Disability Rights Arizona (DRAZ)
Compliance, Oversight, Monitoring, & Investigations Team (COMIT)

2025 Quality of Care Complaint Investigations Annual Report – Year 3 (01/01/2025-12/31/2025)

Group Home Monitoring Pilot
Program ARS § 36-595.03
Developmental disabilities group home monitoring pilot program; clients with complex needs; designated entity duties; expedited referral system; reporting requirements; definition
AZ HB2865
Contract Number: CTR063738

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Program Overview

Legislative History

The Compliance, Oversight, Monitoring, and Investigations Team (COMIT) Program was established pursuant to the enactment of House Bill 2865 (HB 2865). Passed by the Arizona Legislature on June 23, 2022, and signed into law on June 28, 2022, this legislation amended the Arizona Revised Statutes to include A.R.S. § 36-595.03, thereby creating the Developmental Disabilities Group Home Monitoring Pilot Program. Under this statutory mandate, the Department of Economic Security (DES), through its Division of Developmental Disabilities (DDD), was required to contract with Arizona's designated Protection and Advocacy organization, Disability Rights Arizona (DRAZ), to conduct independent monitoring and investigative activities for individuals residing in DDD-licensed group homes.

Within this framework, COMIT receives all Quality-of-Care (QOC) complaints submitted to DDD and assigns investigative priority to allegations involving unexpected death, abuse, neglect, or threats to member health and safety. When COMIT substantiates a QOC allegation, the findings are transmitted to DDD for dissemination to the responsible vendor and the Independent Oversight Committee (IOC). DDD, in turn, conducts its own investigations for all QOCs, irrespective of which cases COMIT elects to investigate.

DDD defines a Quality-of-Care Concern as any allegation indicating that an aspect of care, treatment, or the use of behavioral or physical health services has caused, or had the potential to cause, an acute medical or psychiatric condition, an exacerbation of a chronic condition, or any circumstance that may place a member at risk of harm.

Program Objectives

1. Receive all complaints triaged by the Division of Developmental Disabilities (DDD) as Quality-of-Care Concerns (QOCs) for DDD-funded group homes.
2. Assign QOCs for investigative review, prioritizing those involving allegations of unexpected death, abuse, neglect, or threats to member health and safety.
3. Conduct comprehensive investigations to evaluate and determine the validity of QOC allegations.
4. Transmit all substantiated findings to DDD for appropriate dissemination and follow-up action.

Program Achievements

1. Identification of High-Risk Patterns Across Cases: by reviewing QOC data longitudinally, COMIT identified recurring themes, such as medication errors, inadequate supervision, and delayed reporting, that require targeted corrective action at both the vendor and system levels.
2. Increased Transparency in Oversight Activities: COMIT developed clearer internal documentation practices and improved the structure of investigative reports, enabling DDD and other stakeholders to better understand the basis for substantiated findings and systemic concerns.
3. Strengthened Internal Case Management Systems: COMIT refined its tracking and

prioritization processes and developed internal guidance, templates, and training resources to improve investigative consistency, support new staff, and manage high QOC volumes more effectively.

4. COMIT identified inaccuracies within the QOC tracking system related to the categorization of complaint allegations; DDD subsequently implemented the necessary corrective adjustments.
5. COMIT provided substantive feedback to inform revisions to key DDD policies, including the DDD Behavior Supports Manual and Chapter 54: Group Home Requirements.
6. COMIT has identified numerous investigations closed by DDD as unsubstantiated warrant more comprehensive follow-up to ensure member safety and prevent incidents of abuse, neglect, and death.
7. In response to COMIT's findings, DDD established a new unit, the QITA Team, to collaborate with COMIT and the Quality Vendor (QV) to strengthen corrective action processes and enhance protection for Arizonans with disabilities.
8. COMIT and the Division of Developmental Disabilities (DDD) have cultivated a productive and collaborative working relationship that supports ongoing oversight and investigative coordination.
9. Improved Communication with DDD Leadership: regular monthly meetings with DDD leadership have allowed COMIT to elevate systemic issues more efficiently, resulting in quicker recognition of systemic gaps and recurring deficiencies requiring heightened attention and structural remediation.
10. Improved Inter-Agency Coordination: COMIT expanded and secured communication pathways with statewide law enforcement, medical examiner offices, APS, DCS, medical providers, vendors and regulatory agencies, reducing delays in obtaining critical records and improving the completeness of investigative findings.
11. DRAZ/COMIT engaged in coordinated efforts with State Legislators, to advance statutory amendments, to secure the continuation of the COMIT Program as a permanent program and funding in 2026.

