in the planning process for individuals with identified medical needs. The DDD's Specialty Services Unit has been established to provide medical nurse case management to individuals who are medically involved. These nurses can and do provide assessment of individuals' medical needs. However, to provide CFA's recommended level of involvement by medical personnel in the planning process would require a ratio of one nurse for every 30-50 individuals served by the DDD/ALTCS program. It is doubtful that this could be justified as cost-effective.

The report stated that critical information was not available when IPP teams met. CFA did not find comprehensive IPPs that encompassed assessment results from other agencies working with the client (e.g., local school districts). If a DDD client is in residential service, the provider would maintain medical records, lab results, etc., and the case manager would not necessarily maintain copies in the case file. However, the DDD agrees that this is an area in which they need to tighten their procedures and document information.

CFA also notes that IPP teams "often do not reconvene when appropriate". The DDD has instituted actions, such as an Administrative Directive clarifying the review of ISPP, and addresses this concern in the Policy and Procedure Manual and in Case Manager and ISPP training; DDD acknowledges, however, that more must be done and is committed to taking stronger steps in that direction.

Breakdowns Occur Within the Case Management System

The Auditor General's report noted that the DDD's policies and procedures were appropriate and that communication and lack of training are problems. These problems are being addressed by the DDD through a comprehensive training program.

RECOMMENDATIONS

1. Concur. The DDD has established a Statewide case management training curriculum being implemented in March 1993.

2. Concur. The DDD is conducting a research project through the Arizona Early Intervention Project (AZEIP) field tests in Districts II and III to determine an appropriate tool for this population that can be used Statewide. An assessment tool has been selected for the field tests based upon a review of national best practices.

3. Concur and addressed through new ISPP form.

4. Concur and being addressed in case management training and in ISPP training.

5. Concur, but may not always be possible. Site reviews will incorporate this as an item for the monitoring of case files.

6. Concur. Individual Family Service Plan is addressed with a supplemental sheet in the new ISPP. Policy and Procedures Manual addresses plan coordination.

The Division's Case Management System Cannot Effectively Service Clients

The DDD generally concurs with the recommendations for improving case management.

Case Management is Essential, but Inadequate at DDD

Case management is essential for a system in which services are dispersed and require coordination. CM is also critical to meeting Title XIX, Foster Care, and Statutory requirements. The introduction of Title XIX funded services in December 1988 placed new responsibilities on case managers while none were taken away.

Over the past year, much has been done to institute consistent policies and to clarify case management responsibilities. Administrative Directives were used to provide rapid solutions to policy issues. These directives are now being incorporated into a Statewide policy and procedures manual (scheduled to be distributed in May 1993). Additionally, revisions of the IPP procedure and format have been instituted. Training in the use of the new format (now ISPP) began in January 1993. Where feasible, the districts are moving towards the establishment of specialized case management functions. These initiatives set the stage for significant improvements in the case management system.

Various Factors Hamper DDD's Ability to Provide Good Case Management

The report cites the paperwork requirements, high caseloads, turnover of case managers, and training.

As noted in the report, the new ISPP forms consolidate and eliminate some 18 existing forms which had been used by case managers. In addition, Administrative Operations is doing a review of duplicative forms used by CMs to determine which forms could be consolidated or eliminated. However, many paperwork requirements are out of DDD control (e.g., mandated by AHCCCS requirements).

The DDD recognizes the need to reduce case manager caseload levels and requested additional FTEs to meet a 1:30 case managers ratio for FY 93. Without additional funding to recruit and retain qualified case managers, the DDD, while continuing to effect systems improvements, cannot guarantee that these actions alone will improve case manager/client ratios.

Within current budgetary constraints, there are strategies which the DDD is currently implementing to address the high caseload issue. The DDD in District II is using a specialized case management system to respond to the challenges created by client growth. This approach organizes case managers into specialty categories established based on legal requirements (such as Title XIX and Foster Care) and on high time

demand case types. However, a system of specialty areas could not be supported outside the urban areas of Arizona. The DDD will be reviewing a case management client intensity assessment tool (C.A.S.E.) to determine the tool's utility in distributing case loads in the most effective manner possible within existing resources.

