LA22-08

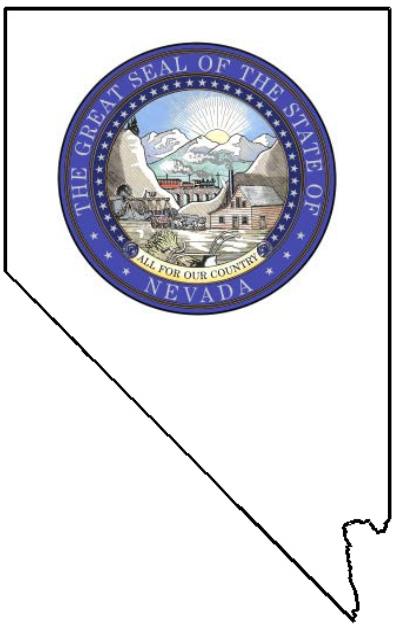
STATE OF NEVADA

Performance Audit

Department of Health and Human Services
Division of Child and Family Services

Management of Maltreatment Reports and Child Health

2021



Legislative Auditor
Carson City, Nevada

Audit Highlights

Highlights of performance audit report on the Division of Child and Family Services issued on March 22, 2022.

Legislative Auditor report # LA22-08.

Background

The Division of Child and Family Services (Division) was established in 1991. The Division's mission is to provide support and services to assist Nevada's children and families in reaching their full human potential. The Division recognizes that children, youth, and families thrive when they live in safe, permanent settings; experience a sense of sustainable emotional and physical wellbeing; and receive support to consistently make positive choices for family and the common good.

Child welfare and protective services functions in three regional services areas: northern, southern, and rural. The Division is responsible for Child Protective Services (CPS) activities and children in state custody in the rural service area, which includes all counties other than Washoe and Clark. Both the northern and southern service areas are state-supervised, county-administered child welfare delivery systems.

CPS receives reports from mandatory reporters and the public about alleged child maltreatment. Reports are assessed or screened for statements or allegations of child abuse and neglect. As part of its responsibilities to care for children in state custody, the Division supports the health of children by ensuring they receive necessary medical, dental, and mental health care.

Purpose of Audit

The purpose of the audit was to evaluate whether the Division adequately ensures the safety and welfare of children for certain Division activities, including maltreatment report response and the supervision of medical care of children in state custody. The audit included a review of the Division's activities for the 18-month period of January 1, 2019, to June 30, 2020, including previous years for case management activities.

Audit Recommendations

This audit report contains 11 recommendations to improve processing of maltreatment reports and oversight of health care services for children in state custody.

The Division accepted the 11 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on June 15, 2022. In addition, the 6-month report on the status of audit recommendations is due on December 15, 2022.

Management of Maltreatment Reports and Child Health

Division of Child and Family Services

Summary

The Division did not completely process certain maltreatment reports and was unaware that some reports lacked supervisory review. In addition, Division staff and management did not always employ adequate report recordkeeping practices and had the opportunity but did not complete necessary investigations in response to certain maltreatment reports. Furthermore, the Division does not assess comprehensive Medicaid claims of children in state custody to identify injuries or medical evaluations indicating potential abuse and neglect. Without effective management of maltreatment incidents and reports, children were exposed to increased risk of harm and neglect.

The Division was lacking in its monitoring of health care for children in state custody. For instance, the Division did not ensure children received required preventative health and dental care or that visits were properly documented in Unified Nevada Information Technology for Youth (UNITY). In addition, the Division's prescribed health care schedule for children in state custody was not updated to align with medical standards. When children do not receive required health care, they are at an increased risk of preventable illness. Maintaining complete records of health care for children in state custody facilitates continuity of care and supports the welfare of children.

Key Findings

Division management was unaware that certain maltreatment reports lacked complete supervisory review and were not processed according to statute and policy. Of over 4,800 rural reports received in calendar year 2019, 107 indicated a lack of supervisory review, which means the report was not completely processed. Unprocessed reports included serious allegations such as physical abuse, parental drug abuse, domestic violence, and child self-harm. Out of the 107 reports, 35 reports identifying alleged victims, perpetrators, and/or maltreatment incidents did not receive complete or timely supervisory review until we notified the Division of the oversight. We assessed all 107 reports and identified 18 in which the welfare of the children was potentially at immediate risk. We promptly notified the Division of these 18 reports. The Division confirmed these reports had not received proper oversight and assessed the safety of the children involved. (page 7)

The case histories associated with 11 of 107 maltreatment reports showed that children were exposed to additional risk of abuse and neglect because of inadequate or untimely report processing by the Division. The Division also delayed reporting alleged crimes of sexual abuse against children to law enforcement. (page 8)

The Division did not have adequate recordkeeping and record retention practices for certain maltreatment reports. Of 133 reports, 11 reports had inadequate report documentation. Examples of inadequate report documentation included insufficient or inaccurate documentation of alleged incidents, alleged perpetrators, alleged victims, or Division actions in response to reports. (page 8)

Some reports were deleted from UNITY even though those contained important incident-related information regarding alleged victims or instances of abuse and neglect. (page 9)

The Division had the opportunity but did not complete necessary investigations in response to allegations of abuse and neglect for 7 of 133 reports we assessed that were received in 2019. Reports not investigated by the Division included allegations of neglect, child abuse, inadequate shelter, failure to protect, threatened violence against a child, potential self-harm, and domestic violence. (page 10)

The Division does not analyze Medicaid claims of children in state custody for injuries or medical assessments indicative of abuse and neglect. Both state and federal entities have evidenced the child welfare benefits of utilizing Medicaid claims to identify potential incidents of child abuse and neglect. The Division was not aware of this best practice. (page 11)

Many children in state custody in 2019 did not receive required preventative health and dental care. A total of 29% of children did not receive annual preventative health care and 28% did not receive any dental care. (page 13)

For 159 of 198 (80%) children in state custody for all of 2019, the Division did not maintain complete health records in UNITY. Division policies are inadequate to ensure all health care records are obtained and entered into UNITY. (page 14)

The Division did not update timely its preventative health care schedule in policy for children in state custody to align with American Academy of Pediatrics recommendations. (page 15)

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Audit Division
Legislative Counsel Bureau

STATE OF NEVADA

LEGISLATIVE COUNSEL BUREAU

CARSON CITY OFFICE
LEGISLATIVE BUILDING
401 S. CARSON STREET
CARSON CITY, NEVADA 89701
(775) 684-6800

LAS VEGAS OFFICE
GRANT SAWYER STATE OFFICE BUILDING
555 E. WASHINGTON AVENUE, SUITE 4400
LAS VEGAS, NEVADA 89101
(702) 486-2800

Legislative Commission
Legislative Building
Carson City, Nevada

This report contains the findings, conclusions, and recommendations from our performance audit of the Department of Health and Human Services, Division of Child and Family Services, Management of Maltreatment Reports and Child Health. This audit was conducted pursuant to the ongoing program of the Legislative Auditor as authorized by the Legislative Commission. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions.