Program Barriers

1. Volume of QOCs received from DDD

Issue: The volume of QOC complaints exceeds the investigative capacity of the current COMIT Program.

In 2025, COMIT received 2,510 QOCs, a workload that is not sustainable with the program's existing staffing structure of one Manager, three Investigators, and limited operational resources.

2. Program Development and Resources

Issue: Delays in closing investigations

COMIT's ability to complete timely, root-cause-based investigations was significantly constrained by the limited information provided by DDD. Outside of the QOC spreadsheet, DDD did not supply case records, background information, investigative files, severity levels, up to date member information or substantiation criteria necessary to support comprehensive

investigative work. As a result, COMIT independently developed processes, tools, and external partnerships to obtain the records needed to complete investigations in year 3.

To secure essential documentation, COMIT established working relationships with multiple statewide entities, including law enforcement agencies, medical providers, regulatory bodies, and other public agencies, to obtain police reports, medical records, witness statements, and other third-party information. While these relationships strengthened the quality of investigations, the additional time required to locate and obtain records contributed to delays in case closure.

To conduct effective, root-cause-oriented investigations, COMIT requires access to the following resources and information:

- DDD investigation specifications and substantiation criteria
- DDD case background information and case records
- Vendor Internal Fact-Finding/Review responses and allocated severity levels
- Historical tracking of incidents related to the member and vendor
- Access to all DDD investigative files
- DDD tracking, trending, and data analysis
- Vendor compliance access to FOCUS or in producing:
    - Historical and current client records
    - Employee and employment records
    - Training documentation
    - Vendor policies and operational procedures
- Access to information from other regulatory agencies to identify patterns of concern, including:
    - Department of Public Safety
    - Local police departments
    - Adult Protective Services or Department of Child Safety
- Expedited access to hospital and behavioral health records

The absence of these foundational resources has required COMIT to build investigative capacity from the ground up, contributing to extended timelines for case completion and underscoring the need for more robust program development support. The revised statutory language taking effect in 2026 should expressly provide for access to these and related investigative documents to ensure COMIT can conduct timely, comprehensive, and well-supported investigations.

3. DDD Group Home Vendor Responsiveness

Issue: Challenges with contacting vendors and obtaining required records

COMIT continues to experience significant difficulty reaching group home vendors and securing the documents necessary to complete investigations. Despite COMIT's requests for guidance from DDD, and multiple contact attempts with vendors, along with DDD's initiatives, including the vendor forum

held on January 27, 2023, and the Vendor Announcement issued on June 11, 2025, non-responsiveness and delays in document production remain persistent barriers to timely and thorough investigative work.

4. **DDD Responsiveness**

Issue: Delays in communication, case coordination, and member location

COMIT has experienced significant delays in receiving essential investigation related information from DDD, which has directly impacted the timeliness and progression of investigations. In several cases, COMIT did not receive responses to inquiries or record requests for extended periods, despite repeated follow-up attempts.

One case demonstrates the impact of these communication delays. DDD provided incorrect whereabouts and support coordinator information and did not respond to repeated requests, which halted the investigation for more than six months. During this time, COMIT was unable to verify the member's location or assess safety concerns. This case involved a high-level safety issue, and the member ultimately suffered irreversible brain damage with no progress reported to date.

These prolonged communication gaps and inaccuracies hinder COMIT's ability to conduct timely, comprehensive investigations and underscore the need for improved responsiveness, accurate case coordination, and more reliable information flow between DDD and COMIT.

5. **Updated Client Contact Information (Resolved)**

Issue: Difficulty obtaining updated contact information for clients who had moved from the vendor listed on the QOC tracker

COMIT encountered challenges obtaining accurate client contact information when members were no longer residing with the vendor identified on the roster. Several processes were attempted without success before an effective resolution was established. The current process allows COMIT to reliably obtain updated placement information and to proceed with required investigative activities both effectively and timely (refer to the Monitoring Report for detailed resolution steps).

