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Progress Report

January 2003 **Report No. 03-08**

Improvements Needed in the Department of Children and Families Adult Services Program

at a glance

To avoid expensive nursing home placement, the Adult Services Program serves vulnerable adult victims of abuse as well disabled adults. This report reviews program performance, suggested operational improvements, and actions taken by the Department of Children and Families in response to two 2001 OPPAGA reports.

- The program has been timely in commencing investigations but not in closing them, resulting in a backlog of cases.
- Both a statewide uniform needs assessment and a funding allocation system are needed to ensure that the highest priority disabled adults are served first.
- Moving 233 general revenue clients to the Medicaid Waiver Program could save at least $319,000 in state general revenue.
- The program's accountability system, including performance data and monitoring and oversight, needs improvement. Data on the number of elder abuse referrals made to the Department of Elder Affairs continues to be faulty.
- The department has not implemented working agreements with law enforcement as mandated by the 2000 Legislature nor has it implemented a uniform fee assessment and collection system for clients eligible to pay for services, although the collection system may not be cost-effective.
- The program could not document that it has implemented our recommendation to reduce optional state supplementation (OSS) case management visits and thus save state general revenue.

Purpose

At the Legislature's request, OPPAGA reviewed the Department of Children and Families Adult Services Program as part of the Legislative Budget Commission zero-based budget review of the program. Our examination focused on

- program performance;
- improvements to more efficiently and effectively operate the program; and
- actions taken by the department as required by state law and in response to two 2001 OPPAGA reports. [1, 2]

[1] Section 11.51(6), *F.S.*

[2] *DCF's Adult Services Program Meeting Goals; Data Reliability, Case Management Need Work,* Report No. 01-08, and *High Risk Elder Victims of Abuse, Neglect, or Exploitation Quickly Served; Data Problems Remain,* Report No. 01-04.

Background

The Adult Services Program serves some of Florida's most vulnerable residents through two types of services.

- **Adult protective services** are intended to prevent further harm from occurring to adults who are victims of abuse, neglect, and exploitation.
- **In-home services for disabled adults** provide care to help clients remain in family-type living arrangements in private homes and avoid placement in nursing homes.

The Legislature's intent is to provide services to these clients to prevent them from being further harmed and to avoid more costly nursing home care.

Adult Protective Services

Chapter 415, *Florida Statutes*, establishes adult protective services to protect vulnerable adults from being harmed. These adults may experience abuse, neglect, or exploitation by second parties or may fail to take care of themselves adequately. [3]

Florida statutes require any person who knows or has reasonable cause to suspect any abuse of vulnerable adults to report that information to the Florida Abuse Hotline. [4] Allegations may include physical abuse, environmental neglect, inadequate food, mental injury, exploitation by deception and/or intimidation, and conditions hazardous to the victim's health. The hotline screens these calls to determine whether the information meets the criteria of an abuse report. In Fiscal Year 2001-02, there were 48,583 reports made to the hotline that alleged abuse, neglect, or exploitation of vulnerable adults. [5]

The program investigates all abuse reports to determine whether there is evidence that abuse, neglect, or exploitation occurred; whether there is an immediate and long-term risk to the victim; and whether the victim needs additional services to safeguard his or her well-being. Abuse report investigations must be completed within 60 days of their commencement. In Fiscal Year 2001-02, the program conducted 41,547 adult protective investigations. [6] From these investigations 43,814 alleged victims were identified and 15,154 (35%) had some or verified findings of abuse, neglect, or exploitation.

The program provides case management to clients who need additional services in order to be protected from further harm. Case management may be intensive, involving frequent contact with the victim (such as two or three visits a week), and typically lasts for three to six months. It may involve removing victims from an unsafe environment and relocating them to a setting where their needs can be safely and suitably met such as a nursing home or an assisted living facility. Some clients may receive OSS, which is a stipend of state and federal funding that enables them to avoid institutionalization and to live in an assisted living facility or adult family care home. [7] Case management for OSS recipients includes assessing clients for eligibility and need for care, developing case plans, making periodic client visits, and annually reassessing eligibility.

The program provides referral services to some clients to help ensure that they are not subject to further abuse. These referrals to state or local social services agencies may include services, such as meals, periodic home visits, personal care,

[3] Section 415.102(26), *F.S.*, defines "vulnerable adult" as "a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her care or protection is impaired due to a mental, emotional, physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging."

[4] Section 415.1034, *F.S.*

[5] The number 48,583 includes initial, additional, supplemental, and duplicate reports received by the hotline. Initial reports are new reports. Additional reports contain new information about one or more subjects of an existing report. Supplemental reports enhance the information of an existing report. Duplicate reports contain no new information about an existing report.

[6] The number 41,547 represents initial and additional reports, which require investigative activities, and does not include reports classified as supplemental and duplicate, which contain no new information to be investigated but may enhance a report already received or under investigation.

[7] OSS clients living in an assisted living facility received an average monthly stipend of $71.80, while clients residing in an adult family care home received an average of $66.64 per month.

transportation assistance, and related support services.

In-home services for disabled adults

Established by Ch. 410, *Florida Statutes*, the Adult Services Program provides care to disabled adults in family-type living arrangements in private homes as an alternative to institutional or nursing home care. Clients are disabled adults aged 18 through 59 years with permanent physical or mental limitations that restrict their ability to perform normal activities of daily living and their capacity to live independently. Through the program components described below, in-home services support and maintain disabled adults' independence and quality of life.

- ***Home Care for Disabled Adults*** gives relatives or other caregivers a monthly subsidy to assist them in keeping disabled adults in their own homes or the homes of their caregivers. The program also may provide special subsidies to purchase additional services or supplies, such as medical equipment or prescribed medicines not covered by insurance. During Fiscal Year 2001-02, the program served 1,689 disabled adults.
- ***Community Care for Disabled Adults*** offers services and case management to disabled adults to make it possible for them to live independently. Services include homemaker service, home-delivered meals, and personal care. Depending on the availability of funding, clients may also receive services, such as adult day care, chore service, emergency alert/response service, respite care, interpreter service, medical equipment/supplies, medical therapeutic service, physical and/or mental examinations, and transportation. During Fiscal Year 2001-02, 1,456 disabled adults received services.
- ***Home and Community-Based Services Medicaid Aged/Disabled Adult Waiver*** utilizes Medicaid funds to serve frail, severely impaired elders and disabled adults who are unable to care for themselves and are eligible for nursing home placement. The program makes services available similar to those provided by the Community Care for Disabled Adults component, such as personal care, home-delivered meals, homemaker service, and adult day care, which allow clients to remain in their homes instead of in nursing homes. During Fiscal Year 2001-02, there were 1,251 Medicaid waiver clients.
- ***Adult Cystic Fibrosis Program*** provides a continuum of services for adults diagnosed with Cystic Fibrosis whose medical and support needs are not being met. Services include, but are not limited to, thAIRpy vests, which help clients breathe; caloric supplements; durable medical equipment; medications, lab tests; and chest physiotherapy. Through a contract with Abilities, Inc., the program served 144 cystic fibrosis clients during Fiscal Year 2001-02.

Organization

The Department of Children and Families administers the Adult Services Program. The central adult services program office in Tallahassee is responsible for administrative and policy development functions, such as planning, budgeting, quality assurance, and maintaining the program's management information system. The department also administers the Florida Abuse Hotline in Tallahassee to receive reports alleging abuse, neglect, or exploitation of any vulnerable adult. [8]

Program services are delivered locally through the department's SunCoast region and 13 district offices. [9] District employees conduct adult protective investigations and provide case management and referral services for adult abuse victims. They also either directly provide or contract with private service providers for case management and support services for disabled clients.

[8] The Florida Abuse Hotline telephone number is 1-800-962-2873.

[9] The 2000 Legislature approved the establishment of a prototype region combining DCF Districts 5 and 6 and DeSoto and Sarasota counties from District 8 to increase accountability, community integration, and support and improve the quality of care.

Exhibit 1
Most (62%) of Program Funding Comes from State General Revenue for Fiscal Year 2002-03

	Adult Protection	In-Home Services					
Funding source	Adult Protective Services	Home Care for Disabled Adults	Community Care for Disabled Adults	Medicaid Waiver	Cystic Fibrosis	Salaries and Expenses	Total
General Revenue Fund	$17,249,755	$2,219,860	$2,724,866	$2,246,619	$243,623	$1,411,611	$26,096,334
Administrative Trust Fund	4,991,175	0	0	0	16,160	418,357	5,425,692
Tobacco Settlement Trust Fund	62,211	0	0	581,425	750,000	16,024	1,409,660
Operations and Maintenance Trust Fund	0	0	0	4,366,668	13,354	0	4,380,022
Social Services Block Grant Trust Fund	4,112,881	0	0	0	0	393,941	4,506,822
Total	**$26,416,022**	**$2,219,860**	**$2,724,866**	**$7,194,712**	**$1,023,137**	**$2,239,933**	**$41,818,530**

Source: Department of Children and Families.

