MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF

ADULT PROTECTIVE SERVICES

DEPARTMENT OF HUMAN SERVICES

July 2014

Doug A. Ringler, C.P.A., C.I.A.
AUDITOR GENERAL

431-2601-13

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– Article IV, Section 53 of the Michigan Constitution

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REPORT SUMMARY

Performance Audit

Adult Protective Services

Department of Human Services

Report Number:
431-2601-13

Released:
July 2014

Adult Protective Services (APS) provides protection to vulnerable adults who are at risk of harm because of the presence or threat of abuse, neglect, and/or exploitation. APS's goal is that its services will provide immediate (within 24 hours) investigation and assessment of situations referred to the Department of Human Services (DHS) when a vulnerable adult is suspected of being or believed to be abused, neglected, or exploited and assure that adults in need of protection are living in a safe and stable situation, including legal intervention, where required, in the least intrusive or restrictive manner.

Audit Objective:
To assess the effectiveness of DHS's efforts in evaluating APS activities to protect vulnerable adults.

Audit Conclusion:
We concluded that DHS's efforts in evaluating APS activities to protect vulnerable adults were not effective. We noted two material conditions (Findings 1 and 2).

Material Conditions:
DHS had not fully developed and implemented a process to evaluate the effectiveness of APS intervention services (Finding 1).

APS supervisors did not consistently review closed APS investigation cases, as required. Also, DHS did not ensure that APS supervisors conducted reviews of closed APS investigation cases that effectively detected unaddressed allegations, incomplete APS client service plans, and missed monthly face-to-face contacts with APS clients (Finding 2).

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Audit Objective:
To assess the effectiveness of DHS's efforts in determining whether a referral of adult abuse, neglect, and/or exploitation should be accepted for investigation, denied, withdrawn, or referred to law enforcement.

Audit Conclusion:
We concluded that DHS's efforts in determining whether a referral of adult abuse, neglect, and/or exploitation should be accepted for investigation, denied, withdrawn, or referred to law enforcement were moderately effective. We noted one reportable condition (Finding 3).

Reportable Condition:
DHS occasionally denied or withdrew referrals of adult abuse, neglect, and/or

exploitation when justification to warrant assignment for an investigation appeared to exist. In addition, APS did not consistently notify law enforcement when a referral indicated potential criminal activity (Finding 3).

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Audit Objective:
To assess the effectiveness of DHS's efforts in investigating accepted referrals of adult abuse, neglect, and/or exploitation.

Audit Conclusion:
We concluded that DHS's efforts in investigating accepted referrals of adult abuse, neglect, and/or exploitation were not effective. We noted three material conditions (Findings 4, 5, and 6) and one reportable condition (Finding 7).

Material Conditions:
DHS county/district offices did not begin and conduct APS investigations in accordance with standards of promptness established by the *Michigan Compiled Laws* and DHS policies (Finding 4).

APS caseworkers did not always conduct monthly face-to-face contacts with APS clients with open APS investigations, as required (Finding 5).

DHS did not investigate all allegations identified in referrals assigned for an APS investigation (Finding 6).

Reportable Condition:
DHS had not instituted annual continuing education training requirements for APS caseworkers and supervisors (Finding 7).

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Audit Objective:
To assess the effectiveness of DHS's efforts in identifying and providing appropriate services for accepted APS referrals of adult abuse, neglect, and/or exploitation.

Audit Conclusion:
We concluded that DHS's efforts in identifying and providing appropriate services for accepted APS referrals of adult abuse, neglect, and/or exploitation were moderately effective. We noted one material condition (Finding 8).

Material Condition:
APS caseworkers did not consistently complete APS client service plans as required. In addition, APS caseworkers did not consistently complete APS client service plans within the required time frames (Finding 8).

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Agency Response:
Our audit report contains 8 findings and 11 corresponding recommendations. DHS's preliminary response indicates that it agrees with 6 findings and agrees in part with 2 findings.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: http://audgen.michigan.gov

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AUDITOR GENERAL

July 9, 2014

Ms. Maura D. Corrigan, Director
Department of Human Services
Grand Tower
Lansing, Michigan

Dear Ms. Corrigan:

This is our report on the performance audit of Adult Protective Services, Department of Human Services (DHS).

This report contains our report summary; a description of agency; our audit objectives, scope, and methodology and agency responses and prior audit follow-up; comments, findings, recommendations, and agency preliminary responses; a schedule of adult abuse, neglect, and/or exploitation referrals received by DHS, presented as supplemental information; and a glossary of abbreviations and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's response at the end of our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Doug Ringler

Doug Ringler, C.P.A., C.I.A.
Auditor General

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DEPARTMENT OF HUMAN SERVICES

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Description of Agency

Adult Services, Children's Services Administration, Department of Human Services (DHS), is responsible for the overall administration of Adult Protective Services (APS), including the development of policies and procedures. DHS's Field Operations Administration oversees APS caseworkers and supervisors located in DHS county/district offices throughout the State and is responsible for implementing the provisions of the Social Welfare Act (Act 280, P.A. 1939, as amended, being Sections 400.1 - 400.119b of the *Michigan Compiled Laws)* and APS policies and procedures.

DHS's APS provides protection to vulnerable* adults who are at risk of harm because of the presence or threat of abuse*, neglect*, and/or exploitation*. APS's goal* is that its services will:

1. Provide immediate (within 24 hours) investigation and assessment of situations referred to DHS when a vulnerable adult is suspected of being or believed to be abused, neglected, or exploited.

2. Assure that adults in need of protection are living in a safe and stable situation*, including legal intervention, where required, in the least intrusive or restrictive manner.

Beginning in March 2012, DHS established a centralized intake unit* to receive all complaints of abuse, neglect, and/or exploitation of vulnerable adults Statewide. Prior to the implementation of the centralized intake unit, DHS county/district offices received complaints of alleged abuse, neglect, and/or exploitation of vulnerable adults. The centralized intake unit receives and logs all complaints of suspected abuse, neglect, and/or exploitation of vulnerable adults at risk of harm and then sends a referral* for each complaint received to the applicable DHS county/district office complaint coordinator for evaluation.

APS received 80,377 referrals of abuse, neglect, and/or exploitation of vulnerable adults during fiscal years 2010-11 through 2012-13. During this time period, DHS realized a

* *See glossary at end of report for definition.*

62% increase in APS referrals (see supplemental information). DHS attributes the implementation of the centralized intake unit in March 2012 as a significant factor in the increase. In addition, according to the National Adult Protective Services Resource Center* (NAPSRC) report entitled *Adult Protective Services in 2012: Increasingly Vulnerable,* the current recession, coupled with rapidly increasing senior populations, has created more of a demand for APS services. Based on a 2012 survey of states conducted by the National Association of States United for Aging and Disabilities* (NASUAD), the NAPSRC stated in its report that 85% of the surveyed states reported increases in their substantiated* reports and caseloads over the past five years.

An APS supervisor initially screens the referral to determine if the referred complaint involves an adult at risk of harm from abuse, neglect, or exploitation and if there is reasonable belief that the individual is vulnerable and in need of APS. When the APS supervisor determines an adult is at risk and the adult is vulnerable and in need of APS, the APS supervisor accepts the referral and assigns it to an APS caseworker for investigation. The APS supervisor must notify the referral source in writing that its complaint has been received and is being investigated or that its complaint is not appropriate for an APS investigation and is being denied, withdrawn, or referred to law enforcement. For a complaint that the APS supervisor denied, the letter must include specific reasons why the APS supervisor did not assign the complaint for investigation.

During the APS investigation process, the APS caseworker determines if evidence exists to substantiate that a vulnerable adult was abused, neglected, or exploited. The APS caseworker must offer APS intervention when the investigation determines that the adult is in need of protective services* because the adult is vulnerable and in danger of harm from the presence or threat of abuse, neglect, or exploitation. The APS caseworker must determine the feasibility and availability of resources needed to meet the protective goals for the adult. The APS caseworker must make available the most appropriate and least restrictive protective services* to the adult in all substantiated cases*. The APS caseworker must take necessary action in all substantiated cases to safeguard and enhance the welfare of the adult, if possible.

The APS caseworker must complete a service plan* for the client* within 30 calendar days of the referral date for all investigation cases for which services will be provided to the adult. Examples of APS client services that APS arranges and pays for are

* *See glossary at end of report for definition.*

housecleaning, emergency housing, or household maintenance/equipment. The APS caseworker must complete one face-to-face contact per month with the client on open APS investigation cases.

APS had approximately 109 full-time equated central office and DHS county/district office employees as of September 30, 2013. DHS determines the number of full-time equated APS employees needed by applying a national caseload ratio standard of 25:1 to the Statewide 12-month caseload average of active APS cases. DHS then allocates the calculated total to each DHS county/district office based on the relative percentage of the county/district office's average number of open APS cases.

During the period October 1, 2010 through September 30, 2013, DHS annually expended an estimated $11.7 million (using a combination of General Fund/general purpose and federal Medicaid funding) on APS operations and activities, of which approximately $209,000 (General Fund/general purpose funds) was annually expended for services on behalf of APS clients.

Audit Objectives

Our performance audit* of Adult Protective Services (APS), Department of Human Services (DHS), had the following objectives:

1. To assess the effectiveness* of DHS's efforts in evaluating APS activities to protect vulnerable adults.

2. To assess the effectiveness of DHS's efforts in determining whether a referral of adult abuse, neglect, and/or exploitation should be accepted for investigation, denied, withdrawn, or referred to law enforcement.

3. To assess the effectiveness of DHS's efforts in investigating accepted referrals of adult abuse, neglect, and/or exploitation.

4. To assess the effectiveness of DHS's efforts in identifying and providing appropriate services for accepted APS referrals of adult abuse, neglect, and/or exploitation.

Audit Scope

Our audit scope was to examine the records and processes related to the Department of Human Services' administration of Adult Protective Services. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered the period October 1, 2010 through September 4, 2013.

* *See glossary at end of report for definition.*

Our audit report includes supplemental information. Our audit was not directed toward expressing an opinion on this information and, accordingly, we express no opinion on it.

Audit Methodology

We conducted a preliminary survey of DHS's APS to gain an understanding of APS operations and activities in order to establish our audit objectives and methodology. During our preliminary survey, we interviewed APS management and staff and APS county/district office directors, managers, supervisors, and caseworkers; reviewed applicable State laws; reviewed APS policies and procedures; and analyzed available APS records, data, and statistics to obtain an understanding of APS operations and activities and internal control*. We also interviewed DHS's APS training coordinator to gain an understanding of the APS training process and requirements for APS caseworkers and supervisors. We performed on-site visits at three DHS county/district offices and interviewed APS managers, supervisors, and caseworkers to gain an understanding of the referral assignment process, investigation process, and the process DHS used to identify and evaluate the services provided to APS clients.

To accomplish our first audit objective, we interviewed key APS management, APS central office staff, and APS county/district office directors, managers, supervisors, and caseworkers at 12 judgmentally selected DHS county/district offices to obtain an understanding of DHS's process to evaluate the effectiveness of APS activities. In addition, we obtained an understanding of DHS's APS goals, desired outcomes* and performance measures*, and risk assessment* process for its APS intervention services provided to vulnerable adults. We reviewed DHS's analyses of a select number of APS outputs* to determine DHS's compliance with legal or policy requirements, such as the 24-hour and 72-hour response times and the completion of service plans within 30 days. We obtained an understanding of APS's monitoring process of closed investigation cases. Based on risk or random selection, we selected 199 closed APS investigation cases to determine if APS supervisors were timely in their review of closed investigation cases; whether the APS supervisory review process was effective in ensuring that closed investigations addressed all allegations identified in the referral or during the investigation; if APS client service plans were completed when required; and whether caseworkers maintained monthly face-to-face meetings with the client throughout the investigation.