COMIT Investigative Process

The COMIT Manager conducts a comprehensive review of the Quality of Care (QOC) complaints received from DDD and assigns cases to Investigators, prioritizing allegations involving abuse, neglect, threats to member health and safety, and unexpected death. Once assigned, COMIT Investigators are responsible for conducting independent, methodical investigations to determine whether the allegations can be substantiated and produce a formal investigative report detailing their findings.

To execute these responsibilities, Investigators employ a multifaceted investigative approach that includes:

- On-site evaluations of the group home environment and operational practices
- Direct interviews with members
- Interviews with group home staff associated with the complaint
- Interviews with family members, guardians, law enforcement agencies, medical examiner investigators and other relevant parties
- Comprehensive review of group home records, including client files, staffing documentation, and internal reports

- Requests for and analysis of third-party records, such as law enforcement reports, medical documentation, and regulatory agency information

Because DDD provided only the QOC spreadsheet and did not supply investigative files, background information, or supporting documentation, COMIT was required to independently cultivate working relationships with a broad network of external entities—including law enforcement agencies, medical providers, regulatory bodies, and other state departments—to obtain the records necessary to conduct and conclude investigations. These independently established partnerships were essential to ensuring that each investigation was thorough, evidence-based, and aligned with the program's statutory mandate for independent oversight.

Program Progress

QOC Tracker: Total QOCs Received in 2025: 2,510

Investigations Assigned Total: 25

Open QOC Investigation Cases: **0**
Closed QOC Investigation Cases: **25**

- Total Investigations Assigned in 2023: 12 (August 2023 - December 2023)
  - Total Investigations Closed In 2023: **0**
- Total Investigations Assigned in 2024: 12
  - Total Investigations Closed in 2024: **4**
- Total Investigations Assigned in 2025: 5 (includes 4 reassignments of 2024 cases)
  - Total Investigations Closed in 2025: **21**

2025 Investigations

Completed/Closed Investigations:

- Total Completed QOC Complaint Investigations: **21**
- Total QOC Complaint Investigations Substantiated: **12**
  - Total Additional Substantiated Findings: **57**
- Total QOC Complaint Investigations Unsubstantiated: **6**
- Total QOC Complaint Investigations Inconclusive: **3**

Closed Cases Opening Allegations

Case ID	Date Closed	QOC Opening Allegation	QOC Complaint Overview	COMIT Outcome
CI0014	02/25/2025	ACCESS	Equipment repair	Unsubstantiated
CI0019	02/27/2025	DEATH	Member death	Unsubstantiated
CI0008	07/30/2025	SAFETY	Member left unattended	Unsubstantiated
CI0010	08/20/2025	SAFETY	Unreported injury	Unsubstantiated
CI0021	08/20/2025	ABUSE	Unreported injury	Unsubstantiated

CI0020	08/21/2025	ABUSE	Alleged abuse	Inconclusive
CI0013	08/22/2025	ABUSE	Alleged abuse	Inconclusive
CI0002	08/29/2025	ABUSE	Alleged neglect	Substantiated
CI0006	09/26/2025	ABUSE	Supervision/food	Inconclusive
CI0001	09/29/2025	ABUSE	Alleged abuse	Substantiated
CI0018	09/30/2025	ABUSE	Alleged neglect	Unsubstantiated
CI0003	10/06/2025	SAFETY	Med errors	Substantiated
CI0011	11/28/2025	EFFECTIVE	Missed Appts	Substantiated
CI0012	11/28/2025	SAFETY	Physical assault	Substantiated
CI0015	11/30/2025	ABUSE	Alleged abuse	Substantiated
CI0016	11/30/2025	ABUSE	Alleged abuse	Substantiated
CI0017	12/31/2025	NEGLECT	Medical care concerns	Substantiated
CI0022	12/31/2025	ABUSE	Injury/staff neglect	Substantiated
CI0023	12/31/2025	DEATH	Member death	Substantiated
CI0024	12/31/2025	DEATH	Member death	Substantiated
CI0025	12/31/2025	ABUSE	Missed Appts	Substantiated

Completed Quality of Care Complaints: Additional Substantiated Findings:
These additional findings emerged during the course of COMIT's investigations and provided sufficient evidence to substantiate further violations under multiple Arizona Revised Statutes, as well as applicable DDD policies and program manuals.

