Developmental Disabilities Division

Clarify and coordinate protective system
June 2001

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MEMORANDUM

Date: 06/08/2001

To: Diane Linn, Multnomah County Chair
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Lonnie Roberts, Commissioner, District 4

From: Suzanne Flynn, Multnomah County Auditor

Subject: Developmental Disabilities Division Audit

The attached report covers our audit of monitoring and protective services systems within the Developmental Disabilities Division in the Department of Community and Family Services. This audit was included in our FY00-01 Audit Schedule.

The Division provides services for individuals who have been diagnosed with mental retardation or with other developmental disabilities. The Division is mandated to provide client services, monitor client care, and provide protective services in a way that balances the safety of the individuals and still allows autonomy in life decisions.

The processes that the Division has in place to ensure client safety and welfare are extensive. Some of the elements, however, are not effectively integrated and coordinated. Although we saw no evidence that client harm had occurred because the Division failed to act, we did identify several weaknesses. These weaknesses cause a lack of consistency in the Division's response to client concerns. Additional stress on the system due to a state expansion of services to clients increases the risk that these weaknesses could lead to client harm.

We have discussed our findings and recommendations with DCFS and Division management and included their responses in the report. Pursuant to our new practice we will follow-up in 6 – 12 months and issue a report at that time.

We appreciate the cooperation and assistance extended to us by the management and staff of the Developmental Disabilities Division.

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Summary

The Developmental Disabilities Services Division (DDSD) serves eligible County residents diagnosed as mentally retarded or with other developmental disabilities. This audit was conducted to determine the ability of DDSD to recognize, prevent, and respond to the abuse and neglect of these vulnerable citizens.

It is the County's responsibility to monitor client care, respond to critical events, and provide protective services. We examined the Division's monitoring processes and analyzed the system developed by DDSD to log, track, and respond to incidents involving clients. Finally, we reviewed the work of the team responsible for gathering and analyzing serious event information and coordinating with the state's data collection efforts.

We found the elements of a comprehensive, sophisticated system in place, but these elements are not effectively integrated and coordinated. Although we saw no evidence that client harm had occurred because DDSD failed to act, the audit team did identify weaknesses that threaten the effectiveness of the monitoring, reporting, and protective service systems. These deficiencies constitute a risk to clients, particularly in light of projected increases in the services individuals will receive.

The system for responding to abuse and neglect is dependent upon the reporting of incidents. Most incident reports (70%) originate with providers who contract with the County to serve clients. Incident reports are the only systematic way for DDSD to receive and track client problems as they occur. We found that providers do not always report incidents in a timely manner, including those incidents that require protective service investigations.

We saw that once incidents are reported to DDSD, internal communication problems impact the work of case managers, the staff most responsible for client care. Case managers may not receive information when actions are taken by other DDSD personnel to resolve client concerns. We also found that follow-up to protective service investigations by Division staff may be delayed and is not always completed.

The system for monitoring of services needs improvement. Monitoring requirements are not clear to staff and the process lacks coordination. Also, these efforts are impacted by high caseload volume. As a result, the quality of monitoring varies.

In February 2001, DDSD initiated a Serious Event Review Team in response to state efforts to improve and standardize protective service reporting throughout the state. While this group could be instrumental in improving some of the weaknesses we found, these efforts are not coordinated with the critical incident reporting or service monitoring systems.

The Division anticipates an expansion in services over the next five years that will bring more services to 1,100 current clients. To prepare for this, DDSD plans to hire more personnel and reduce caseloads, contingent on funding from the state. Based on our findings, we would also urge management to strengthen the critical incident reporting system, and to clarify and coordinate service monitoring activities, as well as all oversight functions.

DDSD is ultimately responsible for protecting clients while ensuring they have choice in their care. This requires well-coordinated processes that are responsive to multiple care concerns. It also requires a system that responds effectively, even when those working closely with clients have not. The problems identified in our audit need to be addressed in order to best serve clients, their families, and the communities of Multnomah County.

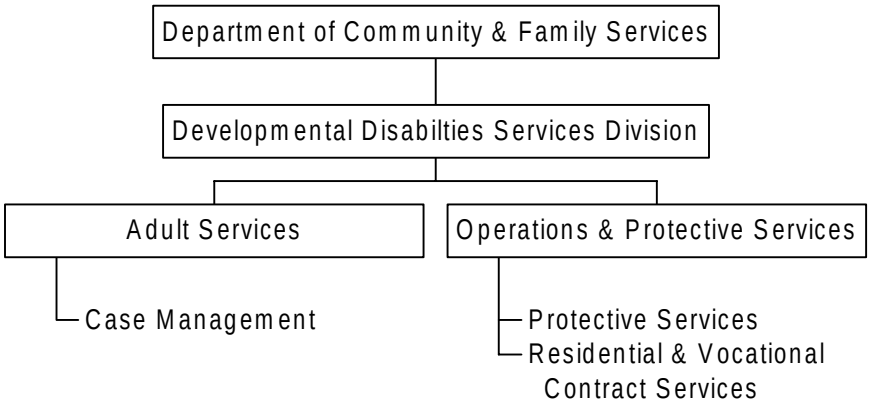
Background

The Developmental Disabilities Services Division (DDSD) is part of the Department of Community and Family Services. The Division provides services for individuals who have been diagnosed with mental retardation or developmental disabilities such as autism or cerebral palsy. In addition to these disabilities, many clients suffer from substance abuse, multiple and complex medical concerns, and/or problem behaviors.

