OFFICE OF INSPECTOR GENERAL
CITY OF ALBUQUERQUE

Investigative Report
Case # 12-211

OFFICE OF INSPECTOR GENERAL
CITY OF ALBUQUERQUE

May 11, 2012

Jorja Armijo-Brasher
Director, Senior Affairs Department
City of Albuquerque

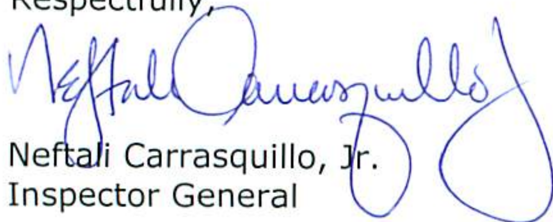
Dear Ms. Armijo-Brasher,

Re: OIG-12-211: Case Management Issues of DSA Employee

On or about March 1, 2012, the Office of Inspector General (OIG) was contacted by Peter Ennen, Risk Management regarding some issues concerning a Department of Senior Affairs (DSA) employee which involved case management issues and possible falsification of documents contained in his cases.

Enclosed please find a copy of the OIG's investigative report regarding this matter.

Respectfully,



Neftali Carrasquillo, Jr.
Inspector General

cc: Richard J. Berry, Mayor
City Council
Robert J. Perry, CAO
John Soladay, COO
Lou Hoffman, Director DFAS

Executive Summary

On or about March 1, 2012, the Office of Inspector General (OIG) was contacted by Peter Ennen, Risk Management regarding some issues concerning a Department of Senior Affairs (DSA) employee, which involved case management issues and possible falsification of documents contained in his cases.

The OIG investigation included conducting interviews with Department of Senior Affairs personnel, reviewing documents and information provided, and gathering evidence. Based on the investigation conducted, the OIG concludes the following:

1. That DSA1 has been a case manager for the Department of Senior Affairs (DSA) since September 2006 and currently has a caseload of approximately 142.

2. That there are various concerns with these cases, to include the following:

- **a) Issues of cutting and pasting, from previous reports, and not updating information that has changed;**
- **b) Approving clients for services that they do not qualify for; not doing the proper assessments or completing the proper forms;**
- **c) Failure to properly evaluate a client's eligibility which could affect the client's well-being and the federal funding for DSA;**
- **d) Proper time and documentation not being entered into the Social Assistance Management System (SAMS);**
- **e) This failure to enter the proper Service Delivery time could affect DSA's funding and could even affect the number of case managers in DSA's program.**

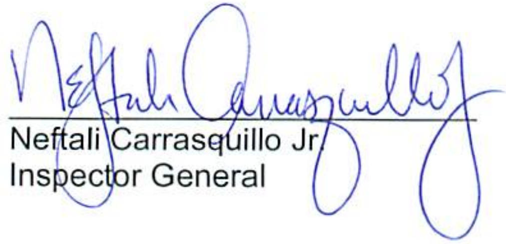
3. That one case was particularly problematic in that the DSA client's husband passed away March 23, 2009; however, progress notes from 10/4/10 and 5/27/11 make no indication that the client's husband had passed away, but instead read as if he was still alive and that he and the client were still living together.

The OIG makes the following recommendations for consideration by the Department of Senior Affairs:

1. That a complete and thorough review of all case files for all case managers be conducted.
2. A review of the Social Assistance Management System (SAMS) and consideration given to modifying accessibility. Currently, changes and updates on cases can be made by various personnel having access to this system. Only the case manager and supervisor should have access to cases which would allow input and modification.

3. That yearly refresher training is considered for case managers as to proper case management and handling.

Details of the investigation are contained within the investigative report and are attached to this executive summary.



Neftali Carrasquillo Jr.
Inspector General

OIG INVESTIGATIVE REPORT

On or about March 1, 2012, the Office of Inspector General (OIG) was contacted by Peter Ennen, Risk Management regarding some issues involving a DSA employee, which involved case management issues and possible falsification of documents contained in his cases. On March 6, 2012 the OIG initiated an investigation regarding these issues.

I. On March 6, 2012, the OIG met with the DSA Director, Senior Social Service Division Manager, Case Management Supervisor, and Personnel Officer, to discuss the issues regarding DSA1. DSA1 started with DSA around September 2006 and was administratively transferred from the Department of Corrections, where he worked as a case manager.

DSA management stated that DSA1 has had, on average, approximately 160 cases, which is comparable to the other case managers; however, DSA1 has always been behind on his caseload. They stated DSA1's reasoning for this was that he had never been properly trained. DSA management stated at one point DSA1 was even placed on a correction plan, to which initially he was thankful for, but then was resistant to taking direction. Per DSA management, there was no rhyme or reason to how DSA1 qualified and denied clients for services. They explained that the proper procedure for case managers is that DSA clients are to have an initial assessment and then the case manager is supposed to conduct follow up visits and reassessments every six (6) months thereafter. However, they were unsure if DSA1 was actually following through with this on his cases. DSA1 was placed on paid administrative leave October 2011 for a separate incident involving a threat of workplace violence issue, and as a result, DSA2, took over his caseload.