The DDD is also pursuing Intergovernmental Agreements with Indian Tribes. Discussions are underway with the Navajo and Tohono O'Odham nations. These IGAs could produce agreements to contract for case management services through the tribal social service system.

Changes are Needed

The DDD is in agreement. Much more work needs to be done to analyze the case management process to identify low value/no value activities and to streamline them. However, case management is not a simple process. It involves the ability to balance and juggle many issues - often in conflict - at the same time. Moreover, the issue is not just paperwork; it is also inappropriate task assignments to CMs; low salaries; and the need to realign caseload types to more evenly balance complex vs. non-complex cases.

RECOMMENDATIONS

The Division concurs with the recommendations and has begun to address them.

The Division Can Improve its System for Investigating Client Abuse and Neglect

Reports, Investigation Required for Protection of Vulnerable Clients

The DDD is currently completing the development and implementation of a computer system to track all Unusual Incident Report (UIR) Investigations, including abuse and neglect, and their outcomes. It is expected that this system will be operational by May 30, 1993 and will be tracking information retroactive to October 1, 1992.

Once fully operational, standard reports on the status of UIRs will be generated monthly. For a picture of current status, the DDD performed a manual random sampling of 275 abuse and neglect UIRs and investigations for 1992 to track outcomes.

Of the 275 abuse and neglect UIRs cases in the sample, 58 were either incorrectly coded as abuse and neglect (14) or the reports were unsubstantiated (44). Twenty four investigations resulted in disciplinary actions which included four terminations of State staff, eight terminations of provider staff members, and two removals of provider staff to a non-client setting. Additional staff training resulted from 15 investigations. An additional 83 investigations resulted in changes for the clients: in 17 cases, the clients were removed to a different setting; in 6, new program plans were developed; in 44, corrective action plans were developed; in 12, monitoring of the client was increased; and in 4, the clients were provided counseling. The remaining 97 investigations are still in process or are pending a final report. To ensure full compliance with standards of performance, in addition to those that address issues of client abuse and neglect, the Division has aggressively pursued non-acceptable personnel performance. Records for

1992 show that a total of 141 disciplinary actions were taken. These include: 39 dismissals, 38 suspensions, and 64 reprimands.

The report cited two case examples to illustrate problems.

Police were called repeatedly for runaway client, no UIRs (unusual incident reports) written.

In a few cases such as this one, it is true that case managers have not filed UIRs. However, this is the exception rather than the rule. Four UIRs had been filed with Central Office by the case manager. There were numerous entries in the case manager's communication log for which no UIRs had been written and forwarded to district administration and the Central Office. When brought to the attention of district and the Central Office administration, there was a change in group homes in accordance with the client's mother's desire. Site visits were conducted, an independent psychiatric evaluation arranged, and multiple staffings held over a seven month period conducted by the DDD's psychiatric medical consultant. The client's mother approves her son's placement in a less restrictive setting and signed an Individual Program Plan which specifically addressed the risk of harm. The Assistant Attorney General was involved in these staffings and has documented his belief that the DDD has taken all reasonable precautions to place the client in the least restrictive environment and to prevent him from harming himself or others.

Group home management implicated in allegations, but DDD did not investigate.

A community complaint was phoned in to Central Office from an anonymous former employee. A UIR was sent to Central Office licensing and the district monitor. Central Office licensing had conducted an investigation which resulted from a former employee complaint on similar issues five months prior to the complaint cited in the Auditor General's report. Due to their earlier investigation, Central Office licensing turned this complaint over to the district monitor. The monitor did not investigate, but contacted the agency and asked them to forward a copy of their findings. The district erred in turning this over to the agency with no involvement by the district. This is contrary to Division policy and not the norm.

Several Factors Contribute to Failures

The report specifically cites: Central Office receives inadequate information for effective oversight, incomplete files, insufficient Central Office staff, and lack of training for investigators.