* *See glossary at end of report for definition.*

To accomplish our second audit objective, we interviewed key APS management, APS central office staff, and APS county/district office managers, supervisors, and caseworkers at 12 judgmentally selected DHS county/district offices to obtain an understanding of APS's process to determine whether a referral of adult abuse, neglect, and/or exploitation should be accepted for investigation. We examined APS's policies and procedures to determine APS's requirements for accepting a referral for investigation. Based on risk or random selection, we selected 124 denied and withdrawn APS referrals to determine if APS supervisors appropriately denied the APS referrals for investigation. Also, we reviewed the denied and withdrawn APS referrals to determine whether APS supervisors notified law enforcement when the APS referral documentation indicated that potential criminal activity occurred. In addition, based on risk or random selection, we selected 219 APS referrals assigned for investigation to ascertain that the assignment was appropriate.

To accomplish our third audit objective, we interviewed key APS management, APS central office staff, and APS county/district office managers, supervisors, and caseworkers at 12 judgmentally selected DHS county/district offices to obtain an understanding of APS's process in investigating accepted referrals of adult abuse, neglect, and/or exploitation. During our visits, we examined selected APS case records to determine the compliance, performance, and timeliness of referrals assigned for investigation; the proper, timely completion of 24-hour and 72-hour standards of promptness requirements; the proper, timely completion of monthly face-to-face visits with clients; and the completion of investigations and service plans. Based on risk or random selection, we selected 219 referrals assigned for investigation to determine if APS made an initial contact within the 24-hour standards of promptness requirement and whether APS conducted a face-to-face interview with the adult within the 72-hour standards of promptness, when required. We also selected 162 open and closed investigations based on risk or random selection that required monthly face-to-face contact to determine if the APS caseworker conducted a face-to-face meeting with the APS client during each month that the APS investigation was open. Based on risk or random selection, we selected 205 closed investigations to determine if APS addressed all allegations identified in the referral or discovered during the investigation. We met with DHS's APS training coordinator to gain an understanding of the APS training process and requirements for APS caseworkers and supervisors. We interviewed 24 supervisors and caseworkers at 12 judgmentally selected DHS county/district offices regarding DHS's APS training process. We compared DHS's annual training

requirements for APS caseworkers and supervisors with the amount of training other states provide APS investigators and/or caseworkers based on the National Adult Protective Services Resource Center (NAPSRC) report entitled *Adult Protective Services in 2012: Increasingly Vulnerable.* This report included a survey of states regarding the amount of annual training that states provided to APS investigators and/or caseworkers.

To accomplish our fourth objective, we interviewed key APS management, APS central office staff, and APS county/district office managers, supervisors, and caseworkers at 12 judgmentally selected DHS county/district offices to obtain an understanding of APS's process in identifying and providing appropriate services for accepted APS referrals of adult abuse, neglect, and/or exploitation. We examined case file documentation located at each of the 12 selected DHS county/district offices during our evaluation of DHS's efforts in identifying and providing appropriate services for accepted APS referrals of adult abuse, neglect, and/or exploitation. We selected 175 APS investigation cases based on risk or random selection that required an APS client service plan to determine if APS caseworkers completed APS client service plans; completed the APS client service plans within the required time frame; addressed all allegations identified in the referral or investigation in the APS client service plan; obtained the required signatures of the applicable parties to the client service plan; and updated service plans when required. Based on risk or random selection, we selected 219 cases assigned for investigation and reviewed 25 payments made on behalf of APS clients associated with these 219 cases to determine if payments made on behalf of the APS clients were allowed by APS policy, properly supported, reasonable, and needed to keep the clients safe from abuse, neglect, and/or exploitation. We also judgmentally selected and reviewed 55 payments made on behalf of other APS clients to determine if the payments were allowed by APS policy, properly supported, reasonable, and needed to keep the clients safe from abuse, neglect, and/or exploitation.

When selecting activities or programs for audit, we use an approach based on assessment of risk and opportunity for improvement. Accordingly, we focus our audit efforts on activities or programs having the greatest probability for needing improvement as identified through a preliminary survey. Our limited audit resources are used, by design, to identify where and how improvements can be made. Consequently, we prepare our performance audit reports on an exception basis.

Agency Responses and Prior Audit Follow-Up

Our audit report contains 8 findings and 11 corresponding recommendations. DHS's preliminary response indicates that it agrees with 6 findings and agrees in part with 2 findings.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments at the end of our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require DHS to develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We released our prior performance audit of Adult Protective Services, Family Independence Agency (43-260-02), in April 2003. Within the scope of this audit, we followed up 12 of the 15 prior audit recommendations. DHS complied with 6 of the 12 prior audit recommendations, and we rewrote 6 of the 12 prior audit recommendations for inclusion in Findings 1, 4, 6, and 8 of this audit report.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFORTS IN EVALUATING ADULT PROTECTIVE SERVICES ACTIVITIES TO PROTECT VULNERABLE ADULTS

COMMENT

Audit Objective: To assess the effectiveness of the Department of Human Services' (DHS's) efforts in evaluating Adult Protective Services (APS) activities to protect vulnerable adults.

Audit Conclusion: We concluded that DHS's efforts in evaluating APS activities to protect vulnerable adults were not effective.

Our audit conclusion was based on our audit efforts as described in the audit scope and audit methodology sections and the resulting material conditions* noted in the comments, findings, recommendations, and agency preliminary responses section.

Our audit efforts disclosed two material conditions related to the evaluation of APS effectiveness and the review of closed investigation cases (Findings 1 and 2). In our professional judgment, the material conditions are more severe than a reportable condition* and could impair management's ability to operate effectively or efficiently.

We took into consideration both quantitative and qualitative factors in reaching a conclusion on the effectiveness of DHS's efforts in evaluating APS activities to protect vulnerable adults. We considered the significant error rates we noted during our testing of DHS's reviews of closed APS investigation cases and the potential impact on DHS's ability to effectively evaluate APS activities. We also considered the significance of the absence of desired outcomes and performance measures on DHS's ability to evaluate the effectiveness of APS intervention services. In addition, we considered the significance of DHS's risk assessment process to evaluate its APS intervention services. We further considered the importance of effective APS intervention services to provide protection to vulnerable adults who are at risk of harm because of the presence or threat of abuse, neglect, and/or exploitation. Because our audit efforts noted that DHS did not perform required reviews of a significant percentage of the closed APS investigation cases, had considerable deficiencies in the reviews of closed APS investigation cases, and had not fully developed or implemented a process to

* *See glossary at end of report for definition.*

evaluate the effectiveness of its APS activities, we determined that a conclusion of not effective was appropriate. We believe that the results of our audit efforts provide a reasonable basis for our audit conclusion for this audit objective.

FINDING

1. Evaluation of APS Effectiveness

   DHS had not fully developed and implemented a process to evaluate the effectiveness of APS intervention services. As a result, DHS could not determine the extent to which its APS intervention services effectively protected vulnerable adults who were at risk of harm because of the presence or threat of abuse, neglect, and/or exploitation. In addition, DHS limited its ability to identify weaknesses or gaps in the APS intervention services it provided and improve existing intervention services to better protect vulnerable adults.

   APS's goal is that its services will (1) provide immediate (within 24 hours) investigation and assessment of situations referred to DHS when a vulnerable adult is suspected of being or believed to be abused, neglected, or exploited and (2) assure that adults in need of protection are living in a safe and stable situation, including legal intervention, where required, in the least intrusive or restrictive manner. Also, Section 400.11b of the *Michigan Compiled Laws* requires APS caseworkers to conduct an investigation within 24 hours of DHS receiving a referral of adult abuse, neglect, and/or exploitation.

   A sound evaluation process should include performance indicators for measuring program inputs*, outputs, and outcomes; performance standards* or goals describing the desired level of performance; a data collection system to accurately gather performance data for assessment; a comparison of actual achieved outcomes related to the services and resources provided to vulnerable adults for a consistent period of time; a reporting of the comparison results to management; an analysis of the performance gaps that exist between the actual and desired performance; and proposals of modifications to improve program effectiveness.

   We interviewed APS management, APS central office staff, and APS supervisors and caseworkers at 12 selected DHS county/district offices to obtain an

* *See glossary at end of report for definition.*

understanding of APS's process to evaluate the effectiveness of APS intervention services. Our review disclosed:

a. DHS had not identified and established desired outcomes and performance measures for its APS intervention services. As a result, DHS could not compare the actual results of the APS services it provided to determine the effectiveness of its efforts to protect vulnerable adults at risk of harm. For example, DHS could not evaluate and compare the extent to which APS intervention services reduced the severity and rate of occurrence of neglect, abuse, and/or exploitation of vulnerable adults. DHS could consider an evaluation and comparison of substantiated allegations, progress in achieving goals identified in the APS client service plans, and the appropriateness of APS services provided to repeat APS investigation cases.

   Our review determined that DHS did analyze a select number of program outputs in regard to compliance with legal or policy requirements, such as the 24-hour and 72-hour response times and the completion of service plans within 30 days. However, DHS was unable to determine the effectiveness of overall APS intervention services solely based on a limited evaluation of outputs related to response times and completion of service plans within 30 days.

   DHS can best evaluate the effectiveness of its APS intervention services and identify areas for improvement by developing a process that includes an evaluation of APS's actual performance in relation to established desired outcomes and performance measures for APS intervention services.

b. DHS had not fully developed its APS risk assessment process. As a result, DHS was unable to utilize the results of its APS risk assessment process to evaluate the impact of its APS intervention services. Our review disclosed that neither APS central office management and staff nor staff at any of the 12 DHS county/district offices used the APS risk assessment results to measure the impacts of the APS intervention services provided by DHS.

   Adult Services Manual Section 205 requires APS caseworkers to complete APS risk assessments, which are to be used to measure the impact of intervention by APS caseworkers.

APS central office staff informed us that they did not have full access to all of the APS data necessary to obtain reports to evaluate the effectiveness of APS intervention services. In addition, APS supervisors and APS caseworkers at the 12 DHS county/district offices we visited informed us that the APS risk assessments are unique to each APS case and caseworker. As a result, APS county/district offices were unable to use the results of individual APS risk assessments to evaluate the collective impact of the county/district offices' APS intervention efforts.

RECOMMENDATION

We recommend that DHS fully develop and implement a process to evaluate the effectiveness of APS intervention services.

AGENCY PRELIMINARY RESPONSE

DHS agrees with the finding.

