State of Arizona Office of the Auditor General

PERFORMANCE AUDIT

ARIZONA DEPARTMENT OF HEALTH SERVICES, DIVISION OF ASSURANCE AND LICENSURE SERVICES

Report to the Arizona Legislature
By Douglas R. Norton
Auditor General

September 1998
Report Number 98-17

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AUDITOR GENERAL

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

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September 17, 1998

Members of the Arizona Legislature

The Honorable Jane Dee Hull, Governor

Dr. James R. Allen, Director
Arizona Department of Health Services

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Arizona Department of Health Services, Division of Assurance and Licensure Services.. This report is in response to a May 27, 1997, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the Sunset review set forth in A.R.S. §§41-2951 through 41-2957.

This is the first in a series of reports to be issued on the Department of Health Services, Division of Assurance and Licensure Services. The report addresses the Division's ability to adequately regulate health and child care providers through facility licensure and inspection, complaint investigation, and licensing standards enforcement. The specific licensing programs the Division is responsible for regulating include Behavioral Health, Child Care, Home and Community Based, Long Term Care, and Medical Facilities.

A review of licensing and complaint files revealed that the Division has not taken sufficient enforcement action against several facilities that have repeatedly violated licensing standards. For example, one child care facility was cited more than 350 times for repeat standards violations, including using inappropriate discipline and hiring unqualified staff. Additionally, the Division has not met its statutory responsibility to restrict or prevent some facilities from operating when they fail to meet licensing standards. Although some enforcement options are available to address continued noncompliance among problem facilities, some additional authority and options, such as higher fine amounts, simplified documentation requirements, and penalty reductions when facilities waive certain rights, could improve the Division's ability to encourage compliance. In addition to problems enforcing licensing standards, the Division also fails to provide consumers with complete, appropriate, and easily accessible regulatory information. Specifically, complaint information contained in files is often not sufficiently detailed for consumers to make informed decisions when selecting providers. Also, although some regulatory information is maintained on computer, complaint and licensing databases are not accurate or complete and currently cannot be used to provide summary information about facilities to the public. Finally, the audit found that one of the licensure programs, Medical Facilities Licensure, does not perform timely complaint investigations. Failure to complete investigations in a timely manner has led to a backlog of 97 complaints, which have remained uninvestigated more than 17 months, on average.

As outlined in its response, the Arizona Department of Health Services, Division of Assurance and Licensure Services agrees with all of the findings and recommendations.

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

This report will be released to the public on September 18, 1998.

Sincerely,

Douglas R. Norton
Auditor General

Enclosure

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SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Health Services, Division of Assurance and Licensure Services, pursuant to a May 27, 1997, resolution of the Joint Legislative Audit Committee. This audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957. This is the first in a series of six audits of the Department of Health Services.

This audit focuses on the Division of Assurance and Licensure Services' (ALS) responsibility for protecting the public's health, safety, and welfare by regulating health and child care providers. ALS' regulatory duties include licensing and inspecting facilities, investigating complaints, and enforcing licensing standards. To perform these duties, ALS is appropriated 114.8 FTEs to manage and staff its three support and five licensing programs. The licensing programs, which are the focus of this audit, include Behavioral Health, Child Care, Home and Community Based, Long Term Care, and Medical Facilities. The Division's activities are funded by both state and federal monies.

ALS Does Not Take Sufficient Action Against Problem Facilities

(See pages 9 through 15)

The audit found that the Division has not taken sufficient action when facilities have histories of noncompliance with licensing rules. A review of licensing and complaint files for 17 supervisory care, adult care, and child care facilities that repeatedly violated licensing standards found that ALS has not taken sufficient enforcement action to ensure compliance. For example, one child care facility was cited more than 350 times for repeat standards violations, including using inappropriate discipline and hiring unqualified staff. Although ALS could have levied civil fines or imposed other sanctions in an attempt to ensure compliance, it only requested that the facility submit 14 separate plans for correcting the cited problems. In cases such as this, failure to use progressive enforcement tools, such as civil fines, may allow problems to continue to the point where license revocation is appropriate.

In addition, ALS has not met its statutory responsibility to restrict or prevent facilities from operating when they fail to meet licensing standards. A review of 120 Home and Community Based licensing files identified 3 facilities where ALS should have used its licensing and enforcement authority to either deny licenses or issue provisional licenses. For example, one facility's license expired in 1994. Since then, ALS has cited the facility for at least 150 violations of licensing standards and has received 18 complaints, but has allowed the

facility to continue operating. In this and the other two cases, action by ALS to either deny licenses or issue provisional licenses may have prevented these facilities from providing substandard care.

Some enforcement options are available to address continued noncompliance among problem facilities; however, some additional authority and options could improve ALS' ability to encourage compliance. ALS is authorized to levy limited civil fines but appears unwilling to regularly use fines as an enforcement tool. Between July 1995 and December 1997, ALS levied only 9 civil fines. During this same period, ALS received more than 5,500 complaints against approximately 3,000 providers licensed by the Home and Community Based and Child Care Licensure Programs. To increase the use and effectiveness of civil fines, ALS should seek statutory changes to allow higher fine amounts, to simplify documentation of violations, and to allow penalties to be reduced if facilities waive their rights to protest fines in administrative hearings. ALS should also be allowed to impose intermediate sanctions immediately rather than wait 15 to 30 days for a facility to appeal an action. Currently such delays are allowed by statute and ALS policy and may make the sanctions an ineffective enforcement tool. Other states, such as Florida and Oregon, can place an immediate ban on admissions.

Consumer Information About Health and Child Care Providers Incomplete, Inaccurate, and Restricted

(See pages 17 through 22)

ALS fails to provide consumers with complete, appropriate, and easily accessible regulatory information even though this information is crucial to consumers who are selecting health and child care services. A review of 50 randomly selected public files revealed that 20 were missing complaint information. Further, the complaint information that is contained in the files is often not sufficiently detailed to enable consumers to make informed decisions when selecting providers. Public files only list broadly categorized complaint allegations, which make it difficult to determine the concern that led to the complaint. For example, a complaint categorized as "care or services" may relate to allegations ranging from nurses being slow to respond to patients, to serious patient neglect. In addition, the review found that files often contained confidential information, such as social security numbers. Specifically, 39 of the 50 files reviewed contained information that ALS is prohibited from releasing to the public.

Although some regulatory information is maintained on computer, complaint and licensing databases are not accurate or complete and currently cannot be used to provide summary information about facilities to the public. Specifically, auditors identified errors in the computerized data for 27 of 48 randomly selected complaints. In addition, ALS' licensure databases currently do not capture information relating to rules violations and enforcement actions.

Once database problems are resolved, ALS can take steps to begin making information about health and child care providers more readily available by telephone. Currently, the 5 licensing programs lack written policies for providing complaints information by telephone. In fact, the Child Care Program is statutorily prevented from releasing information by telephone. To obtain public information about complaints and inspections, consumers generally must either visit ALS in person or pay 25 cents per page for information to be mailed to them. However, visiting ALS can be a hardship for some consumers. Moreover, requesting information by mail can be costly as some files contain several hundred pages.

In addition to providing information by telephone, ALS could take additional steps that would allow consumers to make more informed decisions. Specifically, ALS could consider developing brochures and other resources to make consumers more aware of what information is available about licensed facilities. ALS should also seek statutory amendments requiring licensed providers to make information, such as inspection reports, more readily available to consumers visiting facilities. Similar requirements already exist in federal law for facilities receiving Medicare or Medicaid monies.

Complaint Investigation Process for Medical Facilities Is Slow, Inadequate

(See pages 23 through 27)

The ALS Medical Facilities Licensure Program does not perform timely complaint investigations. ALS policies specify time frames for investigation of some complaints ranging from 48 hours to 30 working days, depending on the severity of the allegations. However, the Medical Facilities Program did not meet those time frames for 43 of 62 priority 1, 2, and 3 complaints received in 1997 and investigated as of May 1998. Failure to complete investigations in a timely manner has led to a backlog of 97 complaints, which have remained uninvestigated more than 17 months, on average. One of the complaints, which has remained open approximately 545 days, should have been investigated within 10 working days. Untimely investigations limit the Program's ability to protect consumers and to resolve their concerns.

In addition, current complaint investigation policies do not include provisions to ensure that low-priority complaints against accredited medical facilities are investigated. The Division's policy for investigating complaints assigned the lowest priority, priority 5, is to perform these investigations at the time it conducts a facility's next regular licensing inspection. This policy helps ensure that priority 5 complaint investigations are completed at a majority of licensed facilities. However, this policy does not address procedures for investigating priority 5 complaints against accredited medical facilities, which are not subject to regular licensing inspections. A review of unresolved complaints identified 28 priority 5 complaints against accredited facilities that have remained uninvestigated, on average, nearly a year and a half.

