

**Consumer Incident Management  
And  
Protection From Harm:  
Results of an MRDD Systems Review**

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**Office of Ohio Health Plans  
Bureau of Community Access  
Protection From Harm Unit**

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## **Regulatory History and Development**

Since 2000, when the Center for Medicare and Medicaid Services (CMS) presented findings regarding the administration of Ohio's Residential Facilities Home and Community-based Services Waiver (RFW), major changes have occurred in Ohio's efforts to protect the health and welfare of individuals with Mental Retardation and Developmental Disabilities (MR/DD). Legislative and administrative initiatives have produced changes in waiver administration in the areas of paid caregiver screening, employee background checks and training requirements, and the development of a registry of documented abusers. Initiatives in service coordination, behavior support, mortality review and the general oversight and assurance of consumer health and safety have also resulted. The Ohio Departments of Job and Family Services (ODJFS) and Mental Retardation and Developmental Disabilities (ODMRDD) have each focused resources to improve the health and welfare of these vulnerable populations. Administrative initiatives in the oversight and management of serious incidents affecting people with MR and DD have been designed and implemented to improve the health and welfare of Ohio's citizens.

## **ODMRDD Incident Management**

Of particular significance has been the development of an ODMRDD administrative unit dedicated to the development and management of an on-line incident tracking system (ITS). The result of one of a series of administrative rule changes, ODMRDD, through its network of providers and county boards of MRDD is charged to report, investigate and prevent the future occurrence of abuse, neglect and other adverse incidents in the lives of individuals with MR and DD. ODMRDD's focused effort to manage incidents has changed and improved over the last three years, so much that in 2003 CMS highlighted Ohio's Incident Reporting and Tracking database as a national model initiative.

Effective in September 2000, Ohio HB 538 established new requirements for review of adverse consumer incidents and authorized ODMRDD to promulgate rules governing incident oversight and investigation for consumers in community settings. Since then, ODMRDD has developed the Major Unusual Incident (MUI) Unit, administered first within its State Operated Services and Supports Administration division, and recently placed in the Division of Legal Services. An assistant deputy position has been dedicated to the planning and administration of a statewide effort to manage annual reports of Abuse, Neglect and other adverse incidents occurring in 88 counties. A new MUI reporting and investigatory procedural rule (OAC 5123:2-17-02) became effective in November 2001. Two ODMRDD supervisory positions were created, one to develop and oversee the administration of investigations conducted by the 88 county boards of MRDD across the state, and the other to manage investigations directly performed by ODMRDD and to manage the abuser registry (5123:2-17-03; effective 8/5/01). Reporting under these supervisory positions are seven Regional Managers who oversee the investigation of incidents across the state. These seven Regional Managers review all new reported incidents, provide oversight, quality assurance, training and technical assistance to local county boards of MRDD. Four additional investigators are assigned to review the most serious cases, perform state-level investigations and review abuser-registry cases, authorized by SB 171. Since the "MUI Rule" has been in effect, ODMRDD has focused significant resources on training investigative agents from across the state in rule compliance, investigative technique and

in use of the on-line Incident Tracking System used to accumulate data and manage investigations. During 2003, over 1600 individuals were trained on the content and procedures of the MUI rule, and nearly 300 individuals were trained in investigative techniques.

Table 1 documents the volume and improvement in reporting over the three years of development and implementation of the MUI rule. Rates presented in this table include MUIs for all individuals in the state with MR or DD whether or not the individual was enrolled in Medicaid.