This report includes 11 recommendations to improve processing of maltreatment reports and oversight of health care services for children in state custody. We are available to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other state officials.

Respectfully submitted,

Daniel L. Crossman, CPA
Legislative Auditor

August 25, 2021
Carson City, Nevada

Management of Maltreatment Reports and Child Health

Table of Contents

Introduction

Background

The Division of Child and Family Services (Division) was established in 1991. The Division's mission is to provide support and services to assist Nevada's children and families in reaching their full human potential. The Division recognizes that children, youth, and families thrive when they live in safe, permanent settings; experience a sense of sustainable emotional and physical wellbeing; and receive support to consistently make positive choices for family and the common good.

The Division is primarily responsible for:

- Child Welfare Services – provides a continuum of services to children and families, including case management, emergency and foster care, and other services. Child Protective Services (CPS) is an integral part of child welfare and functions to respond to reports of abuse and neglect of children under the age of 18, protecting children from harm or risk of harm.

- Children's Mental Health – provides community-based outpatient services and residential and day treatment services. The Division coordinates with the Division of Public and Behavioral Health and other entities to support services in rural areas of Nevada.

- Juvenile Justice Services – supports youth ages 12 to 21 who have been committed to the Division for either delinquent behavior or to access services for mental health treatment.

Child welfare and protective services functions in three regional services areas: northern, southern, and rural. The Division is responsible for CPS activities and children in state custody in the rural service area, which includes all counties other than Washoe

and Clark. Both the northern and southern service areas are state-supervised, county-administered child welfare delivery systems. The rural region is divided into four districts with headquarters in Carson City, Elko, Fallon, and Pahrump.

Staffing and Budget

In fiscal year 2020, the Division had revenues of more than $311 million and expenditures of about $293 million. The Division is funded primarily by state and federal funds. Exhibit 1 shows the Division's revenues and expenditures for fiscal year 2020.

Revenues and Expenditures **Exhibit 1**
Fiscal Year 2020

Revenues	Amounts
Appropriations	$141,702,965
Federal Funds	114,005,762
Fees and Collections	13,450,597
Transfers From Other State Agencies	12,559,417
Beginning Cash	11,269,947
County Assessments	9,269,905
Other Revenue[1]	5,086,028
Intra-agency Transfers	4,405,168
Gifts and Donations	65,294
Total Revenues	**$311,815,083**

Expenditures	Amounts
Program Costs	$203,056,047
Personnel	72,182,021
Operating and Travel	12,812,055
Information Services	3,599,147
State Cost Allocations	1,348,894
Purchasing Assessments	29,905
Total Expenditures	**$293,028,069**
Difference	$ 18,787,014
Less: Reversion to General Fund	(11,232,773)
Balance Forward to 2021	**$ 7,554,241**

Source: State accounting system.

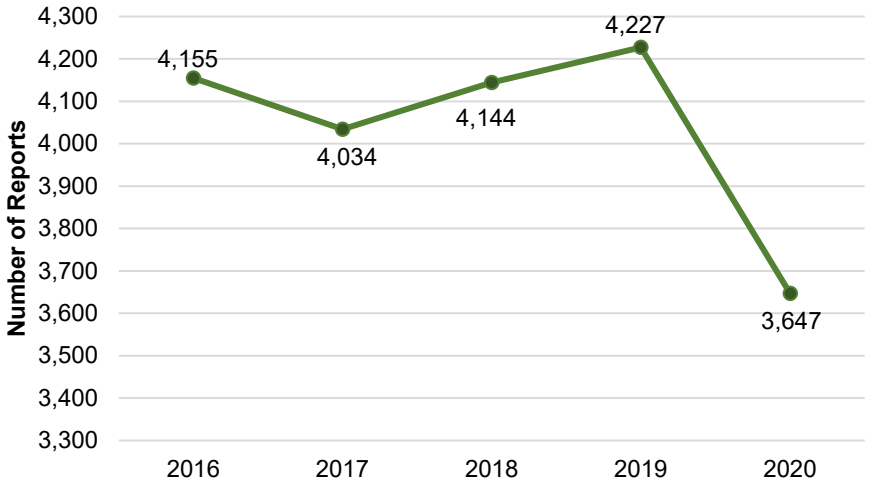
[1] Other revenue includes adjustments, child support payments, fines, interest, recoveries, refunds, and reimbursements.

As of December 31, 2020, the Division had 813 filled positions of 1,065 legislatively authorized positions. The Division's vacancy rate was 24%. The highest vacancy rates were in state juvenile justice facilities.

Process for Review of Rural Child Maltreatment Reports

CPS receives reports from mandatory reporters and the public about alleged child maltreatment. Intake is the point at which reports of suspected child abuse and neglect are received. Information gathered by Division staff is used to make decisions regarding risk, safety, and the type of CPS response required. The Division has standardized policies to support assessment of risk and timely response to reports to support the safety and welfare of children. Reports are received by intake workers or other Division personnel that interview reporting parties to gather sufficient information to evaluate and determine the appropriate agency response. Reports are electronically documented in the Unified Nevada Information Technology for Youth (UNITY) system. Exhibit 2 shows rural reports from fiscal year 2016 through 2020.

Rural Child Maltreatment Reports Received **Exhibit 2**
Fiscal Years 2016 to 2020



Source: Auditor prepared based on Division data.

Maltreatment reports declined about 14% in fiscal year 2020 due to restrictions related to the COVID-19 pandemic as mandatory reporters and others were not in direct contact with children during the last quarter of the fiscal year.

