PROMISING PRACTICES IN STATE SURVEY AGENCIES

Strategies for Quality Management of Abuse and Neglect Complaints

Wisconsin: Office of Caregiver Quality

Summary

The Division of Quality Assurance (DQA) at the Wisconsin Department of Health and Family Services (DHFS) established the Office of Caregiver Quality (OCQ) in 1998 to create a centralized, consistent system for effectively and efficiently managing complaints of caregiver misconduct. Through the application of standard protocols, time frames, and decision-making criteria, the OCQ system has resulted in greater speed and consistency in screening and investigating caregiver misconduct complaints from facilities statewide.

Introduction

This report describes the role of the Office of Caregiver Quality, established by the Division of Quality Assurance, Wisconsin's State Survey Agency (SA). The OCQ operations and processes, their impact, and lessons learned that might benefit other agencies are discussed. The information in the report is based on interviews with agency management staff and review of selected materials, and includes information drawn from the DQA document entitled *Centralized Caregiver Regulation and Investigation Process* submitted to the 2000 Association of Health Facility Survey Agencies (AHFSA) Promising Practices Contest.

Background

The Wisconsin Caregiver Law passed in October 1998 expanded caregiver misconduct reporting requirements beyond 1992 federal and state laws that required nursing homes and intermediate care facilities for persons with mental retardation that receive Medicare or Medicaid reimbursement to report allegations against nurse aides to the DHFS. The expanded requirements under the 1998 Caregiver Law direct all DHFS-regulated facilities to report misconduct incidents related to all noncredentialed caregivers to DHFS. Prior to enactment of the Caregiver Law, DQA already was facing obstacles in effectively and expeditiously completing investigations, experiencing delays of up to 11 months. Recognition of the even greater volume of allegations that would result from the Caregiver Law prompted the DQA to assess the effectiveness of their screening and investigation processes, which were conducted by five regional offices located across the state. A centralized, consistent screening and investigative process did not exist, resulting in variability in processes, time frames, and decision making across the state. The DQA identified several factors that contributed to delays in completing investigations, including unclear policy, a time-consuming and fragmented review process, vague staff workload priorities, and limited training for the staff and supervisors responsible for receiving, reviewing, and investigating caregiver misconduct complaints. In response to these issues, DQA created the OCQ to establish a centralized system and clear policies and procedures that would promote an effective, efficient, and consistent caregiver misconduct complaint screening and investigation process.

Intervention

OCQ receives all complaints of caregiver misconduct alleged to have occurred in any DHFS-regulated facility in the state. OCQ refers allegations involving credentialed caregivers to the Department of Regulation and Licensing and is responsible for addressing complaints related to noncredentialed caregivers. Each year, OCQ receives approximately 2,000 misconduct complaints against noncredentialed caregivers, with approximately half from nursing homes and

half from other provider types. The majority of complaints are self-reported by facilities; other sources are facility residents, family members, and DQA survey staff.

The Caregiver Enforcement Team at the OCQ is responsible for screening and overseeing investigation of complaints. Other OCQ staff coordinate background checks on facility license holders, support the nurse aide training and registry program, and conduct other activities associated with the Caregiver Law. The Caregiver Enforcement Team consists of three consumer protection investigators who screen complaints, coordinate referrals, complete desk investigations in coordination with law enforcement agencies, and conduct other work related to caregiver misconduct allegations. The team also includes a quality assurance program specialist, referred to as the Caregiver Investigation Lead, and three support staff.

OCQ staff use a digital sender to quickly transmit complaint paperwork on the day received to the regional office for the relevant program area. The regional office thus can quickly determine whether to send surveyors to investigate the complaint from the perspective of facility culpability while the OCQ focuses on substantiating findings against the caregiver. Allegations involving nursing homes may be investigated both by OCQ and nursing home surveyors due to federal regulations; however, regional office management for other provider types may defer the decision to send surveyors to investigate until they have reviewed OCQ investigative findings.

OCQ also makes “quick referrals” to the Medicaid Fraud Control Unit at the Wisconsin Department of Justice (DOJ), immediately upon receiving complaints such as sexual assault, serious physical injury, or death that have not already been reported to local law enforcement. If complaints received by OCQ also have been reported by facilities to local law enforcement, criminal charges may be in progress concurrently with OCQ's investigation for the administrative finding.

The OCQ consumer protection investigators review misconduct complaints using a uniform incident report screening protocol to determine whether the allegations meet the Wisconsin Administrative Code definitions of abuse, neglect, or misappropriation of property, and whether investigation is warranted. As part of the screening process, the investigators complete a standard incident review and referral form that ensures the consistency of information reviewed for each complaint, including a check for prior incident reports received by OCQ, substantiated findings of misconduct, law enforcement involvement, and sufficient evidence for investigation based on all available information. The investigators are required to screen complaints within five days of receipt.