**Table 1: OHIO MUI REPORTING 2001-2003**

<b>Data Collection Year</b>	<b>Total Reported Statewide MUIs</b>	<b>Total MUIs*</b>	<b>Substantiated Physical &amp; Sexual Abuse*</b>	<b>Substantiated Neglect*</b>
<b>2001</b>	14,342	241	6.1	3
<b>2002</b>	16,345	254	10.6	12
<b>2003</b>	17,359	253	9.7	10.5

Source: ODMRDD Trends Committee Reports (2004)

\*per 1000 individuals

### **County Board of MRDD Accreditation**

As ODMRDD's MUI Unit has developed, compliance with incident reporting and investigation standards has been incorporated as part of the accreditation review of County Boards of MRDD. Administration of the accreditation process resides in the Community Services Division at ODMRDD. Efforts to integrate trends and patterns in MUI occurrences using the County Board accreditation process are still evolving. Since the accreditation review of County Boards began, ODMRDD has self-reported improvements in several areas of performance. These areas include immediate protection of consumers when an MUI occurs, prevention planning, notifications and reporting. ODMRDD noted areas in need of further improvement in County Board MUI management from these reviews (ODMRDD, 2003) including:

- Completeness of investigations
- Provision of written findings to all required parties
- Notification of provider that an investigation is closed
- Conducting quarterly review of provider UI logs

## **ODJFS Oversight**

ODJFS has developed a Protection from Harm (PFH) Unit within the Bureau of Community Access to oversee sub-recipient Medicaid waiver-administering agencies' efforts in consumer health, welfare and protection. ODJFS, Ohio's Single State Medicaid Agency has committed an administrator position within the Protection from Harm Unit to the oversight of ODMRDD's efforts. CMS' State Medicaid Manual home and community-based services assurances (Sec. 4442.4A) and OAC 5101:3-40-01 Section V(F) require ODJFS to safeguard the health and welfare of waiver recipients. This administrator is responsible for the review and oversight of ODMRDD's efforts to assure health and welfare of waiver recipients. This administrator participates in the Behavior Support Advisory, Mortality Review and MUI Trends and Patterns committees at ODMRDD and performs case-specific oversight and periodic review of MUIs involving Medicaid consumers with MR and DD. Quarterly meetings with ODMRDD's MUI Unit leadership are held to exchange information to improve protections for waiver recipients with MR and DD. This administrator also participated significantly in the development and implementation of this PFH review, authorized by ORC 5111.85(D).

## **MUI Rule Description**

ODMRDD's "MUI Rule" (OAC 5123:2-17-02) became effective on November 23, 2001. Its stated purpose is to "define and establish a system to report, investigate, review, remedy and analyze incidents adversely affecting the health and safety of individuals and to monitor preventative actions taken to ensure health and safety".

The rule distinguishes definitions of incidents reportable as Unusual Incidents (UIs) and Major Unusual Incidents (MUIs). It defines timeframes by which providers must report MUIs to the county Board of MRDD (within 24 hours of awareness of an incident) and specifies that incidents meeting specified criteria also be reported to law enforcement, the Children's Services agency and the service and support administrator (SSA) responsible for the individual's care coordination. The rule defines the timeframe for reporting by the county to ODMRDD (by 5 PM on the working day following provider notification). It defines the timeframes and the processes by which MUIs are investigated and the components that a full or "protocol" investigation must entail. It defines criteria for a "separate investigation" when conflicts of interest for the County Board are inherent to the MUI.

The MUI rule requires written summaries of findings of the investigation and a plan to reduce the risk of reoccurrence of similar incidents be provided to 1). the consumer potentially harmed by the incident or his or her legal guardian or consumer advocate, and 2). the provider. The rule requires notice to the same parties of the right to dispute the findings or submit written comments about the findings.

The rule also requires all providers to have a written policy for internal review of all UIs and MUIs and assigns the provider (with the County Board's assistance) accountability to take "reasonable steps" to prevent the reoccurrence of MUIs. Criteria for closure of investigated cases is also part of the rule, including assurance that the investigation was adequate, verification of whether reasonable preventive measures have been taken, and whether the incident is part of a larger trend requiring action.

The rule requires County Boards to send quarterly reports of all MUIs to the provider for review and identification of trends and patterns specific to that provider. Providers and County Boards are each required to perform an annual review of MUIs to identify trends and patterns in MUI occurrence and devise remedies to prevent future similar incidents. County boards are required to assure that MUI patterns and trends are addressed in individuals' plans of service. ODMRDD must at least semi-annually report on statewide trends and patterns and preventive initiatives. A committee of providers, County Boards, the Ohio Legal Rights Service, Advocacy and Protective Services (APSI), the Association of Retarded Citizens (ARC), other stakeholders and ODJFS is charged with making recommendations to ODMRDD regarding appropriate action.