Reports are assessed or screened for statements or allegations of child abuse and neglect. The Division classifies in policy specific injuries or events that are considered abuse and neglect allegations. Screening in reports for investigation requires three criteria: (1) alleged victim must be a child under the age of 18, (2) alleged perpetrator must be a person responsible for the child's welfare, and (3) the report must contain an allegation of child abuse or neglect or have indications of present danger or a plausible risk of physical injury or sexual abuse. Reports are assigned a priority response time based on the severity of the potential danger:

- Priority 1 – initiate face-to-face contact within 6 hours of receipt of the report.

- Priority 2 – initiate face-to-face contact within 24 hours of receipt of the report. If face-to-face contact is not possible, the Division reaches out to collateral contacts or completes a case review.

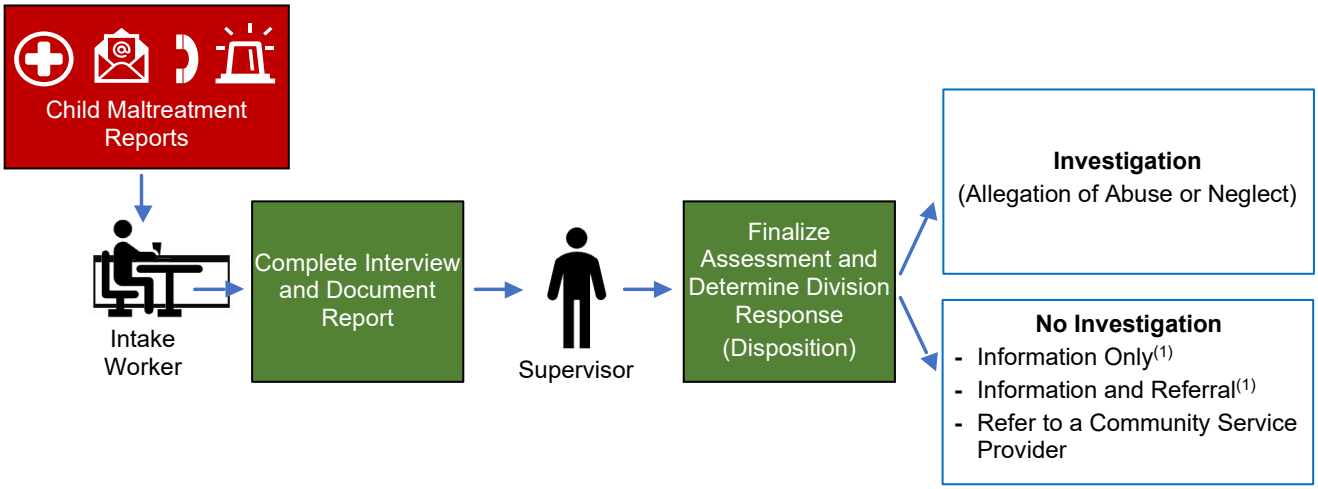
- Priority 3 – initiate face-to-face contact within 72 hours of receipt of the report. If face-to-face contact is not possible, the Division reaches out to collateral contacts or completes a case review.

- If the report does not meet the allegation criteria, the report is documented in UNITY but is not investigated.

The disposition is the final screening decision of an intake report and is determined by a supervisor, who reviews current allegation information and prior reports, if any, and determines in accordance with established policies whether an investigation is necessary. Certain reports received by the Division do not contain allegations of abuse and neglect and are not investigated.

During an investigation, the Division interacts with a family to assess the safety of children, determine the protective capacities of the caretakers, reconcile information contained in the intake reports about alleged maltreatment, and make a conclusion regarding the existence of present and/or impending danger. The Division's process for reviewing maltreatment reports is outlined in Exhibit 3.

Process for Reviewing Maltreatment Reports **Exhibit 3**



Source: Auditor prepared based on Division intake policy.

(1) Information Only and Information and Referral are Division dispositions indicating that a report will be documented in UNITY and the Division can provide services, but it will not be investigated.

Health Services for Children in State Custody

The Division reported 740 children and young adults were under protective, voluntary, and state custody during calendar year 2019. As part of its responsibilities to care for children in state custody, the Division supports the health of children by ensuring they receive necessary medical, dental, and mental health care. Division policy requires children entering state custody to receive a preventative health exam within 30 days. Additionally, the Division is federally required to create a schedule of health screenings that meets reasonable standards of medical practice. The Division relies on recommendations from the American Academy of Pediatrics (AAP) for its child preventative health care schedule. The AAP recommends that children 3 years and older receive at least annual preventative health care, with more

frequent care recommended for younger children. Division policy requires children to receive dental care every 6 months.

The Division entrusts foster providers, relatives, fictive kin, and individuals that provide care in a treatment home or residential treatment facility to care for children in state custody. These individuals support child health care access and maintain evidence of child health care. Division staff must enter reported health information, evaluations, diagnoses, and services provided to children into UNITY. A summary of the child's known health history and current health documentation is compiled into a UNITY report called the Child Medical Passport. This document can be shared with caregivers and other health professionals.

Scope and Objective

The scope of our audit included a review of the Division's activities for the 18-month period of January 1, 2019, to June 30, 2020, including previous years for case management activities. Our audit objective was to:

- Evaluate whether the Division adequately ensures the safety and welfare of children for certain Division activities, including maltreatment report response and the supervision of medical care of children in state custody.

This audit is part of the ongoing program of the Legislative Auditor as authorized by the Legislative Commission and was made pursuant to the provisions of Nevada Revised Statutes (NRS) 218G.010 to 218G.350. The Legislative Auditor conducts audits as part of the Legislature's oversight responsibility for public programs. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions.

Child Maltreatment Report Processing Inadequate

The Division did not completely process certain maltreatment reports and was unaware that some reports lacked supervisory review. In addition, Division staff and management did not always employ adequate report recordkeeping practices and had the opportunity but did not complete necessary investigations in response to certain maltreatment reports. Furthermore, the Division does not assess comprehensive Medicaid claims of children in state custody to identify injuries or medical evaluations indicating potential abuse and neglect. Without effective management of maltreatment incidents and reports, children were exposed to increased risk of harm and neglect.

Report Processing Not Always Completed

Division management was unaware that certain maltreatment reports lacked complete supervisory review and were not processed according to statute and policy. The Division received over 4,800 rural reports in calendar year 2019 documented in the Unified Nevada Information Technology for Youth (UNITY) system. Of these reports, 107 indicated a lack of supervisory review, which means the report was not completely processed. Unprocessed reports included serious allegations such as physical abuse, parental drug abuse, domestic violence, and child self-harm.