Other Pertinent Information
(See pages 29 through 30)

This audit also presents other pertinent information relating to the Department of Health Service's (DHS) responsibility for collecting licensing fees and for licensing speech pathologists and audiologists. Currently, ALS is in the process of implementing a 1989 law requiring collection of licensing fees from health care providers and facilities. Collecting these fees could contribute as much at $917,000 to the General Fund annually, based on the number of health care licensees in 1998. ALS is also currently working to implement a 1995 statute that requires licensure for speech pathologists and audiologists.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Department of Health Services, Division of Assurance and Licensure Services (ALS), pursuant to a May 27, 1997, resolution of the Joint Legislative Audit Committee. The audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957. This is the first in a series of six audits relating to the Department of Health Services.

The State, in its regulation of health and child care facilities, provides consumers two means of helping to ensure that services are appropriate and comply with statutes. First, the State can directly impact the quality of services by inspecting and licensing facilities, taking necessary enforcement action, and investigating complaints. Second, by providing accessible and accurate information regarding the quality of facilities, the State can help consumers make informed choices when selecting services. This audit addresses both of these aspects of state regulation.

Assurance and Licensure Services Organization and Staffing

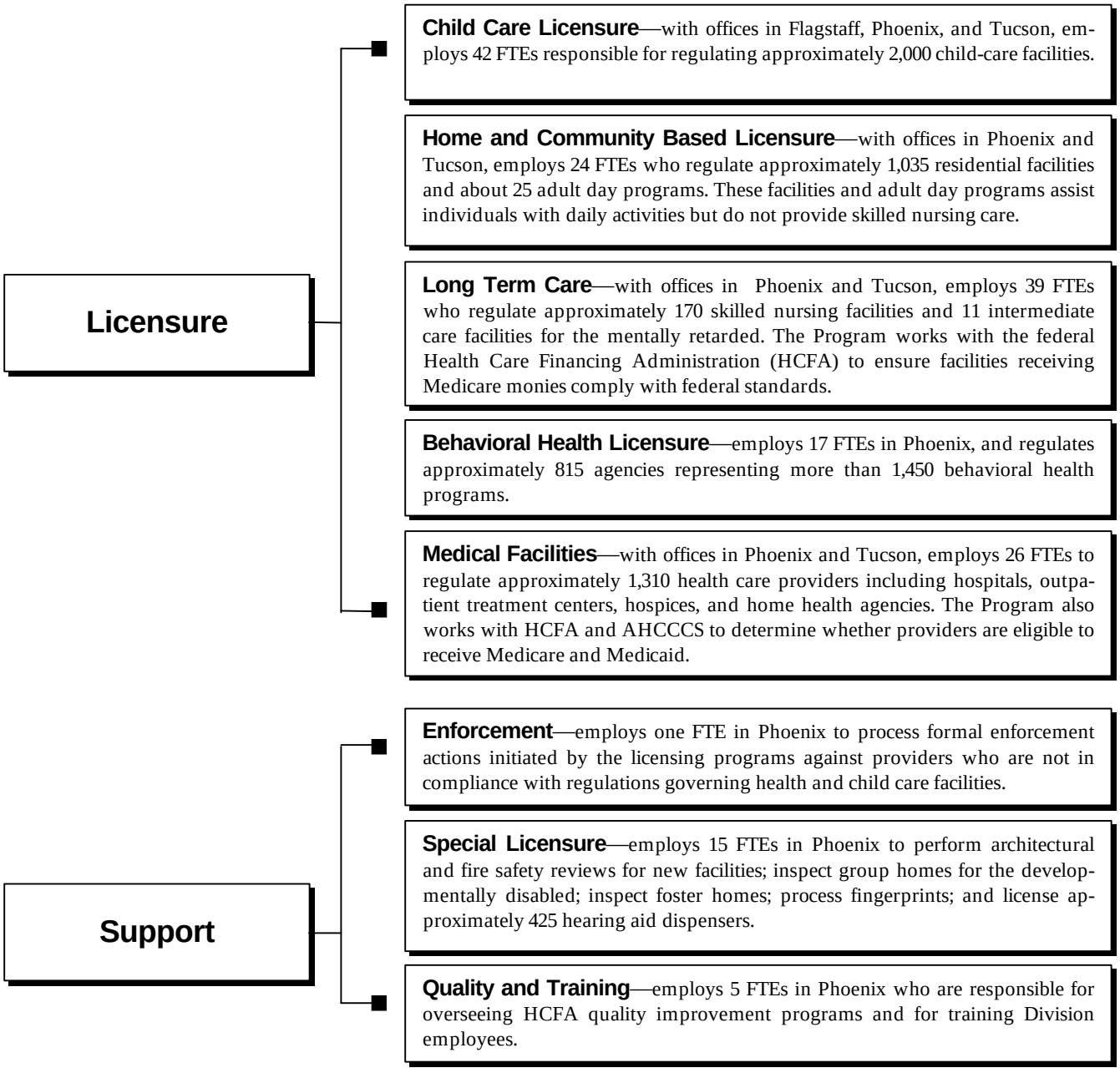
Assurance and Licensure Services, a division of the Department of Health Services, is responsible for protecting the public's health, safety, and welfare through licensing and regulating facilities that provide health and child care services. To carry out its duties, the Division is divided into eight programs. Five of these programs are licensure and three are support, as shown in Figure 1 (see page 2). This audit focuses on the activities of the licensure programs, which are responsible for inspecting and licensing facilities and investigating complaints.

Budget

The Division of Assurance and Licensure Services receives both state and federal monies. As shown in Table 1 (see page 3), approximately half of the Division's activities are funded by General Fund appropriations. The Division also receives between 36 and 42 percent of its revenue from the federal government in return for inspecting and certifying facilities that receive Medicare and Medicaid monies. These federal monies are administered by AHCCCS.

Figure 1

Arizona Department of Health Services
Division of Assurance and Licensure Services, Programs



Source: Auditor General staff compilation of information obtained from the Department of Health Services, Division of Assurance and Licensure Services.

Table 1

Arizona Department of Health Services
Division of Assurance and Licensure Services
Statement of Revenues, Expenditures, and Other Financing Uses [1]
Years Ended June 30, 1996, 1997, and 1998
(Unaudited)

	1996	1997	1998
Revenues:			
State General Fund appropriations	$ 4,318,407	$4,367,678	$4,578,200
Intergovernmental [2]	3,489,313	4,211,798	4,559,174
Licenses, fees, and permits	130,650	158,492	160,279
Fines and forfeits	12,729	2,914	141,544 [3]
Charges for services	14,305	29,332	5,817
Other	2,667	12,782	5,705
Total revenues	7,968,071	8,782,996	9,450,719
Expenditures:			
Personal services	4,203,490	5,028,109	5,411,750
Employee related	1,070,219	1,156,543	1,180,732
Professional and outside services	223,018	261,777	179,850
Travel, in-state	242,094	294,676	315,557
Travel, out-of-state	27,888	62,225	49,422
Other operating	413,197	654,925	543,189
Capital outlay	147,033	40,780	192,967
Total expenditures	6,326,939	7,499,035	7,873,467
Excess of revenues over expenditures	1,641,132	1,283,961	1,577,252
Other financing uses:			
Net operating transfers out	667,384	821,379	872,429
Remittances to the State General Fund [4]	148,940	211,013	162,592
Reversions to the State General Fund	325,212	75,555	12,970
Total other financing uses	1,141,536	1,107,947	1,047,991
Excess of revenues over expenditures and other financing uses	$ 499,596	$ 176,014	$ 529,261

1 Fund balances are maintained at the agency level; therefore, only revenues, expenditures, and other financing uses were available for the Division.

2 Amount includes approximately $3.3 million, $3.2 million, and $3.3 million of federal grants and reimbursements received in fiscal years 1996, 1997, and 1998 respectively.

3 Amount includes federal fines assessed against providers for violation of Health Care Finance Administration rules and regulations. Previously these fines were held by the State's Arizona Health Care Cost Containment System (AHCCCS); however, in April 1998, AHCCCS began transferring the monies to the Division. For fiscal year 1998, the Division received approximately $135,000 in such fines.

4 The Division collects licensing fees, civil fines and forfeits, charges for services, and other revenues that are remitted to the State General Fund in accordance with A.R.S. §35-142.

Source: The Arizona Financial Information System (AFIS) *Accounting Event Extract File* for the years ended June 30, 1996 and 1997; AFIS *Status of Budget by Organization and Program* on-line screen at May 18, 1998, for fiscal years 1996 and 1997, and at July 22, 1998, for fiscal year 1998; and Division-prepared worksheets of revenues, expenditures, and other financing uses for fiscal year 1998.

Follow-up to Previous Auditor General Report

As part of the current audit, concerns previously identified in the Auditor General's 1988 performance audit of the Division of Assurance and Licensure Services were reviewed.[1] The 1988 report raised concerns about the Division's enforcement of licensure standards at long-term care facilities, including nursing homes and supervisory and adult care homes, and at child care facilities. The report also raised concerns about the way the Division processes complaints against child care facilities.