Clients receive a range of services, including case management, residential care, vocational training, youth-to-adult transitional services, crisis diversion, and adult protective services. Changes in service delivery philosophy have moved clients from state operated facilities to community-based services. In addition, the state is working to reduce the number of individuals waiting for services, significantly increasing the number of clients receiving expanded services over the next five years.

Exhibit 1

Organizational chart related to audit scope



In fiscal year 2001, the Division was budgeted at nearly $56 million, with contracted residential services accounting for $33 million (59%). The bulk of this funding originates with federal Medicaid dollars and flows through the Oregon Department of Human Services. DDSD acts as a designee of the state providing locally designed and administered services to over 3,000 clients.

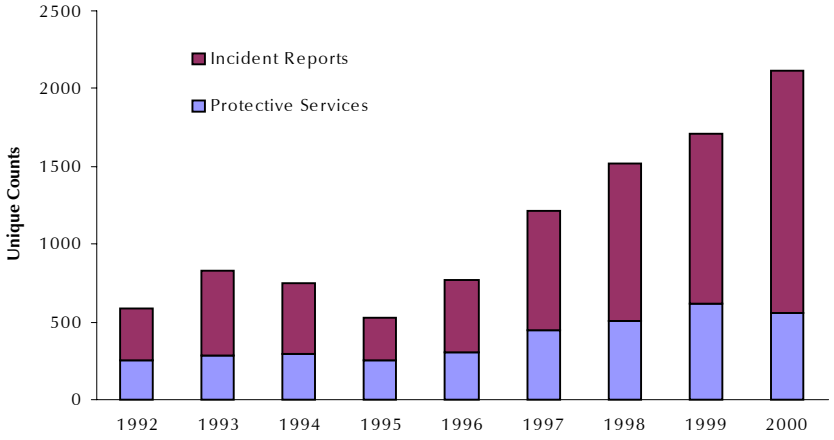
DDSD's staffing for FY 2001 was 95.6 FTE, of which more than half were case managers. Case managers act as client advocates, connecting clients with needed services and supports while emphasizing the importance of choice in the services they receive.

The Division is mandated to provide client services, monitor client care, and provide protective services in a way that maintains a delicate balance between safety and individual rights. Because the Division must allow and encourage client autonomy in life decisions, the potential exposure of clients to harmful situations increases. To ensure client health and safety, the Division provides program monitoring, incident reporting, and the Serious Event Review Team.

As the number of clients and case managers has grown, so has the volume of critical incidents being reported. Since 1992, reports of critical incidents have grown by 381%, and protective services referrals have increased 140% (Exhibit 2). In 2000 a total of 2,361 incidents were reported, some consisting of multiple allegations. Over half of all incident reports were for medical/hospitalization incidents or client behavioral concerns. Fifty-nine percent of all protective services referrals were for allegations of client abuse, with 28% for client neglect/provider negligence.

Exhibit 2

Incident reports and protective service investigations since 1992



Scope and Methodology

The purpose of this audit was to review the County's processes for ensuring that the health, safety, and rights of service recipients are protected. We focused on the monitoring of client care, incident reporting, and the Serious Event Review Team.

Auditors observed DDSD staff as they conducted site visits at several facilities, attended client service plan meetings, and met with providers. We interviewed a number of Division staff and managers, as well as state and federal officials. We performed analyses of DDSD databases and information tracked at the state level, and we conducted a file review from separate random and risk-based samplings of protective service case files.

We reviewed state and federal laws, administrative guidelines, and legislation, and we examined the Division's policies, procedures, and case management standards. The audit team completed a literature review that included research studies and Congressional committee reports. We viewed DDSD staff training videos and pertinent reports and documents. Other jurisdictions were also surveyed.

The audit was included in our FY2001 audit schedule and was conducted in accordance with generally accepted government auditing standards.

Audit Results

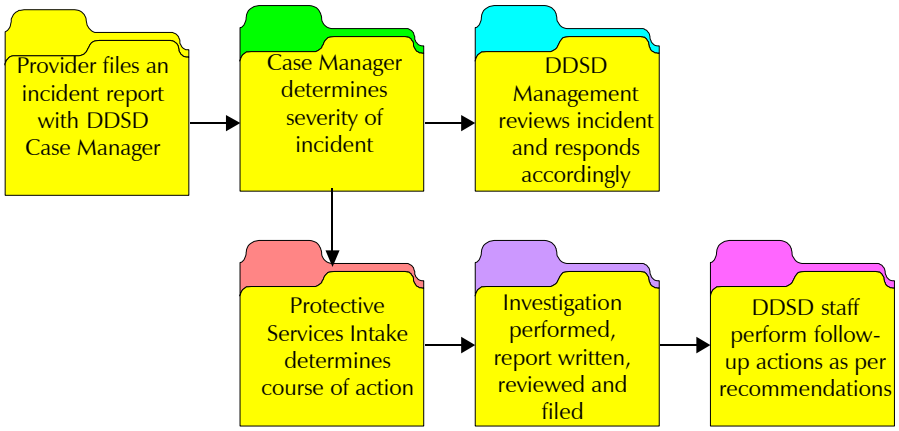
Reports of incidents are essential for client protection

State administrative rules require that the Developmental Disabilities Services Division (DDSD) ensure the protection and safety of the clients they serve. Many individuals receiving service have multiple and complex care concerns, while others function well on their own or have relatively few problems. It is important that the County system consider the differences in client needs and be able to respond effectively in all situations.