The DDD system is no longer decentralized; rather, it is a partnership between the Central Office and the districts. The Central Office Compliance and Review has been understaffed and has had inadequate computer equipment. With the receipt of new equipment, and the present revamping of the system, the districts can now input the UIRs and send both a hard copy and computer diskette (and later via modem) to the Central Office.

Likewise, three of the largest districts have established quality assurance units which work in a partnership with the Central Office unit on UIRs and investigations. The Central Office compliance and review utilizes staff in these units as well as in licensing for investigations. The recently developed policy and procedure for unusual incident reporting addresses investigative techniques, but ongoing training will be provided in

conjunction with the DDD compliance review training unit, Attorney General's office, and internal affairs.

Central Office receives inadequate information for effective oversight

The Central Office files have been incomplete due to inadequate resources. With new equipment and data inputting now developing at the district level, the Central Office files are becoming more complete. The Central Office efforts have been focused on day to day monitoring of incidents and investigations, many of which are complex. Support staff for the Central Office (for inputting, monitoring, and filing) is still lacking. The Central Office is presently conducting training in each district to assist the districts in developing a consistent approach to quality assurance, utilizing the District II model.

Files are incomplete

It is noted by CFA and by the Auditor General that UIRs are not consistently found in client files.

Prior to January 1993, the DDD used DES Unusual Incident Report forms. The DES forms included language limiting access to the UIRs and advising that the UIRs must be retained separate from any client or provider files and records. In January, the DDD developed its own UIR form, in conjunction with the Attorney General's office. The language in this form was modified from the DES model and advises that, although sections may be maintained in a file separate from the client's master file, the UIR remains a part of the client's or provider's overall records. The DDD files reflect this transition period.

DDD agrees with the Auditor General report that clear references to the existence of UIRs should be maintained in the case files. The new DDD UIR form and instructions should resolve this matter.

Central Office staff insufficient

The Central Office of Compliance and Review does lack adequate staff. However, the existing three professional staff, in addition to the Manager, apply their time to the priority UIRs and investigations. It is estimated that 5 percent of the UIRs are sensitive and another 15 percent of the UIRs are serious enough to warrant close monitoring.

Staff who conduct investigations lack training.

Lack of training in conducting investigations has been a problem in the past. In the past year, there have been significant improvements in this area: development of a policy and procedure, assistance by the Attorney General's office and internal affairs, and development of district quality assurance units. This area of improved training will be expanded using internal and external resources.

RECOMMENDATIONS

1. - Concur. Comprehensive investigative training should be provided to all staff who conduct investigations of client abuse and neglect and other serious issues. The DDD will include in its FY 95 budget request, funding for national training previously identified to train the DDD trainers.

- Concur. The staff who report to the Central Office Compliance and Review should conduct all investigations into serious incidents. Another model would be a partnership with district Quality Assurance and monitoring staff as well as the Central Office licensing and managed care staff.

- The DDD rarely allows providers to investigate serious incidents. If the provider administration is aware of an incident, they usually take immediate action with an employee while simultaneously referring the UIR to the DDD. The DDD Assistant Director will establish a policy which would prohibit this practice unless there is adequate justification and approval by the District Program Manager.

2. - Concur. The DDD is committed to Statewide implementation of the new data collection system. Trend reports will be routinely reviewed by the district Program Managers and the Office of Compliance and Review. Corrective action will be required to address all issues identified by the trend reports. Trend report data will be used as part of the provider contract renewal process each year.

- New UIR forms developed by the DDD will remain part of overall client records.

3. Receipt of investigative reports is presently being monitored by the compliance and review specialists. The submission of those reports and UIRs is being coordinated in the three largest districts by Quality Assurance units and by specific personnel in the three smaller districts. This monitoring function is also being computerized.

- Concur. Serious incidents such as abuse and neglect are already a priority. A two tier system is a practical way to separate serious from minor incidents. This system is in place in one district. The DDD will pursue the implementation of such a system on a Statewide basis.