Specific rule requirements will be delineated throughout this report as results of this compliance review are presented. This review is primarily focused on compliance with components of the MUI rule, as revised in November 2001.

### **MUI Reporting: Population Rates**

ODJFS calculated a fourteen percent (14%) prevalence of reported MUI occurrence and investigation in the general MR/DD population during the review period (April 1, 2002-March 31, 2003). In other words, among the 66,848 individuals enrolled in MRDD programs (Medicaid and non-Medicaid) statewide, fourteen percent (14%; n=9457) of those individuals had at least one MUI reported.

The history of all MUI occurrences during the 12-month review period was obtained for the Medicaid waiver sample (see Review Sampling Process). ODJFS' calculation of MUI occurrence rates for Medicaid waiver populations during the sample period showed that MUIs for waiver enrollees are reported at rates more than 35% higher than for the general population served by the MR/DD system overall. Combined IO and RFW waivers produced an MUI rate of 344 per 1000 individuals for the review period. Forty-one (41) counties reported at rates above the mean for both waivers combined. ODMRDD reported rates of 253 MUIs per 1000 individuals for their entire service population during 2003. ODMRDD did not have the system capacity to calculate waiver-specific rates, so comparison of waiver rates with rates for the total MRDD service population has not been available prior to publication of this report.

The IO waiver produced a rate of 359 MUIs per 1000 waiver enrollees per year during the review period. Forty-one (41) counties reported rates above average for this waiver. A chi-square analysis over the four calendar quarters of the sampling period suggested significantly lower than expected MUIs<sup>1</sup> reported in the IO waiver in the first two quarters and greater than expected during the second two quarters (chi square=9.51; p= .0232). This may reflect improvements in provider staff training and overall system accountability to MUI reporting after June 2002.

<sup>1</sup> 'Significance' in this report refers to statistical significance, defined as p=.05 on the statistical test specified. 'Expected' refers to expected frequencies calculated by the specified statistical test.

The Residential Facilities Waiver (RFW) produced an average rate of 320 MUIs per 1000 waiver enrollees per year. Twenty-six (26) counties produced rates above average for this waiver. The same chi square analysis produced a mixed reporting pattern for this waiver, with fewer than expected MUIs occurring during the second two quarters.

**Table 2. MR/DD Population MUI Reporting Rates during the Sample Period**

<b>Population</b>	<b>MUI Rate per 1000 population</b>	<b>Calculation Period</b>
<b>ODMRDD Total Population Served</b>	253	Calendar Year 2003
<b>ODMRDD Individual Options Waiver</b>	359	April 1, 2002- March 31, 2003
<b>ODMRDD Residential Facilities Waiver</b>	320	April 1, 2002- March 31, 2003
<b>ODMRDD Combined IO and RFW Waiver populations</b>	344	April 1, 2002-March 31, 2003

Part of this higher MUI rate for waiver enrollees may be explained by the requirement that all providers report incidents. Formal, specialized services provided to waiver recipients may produce a higher reporting rate for waiver enrollees than for those individuals not served by providers. Some part may also be due to the more vulnerable nature of waiver enrollees, all of whom meet ICF/MR level of care requirements.

### **Purpose**

ODJFS' purpose for this review was to evaluate ODMRDD's initiatives in health and welfare protection for individuals with MR and DD, primarily focused on statewide compliance with the new MUI rule. It also intended to develop a descriptive profile of the frequency, type and outcomes of MUIs occurring for individuals in the waiver programs. A small component of peer review was included, specific to MUI categorization and expected staff training. Because ODJFS had not previously developed a review focused entirely on Protection from Harm, this initiative involved a broad reach across many areas that contribute to the system's protective capacity. It was designed to identify areas for further consideration in subsequent, more focused reviews.