DHS stated:

a. *On May 2, 2014, the Michigan Department of Human Services launched its latest Business Service Center (BSC) and created a more centralized authority structure to deal specifically with Adult Services, making the safety of vulnerable adults a statewide priority. The Adult Services BSC will specialize in the delivery and monitoring of services related to investigating allegations related to the abuse, neglect and exploitation of vulnerable adults, adult community placement and independent living services/home help. This new business service center will assure DHS meets the legal requirements of timeliness in investigations and providing services, that face-to-face meetings with clients and providers are taking place, and that required referrals to law enforcement are being made. The Adult Services BSC for Michigan will also develop a risk assessment tool that closely mirrors one in place for children's services, thus ensuring all possible cases involving abuse and neglect are properly assessed, serviced and monitored for outcomes.*

b. *DHS takes with the utmost seriousness all allegations of willful neglect of duty or failure to carry out assigned tasks in compliance with law and policy. DHS has taken swift action to address the audit findings and has initiated formal investigation of cases cited in the audit to determine that staff acted appropriately. If any investigation determines that there was noncompliance with law and policy, appropriate corrective and/or disciplinary action will be taken, including demotion and/or dismissal.*

c. *In order to further protect vulnerable individuals, DHS is recommending codifying a criminal penalty for falsifying records. The provision will apply to any DHS employee who falsifies, alters, destroys, defaces, overwrites, removes, or discards an official record which has the potential to detrimentally affect the health, safety, or welfare of that individual.*

d. *By August 1, 2014, DHS will implement for the adult services program a uniform standard of action protocol for workers who fail to make required contacts and face-to-face visits or falsify records. This protocol will also apply to supervisors who do not monitor employee performance or complete required case reviews to determine compliance with the protocol. Compliance with the protocol will also be monitored by DHS county directors/district managers and Business Service Centers. By implementing this protocol and monitoring and enforcing compliance, DHS will have reasonable assurance that vulnerable adults receive all/only the services and protections they are eligible for.*

e. *By September 1, 2014, DHS will identify and establish outcomes and performance measures for APS.*

f. *By September 1, 2014, DHS will develop and use case activity reports to monitor performance.*

g. *By January 1, 2015, DHS will evaluate the effectiveness of APS intervention services by identifying weaknesses and gaps in the services meant to protect vulnerable adults who are at risk of abuse, neglect, and/or exploitation.*

h. *By January 1, 2015, DHS will review and revise the risk assessment tool and use these results to measure the impact of intervention.*

i. *By August 1, 2014, because of the similarities between Children's Protective Services (CPS) and APS, DHS will identify and utilize existing resources and tools in the DHS CPS program, and will incorporate outcomes, measures and goals applicable to APS.*

j. *By July 1, 2014, DHS will research other state APS programs and the National Adult Protective Services Association to incorporate best practices to effectively protect vulnerable adults.*

k. *By October 1, 2014, DHS will develop a comprehensive adult services strategic plan to evaluate the outcomes, measures and goals to determine the effectiveness of the APS program and enhance the safety and well-being of vulnerable adults in Michigan.*

FINDING

2. Review of Closed Investigation Cases

APS supervisors did not consistently review closed APS investigation cases, as required. Also, DHS did not ensure that APS supervisors conducted reviews of closed APS investigation cases that effectively detected unaddressed allegations, incomplete APS client service plans, and missed monthly face-to-face contacts with APS clients. As a result, DHS could not ensure that APS caseworkers consistently conducted timely and thorough APS investigations; developed appropriate service plans to effectively address identified abuse, neglect, and/or exploitation; and provided and/or coordinated the services necessary to protect APS clients prior to closing APS investigations.

Adult Services Manual Section 205 requires APS supervisors to review all closed APS investigation cases. DHS management's goal is for APS supervisors to review all closed APS investigation cases within 30 days from the date of closure. APS supervisors are required to review each closed APS investigation case to ensure that APS caseworkers addressed all allegations stated in the referral or identified in the investigation, completed service plans, and maintained monthly face-to-face contact with the client.

Our testing of 199 selected closed APS investigation cases at 12 DHS county/district offices for the period October 1, 2010 through April 14, 2013 disclosed:

a. APS supervisors did not review 53 (27%) of 199 closed APS investigation cases.

b. APS supervisors reviewed 47 (24%) of 199 closed APS investigation cases more than 30 days from the date of closure of the APS investigation case. The APS supervisors' reviews for these 47 closed APS investigation cases ranged, on average, by county from 30 to 149 days late, with an overall average of 66 days late.

The following table summarizes the APS supervisors' review activity for the 199 closed APS investigation cases we tested:

DHS County/District Office	Number of Closed APS Investigation Cases: Tested	Not Reviewed by an APS Supervisor	Reviewed More Than 30 Days From Case Closure	Average Number of Days APS Supervisors Conducted Reviews After Case Closure
Berrien	9	5	4	54
Calhoun	16	0	5	31
Clare	20	0	11	86
Eaton	14	0	0	N/A
Genesee	19	8	5	45
Grand Traverse	17	4	7	90
Ingham	12	7	0	N/A
Jackson	15	0	9	149
Kent	16	2	3	40
Oakland	20	1	3	30
Van Buren	15	0	0	N/A
Wayne	26	26	0	N/A
	199	53	47	66

N/A = Not applicable.

Our testing of the closed APS investigation cases for which APS supervisors conducted a review disclosed:

a. APS supervisors did not detect unaddressed allegations in 23 (16%) of the 146 closed APS investigation cases we tested (see Finding 6).

b. APS supervisors did not detect incomplete APS client service plans in 66 (61%) of the 109 closed APS investigation cases we tested that required a service plan. We noted instances in which the APS caseworker did not complete the service plan and instances in which the APS caseworker and/or APS supervisor and the APS client or responsible party did not sign the service plan (see Finding 8).

c. APS supervisors did not detect instances when the APS caseworker did not conduct monthly face-to-face meetings with the APS client in 60 (60%) of the 100 closed APS investigation cases we tested that required monthly visits (see Finding 5).

These deficiencies likely occurred because DHS had not established effective controls to ensure that APS supervisors conducted reviews of all closed APS investigation cases timely and effectively. For example, DHS did not provide APS supervisors with monitoring reports to assist with tracking the review status of closed APS investigation cases. In addition, APS supervisors often supervised both APS caseworkers and workers assigned to other DHS programs, which could have contributed to the deficiencies noted in APS supervisory reviews of closed APS investigation cases.

RECOMMENDATIONS

We recommend that APS supervisors consistently review closed APS investigation cases, as required.

We also recommend that DHS ensure that APS supervisors conduct reviews of closed APS investigation cases that effectively detect unaddressed allegations, incomplete APS client service plans, and missed monthly face-to-face contacts with APS clients.

AGENCY PRELIMINARY RESPONSE

DHS agrees with the finding.

DHS stated:

DHS APS supervisors will review closed APS investigation cases, as required. In addition, DHS APS supervisory reviews of closed APS investigation cases will focus on unaddressed allegations, incomplete APS client service plans, and missed monthly face-to-face contacts with APS clients. This will be achieved by implementing the following:

a. On May 2, 2014, the Michigan Department of Human Services launched its latest Business Service Center (BSC) and created a more centralized authority structure to deal specifically with Adult Services, making the safety of vulnerable adults a statewide priority. The Adult Services BSC will

specialize in the delivery and monitoring of services related to investigating allegations related to the abuse, neglect and exploitation of vulnerable adults, adult community placement and independent living services/home help. This new business service center will assure the DHS meets the legal requirements of timeliness in investigations and providing services, that face-to-face meetings with clients and providers are taking place, and that required referrals to law enforcement are being made. The Adult Services BSC for Michigan will also develop a risk assessment tool that closely mirrors one in place for children's services, thus ensuring all possible cases involving abuse and neglect are properly assessed, serviced and monitored for outcomes.

b. *DHS takes with the utmost seriousness all allegations of willful neglect of duty or failure to carry out assigned tasks in compliance with law and policy. DHS has taken swift action to address the audit findings and has initiated formal investigation of cases cited in the audit to determine that staff acted appropriately. If any investigation determines that there was noncompliance with law and policy, appropriate corrective and/or disciplinary action will be taken, including demotion and/or dismissal.*

c. *In order to further protect vulnerable individuals, DHS is recommending codifying a criminal penalty for falsifying records. The provision will apply to any DHS employee who falsifies, alters, destroys, defaces, overwrites, removes, or discards an official record which has the potential to detrimentally affect the health, safety, or welfare of that individual.*

d. *On June 2, 2014, DHS issued formal and directed correspondence to APS staff to clearly reaffirm DHS APS policy requirements to review closed APS investigation cases and to inform APS staff that the consequences for noncompliance will be corrective and/or disciplinary action in accordance with Civil Service rules.*

e. *By August 1, 2014, DHS will implement for adult services a uniform standard of action protocol for supervisors who fail to conduct closed case file reviews or falsify records. This protocol will also apply to supervisors who do not monitor employee performance or complete required case reviews to determine compliance with the protocol. Compliance with the protocol will also be monitored by the DHS county office director/district manager and by the DHS Business Service Centers.*

f. *By September 1, 2014, DHS will implement a comprehensive system of accountability. Monthly case activity reports will be generated and monitored by DHS management at all levels. Compliance with requirements will be reflected in employee performance evaluations.*

g. *By September 30, 2014, APS supervisors will complete mandatory APS core training that includes investigation requirements and the required supervisory review of all closed investigation cases. Noncompliance with training requirements will result in corrective action and/or disciplinary action in accordance with Civil Service rules.*

h. *By October 1, 2014, DHS will develop a comprehensive adult services strategic plan with focus on all aspects of adult services including APS, appropriate decisions on referral assignment and referrals to law enforcement to enhance the safety and well-being of vulnerable adults in Michigan.*

EFFORTS IN DETERMINING WHETHER A REFERRAL OF ADULT ABUSE, NEGLECT, AND/OR EXPLOITATION SHOULD BE ACCEPTED FOR INVESTIGATION, DENIED, WITHDRAWN, OR REFERRED TO LAW ENFORCEMENT

COMMENT

Audit Objective: To assess the effectiveness of DHS's efforts in determining whether a referral of adult abuse, neglect, and/or exploitation should be accepted for investigation, denied, withdrawn, or referred to law enforcement.

Audit Conclusion: We concluded that DHS's efforts in determining whether a referral of adult abuse, neglect, and/or exploitation should be accepted for investigation, denied, withdrawn, or referred to law enforcement were moderately effective.

Our audit conclusion was based on our audit efforts as described in the audit scope and audit methodology sections and the resulting reportable condition noted in the comments, findings, recommendations, and agency preliminary responses section.

Our audit efforts disclosed one reportable condition related to denied or withdrawn referrals (Finding 3). In our professional judgment, the reportable condition is less severe than a material condition but represents a deficiency in internal control and an opportunity for improvement.

We took into consideration both quantitative and qualitative factors in reaching a conclusion on the effectiveness of DHS's efforts in determining whether a referral of adult abuse, neglect, and/or exploitation should be accepted for investigation, denied, withdrawn, or referred to law enforcement. We considered the total number of adult abuse, neglect, and/or exploitation referrals during the audit period that DHS assigned for investigation, denied, and/or withdrew and the overall error rate we noted in our testing of assigned, denied, and withdrawn referrals during the audit period. We also considered the potential risks to vulnerable adults associated with inappropriately denied and/or withdrawn referrals of adult abuse, neglect, and/or exploitation. In addition, we considered the potential impact of DHS not consistently notifying law enforcement when APS referrals indicated potential criminal activity. Because our audit efforts noted that DHS inappropriately denied or withdrew 29 (8%) of the 343 total referrals we reviewed when justification to warrant assignment of an investigation appeared to exist, and DHS did not consistently notify law enforcement when an APS referral indicated potential criminal activity, a conclusion of moderately effective was appropriate. We believe that the results of our audit efforts provide a reasonable basis for our audit conclusion for this audit objective.