- Concur within budget constraints.

Licensing Inspections Need to be More Timely and Enforcement Should be Strengthened

The scope of the performance audit was confined only to group home licensing and did not address roughly one-half of the remaining responsibilities of the DDD Licensing Unit; namely, child development foster home and adult developmental home licensing and fingerprint clearances for all of the DDD.

This additional workload includes 245 child developmental foster homes with licensed capacities totaling 590 children, 162 adult developmental homes with licensed capacities of 295 adults and 490 fingerprint results per month. This workload is accomplished using the same manager, supervisors and clerical support staff as required for licensing and monitoring group homes.

The Division's Licensing Process is Inconsistent and Inefficient

The report states that the DDD routinely fails to inspect, initially license and relicense residential facilities and fails to follow up on violations.

For the past year, the DDD has concentrated its efforts on eliminating the backlog of expired licenses and on licensing residential settings in a timely manner.

On June 30, 1992 there were 69 provisional licenses issued by the DDD in the absence of a licensing inspection. As of February 9, 1993 there were four provisional licenses still existing without a licensing inspection. After February 1993, provisional licenses were issued consistent with statute and only for a period of corrective action, subsequent to a licensing inspection.

The DDD acknowledges that the average time from the date of inspection to the date a licensing report was issued was 35 days. However, that average has been reduced to 22.7 days in the past two months and will be reduced further, as automation resources can be acquired for licensing specialists.

The report states that the DDD failed to inspect State-operated facilities annually as required by statute. Although not completed during the period of the Auditor General's review, all State operated facilities were inspected during calendar year 1992, according to statute, with reports issued, corrective action plans prepared, and follow-up visits conducted. As of February 9, 1993, one-third of the 38 State operated facilities have already received an inspection for 1993.

Since licensing inspections are now timely, and the backlog eliminated in February 1993, the dates of monitoring visits will become predictable and can be scheduled in advance to be timely. The DDD currently is implementing procedures whereby monitoring visits, to verify corrective action, are conducted thirty days after the licensing inspection report is mailed to the service provider. The purpose of the 30 day inspection is to inform the agency of the status of corrective action in advance of the expiration of the provisional license. Since implementation of the 30 day reinspection, more than fifty per cent of the settings convert to a regular license at the time of the reinspection, or within two months of the licensing inspection.

Since December 1992, 29 six-month monitoring inspections have been completed. An average of 34 monitoring inspections per month is required to stay current each year. Additional resources are required to increase the monthly average of completed inspections. A budgetary hiring freeze prevents filling two vacant monitoring positions, which would significantly contribute to more timely monitoring.

DDD fails to effectively follow-up on licensing violations

Even though systemic issues were not addressed in the past, licenses were not issued until all deficiencies were corrected. Licensing inspections did not focus on systemic problems and corrective action plans did not require systemic corrections. Since August 1992, systemic corrective action has been emphasized and training provided to licensing specialists and monitors. Monitors are required to look for systemic corrections as part of their monitoring visits.

Since March 1989, sixteen group home licenses were revoked by the DDD because of licensing violations. Contracts for FY 1992-93, for the DDD's largest service

providers, contain a monetary sanction provision which is linked to licensing violations that are not remedied within a reasonable period of time.

Licensing Process could be streamlined and administered more consistently

Licensing standards are vague and subjective

The 325 licensing standards referenced in the findings no longer exist; they were eliminated by H.B. 2487, which was referred to in the Report and enacted during the 1992 legislative session. The DDD now uses only 102 statutes and rules to license. They are complemented by "Conditions of Noncompliance", which are guidelines and examples for use by inspectors and service providers to minimize subjectivity in interpretations. However, each rule should be extensively and individually reviewed, as addressed by the committee created in H.B. 2487, and as already has been done for A.C.C. R6-6-1502 and A.C.C. R6-6-409.

Licensing process is not uniformly administered

Separating licensing inspections and monitoring reviews under two supervisors has improved accountability. Schedules, inspection protocols, report formats, training and administrative reviews of products have improved efficiency and consistency.