Program resources

For Fiscal Year 2002-03, the Legislature appropriated $41.8 million to the Adult Services Program and authorized 605 full-time equivalent (FTE) positions. The Adult Services Program receives funding from several sources, of which the largest single source (62%) is general revenue. Exhibit 1 shows the sources of program funding for Fiscal Year 2002-03.

Findings

The program has been timely in commencing investigations but not in closing them, resulting in case backlogs

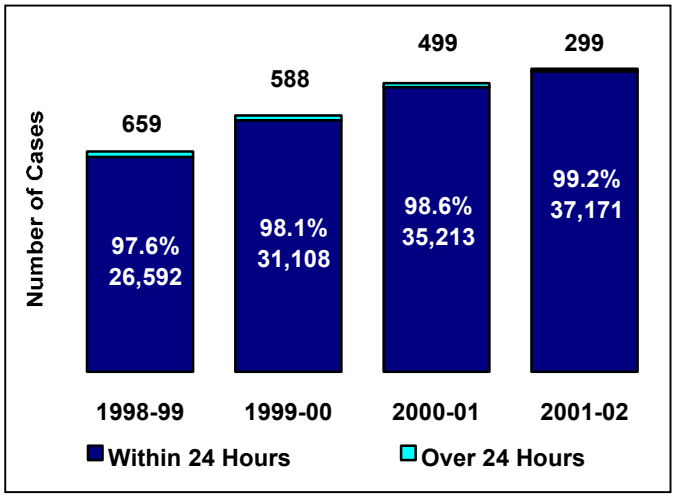
As expressed in ss. 415.104(1) and 415.104(4), *Florida Statutes*, the department is mandated to commence all adult protective investigations within 24 hours and close all investigations within 60 days. Because a vulnerable adult's safety may be at risk, it is important that protective investigations be initiated quickly to assess the situation and begin services to prevent further harm. Before a case is closed, the program must ensure that certain minimum requirements have been met, such as whether there is any indication that the vulnerable adult has been abused, neglected, or exploited; whether the vulnerable adult is at risk of further harm; and whether the alleged victim is in need of further services. Investigations must be closed expeditiously to enable investigators to maintain manageable caseloads as they are assigned new investigations.

In the past four fiscal years, the program has substantially met the Legislature's timeliness goals for initiating cases, but not closing cases. Florida law requires that the program, upon receipt of a report alleging abuse, neglect, or exploitation of a vulnerable adult, begin within 24 hours a protective investigation of the alleged facts.[10] As shown in Exhibit 2, the program has consistently initiated 98% or more of its investigations within 24 hours. For example, in Fiscal Year 2001-02, the program commenced 99.2% of the 37,470 initial reports within 24 hours. This level of performance is commendable, because the number of reports commenced increased by 37.5% (from 27,251 in 1998-99 to 37,470 in 2001-02) while the number of FTE positions assigned to conduct adult protective investigations increased by 10.8% (from 190.5 in 1998-99 to 211 in 2001-02) during the past four years.

[10] Section 415.104(1), *F.S.*

The program does not electronically track data on reasons why it does not meet the timeliness goal in some cases. Program officials cited factors, including workload, the time needed to travel to the alleged victims' homes (particularly in rural areas), and employees failing to accurately enter case initiation dates into the computer system, as reasons why some investigations are not initiated within the 24-hour time period.

Exhibit 2
Program Has Substantially Met the Statutory Goal of Initiating Adult Protective Investigations Within 24 Hours [1]



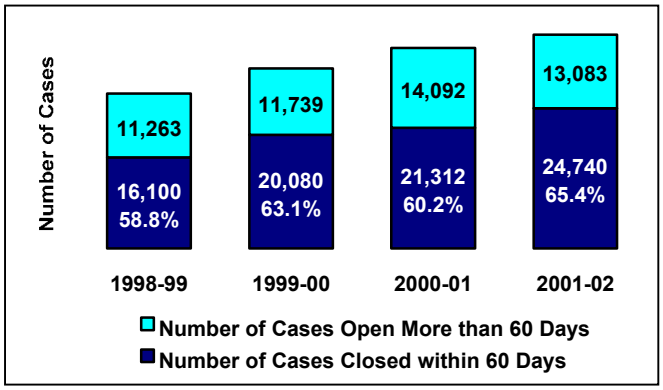
[1] Commencement date and time are recorded in the Florida Abuse Hotline Information System (FAHIS) only for the initial report.

Source: Department of Children and Families.

However, the program has not met its statutory goal of closing all cases within 60 days. [11] As shown in Exhibit 3, the program closed only 65.4% of the 37,823 adult protective investigations completed in Fiscal Year 2001-02 within 60 days. This is an improvement over the prior year's performance when only 60.2% of the 35,404 adult protective investigations were closed within 60 days.

[11] Section 415.104(4), *F.S.*

Exhibit 3
Although Performance Has Improved, the Program Has Not Met Its Goal to Close All Investigations within 60 Days

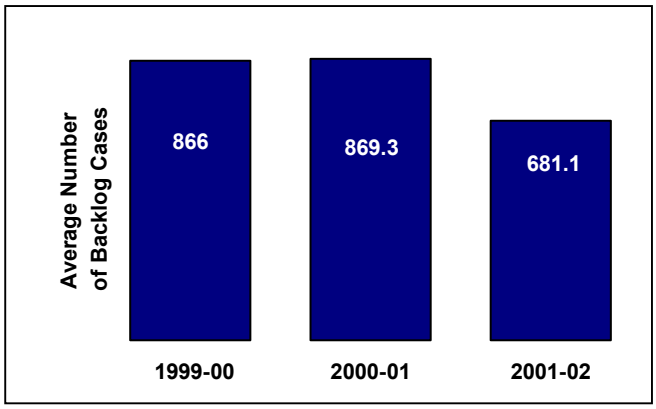


Source: Department of Children and Families.

Not closing all cases in a timely manner increased workloads and contributed to case backlogs. As shown in Exhibit 4, the program has reduced the average number of backlogged cases per month over the last three fiscal years, but this backlog remains substantial. Between Fiscal Years 2000-01 and 2001-02, the program reduced its average monthly backlog by 21.4%. However, during Fiscal Year 2001-02, the program had an average monthly backlog of 681.1 cases, representing 19.6% of the average monthly caseload. [12] Program officials said this improved performance is due to districts implementing plans to monitor active investigations and ensuring more timely completion of investigations, such as conducting weekly reviews of open cases with unit staff to determine the status of investigations. According to program officials, vacancies and employees being on leave have contributed to their inability to significantly reduce the backlog.

[12] Average monthly caseload for Fiscal Year 2001-02 was 3,464.8.

Exhibit 4
Program Performance in Reducing Average Number of Backlog Cases Per Month Improved During Fiscal Year 2001-02

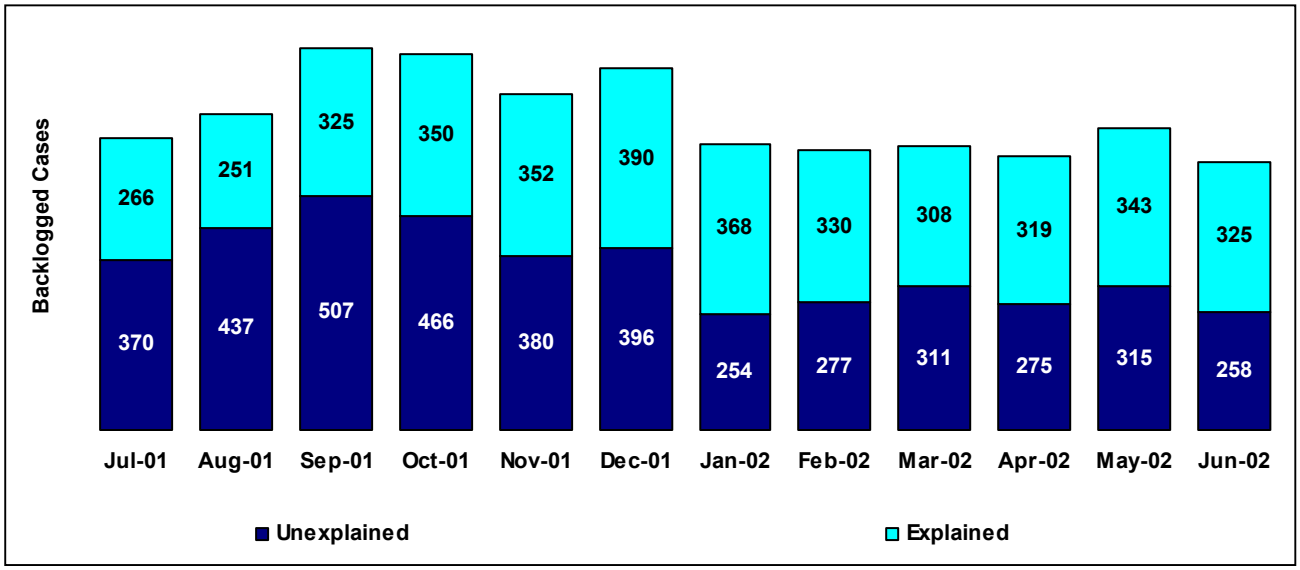


Source: OPPAGA analysis of Department of Children and Families data.