Case ID	Date Closed	AHCCCS Category Allegation	QOC Complaint Overview	COMIT Outcome
CI0002	08/29/2025	SAFETY	Failure/delayed/inadequate reporting requirements	Substantiated
CI0002	08/29/2025	RIGHTS	Inappropriate use of physical, mechanical, personal, chemical restraint, or seclusion	Substantiated
CI0001	09/29/2025	EFFECTIVE	Article 9 violation	Substantiated
CI0001	09/29/2025	SAFETY	Failure/delayed/inadequate reporting requirements	Substantiated
CI0001	09/29/2025	EFFECTIVE	Inadequate documentation/treatment below medical standards/ineffective treatment	Substantiated
CI0003	10/06/2025	EFFECTIVE	Article 9 violation	Substantiated
CI0003	10/06/2025	SAFETY	Failure/delayed/inadequate reporting requirements	Substantiated
CI0003	10/06/2025	EFFECTIVE	Inadequate documentation/treatment below medical standards/ineffective treatment	Substantiated
CI0012	11/28/2025	SAFETY	Failure/delayed/inadequate reporting	Substantiated

			requirements	
CI0015	11/30/2025	ABUSE	Physical abuse on a member	Substantiated
CI0015	11/30/2025	ABUSE	Verbal/emotional abuse on a member	Substantiated
CI0015	11/30/2025	ABUSE	Neglect of physical, medical, or behavioral needs of a member	Substantiated
CI0015	11/30/2025	EFFECTIVE	Ineffective or Inadequate service plan and/or treatment plan	Substantiated
CI0015	11/30/2025	RIGHTS	Article 9 violation	Substantiated
CI0015	11/30/2025	RIGHTS	HIPAA Breech	Substantiated
CI0015	11/30/2025	RIGHTS	Disrespectful/unprofessional conduct by provider	Substantiated
CI0015	11/30/2025	SAFETY	Failure/delayed/inadequate reporting requirements	Substantiated
CI0015	11/30/2025	SAFETY	Inadequate staffing and supervision	Substantiated
CI0015	11/30/2025	SAFETY	Unsafe environment	Substantiated
CI0016	11/30/2025	ABUSE	Physical abuse on a member	Substantiated
CI0016	11/30/2025	ABUSE	Verbal/emotional abuse on a member	Substantiated
CI0016	11/30/2025	ABUSE	Neglect of physical, medical, or behavioral needs of a member	Substantiated
CI0016	11/30/2025	EFFECTIVE	Ineffective or inadequate service plan and/or treatment plan	Substantiated
CI0016	11/30/2025	RIGHTS	Article 9 violation	Substantiated
CI0016	11/30/2025	RIGHTS	HIPAA breech	Substantiated
CI0016	11/30/2025	SAFETY	Failure/delayed/inadequate reporting requirements	Substantiated
CI0016	11/30/2025	SAFETY	Inadequate staffing and supervision	Substantiated
CI0016	11/30/2025	SAFETY	Unsafe environment	Substantiated
CI0017	12/31/2025	ABUSE	Neglect of physical, medical, or behavioral needs of a member	Substantiated
CI0017	12/31/2025	EFFECTIVE	Inadequate documentation	Substantiated
CI0017	12/31/2025	EFFECTIVE	Treatment below medical standards/ineffective treatment	Substantiated
CI0017	12/31/2025	SAFETY	Failure/delayed/inadequate reporting requirements	Substantiated
CI0017	12/31/2025	SAFETY	Avoidable injury or complication	Substantiated
CI0017	12/31/2025	SAFETY	Injury occurring on the premises or during a registered provider sponsored activity that requires medical attention	Substantiated
CI0017	12/31/2025	SAFETY	Police/Fire/EMS called to a licensed facility	Substantiated