The incident reporting system is designed to receive and track reports generated by providers and DDSD staff. Incident reports are the only systematic way for DDSD to identify client concerns as they occur. The incident reporting system is used to document and respond to problems, as well as initiate protective service investigations. Generally, the system is comprised of these processes: provider incident reporting; case manager intake and evaluation; protective service intake and investigations; and recommendations and follow-up. The flow chart below illustrates these processes.

Exhibit 3

Incident report and protective service process



Incident reports can be used to inform case managers about a variety of day-to-day matters, such as a client's vacation plans or to request service changes. They can also be used to document more significant concerns, like provider paperwork errors, scheduled or unscheduled medical care, client injuries, and allegations of abuse or neglect.

Included in the report is specific information regarding the incident or event (time, date, location, persons involved), its description, what led up to the incident, and the outcome.

In 70% of occurrences, it is the service provider who sends a report to the case manager. Those reports that simply update client information are usually recorded in the client's progress notes. More serious events are documented as incidents reports and include:

- medication irregularities
- injuries
- accidents
- acts of physical aggression
- unusual incidents involving a client

During the "intake" process, the case manager usually conducts the initial review of the report and determines the nature and severity of the incident. If the case manager decides the report is a more serious event, it is routed to a supervisor for review and possible response. This typically takes 2.6 days to complete. The report information is then entered into a database and the paper document is filed. Suspected cases of abuse or neglect bypass this process and are immediately sent to the protective service unit.

Providers do not report incidents in a timely manner

The critical incident reporting system provides a safety net for identifying situations of client abuse and for predicting protective service activity. This makes it particularly important that providers promptly report incidents. Our analyses of the incident report data for 2000 found that DDSD does not receive information from providers in a timely manner, including those cases where neglect or abuse is suspected.

According to state administrative rules, providers must send information in writing to DDSD within five working days of the event and immediately in cases where abuse or neglect is suspected. The average time period between the event and the initial report, excluding cases of suspected neglect or abuse, was 7.85 working days. Five hundred ten (33%) incident reports were reported to DDSD beyond the required five working days.

Cases in which neglect or abuse was suspected averaged 6.2 working days between the event and DDSD notification. Two hundred thirty

cases (41%) of alleged abuse or neglect were reported to the County beyond one working day. In addition, analyses found no statistically significant difference between reporting time for cases of suspected abuse or neglect and less serious incidents. This suggests that many provider staff may not distinguish between less serious events and incidents of alleged abuse or neglect. Provider agencies we spoke with regularly train their employees to report incidents, but high turnover rates may contribute to reporting problems.

An examination of several case files supported the findings that emerged from the data. There were multiple examples of a significant time lag between date of incident and DDSD intake. One protective service referral we reviewed showed that a client's serious infection went unreported by group home staff for 27 days. In another case that took 23 days to report to the Division, a client was injured, police were called, and the client was taken to the emergency room. We found that provider performance ranged from those who report incidents within the required period to those that are less timely. The County's system must be able to identify and respond effectively to these differences.

DDSD expressed concern about providers that do not file incident reports. Management stated providers who are known to not submit reports are monitored more actively. However, there is currently no formal process for tracking and addressing potential reporting problems, such as a lack of incident reporting. It is possible that critical incidents may go unreported in facilities that initiate few or no reports. Without incident reports, important information is not available for decision-making and to direct monitoring activities.

Follow-up on protective service cases may be delayed

DDSD protective service investigators conduct intake of alleged cases of client abuse, client neglect, or client rights restrictions. Intake responsibilities are rotated among the investigators who review all referrals to determine if further investigation is needed. If the intake investigator finds that abuse criteria were not met, the incident report is usually referred back to the case manager. For cases that require further review, the intake investigator must 1) begin an investigation into the nature and cause of the alleged abuse, 2) conduct an assessment of the need for protective services, and 3) provide protective services if those services are needed. During the course of our review, DDSD had two levels of investigation - full and "tracked," a less intensive procedure.

Full investigations begin by contacting the provider administration, and when necessary taking immediate action such as removal of the client or reassignment of provider staff. The investigators interview witnesses, gather evidence, and log other pertinent information in the case file. When an investigation is complete, the investigator determines whether an allegation is substantiated, unsubstantiated, or inconclusive and drafts a report with follow-up recommendations. Once the supervisor reviews and approves the report, it is disseminated to DDSD staff involved with the case and the state Office of Developmental Disability Services.

We reviewed data during our audit that included cases (65%) that were tracked by protective services instead of receiving full investigations. In tracked cases, intake investigators conducted brief investigations, made recommendations, and assigned follow-up. For example, a case might have been tracked instead of fully investigated if the alleged perpetrator was a provider staff person who had since left the agency.

The Division is required by state administrative rules to initiate a review within 24 hours of receiving a report of alleged abuse or neglect. In addition, DDSD is required to complete its investigations and reports within 45 calendar days from referral to the County. Results of our analyses found that protective services initiates investigations in a timely manner, but does not always complete reports within the required time. Since recommendations are not circulated until the report is finalized, some essential follow-up activities may be delayed.

According to 2000 data, once DDSD received allegations of abuse and neglect, they were typically referred to the protective service unit in less than one working day. On average it took protective services 42 days to complete a full investigation and less than one day to complete a tracked case. However, 52 protective service investigations took more than the mandated 45 calendar days to complete.