Although some investigations remain open for reasons beyond the investigator's control, the program does not have complete information on reasons why investigations are kept open for longer than 60 days. In some cases, investigations may remain open for valid reasons, such as when an investigator is waiting for evidence like financial records in an exploitation case. Investigations also can remain open when the investigator receives an additional report from the hotline adding additional victims, possible responsible persons, or additional maltreatments to the initial report. Of the 8,173 cases that were not closed within 60 days during Fiscal Year 2001-02, valid reasons were given for only 48.1% of them. These reasons included 2,433 (29.8%) investigations remaining open because the investigator was waiting on additional evidence to complete the investigation and 642 (7.9%) investigations remaining open because an additional report had been received from the hotline. [13] However, in over half of the cases, investigators did not provide reasons for delays in case closures (see Exhibit 5).

[13] There were also 273 (3.3%) investigations open due to court actions; 245 (3.0%) investigations remained open because the investigator was waiting for pertinent medical information; 168 (2.1%) remained open because an essential collateral witness could not be interviewed; and 166 (2.0%) remained open at the request of law enforcement.

Exhibit 5
Over Half of Backlogged Cases Had No Reason Listed for Closure Delays During Fiscal Year 2001-02



Source: Department of Children and Families.

Program officials said that they are working to address backlog, caseloads, and other staffing issues. For example, program officials recently began presenting caseload, backlog, and vacancy rates when briefing the department secretary each month. In addition, the department's Fiscal Year 2003-04 Legislative Budget Request seeks funding for 89 additional protective investigators and 15 additional protective investigator supervisors in order to reduce caseloads. Program officials also said they recently implemented a new process in District 9 for prioritizing new and backlogged investigations. These procedures are aimed at assisting protective investigators and supervisors to complete their work in a more efficient manner.[14] The program plans to implement the prioritization process in other districts that have more than 50 backlogged cases.

Although the program has had some success in managing the number of backlogged cases during the last fiscal year, we recommend additional actions the program should take to reduce case backlog. We recommend that the program continue to focus its efforts to ensure that cases are closed within 60 days, to document reasons for closure delays for all cases open for more than 60 days, and to identify and implement best practices for backlog reduction.

Program could further improve the efficiency and effectiveness of services to disabled adults

The primary purpose of in-home services is to help disabled adults remain in private homes as an alternative to institutional or nursing home care. This is important because it is much less costly to provide clients with in-home services ($1,500-$6,975 annually) than to provide them with care in a publicly supported nursing home ($42,847 per year).[15, 16]

The program should take two actions to improve its efficiency and effectiveness in serving disabled adults.

- Establish a uniform waiting list priority and funding allocation system that ensures that disabled adults at the greatest risk of institutionalization are served first within existing resources.
- Move 233 general revenue clients to the Medicaid Waiver Program to save at least $319,000 in state general revenue.

The program lacks an effective system for serving the highest risk disabled adults. To ensure disabled adults at the greatest risk of nursing home placement receive priority for in-home services, the program needs a uniform statewide needs assessment and a funding allocation system that ensures individuals at the highest risk are served first when a vacancy occurs. The first step in a uniform needs assessment is to screen and prioritize disabled adults on a waiting list based upon the immediacy of their needs and risk of nursing home placement, taking into account factors, such as the presence of an able caregiver, the disabled adult's ability to complete activities of daily living (e.g., bathing, walking, and eating) and instrumental activities of daily living (e.g., taking medication, doing household chores, and using the phone) and the disabled adult's income and overall health. When a slot becomes open, the individual on the waiting list with the highest need should receive a full needs assessment and be served first, regardless of where he or she lives. The allocation mechanism should allocate funds to districts based upon which ones have the highest risk disabled adults.

However, our review determined that the program lacks both a uniform screening and prioritization process and an effective funding allocation mechanism, which has resulted in

[14] According to program documentation, reports received from the hotline as well as open cases will be assigned to a priority level based on the allegation narrative received from the hotline. Those representing an immediate risk of danger or harm to the victim are given highest priority. Highest priority reports are those that contain allegations, such as physical, sexual, or medical abuse or neglect, including bruises, cuts, burns, bone fractures, sexual abuse, malnutrition, and poisoning.

[15] We do not include the Cystic Fibrosis Program in our discussion of in-home services, because clients are not at high risk of nursing home placement.

[16] The average care plan changes depending upon the program for which the client is enrolled. Direct average costs for care for Home Care for Disabled Adults, Community Care for Disabled Adults, and Medicaid waiver are $1,492, $2,645, and $6,972, respectively. These figures exclude the department's case management costs, which the department was unable to estimate for all districts.

delaying services to disabled adults with the greatest risk of nursing home placement. Districts use various instruments to screen and prioritize disabled adults, and three districts do not use any screening instrument for certain program components, resulting in both inefficiencies and ineffectiveness in serving disabled adults. The department client services manual requires the program to prioritize disabled adults on waiting lists based upon a screening score, but only seven districts and part of the SunCoast Region use an instrument that gives a priority score, and even this instrument needs improvement. These districts use a screening instrument designed by the Department of Elder Affairs, and while the instrument gives a priority score, program officials say the elder screening instrument needs to be modified for disabled adults. Four districts screen disabled adults based on forms that do not give priority scores. As a result, case managers try to determine which potential client is most at-risk by examining all assessments each time a vacancy occurs. This method is both inefficient and ineffective since it requires increased staff time to re-examine all assessments and does not objectively weigh specific criteria used to determine who should be served next. Finally, two districts and part of the SunCoast Region do not use any screening instrument when signing up disabled adults for certain program components. [17] Instead, they serve clients based on a first come, first serve basis, so those who are at the greatest risk of nursing home placement are served first only if they have been waiting for services the longest. Consequently, by not uniformly screening potential clients, services to the highest priority disabled adults are delayed.

In addition to the districts' use of various screening instruments, they implement various waiting list procedures, resulting in the program possibly serving lower priority clients ahead of more needy individuals. Nine districts have more than one waiting list for each program component, dividing up waiting lists geographically. With more than one waiting list, districts make it possible for a disabled adult who is more at-risk in one part of the district to get served later than a disabled adult in another part of the district because of where the slot opens. Also, while most districts periodically re-screen disabled adults on waiting lists to see if their needs and priority have changed, four districts do not re-screen at all. [18] The lack of re-screening potential clients results in the program sometimes being unaware of a disabled adult whose health has deteriorated and is in more need of services. These differences make up an ineffective statewide system to place and maintain disabled adults on the program's waiting list.

The method for allocating funding to districts also does not ensure that higher priority disabled adults are served first. Because the program does not have a uniform screening process to prioritize potential clients and program funding has not changed in several years, the program allocates funds to districts based upon historical funding levels rather than need. Thus, some districts can serve lower priority disabled adults because they have funds available to serve them, while other districts cannot serve higher priority disabled adults because they do not have available funds. We identified 48 clients in District 10 who were served during Fiscal Year 2001-02 although they had lower priority scores than at least 178 disabled adults on waiting lists in other districts that use the same screening instrument. [19, 20] This occurred because District 10 had available funds to serve the clients, while the other districts did not have available funds. The 178 higher priority disabled adults had been waiting for services for an average of over 16 months (see Exhibit 6).

[17] District 1 serves clients based on a first come, first serve basis for both Community Care for Disabled Adults and Home Care for Disabled Adults programs. District 14 and part of the SunCoast Region (formerly District 6) use this method to serve clients in only the Home Care for Disabled Adults Program.

[18] Re-screening includes contacting the disabled adult to see if his/her needs have changed and if he/she is still interested in waiting for services. If the needs have changed, the case manager re-assesses the disabled adult and places the individual higher or lower on the waiting list.

[19] The number of clients could have been higher than 178, but we did not receive priority scores of all disabled adults on waiting lists in the SunCoast Region and District 8.

[20] Priority was based upon scores calculated by the Department of Elder Affairs Telephone Screening Form 111 Part V. Scores range from 1-35, and any client with a score of at least 16 is considered high-risk. District 10 served 48 clients with a score between 16 and 24, while the six other districts had at least 178 disabled adults on waiting lists that had a score of 25 or above.