CI0022	12/31/2025	SAFETY	Inadequate Incident reporting	Substantiated
CI0022	12/31/2025	ACCESS	Inadequate access to care/services	Substantiated
CI0022	12/31/2025	EFFECTIVE	Inadequate treatment plan	Substantiated
CI0023	12/31/2025	EFFECTIVE	Inadequate treatment plan	Substantiated
CI0023	12/31/2025	SAFETY	Avoidable injury or complication	Substantiated
CI0023	12/31/2025	SAFETY	Failure/delayed/inadequate reporting requirements	Substantiated
CI0023	12/31/2025	SAFETY	Inadequate staffing and supervision	Substantiated
CI0023	12/31/2025	SAFETY	Alleged or suspected criminal activity	Substantiated
CI0024	12/31/2025	EFFECTIVE	Inadequate treatment plan	Substantiated
CI0024	12/31/2025	SAFETY	Avoidable injury or complication	Substantiated
CI0024	12/31/2025	SAFETY	Failure/delayed/inadequate reporting requirements	Substantiated
CI0024	12/31/2025	SAFETY	Inadequate staffing and supervision	Substantiated
CI0025	12/31/2025	ACCESS	Delay in treatment, service, or referral	Substantiated
CI0025	12/31/2025	SAFETY	Inadequate staffing and supervision	Substantiated
CI0025	12/31/2025	SAFETY	Unsafe environment	Substantiated
CI0025	12/31/2025	SAFETY	Failure/delayed/inadequate reporting requirements	Substantiated
CI0025	12/31/2025	EFFECTIVE	Ineffective or inadequate service plan and/or treatment plan	Substantiated
CI0025	12/31/2025	EFFECTIVE	Inadequate documentation	Substantiated
CI0025	12/31/2025	EFFECTIVE	Lack of coordination of care	Substantiated
CI0025	12/31/2025	FRAUD	Fraudulent actions: billing, documentation, services, licensure	Substantiated
CI0025	12/31/2025	RIGHTS	Article 9 violation	Substantiated
CI0025	12/31/2025	RIGHTS	Disrespectful/unprofessional conduct by the provider	Substantiated

QOC Opening Allegations	**Code**
Abuse	ABUSE
Availability, Accessibility, Adequacy	ACCESS
Effectiveness/Appropriateness of Care	EFFECTIVE
Fraud	FRAUD
Members Rights/Respect and Caring	RIGHTS
Neglect of physical, medical, or behavioral needs of a member	NEGLECT
Safety/Risk Management	SAFETY
Unexpected Death	DEATH

COMIT does not receive DDD's investigative reports or outcome determinations for QOC investigations selected by COMIT for independent review. Additionally, COMIT has not been provided

with feedback or notification of any subsequent actions taken by DDD in response to COMIT's submitted Final Reports.

2025 Investigations: Cities

Cities	Count
Avondale	1
Chandler	3
Flagstaff	1
Glendale	1
Mesa	3
Peoria	3
Phoenix	4
Prescott Valley	1
Surprise	1
Tucson	3

Completed Quality of Care Complaints: Age Ranges

Age Range	Count
0-6	2
7-17	1
18-35	10
36-64	5
65+	3

Systemic Issues Identified

1. DDD Investigation

COMIT has identified systemic concerns with the depth and rigor of DDD's investigative practices. COMIT found that reviews often relied on surface-level determinations and lack the comprehensive fact-gathering needed to fully assess Quality of Care allegations. DDD does not routinely obtain police reports, witness statements, or other third-party records, limiting the ability to evaluate incidents accurately. In addition, DDD does not appear to conduct true root-cause analysis, resulting in missed operational patterns and contributing factors that lead to recurring QOC events. These gaps highlight the need for more robust investigative methods, expanded evidence collection, and a structured root-cause framework which would properly evaluate vendor operational practices that may be contributing to recurring QOC events.

2. DDD Data Collection/Analysis and Reporting Practices

COMIT identified significant limitations in DDD's data-collection and reporting processes. The

current system cannot detect patterns of concern within incident or complaint details, limiting vendor oversight and accountability. Because vendors lack access to the AHCCCS portal, DDD staff manually enter all incident reports and complaints into the QOC tracking system. However, critical information, such as staff involved, emergency measures used, required notifications, regulatory agency involvement, and report accuracy, is not consistently captured.