### **Data Collection Tool**

The data collection tool was developed to evaluate compliance with components of ODMRDD's MUI rule. Other requirements in Ohio's Administrative and Revised Codes defined additional components related to specific requirements for Ohio's MRDD providers.

Areas of focus were organized based upon the CMS Key Components for Abuse and Neglect Detection and Prevention (currently found in the CMS State Operations Manual, Appendix Q). While this model was designed for oversight in long-term care facilities, its basic structure is applicable to home and community-based service providers. The review tool was designed to evaluate specific incident occurrences linked to individual waiver consumers. The tool included nine sections: prevention (policy/procedure review); employee background screening; training; identification of incident trends and patterns; immediate protection; reporting; investigation; resolution; and accuracy of the incident information reported in the ITS database. All information was gathered from document review; individual consumers were not interviewed due to the potentially emotional content of incidents. The data collection tool was field tested and revised based on focus group feedback.

## **Data Collection**

A team of ten field review staff were trained on the final tool content and the protocol for data collection using formal training and case review. Multiple case scenarios were used to train reviewers to evaluate the content and process of each investigation. This training was reiterated in small group meetings. This review involved paper-review only; no consumer or provider interviews were conducted. In order to assure that complete information was pursued and all possible evidence was considered, reviewers conferred with providers and County Boards regarding available sources of data to complete the tool within their required protocols. Data collection was completed during the period June 2003 to February 2004.

ODJFS Adverse Outcomes (AO) standard process applied (See Appendix A), to address reviewers field concerns that any part of the system had failed to meet basic standards of health and welfare. AO reports are made by field review staff any time a “sub-recipient has failed to meet basic standards of care resulting in a threat to health and welfare”. An ODJFS committee was established for review and remedy for those individualized circumstances. Results of this process are presented in this report.

The ODJFS Protection from Harm administrator performed an analysis of the high-level “Alerts” cases that occurred during the review period. “Alerts” cases are defined as those cases specifically reported by ODMRDD to ODJFS because they meet a standard of high risk. This analysis was also the oversight agency’s first attempt to develop a descriptive profile of the frequency, type and outcomes of particularly egregious MUIs occurring for individuals in the waiver programs. Results of this analysis are also presented as part of this report.

## **Review Sampling Process**

A representative sample of individuals experiencing MUIs was selected for the period April 1, 2002 through March 31, 2003. When more than one MUI was reported for an individual during the sample period, the latest occurring MUI in the sample period for that individual was selected. In order to obtain a generalizable sample, 100% of MUIs were included for thirty (30) counties reporting a small number of MUIs. A sample size large enough to represent the total MUI population was drawn within large-volume counties. Sample sizes were calculated for each county with a +/- 7% margin of error and a 95% confidence level assuming a .5 proportion for binary responses.

During the sample period statewide, based on data extracted from ODMRDD's Incident Tracking System (ITS) 9,457 individuals with MR or DD experienced a total of 15,379 MUIs. Prior to and during the review period, ODMRDD's tracking system was unable to produce information identifying individuals experiencing MUIs by type of program enrollment. Therefore, ODJFS matched all individuals experiencing MUIs during the sampling period with its Medicaid Management Information System (MMIS) to determine whether the individual was enrolled in Medicaid and if so, in what program(s). Almost one third of those individuals (30.9%; n=2,924) were found to be enrolled in ODMRDD's Individual Options (I/O) or Residential Facilities (RFW) waivers at the time the MUI occurred. A sample of 1974 individuals were selected from this group. The most recent MUI for each unduplicated individual was included in the sample. Sixty eight individuals (68) were added to the sample by reviewers identifying cases in the field, and 125 were excluded because they were found not to be enrolled in a waiver at the time of the incident. A sample of 2042 individuals was the final total sample size. A completion rate of 96.7% produced a total of 1854 completed MUI records analyzed for this report.