Management indicated certain reports may not have been completely processed due to staff's lack of familiarity with a new upgraded version of UNITY with reconfigured program screens and system processes. Additionally, supervisory monitoring procedures, including management reports, did not identify all reports lacking supervisory review. The 107 reports had remained in an incomplete processing status for an average of 212 days, with one remaining incomplete for over a year.

We obtained additional report documentation from UNITY for the 107 reports lacking evidence of supervisory review. Our assessment of these additional records found 35 reports identifying alleged victims, perpetrators, and/or maltreatment incidents that did not receive complete or timely supervisory review until we notified the Division of the oversight. State law requires the Division to conduct an evaluation of reports of alleged abuse and neglect no later than 3 days after the report is received to determine whether an investigation is warranted. The Division did not comply with this requirement for these 35 reports.

Risk Assessment of Unprocessed Reports

Due to concerns that child safety could be in question, we immediately assessed all unprocessed reports for instances in which children were potentially at risk. Our review identified 18 reports in which the alleged victims were potentially at immediate risk. We promptly notified the Division of these 18 reports. The Division confirmed these reports had not received proper oversight and subsequently assessed the safety of the children involved.

Children Exposed to Additional Maltreatment Risk

After assessing all 107 unprocessed reports, we noted the case histories associated with 11 maltreatment reports showed that children were exposed to additional risk of abuse and neglect because of inadequate or untimely report processing by the Division. Additionally, a consequence of the Division failing to timely process reports was that the Division delayed reporting alleged crimes of sexual abuse against children to law enforcement. In one report, the delay was over 3 months, while another report was delayed for over a year.

Inadequate Report Recordkeeping Practices

The Division did not have adequate recordkeeping and record retention practices for certain maltreatment reports. We completed a detailed assessment of 133 reports from 2019 lacking indications of supervisory review or containing conflicting child safety and welfare risk assessments. Of these 133 reports, 11 were inadequately documented. Examples of inadequate report documentation included insufficient or inaccurate documentation of alleged incidents, alleged perpetrators, alleged

victims, or Division actions in response to reports. Statute requires that caseworkers gather, when obtainable, information about the children and primary caretakers and the nature and extent of the abuse or neglect.

Inadequately documented or incomplete reports were due to intake staff report processing errors and staff not complying with documentation requirements. Additionally, supervisory review procedures detailed in Division policy were inadequate to detect and correct deficiencies. As a result of weak recordkeeping, a complete record of maltreatment reports and the Division's subsequent interventions was not maintained in UNITY. Future decision making based on insufficient information may occur because of this. Since UNITY data is utilized for state and federal reporting, accuracy and completeness are of paramount importance to verify the Division is fulfilling its responsibility to ensure children are protected. An incomplete or inaccurate history could also impact the ability of future caseworkers to appropriately characterize the needs of abused or neglected children.

Improper Report Deletions

Some reports were deleted from UNITY even though those contained important incident-related information. Staff and supervisors are restricted from deleting reports in UNITY and must submit special requests with justification to management for reports to be deleted. According to Division management, reports should only be deleted when created in error. This process ensures reports are maintained in UNITY to preserve historical information regarding alleged incidents, perpetrators, and victims.

Notwithstanding this process, 3 of 133 reports assessed from 2019 were deleted from UNITY despite the fact that they contained important information regarding alleged victims or instances of abuse and neglect. As a result, UNITY lacks a complete history of reports received. Division management's justification for report deletions was that these reports were incomplete. This justification displays a lack of consensus in the Division regarding when reports can be deleted. Deleting reports, even if report information is incomplete, eliminates historical

information that could later be useful in legal proceedings or in identifying trends regarding specific perpetrators, victims, or report sources to appropriately disposition future allegations. There is no policy governing report deletion, but the Division stated that it will develop a policy.

Priority Reports Not Always Investigated

The Division had the opportunity but did not complete necessary investigations in response to allegations of abuse and neglect for 7 of 133 reports received in 2019. The following factors need to be present to screen in a report for investigation:

- Alleged victim must be under the age of 18;
- Alleged perpetrator must be someone who is responsible for the child's welfare; and
- Report must contain an allegation of child abuse or neglect, or indications of present danger and/or plausible risk of physical injury or sexual abuse.

In all seven maltreatment reports, there were allegations of child maltreatment by a person responsible for the child's welfare. For example, the Division received a report that a child had been physically abused by a stepparent. Even though this report met criteria in policy requiring investigation, the Division did not investigate this report. Reports not investigated by the Division included allegations of neglect, child abuse, inadequate shelter, failure to protect, threatened violence against a child, potential self-harm, and domestic violence. For five reports, there was no evidence in UNITY that the Division had subsequent direct contact with the affected children. For the remaining two reports, the Division had contact in response to reports received later.

The primary purpose of investigations is to identify families in which children are unsafe and therefore in need of child protective services. Critical reasons for the Division to investigate maltreatment allegations is to protect children and to restore caregivers to their protective role and responsibility. The causes of these maltreatment reports not being investigated were judgmental error and supervisory noncompliance with policy.

Not investigating these reports put children at additional risk of abuse and neglect.

Medicaid Claims Not Assessed for Potential Abuse and Neglect

The Division does not analyze Medicaid claims of children in state custody for injuries or medical assessments indicative of abuse and neglect. When children enter state custody, the Division works to enroll them in Medicaid to support health care access. Thus, Medicaid claim records are an excellent source of information regarding injuries and medical assessments for these children. Both state and federal entities have evidenced the child welfare benefits of utilizing Medicaid claims to identify potential incidents of child abuse and neglect. The Division was not aware of this best practice.

We queried 2018 and 2019 Medicaid claims of children in state custody for diagnoses codes indicative of possible abuse and neglect. Examples of diagnosis and evaluation code descriptions include:

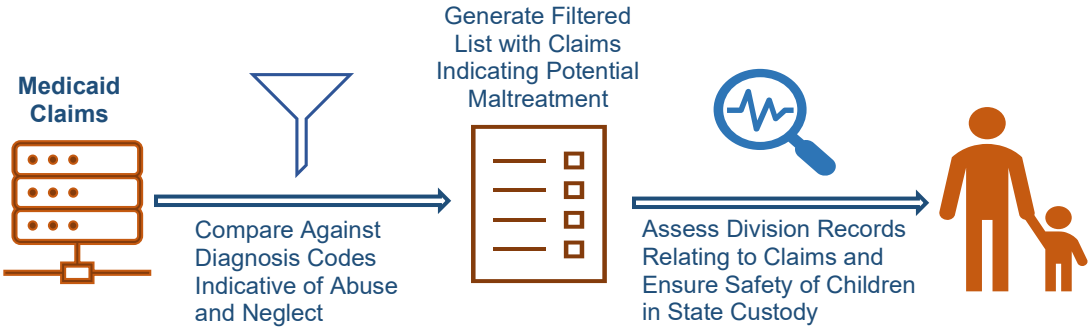
- Examination following alleged adult physical abuse;
- Assault by blunt object;
- Fracture of one rib; and
- Anoxic brain injury.