FINDING

3. Denied or Withdrawn Referrals

DHS occasionally denied or withdrew referrals of adult abuse, neglect, and/or exploitation when justification to warrant assignment for an investigation appeared to exist. In addition, APS did not consistently notify law enforcement when a referral indicated potential criminal activity. As a result, DHS limited its assurance that it appropriately provided protective services to adults who were potentially at risk of harm from abuse, neglect, and/or exploitation.

Adult Services Manual Section 205 states that the APS complaint coordinator must review the referral information and determine if there is sufficient justification to warrant assignment for an APS investigation. Sufficient justification to warrant assignment for an APS investigation must include a reasonable belief that the subject of the referral was harmed or is at risk of harm from abuse, neglect, and/or exploitation or is vulnerable and in need of protective services. APS requires the complaint coordinator to fully document the reasons for not assigning a referral for an APS investigation.

Adult Services Manual Section 210 states that the APS caseworker must involve law enforcement agencies immediately in referrals involving suspected criminality, e.g., spouse abuse/domestic violence, other physical abuse, financial exploitation, and/or intentional neglect. APS caseworkers must first confer with their APS supervisor and a law enforcement agency to determine if the referral is appropriate and if APS services are still needed. If APS services are not needed, documentation must reflect why there was no follow-up on the referral beyond initial inquiries and notification to a law enforcement agency.

We reviewed APS's documentation for 124 selected denied and withdrawn referrals for the period October 1, 2010 through April 14, 2013 at 12 DHS county/district offices. Our review disclosed:

a. APS did not assign 29 (23%) denied and withdrawn referrals for an investigation when APS's documented allegations in the referral appeared to indicate that a vulnerable adult was harmed or at risk of harm from abuse, neglect, and/or exploitation. For example, our review found:

(1) The referral source asserted that an intellectually disabled, epileptic adult was temporarily staying with a friend because the adult's caretaker was not expected to live as a result of a stroke. The referral source had concerns about the care needed for the adult and stated that neither the adult nor the friend with whom the adult was staying was able to care for the adult. The county office APS complaint coordinator denied the referral without making any contact with the client or a collateral contact. The APS referral documentation supported that the adult was vulnerable because of mental and physical impairments and a reasonable belief that the adult was at risk of harm from neglect.

(2) The referral source asserted that an elderly adult, who suffered from dementia, was being financially exploited by her daughter who was also the adult's guardian*. The referral source asserted that the daughter managed her mother's bank account and had not paid for her mother's nursing home care for 3 months and owed the nursing home $5,000.

* *See glossary at end of report for definition.*

The county office APS complaint coordinator denied the referral but required an APS supervisor to send a letter to the daughter instructing the daughter to make an agreement with the nursing home to pay the amount owed to the nursing home. The APS referral documentation supported that the adult was vulnerable because of her advanced age, frailty, and dependency and a reasonable belief that the adult was at risk of harm from financial exploitation.

(3) For four adults, APS concluded that there were already current open APS cases to investigate the same allegations of the referrals for 5 withdrawn or denied referrals we reviewed (one adult had 2 referrals). However, our review determined that 3 referrals had additional allegations that were not a part of the current open APS investigations and 2 referrals did not have open APS investigations at the time of the referral. The APS referral documentation supported that these adults were vulnerable and at risk of harm.

b. APS did not notify law enforcement for 4 (3%) denied and withdrawn referrals when the APS referral documentation indicated potential criminal activity. The potential criminal activity documented in the file at the time of the referrals included 3 referrals with allegations of sexual abuse and 1 referral with an allegation of physical abuse. APS policy requires APS supervisors or APS caseworkers to notify law enforcement agencies immediately in referrals involving a suspected criminality.

These deficiencies likely occurred because DHS's referral assignment process did not include a review of the APS complaint coordinator's decisions. A review of the APS complaint coordinator's decision to deny or withdraw a referral may reduce the number of incorrectly denied or withdrawn referrals of adult abuse, neglect, and/or exploitation. In addition, a review of the APS complaint coordinator's decisions may assist DHS in ensuring that it appropriately notifies law enforcement agencies when required.

RECOMMENDATIONS

We recommend that DHS deny or withdraw referrals of adult abuse, neglect, and/or exploitation for investigation only when justification to warrant assignment for investigation does not exist.

We also recommend that APS consistently notify law enforcement when a referral indicates potential criminal activity.

AGENCY PRELIMINARY RESPONSE

DHS agrees in part with the finding.

DHS stated:

a. *DHS completed a safety and well-being assessment of the seven denied or withdrawn cases cited in part a of the finding:*

   (1) *The worker met with the client in April 2014. The client was referred to Community Mental Health in February 2013 and received help to locate to subsidized housing with assistance from a friend. The friend visited the client on a regular basis. In addition, the client had two friends from the neighborhood that formed part of the client's network. The apartment was modestly furnished and clean. The client received food assistance and was in regular contact with his DHS eligibility specialist.*

   (2) *The client's Medical Assistance (MA) ended after the client passed away in June 2013. The daughter agreed to a repay agreement with the nursing home. The county/district office verified the daughter is complying with the repay agreement in April 2014.*

   (3) *County/district offices followed up with the four cases.*

      (a) *The worker met with the client in April 2014. The client is staying in an Adult Foster Care (AFC) home where he has been for approximately eight years. The client stated he is doing great with no concerns. The AFC owner indicated he has been going to the doctor on a regular basis, has a job cleaning vehicles, and has recently taken up fishing as a hobby.*

      (b) *The worker met with the client in April 2014. The client resides in an AFC home and is dealing with chronic behavioral issues. The client has a case manager. The AFC manager indicated the client has been doing quite well over the past year.*

      (c) *DHS disagrees with the auditor's conclusion. The client had an open APS investigation at the time of the referral with similar complaints. APS conducted another investigation in December 2013. Similar to previous investigations, this was regarding neglect and abuse by the*

client's parents. The client was provided assistance to relocate to an adult foster care facility but the client chose to return home with the parents. The client was evaluated at the hospital and found able to make informed decisions.

(d) The worker met with the client in April 2014 and found the client to be alert and orientated. The home environment was clean and appropriate. The worker made contact with the Area Agency on Aging who reported the client is receiving numerous services, including weekly counseling.

b. DHS completed a safety and well-being assessment for three of the four denied or withdrawn cases cited in part b of the finding which were not referred to law enforcement. DHS was unable to locate one client.

(1) The alleged sexual abuse occurred six years prior to the referral made in March 2013, and the client was a minor. The alleged perpetrator was a relative and the incident occurred in another state. The client was not vulnerable or at risk of additional harm when the referral was received. The county/district office was able to contact the client's sister in April 2014 who stated the client was doing well and living with their parents.

(2) The county/district office followed up with the client in April 2014 who indicated she moved and is no longer living with anyone connected to that household. The client is living with an aunt and feels safe there.

(3) The worker met with the client at his home in April 2014 where he resides with his mother. The client last saw the doctor in early April 2014 and regularly attends AA meetings. Although the client is diagnosed with mental health issues, he appears to be high functioning and has a support system in place that includes family and medical professionals.

(4) The referral was made in June 2011, alleging abuse by the mother when the client was a child and that the mother and sister tried to kill the client in a high speed chase. The client was 50 years old at the time of the referral. The client was not in Michigan at the time of the referral and was not at risk. DHS was unable to locate the client in April 2014.

c. On May 2, 2014, the Michigan Department of Human Services launched its latest Business Service Center (BSC) and created a more centralized authority structure to deal specifically with Adult Services, making the safety of vulnerable adults a statewide priority. The Adult Services BSC will specialize in the delivery and monitoring of services related to investigating allegations related to the abuse, neglect and exploitation of vulnerable adults, adult

community placement and independent living services/home help. This new business service center will assure DHS meets the legal requirements of timeliness in investigations and providing services, that face-to-face meetings with clients and providers are taking place, and that required referrals to law enforcement are being made. The Adult Services BSC for Michigan will also develop a risk assessment tool that closely mirrors one in place for children's services, thus ensuring all possible cases involving abuse and neglect are properly assessed, serviced and monitored for outcomes.

d. *DHS takes with the utmost seriousness all allegations of willful neglect of duty or failure to carry out assigned tasks in compliance with law and policy. DHS has taken swift action to address the audit findings and has initiated formal investigation of cases cited in the audit to determine that staff acted appropriately. If any investigation determines that there was noncompliance with law and policy, appropriate corrective and/or disciplinary action will be taken, including demotion and/or dismissal.*

e. *By August 1, 2014, APS referral assignment decisions will be made in the Centralized Intake Unit by staff specialized in APS.*

f. *DHS will establish requirements and expectations for: (1) denying or withdrawing referrals of adult abuse, neglect, and/or exploitation for investigation only when justification to assign for investigations does not exist, and (2) notifying law enforcement when a referral indicates potential criminal activity. This will be achieved by implementing the following:*

   (1) *To further protect vulnerable individuals, DHS is recommending codifying a criminal penalty for falsifying records. The provision will apply to any DHS employee who falsifies, alters, destroys, defaces, overwrites, removes, or discards an official record which has the potential to detrimentally affect the health, safety, or welfare of that individual.*

   (2) *By August 1, 2014, DHS will implement for adult services a uniform standard of action protocol for workers who do not document why referrals of adult abuse, neglect, and/or exploitation are denied or withdrawn, fail to notify law enforcement when a referral indicates potential criminal activity or who falsify records. This protocol will also apply to supervisors who do not monitor employee performance or complete required case reviews to determine compliance with the protocol. Compliance with the protocol will also be monitored by the DHS county office director/district manager and by the DHS Business Service Centers.*

   (3) *DHS will conduct an in-depth review of all cases cited in the report to ensure the safety and well-being of each client and file reports with law enforcement as required by law.*

(4) *By September 1, 2014, DHS will implement a comprehensive system of accountability. Monthly case activity reports which identify denied or withdrawn cases will be generated and monitored. DHS management, at all levels, will monitor compliance with statutory requirements and DHS policy regarding referral assignment and reporting potential criminal activity to law enforcement. Non-compliance with referral assignment requirements and reporting potential criminal activity to law enforcement will result in corrective and/or disciplinary action.*

(5) *By August 1, 2014, DHS will revise and clarify policy requirements for denied or withdrawn APS referrals and require staff to comply with the requirement to document the detailed reasons for denial or withdrawal.*

(6) *By August 1, 2014 and on an ongoing basis, a sample of denied/withdrawn referrals will be reviewed monthly by the county/district office program manager for accuracy of the decision.*

(7) *On June 2, 2014, DHS issued formal and directed correspondence to DHS employees working with the APS program to clearly reaffirm statutory and DHS policy requirements and the expectations for denying and withdrawing referrals and notifying law enforcement when a referral indicates potential criminal activity; and will inform DHS employees that the consequences for noncompliance will be corrective and/or disciplinary action in accordance with Civil Service rules.*

(8) *Statewide training has been completed for the Michigan Model Vulnerable Adult Investigation Protocol (MI-MVP). Utilizing the protocol, DHS will continue to leverage relationships with law enforcement and prosecutors to reduce harm and victimization of vulnerable adults through a coordinated team approach.*

(9) *By October 1, 2014, DHS will develop a comprehensive adult services strategic plan with focus on all aspects of adult services including APS, appropriate decisions on referral assignment and referrals to law enforcement to enhance the safety and well-being of vulnerable adults in Michigan.*

EFFORTS IN INVESTIGATING ACCEPTED REFERRALS OF ADULT ABUSE, NEGLECT, AND/OR EXPLOITATION

COMMENT

Audit Objective: To assess the effectiveness of DHS's efforts in investigating accepted referrals of adult abuse, neglect, and/or exploitation.