ODJFS experienced difficulty in developing this sample, as the ITS database does not include a unique identifier (SSN or MMIS number) for individuals involved in MUIs. Thus, a name-match was performed with MMIS to determine the enrollment status of at the time of the incident for each individual in ITS during the sample period. Reviewers and County Board participants had difficulty verifying the sample at the implementation of the review. Adjustments were made as on-site program enrollment verification was made. ODJFS has since requested the inclusion of an accurate waiver-indicator field to the ITS reporting function.

### **Inter-Rater Reliability**

In order to verify the reliability of the data gathered among ten (10) reviewers, a sub-sample of twenty-five (25) cases were randomly selected for inter-rater analysis. The ODJFS dedicated MRDD PFH administrator served as the standard of review for all of these cases. Collateral documentation was gathered by field reviewers and submitted for comparison review. Percent agreement and Cohen's Kappa tests were used to evaluate the frequency of agreement and the relative likelihood that each question's result would have been produced by chance. Questions which produced less than acceptable agreement (kappa values of  $\leq .4$ ; Landis and Koch, 1977) were typically found in areas of rule that are less clear and specific than others. Variability in any question with less than acceptable inter-rater results is explained as necessary in the analysis.

## Sample Description

**Table 3. Sample Description: Waiver Enrollment, Age, Provider Involvement**

<b>Individual's Waiver Enrollment</b>	<b>Sample Distribution</b>	<b>Individual Average Age</b>	<b>Involved Providers</b>
<b>IO Waiver</b>	1284 (69.5%)	42 years	251
<b>RFW Waiver</b>	563 (30.5%)	48 years	158
<b>Total</b>	<b>1854 (100%)<sup>1</sup></b>	<b>44 years</b>	<b>336<sup>2</sup></b>

<sup>1</sup> 7 individuals missing enrollment data

<sup>2</sup> Duplication of providers across individuals produced 409 unique provider-waiver pairs, but only 336 unique providers.

The sample produced results based on a review of 1854 waiver consumer incidents. These incidents involved 336 unique providers. These included contracted agencies (83%), county boards of MRDD (15%), and contracted Independent Providers (2%) involved with consumers. Seventy-three (73) providers were involved in incidents for both IO and RFW waiver recipients. Providers were not distinguished by the type of involvement; involvement included both providers reporting incidents and those alleged to have been involved in the incident circumstances. Location of the incident was used to distinguish provider type. Neither provider number nor provider type is available from ODMRDD's ITS database, thus the data was collected on-site and further researched in MMIS.

Individuals in the IO and RFW waivers differed significantly by age ( $t = -7.20, p < .0001$ ). The average age for IO enrollees was 42 versus 47.6 years for RFW enrollees.