Without these data elements, DDD cannot conduct meaningful trend analysis or identify systemic issues requiring corrective action. Incorporating this information would strengthen vendor compliance efforts and enhance member safety.

3. High Volume QOC Complaints with No Decline

DDD continues to experience persistently high volumes of Quality-of-Care (QOC) complaints, with 2,168 complaints reported in 2023, 2,513 in 2024, and 2,510 in 2025. Despite ongoing concerns and repeated indicators of risk, the number of QOCs has not demonstrated any meaningful decline. This continued high number of complaints suggests systemic deficiencies in accountability, oversight, and corrective action. The absence of measurable improvement, as it pertains to continued increase in QOC numbers per year, raises significant concerns regarding the effectiveness of current safeguards intended to protect member health and safety.

4. Vendor Employee Qualifications/Clearance to Work

During the course of an investigation, COMIT identified that a vendor employee had been working in the group home despite being placed on DDD's "no contact list" following a prior abuse/neglect incident. DDD's "no contact list" is an internal administrative mechanism used to restrict certain individuals or provider agencies from contact with specific DDD members, specifically individuals receiving services. COMIT also discovered that this vendor also employed an individual that had an active arrest warrant, did not possess a valid fingerprint clearance card, and had substantiated APS cases, yet was still permitted to work in the group home setting with disabled children. Through discussions with DDD, COMIT learned that employees placed on the "no contact list" are flagged for vendor notification; however, DDD has no mechanism to verify whether vendors are preventing these individuals from working unless a violation is reported. This case underscores the need for stronger checks and balances to ensure that all group home employees maintain required qualifications, clearances, and safety standards before having access to members.

5. Inadequate Pre-Placement Risk Assessment for Complex-Needs Members

The trend of repeated placement failures indicates that DDD's pre-placement assessment process does not sufficiently evaluate vendor capacity, staffing competency, or environmental suitability before assigning a complex-needs member. This results in placements that are not equipped to manage behavioral acuity or long-term stability.

6. Lack of Continuity and Oversight in Support Coordination

Turnover in Support Coordinators disrupts service continuity, delays implementation of PCSP requirements, and contributes to inconsistent monitoring of member needs. High turnover also limits the ability to identify emerging risks or intervene early in deteriorating placements.

7. Vendor Refusal to Retrieve Members From Hospitals/BH Facilities

Multiple QOC complaints from hospitals and BH facilities indicate a systemic issue in which

vendors decline to retrieve members who are discharge-ready. This practice disrupts continuity of care, increases institutionalization risk, and reflects insufficient vendor accountability mechanisms

8. **Limited Monitoring of New or High-Risk Vendors**

The assignment of a complex-needs member to newly licensed QVs without enhanced oversight reflects a systemic gap in monitoring vendor readiness. New vendors require structured support, increased monitoring frequency, and restrictions on high-acuity placements until competency is demonstrated

9. Failure to Address Recurring Emergency Intervention Patterns

The repeated use of crisis teams, police involvement, and APS reports indicates unresolved underlying behavioral and environmental issues. DDD does not appear to have a mechanism to flag or escalate cases with high emergency-intervention frequency for targeted review.

10. Fragmented Communication Across DDD Units and External Partners

The instability across placements, case management, and BH services suggests inconsistent communication between DDD units, vendors, and external providers. This fragmentation contributes to delays in addressing safety concerns, implementing behavioral plans, and coordinating transitions.

11. Insufficient Accountability for Vendor Non-Compliance

Vendors involved in repeated QOC events do not appear to face timely or meaningful corrective action. The lack of enforcement allows unsafe practices to persist across the system, contributing to ongoing patterns of abuse, neglect, and an observable increase in high-severity incidents, including death.

12. Inadequate Recordkeeping and Documentation Practices

Across multiple sites, required records were either unavailable, incomplete, or of poor quality. This prevents DDD, COMIT, and other oversight entities from verifying service delivery, medication administration, staffing ratios, and adherence to care plans. The inability to produce accurate records is a significant risk factor for member safety and regulatory compliance.