Audit Conclusion: We concluded that DHS's efforts in investigating accepted referrals of adult abuse, neglect, and/or exploitation were not effective.

Our audit conclusion was based on our audit efforts as described in the audit scope and audit methodology sections and the resulting material conditions and reportable condition noted in the comments, findings, recommendations, and agency preliminary responses section.

Our audit efforts disclosed three material conditions related to investigation standards of promptness, monthly face-to-face contacts, and investigation of allegations (Findings 4 through 6) and one reportable condition related to continuing education training (Finding 7). In our professional judgment, the material conditions are more severe than a reportable condition and could impair management's ability to operate effectively and/or efficiently. Also, in our professional judgment, the reportable condition is less severe than a material condition but represents an opportunity for improvement.

We took into consideration both quantitative and qualitative factors in reaching a conclusion on the effectiveness of DHS's efforts in investigating accepted referrals of adult abuse, neglect, and/or exploitation. We considered the significance of the number of instances we noted in which DHS did not meet legally required time frames for standards of promptness and the potential impact of noncompliance on the protection of vulnerable adults. We also considered the significance of the number of instances we noted in which DHS did not maintain required monthly face-to-face contact with APS clients during open APS investigations and the potential risk to APS clients when DHS did not conduct required face-to-face contacts with APS clients. In addition, we considered the number and types of allegations that DHS did not address during APS investigations and the potential risk of not investigating all allegations on APS clients. Further, we considered the overall levels of initial and annual training that DHS provided to its APS caseworkers and supervisors and the potential impact on the effectiveness of APS activities.

We determined that a conclusion of not effective was appropriate because our audit efforts noted that DHS did not:

- Make an initial contact with either the adult or a collateral contact within the 24-hour requirement in 19% of the investigations we reviewed.

- Conduct a face-to-face interview with the adult within the 72-hour requirement in 30% of the investigations we reviewed.

- Maintain required monthly contact with APS clients in 69% of the investigations we reviewed.

- Address all allegations prior to closing APS investigation cases in 20% of the investigation cases that were reviewed.

- Provide annual training to its APS caseworkers and supervisors, therefore vulnerable adults could remain at risk of harm from abuse, neglect, and/or exploitation.

We believe that the results of our audit efforts provide a reasonable basis for our audit conclusion for this audit objective.

FINDING

4. Investigation Standards of Promptness

   DHS county/district offices did not begin and conduct APS investigations in accordance with standards of promptness established by the *Michigan Compiled Laws* and DHS policies. As a result, DHS did not always assess situations within required time frames for standards of promptness that are critical to ensure the protection of a vulnerable adult who is believed to be abused, neglected, or exploited.

   Section 400.11b of the *Michigan Compiled Laws* requires that DHS county/district offices begin an APS investigation within 24 hours after receiving a referral to determine whether the person believed to be abused, neglected, and/or exploited is an adult in need of protective services. Also, Adult Services Manual Section 205 requires that one contact be made within 24 hours by phone or in person with either the adult or a collateral contact for all cases assigned for an APS investigation. In addition, the Manual requires the APS caseworker to conduct a face-to-face interview with the adult within 72 hours from the time the referral was received by means of a personal visit in the adult's dwelling, the worker's office, or any other suitable setting.

Beginning investigations and conducting initial face-to-face interviews in a timely manner is necessary to help DHS ensure that APS caseworkers obtain critical information pertinent to APS investigations as soon as possible.

We reviewed 219 assigned APS investigations for the period October 1, 2010 through April 14, 2013. DHS did not begin the APS investigation and make an initial contact within the 24-hour requirement in 41 (19%) of the investigations. Also, DHS did not conduct a face-to-face interview with the adult within the 72-hour requirement in 66 (30%) of the investigations.

The following table summarizes the results of our review of the 219 assigned APS investigations conducted at 12 selected DHS county/district offices:

DHS County/District Office	Total APS Investigations Reviewed	APS Investigations That Did Not Meet the 24-Hour Requirement		APS Investigations That Did Not Meet the 72-Hour Requirement	
		Number	Percentage	Number	Percentage
Berrien	15	0	0%	2	13%
Calhoun	17	2	12%	3	18%
Clare	20	1	5%	5	25%
Eaton	15	0	0%	4	27%
Genesee	20	5	25%	7	35%
Grand Traverse	20	3	15%	7	35%
Ingham	15	3	20%	6	40%
Jackson	15	2	13%	5	33%
Kent	20	9	45%	12	60%
Oakland	20	4	20%	3	15%
Van Buren	15	0	0%	0	0%
Wayne	27	12	44%	12	44%
	219	41	19%	66	30%

DHS's deficiencies in meeting APS investigation standards of promptness likely occurred because APS supervisors did not always monitor the progress of assigned referrals at the beginning of investigations. In addition, DHS did not ensure that its Adult Services Comprehensive Assessment Program* (ASCAP) system provided monitoring reports for APS supervisors to assist them with tracking the status of assigned referrals.

* *See glossary at end of report for definition.*

RECOMMENDATION

We recommend that DHS county/district offices begin and conduct APS investigations in accordance with standards of promptness established by the *Michigan Compiled Laws* and DHS policies.

AGENCY PRELIMINARY RESPONSE

DHS agrees with the finding.

DHS stated:

DHS county/district offices will conduct APS investigations within 24 hours of referral as required by MCL 400.11b and DHS policy. This will be achieved by implementing the following:

a. *On May 2, 2014, the Michigan Department of Human Services launched its latest Business Service Center (BSC) and created a more centralized authority structure to deal specifically with Adult Services, making the safety of vulnerable adults a statewide priority. The Adult Services BSC will specialize in the delivery and monitoring of services related to investigating allegations related to the abuse, neglect and exploitation of vulnerable adults, adult community placement and independent living services/home help. This new business service center will assure DHS meets the legal requirements of timeliness in investigations and providing services, that face-to-face meetings with clients and providers are taking place, and that required referrals to law enforcement are being made. The Adult Services BSC for Michigan will also develop a risk assessment tool that closely mirrors one in place for children's services, thus ensuring all possible cases involving abuse and neglect are properly assessed, serviced and monitored for outcomes.*

b. *DHS takes with the utmost seriousness all allegations of willful neglect of duty or failure to carry out assigned tasks in compliance with law and policy. DHS has taken swift action to address the audit findings and has initiated formal investigation of cases cited in the audit to determine that staff acted appropriately. If any investigation determines that there was noncompliance with law and policy, appropriate corrective and/or disciplinary action will be taken, including demotion and/or dismissal.*

c. *In order to further protect vulnerable individuals, DHS is recommending codifying a criminal penalty for falsifying records. The provision will apply to any DHS employee who falsifies, alters, destroys, defaces, overwrites, removes, or discards an official record which has the potential to detrimentally affect the health, safety, or welfare of that individual.*

d. DHS will review the cases cited in the report to ensure the safety and well-being of each client and to ensure that performance issues are addressed with staff and supervision.

e. By August 1, 2014, DHS will transfer APS referral assignments to the Centralized Intake Unit. The Centralized Intake Unit's APS referral decisions will be made by staff specializing in APS.

f. On June 2, 2014, DHS issued formal and directed correspondence to DHS employees working with the APS program to clearly reaffirm statutory and DHS policy requirements for completing investigations within the established standards of promptness, and will inform DHS employees that the consequences for noncompliance will be corrective and/or disciplinary action in accordance with Civil Service rules.

g. By August 1, 2014, DHS will implement for the adult services program a uniform standard of action protocol for workers who fail to meet the standards of promptness or falsify records. This protocol will also apply to supervisors who do not monitor employee performance or complete required case reviews to determine compliance with the protocol. Compliance with the protocol will also be monitored by DHS county directors/district managers and Business Service Centers. By implementing this protocol and monitoring and enforcing compliance, DHS will have reasonable assurance that vulnerable adults receive all/only the services and protections they are eligible for.

h. By September 1, 2014, DHS will implement a comprehensive system of accountability. Monthly case activity reports will be generated and monitored. DHS management at all levels will monitor compliance with all statutory requirements and DHS policy regarding standards of promptness. Compliance with requirements will be reflected in employee performance evaluations. Non-compliance with standards of promptness requirements will result in corrective and/or disciplinary action in accordance with Civil Service rules.

i. By September 30, 2014, all APS staff will complete mandatory APS core training that includes investigation standards. Noncompliance with training requirements will result in corrective action and/or disciplinary action in accordance with Civil Service rules.

j. DHS will work with DCH, Office of Services to the Aging and LARA to prevent and reduce abuse, neglect, and exploitation of vulnerable adults.

k. *By October 1, 2014, DHS will develop a comprehensive adult services strategic plan to focus on all aspects of adult services including compliance with standards of promptness requirements, intervention, and service delivery to enhance the safety and well-being of vulnerable adults in Michigan.*

FINDING

5. Monthly Face-to-Face Contacts

APS caseworkers did not always conduct monthly face-to-face contacts with APS clients with open APS investigations, as required. As a result, DHS could not ensure that APS caseworkers properly monitored the status of APS clients with open APS investigations and observed, in a timely manner, that active APS clients remained in a safe and stable environment.

Adult Services Manual Section 205 requires a minimum of one face-to-face contact with an APS client each month the investigation is open. Maintaining contact with APS clients is necessary to help ensure that APS caseworkers thoroughly and expeditiously investigate the alleged harm, provide and/or coordinate needed services, and monitor the cases appropriately to ensure that clients remain in safe and stable living situations. The Manual also requires an APS supervisor to approve all open investigations that need to remain open for more than six months.

We reviewed 162 selected open and closed APS investigations that required monthly face-to-face contact for the period October 1, 2010 through April 14, 2013. We noted that the APS caseworker did not conduct a face-to-face contact with the APS client during each month an APS investigation was open for 112 (69%) of the

162 APS investigations. The following table summarizes the 162 open and closed APS investigations that we reviewed at 12 DHS county/district offices:

DHS County/District Office	Number of APS Investigations Reviewed	APS Investigations That Did Not Meet the Monthly Face-to-Face Contact Requirement	
		Number	Percentage
Berrien	10	10	100%
Calhoun	9	3	33%
Clare	6	1	5%
Eaton	6	0	0%
Genesee	18	12	67%
Grand Traverse	20	20	100%
Ingham	13	9	64%
Jackson	11	10	91%
Kent	20	10	50%
Oakland	18	12	67%
Van Buren	10	9	90%
Wayne	21	16	76%
	162	112	69%

Specifically, our review determined:

a. APS caseworkers did not conduct from 1 to 3 required monthly face-to-face contacts with the APS client for 64 (57%) of the 112 investigations we reviewed (see part c.(3) of this finding for an example).

b. APS caseworkers did not conduct from 4 to 6 required monthly face-to-face contacts with the APS client for 27 (24%) of the 112 investigations we reviewed, including 2 instances in which the APS caseworker never made a face-to-face contact with the APS client. One of these investigations was open for approximately 4 months and the other was open for approximately 6 months.

c. APS caseworkers did not conduct 7 or more required monthly face-to-face contacts with the APS client for 21 (19%) of the 112 investigations we reviewed (see parts c.(1) and c.(2) of this finding for examples). These

21 investigations were open for periods ranging from 7 to 26 months; however, our review determined that an APS supervisor did not approve any of these 21 investigations to remain open for more than six months, as required.