- **Weak enforcement action threatens the health and safety of residents in long-term care facilities and children in day care—**The 1988 audit found that the Division did not take sufficient enforcement action to prevent repeated noncompliance and to ensure that facilities corrected serious deficiencies. The report identified extensive and often repeated noncompliance among long-term care facilities. The report also identified instances of repeated noncompliance among child care providers, which it attributed partially to the Division's philosophy of "working with centers" in lieu of strong enforcement action. To improve enforcement in both programs, the report recommended that the Division develop a stronger commitment to enforcement and seek statutory changes to upgrade its enforcement capabilities.

  Follow-up: Although regulation of nursing homes that receive federal Medicare monies has changed substantially since the 1988 audit, the Division's enforcement philosophy and its statutory authority over other facilities has not. In July 1995 the Division's Long Term Care Program, which currently oversees nursing homes, implemented the federal Health Care Financing Administration (HCFA) enforcement process, which resulted in a number of improvements to nursing home regulation. Specifically, HCFA supplied the State with a definition of substandard care, classified the seriousness of deficiencies, increased enforcement authority and tools, and provided for increased penalties in cases of repeated noncompliance.

  However, little has changed in the way licensing standards are enforced at facilities such as supervisory care and adult care homes, and child care facilities, that are typically subject to only state regulation. The Division still does not take progressive steps to enforce licensing standards when facilities have a history of repeated noncompliance. In addition, its enforcement authority and options have not changed substantially since the 1988 report was issued. For example, maximum civil fine amounts allowed by statute remain the same as in 1988. (For further discussion of this issue, see Finding I, pages 9 through 15).

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[1] At the time the 1988 report was issued, the Division of Assurance and Licensure Services was known as the Division of Emergency Medical Services / Health Care Facilities.

- **Day care complaint-handling procedures should be improved—**The 1988 report found that ALS' Child Care Licensing Program did not follow established policies and procedures regarding timeliness of complaint investigations. At the time of the 1988 audit, the Program investigated only 71 percent of complaints against child care facilities within its own specified time frames, partially because it lacked an efficient tracking system. The audit recommended that the Program develop an efficient computerized system to track complaints and ensure timely investigation.

  Follow-Up: Since 1988, the ALS has implemented a computerized complaint tracking system in its Child Care Program. Analysis of the computerized complaint information revealed that complaints received and investigated during 1997 were investigated within required time frames approximately 77 percent of the time. Specifically, for complaints received and investigated in 1997:

  - 43 percent of the priority 1 complaints were investigated within the required 48 hours. The average time to investigate all 196 priority 1 child care complaints was 6 days.

  - 82 percent of priority 2 complaints were investigated within the required 10 working days. The average time to investigate all 1,076 priority 2 complaints was 8 days.

  - 92 percent of priority 3 complaints were investigated within the required 30 working days. The average time to investigate all 109 priority 3 complaints was 14 days.

Scope and Methodology

Audit work included using a number of different methodologies to determine whether ALS meets its responsibilities for protecting the public's health, safety, and welfare through its regulation of health care facilities and child care providers. The results of file reviews, surveys, and other research were used to develop findings and recommendations in the following three areas:

- The need for ALS to take swift and progressive enforcement action against home- and community-based facilities, such as supervisory care and adult care homes, and child care facilities that repeatedly fail to comply with licensing standards.

  To determine whether ALS enforcement actions effectively ensure compliance among problem facilities, files for child care and home- and community-based providers with the greatest potential for compliance problems were identified and reviewed. Files were selected based on the relative number and seriousness of complaints received and how recently the complaints were filed. Some additional files were identified by program

managers and surveyors in the Child Care and Home and Community Based Licensure Programs. The review involved examination of files for 11 child care facilities, which serve between 90 and 140 children each; and files for 10 supervisory and adult care homes, which serve between 5 and 70 residents each.

In addition, to determine whether the Home and Community Based Program ensures that facilities are appropriately licensed, a total of 120 licensing files for Home and Community Based facilities were reviewed. Auditors reviewed the Program's actions relating to 38 facilities with outdated or expired licenses as identified from the Program's licensing database. Also, a random sample of files for 82 more facilities was reviewed to determine whether the Program had allowed licenses for other facilities to lapse or become outdated.

- The need to improve the quality and quantity of information available about health and child care providers to enable consumers to make informed decisions when selecting services.

  To determine whether the information available to the public is sufficient, complete, accurate, and appropriate, a random sample of 50 facility licensing and complaint files was selected. The information in these files was reviewed and compared to the Division's statutory, rule, and policy requirements relating to public licensing and complaint files. Also as part of this review, the file documentation was compared to information available in the computerized complaint tracking system to determine whether the computerized database could be used to provide information to the public.

- The need to establish policies and procedures to ensure complaints against medical facilities, particularly hospitals, are investigated in a timely manner.

  To determine whether the Medical Facilities Program meets its responsibility to investigate complaints, 191 complaints against medical facilities were reviewed. The complaints reviewed were those listed as open, or unresolved, on the Program's computerized complaint tracking system as of January 1998.

Other methods used to obtain relevant information relating to the three findings included interviewing Division management and staff; health and child care providers; professional associations; and representatives of agencies, such as the Department of Economic Security, that work with licensed providers. Auditors also accompanied Division surveyors on inspections at health and child care facilities and interviewed providers. In addition, as part of a literature search, 9 states' statutes relating to enforcement and public information were reviewed. Finally, other states' regulatory agencies were contacted for information relating to the impact of their statutory enforcement tools and authority and their public information policies.

In addition to the three findings, this report includes other pertinent information (see pages 29 through 30) that discusses the Division's progress toward collecting licensing fees from health care facilities and for licensing speech pathologists and audiologists.

This audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the Director of the Department of Health Services, the Acting Assistant Director of the Division, and staff for their cooperation and assistance throughout the audit.

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FINDING I

ALS DOES NOT TAKE SUFFICIENT ACTION AGAINST PROBLEM FACILITIES

The Department of Health Services Assurance and Licensure Division (ALS) does not sufficiently address supervisory and adult care homes and child care facilities that consistently fail to meet minimum licensure standards and threaten the health, safety, and welfare of those in their care. Some facilities have been chronically out of compliance with rules and regulations, but ALS has not taken enforcement action. For example, 2 child care facilities that have accumulated more than 350 repeat violations each during the 5-year period reviewed have not been sanctioned. In other cases, ALS has not used its statutory enforcement and licensing authority to ensure that substandard facilities either correct violations or discontinue services. To help ensure increased compliance in the future, ALS should use existing enforcement tools and develop additional sanctions.

ALS is statutorily required to regularly survey facilities and investigate complaints to ensure that facilities remain in compliance with licensing standards. If these surveys or investigations identify violations in the facility's operations or management, ALS policy requires that the facility respond with a plan of correction. Correction plans, signed by facility managers or owners, should detail how and when the facility will correct the violation and how it will prevent it from reoccurring. If violations continue, ALS program managers can meet with the provider to ensure the facility owner knows what action is necessary to achieve compliance with state regulations. If the same violations continue to occur after a provider meeting, ALS can take progressive enforcement actions. These actions can include levying civil fines and imposing intermediate sanctions, such as placing bans on admission, restricting services, and reducing the facility's licensed capacity. If the facility continues to violate licensing regulations, ALS can suspend, revoke, or deny licensure.

ALS Fails to Take Progressive Enforcement Steps When Warranted

ALS' failure to take increasingly strict enforcement actions has allowed some providers to establish long histories of noncompliance with licensing standards. Auditors reviewed licensing and complaint files for supervisory care, adult care, and child care facilities to determine if ALS actions were sufficient to ensure compliance with licensing standards. The review found that some providers repeatedly violate standards and continue to operate without restriction.

A file review of 21 potential problem child care facilities and supervisory and adult care homes found that 17 repeatedly violated licensing rules, but in most cases ALS' only actions were to require a plan of correction or hold a provider meeting. The need for stronger enforcement actions was most apparent in 2 child care cases where the facilities were cited for more than 350 repeat violations each, and 5 supervisory and adult care homes that were cited for more than 75 repeat violations each during the 5-year period reviewed.[1] For example:

- Between 1993 and 1996, one child care facility was cited on 9 separate occasions for hiring underaged/unqualified staff and 8 times for not having proof that employees were immunized. ALS requested 14 plans of correction to resolve these issues even though, in some cases, the citations referred to the same employees. This facility was one of those cited over 350 times for repeat violations, which also included 7 citations for inappropriate discipline.

- One supervisory care facility that repeatedly violated rules was cited a total of 19 times between October 1996 and October 1997 for holes in the walls of residents' rooms, broken windows and floor tiles, and various hazards on the grounds, including exposed electrical wires and piles of sheet metal, wood, and broken glass. ALS continued to require only a plan of correction each time the facility was cited even though the facility had responded with as many as 5 previous plans of correction that the repairs had been made.