Exhibit 6
As of June 2002, Districts Using the Same Screening Instrument Had Highest Priority Disabled Adults Waiting for Community Care for Disabled Adults or Medicaid Waiver Services an Average of 487 Days

District/Region	Unduplicated Number of Disabled Adults Waiting for Services	Number of Highest Priority Disabled Adults (With a Score of 25 or Higher) Waiting for Services	Average Priority Score of Highest Priority Disabled Adults	Average Days the Highest Priority Disabled Adults Have Been Waiting for Services
District 3	27	5	29	72
District 4	235	20	27	301
SunCoast Region	873	84	28	616
District 8	84	35	28	513
District 10	139	7[1]	30	28
District 12	128	7	27	181
District 15	216	27	29	466
Total	**1,702**	**185**	**28**	**487**

[1] District 10 added seven highest priority disabled adults to the waiting list near the end of the fiscal year. All seven disabled adults were not on the waiting list when it served the 48 clients who were lower priority.

Source: OPPAGA analysis of Department of Children and Families data.

The program has begun addressing the problems with its waiting list assessment and prioritization process, but not its allocation methodology. The program is developing a waiting list prioritization form that it planned to have ready for statewide implementation by March 2003. Program officials believe that this form will enable employees to screen and prioritize clients uniformly based on need.[21] The program also is working with its legal counsel to develop program waiting lists that are consistent statewide so that disabled adults with the highest priority will be served first.[22] In addition, the program is in the process of updating its policies and procedures for in-home services to replace its outdated 1986 client services manual.[23] These updates will help district employees administer the in-home services programs more uniformly.

To maximize limited resources and fulfill its mission to keep disabled adults out of nursing home care, the program should serve disabled adults who are at greatest risk of nursing home placement. Therefore, we recommend that the program establish and implement a uniform statewide intake screening assessment, a prioritization mechanism that ensures individuals with the highest risk of nursing home placement are served first, and an allocation system based on priority need rather than historical levels.

Specifically, the program should take two actions.

- Create policies and procedures for a statewide waiting list prioritization process by the end of Fiscal Year 2002-03. These policies and procedures should include instructions on how to implement the prioritization form, require districts to re-screen disabled adults on waiting lists at least annually, and clarify how each district should maintain its program waiting list geographically.
- Develop a statewide funding allocation method that provides for ready transfer of funds among districts to ensure that clients who are at greatest risk of nursing home

[21] The form will screen disabled adults waiting for Home Care for Disabled Adults, Community Care for Disabled Adults, and Medicaid waiver components.

[22] The program is also working with the Agency for Health Care Administration and Department of Elder Affairs regarding the Medicaid waiver waiting list policies.

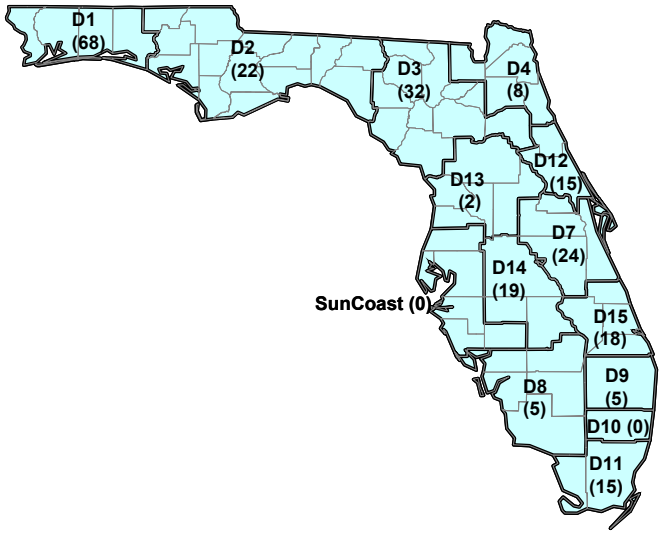
[23] The Home Care for Disabled Adults operating procedure and the Community Care for Disabled Adults operating procedure and manual will be completed by June 2003.

placement are served regardless of their location.

The program could save at least $319,000 in state general revenue funds by moving clients to the Medicaid waiver. Program clients may be served through a variety of components, some of which are relatively less expensive for the state. Clients who are served through the Community Care for Disabled Adults component are funded entirely with state general revenue, while clients served in the Medicaid waiver component are funded in part through federal grants. To the extent possible, the program should seek to maximize its use of federal funds and thus minimize its use of state general revenue.

With the assistance of program staff, we identified 233 clients who are currently funded through general revenue who could likely be served through the Medicaid waiver at a lower cost to the state (see Exhibit 7).[24,25] These clients are currently served through the program's Community Care for Disabled Adults component because the program allocates each district a specific amount of funding for its Community Care for Disabled Adults, Home Care for Disabled Adults, and Medicaid waiver services, and the central office has instructed districts not to transfer funds, but to spend down each service category as closely as possible without overspending.[26] Consequently, districts have had little incentive to transfer clients between programs although this would produce cost savings for the state.

Exhibit 7
233 Disabled Adult Clients Are Likely Eligible for the Medicaid Waiver Program in the Districts



Source: Department of Children and Families.

District estimates show that transferring these clients to the Medicaid waiver would produce a general revenue savings of approximately $319,000. Because Medicaid waiver clients typically receive more services than Community Care for Disabled Adults clients, we asked each district to estimate the cost to serve these clients on the Medicaid waiver. Currently, these clients are funded with an estimated $917,584 in state general revenue. Serving these clients through the Medicaid waiver would require funding of an estimated $1,452,664. However, the federal government provides 58.83% of the Medicaid waiver funding. Thus, state match funding for these clients would be an estimated $598,062, resulting in a savings to the state of $319,522.

The Legislature could use these funds for other purposes or reinvest them in the program, which would enable it to serve an estimated 115 additional disabled adults and help them stay in

[24] We asked each district's case managers to evaluate their clients and determine how many of their Community Care for Disabled Adults clients are likely to be eligible for the Medicaid waiver. While the clients have not completed the formal eligibility determination process, their case managers, who are familiar with the eligibility criteria, identified 233 clients likely to be eligible for the program.

[25] To be eligible for the Medicaid Waiver Program, a client must be certified as being at risk of nursing home placement by CARES (Nursing Home Preadmission Screening Program) and meet Medicaid financial eligibility, as determined by the Department of Children and Families.

[26] According to s. 216.292(3)(a), *F.S.*, districts can transfer up to 5% of their funds from one funding category to another each year. However, these transfers are not permanent, and funds revert back to their original allocations the following year. Thus, the districts do not move Community Care for Disabled Adults clients to Medicaid waiver, since the cost of their care plans is an annual expense and would require the districts to make yearly transfers.

their own homes and prevent their entrance into nursing homes. [27]

While program officials agree that moving clients to the Medicaid waiver benefits both the client and the program, they expressed two concerns. First, they were concerned that it could be more difficult to control the costs of care under the Medicaid waiver than the Community Care for Disabled Adults component. The care needed by clients tends to increase over time as their health deteriorates. Under the Medicaid waiver, the program must meet all of the clients' needs while the program can more readily limit the amount of services given to clients in the Community Care for Disabled Adults component based upon budget constraints. While we acknowledge this concern, the program has served about the same number of Medicaid waiver clients over the last two fiscal years with the same amount of funding. [28] Thus, the program appears to be controlling costs reasonably well. Second, they noted that some districts may lack the needed Medicaid providers to serve the clients, particularly in rural areas. We agree that Districts 1 and 3 do not currently use Medicaid providers in certain areas, but only 12 of their 100 Medicaid-probable clients live in these areas and may have difficulty moving to the waiver. In addition, Department of Elder Affairs currently uses Medicaid providers in these areas, and we believe the district program administrators could work with the Department of Elder Affairs to recruit these providers to serve disabled adults as more clients are moved to the Medicaid waiver.

To address these concerns and ensure that the optimal number of clients at the highest risk of nursing home placement receives adequate services to keep them from being institutionalized, we recommend that the program take the actions discussed below.

- The program should work with each district to determine how much of a district's general revenue and how many of its clients should be moved from Community Care for Disabled Adults to the Medicaid Waiver Program. Then, the program should submit a budget amendment to the Legislative Budget Commission so that these funds and the specified clients (once they are deemed eligible for the waiver) can be moved from Community Care for Disabled Adults to the Medicaid Waiver Program.
- The program should develop a mechanism to control the cost of Medicaid waiver clients' care plans. One way the program could do this is to cap per-client spending based on level of need and develop a plan for limiting per-client spending. The program could also work with Department of Elder Affairs to ensure that provider rates for Medicaid are similar to the rates for general revenue programs.
- The program should continue to work with the Department of Elder Affairs to recruit Medicaid providers, so that all disabled adults eligible for the Medicaid Waiver Program can be served in the waiver as funding becomes available.