The following are examples of circumstances documented within the APS investigation files that we reviewed when APS caseworkers did not conduct the required monthly face-to-face contacts with the APS client:

(1) The referral source stated that the client had spinal stenosis and needed 24-hour care as the client could not bear any weight. The client lived with a relative and it was alleged that the relative was leaving the client alone for extended periods of time and was not giving the APS client needed medication. Within a three-week period, APS made two unsuccessful, unannounced home visits. An APS best practice states that, after unsuccessful attempts for face-to-face visits, the APS caseworker should leave a letter at the APS client's home stating that the client should contact APS. The APS caseworker did not leave this type of letter at the client's home at the time of the last unsuccessful attempt and did not make any additional attempts to contact the client for the next 23 consecutive months. After 23 consecutive months without contact, APS contacted the client, unsubstantiated the investigation, and immediately closed the case with unaddressed allegations (see Finding 6).

(2) The referral source stated that the client was continuously going to the hospital because the client's insulin was not managed properly. In addition, the referral source stated that the client's house was almost uninhabitable because of intense hoarding, unsanitary conditions, and a broken furnace. The APS caseworker provided the client with services to clean and make repairs to the home for a three-month period. However, APS did not make face-to-face contact with the client for 10 consecutive months during and after these services.

(3) The referral source stated that the client lived alone with 30 or more cats, the client was not eating, and the client had been seen several times wandering around looking for more cats after midnight. The APS caseworker's first attempt for a face-to-face visit with the client was

3 days after receiving the referral, which was unsuccessful. The APS caseworker made a second unsuccessful attempt for a face-to-face visit with the client 20 days later. After the APS caseworker's second unsuccessful attempt, 7 days elapsed before the APS caseworker sent a certified letter requesting contact with the client and another 11 days elapsed prior to the initial face-to-face contact occurring between the APS caseworker and the client. As a result, a total of 41 days elapsed before the APS caseworker made an initial face-to-face contact with the client to address an alleged risk of malnutrition and risks to the client's personal safety.

These deficiencies likely occurred because DHS had not established an effective control to ensure that APS caseworkers conducted the required monthly face-to-face visits with APS clients who had an open APS investigation.

RECOMMENDATION

We recommend that APS caseworkers conduct monthly face-to-face contacts with APS clients with open APS investigations, as required.

AGENCY PRELIMINARY RESPONSE

DHS agrees with the finding.

DHS stated:

a. DHS completed safety and well-being assessments of the three clients cited in the audit finding.

(1) The first contact with the client occurred in October 2012. The client was found to be able to make informed decisions and denied any prior neglect allegations. The client stated she had a history of nursing home stays and wanted to maintain her independence. The client was offered assistance with adult foster care or a guardian. The client wanted neither, choosing to maintain her independence living alone in her apartment. The client moved out of state and the case was closed in January 2014.

(2) An August 2013 referral was closed in October 2013 when the client and spouse refused services. A medical evaluation in October 2013 found the client was competent to make her own decisions. A few weeks later a

referral was made for medical issues and readmission to the hospital. The client told the worker in December 2013 that she no longer wanted to see him. A worker update indicated that the client and husband are now in assisted living where they have some assistance and monitoring. APS was told they can only visit when the client's attorney is present. The worker was able to make a home visit in April 2014 and noted the client looked better than she had ever seen. The home was reasonably clean and uncluttered. The client was competent and keeping up with health needs. This case has been closed.

(3) *When the worker was able to make contact with the client the client would not allow the worker in the home and stated she only had five cats. The worker observed that the client was appropriately dressed and appeared to be at a healthy weight. The client denied all allegations and stated she did not want APS intervention. The worker made a safety and well-being home visit in April 2014 and stated the client's home was observed to be free of clutter and debris with operable utilities. The client was well with no serious health concerns and did not appear to be in need of APS intervention services*.

b. *On May 2, 2014, the Michigan Department of Human Services launched its latest Business Service Center (BSC) and created a more centralized authority structure to deal specifically with Adult Services, making the safety of vulnerable adults a statewide priority. The Adult Services BSC will specialize in the delivery and monitoring of services related to investigating allegations related to the abuse, neglect and exploitation of vulnerable adults, adult community placement and independent living services/home help. This new business service center will assure DHS meets the legal requirements of timeliness in investigations and providing services, that face-to-face meetings with clients and providers are taking place, and that required referrals to law enforcement are being made. The Adult Services BSC for Michigan will also develop a risk assessment tool that closely mirrors one in place for children's services, thus ensuring all possible cases involving abuse and neglect are properly assessed, serviced and monitored for outcomes.*

c. *DHS takes with the utmost seriousness all allegations of willful neglect of duty or failure to carry out assigned tasks in compliance with law and policy. DHS has taken swift action to address the audit findings and has initiated formal investigation of cases cited in the audit to determine that staff acted appropriately. If any investigation determines that there was noncompliance with law and policy, appropriate corrective and/or disciplinary action will be taken, including demotion and/or dismissal.*

d. DHS county/district offices will conduct monthly face-to-face contact with APS clients and supervisory approval of APS cases that remain open longer than six months as required by DHS policy. This will be achieved by implementing the following:

(1) In order to further protect vulnerable individuals, DHS is recommending codifying a criminal penalty for falsifying records. The provision will apply to any DHS employee who falsifies, alters, destroys, defaces, overwrites, removes, or discards an official record which has the potential to detrimentally affect the health, safety, or welfare of that individual.

(2) DHS will complete independent review of the remaining cases reviewed as part of the audit. Review findings will be a basis for appropriate corrective and/or disciplinary action per civil service rules.

(3) On June 2, 2014, DHS issued formal and directed correspondence to DHS employees working with the APS program to clearly reaffirm DHS policy requirements and the expectations for completing timely face-to-face contacts and the requirement to obtain supervisor approval when cases must be open longer than six months; and will inform DHS employees that the consequences for noncompliance will be corrective and/or disciplinary action in accordance with Civil Service rules.

(4) By August 1, 2014, DHS will implement for adult services a uniform standard of action protocol for workers who fail to make required contacts and face-to-face visits or falsify records. This protocol will also apply to supervisors who do not monitor employee performance or complete required case reviews to determine compliance with the protocol. Compliance with the protocol will be monitored by the DHS county office director/district manager and by the DHS Business Service Centers.

(5) By September 1, 2014, DHS will implement a comprehensive system of accountability. Monthly case activity reports will be generated and monitored by DHS management at all levels. Compliance with requirements will be reflected in employee performance evaluations.

(6) By September 30, 2014, all APS staff will complete mandatory APS core training that includes monthly face-to-face requirements and supervisory approval of cases remaining open longer than six months. Noncompliance with training requirements will result in corrective and/or disciplinary action in accordance with Civil Service rules.

(7) *DHS will work with DCH, Office of Services to the Aging and LARA and other community partners to provide needed services (for example, Adult Home Help Services) to reduce the length of time vulnerable adults require APS intervention.*

(8) *By October 1, 2014, DHS will develop a comprehensive adult services strategic plan with focus on all aspects of adult services including APS, appropriate decisions on referral assignment and referrals to law enforcement to enhance the safety and well-being of vulnerable adults in Michigan.*

FINDING

6. Investigation of Allegations

DHS did not investigate all allegations identified in referrals assigned for an APS investigation. As a result, DHS closed investigations that had unaddressed allegations of abuse, neglect, and/or exploitation and may have left adults vulnerable to continued alleged abuse, neglect, and/or exploitation.

Adult Services Manual Section 205 states that referrals are assigned when there is reasonable belief that the subject of the reported referral is an adult at risk of harm from abuse, neglect, or exploitation or if there is reasonable belief that the person is vulnerable and in need of protective services. The Manual also states that all alleged harm identified in the referral or discovered during the investigation must be addressed in the service plan. In addition, the Manual requires an APS supervisor to review all case closures after the APS caseworker has completed the closing to ensure that the worker addressed all allegations.

Our review of 205 selected closed APS investigation cases disclosed that DHS did not address all allegations identified during its investigation for 41 (20%) of the closed investigation cases. In addition, we determined that an APS supervisor reviewed and approved 23 (56%) of the 41 investigation cases that were closed with allegations not addressed.

The following table summarizes the 205 closed APS investigation cases that we reviewed at 12 DHS county/district offices that had allegations not addressed during the investigation:

DHS County/District Office	Number of Closed Investigation Cases Reviewed	Closed Investigation Cases That Had Outstanding Allegations Remaining		Investigation Cases Reviewed by an APS Supervisor That Had Outstanding Allegations Remaining	
		Number	Percentage	Number	Percentage
Berrien	14	3	21%	1	33%
Calhoun	16	1	6%	1	100%
Clare	20	5	25%	5	100%
Eaton	14	0	0%	0	0%
Genesee	19	5	26%	1	20%
Grand Traverse	17	3	18%	2	50%
Ingham	12	2	17%	0	0%
Jackson	15	2	13%	2	100%
Kent	16	2	13%	2	100%
Oakland	20	5	25%	5	100%
Van Buren	15	4	27%	4	100%
Wayne	27	9	33%	0	0%
	205	41	20%	23	56%

The following are examples of closed APS investigation cases that had allegations not addressed during the investigation:

a. The referral source stated that a mentally ill client was being financially exploited and his medications were not managed properly by the client's sister. The APS investigation determined that the client's prescription medication had not been refilled in months and that a relative agreed to get the medication refilled. The APS investigation also determined through contact with a collateral source that the client was being financially exploited. APS policy requires monthly face-to-face visits to help provide accurate and complete services; however, APS closed the case after 13 months without making any face-to-face contacts or documenting what investigative activities occurred to ensure that the client was not being financially exploited and that his medications were being managed properly.

b. The referral source stated that a learning disabled client was assaulted by the client's father and that the client was removed from the home by the client's mother and placed in temporary housing for 5 days. The APS caseworker attempted to make contact with the client but was unsuccessful. APS closed the investigation 7 days after the referral was assigned with the assumption that the client did not want APS services. Instead of closing the investigation, APS should have had a greater urgency to continue its attempts to contact the client and provide any needed services as APS knew where the client was temporarily staying and that the potential for harm remained.

c. The referral source stated that a bedridden, chronically ill client was not being cared for properly and lived in a home that was in poor condition. The APS investigation substantiated the allegations that the home was in poor condition and that the client was bedridden and determined that the primary caregiver for the client became ill for a few days and could not assist with the client's daily needs. APS closed the investigation 11 days after receiving the referral, but it did not address the need for a backup caregiver or the poor conditions of the home.

DHS had not established an effective control to ensure that DHS investigated all allegations identified in the assigned referrals prior to closing the APS investigation cases.

RECOMMENDATION

We recommend that DHS investigate all allegations identified in referrals assigned for an APS investigation.

AGENCY PRELIMINARY RESPONSE

DHS agrees in part with the finding.

DHS stated:

a. DHS completed reviews, as appropriate, and safety and well-being assessments of the three clients cited in the audit finding.