Swift and progressive enforcement action is necessary to enable ALS to ensure health and child care facilities provide safe and adequate care. A four-state comparative study of child care regulatory enforcement found that failure to take progressive enforcement actions, such as imposing intermediate sanctions, can result in children being placed in harm's way.[2] However, ALS does not regularly take progressive enforcement actions because management considers them costly, time consuming, or difficult to enforce. Instead, ALS has either required the provider to submit a plan of correction or has attempted to revoke or deny a license. However, reliance on these two extremes may mean that ALS is unable to intervene and correct noncompliance prior to a situation escalating to the point at which licensure revocation is appropriate.

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[1] For this analysis, auditors counted any licensure violation that ALS had cited 2 or more times. Violations that were corrected after being cited once were not included in this count.

[2] Gormley, Jr., William T. Regulatory Enforcement: Accommodation and Conflict in Four States. *Public Administration Review*. July/August 1997, 57(4), p. 293.

ALS Allows Some Problem Facilities to Operate on Expired Licenses

In addition, the Home and Community Based Program within ALS has not acted to ensure that facilities that do not meet licensure standards are either restricted from providing services or are issued provisional licenses. Statute requires the Department to either deny or issue a license based on inspection results. However, a few facilities have been unable to meet licensure standards, but were allowed to continue operations.

A.R.S. §36-425 requires ALS to inspect facilities and to issue regular licenses to those that meet minimum standards. If a facility is not in substantial compliance, ALS may issue a one-year provisional license enabling the facility to provide services while correcting violations. Provisional licenses cannot be issued for more than one year; and, all violations must be corrected before a regular license can be issued. If ALS determines that a provisional license is not appropriate, it should deny the facility's licensure application and prevent it from providing services.

ALS, however, does not always fulfill its responsibility to ensure facilities are appropriately licensed to protect residents' health, safety, and welfare. A review of 120 Home and Community Based licensing files revealed 3 cases where ALS should have used the denial of licensure or provisional licensure as an enforcement action, which may have prevented facilities from providing substandard care. Specifically:

- Two supervisory care facilities, serving up to 5 and 39 residents, respectively, have been allowed to continue operating as long as 2 years after their provisional licenses have expired and they continue to remain unable to meet requirements for a regular license. ALS did not deny licensure to either facility. Instead, ALS has continued to treat both facilities as if they had valid licenses, including conducting inspections and complaint investigations.

  One of these 2 facilities has been cited for 53 violations and has received 4 complaints since its provisional license lapsed in February 1996. One of the complaints alleged that the facility did not inform a woman that her husband, who was a resident of the facility, had died. Instead, facility management continued to receive and cash the man's social security checks. According to the Maricopa County Public Fiduciary, the facility reported the deceased resident's marital status as unknown and the body was buried as an indigent. Although ALS reported the situation to the Social Security Administration, it took no other action. This facility continues to operate without a regular or provisional license.

- In addition, ALS failed to either deny licensure or issue a provisional license to another supervisory care facility that has been unable to meet licensing standards. The facility,

which serves 35 residents, continues to operate even though its license expired in October 1994. ALS has cited the facility for at least 150 violations of licensing rules and statutes and has received 18 complaints since the facility's license expired. ALS did not take progressive enforcement action against the facility even though the facility failed to submit at least three plans of correction and submitted at least two plans that did not adequately address problems. ALS did meet with the facility's management in March 1997, but instead of addressing noncompliance issues, ALS only requested that the facility submit a license renewal application.

ALS Needs to Use Existing Enforcement Authority and Develop Additional Sanctions

ALS has enforcement options available to address continued noncompliance at problem facilities, but additional enforcement options could improve ALS' ability to encourage compliance among facilities with a history of violations. Specifically, ALS should use its existing authority to assess civil fines against facilities that repeatedly violate licensure rules. To further increase the effectiveness of civil fines, ALS should seek statutory changes to improve assessment and collection. In addition, statutory changes are needed to allow for more immediate enforcement of intermediate sanctions. Finally, some other options for improving compliance could be considered.

ALS needs to expand its use of civil fines—ALS rarely assesses civil fines as provided for in statute. Through its Child Care and Home and Community Based Licensure Programs, ALS regulates approximately 3,000 facilities. Between July 1995 and December 1997, ALS received more than 5,500 complaints for investigation. During this same period, ALS assessed only 9 civil fines against these facilities. None of the fines assessed were levied against the 17 facilities auditors identified as repeatedly violating licensing standards. Officials from other states report that fines, and a willingness to use them, can be an effective enforcement tool. Additionally, state performance audits conducted by Kansas, Virginia, and Wisconsin concluded that the use of fines may reduce the economic incentive for noncompliance because facility owners must both correct the violation and pay a penalty.

Additional options for assessing and collecting civil fines are needed—ALS has statutory authority to levy civil fines, but some statutory changes could improve assessment and collection. A.R.S. §§36-897.06 and 36-891 give ALS the authority to levy fines between $50 and $100 per violation per day against child care facilities that violate licensing standards. A.R.S. §36-431.01 gives ALS the authority to levy fines up to $300 per violation per day against health care facilities. In comparison, a review of the federal government's civil fine authority and 7 states selected for best practices found that higher fines are allowed, as shown in Table 2 (see page 13). In addition, several states can assess fines based on a number of factors, including the facility's size and the severity of the violation.

Table 2

Arizona Department of Health Services
Division of Assurance and Licensure Services
Comparison of Civil Fines and Assessment Guidelines
for Rules Violations at Child Care and Health Care Facilities
As of May 1998

Entity	Fine Maximum	Assessment Guidelines
Child Care Facilities		
Arizona	$ 100	Per violation, per day; each day must be documented as a separate violation
Florida	500	Per violation, per day
Georgia	500	Per violation, per day based on severity and past history of noncompliance
Maryland	1,000	Per violation, per day
Massachusetts	1,000	Per violation
Health Care Facilities		
Arizona	$ 300	Per violation, per day
Florida	5,000	Per violation based on severity, past history of noncompliance, financial benefit to the facility for committing the violation, and facility size
Indiana	10,000	Per violation based on severity and past history of noncompliance
Missouri	10,000	Per violation, per day based on severity and facility size; can be doubled if violation is repeated within 12 to 24 months
Wisconsin	10,000	Per violation, per day based on severity, past history of noncompliance and financial benefit to the facility for committing the violation; can be tripled if violation is repeated within 36 months
Federal government	10,000	Per violation, per day based on severity and past history of noncompliance; assessed against facilities receiving Medicare and/or Medicaid monies

Source: Auditor General staff analysis of state statutes and federal regulations.

Moreover, in contrast with Arizona, several states follow the federal model for assessing, collecting, and using civil fines. In Arizona, each day the facility remains out of compliance constitutes a separate violation; however, A.R.S. §36-891(A) requires ALS to visit child care facilities and physically document each day that the facility is out of compliance. In addition, A.R.S. §§36-891(A) and 36-897.06(A) require a hearing to impose civil fines against child care facilities. Finally, in Arizona, fines from child care facilities are currently deposited in the General Fund and fines from all health care facilities are deposited in a fund for the protection of nursing home residents. Other states and the federal government have more options.

For instance:

- Other states and the federal government have the authority to assess fines each day the facility remains out of compliance and presume the violation continues until the facility provides evidence that it has been corrected.

- Some states and the federal government can offer a reduction in penalties if the facility agrees to waive its right to a hearing to contest fines. This option can reduce costs to both the licensing agency and the facility.

- Some state and federal civil fine monies are used to improve the quality of care at licensed facilities through training programs that educate the public or the providers.

Allowing more immediate sanctions may improve compliance—Strengthening ALS' authority to more quickly impose intermediate sanctions may increase their use. Currently, A.R.S. §§36-891.01(C) and 36-897.08(C) delay the enforcement of intermediate sanctions against child care facilities until the facility has had an opportunity to appeal, or between 15 and 30 days. If a child care facility does appeal, sanctions cannot be enforced until a decision has been made on the appeal. Although the health care facilities statute does not include the same appeals provisions, ALS allows the same initial enforcement delay. According to ALS management, the delays make intermediate sanctions ineffective, and ALS has unsuccessfully sought statutory authority to allow intermediate sanctions against child care facilities to be enforced immediately. However, even with the delay, the file review of facilities with repeated violations identified several instances where violations existed for more than 30 days and intermediate sanctions could have been effective. ALS' limited use of intermediate sanctions makes it impossible to determine if the 30-day waiting period undermines the desired results.

Other states that have the authority to enforce intermediate sanctions immediately have found them effective in improving compliance. In Florida and Oregon, the licensing agency can place an immediate ban on admissions with no waiting period and no delay for appeals. In Florida, the ban remains in effect until the facility corrects the problem, or until a judge overturns it. Facilities do not often appeal because it is easier to correct the problem and they do not want the bad publicity. In addition, the potential for losing income provides a strong incentive to achieve compliance. Florida used this authority 49 times in the period between January 1995 and April 1998. The Oregon licensing agency can also post signs on the doors of the facility to inform the public that the facility can no longer accept new residents.