II. On March 16 2012, the OIG met with DSA2. DSA2 explained the duties of a Case Manager and what is involved in handling DSA client cases.

DSA2 stated that each case manager is expected to evaluate a client's eligibility for various programs and services. DSA2 explained that services offered by DSA are limited and are actually considered services of "last resort". DSA2 added that one of the overall goals is to keep seniors in the community with services, rather than placing them in long term care and that is why it is important to evaluate their eligibility for other services which provide more comprehensive support. DSA2 stated that seniors do not qualify for DSA services if they are participating in a higher level of care and, if there are seniors who are eligible for a higher level of care, then they must apply for those services. Per DSA2, it is for these reasons the Benefits and Services Eligibility Checklist is a very important part of the assessment process. Failure to properly evaluate a client's eligibility can affect the client's well-being, as well as funding for DSA. DSA2 stated that in many cases, DSA1 did not correctly assess clients and because of this, some clients were receiving services when they did not meet the requirements to receive them.

Another part of case management that DSA2 explained is Service Delivery. DSA2 stated DSA is expected to meet a certain number of hours set each year according to annual goals. When a caseworker fails to enter their Service Delivery time, it can affect

DSA's funding and can even affect the number of case managers in DSA's program. DSA2 indicated that Service Delivery time should be entered onto the Social Assistance Management System (SAMS). DSA2 stated that DSA1 did not regularly enter all his time, and when he did, it was often excessive.

Finally, with regard to case files and case documentation, DSA2 stated that it is important for the case managers to keep accurate records both on the SAMS database and in the hard copy files. DSA2 explained that DSA is audited by its funding source, and when files are reviewed DSA can be cited for inconsistencies and work that does not follow the guidelines set forth by the Area Agency on Aging (AAA). DSA2 stated the majority of DSA1's files are not in order and do not follow those guidelines. DSA2 added that in a past monitoring report received from AAA after an audit, DSA1's work was noted as being inferior.

DSA2 stated that when there are issues with these three areas, it can jeopardize DSA's program for future funding and services.

III. After reviewing the cases of DSA1, the OIG concurred with DSA2's assessment/review and notes the following:

- Approximately 66% of the cases did not have a hard copy of the progress notes completed and/or placed in the case file. This puts into question whether or not visits were undertaken and does not offer any update to the current condition and circumstance of the client(s);

- Approximately 86% of the cases did not have completed Benefits and Services Eligibility forms. This is vital so that the appropriate level of care and service is made available and provided to the client(s);

- Approximately 55% of the cases, had unsigned Reassessment forms which could pose a legal issue and raises questions as to whether home visits and reassessments were actually done;

- Approximately 10% of the cases did not have assessments completed every six (6) months which again puts in doubt whether or not the required visits and assessments were done;

- Approximately 21% of the cases did not have a current Registration Form. An updated registration form has to be completed every six (6) months (when reassessments are done) because clients move to new addresses, change doctors, etc., and so updates have to be made on a new registration form and the new form needs to be printed out and put in the physical file. This also ties in with AAA requirements and funding

- Approximately 37% of the cases did not have a signed Release of Information form which can be indicative of sloppy case management. This is important so that the client's information can be provided to others to see if

the client qualifies for in-home meals, homemaker service, medical services, higher level of care, etc.

- Approximately 15% of cases had duplicate files which are problematic since no other case managers were found to have duplicate files. Some other issues with his case files were that some of them were lost/missing, the supervisor found a stack of empty folders in DSA1's office with client's names on the tab, but nothing in the files and it is believed that there might have been possible shredding of documents because of this.

- Approximately 10% of cases were found to have progress notes that were copied and pasted from one home visit and assessment to another. This is not allowed and potentially incorrectly depicts the status of the client(s) as will be shown in a specific cases discussed.

The OIG then conducted a more in depth review of eleven (11) case files. Three (3) of these cases were a cause of concern for the OIG. The first case involved DSA Client1. An issue identified was that the same progress note was used for two different dates. On 11/29/07 a progress note from DSA1 states:

> "HV for Re-assessment. demographics: Client is a 84 year old Hispanic female. Client had her daughter present during the assessment, due to client has Dementia. Client lives in the northeast area of Albuquerque …"

A progress note from DSA1, dated 1/5/11, a little over 3 years later, stated the exact same information, including the fact that DSA Client1 is an "84 year old Hispanic female". The age should have been reflected as an 87 year old and not 84 as this was 3 years later as previously noted.

Per DSA2, copying progress notes and using them for different dates is not allowed, as each visit or contact is different and therefore, should be documented as such. Some other issues with this case were that DSA1 did not complete reassessments every six months for this client. In addition, a Benefits and Services Eligibility Checklist was not completed. With this, DSA2 indicated there would be no way for DSA1 to know if this client is participating in or eligible for a higher level of service, which would make her ineligible for DSA services.