(1) DHS disagrees the client was being exploited. The APS referral was assigned in September 2012. The worker determined how the client's

money was being spent and facilitated contact with CMH. The client received ongoing independent living services. Another referral was assigned in December 2012. The client was receiving VA services, independent living services, as well as family and community support. It was determined that due to the nature of the client's illness there would be a period where intervention was needed. The client was placed in an adult foster care home in February 2013. Based on the client's increased needs, the client was later moved to a more intensive level of care in February 2014.

(2) DHS disagrees with the auditor's conclusion. The referral was made in October, 2011. The worker attempted to make contact with the client three times before closing the case seven days after the referral. The threat and risk of harm was removed when the mother moved the client away from the father. An APS referral was made in August 2013. At that time the client was living with a girlfriend and complied with the worker's requests for repairs and cleaning. The client had obtained help maintaining the apartment and paying bills. In November 2013, the APS worker made face-to-face contact with the client, reviewed his current circumstances, and closed the case.

(3) The APS worker made a safety and well-being check in April 2014 and stated the client's home was observed to be cluttered, but there are no safety issues. The clutter is mostly due to moving to a smaller home, and the client has plans for help removing some of the items. The client believes the 2012 APS referral was the result of a disagreement and argument with a friend. The client now has a backup caregiver and is receiving home services and has a nurse and physical therapist visit two times per week.

b. On May 2, 2014, the Michigan Department of Human Services launched its latest Business Service Center (BSC) and created a more centralized authority structure to deal specifically with Adult Services, making the safety of vulnerable adults a statewide priority. The Adult Services BSC will specialize in the delivery and monitoring of services related to investigating allegations related to the abuse, neglect and exploitation of vulnerable adults, adult community placement and independent living services/home help. This new business service center will assure DHS meets the legal requirements of timeliness in investigations and providing services, that face-to-face meetings with clients and providers are taking place, and that required referrals to law enforcement are being made. The Adult Services BSC for Michigan will also develop a risk assessment tool that closely mirrors one in place for children's services, thus ensuring all possible cases involving abuse and neglect are properly assessed, serviced and monitored for outcomes.

c. DHS takes with the utmost seriousness all allegations of willful neglect of duty or failure to carry out assigned tasks in compliance with law and policy. DHS has taken swift action to address the audit findings and has initiated formal investigation of cases cited in the audit to determine that staff acted appropriately. If any investigation determines that there was noncompliance with law and policy, appropriate corrective and/or disciplinary action will be taken, including demotion and/or dismissal.

d. DHS will develop and implement a quality assurance process to ensure all allegations of harm identified in assigned APS referrals are investigated and documented prior to closing the case. This will be achieved by implementing the following:

(1) In order to further protect vulnerable individuals, DHS is recommending codifying a criminal penalty for falsifying records. The provision will apply to any DHS employee who falsifies, alters, destroys, defaces, overwrites, removes, or discards an official record which has the potential to detrimentally affect the health, safety, or welfare of that individual.

(2) DHS will conduct an in-depth review of the remaining 38 cases cited in the report to ensure the safety and well-being of each client and file reports with law enforcement as required by law.

(3) By September 1, 2014, DHS will implement a comprehensive system of accountability. Sample case reads will be reviewed to ensure all allegations are addressed. In addition, supervisors review all closed cases to ensure all allegations were addressed (see corrective action plan for finding 2). DHS management, at all levels, will monitor compliance with DHS policy regarding the requirement to address all referral allegations. Compliance with requirements will be reflected in employee performance evaluations. Noncompliance will result in corrective and/or disciplinary action.

(4) On June 2, 2014, DHS issued formal and directed correspondence to DHS employees working with the APS program to clearly reaffirm statutory and DHS policy requirements and the expectations to address all referral allegations, and will inform DHS employees that the consequences for noncompliance will be corrective and/or disciplinary action in accordance with Civil Service rules.

(5) By August 1, 2014, DHS will implement for adult services a uniform standard of action protocol for workers who fail to address all allegations identified in the referrals assigned for an APS investigation or who falsify records. This protocol will also apply to supervisors who do not monitor employee performance or complete required case reviews to determine

compliance with the protocol. Compliance with the protocol will also be monitored by the DHS county office director/district manager and by the DHS Business Service Centers.

(6) By September 30, 2014, all APS staff will complete mandatory APS core training that includes the requirements to address all referral allegations. Noncompliance with training requirements will result in corrective and/or disciplinary action in accordance with Civil Service rules.

(7) Statewide training has been completed for the Michigan Model Vulnerable Adult Investigation Protocol (MI-MVP). Utilizing the protocol, DHS will continue to leverage relationships with law enforcement and prosecutors to reduce harm and victimization of vulnerable adults through a coordinated team approach.

(8) By October 1, 2014, DHS will develop a comprehensive adult services strategic plan with focus on all aspects of adult services including APS, appropriate decisions on referral assignment, and referrals to law enforcement to enhance the safety and well-being of vulnerable adults in Michigan.

FINDING

7. Continuing Education Training

DHS had not instituted annual continuing education training requirements for APS caseworkers and supervisors. Without continuing education requirements, DHS could limit its assurance that APS caseworkers and supervisors maintain the skills necessary to effectively perform APS duties and protect vulnerable adults.

Section 722.629 of the *Michigan Compiled Laws* requires that DHS ensure a continuing education program for its child welfare staff. DHS requires some child welfare services specialists, foster care workers, and adoption workers to meet a minimum of 32 hours of continuing education each year; however, DHS does not require annual continuing education training for its APS caseworkers and supervisors. APS caseworkers and supervisors have roles that are similar to the roles of child welfare staff; however, APS caseworkers' and supervisors' efforts are directed toward protecting vulnerable adults rather than children.

Although DHS recently instituted a one-time mandatory minimum training program for APS caseworkers and supervisors, DHS had not instituted requirements for continuing education training beyond the one-time mandatory training program. The mandatory one-time training includes four days of APS program training and two days of APS legal training.

To determine the amount of annual training other states provided APS investigators and/or caseworkers, we examined the National Adult Protective Services Resource Center (NAPSRC) report entitled *Adult Protective Services in 2012: Increasingly Vulnerable.* This report included a survey of states regarding the amount of annual training states provided to APS investigators and/or caseworkers. The survey disclosed that 34 (85%) of the 40 states responding to the survey provided APS investigators and/or caseworkers annual training programs ranging in duration from less than one week to as much as of four weeks. Michigan reported that it provided no annual training to existing APS investigators and/or caseworkers.

We met with 24 APS caseworkers and supervisors during our visits to 12 DHS county/district offices. All 24 APS caseworkers and supervisors indicated a desire for annual APS continuing education. In particular, some APS caseworkers and supervisors expressed a need for training in the areas of investigating APS financial exploitation referrals and/or APS domestic violence referrals.

RECOMMENDATION

We recommend that DHS institute annual continuing education training requirements for APS caseworkers and supervisors.

AGENCY PRELIMINARY RESPONSE

DHS agrees with the finding.

DHS stated:

DHS will establish professional standards for continuing education requirements for APS caseworkers and supervisors.

a. *On May 2, 2014, the Michigan Department of Human Services launched its latest Business Service Center (BSC) and created a more centralized*

authority structure to deal specifically with Adult Services, making the safety of vulnerable adults a statewide priority. The Adult Services BSC will specialize in the delivery and monitoring of services related to investigating allegations related to the abuse, neglect and exploitation of vulnerable adults, adult community placement and independent living services/home help. This new business service center will assure DHS meets the legal requirements of timeliness in investigations and providing services, that face-to-face meetings with clients and providers are taking place, and that required referrals to law enforcement are being made. The Adult Services BSC for Michigan will also develop a risk assessment tool that closely mirrors one in place for children's services, thus ensuring all possible cases involving abuse and neglect are properly assessed, serviced and monitored for outcomes.

b. *Because of the similarities between Child Protective Services and Adult Protective Services, APS continuing education training requirements will be similar to child welfare standards. Training subject matter will be based on information from the National Adult Protective Services Association and other partners and will be developed by DHS Office of Workforce Development and Training (OWDT).*

c. *By August 1, 2014, DHS will research Michigan's current Children's Protective Services (CPS) core standards and adopt those applicable to APS.*

d. *On an ongoing basis, based on assessments of performance, identified deficiencies and gaps, DHS will identify required continuing education subjects, which support and/or enhance current core APS training. The identified subjects may include such topics as investigation, legal, documentation and assessments.*

e. *Completion of continuing education requirements will be included in the yearly performance plans for APS supervisors and caseworkers and will be reflected in performance evaluations.*

f. *By September 1, 2014, DHS will implement a comprehensive system of accountability where DHS management at all levels will monitor compliance with training requirements. Noncompliance will result in corrective and/or disciplinary action in accordance with Civil Service rules.*

g. *By October 1, 2014, DHS will develop a comprehensive adult services strategic plan with focus on all aspects of adult services including APS, appropriate decisions on referral assignment and referrals to law enforcement to enhance the safety and well-being of vulnerable adults in Michigan.*

EFFORTS IN IDENTIFYING AND PROVIDING APPROPRIATE SERVICES FOR ACCEPTED APS REFERRALS OF ADULT ABUSE, NEGLECT, AND/OR EXPLOITATION

COMMENT

Audit Objective: To assess the effectiveness of DHS's efforts in identifying and providing appropriate services for accepted APS referrals of adult abuse, neglect, and/or exploitation.

Audit Conclusion: We concluded that DHS's efforts in identifying and providing appropriate services for accepted APS referrals of adult abuse, neglect, and/or exploitation were moderately effective.

Our audit conclusion was based on our audit efforts as described in the audit scope and audit methodology sections and the resulting material condition noted in the comments, findings, recommendations, and agency preliminary responses section.

Our audit efforts disclosed one material condition related to DHS's completion of APS client service plans (Finding 8). In our professional judgment, the material condition is more severe than a reportable condition and could impair management's ability to operate effectively and/or efficiently.

We took into consideration both quantitative and qualitative factors in reaching a conclusion on the effectiveness of DHS's efforts in identifying and providing appropriate services for accepted APS referrals of adult abuse, neglect, and/or exploitation. We considered the significance of the error rate we noted in our review of DHS's APS client service plans and the resulting impact on DHS's ability to identify and provide appropriate services to vulnerable adults. We also considered situations we noted when DHS provided APS clients with appropriate services, but DHS did not appropriately complete an APS client service plan. In addition, we considered the results of our review of selected payments for APS services on behalf of APS clients that disclosed the payments we reviewed were allowed by APS policy, reasonable, properly supported, and necessary to keep the adults safe from abuse, neglect, and/or exploitation. Because our audit efforts noted that APS service plans are DHS's key internal control to ensure that APS caseworkers address all allegations and provide the

proper APS services to APS clients and because we identified significant error rates in DHS's completion, timeliness, and thoroughness of APS client service plans, we determined that a conclusion of moderately effective was appropriate. We believe that the results of our audit efforts provide a reasonable basis for our audit conclusion for this audit objective.

FINDING

8. APS Client Service Plans

APS caseworkers did not consistently complete APS client service plans as required. In addition, APS caseworkers did not consistently complete APS client service plans within the required time frames. As a result, DHS could not ensure that APS caseworkers appropriately focused services on protecting APS clients from abuse, neglect, and/or exploitation and provided APS clients the most beneficial services to meet all of their identified needs in a timely and effective manner.