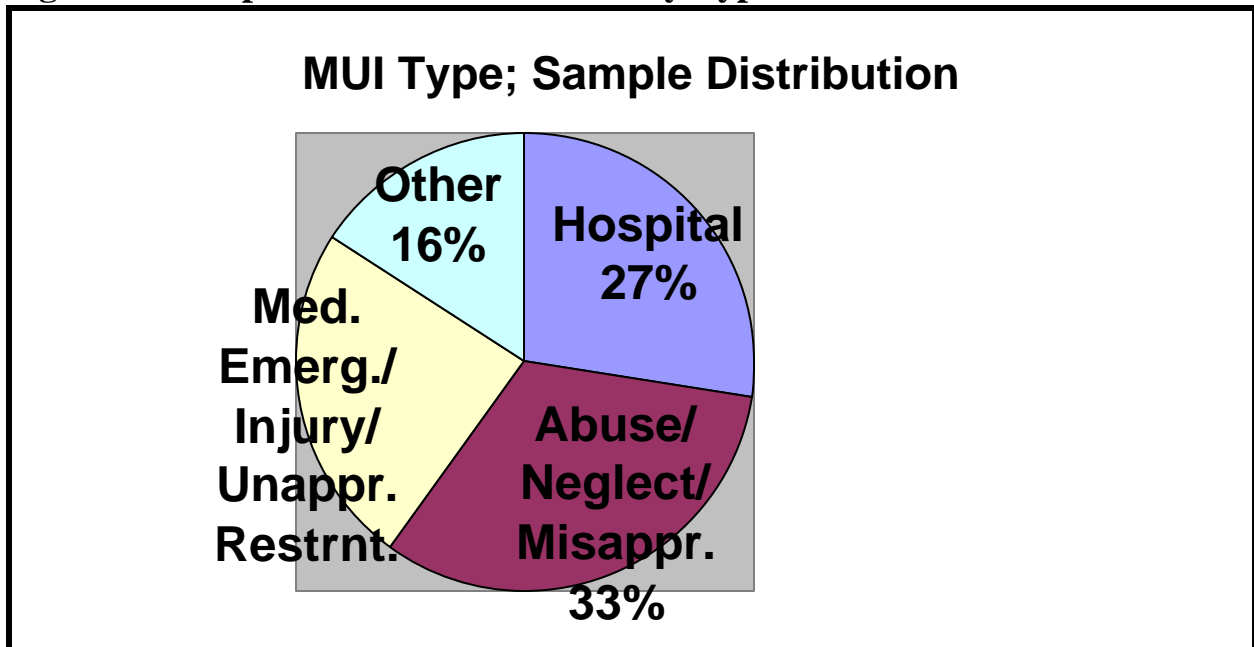
Table 4 presents the sample MUIs by type of incident. Categories described here include all MUI subtypes used by the field at the time of the review. The percent distribution of the sample parallels the overall distribution of MUIs reported by ODMRDD during the same period for the total service population ( $n = 15,379$  MUIs).

**Table 4. MUI Sample by Type of Incident**

<b>MUI Type</b>	<b>Number</b>	<b>Percent</b>
<b>Hospitalization</b>	509	<b>27.5%</b>
<b>Abuse</b>	275	<b>14.9%</b>
<b>Injury</b>	228	<b>12.3%</b>
<b>Neglect</b>	168	<b>9.1%</b>
<b>Misappropriation</b>	162	<b>8.7%</b>
<b>Unapproved Behavior Restraint</b>	119	<b>6.4%</b>
<b>Medical Emergency</b>	98	<b>5.3%</b>
<b>Death</b>	61	<b>3.2%</b>
<b>Series of MUIs</b>	60	<b>3.2%</b>
<b>Law Enforcement</b>	48	<b>2.6%</b>
<b>Missing Person</b>	42	<b>2.3%</b>
<b>Rights Violation</b>	39	<b>2.1%</b>
<b>Relocation</b>	26	<b>1.4%</b>
<b>Attempted Suicide</b>	10	<b>.5%</b>
<b>Missing</b>	10	<b>.5%</b>
<b>Total</b>	<b>1854</b>	<b>100%</b>

Hospitalization of waiver consumers is by far the most common MUI type (27.5%). This number reflects all unplanned hospitalizations as required by the MUI rule. Abuse (14.9%), Neglect (9.1%) and Misappropriation (8.7%) together represent another one-third of MUIs. Injuries (12.3%), Medical Emergencies without hospitalization (5.3%) and Unapproved Behavior Restraints (6.4%) represent nearly one quarter of all MUIs in the sample.

**Figure 1: Sample Distribution of MUIs by Type**



A chi square was not possible to analyze differences in incident occurrences among provider types, as incident types did not occur with adequate frequency in each provider category. However, the distribution of MUIs in major categories by provider type is presented in Table 5 below.

**Table 5. Percentage of Sample MUIs by Agency and Incident Types\***

MUI Type	Agency	County Board	Independent Provider
Abuse	11.1%	3.54%	.16%
Neglect	7.7%	1.2%	.05%
Injury/Medical Emergency	13.7%	3.1%	.71%
Death	2.8%	.2%	.05%
Hospitalization/Suicide Attempt	25.1%	2.1%	.65%
Law Enforcement	2.0%	.38%	0.00%
<b>Total</b>	<b>82.61%</b>	<b>14.67%</b>	<b>2.02%</b>

\* Missing data accounts for .55%, so totals do not equal 100.