These diagnoses or examinations do not always result from abuse or neglect but can be early risk indicators. Out of 62,162 Medicaid claims, 22 claims contained these specified diagnoses codes. For all but one claim, the Division was aware of the injuries and had previously assured the safety of the children. For this claim, the Division was not aware of a skull fracture of a child in state custody.

This analysis did not include children in state custody in Clark and Washoe Counties; however, expanding this analysis statewide would provide additional opportunities to identify potential maltreatment. The Division stated it would review various options on implementing this concept into its ongoing child safety and

welfare efforts. Exhibit 4 outlines the protocol for identifying Medicaid claims that indicate possible abuse or neglect.

Protocol to Identify Medicaid Claims That Indicate Possible Abuse or Neglect **Exhibit 4**



Source: Auditor prepared.

Recommendations

1. Implement staff training when changes to the UNITY system occur to ensure proper processing of maltreatment reports.
2. Develop and review a management report to ensure all maltreatment reports are timely and properly processed.
3. Improve policies and management oversight controls to ensure critical information is documented in UNITY related to maltreatment reports.
4. Improve controls to prevent deletion of necessary maltreatment reports.
5. Comply with policy and investigate maltreatment reports that meet established criteria.
6. Implement a process to identify and assess Medicaid claims that indicate possible abuse and neglect for children in state custody. Perform follow-up activities to ensure the welfare of children as necessary.

Health Care Management of Children in State Custody Insufficient

The Division was lacking in its monitoring of health care for children in state custody. For instance, the Division did not ensure children received required preventative health and dental care or that visits were properly documented in UNITY. In addition, the Division's prescribed health care schedule for children in state custody was not updated to align with medical standards. When children do not receive required health care, they are at an increased risk of preventable illness. Maintaining complete records of health care for children in state custody facilitates continuity of care and supports the welfare of children.

Division Did Not Ensure Children Received Required Health Care

Many children in state custody in 2019 did not receive required preventative health and dental care. Division policy requires children entering state custody to receive a preventative health exam within 30 days of entering state custody and at least annually thereafter. Children must have dental check-ups and cleanings every 6 months. Caseworkers and supervisors should ensure children receive this care and that care is documented in UNITY. In 2019, 198 children were in state custody for the entire year. Exhibit 5 shows the number and percentage of children in state custody during 2019 who did not have evidence of required preventative health and dental care.

Number and Percentage of Children in State Custody Lacking Evidence of Preventative Care[1] **Exhibit 5**

	Count	Percentage
No Preventative Health Care	57	29%
No Preventative Health Care Within 30 Days of Entry Into State Custody	29	35%
No Preventative Dental Care[2]	43	28%
Child Received One But Not Two Preventative Dental Care Visits[2]	31	20%

Source: Auditor prepared from Division records.

[1] Child preventative dental care during 2019 was verified. Annual preventative health care was verified between child birthdays in 2018 and 2019. The Division's health care schedule does not follow a calendar year for annual care, but instead utilizes child ages.

[2] Division policy requires dental care for children 3 and older. For this reason, we excluded children younger than 3 from our analysis.

Caseworkers and supervisors did not adequately ensure that children received required health care. Although policy is clear regarding responsibilities to ensure children receive required care, policy lacks specificity regarding the frequency in which caseworkers should inquire about health-related visits. Similarly, the frequency of supervisory review is not defined in policy. The Division stated that supervisory review does not appear to be happening on a consistent basis. In response to these identified issues, the Division stated it will implement additional training to ensure caseworkers and supervisors understand and comply with policy.

Incomplete Child Health Records

For 159 of 198 (80%) children in state custody for all of 2019, the Division did not maintain complete health records in UNITY. There were 15 children without any evidence of health care in 2019 that could not be assessed for documentation of care in UNITY. One of the major benefits of health information stored in UNITY is that it can be readily compiled into summary documents by caseworkers and shared with care providers that may not have complete health histories of children in their care. Care providers need this information to properly support the health of children.

To identify if child paper records had additional evidence of required health care, we assessed 14 judgmentally selected paper files. In five instances (36%), additional health care records were present in paper files but not in UNITY. Division policy requires

preventative health exams be entered into UNITY within 5 days of service. Additionally, all other health information, evaluations, diagnosis, services, or prescription medications, provided to a child must be entered into UNITY within 5 days of receipt of information.

As a result of inadequate documentation practices, Division staff, health providers, and other child care providers may not have access to comprehensive centralized health information to make informed decisions. Division policies are inadequate to ensure all health care records are obtained and entered into UNITY. Specifically, policy lacks defined frequencies for staff to obtain health care documentation from foster or health care providers. Additionally, the frequency of supervisory review is not defined. The Division stated that barriers to documentation are based on limited staffing capacities resulting in staff focusing on immediate and critical needs.

Automatically transferring Medicaid claims into UNITY is an efficient approach that could improve the completeness of UNITY child health records and reduce manual data entry and time-consuming data collection procedures employed by the Division. Currently, the Medicaid claims database is not directly linked to UNITY; however, the Division has expressed interest in developing this type of connection.

Preventative Health Care Schedule Not Updated Timely

The Division did not update timely its preventative health care schedule in policy for children in state custody. It is federally required to create a schedule of health screenings that meets reasonable standards of medical practice. The Division relies on American Academy of Pediatrics (AAP) recommendations for its preventative health care schedule. The Division's current schedule conflicts with AAP recommendations in that it does not require annual preventative health care for children ages 11, 13, 15, and 17. Because policy does not meet federal requirements and AAP recommendations, children could be receiving inadequate health care.

Division management did not adequately compare policy to federal requirements and AAP recommendations. The Division

stated policy does not refer directly to the up-to-date periodicity schedule on the AAP website so the Division must update policy when recommendations change. Division management plans on updating its policy so that it refers directly to the AAP website, allowing it to remain in compliance with future updates.