Our review of case files confirmed that considerable time often elapses between the end of an investigation and issuing the final report. In a number of examples, the report and recommendations were not distributed until months after the investigation was completed. One contributing factor revealed by data analysis was the variance in the time individual investigators take to complete reports.

Case managers do not always receive critical information

After a case manager routes an incident report to a supervisor, it is often forwarded to specialists who interact with providers to resolve concerns. While case managers usually receive acknowledgement of

the supervisor's review, they are not always informed how concerns identified in the report were addressed. We also found that decisions made as a result of incident reports often occur without case manager input. In addition, those decisions are not necessarily shared with case managers. These are examples of significant communication concerns that can ultimately impact service quality. DDSD has taken some initial steps to improve the internal information loop, but communication problems will continue without concerted efforts by management to prevent them.

Communication about protective service investigations could also be improved. Case managers and providers often cannot respond promptly because protective service investigation findings and recommendations are not timely. In addition, providers only receive reports if they submit a formal request. Although some protective service staff indicated that investigative findings might be shared by phone with agency administrators prior to the completion of the report, this does not appear to be standard procedure.

Because the average full investigation and reporting process takes six weeks to complete and since additional time is needed for providers to request reports, timeliness of report dissemination may be hindered. This may also prevent full understanding and implementation of report follow-up recommendations and contribute to poor communication.

Further, protective service investigators may not seek case manager input when formulating their formal recommendations. Follow-up recommendations and other decisions are often made without considering the case manager's perspective and understanding of a client's needs and history.

Follow-up could be improved

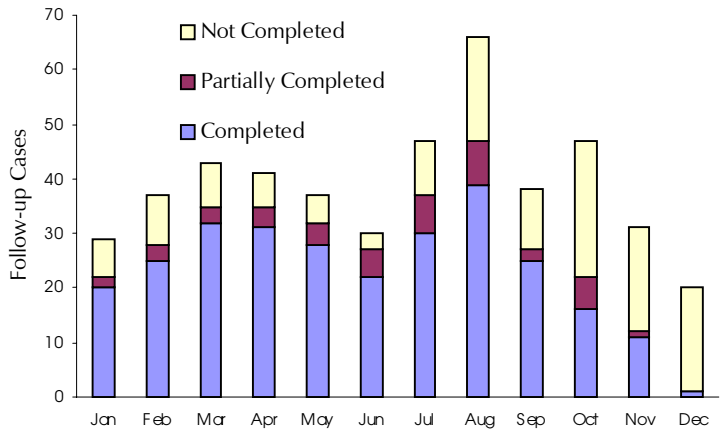
Follow-up actions are an important component of ensuring client health and safety. Typically, the case managers and contract monitoring staff are expected to ensure that protective service recommendations are carried out. Those activities range from checking client status, to carrying out legal actions, to placing a client in another facility.

While a follow-up policy exists, management enforcement of this policy is inconsistent and crisis driven. This has led to several problems with the follow-up process. Reports tracking follow-up completion are not consistently produced nor disseminated to management and staff. The follow-up database indicated that only 60% of cases that were assigned follow-up were completed. Data also showed that a number of

personnel had outstanding follow-ups, some going back several years. File review revealed several cases where follow-up activities might actually have occurred, but the information was not captured in the database. In some of these instances, documentation of follow-up was not completed or not forwarded to data entry. Exhibit 4 shows the volume of cases fully, partially, and not completed in 2000.

Exhibit 4

Follow-up recommendations fully, partially, and not completed in 2000



In mid-year 2000, management began tracking the number of days staff take to perform follow-up. Analysis of these limited data showed positive evidence of time requirements being met. We found that of the 68 cases where follow-up was completed, only three cases took longer than one month (31 calendar days).

According to Division policy, personnel assigned to follow-up recommendations must complete those activities within one month after the report is distributed. Management has acknowledged that follow-up policies may not have been regularly enforced and that the completion and documentation of follow-up activities has not always been a priority. DDSD administrators attribute this to the need to be crisis driven and the effect that has on staff resources. There is no doubt that crisis response is a major portion of the Division's work, but good follow-up could make DDSD more proactive and less reactive.

Recent efforts to more closely supervise follow-up documentation appear to have had results, but improvements are needed. Until the follow-up procedures are used consistently, management will not be able to accurately determine if proper follow-up occurred or wheather it occurred in a timely fashion.

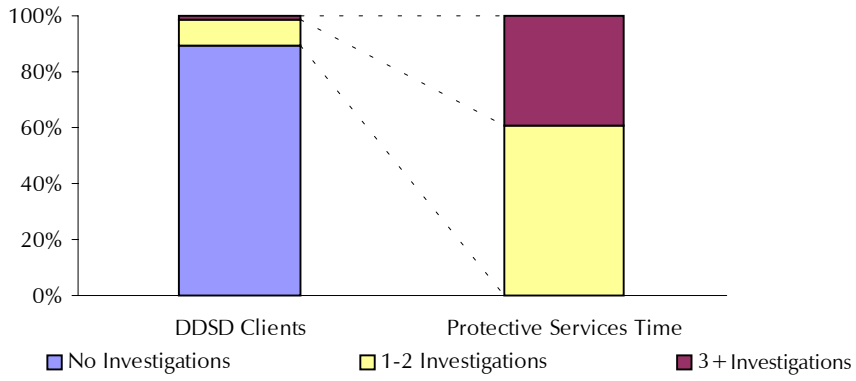
Workload could be managed more effectively

The Division has data available that could be used to increase the effectiveness of the incident reporting system and improve their response to client problems. Our analysis suggests that workload and intake duties, rather than the application of specific investigation criteria, may affect the decision by protective service personnel to investigate.