13. High Volume of Serious QOC Events Across All Licensed Settings

Some QV's had documented QOCs in all their licensed group homes, reflecting system-wide performance issues rather than location-specific problems. The breadth of concern demonstrates a pervasive breakdown in operational standards.

14. Inadequate Staffing Competency and Oversight

A substantial volume of QOC complaints describe staff sleeping on shift, failing to supervise members, refusing to cook, lacking basic caregiving skills, and demonstrating poor judgment. Emergency responders repeatedly documented staff incompetence and an inability to manage members' medical needs. This reflects systemic failures in hiring, training, supervision, and performance management.

15. Repeated Member Rights Violations and Unsafe Living Conditions

Reports of verbal and physical abuse, threats, rights restrictions, and unsafe home environments, indicate QVs systemic disregard for member rights and safety.

Recommendations/Recommended Remediation

1. DDD Quality of investigation

There is a need for DDD investigations to incorporate full root-cause analyses rather than limiting reviews to surface-level determinations. A structured root-cause approach would identify underlying organizational issues within vendor operations that contribute to recurring incidents. More comprehensive investigative practices would reduce the frequency of QOC events and provide stronger safeguards for members moving forward.

2. Data Collection, Analysis, Tracking, and Trending System

Due to the limitations of DDD's current incident report and complaint tracking system, a more advanced platform is needed and should be required to be utilized statewide. One capable of capturing all relevant incident and complaint details to support meaningful trend analysis. A system with more robust data-collection capabilities would allow DDD to identify significant and recurring patterns of vendor noncompliance, intervene earlier, and implement corrective actions. Strengthening this infrastructure is essential for improving group home service quality and enhancing member safety.

3. Additional Checks and Balances for Employee Qualifications

Given the ongoing concerns regarding vendor employees who do not meet required qualifications or lack proper clearance to work with clients, additional checks and balances are necessary to safeguard member safety. Two key systemic improvements are recommended:

- Regulatory Agency System for Data Sharing
    - In 2020, APS proposed a statewide data-sharing system for Arizona regulatory agencies (DES, AHCCCS, DHS, DCS, DPS) to address a long-standing systemic gap. Information collected during investigations varies widely across agencies due to differing statutory requirements, investigative purposes, and documentation formats. Agencies operate separate systems, none of which communicate with one another, and there is no mechanism to search multiple names simultaneously. As a result, critical information is siloed, and employers receive no automatic notification when an employee's work status changes—allowing some individuals to "fall through the cracks."
        - The proposed system aimed to centralize background checks and provide automatic alerts to employers when an employee becomes involved in an event that may affect their eligibility to work with vulnerable populations. Although the outcome of this initiative remains unclear, further development is strongly recommended to identify and address patterns of concern among potential perpetrators of abuse or neglect. DDD system to capture current vendor employee rosters and/or employees associated with complaint and incident reports to determine if an employee is actively working while on the "no contact" list.
- DDD System for Tracking Vendor Employee Rosters and "No Contact" status
    - DDD would benefit from a system capable of capturing current vendor employee rosters and linking employees to incident reports and complaints. Such a system would allow DDD to determine whether an employee is actively

working while on the “no contact” list and ensure that individuals who pose a risk to client safety are not permitted to work in group home settings.

4. **Strengthening DDD’s Internal Communication and Response Protocols**

Delayed or incomplete communication from DDD to COMIT significantly impedes investigations and compromises member safety. A standardized response timeline, escalation pathway, and accountability structure are needed to ensure timely information exchange with COMIT and other oversight entities.

5. **Enhanced Data Integration and Incident Tracking Systems**

DDD’s current tracking system lacks the ability to capture critical incident-level details and identify patterns of concern. A modernized, integrated data system is needed to support trend analysis, risk identification, and proactive oversight of vendors serving complex-needs members.

6. **Clearer Enforcement Mechanisms for Vendor Non-Compliance**

Current enforcement actions are inconsistent and often delayed. A more transparent and predictable system of sanctions, corrective action timelines, and follow-up monitoring is needed to ensure vendors address deficiencies promptly and effectively