Recommendations

7. Provide training to ensure staff understand health care documentation requirements and the necessary health care for children in state custody.
8. Improve policies by requiring a consistent frequency in which caseworkers and supervisors perform activities to monitor and obtain documentation regarding health care.
9. Ensure health care for children in state custody is documented in UNITY.
10. Complete a feasibility assessment of linking the Medicaid claims database to UNITY.
11. Revise Division policies and procedures to incorporate current American Academy of Pediatrics recommendations.

Appendix A
Audit Methodology

To gain an understanding of the Division of Child and Family Services (Division), we interviewed staff and reviewed statutes, regulations, and policies and procedures significant to its operations. We also reviewed financial information, prior audit reports, budgets, legislative committee minutes, and other information describing the Division's activities. In addition, we documented and assessed the Division's internal controls related to the processing of maltreatment reports and the oversight of health care services for children in state custody.

Our audit included a review of the Division's internal controls significant to our audit objective. Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. Internal control comprises the plans, methods, policies, and procedures used to fulfill the mission, strategic plan, goals, and objectives of the entity. The scope of our work on controls related to processing of child maltreatment reports and oversight of health care services for children in state custody included the following:

- Performance of monitoring activities (Monitoring);
- Establishing structure, responsibility and authority, and demonstrating competence (Control Environment); and
- Design and implementation of control activities through policy (Control Activities).

Deficiencies and related recommendations to strengthen the Division's internal control systems are discussed in the body of this report. The design, implementation, and ongoing compliance with internal controls is the responsibility of agency management.

To evaluate whether the Division adequately ensured the safety and welfare of children in its processing of child maltreatment reports, we obtained a download that included 4,823 rural region report records documented in 2019. Division records were obtained from Unified Nevada Information Technology for Youth (UNITY), Nevada's statewide automated child welfare information system. To ensure the reliability of maltreatment report information, data was assessed by examining trends in the data, reviewing for duplicate or missing information, testing for illogical values, and interviewing Division staff knowledgeable about the data. We determined the data to be sufficiently reliable for the purposes of the audit.

We analyzed maltreatment reports for documentation of supervisory oversight and identified 107 lacking system indicators of supervisory review. Using the dates the reports were received and the dates they were subsequently downloaded for assessment from UNITY, we calculated the average number of days these reports were incompletely processed. For all 107 records, we obtained additional detailed report documentation to identify any evidence of supervisory review and potential cases in which the welfare of the alleged victims was at risk. Out of all rural reports received in 2019, we judgmentally selected an additional 26 reports with conflicting child safety and welfare risk assessments for subsequent analysis.

Division records for the 133 reports lacking indications of supervisory review or containing conflicting assessments were reviewed for: (1) adequacy of recordkeeping practices; (2) appropriateness of report deletion, if applicable; and (3) proper assignment of investigations, if required by Division policy. We reviewed UNITY documentation and interviewed Division staff to identify reports inadequately processed by the Division that increased the risk of exposure of children to additional maltreatment. Additionally, delays in referrals of alleged crimes to law enforcement were calculated from the dates the reports were received to the dates the Division forwarded the reports to law enforcement. We confirmed our assessment and understanding of cases with Division management.

To assess Division monitoring of the health and safety of children in state custody, we received a download of 2018 and 2019 Medicaid claims for children in state custody. To ensure the reliability of Medicaid claims information, data was assessed by examining trends in the data, reviewing for duplicate or missing information, testing for illogical values, and interviewing staff knowledgeable about the data. We determined the data to be sufficiently reliable for the purposes of the audit.

We queried 2018 and 2019 Medicaid claims of children in state custody for medical diagnosis codes that indicate potential abuse and neglect. We engaged in discussions with the Division and assessed child paper files and UNITY records to determine if the Division was aware of the identified injuries, and if so, if it completed sufficient follow-up activities to ensure the safety and welfare of children.

Next, we evaluated whether children received medical and dental care as outlined in policy and federal requirements. We assessed if children in state custody for all 2019 received required preventative health and dental care by reviewing 2018 and 2019 Medicaid, UNITY, and paper records. We also determined the adequacy of Division health care requirements for children in state custody through discussions with the Division and review of Division policy, federal requirements, and American Academy of Pediatrics recommendations.

To evaluate the completeness of UNITY health records, we compared UNITY health care documentation to 2019 Medicaid records for all children in state custody for all of 2019. We also assessed the completeness of UNITY health records compared to Division paper files. A sample of 14 paper files was judgmentally selected for children lacking evidence of preventative health and/or dental care in UNITY and Medicaid. We then determined if there was additional health care documentation in paper files compared to UNITY records.

We used nonstatistical audit sampling for our audit work, which for these analyses was the most appropriate and cost-effective method for concluding on our audit objective. Based on our

professional judgement, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provided sufficient, appropriate audit evidence to support the conclusions in our report. We did not project the exceptions to the population, because tests were not intended to be projected or items were selected judgmentally. Our samples included both randomly and judgmentally selected items.

Our audit work was conducted from January 2019 to January 2021. 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In accordance with NRS 218G.230, we furnished a copy of our preliminary report to the Administrator of the Division of Child and Family Services. On August 10, 2021, we met with agency officials to discuss the results of the audit and requested a written response to the preliminary report. That response is contained in Appendix B, which begins on page 21.

Contributors to this report included:

Scott Jones, PhD, CIA
Deputy Legislative Auditor

Jordan T. Anderson, MBA
Deputy Legislative Auditor

Tammy A. Goetze, CPA
Audit Supervisor

Shannon Riedel, CPA
Chief Deputy Legislative Auditor

Appendix B

Response From the Division of Child and Family Services

Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Child and Family Services
Helping people. It's who we are and what we do.

Ross Armstrong
Administrator

MEMORANDUM

August 20, 2021

TO: Daniel L. Crossman, Legislative Auditor

FROM: Ross Armstrong, Administrator

SUBJECT: Division Response to the 2021 Performance Audit of the Department of Health and Human Services, Division of Child and Family Services

INTRODUCTION

Thank you for the opportunity to respond to the 2021 Performance Audit findings. The Division of Child and Family Services (DCFS or Division) has worked to immediately address the findings in this audit related to incomplete reports in UNITY and, as a result, those issues have largely been resolved. Other identified issues related to health services windows had previously been identified through the federally-mandated Child and Family Services Reviews (CFSR). In response to the CFSR review findings, our federal Performance Improvement Plan (PIP) prompted the creation of data reports that we now have access to which will provide additional layers of oversight of health services information in UNITY.