An analysis of the year 2000 investigation data found that 11% (330) of DDSD clients were involved in protective services investigations. Of those, 288 clients were involved in one or two isolated investigations each, with the remaining 42 involved in three or more investigations each. Thus, 1% of DDSD clients accounted for 39% of the total investigation time expended (see Exhibit 5). On average, it took investigators 45% more time (17.8 days) to investigate cases with clients involved in frequent investigations (three or more). Cases with clients involved in isolated investigations (one or two investigations) required an average of only 12.3 days to investigate.

Exhibit 5

Protective services time expended on clients



There are various reasons for the higher number of incidents involving a small group of DDSD clients. In some cases, the clients are medically fragile with multiple and complex medical problems. Other times, clients may harm themselves or others because of self-injurious, violent, or adventure-seeking behaviors. The Division is mandated to allow clients autonomy in life decisions, and this can potentially expose clients to more harmful situations. DDSD must also monitor client care and provide protective services in a way that maintains a delicate balance between safety and clients' rights. In one case we reviewed with multiple protective service referrals, the client chose to continue an abusive relationship. In keeping with client choice standards, the goals of the provider and DDSD in this example were to protect and support the client and maintain a stable living situation.

Using multiple regression models of client and incident report databases, we found that incident reports were the single best predictor of future protective services investigations. These models were able to predict 20% of the volume of protective services investigations by facilities and 85% by case managers.

Our review of case files confirmed the predictive link between incident reporting and protective services. In one incident report we saw, group home staff could not account for a client's vacation receipts and missing money. The client's funds were not reimbursed until months later when another report was filed and referred to protective services. Earlier resolution or attention might have reduced the need for additional investigation.

We also found that the protective service intake function affects the performance of the unit. Assigning investigators intake responsibility for one week each month extends the amount of time needed to complete their ongoing investigations. Some investigators expressed frustration with the way these intake duties interfere with investigative responsibilities.

Rotating intake investigators may also impact the consistency of cases routed to full protective service investigations. A review of the past three years of event data suggests some instances where either increased referrals and/or reduced number of investigators were associated with decreases in the portion of cases receiving a full investigation. Although the team of investigators conducts ongoing peer review to ensure objectivity and consistency in decisions, some protective service staff did acknowledge the potential for conflict between intake duties and workload.

Monitoring lacks coordination

It is also the responsibility of the Division to monitor the services clients receive. The intent of monitoring is to identify problems early, but specific procedures are not clearly outlined in the state administrative rules. How the monitoring function is carried out is generally subject to interpretation by DDSD.

We identified four distinct monitoring functions performed by various DDSD staff:

- client care plan monitoring
- monitoring of the facility environment
- facility licensing reviews
- monitoring of contractual agreements

These approaches to monitoring often require that staff adopt multiple roles. Also, activities regularly involve different DDSD work units. This has created some confusion about who is responsible for monitoring, as well as the level of monitoring required in each situation.

Case managers generally conduct client care plan monitoring. Each care plan is tailored to individual clients and is an agreement that obligates contractors to deliver specific services. Clients, providers, and case managers collaborate to identify service needs (i.e. type of residential care, amount of staff oversight, special medical needs, and type and number of vocational hours) and develop a plan with those needs in mind.

Facility environmental monitoring is usually carried out in brief, unannounced site visits, where staff "look, listen, and smell" to identify problems. Superficial in nature, these visits are intended to maximize staffing resources to allow for more monitoring coverage. Recently, in response to concerns raised by various Division staff about particular residential facilities, all DDSD personnel were directed to participate in environmental monitoring. These efforts have increased the level of overall monitoring and added to the information collected by DDSD.

Facility licensing reviews of residential sites are performed by the state licensing team and include one DDSD program specialist. The monitoring of contractual agreements is also conducted by program specialists and focuses on concerns the Division has with contracting agencies. These approaches to monitoring provide additional information to case managers, as well as being a means of management oversight of the work of case managers.

Monitoring may not be clearly understood or accepted by DDSD personnel, and this may contribute to ineffective coordination of these efforts. Also, perspectives on monitoring vary throughout DDSD. Some case managers believe strongly that monitoring is an essential part of their role, including the need to work with contract agency staff to correct deficiencies. Other case managers view it as a risk to their relationship with residential providers and a responsibility best carried out by program specialists. Some Division managers agree that the lack of role clarification is a concern.

Monitoring requirements are not clear to staff

We identified a number of problems that reduce the effectiveness of service monitoring by DDSD staff. Monitoring guidelines lack clarity and are applied inconsistently. What should be reviewed during monitoring visits or how frequently these visits should occur, has not been specified.

Orientation of new case managers and ongoing training do not prepare case managers for in depth monitoring of client care plans. According to DDSD standards, new employees are to be mentored in order to learn DDSD case management practices. Management acknowledged that mentoring does not occur on a formal basis, nor does it occur at the frequency or the depth that is needed for consistent skill building. They attribute much of this to high caseload size and lack of resources within the organization.

Just prior to our audit, a cross-functional team developed monitoring training for DDSD staff. The training was primarily designed to introduce all personnel to the concept of facility environmental monitoring. A review of the training videos and staff evaluations revealed that the training did not prepare participants to conduct thorough, organized monitoring. Additional training was supposed to follow, but that has not yet occurred. Managers did develop a checklist to use during monitoring, but according to veteran case managers, it provides inadequate guidance.