## Incident Location

**Table 6. Location of Sample MUIs**

<b>MUI Location</b>	<b>Number</b>	<b>Percentage</b>
<b>Own or Family Home (IO)</b>	907	49.2%
<b>Residential Facility (RFW)</b>	418	22.7%
<b>County Board Program</b>	202	11.0%
<b>Community Setting</b>	163	8.8%
<b>Transportation</b>	51	2.8%
<b>Other</b>	101	5.4%
<b>Missing</b>	12	.006%
<b>Total</b>	<b>1854</b>	<b>100%</b>

The majority (49.2%; n=907) of incidents in the sample occurred in individuals' private homes. Less than a third (22.7%; n=418) occurred in Residential Facilities. Just over ten percent (11%; n=202) of incidents occurred at county board programs, and fewer than ten percent (8.8%; n=163) occurred in other community settings.

## Elapsed Time from Date of Incident to Closure of Investigation

The MUI rule directs County Boards of MRDD to complete investigations within 30 working days of incident notification. On average, investigations extended for nearly seventy two calendar days (71.9). Adjusting calendar days to a working day standard averages 51.3 days. A significant difference in the average duration of an MUI investigation was identified between provider types, as evidenced by a Kruskal-Wallis Test (chi square=11.4; p=.0096) with independent providers showing the shortest mean investigation time. Thirty-four (34) counties presented with results above the mean for MUIs investigated over the entire sample period. There was no significant difference in elapsed time based on the waiver in which the individual was enrolled (73 days for IO and 69 for RFW enrollees).

**Table 7. Average Investigation Time by Provider Type (in Days)\***

<b>Provider Type</b>	<b>Average MUI Investigation Time</b>
<b>Agency</b>	70.8 Days
<b>County Board</b>	74.6 Days
<b>Independent Provider</b>	62.3 Days
<b>Total Average</b>	<b>71.8 Days</b>

\*Elapsed number of calendar days from MUI date of occurrence to date closed.

The difference in average investigation time between quarters was also found to be significant using a Kruskal-Wallis Test (f=13.22; p=.0071). The following table documents improvement in overall investigation time for each successive quarter during the sample period.

**Table 8. Elapsed Number of Calendar Days from Incident Date to Investigation Closed Date**

<b>Sample Quarter</b>	<b>Average MUI Investigation Time</b>
<b>April 1-June 30, 2002</b>	85.5 Days
<b>July 1-September 30, 2002</b>	81.2 Days
<b>October 1-December 31, 2002</b>	69.4 Days
<b>January 1-March 31, 2003</b>	60.3 Days
<b>Total Sample Period</b>	<b>71.7 Days</b>

Although the MUI rule requires that investigations be completed within 30 working days unless an extension is requested, average investigation time had shortened to just over 60 calendar (42.8 working) days at the end of the sample period. There has been significant improvement in the timeliness of investigations over the rule-implementation period, but the timeliness requirement in rule has not been met. This analysis did not consider ODMRDD-issued extensions to the timeframe specified in rule.

A Kruskal-Wallis test produced significantly different investigation time among MUI types during the sample period (chi square=12.09; p=.0071). Death cases and rights code violations were among the longest investigative processes. The distribution by MUI type is presented in Table 9 below.

**Table 9. Elapsed Number of Calendar Days from Incident Date to Investigation Closed Date by MUI Type**

<b>MUI Type</b>	<b>Number in Sample</b>	<b>Average Investigation Time</b>
<b>Death</b>	60	122.1
<b>Rights Code Violation</b>	39	104.8
<b>Misappropriation</b>	161	95.0
<b>Neglect</b>	168	93.7
<b>Abuse</b>	275	93.0
<b>Behavior Restraint</b>	119	88.5
<b>Relocation</b>	26	72.3
<b>Missing Person</b>	42	60.2
<b>Law Enforcement</b>	48	59.3
<b>Series</b>	60	53.8
<b>Injury/Medical Emergency</b>	322	52.2
<b>Hospitalization/Suicide Attempt</b>	521	49.2
<b>Missing</b>	10	N/A
<b>Total</b>	<b>1851</b>	<b>71.7 Days</b>