Improvements needed in the program's accountability system

A strong accountability system is critical for the Adult Services Program because its service delivery system is multi-layered and many of its services (particularly in-home services) are delivered through private providers. [29] A good accountability system provides quality information to help policymakers and program managers ensure that public monies are spent to

[27] As of June 2002, there were over 4,000 disabled adults on the program's waiting list for Community Care for Disabled Adults or Medicaid waiver services. If the program used all the general revenue to serve more Medicaid waiver clients, it could draw down an additional $450,000 in federal matching funds.

[28] At the beginning of Fiscal Year 2000-01, the program was serving 1,063 Medicaid waiver clients. At the end of Fiscal Year 2001-02, the program was serving 1,032 Medicaid waiver clients, a 2.9% decrease for the two-year period.

[29] Depending upon the district, the program delivery system consists of as many as four layers, with the central office overseeing the district offices; district offices supervising their own workers in unit offices and contracted provider agencies for certain in-home services; and provider agencies responsible for managing sub-contracts with other providers.

achieve desired outcomes and to improve public services. The program also must have effective monitoring and oversight mechanisms to ensure that effective services are delivered that protect vulnerable adults and enable disabled adults to remain in the community.

We identified deficiencies with the accountability system that hinder legislative and department oversight responsibilities.

- Weaknesses with the department's Client Information System hinder the program's ability to make available basic information, such as the number of clients receiving some specific program services, and to present the Legislature and other policymakers with reliable performance data.
- Continuing problems with the accuracy of data on the number of elder abuse referrals made to the Department of Elder Affairs impede program accountability and effectiveness.
- Ineffective monitoring and oversight of program services diminish program effectiveness.

Unreliable performance data impedes effective program management and accountability. Historically, the program's accountability system has been insufficient to ensure quality information. As addressed in a 2001 OPPAGA report, the program operates without basic information, such as the number of clients receiving specific program services, due to problems with the department's Client Information System (CIS).[30] Our current evaluation found that output data collected manually for the in-home services components is also inaccurate because it counts the same client more than once. Without accurate CIS and manual output data, the program cannot accurately report performance on its two key legislative outcome measures.[31] These measures provide information regarding the program's ability to protect clients from re-abuse and prevent clients from being placed in nursing homes. The unreliable data is problematic, because it impedes the program's ability to report the number of clients receiving services, assess the effect of program services, efficiently manage the program, and be accountable to stakeholders. The program is acting to address problems with CIS, but its efforts have been insufficient to ensure quality information. In addition, these efforts may be inefficient, because the department is essentially phasing out CIS.

For several years, the program has reported inaccurate data for its two key legislative outcome measures due to problems with its output data, which is necessary to calculate the measures. The in-home services outcome measure uses two output counts: the number of in-home services clients and nursing home placements. The protective services measure includes the number of protective supervision cases in its calculations.[32]

Program output counts are unreliable, rendering the outcome measures unreliable. The program manually collects the number of in-home services clients, but it counts some clients more than once because they either receive more than one program service component or switch to another component during the year. For example, District 10 reported serving 578 disabled adult clients in its in-home services components in Fiscal Year 2001-02, when it actually served 452 unduplicated disabled adult clients, an over-count of 27.9%. We also found inaccuracies with the nursing home placements count due to the use of inaccurate Client Information System data. In 12 districts that manually count nursing home placements, CIS showed 44 nursing home placements, while

[30] *DCF's Adult Services Program Meeting Goals: Data Reliability, Case Management Need Work,* Report No. 01-08.

[31] The key legislative performance measures are percentage of protective supervision cases in which no report alleging abuse, neglect, or exploitation is received while the case is open (from beginning of protective supervision for a maximum of one year) and percentage of adults with disabilities receiving services who are not placed in a nursing home.

[32] Adult protective supervision includes services arranged for or implemented by the department to protect vulnerable adults from further occurrences of abuse, neglect, or exploitation. The supervision involves personal contact with all victims as often as necessary to ensure the victims' continued safety.

the manual count reported 58. Finally, the protective supervision output is inaccurate, because program officials noted that the data comes from CIS, and district employees do not always terminate the client record in the system once the client is no longer receiving services. These data problems hinder the program's ability to accurately calculate outcome measures and provide accurate output data to the Legislature and other policymakers.

The program has addressed some data reliability problems, but these initiatives have not yet proven successful. In July 2002, the program began correcting CIS data to enable more accurate information to be reported in the future. District employees matched active client files with CIS data to correct inaccuracies. In September 2002, the central office also began sending bi-weekly CIS data reports to the districts for the purpose of matching the number of current in-home services clients with their manual counts. Finally, program officials said they and/or the department inspector general would conduct audits of CIS records by comparing random manual files to the CIS data at least once a year. They believe these changes will ensure that CIS data integrity is maintained. However, the tracking and reporting of data manually and electronically is inefficient, and the program has not yet conducted an evaluation of the data to determine whether the changes have resulted in accurate and reliable CIS data.

As the program continues to reconcile data problems in CIS, it also needs to address its overall information system needs. The department is essentially phasing out CIS, its client registration and services tracking system, and the Florida Abuse Hotline Information System (FAHIS), its abuse investigation tracking system, both of which are also used by the child protection program. The Adult Services Program will bear almost all of the cost of CIS and FAHIS, since the child protection program is moving to its new information system, HomeSafenet. [33] For the last 15 years, the program has relied upon CIS and FAHIS to provide performance data and basic client demographics. However, the systems have become increasingly outdated and more difficult to use. While the program has recommended that it transition to HomeSafenet, the department has not made a decision as to how it will address the program's information system needs as of December. As shown in Exhibit 8, we identify two options the department can implement: either maintain its current information systems and correct deficiencies in CIS, or make plans to move to HomeSafenet.

Option 1 - Maintain the Current Systems

The program can maintain its information systems and correct deficiencies in CIS. This option has the advantage that workers are familiar with the systems and would not have to receive additional training. In addition, the program has worked to clean the CIS data, and program officials believe data in CIS is now accurate. However, there are several disadvantages. First, the program will bear the majority of the cost to maintain CIS and FAHIS once the child protection program completes its data transition to HomeSafenet. Program officials estimate that it would cost between $1.8 million and $2.0 million a year to maintain and operate its information systems. This represents more than a 100% increase from the $800,000 it currently costs the program to maintain the information systems. A second disadvantage is that the program would need to correct deficiencies within CIS, including fixing routine reports used to manage the program and adding codes to the system so that program management can use other vital information. For example, CIS has not been changed to reflect the department's SunCoast Region and is therefore still calculating data based on the former district configuration. In addition, CIS does not contain codes for client income and new programs like Cystic Fibrosis and Consumer Directed Care. Further, with advancing technology, CIS and FAHIS do not interface well with other information systems and will become more difficult and expensive to maintain.

[33] HomeSafenet is Florida's child welfare and client management information system.

Exhibit 8
Program Officials Estimate Cost to Maintain Information Systems May Increase More Than 100%

Options	Advantages	Disadvantages
1 Maintain Current System	▪ Program employees are familiar with the systems. ▪ The program has worked to clean data in CIS, and officials believe that data in CIS is now accurate.	▪ Program officials estimate it will cost the program $1.8 to $2.0 million to maintain its information systems once child protection moves to HomeSafenet, an increase of more than 100% above current cost. ▪ The program needs to correct current deficiencies in CIS, such as routine reporting capabilities and adding additional client codes, for management purposes. ▪ With advancing technology, the systems will be more difficult and expensive to fix and will not interface well with newer computer systems.
2 Move to HomeSafenet	▪ The department will not have to fund three separate information systems, which perform similar functions. ▪ The program can utilize state-of-the-art data technology to replace an older information system.	▪ The department will need to make some modifications to HomeSafenet in order to meet the program's needs.

Source: OPPAGA.

Option 2 - Move to HomeSafenet

The program can move into HomeSafenet, the new information system the department is developing to replace older information systems used by the child protection program, including CIS and FAHIS. The primary advantage of this option is that the program can benefit from the state investment in HomeSafenet and use the new system's state-of-the-art data technology to replace older information systems. This would avoid the need for the department to fund multiple information systems, which have similar functions. It also would provide electronic management tools, better information storage, and the automation of forms. One disadvantage is that the department would need to make some modifications to HomeSafenet in order to meet the program's needs. In October 2002, the department began a partnership with the State Technology Office to improve and integrate technology services, including HomeSafenet. The two agencies are providing new technical direction for the system. The Adult Services Program is awaiting a decision from the department and the State Technology Office for inclusion of Adult Services into HomeSafenet.