The lack of clear policy and effective training has resulted in monitoring based on individual approaches rather than proven standards. This has led to inconsistent monitoring practices. We found that monitoring ranged from meticulous review and comparison of documentation, to a quick, superficial examination of client notes. On multiple occasions, we observed staff glancing through client medication logs without scrutinizing the entries. Also during some monitoring visits, the audit team discovered problems that DDSD staff likely would have found if they had conducted more thorough review.

We found a range of skill and experience among case managers, which impacts how monitoring is carried out and how client problems are addressed. Regardless of the differences in staff abilities, the County's system must be able to respond effectively.

Monitoring quality impacted by caseload size

High caseload volume reduces the amount of time available for case managers to conduct quality monitoring of client care. As a result, thorough and frequent review of services may not be feasible. Case managers working with clients receiving contracted services have caseloads that range from 72 to 86. Some case managers confirmed that high caseloads were a problem and that client care plan monitoring was often not being done as a result of those caseloads. In addition, the new requirement for staff to perform facility environmental monitoring leaves even less time available to perform more in depth

monitoring. DDSD managers agreed that the size of caseloads was a concern for all of their services. However, management believes the impact on monitoring of contracted services is minimized by the range of monitoring activities being conducted.

Monitoring and investigations system lacks oversight coordination

The Serious Event Review Team (SERT) was initiated February 2001 in response to state efforts to improve and standardize protective service reporting throughout the state. Its function is to integrate the Division's existing data collection mechanisms with the state's new system. County-level protective service referrals and incident information will be entered online and used to identify state and local trends. The data will be available by individual client, provider, or any number of combinations. The state mandated this system as a means of responding to new federal Health Care Finance Administration requirements.

The SERT is a multidisciplinary group of personnel from throughout the Division. They are beginning to analyze incident report data, have redesigned the incident report form, and are working to bring about full implementation. Another SERT goal is to build better communication that includes case managers.

DDSD collects a great deal of data, yet it has struggled with using that information to improve monitoring and decision-making. The work of SERT will assist the Division's efforts. Administrators identified some ways in which they would like to see the information used, including prediction of problem sites and tracking of incident reports by facility. But managers cited lack of time related to high caseloads and lack of available training as the primary reasons for not taking advantage of the information available to them.

The current monitoring functions, the incident reporting system, and the SERT are independent structures that operate with a low degree of integration. This has led to a fragmented risk management system that could be strengthened by coordination of internal and external processes. For instance, clarifying the purpose of various monitoring activities for staff could increase incident reporting. Increased incident reporting could address issues identified by SERT and provide more comprehensive information. Further, SERT could conduct risk-based analyses to identify facilities or provider agencies where monitoring activities should be focused.

The Division recognizes many of the weaknesses we identified in our audit. In some cases, management has been working to correct

problems. For example, prior to our audit, DDSD formed the monitoring committee and the case management redesign committee to address some of the concerns noted in our report. Managers and the SERT also took steps to strengthen data collection and analysis before and during the audit. We support these efforts, and we encourage further improvements and greater coordination of existing processes to ensure client health and safety.

Increased responsibilities will strain system

The state Department of Human Services has recently committed to expanding services to all adults with developmental disabilities in Oregon. As a result, DDSD anticipates that over the course of the next five years, approximately 1,100 of current clients will receive more services. This represents an increase in the client population receiving expanded services.

To prepare for the expansion of services, DDSD plans to hire more personnel and reduce caseload ratios, contingent on funding from the state. These changes would address our concerns about high workload volume, as long as case managers are adequately prepared and supported. Management's priority must be to specify practices for in depth monitoring of client care plans. They also must provide training and mentoring, reinforce reporting and follow-up standards, and clarify staff roles. Doing so will build greater consistency and strengthen the Division's ability to intervene and respond when problems occur.

Existing monitoring and incident reporting processes rely heavily on the work of committed staff with good intentions. These professionals are responsible for protecting clients, but they do so without adequate guidelines, direction, or supervision. They perform this work in an uncertain environment, where even the best providers can fail to properly care for clients. The risk of client harm is high, and the expansion of services means the risk likely increases unless DDSD takes steps to address weaknesses identified in the audit.

During our audit, the Division also announced that the protective service unit would likely be moved to operate independently outside of DDSD. The plan is to centralize all the protective service activities within the Department of Community and Family Services. Whether centralized or decentralized, the problems we observed could remain. Further, this change would not resolve the conflict between the protective service intake and investigation functions. More importantly, it does not contribute to improved internal communication; in fact, management should guard against any further break down in communication between investigators and the case

managers working most closely with clients. These concerns each impact effective intervention and response, and they should be addressed whether or not the protective service unit remains in DDSD.