Other options for improving compliance include mentoring and monitoring programs— Other states have developed training and monitoring programs to improve compliance. For instance, Maryland has implemented a mentoring program that pairs facility managers from poorly performing child-care facilities with facility managers from model facilities. The

mentoring program allows the facility's staff to improve operating skills in a non-threatening, real-world environment. In addition, Missouri and Indiana can require health care facilities to pay for independent monitors as part of consent agreements when a probationary license is issued, or when other action such as revocation is initiated. These monitors perform the necessary follow-up to ensure compliance. The independent monitors must be approved by the licensing agency and submit reports on the facility's progress toward achieving compliance.

Recommendations

1. ALS should use all available enforcement authority, including assessing civil fines and progressing to stronger enforcement actions, such as banning admissions, restricting services, and reducing licensure capacity, when it cites repeat violations.

2. ALS should seek statutory changes to strengthen its enforcement authority, which would include:

    a. Modifying A.R.S. §§36-891, 36-897.06, and 36-431.01 to allow for higher civil fine amounts and to allow monies collected to be used for programs that improve the quality of care;

    b. Amending A.R.S. §36-891 to allow civil penalties to be levied against child care facilities without requiring ALS to physically document each day a violation occurs;

    c. Modifying A.R.S. §§36-891(A), 36-897.06(A), and 36-431.01 to allow for reductions in civil fines if a facility waives its right to a hearing; and

    d. Amending A.R.S. §§36-891.01 and 36-897.08 to allow intermediate sanctions to be imposed immediately against child care facilities and possibly amending A.R.S. §§36-427(C), 36-891.01(A), and 36-897.08(A) to allow for mentoring and/or monitoring as intermediate sanction options.

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FINDING II

CONSUMER INFORMATION ABOUT HEALTH AND CHILD CARE PROVIDERS INCOMPLETE, INACCURATE, AND RESTRICTED

Barriers impede the public's ability to obtain adequate, accurate information needed to make informed decisions about health and child care facilities. Easily accessible information regarding licensed facilities is crucial to help consumers select appropriate services and to avoid inadequate health and child care providers. However, the public information available at the Division of Assurance and Licensure Services (ALS) offices is often incomplete, inappropriate, and inaccurate. ALS needs to correct these problems, and then make public information available by telephone. In addition, ALS could also develop other means of providing public information to further benefit consumers.

Consumers can choose to protect themselves against problem facilities if they have easy access to accurate regulatory information. Studies show that consumers can affect the quality of services available when they have access to regulatory information about facilities.[1] Consumers who lack knowledge of available options and quality standards reduce the demand for good quality care. In contrast, consumers can encourage quality care if they are provided with information that enables them to choose higher-quality care and ask appropriate questions of lower-quality facilities.

Available Information Is Often Incomplete, Inappropriate, and Inaccurate

ALS is responsible for maintaining information about health and child care providers' complaint and licensing histories; however, the information currently contained in files available to the public and on its computerized databases is often incomplete, inappropriate, or inaccurate. In many cases, the public files available for review do not contain sufficient information to enable consumers to make informed decisions when selecting services. Further, the public files often inappropriately include confidential information. Finally, ALS' computer-

[1] Studies reviewed included the 1995 report, *Cost, Quality and Child Outcomes*, conducted by the University of Colorado, the University of California, the University of North Carolina, and Yale University; the 1998 Wisconsin Legislative Audit Bureau evaluation of Nursing Home Regulation; and the 1994 Families and Work Institute, *The Study of Children in Family Child Care and Relative Care.*

ized complaint and licensing databases cannot currently be relied upon to provide consumers with information due to data inaccuracies.

Public files are incomplete—ALS public files lack information consumers need to make informed decisions regarding licensed health and child care providers. To determine public file completeness, 50 randomly selected public files, 10 from each licensure program, were reviewed. ALS policy requires these public files to include approximately 3 years' worth of complaint investigation, enforcement, and licensing inspection information; however, 20 of the 50 files reviewed were missing records relating to complaints. By failing to maintain complete files, ALS makes it difficult for consumers who review the files to avoid problem facilities. To improve its files, ALS management needs to provide sufficient oversight to ensure files contain all required complaint information.

In addition, the complaint information that is available in the files lacks sufficient detail to enable consumers to judge facilities. Files contain complaint records that broadly categorize complaint allegations. However, these broad categories make it impossible to determine the concern that led to the complaint. For example, a complaint categorized as "care or services" may relate to allegations ranging from nurses being slow to respond to patients, to serious patient neglect. Although more detailed information about complaints is available, consumers must specifically request copies. To improve the accessibility of complaint information, ALS should include greater detail in the public files regarding allegations.

ALS fails to remove confidential information from the public files—Problems found with the information available in public files are further compounded by ALS' failure to remove confidential information. Arizona statutes, and ALS administrative rules and policies, require information to be kept confidential if it would identify children, patients, residents, the complainant, or the accused. Other identifying information, such as social security numbers and birth dates, should also be removed. Including this information is not only a violation of the law, it is also an invasion of privacy, and those identified may potentially be subject to fraud, retaliation, and damaged reputation. However, 39 of the 50 public files reviewed, or 78 percent, inappropriately included confidential information. For example, inappropriate confidential information contained in the public files identified:

- A resident of an adult care home by name, address, date of birth, social security number, and Medicare number; and,

- A facility employee accused of abuse by name, address, phone number, date of birth, and social security number.

ALS can implement both short-term and long-term solutions to resolve this problem. To remove confidential information currently in public files within one year, ALS license inspectors could review each licensed facility's public file prior to inspection or relicensure. At

that time, they should remove inappropriate information and ensure that dated information is purged. To prevent the reoccurrence of problems, ALS management needs to train staff in proper procedures and document compliance with ALS' current policy to monitor files quarterly.

Computer databases are inaccurate, inconsistent, and lack information—Currently, ALS computer complaint and licensing databases include inaccurate and incomplete information and therefore cannot be used as a substitute for public files to provide consumer information. A random sample of 50 complaints was reviewed to test the complaint databases for accuracy and completeness. The complaint databases contained inaccurate data for 27 of 48 complaints. The remaining two complaints could not be tested because paper files were missing information.

Further, the complaint database lacks sufficient controls to ensure data is entered correctly and consistently. For example, complaints for one adult care home were listed under ten different spellings of the facility's name and two different spellings of its address. To improve future accuracy, ALS needs to program additional data edit controls, train data entry personnel in proper and consistent procedures, and routinely monitor the database to ensure policies and procedures are being implemented.

ALS also needs to review the feasibility of expanding the information contained on its databases. The licensure databases currently only include information about the status of facility licenses. They do not include information about rule violations identified during regular license inspections. Further, only the Child Care Program licensing database can capture information about enforcement actions, such as stipulation agreements or civil penalties. ALS should work with DHS Management Information Systems staff to add fields for rule violations to all licensing databases and enforcement actions to the current health care licensure databases. Adding fields to the databases could enable ALS management to obtain more useful reports and could also allow the Division to better assist consumers.

Public Information Not Available by Telephone

Once database problems with accuracy and completeness are resolved, ALS should make health and child care regulatory information more readily available to consumers by telephone. Currently, the five licensure programs do not consistently provide consumers with information relating to complaints and inspection results by telephone.[1] In fact, A.R.S. §36-887, which was enacted in 1976 to provide for inspection of DHS child care files, prevents the Child Care Program from releasing information over the telephone because consumers

[1] The five licensing programs include Behavioral Health, Child Care, Home and Community Based, Long Term Care, and Medical Facilities.

must sign requests to review records. Although the other four licensure programs are not prohibited from providing public information by telephone, they lack a written policy for doing so. Consumers who call for information are typically asked to visit ALS offices and review public files in person.

Since telephone information about complaints and inspections is not consistently provided, consumers generally must choose between physically visiting ALS, the delay and cost of receiving mailed information, or remaining uninformed. For some consumers, visiting ALS can be a hardship. If consumers are unable to visit, ALS will mail copies of file contents for a fee of 25 cents per page. However, some files contain several hundred pages and copying an entire file's contents could be expensive. In addition, consumers are unlikely to know what information to specifically request.

Therefore, ALS should take steps to ensure consumers can easily obtain information regarding facilities. First, ALS should seek a statutory change to A.R.S. §36-887 to remove the signature requirement for reviewing child care public files to enable it to provide public information over the telephone. At the same time, ALS should develop and implement policies and procedures to allow it to provide public information about health care facilities by telephone. These same policies should be adopted by the child care program if the Legislature amends A.R.S. §36-887.