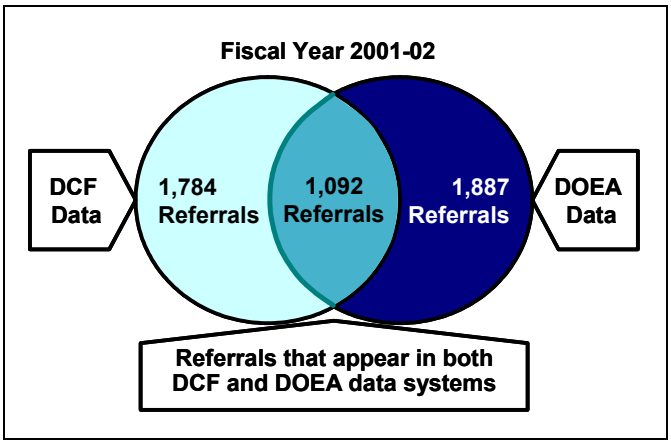
We recommend that the department and the program take the actions which follow in order to address data reliability problems and information system needs. In accordance with s. 20.055(2)(b), *Florida Statutes*, the department inspector general should assess the reliability and validity of the program's CIS data. If the data is valid and reliable, the program should report fiscal year-to-date program performance for its two key outcome measures and the number of unduplicated clients served in all program components to the 2003 Legislature. If the data is not valid and reliable, the program should present to the 2003 Legislature its plan to correct data deficiencies. We also recommend that the program assess the feasibility of implementing the two information system options we identified by working with the State Technology Office and conduct a formal cost-benefit analysis. If the program determines moving to HomeSafenet is prudent, they should work with the State Technology Office to develop a transition plan for consideration by the 2003 Legislature.

Elder abuse referral data continues to be inaccurate. Department of Children and Families (DCF) and Department of Elder Affairs (DOEA) are both charged with protecting high-risk elder

victims of abuse, neglect, or exploitation. Thus, it is essential that the two agencies coordinate efforts to ensure that victims are provided services quickly and protected from further harm. Due to concerns about some elder victims not being served in a timely manner, the 1998 Legislature amended state law to require DCF to refer to DOEA all elder victims of neglect not caused by a second party who need services.[34] The law also requires that DOEA serve referrals from DCF who need immediate services to prevent further harm within 72 hours (three days) or according to local protocols developed between DCF and DOEA.[35] Both departments have taken steps to improve the referral process by entering into an interagency agency agreement and implementing local level protocols between DCF districts and DOEA planning and service areas. Program officials said these steps have improved communication between the two agencies and they are continuing to work together to address data discrepancy problems.

However, data problems remain. In our January 2001 report, we found substantial differences between what the program and DOEA reported were the number of elder abuse clients referred to DOEA during Fiscal Year 1999-2000.[36] As shown in Exhibit 9, for Fiscal Year 2001-02, DCF data show that 1,784 referrals were made to DOEA, while DOEA data show that 1,887 referrals were received. Only 1,092 (42.3%) referrals were common to both departments' information systems. While this is a slight improvement since our previous report, data faults persist.

Exhibit 9
Data on Number of Referrals Not Reconciled Between Departments' Data Systems



Source: OPPAGA analysis of DOEA data.

Since our prior report, the program has taken several actions to improve the accuracy of its elder abuse referral data, but these actions have not resolved the data discrepancy problems. First, DCF and lead agency employees have been given access, via the DOEA website, to reports that aid in the reconciliation of referral data. The reports list the referrals made in one system that do not have a match in the other system. Each month employees identify referral differences and correct them in the appropriate information system.[37] Second, beginning in May 2002, program officials said that protective investigators were required to make sure DOEA referral codes were the final disposition in the system regardless of any subsequent action in the investigation. In the past, protective investigators would denote the referral of high-risk elders in their information system, but could later change the referral code as subsequent actions took place during the protective investigation. As a result, the program's information system would have no record that a referral was made to DOEA.

[34] Section 415.105, *F.S.*

[35] Section 430.205(5), *F.S.*

[36] *High Risk Elder Victims of Abuse, Neglect, or Exploitation Quickly Served; Data Problems Remain,* Report No. 01-04.

[37] DOEA Area Agencies on Aging contract with lead agencies to provide Community Care for the Elderly case management, as well as other services. Lead agencies offer services, such as homemaker services, home health aides, respite care, and personal care, either directly or through subcontracts with providers.

Program officials said that they worked to resolve this problem during April through June 2002 and reported a reduction in the data discrepancies beginning with July 2002. For the first quarter of Fiscal Year 2002-03, DCF data show that 723 referrals were made to DOEA, DOEA data show that 710 referrals were received, and 567 (65.5%) referrals were common to both departments' information systems. While this is an improvement, data discrepancies remain.

We recommend that both departments continue their work to resolve data discrepancies and report to the Legislature through the legislative budget process the number of high-risk referrals made by DCF, the number of high-risk referrals received by DOEA and the number of referrals common to both departments' information systems for Fiscal Year 2002-03.

Ineffective monitoring and oversight system diminishes program effectiveness. Effective monitoring and oversight is essential to help ensure quality services are delivered to protect vulnerable adults from further harm and enable disabled adults to remain in the community. A good monitoring and oversight system should give program managers detailed information on the adherence to policies and procedures so that program managers can identify and correct problems to improve program services. Effective oversight should provide sufficient policies and procedures to govern the implementation of program services.

We identified two deficiencies with the program's monitoring and oversight system.

- The central office has not provided systematic and routine monitoring of district units responsible for delivering services for several years to ensure that effective and quality services are provided, although it is beginning to take steps to provide more oversight of district operations.
- The program has not provided adequate policy guidance to district employees and providers regarding the use of purchase orders and vouchers to procure client services to ensure that services are purchased appropriately.

The central office has not conducted systematic and routine monitoring for the protective investigation program in over 3 years and the in-home services program in 10 years. The central office is responsible for establishing specific standards that define acceptable levels of program performance and for monitoring district operations to ensure that services are being provided in accordance with those standards and program policies. Lack of monitoring is problematic because the central office may be unaware of existing problems in the districts. Such problems have been detected by special reviews that the central office has conducted of some districts. For example, the central office conducted special quality assurance monitoring reviews of three districts in the past three years (District 8 in February 1999, District 7 in March 2000, and District 9 in May 2002). Each review identified problems with investigators' assessments of capacity to consent and supervisors not reviewing cases in accordance with procedures. [38] In addition, the District 7 and District 9 reviews found that protective investigators were not closing some cases appropriately. While the central office responded to the specific problems found in these cases by providing additional training to district employees, it has little assurance that such problems do not exist in other districts. Program officials cited other priorities and travel constraints as reasons why routine monitoring has not been conducted.

The program is developing procedures and a monitoring validation instrument that will allow the central office to validate districts' monitoring results. [39] This monitoring instrument will help the central office review a sample of cases

[38] "Capacity to consent" means that a vulnerable adult has sufficient understanding to make and communicate responsible decisions regarding his or her person or property, including whether or not to accept protective services offered by the department.

[39] In accordance with program policies, district employees conduct semi-annual monitoring of their local programs.

previously monitored by district staff to ensure adherence to policy and to ensure that the monitoring at the district level is conducted appropriately. The program plans to implement the monitoring validation instrument by January 2003. This plan of action is reasonable, given the limited number of employees available to travel to each district to conduct monitoring.

The program also has not developed a policy and procedures to govern the use of purchase orders and vouchers when procuring client services. This is important to ensure adherence to established standards. In the absence of guidance from the central office, districts have implemented varied practices when using these procurement methods. This is problematic because the absence of standardized practices limits the program's assurance that the districts are using cost-effective procurement processes. For example, since there are no minimal criteria for provider selection, district staff selects providers based on different criteria. Depending on the district, these criteria include which provider has the best service price, whether the provider is a licensed DOEA provider, and whether clients have knowledge of an available provider. In addition, only the SunCoast Region reported it was in compliance with departmental procedures that require performance measures to be included in purchase orders for client services. Without a formal policy and procedures, the program has no standards by which to oversee these purchases effectively to ensure that the state is using resources appropriately.

The program is developing and implementing a policy and procedures to govern off-contract purchases of client services. This policy will provide guidance to program employees in the procurement of client services via purchase order and voucher, thereby increasing accountability through the standardization of processes. The program plans to implement this purchase order and voucher policy by March 2003.

While these actions will help to correct the monitoring and procurement deficiencies, additional steps should be taken. For example, the program could implement Internet surveys or in-service training modules, such as videoconference training, to guide and test the district staff's interpretation of policies and procedures. Further, the program's new policy and procedures governing client services procured with purchase orders and vouchers will include guidelines outlining when each purchasing mechanism is appropriate for use and systematic methods for authorizing payments for services. These actions will improve the program's monitoring and oversight system.

The program has not implemented provisions required by Florida law

The program has failed to implement two requirements of state law.

- The program has not yet implemented working agreements with law enforcement agencies more than two years after the Legislature established this requirement.
- The program has not assessed or charged fees for Community Care for Disabled Adult clients who are eligible to pay for services, although such a system would likely not be cost-effective.