Recommendations

1. To improve the effectiveness of monitoring activities, management should:
    a. Create specific guidelines that address monitoring frequency, depth, and timeliness and clarify staff roles
    b. Improve training for client care plan monitoring practices for case managers
    c. Direct the Serious Event Review Team to use incident report data to coordinate monitoring efforts throughout DDSD
    d. Work with providers to increase the timeliness of incident reporting

2. To improve service quality, management should:
    a. Strengthen internal communication by seeking case manager input when making decisions about clients
    b. Determine equitable workload and caseload criteria for case managers

3. To improve protective service activities, management should:
    a. Increase the timeliness of communication with case managers and providers
    b. Consider creating a separate intake function for protective services
    c. Clarify expectations and enforce policy regarding follow-up on protective service investigations

Responses to the Audit

MULTNOMAH COUNTY OREGON

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To: Suzanne Flynn, Multnomah County Auditor

From: Lolenzo Poe, Director DCFS
Howard Klink, Senior Manager, DDSD

Re: **AUDIT RESPONSE**

Date: June 12, 2001

We appreciate the thorough analysis and recommendations contained in the report of the Audit of the Developmental Disabilities Services Division's (DDSD) Incident Reporting, Protective Services, and Monitoring systems. The report identifies a broad range of issues of concern to DDSD, most of which were being addressed as part of a systems change effort that was initiated before the Audit began and will continue to be addressed as part of our commitment to continuous quality improvement. The information provided by the Audit will help us to refine our strategies and hopefully accelerate the improvement process.

DDSD staff have a strong commitment to ensure client health and safety and protect clients from abuse and neglect. Adults with developmental disabilities are among the most vulnerable to be found in the human services delivery system. Faced with mobility, speech and cognitive challenges, it is frequently impossible for individuals with developmental disabilities to protect themselves or even report abuse or neglect. Consequently, DDSD staff are vigilant and aggressive in their identification of and response to client abuse, limited primarily by inadequate funding, high case loads, and the crisis driven nature of the system.

We were extremely pleased to read that the Auditor's, "**found elements of a comprehensive, sophisticated system in place,"** and further**, "saw no evidence that client harm occurred because DDSD failed to act."** We accept all of the recommendations as legitimate and valid areas of focus to make system's improvements. Attached is an outline of the Audit's recommendations and summary of DDSD efforts completed or underway in each area. Additional information is provided below to clarify a few important elements of the Incident Reporting, Protective Services and Monitoring systems that were understated or incompletely described. That information is outlined as follows:

1) Although the Audit did touch on issues related to high county caseloads and provider capacity, most system weaknesses in the areas of response time, follow-up consistency, communication and coordination are closely related to the inadequacy of state funding. Multnomah County Case Managers carry average caseloads of 88 individuals. This average is about twice the national standard recommended to provide adequate support for individuals and families. In addition, according to state data, provider agencies experience staff turnover rates of about 100% annually and extremely high vacancy rates. Both of these factors can be directly attributed to low wages and inadequate or non-existent benefit packages, also attributable to inadequate state funding. None of these factors are unique to Developmental Disabilities Services, but should be clearly identified as system's conditions that present significant challenges to improvements in the areas identified in the Audit.

2) On page 8 of the Audit, paragraph 3 expresses concern about the absence of "a formal process for tracking and addressing potential reporting problems such as a lack of incident reporting." This information is not completely accurate. DDSD maintains an extensive historical data base to record and track incident reports. While it is clearly a challenge to track or respond to incidents that we may never have been made aware of, the following system's elements are in place: When information about incidents that were unreported is brought to our attention staff immediately respond to the provider agency and actively engage management to identify the cause and ensure that non-reporting does not continue to occur. Increased monitoring of such agencies is also part of the follow-up. In addition, DDSD Supervisors and PDS staff track non-reporting patterns, intervene with those agencies and increase monitoring activities to more accurately determine if reporting requirements are being met. This process could be improved, it but does exist.

3) This Audit was conducted during the first 3-4 months of 2001. At that time DDSD was in the midst of initiating a number of changes in the Incident Reporting, Protective Services and Monitoring systems. These changes were the result of changes made by the state in requirements for serious events reporting, a comprehensive rewrite of DDSD's policies governing incident reporting and protective services, and a dramatic change in requirements for Case Managers to conduct monitoring efforts and participate in training to increase monitoring effectiveness. All of these efforts began before the Audit was initiated, and in general, directly respond to the Audit recommendations.

Again, we thank the Auditor for this report. We will put it to good use. Our response to the recommendations is attached for your review.

ATTACHMENT

RESPONSE TO AUDIT RECOMMENDATIONS
DDSD AUDIT: JUNE, 2001

1) AUDIT RECOMMENDATION: TO IMPROVE THE EFFECTIVENESS OF MONITORING ACTIVITIES, MANAGEMENT SHOULD:

RECOMMENDATION 1A: CREATE SPECIFIC GUIDELINES THAT ADDRESS MONITORING FREQUENCY, DEPTH, TIMELINESS AND CLARIFY STAFF ROLES.

ACTIONS COMPLETED OR IN PROGRESS:

- The Serious Events Review Team (SERT) has been established, trained and is in the process of finalizing and refining its policies and procedures. Effective functioning of this team will significantly address this recommendation.

- While the Audit was in progress, DDSD developed and implemented a new Protective Services Policy and Procedure. This document was developed with staff input and was designed to clarify roles, reporting procedures and refined our data base to assist monitoring activities. It has been distributed to all staff and will be a subject of training activities. Training will be ongoing.

- In August 2000, a Monitoring Workgroup was established to address a wide range of monitoring issues of concern to DDSD, including some of those later identified by the Audit. This group will be ongoing.

- While the Audit was in progress, a monitoring check list was developed, tested, and reviewed by staff. Final revisions are being made. It will be fully implemented within the next 60 days. It defines the scope of monitoring and helps clarify the role of staff in monitoring activities.

- While the Audit was in progress, a monitoring system was set up to ensure that all staff were involved in monitoring. Supervisors oversee this system and with the assistance of PDS staff and identify which service sites are priorities for monitoring.