ALS Should Publicize the Availability of Information

While ALS is working to improve its files and databases, it could do more to promote the availability of information and to make more information available at facilities. For example, the Child Care Program publishes brochures that explain the regulatory process and educate consumers on how to select facilities. To assist consumers of health care services, ALS could consider developing similar brochures for its health care licensure programs. In addition, only the Child Care Program has consumer information available through the Yellow Pages Q & A line. These public information efforts are funded by the Department of Economic Security. The Q & A program provides information regarding selecting facilities, filing complaints, and how to become a licensed provider. Expanding this program to include the other ALS licensure programs could be done for approximately $10,000 annually. Finally, ALS could also develop additional promotional efforts. For example, California's Department of Health Services publicizes its regulatory functions during its Public Health Week events.

To further benefit consumers, ALS could require licensed facilities to provide consumers with information relating to inspection results. Currently, ALS rules differ by program as to what information facilities are required to provide consumers. For example, small facilities that provide child care are required to give enrollees copies of their most recent inspection results, but Home and Community Based facilities, such as adult and supervisory care

homes, are not even required to keep a copy of the inspection results on site. Federal law, 42 CFR §483.10(g), requires that facilities receiving Medicare or Medicaid monies, such as nursing homes, make inspection results readily accessible and post a notice of their availability. ALS should seek statutory amendments to A.R.S. §§36-425(A), 36-882(L), and 36-897.01(H) to require all facilities to follow the federal model for making inspection results available. If inspection results were available at the licensed facilities, it would make the information more easily accessible to consumers and could reduce ALS staff costs for providing consumer information.

Recommendations

1. ALS should improve public files by:

    a. Ensuring files contain all required complaint information;

    b. Removing confidential information from the public files by fully implementing current policies to remove confidential and dated information, and documenting quarterly management monitoring for compliance. Full implementation of the current policy by licensing inspectors prior to the next annual inspection or relicensure should result in appropriate files within one year; and,

    c. Providing consumers with a more detailed summary of complaint allegations.

2. ALS should improve the usefulness of its computer complaint and licensing databases by:

    a. Developing additional data edit controls and additional policies to ensure future data is accurate, complete, and consistent; training data entry staff in their proper implementation; and developing policies for documented management oversight to confirm compliance; and,

    b. Working with DHS Management Information Systems staff to develop additional information fields for rule violations and enforcement actions to the current licensure database. Once this additional information is captured, it can be used to provide complete facility profiles for management and for consumers.

3. ALS should develop and implement policies and procedures to allow it to provide public information about health care facilities by telephone.

4. ALS should seek a legislative amendment to A.R.S. §36-887 to remove the signature requirement for reviewing child care public files to enable it to provide public information over the telephone. Once the statute is amended, ALS should develop and implement policies and procedures to allow it to provide public information about child care facilities by telephone.

5. ALS should develop a more comprehensive and effective public information strategy to assist consumers by:

    a. Developing efforts such as brochures and advertising to inform consumers about the regulatory process and how to obtain public information; and,

    b. Seeking statutory amendments to A.R.S. §§36-425(A), 36-882(L), and 36-897.01(H) to require all licensed health and child care providers to post the availability of regulatory information and to make this information available in an area readily accessible to all consumers.

FINDING III

COMPLAINT INVESTIGATION PROCESS FOR MEDICAL FACILITIES IS SLOW, INADEQUATE

The Division of Assurance and Licensure's Medical Facilities Program does not adequately fulfill its complaint investigation responsibilities. Although the Division has policies establishing complaint investigation time frames, the Program's investigations do not always occur in a timely manner. Slow investigations have contributed to a backlog of complaints and limited the Program's ability to protect and serve the public. Further, the Program's policies and procedures are not sufficient to ensure low-priority complaints against accredited medical facilities, such as hospitals, are investigated.

The Medical Facilities Program is responsible for regulating approximately 1,300 licensed or certified health care facilities and providers throughout the State. The licensed facilities include approximately 86 hospitals; 70 inpatient facilities, such as hospices and infirmaries; 713 outpatient treatment and surgery centers; and 157 home health agencies. In addition, the Program works closely with the federal government's Health Care Financing Administration regarding certification of approximately 285 providers, such as independent physical therapists, who receive Medicare monies. As part of its regulatory duties, the Program is responsible for investigating complaints against these licensees and certificate holders. In 1997, the Program received 167 complaints against health care facilities and providers.

The Program Does Not Perform Timely Complaint Investigations

The Medical Facilities Program does not ensure complaints are investigated in a timely manner. Complaints are not always investigated within the time frames established by the Division's complaint prioritization policy. Division policies require complaints to be prioritized according to the seriousness of allegations. Specifically:

- **Priority 1—**Complaints involve situations of extreme emergency, and must be investigated within 48 hours;

- **Priority 2—**Complaints involve situations where hazards to health and safety may exist, but there is no indication of immediate danger. These complaints must be investigated within 10 working days;

- **Priority 3—**Complaints relate to situations where health and safety concerns are not major issues, and must be investigated within 30 working days;

- **Priority 4—**Complaints relate to infrequent situations that may be resolved based on communication with the complainant, and an on-site visit to the facility is unnecessary. There is no required investigation time frame associated with priority 4 complaints;

- **Priority 5—**Complaints that may be investigated at the next on-site visit to the facility. There is no investigation time frame set for priority 5 investigations.

The Program did not complete investigations within the required time frames for most of the complaints received in 1997. Of the 62 priority 1, 2, and 3 investigations performed, the Program did not complete 43 of them within required time frames, as shown in Table 3.

Table 3

Arizona Department of Health Services
Division of Assurance and Licensure Services, Medical Facilities Program
Number of Investigations Exceeding Standard Investigation Time
for 1997 Complaints Investigated[1]
As of May 1998

Priority	Number of 1997 Complaints Received	Number of 1997 Complaints Investigated	Number of Investigations Exceeding Standard Investigation Time
1	1	1	1
2	5	5	3
3	83	56	39
4	10	5	Not applicable
5	68	39	Not applicable

[1] As of May 1998, 106 of the 167 complaints received in 1997 were investigated. Of the remaining 61 complaints, 53 have yet to be investigated and 8 were closed without investigation because facilities closed, or because ALS considered the complaints outside its jurisdiction.

Source: Auditor General staff analysis of the Division of Assurance and Licensure Services complaint investigation policy and analysis of information contained on the Medical Facilities Program's complaint database.

Some Complaints Remain Uninvestigated

Failure to perform timely investigations has contributed to a backlog of complaints and limits the Program's ability to protect consumers and resolve their concerns. The Program has not investigated 46 priority 2 and 3 complaints received between 1994 and 1997. By not investigating these complaints in a timely manner, the Program has allowed allegations of substandard service to remain unaddressed. In addition, the Program has not adequately met the needs of consumers seeking to resolve complaints. Finally, the Program has limited its ability to substantiate complaints.

Slow investigations have resulted in a backlog of complaints—As of May 1998, the Program had not investigated a total of 97 complaints, 46 of which were priority 2 and 3 complaints, that were received between October 1994 and December 1997. These complaints have remained open more than 17 months on average, as shown in Table 4.

Table 4

Arizona Department of Health Services
Division of Assurance and Licensure Services, Medical Facilities Program
Comparison of Standard Investigation Times Versus the
Average Number of Days Open Complaints Remain Uninvestigated
As of May 1998

Priority	Number of Uninvestigated Complaints	Standard Investigation Time	Average Number of Days Uninvestigated Complaints Have Remained Open
2	1	10 working days	546 days
3	45	30 working days	550 days
4	7	Not applicable	558 days
5	44	Not applicable	525 days

Source: Auditor General staff analysis of the Division of Assurance and Licensure Services complaint investigation policy and analysis of information contained on the Medical Facilities Program's complaint database.

Although Program management receives reports indicating the length of time complaints have remained open, these complaints have not been assigned for investigation because there are limited surveyor staff. Surveyors are responsible for investigating complaints as well as inspecting facilities for compliance with licensing standards. In January 1997 the Program had 6 vacant surveyor positions out of a total of 15. However, the Program has since hired surveyors and, as of May 1998, the Program had only one vacant surveyor posi-

tion remaining. Management expects the additional surveyors to help improve the timeliness of complaint investigations. To ensure timeliness does improve, management needs to monitor the status of complaints and assign aging complaints to surveyors for investigation.

When complaints are not investigated, substandard practices may continue—When the Program fails to perform timely investigations, providers may continue to give substandard service. Twenty-three providers are the subject of multiple unresolved complaints. Some of the complaints against 7 of these providers contain similar allegations. For instance, one hospital is the subject of three separate unresolved complaints alleging inadequate provision and documentation of medications.

Failure to investigate leaves consumers' concerns unresolved—In addition, failure to investigate complaints in a timely manner negatively impacts consumers seeking to resolve concerns. A review of the 97 unresolved complaints identified at least 6 complainants who requested to be kept informed about their complaints. In fact, one complainant contacted the program at least 6 times—including 5 times in writing—attempting to have his complaint resolved, but the Program has been unresponsive. Although the complaint was received in January 1997, it was not until April 1998 that the Program informed the complainant that it intended to begin an investigation in July 1998.