The next case involved DSA Client2 who had been receiving 100 hours of service per week through the Mi Via program since 2008. Because no Benefits and Services Eligibility Checklist was completed for this client, which should have noted the Mi Via services he was receiving. DSA Client2 received homemaker services from DSA for over three years which he was not eligible for. Per DSA2, if a client is receiving services through a program such as Mi Via, they do not qualify for services through DSA, as Mi Via is one of the services which provide a more comprehensive support and higher level of care. DSA2 provided an example of in-home meals; through DSA, a client can only receive in-home meals three (3) days a week. DSA2 explained that if DSA Client2 was receiving 100 hours of service per week through Mi Via, he likely had

a caregiver who could cook for him throughout the week rather than only three (3) days. DSA2 stated this case is also concerning because until very recently there was a waiting list and someone who was eligible did not receive services because DSA Client2 had been receiving the services and did not qualify for them.

The final case involved DSA Client3 who has been receiving services from DSA since at least 2004 and had been living with her ex-husband until he passed away March 23, 2009. DSA2 indicated that upon review of some of the progress notes in the SAMS system, she noticed incorrect information, which suggested the issue of DSA1 cutting and pasting progress notes. Progress notes dated 9/19/08; 10/4/10; and 5/27/11 read as follows:

> "Hv per re-assessment completed. Client is a 93 year old Caucasian female. Client and ex-husband live together and reside in the southeast area of Albuquerque …"

Although the progress note dated 9/19/08 may be accurate, the notes dated 10/4/10 and 5/27/11 posed an issue because the ex-husband passed away in March 2009. A copy of the ex-husband's obituary, reflecting a printout date of December 10, 2009, was found in the physical file. In addition, per the progress notes, DSA Client3 remains 93 years of age in 2008, 2010 and 2011; this also reflects the issue of cutting and pasting progress notes which were inaccurate. Some additional issues that DSA2 referenced with regard to DSA Client3's case is that there was a blank Benefits and Services Eligibility list, an incomplete release of information form, some assessments were not signed and there was no current registration form.

IV. On April 17, 2012, DSA1 was interviewed by the OIG regarding his work performance. DSA1 was advised of his obligation to cooperate and that he was being taped and would be placed under oath, to which he acknowledged. DSA1 was advised that he had the right to consult with a union or legal representative and he had union representation present for this interview.

DSA1 was advised there were concerns with many of his cases. One case raised a red flag because progress notes dated 11/29/07 and 1/5/11 read exactly the same way -- including the fact that the client was an "84 year old Hispanic female". Being there was over a three (3) year lapse between these two progress notes, it was not possible for this client to be the exact same age. DSA1 acknowledged the mistake and stated that this must have just been an error on his part.

DSA1 was advised of another case in which the client had been receiving 100 hours of service per week through the Mi Via program since 2008. As a result, this client was not eligible to receive services through DSA. DSA1 confirmed it was his understanding as well that a client would not be eligible for DSA services if they were receiving services through Mi Via. DSA1 asked if it indicated anywhere in the case file that this client was on Mi Via, but other than that, did not have much of an explanation as to what may have happened with this case. When it was pointed out to DSA1 that he had not entered any Service Delivery time in SAMS for this same case since October 2010, DSA1's reasoning was maybe it was just due to oversight and being overloaded.

DSA1 was asked to explain his recollection of a case involving DSA Client3. DSA1 stated that DSA Client3 had been a DSA client for a long time. He stated that DSA Client3's husband passed away a few years ago and DSA Client3 had been going back and forth staying with her daughter and then staying with her son. DSA1 believed almost everybody knew DSA Client3's ex-husband passed away. He indicated it was even discussed in meetings, as DSA Client3 was one of DSA's more vocal and "needier" clients.

The OIG pointed out two progress notes, which appear to have been written by DSA1: one progress note is dated 10/4/2010 and one progress note is date 5/27/2011 -- both of which state: "Hv per re-assessment completed. Client is a 93 year old Caucasian female. Client and ex-husband live together and reside in the southeast area of Albuquerque …" Furthermore, these two progress notes read the same as one dated 9/19/2008. DSA1 was advised that this case was viewed as the most problematic being that the 2010 and 2011 progress notes reflect as if DSA Client3's husband was still alive and they were still living together, when in actuality, he passed away on March 23, 2009. DSA1's response to this was that it was an "error." DSA1 then stated that any person can go into journal notes in the SAMS database, take the information that is in there and change the date or add or delete information. DSA1 indicated he is not saying that is the situation that happened, but it is possible for someone to go into SAMS and change dates or information. Discounting that possibility, DSA1 stated he did not have a good answer other than he takes full responsibility. However, DSA1 then added that he could say it is because he is the person in that department with the least amount of experience and was never properly trained. DSA1 also stated that he has the highest caseload and where some workers are seeing two (2) clients in a day, he is going out to see three (3), four (4) and sometimes even five (5) clients in a day just to stay ahead and not fall behind. DSA1 also commented he is not the only case manager who cuts and pastes, but reiterated that he takes full responsibility.

DSA1 acknowledged he had made the mistakes we discussed in this interview but reiterated his lack of experience and training was the reason why. DSA1 was then asked why he was stating he had the least experience and was not properly trained when he was a case manager in the Department of Corrections, for a number of years, and more or less did the same job functions and the fact that he had been doing his current job for at least 5 years. DSA1's response remained that same in stating he was never properly trained.