The Division of Child and Family Services (DCFS or Division) Rural Region agency provides child welfare services to all Nevada counties except Clark and Washoe. Like many child welfare agencies across the nation, the DCFS Rural Region struggles with substantial vacancy rates which can frustrate efforts to comply with the many federal and state child welfare requirements. A federal review in 2018 found that as a state, Nevada's child welfare agencies struggled with 6 of the 7 federal standards. This placed the State of Nevada on a 2-year program improvement plan. System changes have taken place over the past two years and Nevada is on target to meet the federal requirements for systems improvements.

The audit results can be divided into two main categories of findings: 1) Child Maltreatment Report Processing and 2) Health Care Management of Children in State Custody.

Below are the Legislative Counsel Bureau audit recommendations and our responses. If you have additional questions, please do not hesitate to contact us.

CHILD MALTREATMENT REPORT PROCESSING

Complete documentation and report processing is critical to ensure the safety of children and youth. This set of recommendations focuses on five considerations to improve Division compliance with policy and one recommendation related to an emerging best practice. The Division accepts all six recommendations related to child maltreatment report processing.

6171 W Charleston Blvd, Bldg. 8 • Las Vegas, NV 89146
Phone 702-486-6118 • Fax 702-486-4244 • dcfs.nv.gov

Recommendation 1: Implement staff training when changes to UNITY system occur to ensure proper processing of maltreatment reports.

Response: This recommendation is accepted.

The UNITY team will be utilizing online training options as new or updated features are introduced. The UNITY team has seen success with an online version of the introduction to UNITY course and will use a similar approach with any UNITY updates, frequently asked questions, and quality control features for managers and supervisors.

The Rural Region Quality Assurance and Training unit is responsible for ensuring the appropriate staff are informed of upcoming UNITY rollouts and providing or ensuring training is available so staff can perform their jobs in response to changes made in UNITY on an ongoing basis. Rural Region child welfare has provided training on the new intake windows created in UNITY to Crisis Call Center contracted intake staff and any DCFS employees who were identified as having incomplete reports in the system since November 2020. A guide, instructing staff on how to resolve existing incomplete reports as "unknown" was provided to staff in June 2020.

Recommendation 2: Develop and review a management report to ensure all maltreatment reports are timely and properly processed.

Response: The Division accepts this recommendation.

The Family Programs Office (FPO) and Information Services (IS) created Report (COG 184), titled, *Oversight – Intake Referrals Received by State* to capture maltreatment reports that were incomplete or had no final disposition in the UNITY system which was developed and disseminated in March 2020. This report is generated by Information Services and distributed by the Family Programs Office monthly to the Rural Region managers and supervisors.

DCFS Rural Region will monitor the report monthly to capture any incomplete maltreatment reports and addresses them immediately. Additionally, the DCFS Rural Region Manager that supervises intake now monitors the Intake Queue weekly and provides instruction to any personnel or the Crisis Call Center if an incomplete maltreatment report is found.

Recommendation 3: Improve policies and management oversight controls to ensure critical information is documented in UNITY related to maltreatment reports.

Response: The Division accepts this recommendation.

During the 2019 Legislative Session, the Legislature approved the creation of an internal Intake Unit within DCFS for the Rural Region. DCFS Rural Region is in the process of finalizing an Intake Procedure for the newly-created Intake unit that details the critical information that must be gathered and entered in UNITY for all reports of maltreatment. The procedure emphasizes adequate information collection, intake process steps, investigation assignments and priority response times as well as supervisory review duties, data collection, and quality assurance measures.

The Intake supervisor will be responsible for ensuring Intake reports meet minimum standards. Quarterly, the Rural Region Quality Assurance unit will pull a random sample of *Information Only* reports and assigned reports by region to review for compliance with policy and procedure.

The Intake Procedure is scheduled to be finalized no later than October 1, 2021.

Recommendation 4: Improve controls to prevent deletion of necessary maltreatment reports.

Response: The Division accepts this recommendation.

The UNITY team and the Rural Region implemented a protocol in December 2021 to ensure referrals cannot be deleted from the system via request through the DCFS Help Desk and require that referrals must be completed in the approved manner.

In addition, DCFS Information Systems has provided Rural Region child welfare with a process to complete an incomplete report of maltreatment in the system as "unknown" thereby eliminating the use of deletions. The number of incomplete reports being closed as "unknown" can now be monitored via the COG 184 report for quality assurance purposes.

Recommendation 5: Comply with policy and investigate maltreatment reports that meet established criteria.

Response: The Division accepts this recommendation.

In the 80th (2019) Session of the Nevada Legislature, DCFS Rural Region was approved for positions intended to create a Centralized Intake unit. This will improve consistency in the way reports are being dispositioned across the Rural Region.

As implementation of the Intake Unit proceeds, DCFS Rural Region and the UNITY will work together to ensure all reports and referrals are being seen by a supervisor to assign. Previous issues with the UNITY system providing this information to supervisors in all instances have been resolved and continued supervisor compliance with policy will be regularly monitored by the DCFS Rural Region management team.

Recommendation 6: Implement a process to identify and assess Medicaid claims that indicate possible abuse and neglect for children in state custody. Perform follow-up activities to ensure the welfare of children as necessary.

Response: The Division accepts this recommendation.

The UNITY system was recently upgraded with the capacity to allow secure bi-directional data exchanges. In addition, the Department of Health and Human Services maintains a master client index that allows certain DHHS systems to communicate with each other. As discussed in recommendation 10, the Division is proceeding with a plan to create a secure connection with the Medicaid claim database to allow for periodic review of information.

HEALTH CARE MANAGEMENT

Ensuring proper health care management of the children in DCFS custody is an important function of an effective child welfare agency. It is also in alignment with the Division's vision of *Safe, Healthy, and Thriving Kids in Every Nevada Community*. There are five recommendations related to the health care management of children in the Rural Region agency's care. The Division accepts all five recommendations.