Adult Services Manual Section 205 requires the APS caseworker to address in the service plan all alleged harm identified in the referral or discovered during the investigation. The Manual also requires the APS caseworker to complete a service plan within 30 calendar days of the referral date for all substantiated cases and unsubstantiated cases* for which ongoing services are being or will be provided. The service plan must include the plan of action that the worker will take to remedy the problems identified during the investigation. The plan of action will show how the plan will be accomplished, time frames, and any resources provided to the client.

In addition, the Manual requires that, once the initial service plan is completed, the worker must sign and date the form and request the client or the responsible party to sign and date the form. The signature date on the service plan provides supporting documentation that the initial service plan was in place on that date. If the client is unable to sign the service plan because of physical or cognitive limitations or is unwilling to sign, the APS caseworker must then obtain his/her supervisor's signature and date reflecting that the initial service plan has been completed. Further, the Manual requires that an updated service plan be completed on a quarterly basis or whenever there are significant developments that

* *See glossary at end of report for definition.*

affect the service plan, whichever occurs first. The updated service plan provides evidence of the progress achieved toward resolving each allegation.

Our review of 175 selected APS cases that required an APS client service plan during the period October 1, 2010 through April 14, 2013 disclosed:

a. APS caseworkers did not complete an APS client service plan for 31 (18%) cases we reviewed. As a result, our review also determined that APS caseworkers did not address all of the allegations identified in 12 (40%) of 30 cases prior to closing the APS investigations.

b. APS caseworkers did not address in the APS client service plan all of the allegations identified in the referral or investigation for 25 (17%) of the 144 cases we reviewed with an APS client service plan.

c. APS caseworkers did not complete the APS client service plan within 30 days for 31 (22%) of the 144 cases we reviewed with an APS client service plan. On average, APS caseworkers did not complete the APS client service plan until 132 days after the 30-day completion requirement for these 31 cases.

d. APS caseworkers did not obtain the required signatures of the applicable parties to the APS service plan for 84 (58%) of the 144 cases we reviewed with an APS client service plan.

e. APS caseworkers did not update the APS client service plans for any of the 77 cases we reviewed with investigations open longer than 90 days.

These deficiencies likely occurred because DHS had not established effective controls to ensure that APS caseworkers completed service plans as required. In addition, DHS's ASCAP system did not provide monitoring reports to APS caseworkers and supervisors to assist with tracking the timeliness of service plans.

RECOMMENDATIONS

We recommend that APS caseworkers consistently complete APS client service plans as required.

We also recommend that APS caseworkers consistently complete APS client service plans within the required time frames.

AGENCY PRELIMINARY RESPONSE

DHS agrees with the finding.

DHS stated:

APS workers will complete service plans within required time frames in accordance with policy. This will be achieved by implementing the following:

a. *On May 2, 2014, the Michigan Department of Human Services launched its latest Business Service Center (BSC) and created a more centralized authority structure to deal specifically with Adult Services, making the safety of vulnerable adults a statewide priority. The Adult Services BSC will specialize in the delivery and monitoring of services related to investigating allegations related to the abuse, neglect and exploitation of vulnerable adults, adult community placement and independent living services/home help. This new business service center will assure DHS meets the legal requirements of timeliness in investigations and providing services, that face-to-face meetings with clients and providers are taking place, and that required referrals to law enforcement are being made. The Adult Services BSC for Michigan will also develop a risk assessment tool that closely mirrors one in place for children's services, thus ensuring all possible cases involving abuse and neglect are properly assessed, serviced and monitored for outcomes.*

b. *DHS takes with the utmost seriousness all allegations of willful neglect of duty or failure to carry out assigned tasks in compliance with law and policy. DHS has taken swift action to address the audit findings and has initiated formal investigation of cases cited in the audit to determine that staff acted appropriately. If any investigation determines that there was noncompliance with law and policy, appropriate corrective and/or disciplinary action will be taken, including demotion and/or dismissal.*

c. *In order to further protect vulnerable individuals, DHS is recommending codifying a criminal penalty for falsifying records. The provision will apply to any DHS employee who falsifies, alters, destroys, defaces, overwrites, removes, or discards an official record which has the potential to detrimentally affect the health, safety, or welfare of that individual.*

d. On June 2, 2014, DHS issued formal and directed correspondence to DHS employees working with the APS program to clearly reaffirm DHS policy requirements and the expectations for completing client service plans and will inform DHS employees that the consequences for noncompliance will be corrective and/or disciplinary action in accordance with Civil Service rules.

e. By August 1, 2014, DHS will implement for the adult services program a uniform standard of action protocol for workers who fail to complete service plans within the established timeframes or who falsify records. This protocol will also apply to supervisors who do not monitor employee performance or complete required case reviews to determine compliance with the protocol. Compliance with the protocol will also be monitored by DHS county directors/district managers and Business Service Centers. By implementing this protocol and monitoring and enforcing compliance, DHS will have reasonable assurance that vulnerable adults receive all/only the services and protections they are eligible for.

f. By September 30, 2014, all APS staff will complete mandatory APS core training that includes client service plan requirements. Noncompliance with training requirements will result in corrective and/or disciplinary action in accordance with Civil Service rules.

g. By September 1, 2014, DHS will implement a comprehensive system of accountability. Monthly case activity reports will be generated and monitored by DHS management at all levels. Compliance with requirements will be reflected in employee performance evaluations.

h. By October 1, 2014, DHS will develop a comprehensive adult services strategic plan, which will include APS, and focus on all aspects of adult services including intervention and service delivery to enhance the safety and well-being of vulnerable adults in Michigan.

SUPPLEMENTAL INFORMATION

UNAUDITED

ADULT PROTECTIVE SERVICES
Department of Human Services (DHS)

Schedule of Adult Abuse, Neglect, and/or Exploitation Referrals Received by DHS
For Fiscal Years 2010-11, 2011-12, and 2012-13

	Fiscal Year		
	2010-11	2011-12	2012-13
October	1,519	1,819	2,868
November	1,351	1,708	2,462
December	1,233	1,654	2,279
January	1,235	1,930	2,782
February	890	1,846	2,444
March	3,391	2,207	2,618
April	2,008	2,140	2,791
May	1,670	2,262	2,880
June	1,883	2,266	2,923
July	1,818	2,641	3,392
August	2,040	2,891	3,277
September	1,819	2,446	2,994
Total	20,857	25,810	33,710
Average number of referrals DHS received:			
Per month	1,738	2,151	2,809
Per day	57	71	92
Per hour	2.4	2.9	3.8

Source: The Office of the Auditor General prepared this schedule based on unaudited data obtained from DHS.

GLOSSARY

abuse	Harm or threatened harm to an adult's health or welfare caused by another person. Abuse includes, but is not limited to, nonaccidental physical or mental injury, sexual abuse, or maltreatment (Section 400.11(a) of the *Michigan Compiled Laws)*.
adult in need of protective services	A vulnerable person not less than 18 years of age who is suspected of being or believed to be abused, neglected, or exploited (Section 400.11(b) of the *Michigan Compiled Laws)*.
Adult Services Comprehensive Assessment Program (ASCAP)	The automated workload management tool for APS. Documentation for all the APS functions must be completed on ASCAP, including all collateral and face-to-face contacts.
AFC	Adult Foster Care.
APS	Adult Protective Services.
BSC	Business Service Center.
centralized intake unit	A unit with a single physical location established to ensure consistency across the State in how abuse and neglect complaints to CPS and APS are documented.
client	A vulnerable adult in need of protection.
CPS	Children's Protective Services.
DHS	Department of Human Services.
effectiveness	Success in achieving mission and goals.

exploitation	An action that involves the misuse of an adult's funds, property, or personal dignity by another person (Section 400.11(c) of the *Michigan Compiled Laws)*.
goal	An intended outcome of a program or an entity to accomplish its mission.
guardian	A person or other entity appointed by probate court to provide necessary supervision and care of a legally incapacitated person (one who lacks understanding or capacity to make or communicate informed decisions because of a mental or physical impairment or because of the use of drugs or chronic intoxication).
input	A resource (e.g., staff hours or expenditures) that is consumed in producing outputs.
internal control	The plan, policies, methods, and procedures adopted by management to meet its mission, goals, and objectives. Internal control includes the processes for planning, organizing, directing, and controlling program operations. It also includes the systems for measuring, reporting, and monitoring program performance. Internal control serves as a defense in safeguarding assets and in preventing and detecting errors; fraud; violations of laws, regulations, and provisions of contracts and grant agreements; or abuse.
material condition	A matter that, in the auditor's judgment, is more severe than a reportable condition and could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.

National Adult Protective Services Resource Center (NAPSRC)	A project of the U.S. Administration for Community Living, U.S. Department of Health and Human Services, administered by the National Adult Protective Services Association (NAPSA). NAPSA is a national nonprofit 501(c)(3) organization whose mission is to improve the quality and availability of protective services for adults with disabilities and older persons who are abused, neglected, or exploited and are unable to protect their own interests.
National Association of States United for Aging and Disabilities (NASUAD)	An organization that represents the nation's 56 state and territorial agencies on aging and disabilities. NASUAD's mission is to design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability and their caregivers.
neglect	Harm to an adult's health or welfare caused by the inability of the adult to respond to a harmful situation or by the conduct of a person who assumes responsibility for a significant aspect of the adult's health or welfare. Neglect includes the failure to provide adequate food, clothing, shelter, or medical care (Section 400.11(d) of the *Michigan Compiled Laws)*.
outcome	An actual impact of a program or an entity.
output	A product or a service produced by a program or an entity.
performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.

performance measure	A composite of key indicators of a program's or an activity's inputs, outputs, outcomes, productivity, timeliness, and/or quality. Performance measures are a means of evaluating policies and programs by measuring results against agreed upon program goals or standards.
performance standard	A desired level of output or outcome.
protective services	Includes, but is not limited to, remedial, social, legal, health, mental health, and referral services provided in response to a report of alleged harm or threatened harm because of abuse, neglect, or exploitation (Section 400.11(e) of the *Michigan Compiled Laws)*.
referral	An allegation, report, or other communication that contains information about known or suspected abuse, neglect, or exploitation of vulnerable adults.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the audit objectives; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.
risk assessment	An APS tool used to measure the level of risk of harm to the client and to measure the impact of intervention by an APS worker. Each risk factor is scored from 1 through 5.
safe and stable living situation	An environment in which there is no immediate threat to the life, health, or welfare of an adult from self or others and there is reason to believe that this status will continue for the foreseeable future.

service plan	Plan of action, based on the information from the investigation, indicating what the caseworker will do to remedy the identified problems, how the plan will be accomplished, time frames, resources needed, and documentation of the client's consent to services.
substantiated	A determination that the subject of a complaint is an adult and is vulnerable and threatened by actual harm because of abuse, neglect, or exploitation.
substantiated case	A case in which an APS worker determines that the subject of the complaint is an adult who is vulnerable and is threatened by actual harm because of abuse, neglect, or exploitation.
unsubstantiated case	A case in which an APS worker determines that the subject of the complaint is an adult who is either not in danger of any harm or not vulnerable or that the referral is one which is inappropriate for APS.
vulnerable	A condition in which an adult is unable to protect himself or herself from abuse, neglect, or exploitation because of a mental or physical impairment or because of advanced age (Section 400.11(f) of the *Michigan Compiled Laws)*.

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