The program has not implemented working agreements with law enforcement. The 2000 Legislature mandated the program to establish working agreements with the jurisdictionally responsible county sheriff's office or local police department that will be the lead agency when conducting any criminal investigation arising from an allegation of abuse, neglect, or exploitation of a vulnerable adult.[40, 41] These agreements are intended to facilitate standard, consistent, and thorough investigations through improved cooperation, communication, and sharing of information during the investigative process.

[40] Section 415.1045(6), *F.S.*

[41] As expressed in s. 39.306, *F.S.,* Florida's child protection program has been required to establish working agreements with law enforcement since 1998; however, according to program documents only one-quarter of these agreements had been established as of October 2002.

While counties in 10 districts have agreements, most of the state does not have working agreements in place more than two years after the law was passed. As of January 2003, the department reported that it had executed 129 local working agreements with law enforcement agencies, including 30 of 66 county sheriffs' offices. However, 210 agreements are still in negotiation, and four districts have not yet established working agreements with any local law enforcement.

A primary reason for this slow progress is that in March 2001, the central office instructed the district offices to wait until a statewide model agreement was developed before proceeding. Central office staff and department legal staff subsequently worked in collaboration with law enforcement organizations (e.g., Florida Department of Law Enforcement, the Florida Sheriffs Association, and the Florida Police Chiefs Association) to develop the model agreement, but this progress was slow. In August 2002, the central office completed the statewide model agreement and subsequently sent the model agreement to the districts as a starting point for development of local level agreements and implementation in September 2002. The central office has not set a deadline for full implementation because of the varying number of law enforcement entities the districts will have to negotiate with and because there is no requirement for law enforcement to enter into the agreements. However, program officials have requested districts to submit status reports on the implementation of the agreements every two weeks.

The program should establish a deadline requiring all districts to have signed working agreements, such as June 30, 2003. Further, we recommend that the program conduct a review to evaluate the results of the working agreements one year after full implementation has been reached. At a minimum, the program should survey law enforcement entities that have entered into these agreements to identify benefits, as well as areas in need of improvement. The survey should assess qualitative benefits derived from the working agreements, such as improved cooperation and communication between the program and law enforcement, and quantitative indicators resulting from the establishment of working agreements, such as any increase in the number of persons arrested for abuse, neglect, and exploitation of vulnerable adults.

The program has not implemented a uniform fee assessment and collection system for clients who are eligible to pay for services, although the collection system may not be cost-effective. The 1988 Legislature, in s. 410.604(6), *Florida Statutes*, mandated the program to assess and charge fees for services to Community Care for Disabled Adult clients who had incomes above the Institutional Care Program (ICP) level. [42, 43] These fees were to be used to expand the program and serve more disabled adults.

Although the department promulgated rules in 1989 that established a fee assessment process, including verification of income and expenses and the collection of fees, four districts had not implemented the fee assessment and collection system for these clients. [44] As of September 2002, 10 of the 14 districts were completing the fee assessment process. [45] In these districts, five clients were above the ICP level and none were charged a fee because their monthly expenses eliminated them from paying. In the other districts, clients' incomes were not always

[42] According to s. 410.604(6), *F.S.*, "The department and providers shall charge fees for services that the department provides a disabled adult whose income is above the existing institutional care program eligibility standard, either directly or through its agencies or contractors. The department shall establish by rule, by January 1, 1989, a schedule of fees based on the disabled adult's ability to pay. Services of a specified value may be accepted in lieu of a monetary contribution."

[43] As of October 2002, the Institutional Care Program level (ICP) is $1,635 for an individual.

[44] Chapter 65C-2.007, *Florida Administrative Code.*

[45] Each year, counselors must verify each Community Care for Disabled Adult client's income. If the client's income is above the ICP level, he/she must complete a fee assessment. Applicants who have $200 or more of disposable income remaining once monthly expenses are subtracted from monthly income are asked to pay 10% of their disposable income or the unit cost of the service they are to receive, whichever is less.

validated or clients were not assessed and charged fees.

The program is acting to implement a uniform fee assessment and collection system. The program recently developed an income verification form to be completed by case managers for each Community Care for Disabled Adult applicant and client at the points of their initial assessment and annual reassessments. Program officials said this process was completed for all current clients on November 30, 2002. They also said that all clients above the ICP level will be assessed and, if applicable, charged fees by December 31, 2002.

However, because only a few clients have incomes that exceed the ICP level, the administrative costs involved in collecting these fees will likely be approximately equal to the dollar amount that would be collected. Based on a survey of districts, only 18 of the program's 932 current clients have incomes above the ICP level and thus are subject to fees.[46] According to conversations with program managers, we estimate the program will incur administrative costs of approximately $1,500 per year. This equals the amount of fees we estimate the program will collect from the clients.[47] However, we will not know for certain the amount of fees to be collected annually until the program has completed the fee assessments for all clients above the ICP level in December. If this level does not exceed the administrative costs to assess and collect the fees, the system should be eliminated and the statutory requirement rescinded.

[46] We spoke with each district program administrator, and they told us that 18 people were above the ICP level throughout the state, with 13 of them being in the SunCoast Region.

[47] Based on conversations with program managers, we estimate that the most a client will be charged is $10 per month. If all 13 clients who have not been assessed are charged this fee, the maximum amount of fees collected would only be $1,560.

The program could not document that it has implemented our 2001 recommendation to improve the efficiency and effectiveness of OSS case management

Optional State Supplementation (OSS) provides payments to persons who are placed in an assisted living facility, adult foster care, family placement, or another specialized living arrangement. The program has 130.5 case managers, some of whom provide OSS case management. OSS case managers establish eligibility for these disabled and elderly clients, evaluate their need for care, prepare case plans for them, and periodically review the stability and suitability of their placements. Although many OSS clients are not victims of abuse, neglect, or exploitation, officials believe that case management helps to keep OSS clients free from abuse, neglect, or exploitation, because it enables program staff to periodically assess the quantity and quality of services that OSS clients receive and make the necessary modifications to help protect them from harm.

In our February 2001 report, we concluded the program should take steps to improve the efficiency and effectiveness of OSS case management and maximize the program's limited resources.[48] We recommended that the program fully implement its May 2000 policy to reduce the number of quarterly case management visits to OSS recipients who were stable enough in their placements to require only annual visitations. We estimated that reducing these visitations would eliminate the need for 23.75 FTE OSS case management-related positions, which would result in potential cost savings of $885,000. These cost savings could be used to serve other critical program needs such as conducting adult protective supervision or protective investigations.

As of November 2002, the program had not implemented our recommendation to reduce the number of unnecessary case management visits.

[48] *DCF's Adult Services Program Meeting Goals: Data Reliability, Case Management Need Work,* Report No. 01-08.

Program officials said they had begun the process of discontinuing quarterly case management visits, but they could not document the number of clients that had moved from Level I (quarterly visits) to Level II (annual visits) since May 2000 due to a lack of available data. Our analysis of state personnel (COPES) data indicated a reduction of 4.75 case manager positions since the adoption of the program's May 2000 policy. Program officials said these positions were shifted to adult protective investigators. However, they could not provide us with information to demonstrate that these changes were due to a reduction in OSS case management, since the data is maintained in CIS, and as previously discussed, has not been reliable. They also could not show us whether any of the other 19 FTE positions identified by OPPAGA were re-assigned to conduct additional adult protective services or were eliminated to save the state general revenue dollars. We believe that the program should further reduce and document the number of case management visits given to OSS clients who are stable in their placements, and thus, maximize its limited resources and provide more clients with other program services or save the state general revenue dollars.

Without reliable information, program officials are unable to determine whether more quarterly case management visits can be reduced to annual visits and more positions can be terminated or re-assigned to other needed program functions. We recommend that the program report to the 2003 Legislature the current number of Level I and Level II case management cases, how many Level I cases the program will reduce to Level II cases by the end of the fiscal year, and how many OSS-related FTE positions will be terminated or re-assigned to other needed program components as case management is reduced. Program officials told us that CIS was modified to distinguish between Level I and Level II clients beginning in December 2002.

Appendix A

Jeb Bush
Governor

Jerry Regier
Secretary

Florida Department of Children and Families
Office of the Secretary

January 9, 2003

Mr. John W. Turcotte
Director
The Florida Legislature
Office of Program Policy Analysis and
Government Accountability
111 West Madison Street
Room 312, Claude Pepper Building
Tallahassee, Florida 32399-1475

Dear Mr. Turcotte:

Enclosed is the Department's response to the January 2003 OPPAGA Progress Review of the Adult Services Program. We are appreciative of the professionalism demonstrated during this review by your staff, Ms. Brenda Hughes and Mr. Scott Stake. We believe their thorough review and recommendations will result in a more effective and efficient Adult Services Program operation.

If you have further questions, please call Dr. Samara Navarro, Director of Adult Services, at (850) 488-2881.