Untimely investigations limit the Program's ability to substantiate complaints—Finally, failure to investigate complaints in a timely manner has resulted in some complaints becoming so old that they were closed without investigation. Based on a review of complaint files closed between January 1998 and May 1998, the Program did not investigate 11 of 94 complaints before closing them. Most of these complaints alleged that facilities provided inadequate care to patients. According to Division and Program management, 5 of the 11 complaints were closed because they were so old that it would have been difficult to substantiate the allegations. In addition, the Program closed 6 more complaints without investigation because, according to management, the facilities had gone out of business. However, at the time the complaints were received, the facilities were still operating. Program records show that 5 of the 6 complaints were rated priority 3 and should have been investigated within 30 days.

Some Complaints Against Medical Facilities May Not Result in Investigations

The Program has not established procedures to ensure that low-priority complaints against accredited medical facilities are investigated. The Division's formal policy for investigating complaints assigned the lowest priority, priority 5, is to perform these investigations at the time it conducts a facility's next regular licensing inspection. This policy helps ensure that

priority 5 complaint investigations are completed at a majority of licensed facilities. However, this policy does not address procedures for investigating priority 5 complaints against accredited medical facilities, which are not subject to regular licensing inspections.

A review of the Program's 97 unresolved complaints identified 28 priority 5 complaints against accredited facilities. These complaints include allegations ranging from unsanitary room conditions to a patient dying from complications of an alleged overdose of medication administered by hospital staff. As of May 1998, these complaints had been open an average of 18 months, with the oldest dating back to October 1994.

According to Program management, the informal policy is to investigate priority 5 complaints against accredited facilities when a higher priority complaint is received and investigated. However, priority 5 complaints are only completed if time permits. If a surveyor is unable to complete a priority 5 investigation, the complaint is held until another higher-priority complaint against the facility is received and investigated.

Recommendations

1. The Medical Facilities Program needs to improve its complaint-handling practices, policies, and procedures. Specifically:

    a. Medical Facilities Program management needs to monitor whether complaints are investigated within time frames set by Division policy and to assign aging complaints to surveyors for investigation; and

    b. Management needs to make efforts to ensure that priority 5 complaints against accredited medical facilities are investigated and resolved.

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OTHER PERTINENT INFORMATION

During the audit, we gathered other pertinent information regarding the Department of Health Services' statutory responsibilities to collect licensing fees from health care facilities and to regulate speech pathologists and audiologists.

Health Care Licensing Fees Not Collected

The Department has recently begun taking steps to implement a 1989 law requiring it to collect licensing fees from health care facilities. Although ALS has made attempts to implement the fees in the past, all efforts to collect the monies were postponed. ALS is now drafting rules that should facilitate collection of the fees by late 1999.

Collecting licensing fees from health care facilities could contribute as much as $917,000 to the General Fund based on the number of facilities licensed in 1998. Health care licensing fees range from $100 to $500, depending on the size of the facility, plus an additional charge of $10 per bed. These monies would be in addition to the approximately $160,000 in licensing and other fees currently collected each year from child care providers and from hearing aid dispensers.[1]

Speech Pathologists and Audiologists Not Yet Licensed

The Assurance and Licensure Division is also currently working to implement a 1995 law requiring it to license speech pathologists and audiologists. A.R.S. Title 36, Chapter 17, which established licensing requirements for hearing aid dispensers in 1970, was amended in 1995 to include licensure for speech pathologists and audiologists. The amendment added substantially to ALS' existing responsibilities for licensing hearing aid dispensers, but monies were not appropriated for additional staffing. Currently 2 full-time ALS staff are dedicated to licensing approximately 400 hearing aid dispensers. The Department of Health Services, as part of its 1999 budget request, is seeking appropriations for 1 additional FTE to perform the licensing activities for the more than 1,000 speech pathologists and audiologists estimated to be practicing in the State.

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[1] Licensing fees for child-care facilities were first established in 1966, and licensing fees for hearing aid dispensers were established in 1991.

Although additional staff have yet to be funded, ALS has progressed in the rule-making process. The Department estimates that the proposed rules will become effective in early 1999.

Agency Response

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Office of the Director

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(602) 542-1025
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September 14, 1998

Mr. Douglas R. Norton, CPA
Auditor General
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85004

Dear Mr. Norton:

Thank you for the opportunity to review the report of the Performance Audit, conducted as part of the Sunset Review set forth in A.R.S. §§41-2951 through 41-2957, of the Arizona Department of Health Services (ADHS), Division of Assurance and Licensure Services.

The findings and recommendations contained in your report have been carefully reviewed by the staff of ADHS, and in accordance with the instructions contained in your letter of September 3, 1998, the attached response is provided.

ADHS greatly appreciates the hard work and professionalism shown by your staff during the conduct of their audit. We also appreciate the insights provided by your staff during the audit process and through the audit's findings and recommendations. From the knowledge gained as a result of your efforts, we will be able to significantly change many of the work processes that relate to the licensing and regulation of health and child care facilities. As a result of such changes, we will be able to better serve both providers and consumers of health and child care services within the State of Arizona.

Sincerely,

James R. Allen, M.D., M.P.H.
Director

JRA:gw

Attachments (2)

Arizona Department of Health Services
Responses to Recommendations of the Office of the Auditor General's Report on the Division of Assurance and Licensure Services*

Finding I Recommendations and Responses

1. ALS should use all available enforcement authority, including assessing civil fines and progressing to stronger enforcement actions, such as banning admissions, restricting services, and reducing licensure capacity, when it cites repeat violations.

   Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

2. ALS should seek statutory changes to strengthen its enforcement authority, which would include:

   a. Modifying ARS §§36-891, 36-897.06, and 36-431.01 to allow for higher civil fine amounts and to allow monies collected to be used for programs that improve the quality of care;

   b. Amending ARS §§36-891 to allow civil penalties to be levied against child care facilities without requiring ALS to physically document each day a violation occurs;

   c. Modifying ARS §§36-891(A), 36-897.06(A), and 36-431.01 to allow for reductions in civil fines if a facility waives its right to a hearing; and

   d. Amending ARS §§36-891.01 and 36-897.08 to allow intermediate sanctions to be imposed immediately against child care facilities and possibly amending ARS §§36-427(C), 36-891.01(A), and 36-897.08(A) to allow for mentoring and/or monitoring as intermediate sanction options.

   Response: The finding of the Auditor General is agreed to and the audit recommendations will be implemented. ***Note: In addition to the identified changes in legislation, additional funding for the implementation of those changes will also be required.***

Finding II Recommendations and Responses

1. ALS should improve public files by:

   a. Ensuring files contain all required complaint information.

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*See also the attached Appendix for additional discussion.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

b. Removing confidential information from the public files by fully implementing current policies to remove confidential and dated information, and documenting quarterly management monitoring for compliance. Full implementation of the current policy by licensing inspectors prior to the next annual inspection or relicensure should result in appropriate files within one year.

Response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented. Specifically: Support staff will be responsible for removing confidential and dated information from the public files. Through the use of a quality review protocol, this staff work will be reviewed to ensure that public files are free from confidential and dated material.

c. Providing consumers with a more detailed summary of complaint allegations.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

2. ALS should improve the usefulness of its computer complaint and licensing databases by:

a. Developing additional data edit controls and additional policies to ensure future data is accurate, complete, and consistent; training data entry staff in their proper implementation; and developing policies for documented management oversight to confirm compliance; and

b. Working with DHS Management Information Systems staff to develop additional fields for rule violations and enforcement actions to the current licensure database. Once this additional information is captured, it can be used to provide complete facility profiles for management and for consumers.

Response: The finding of the Auditor General is agreed to and the audit recommendations will be implemented.

3. ALS should develop and implement policies and procedures to allow it to provide public information about health care facilities by telephone.

Response: The finding of the Auditor General is agreed to and a different method of dealing with the recommendation will be implemented. ALS will do the following to address the finding:

a. Adopt a telephone information policy. This policy will standardize the set of information that will be provided via the telephone to consumers. Further, ALS

will ensure that staff is trained to the policy's standards. While ALS currently, and has for many years, provided telephonic information to consumers, it is apparent that the lack of an overall Division policy has contributed to an inconsistent practice regarding the dissemination of information over the telephone.

b. Begin the process of identifying material that is suitable to post on the Internet. An Internet option can be a valuable tool for those persons that cannot make a trip to the ALS offices to view provider files in person.

ADHS would like to stress, however, that the demand for public information must be balanced with (1) the resources that are made available for Division operations and (2) the need to ensure a measure of fairness exists to those parties regulated by ADHS. ALS neither has, nor is likely to obtain, the resources necessary to operate a full-scale public information section. In addition, the nature of the licesning process often does not produce the "black and white" answers that are generally desired by those making inquiries of ALS. Even with the Internet, the materials associated with licensing surveys and complaint investigations do not readily help someone answer the typical questions often posed to ALS such as:

"Is this a good or bad provider?"
"If a facility has a lot of complaints against it, doesn't that say something, even if the complaints are not substantiated?"
"What facility would you recommend?"