In addition to the specific responses, the results of this review have highlighted the Rural Region's lack of capacity to manage the health of children in our care effectively. While the Rural Region has dedicated staff trained and experienced in child safety, foster care, and adoption services, the agency currently does not have any staff specifically focused on the health care management of children. As the Division considers requests for future enhancements or reallocations of resources, the Division will focus on potential improvements to the agency's capacity to properly manage the health care of children in our custody.

Recommendation 7: Provide training to ensure staff understand the health care documentation requirements and the necessary health care for children in state custody.

Response: The Division accepts this recommendation.

A webinar training has been developed and administered to caseworkers educating staff on how to accurately enter health care data into the UNITY system. In policy and through the federally mandated Child and Family Services Review (CFSR) process staff are educated about the necessity of providing preventive health care for children in state custody. To provide ongoing training regarding health care periodicity tables, the Division has developed a training for use with new employees and as well as a refresher for established staff on the necessity of routine dental/vision and medical care. This is accessible on our shared drive for managers, supervisors, and staff as well as periodically to be presented at each District Office during an all-staff meeting.

Community Health Nursing Services from our sister agency, the Division of Public and Behavioral Health, are located throughout the Rural Region. They have agreed to provide a representative to attend each district's all staff meeting over the next 3 months to discuss and educate DCFS team members about the importance of preventive health care for youth.

Additionally, this curriculum has been added to the Quality Assurance and Training unit's first year internal training plan mandatory for all new caseworkers and offered for remediation at a supervisor's request.

Recommendation 8: Improve policies by requiring a consistent frequency in which caseworkers and supervisors perform activities to monitor and obtain documentation regarding health care.

Response: The Division accepts this recommendation.

Rural Region Supervisors are now expected to monitor health care data as part of each case-specific consultation. Supervisor and caseworkers review the medical passport and identification of missing preventative health care appointments, and a plan is then developed by the caseworker to ensure needed preventative health care exams are scheduled. Follow-up at the next case-specific consultation occurs to ensure follow through with the identified preventive health care appointments.

This expectation has been discussed in leadership team meetings and is in the process of specifically being added to supervisor Work Performance Standards

Recommendation 9: Ensure health care for children in state custody is documented in UNITY.

Response: The Division accepts this recommendation. COG report 209 – *Foster Care Children with Early and Periodic Screening, Diagnostic, and Treatment (EPTSD) within 30 Days of Removal* has been developed and is currently in use.

The purpose of this report is to track statewide compliance with Policy 0207 Health Services and assist workers in the field identify when an EPSDT appointment needs to be scheduled and/or attended. The report also encourages/tracks timely entry of health services into UNITY. Three reports were created:

1. QA Summary Report - to show all EPSDT appointments for the life of the case

2. Compliance (supervisor) Report - to ensure timeliness of EPSDT appointments and services

3. Due Date (caseworker) Report - to help identify when an upcoming appointment should be scheduled and/or attended.

The goal is to monitor compliance within the boundaries of the recommendations for Wellness Exams made by the American Academy of Pediatrics Periodicity Schedule. Caseworkers receive due dates weekly and supervisors will receive at least a monthly report.

A report that will provide data at the case level about the preventive exams (dental, vision and medical) that have occurred and what is still needed has been requested for the UNITY team to develop.

To improve wellness and data outcomes for children in foster care a staff training called "How to Apply UNITY to Practice" has recently been created. The training is designed to build independence among the workforce to increase capacity on how to independently run reports and accurately enter and monitor EPSDT appointments. The training will briefly review the statewide policies for caseworker contact and health services, including how to locate the statewide policies in the future. The goal is to teach caseworkers how to locate the policy and quickly search statewide requirements to build capacity over time. Caseworker training is set to begin no later than October 13, 2021.

Recommendation 10: Complete a feasibility assessment of linking the Medicaid claims database to UNITY.

Response: The Division accepts this recommendation.

DCFS was recently awarded grant funding from the National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved Populations Grant to contract with a vendor to link the Medicaid and DCFS databases (including UNITY). The funding was approved at the August 2021 Interim Finance Committee and the Division will be immediately proceeding with the Purchasing Division Request for Proposal purchasing process.

Recommendation 11: Revise Division policies and procedures to incorporate current American Academy of Pediatrics recommendations.

Response: The Division accepts this recommendation.

The Family Programs Office (FPO) updated 0207 Health Services policy. The policy update was completed on August 17, 2021. The following changes were made to update that policy.

1. The American Academy of Pediatrics Periodicity Schedule has been added as a link in the policy for staff to reference and the outdated table has been removed from the policy. Youth will now have an EPSDT exam every year. The policy has been updated regarding how to enter an EPSDT exam into UNITY. Additionally, FPO specialists will review the AAP Periodicity schedule annually to ensure policy remains in compliance with the updates/changes posted. FPO oversight will include monitoring compliance through the Cognos EPDST compliance report (COG 209), and through CFSR/Case Reviews.

2. Dental screenings now start with youth at age 1 and every year thereafter as recommended by the National Association for Dental Research. This is a change from dental screening starting at age 3.

Compliance with the policy will be monitored by the DCFS Rural Region management team.

CONCLUSION

We again thank the Legislative Council Bureau audit team for their time and work on this important audit as we work together in partnership to ensure the safety and health of children in rural Nevada. We look forward to being able to report positive improvements on these findings in the future.

Division of Child and Family Services' Response to Audit Recommendations

	Recommendations	Accepted	Rejected
1.	Implement staff training when changes to the UNITY system occur to ensure proper processing of maltreatment reports	X	
2.	Develop and review a management report to ensure all maltreatment reports are timely and properly processed	X	
3.	Improve policies and management oversight controls to ensure critical information is documented in UNITY related to maltreatment reports	X	
4.	Improve controls to prevent deletion of necessary maltreatment reports	X	
5.	Comply with policy and investigate maltreatment reports that meet established criteria	X	
6.	Implement a process to identify and assess Medicaid claims that indicate possible abuse and neglect for children in state custody. Perform follow-up activities to ensure the welfare of children as necessary	X	
7.	Provide training to ensure staff understand health care documentation requirements and the necessary health care for children in state custody	X	
8.	Improve policies by requiring a consistent frequency in which caseworkers and supervisors perform activities to monitor and obtain documentation regarding health care	X	
9.	Ensure health care for children in state custody is documented in UNITY	X	
10.	Complete a feasibility assessment of linking the Medicaid claims database to UNITY	X	
11.	Revise Division policies and procedures to incorporate current American Academy of Pediatrics recommendations	X	
	TOTALS	11	