Sincerely,

/s/
Jerry Regier
Secretary

Enclosure

cc: Lucy Hadi, Deputy Secretary
Jim Clark, Assistant Secretary for Programs
Sheryl Steckler, Inspector General
Dr. Samara Navarro, Director of Adult Services

Department of Children and Families
RESPONSE TO OPPAGA PROGRESS REPORT
Review of Adult Services Program

The program has been timely in commencing investigations but not in closing them, resulting in a backlog of cases.

The Department will continue to focus its efforts to ensure that cases are closed within 60 days. All districts with a backlog have submitted a backlog reduction plan that will be monitored by the Adult Services Program Office ("Program Office"). This will be an ongoing requirement in the event that a district experiences backlog cases in the future. Adult Protective Services procedures have been modified to ensure that supervisory reviews occur earlier and more frequently than required historically for all cases, depending on level of risk. Additional supervisory oversight and direction will assist in reducing the number of cases that are not completed timely. These "early intervention" procedures will supplement existing backlog procedures. Existing policies and procedures have also been revised where appropriate to ensure that reports accepted are limited to those mandated by Chapter 415, F.S., and to streamline required activities to minimize duplication of effort and unnecessary tasks. Additionally, caseload, backlog and other performance data continues to be presented to the Department's leadership team on a monthly basis as described in OPPAGA's report.

The Department will also be redirecting limited additional federal funds earned by Adult Services staff to fund backlog reduction activities in the coming months. Lastly, the Department has submitted a legislative budget request as noted in the OPPAGA report in order to reduce caseloads to a manageable level.

The Program lacks an effective system for serving the highest risk disabled adults

The Department has been working for the past several months to develop a uniform screening and prioritization process for its disabled clients. Work to date, while still in draft, includes development of a single intake and assessment instrument to be used by all districts and providers, development of criteria for statewide waiting list prioritization, development of a due process brochure and development of more user-friendly client literature and notices regarding available programs. As recommended by OPPAGA, proposed criteria for prioritization includes level of risk (as determined through the client assessment process) and then date of application within level of risk (first come, first served).

The Department has also developed preliminary specifications to include wait list tracking and financial management capabilities in the HomeSafenet system. The use of a statewide automated system will allow the Program Office and budget staff to shift funds within districts to ensure that clients with higher level of need will be served first, regardless of where they reside within the State.

The program could save at least $319,000 in state general revenue funds by moving clients to the Medicaid waiver.

The Department concurs that clients who are Medicaid eligible and currently receiving services through a general revenue funded program such as Community Care for Disabled Adults can, in most cases, be served more cost effectively through the Aged and Disabled Adults waiver. Program Office will oversee the verification of all eligible clients and their move to the waiver program prior to July 1, 2003.

Unreliable performance data impedes effective program management. and accountability.

The Department concurs with the recommendation that the DCF Inspector General's office should assess the reliability and validity of CIS data. In addition, Program Office is conducting on-site district sample testing of CIS data to verify the reconciliation activities.

The Department is also working aggressively with the Department of Elder Affairs (DOEA) staff to reconcile exceptions in elder abuse referral data. The reconciliation process is expected to be completed within 60 - 90 days and reporting will be completed as recommended by OPPAGA within that timeframe.

In order to ensure that the Department has accurate and timely information for management reporting, the agency is proposing to migrate Adult Services program data to the HomeSafenet system. This will allow the Department to maintain a comprehensive electronic case record for each client and will allow the Department to maintain all necessary client information in a reliable and accessible manner. The Secretary has approved development activities to commence this fiscal year.

Ineffective monitoring and oversight system diminishes program effectiveness.

As noted in the OPPAGA report, the Program Office is developing a monitoring validation instrument that will allow central office to validate district monitoring results. Given limited program office staff and funds available to travel to conduct district monitoring, OPPAGA's report comment that this plan of action is reasonable is appreciated.

As noted in the OPPAGA report, the Program Office is developing and implementing policy and procedures to govern off-contract purchases of client services. The Department is in the process of amending the Community Care for Disabled Adults rule, 65C-2, F.A.C. to include regulations for the districts to follow when purchasing CCDA services by voucher or purchase order. Immediately following the adoption of the rule requirements governing the use of vouchers and purchase orders for procuring CCDA services, district instructions for rule implementation will be drafted and incorporated into the CCDA Operating Procedures, CFOP 140-8. Reporting mechanisms will also be developed to validate district interpretation for compliance purposes.

The program has not implemented working agreements with law enforcement

The Department will continue to diligently pursue execution of law enforcement agreements in addition to the 129 that have been executed as of January 6, 2003. An additional 210 law enforcement agreements are in active negotiation. Districts will continue to provide Program Office with biweekly updates of their continuing efforts. District Administrators in the four districts which have not yet successfully negotiated any agreements will assist district Adult Services staff in their negotiation efforts. The Department also concurs that it would be beneficial to evaluate the results of the working agreements one year after full implementation has been reached and will conduct that assessment.

The program has not implemented a uniform fee assessment and collection system for clients who are eligible to pay for services, although the collection system may not be cost-effective.

All districts are currently complying with the statutory requirements for fee collection and assessment. District staff have reviewed the 18 cases of clients whose incomes exceeded the ICP level and preliminary information indicates that in all cases, the net disposable income of these clients is such that fee assessment is not mandated. The Department concurs with the OPPAGA recommendation that the fee assessment system should be eliminated and the statutory requirement should be rescinded if administrative costs exceed revenues generated. The Department will finalize its analysis and proceed accordingly.

The program could not document it has implemented our prior report recommendation to improve the efficiency and effectiveness of OSS case management.

In response to the previous OPPAGA finding, Adult Services implemented revised criteria for moving OSS clients from Level I case management to Level II effective May 2000. The reduced frequency of client contact which resulted from required annual (Level Il) rather than quarterly visits (Level 1) for clients changing Levels was expected to result in reduced case management workload. As noted by OPPAGA, some positions were redirected during that time period. However, due to a deficient data system which did not capture client placement levels coupled with limited state oversight, it is unclear' how many clients were actually affected and how much workload reduction actually occurred.

On December 13, 2002, guidelines were provided to district staff regarding system tracking of various data elements including placement data by level of case management. Data conversion efforts should be completed by January 31, 2003. Adult Services also

completed the newly developed Protective Intervention Operating Procedure (CFOP 140-4). This operating procedure provides case managers additional options for moving clients in stable and continuous placement from Level I to Level II case management. The new operating procedure also has enhanced documentation requirements to ensure more comprehensive reporting of client contacts, objectives for each contact and follow-up activities. Consequently while there are now more options for fewer case management responsibilities and activities, the quality of these has been significantly enhanced.

As recommended by OPPAGA, the Department shall prepare a report that includes the actual, current number of Level I and Level II clients as well as the number of clients expected to change levels due to the new operating procedures. The report shall also include an analysis of workload reduction associated with those activities and will state the number of positions that could be shifted and the evidentiary documentation to support that conclusion.

DEPARTMENT OF ELDER AFFAIRS
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January 21, 2003

John W. Turcotte, Director
Office of Program Policy
Analysis and Government Accountability
111 West Madison Street
Tallahassee, Florida 32399-1475

Dear Mr. Turcotte:

This is in response to the preliminary and tentative findings in the draft of OPPAGA's progress report titled "Improvements Needed in the Department of Children and Families Adult Services Program," dated December 13, 2002.

1. On page 12, the report states, "the program could also work with The Department of Elder Affairs to ensure that provider rates for Medicaid are similar to the rates for general revenue programs."

   DOEA Response: The department would welcome this opportunity since it has discussed conducting rate studies with the Florida Agency for Health Care Administration in an effort to standardize rates across programs on a statewide basis.

2. On page 12, the report states that ". . . the Department of Elder Affairs currently uses Medicaid providers in these areas, and we believe the district program administrators could work with the Department of Elder Affairs to recruit these providers to serve disabled adults as more clients are moved to the Medicaid Waiver," referring to areas in Districts 1 and 3.

   DOEA Response: Throughout the years, DCF (formerly HRS) has contracted with some of the current CCE lead agencies for CCDA services. These lead agencies are also Medicaid waiver providers. DOEA welcomes the chance to assist DCF in identifying additional providers for their under 60 Medicaid eligible population, and to this end will offer DCF their current list of Medicaid waiver providers. In addition, the DOEA continues to recruit new providers through local recruitment efforts at the Area Agencies on Aging. DOEA will notify DCF that their district offices are encouraged to contact their local Area Agency on Aging office for information about new recruitment efforts.

Thank you for the opportunity to respond to your draft report. If you have any questions, please feel free to call Stanley Behmke at 850-414-2000.

Sincerely,

/s/
Terry White
Secretary

TFW/ms

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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John W. Turcotte, OPPAGA Director