- Prior to and during the Audit, a training program was developed and implemented specifically to address concerns about monitoring frequency, depth, timeliness and staff roles. This training is mandatory, will be refined and is ongoing.

RECOMMENDATION 1B: IMPROVE TRAINING FOR CLIENT CARE PLAN MONITORING PRACTICES FOR CASE MANAGEMENT:

ACTIONS COMPLETED OR IN PROGRESS:

- The Monitoring Work Group is in the process of soliciting feedback from DDSD staff regarding the monitoring process, on-site visits and further needs for training and role clarification. DDSD Contract staff have reviewed recently collected monitoring data, will share this with the workgroup and review how providers are selected for monitoring. The Audit will also be made available to assist with this process.

RECOMMENDATION 1C: SERT SHOULD USE CRITICAL INCIDENT REPORT DATA TO COORDINATE MONITORNG EFFORTS THROUGHOUT DDSD.

ACTIONS COMPLETED OR IN PROGRESS:

· DDSD began implementation of SERT in January 2001. Management and PDS staff and Protective Service Investigators have all been trained in SERT process, requirements, policies and procedures. In June 2001, DDSD began using a state created web site data base and data entry system. This will enable SERT data to be incorporated into monitoring selection, measurement and analysis activities. Within the next 6 months, Case Managers will all be trained in accessing SERT data online.

RECOMMENDATION 1D: INCREASE THE TIMELINESS OF INCIDENT REPORTING.

ACTIONS COMPLETED OR IN PROGRESS:

· DDSD currently tracks and identifies providers who are not reporting incidents as required by timelines mandated in the Oregon Administrative Rules (OAR'S). Staff intervene with providers when patterns are indicated. Limitations in our current data system make it difficult to identify such patterns and partially explain the data represented in the Audit. In addition, high staff turnover in provider agencies present challenges in maintaining a workforce trained in incident reporting requirements. Improvements in the SERT data system will assist in responding to this recommendation. DDSD identifies this as an area in need of significant improvement.

2) TO IMPROVE SERVICE QUALITY MANAGEMENT SHOULD:

RECOMMENDATION 2A: STRENGTHEN INTERNAL COMMUNICATION BY INCREASING CASE MANAGER INPUT AND SUPPORT IN CLIENT DECISIONS.

ACTIONS COMPLETED OR IN PROGRESS:

- Case Managers currently receive all incident reports, screen reports for seriousness and the need for a protective services referral and forward for entry into the SERT system. The SERT system, when fully implemented, will enable Case Managers to access complete information concerning actions and follow-up actions taken.

- The Monitoring Work Group will review the Audit recommendations regarding improvements in Case Manager input into client decisions and identify strategies to address this issue.

RECOMMEDATION 2B: DETERMINE EQUITABLE WORKLOAD AND CASELOAD CRITERIA FOR CASE MANAGERS.

ACTIONS COMPLETED OR IN PROGRESS:

- In February 2000, DDSD established the Case Management Redesign Workgroup, which was charged with developing a system's redesign proposal to address caseload issues, equity and service quality. Two specific proposals emerged from this group, which are in the process of being reviewed as part of implementation of Universal Access.

- Improvements in caseload ratios and workload equity are primarily dependent on increased state funding for case management which has not been historically available and may or may not be available as a result of the Staley lawsuit settlement agreement. However, DDSD management in consultation with the Case Management Redesign Workgroup has developed a reorganization plan that even without an increase in state funding will result in some degree of case load reduction.

3) TO IMPROVE PROTECTIVE SERVICES ACTIVITIES, MANAGEMENT SHOULD:

RECOMMENDATION 3A: INCREASE THE TIMELINESS OF COMMUNICATIONS WITH CASE MANAGERS AND PROVIDERS.

ACTIONS COMPLETED OR IN PROGRESS:

- In November of 2000, the state Office of Developmental Disability Services indicated that DDSD had an "effective, efficient protective services operation and set high standards for investigations." At that time, in response to mutual concerns about an imminent Health Care Finance Administration audit, DDSD initiated a rewrite of outdated protective service policies and procedures to address timeliness, communication and other issues of concern. This new policy and procedure has been approved by the state distributed to all staff, and will be included in training activities. We have already identified improvements in reporting and tracking protective service incidents.

- Full implementation of the SERT system, through the availability of online data entry and report access, will eliminate many paper system communication delays that occur in the current system.

RECOMMNENDATION 3B: CONSIDER CREATING SEPARATE INTAKE FUNCTIONS FOR PROTECTIVE SERVICES.

ACTIONS COMPLETED OR IN PROGRESS:

- DCFS is in the process of consolidating protective service activities that currently operate within the DD and Behavioral Health programs. These functions and staff will be moved from the program Divisions to the Department under the supervision of the Medical Director. This action has been taken to achieve administrative efficiencies. This recommendation will be reviewed by the team planning this transition.

RECOMMENDATION 3C: CLARIFY EXPECTATIONS AND ENFORCE POLICY REGARDING FOLLOW-UP ON PROTECTIVE SERVICE INVESTIGATIONS.

ACTIONS COMPLETED OR IN PROGRESS:

When fully implemented the SERT system will automatically notify case managers and supervisors via email of any serious event that does not contain an investigation or review completion date. This automatic notification will continue on a weekly basis until the case is closed and no case will be considered closed until all outcomes are reported. SERT Committee members will also receive these emails as part of the quality assurance process to ensure that follow-up requirements are met.