While ALS can clearly do a better job in disseminating information, we will always have a challenge in determining the proper boundaries of our public information role. Where information ends and advocacy/advice begins is often a very fine line. The Office of the Auditor General has consistently been a voice for public/consumer information. ADHS agrees with this perspective. As the entity tasked with licensing and regulating various activities and persons, however, we must also be cognizant of issues of fairness and due process as they pertain to providers. Ensuring that both consumer and provider demands regarding public information are met, and striking an appropriate balance when the two are in conflict, remain on-going challenges for ADHS.

4. ALS should seek a legislative amendment to ARS §36-887 to remove the signature requirement for reviewing child care public files to enable it to provide public information over the telephone. Once the statute is amended, ALS should develop and implement policies and procedures to allow it to provide public information about child care facilities by telephone.

Response: The finding of the Auditor General is agreed to and a different method of dealing with the recommendation will be implemented. ALS agrees that a legislative amendment to ARS §36-887 is needed to ensure a more "user-friendly" means of

obtaining public information. Regarding the remainder of the recommendation, please see the previous response to Recommendation 3.

5. ALS should develop a more comprehensive and effective public information strategy to assist consumers by:

   a. Developing efforts such as brochures and advertising to inform consumers about the regulatory process and how to obtain public information.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. ***Note: To be effective, additional funding will be needed to implement this recommendation.***

   b. Seeking statutory amendments to A.R.S. §§36-425(A), 36-882(L) and 36-897.01(H) to require all licensed health and child care providers to post the availability of regulatory information and to make this information available in an area readily accessible to all consumers.

Response: The finding of the Auditor General is agreed to and ADHS will seek legislative change to facilitate the implementation of the recommendation.

Finding III Recommendations and Responses

1. The Medical Facilities Program needs to improve its complaint-handling practices, policies, and procedures. Specifically:

   a. Medical Facilities Program management needs to monitor whether complaints are investigated within time frames set by Division policy and to assign aging complaints to surveyors for investigation; and

   b. Management needs to make efforts to ensure that priority 5 complaints against accredited medical facilities are investigated and resolved.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented. ***Note: The ability for the Office of Medical Facilities to eliminate completely the backlog of complaint investigations, and to keep up with the ever increasing number of licensing inspections, is predicated on the appropriation of additional funding to increase surveyor staffing levels. To this end, the Division of Assurance and Licensure Services has requested, and will continue to request, funding for additional survey staff in this program area.***

APPENDIX
Arizona Department of Health Services
Response to the Findings Narratives Contained in the Office of the Auditor General's Report on the Division of Assurance and Licensure Services

Finding I: ALS Does Not Take Sufficient Action Against Problem Facilities

Response:

While the Department agrees with the finding of the Auditor General, it also believes that the following information should be considered:

1. The Division of Assurance and Licensure Services has long recognized the need to expand the use of progressive enforcement steps when warranted, and within the past year has begun assessing civil fines in both long-term care and home and community based facilities. However, in order to maximize the utilization of civil monetary penalties as a progressive enforcement tool, and assure that those civil monetary penalties are appropriately assessed, the following additional requirements are needed:

    a. Authority to determine the best use of civil monetary penalties collected.

    b. Development and implementation Administrative Rules.

    c. Appropriation of adequate funding for staff to collect and monitor civil monetary penalties.

2. Within the past two years the Division of Assurance and Licensure Services has expanded the Informal Dispute Resolution requirements of Long-Term Care facilities to include all licensed health and child care facilities. This action has served as a tool that has been used to communicate effectively with facilities and to determine whether a facility is in substantial compliance with licensure rules and regulations.

3. The Division of Assurance and Licensure Services initiated, in the Fall of 1997, an internal Task Force to review and develop internal policies and procedures to establish parameters and thresholds for the application of intermediate sanctions. This includes the banning of admissions and/or the limiting of services.

4. While the Department of Health Services has statutory authority to apply intermediate sanctions, it does not have the authority to enforce them, and through the use of the appeals process some facilities have been able to circumvent the intermediate sanctions applied by the Department. In the last year the Department sought the statutory changes required to allow it to enforce intermediate sanctions that were imposed. These proposed statutory changes were rejected by the Legislature.

5. During the 1998 legislative session, the Department of Health Services sought and obtained statutory authority [ARS §36-425.(F)] to deny a health care institution license to any individual who has had a health care institution license or professional license or certificate denied, revoked or suspended, or who has recent serious violations against their health care license. The Department sought this statutory change to prevent facility operators who have a history of substantial non-compliance from moving to another facility or from re-licensing a facility whose license has been denied or revoked.

In addition, the narrative for this finding contains a section titled *Other options for improving compliance include mentoring and monitoring programs* - which states: "Other states have developed training and monitoring programs to improve compliance. For instance, Maryland has implemented a mentoring program that pairs facility managers from poorly performing facilities with managers from model facilities. The mentoring program allows the facility's staff to improve operating skills in a non-threatening, real-world environment. In addition, Missouri and Indiana can require health care facilities to pay for independent monitors as part of consent agreements when a probationary license is issued, or when other action such as revocation is initiated. These monitors perform the necessary follow-up to ensure compliance. The independent monitors must be approved by the licensing agency and submit reports on the facility's progress toward achieving compliance." In order to determine how each of these mentoring and monitoring programs were administered, each State indicated in this example was called. The following information, which differs somewhat from that provided in the Auditor General's report, was obtained:

Maryland:

The Department of Health in Maryland does not have a mentoring program. The only one that the Department knows about is one that the State Association for Community Service Providers established several years ago. This association is composed of providers serving the developmentally disabled and elderly in home and community based facilities. The mentoring program is entirely run by the provider association, and they do not share any information on their program with the State of Maryland.

Indiana:

Under Indiana statute (Indiana Code 16-28-7-1), a monitor may be appointed when the Department has initiated license revocation procedures, such as when the life, health, safety, security, rights, or welfare of the patients cannot be adequately assured. When a monitor is appointed, the facility is required to pay all direct costs. However, it should be noted that the State of Indiana has sometimes had difficulty finding qualified individuals to serve as monitors. If no independent monitor is available when needed, a state surveyor(s) is assigned to monitor the facility. When a state surveyor is used as a monitor, the state assumes responsibility for all direct costs. In addition, there is one state staff person (a long term care surveyor) who manages this project as part of the state's long term care enforcement effort.

Finding II: Consumer Information About Health And Child Care Providers Incomplete, Inaccurate, And Restricted

Response:

With the exception of that portion of this finding that deals with the provision of telephonic complaint information to consumers, the Department agrees with the finding of the Auditor General. The Department also believes that the following information should be considered:

1. Public files contain detailed information on substantiated complaint allegations, as well as the facility's Plan of Correction. Allegations are stated in broad categories only when the complaint cannot be substantiated.

2. In 1997, as an aid to summarize complaint information in the public files, the Division of Assurance and Licensure Services developed a "findings letter" that informs individuals filing complaints of the outcome of the investigation. This findings letter, which was developed with input and support from industry representatives, consumer advocates, and the Attorney General's Office, is maintained in the public file of each facility.

3. The Department of Health Services recognizes the importance of accurate and complete database information. However, the number of staff available to develop and maintain these databases has not kept pace with growth in the number of health and child care facilities licensed and monitored by the Division of Assurance and Licensure Services.

Finding III: Complaint Investigation Process For Medical Facilities Is Slow, Inadequate

Response:

The Department concurs with the finding of the Auditor General. The Department also believes that the following information should be considered:

1. The Office of Medical Facilities, whose licensing surveyors are all Registered Nurses, has worked diligently to improve the salary schedule for its survey personnel. In May 1996 a Special Entrance Rate was established for licensing surveyors, and only since then has this program been able to attract and retain qualified professionals to perform licensure and Medicare certification surveys, and complaint investigations.

2. The number of medical facilities in Arizona has increased by 60% since 1992, ranging from new hospitals (e.g., the Mayo Clinic Hospital) to a rapid increase in the number of home health agencies which are complex to review for licensure and certification. This increase has significantly impacted the number of licensure and Medicare certification surveys as well as complaint investigations required to be completed by staff of the Office of Medical Facilities. Since 1992 the Office of Medical Facilities has been unable to secure an increase in the

number of authorized FTEs (Full Time Equivalent Positions) needed to accomplish this increased workload.

3. The management of the Office of Medical Facilities has recently implemented a process of reviewing the complaint backlog on a weekly basis, and since October 1997 has assigned one staff member the task of coordinating and facilitating the complaint investigation process. As a result, the complaint backlog for the Office of Medical Facilities has been reduced from 112 in October 1997, to its current level of 80 (a 29% reduction).

4. As a result of process improvement initiatives, in addition to reducing the backlog, the Office of Medical Facilities is now keeping current on the investigation of new complaints. Each complaint is evaluated and assigned a priority ranking based on potential risk to patients, and those that are of highest priority (complaints that potentially impact on the health and safety of patients) are investigated first.