OCQ currently contracts with a company of licensed private investigators to investigate complaints that meet the screening criteria for possible abuse, neglect, or misappropriation (in the past, OCQ investigators also conducted on-site investigations). The contractors follow an investigation protocol developed by OCQ and provide a statement of facts using a required investigative report template. The contractors are paid by the case and must complete the on-site investigation process within 45 days, although most investigations are completed in fewer than 30 days. The OCQ Caregiver Investigation Lead reviews all completed investigation reports to verify that all steps have been completed and sufficient evidence is documented, and then makes the final substantiation decisions. When findings are substantiated against a caregiver, the caregiver's name is added to the Wisconsin Caregiver Misconduct Registry and OCQ refers the case to the DOJ for decisions regarding the pursuit of criminal charges against the caregiver. The entire process, from receiving a complaint to adding a name to the Caregiver Misconduct Registry — including screening, on-site investigation by the contractors, OCQ review and substantiation, and the required 30-day appeal

time period — typically encompasses approximately six months, compared to up to two years prior to establishing the OCQ.

OCQ investigations continue even if a caregiver's employment is terminated at the facility where an incident is alleged to have occurred. Based on their investigations, OCQ is able to establish a record of incidents, alleged and substantiated, related to individual caregivers. Each time a complaint is filed, OCQ investigators access these records and examine a caregiver's past incidents and behavior patterns.

To promote consistency in provider reporting, OCQ established a reporting process for provider facilities and disseminated a flowchart to guide providers in determining when an incident must be reported to OCQ. In 1999, OCQ staff also collaborated with the University of Wisconsin and the DHFS Office of Legal Counsel to develop and conduct ten statewide Caregiver Program training sessions for regulated providers and DQA surveyors to clarify facility requirements for investigation and reporting under the Caregiver Law and instruct providers on the use of the flowchart as a helpful tool.

To further promote and facilitate adherence to reporting requirements and processes, OCQ maintains a Website with extensive information and links related to the Caregiver Law, caregiver misconduct reporting requirements, required caregiver background checks, and related issues. The Website, which won a 2001 AHFSA Promising Practice award, houses instructional manuals for providers, complaint reporting forms for use by family members or others, and information for reporting complaints by phone.

Impact

Agency management staff report that the centralized OCQ system has resulted in the implementation of consistent protocols, time frames, and decision-making criteria that ensure thorough and fair screening and investigation of all caregiver misconduct complaints. The OCQ approach also substantially improved the timeliness of responding to complaints, which is critical in protecting the safety and welfare of facility residents and clients. The average disposition of cases went from 300 days between April 1992 and December 1998 to 47 days between July 1999 (when OCQ was established) and February 2000. Agency management staff attribute this dramatic improvement to the streamlined, centralized process, the assignment of staff dedicated for the specific purpose of addressing caregiver misconduct allegations, the five-day screening requirement, and the speed of the contract investigators.

Agency management staff also note that the OCQ system has improved communication between the DQA central and regional offices by facilitating quick transmission via digital sender of complaint information. Regional offices (for program types other than long-term care) often review OCQ findings before deciding whether to conduct their own investigation, thereby minimizing redundant efforts and costs and maximizing appropriate use of valuable staff resources.

Agency management staff indicate that OCQ's dissemination of the standard provider reporting process and flowchart for determining when to report a misconduct complaint, as well as the training sessions delivered soon after establishing the OCQ, increased facility awareness of their responsibilities and role under the Caregiver Law and produced more consistent and effective reporting by provider facilities across the state and across provider types. The centralized system also is noted to allow surveyors to focus their efforts on assessing facility culpability in an alleged caregiver misconduct incident, while OCQ investigates culpability at the caregiver level.

Lessons Learned

Agency management staff indicate that although some veteran surveyors who were accustomed to investigating caregiver misconduct complaints themselves initially showed minor resistance to the new system, surveyors and providers now are

comfortable with and appear to appreciate the OCQ system. It is valuable to invest substantial effort at the outset to promote a smooth and clear transition to a new system such as the OCQ process, while recognizing that it may take time for surveyors and providers to accept and become comfortable with the new approach. Efforts supporting the transition to the OCQ system at DQA included developing detailed procedure manuals and supporting materials and conducting training for providers and surveyors across the state. It is important to clearly and simply define and disseminate information on roles and responsibilities for providers and surveyors, and to ensure clear communication of workload priorities and procedures for staff involved in implementing OCQ tasks.

Agency management staff advocate for the use of data as a valuable management tool to help track performance and identify necessary changes. OCQ was able to demonstrate a dramatic improvement in the speed of the complaint management process by tracking data on time spent before and after establishing the OCQ. Ongoing evaluation of any program can help identify strengths to build on and weaknesses to correct, thereby enabling managers to maximize the program's effectiveness in improving performance.

Contact Information and Resources

For more information regarding the OCQ system for managing caregiver misconduct complaints, please contact Shari Busse, Director of the Office of Caregiver Quality at the Wisconsin Department of Health and Family Services, at BusseSE@dhfs.state.wi.us or 608/264-9876.

Information on provider reporting requirements, forms, and decision-making tools such as the provider flowchart described in this report is available on the DHFS Website at http://dhfs.wisconsin.gov/caregiver/contacts/Complaints.htm.

This document is part of an issue brief on strategies for quality management of abuse and neglect complaints in State Survey Agencies. The issue brief is one of a series by the Division of Health Care Policy and Research, University of Colorado Health Sciences Center, for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in State Survey Agencies. The entire series is available online at CMS' Website, http://www.cms.hhs.gov/SurvCertPromPractProj. The issue briefs are intended to share information about practices used in State Survey Agencies and are not an endorsement of any practice.