Automation of inspection information has enabled the DDD to forecast workloads, schedule reviews and manage the licensing and monitoring functions more effectively.

Staff turnover and lack of training contributes to DDD's licensing problems

Licensing specialists work long hours, usually into the evening; must travel Statewide and must observe a rigid work schedule. The job is not attractive, except to highly motivated people, and "burnout" is not uncommon. Since September 1992, six training meetings have been conducted with the district monitors. In addition, quarterly monitoring training occurred Statewide in 1992.

Effective October 1, 1992, monitoring activities were centralized under one supervisor in the DDD Central Office for improved consistency in supervision, training, and reviews. At the same time, licensing activities were also centralized under a separate supervisor for the same purpose.

Effective December 1, 1992, all six-month monitoring inspection reports receive an administrative review for appropriateness, content and tone, prior to being sent to service providers.

RECOMMENDATIONS

1. Effective January 1, 1993, all schedules for monitoring reinspections and six month inspections are prepared in the DDD Central Office to improve the timeliness scope and consistency of inspections. Lack of staff is a factor.

2. Effective January 1, 1993, standard procedures were established for all monitors, with a consistent format for reinspection and six month monitoring reports.

3. Standards were rewritten based on H.B. 2487.

4. In process.

5. Concur.

6. Completed.

The Division Needs to Continue and Extend Efforts to Strengthen its Contracting Process

Most Division Services are Contracted Out

Most district contracting activities are supervised by Administrative Services Officers who are located in district offices, but who report to the Business Operations Director. The Central Office has steadily increased its oversight role through policy direction to these individuals, by review of requests to amend existing contracts, and in the review of contracts/amendments as they are processed by contracts management staff.

The Central Office provided technical training to district contracts negotiators in the area of DES Cost Principles and in review of itemized service budgets and allowable costs. District staff involved in central negotiations have returned to the districts to promulgate "best practice" techniques in all areas of contract negotiations, proposal reviews, and rate determination. Staff with contracts management oversight in the Central Office and in the districts are showing steady improvement in the area of rate negotiations. Previously negotiated rates are being renegotiated to obtain more favorable rates. All staff are showing increased awareness in the areas of allowable and unallowable costs. The Central Office finance section has developed procedures for performance based financial reviews of providers. These procedures will be implemented in the near future.

Weak Financial Review and Oversight has been Costly

The DDD agrees that improvement is needed in the area of financial reviews of providers' budgets and costs. The Auditor General's report discussed the auditing and management consulting services for which DDD contracted in FY 92. The results of this audit were very substantial. Final annualized contract values on the DDD's 38 largest providers were $20 million less than the providers' original submittals for FY 93 and were, in the aggregate, less than the previous year's contract totals. The DDD and DES Internal Audit are viewing the results of these audits and claims will be sent to providers to recover for unallowable costs.

The budget request for auditing support was not approved for FY 94 despite the large return on the investment in FY 92.

The Division Needs to Continue its Efforts to Strengthen the Contracting Process

The DDD is simplifying contracting procedures and the budget structure to reduce the number of amendments and other related contract paperwork that has to be filed. The Business Operations Director has developed a short term plan to renew existing contracts for Fiscal Year 1994. Staff time in non-value added activities will be reduced and staff will be able to attend to network expansion, monitoring, and training.

The DDD concurs with the report's assessment to clarify and more effectively communicate to staff the lines of authority on contracting matters. Through the Business Operations Director, who has functional authority over all contracting activities as the agency's contracts officer and who is a member of the DDD management staff, improvements have been realized in policy decisions and contracts activity.

RECOMMENDATIONS

Concur with all recommendations.

Other Pertinent Information

The Auditor General's report suggested that DDD consider more creative solutions for provision of services, in particular, recommending use of a voucher system

The Division created a work group to investigate the use of a voucher system. A draft of their report has been submitted to the Assistant Director and is currently under review.