For the entire sample period, the average investigation time was nearly seventy-two calendar (71.7) days. All death cases are reviewed by ODMRDD physician reviewers after investigations are completed, but before cases are closed. This may explain the length of time these MUI cases remain open. Abuse, Neglect and Misappropriation cases frequently involve outside parties such as Public Children Services Agencies or law enforcement investigators, which makes case investigation dependent on outside parties and may delay closure. The thirty (30) working day investigation completion requirement in the MUI rule may merit further analysis with consideration of extensions issued by ODMRDD.

### **Incident Effects on Individual Consumers**

The review also assessed the effects of MUIs on individual waiver consumers. Effects of MUIs were categorized into four areas: injuries, change in individual location, use of restraint, and staffing changes. Overall, these outcomes occurred in less than half of all sampled cases (44.5%; n=817). Injuries occurred in less than a fifth of cases (13.3%; n=244). Change in the individual's physical location (such as a respite stay, or move to an ICF/MR or other family setting) occurred in only a few cases (6.3%; n=117). Restraints were used in fewer cases (4.8%; n=88). Staffing changes, however, were documented in a higher percentage of cases (20.1%; n=368). Table 10 documents these results.

Results from a chi square analysis suggest that restraints were used more frequently than expected in County Board settings and less frequently than expected when agency and independent providers were identified as the provider type (chi square= 47.84; p<.0001). Restraint reporting by county boards may be more prevalent than for other provider types. Another chi square analysis (chi square=8.49; p=.0144) produced fewer than expected staff changes among independent providers and slightly more than expected changes among agency and county board provider organizations.

Staff removal is most frequent in allegations of Abuse, Neglect and Misappropriation, which occurred or were reported infrequently when independent providers were involved. Staffing changes occurred more frequently than expected when the MUI type was Abuse, Neglect, Misappropriation, Rights Code Violation, Unapproved Behavior Restraint, and Missing Person (chi square=445.13; p<.0001). These results can be reasonably explained by the MUI rule requirement that staff be removed from contact in certain MUI circumstances.

There were no significant differences between waivers for any of these four effects categories. Significantly more review may be required to evaluate the immediate and long-term effects of MUIs on individuals, particularly with regard to the formulation and implementation of legitimate prevention plans and the re-occurrence of similar incidents. ODMRDD should consider case-specific evaluation of incident cause and effects on the individuals as its focus on improving consumer outcomes develops.

**Table 10. Individual Effects by Frequency, Provider Type and MUI Type**

<b>Effects of MUI</b>	<b>Percent of MUIs</b>	<b>Occurs more/less frequently than expected for these Provider Types</b>	<b>Occurs more frequently than expected for these MUI Types</b>
<b>Injury</b> (n=244)	13.3%	No significant differences	Injury
<b>Change in Individual Location</b> (n=117)	6.3%	No significant differences	Hospitalization Relocation Law Enforcement
<b>Restraint Used</b> (n=88)	4.8%	More frequent than expected for County Board Providers (13% of CB providers)	Behavior Restraint
<b>Staffing Changes</b> (n=368)	20.1%	Less than expected for Independent Providers	Rights Code Violation Behavior Restraint Misappropriation Abuse Neglect

**Review of Provider Policy and Procedure**

As part of this review, providers were asked to provide documentation of policy and procedure consistent with the November 2001 MUI rule revision. The majority of providers were able to document compliance with this rule expectation (85.2%; n=328).

**Table 11. Provider Compliance with Updated Policy and Procedure by Provider Type**

<b>Provider Type</b>	<b>Percent Compliant</b>
<b>Agency</b>	83% (222)
<b>County Board</b>	99% (84)
<b>Independent Provider</b>	63% (19)

chi square=22.4; p<.0001

Provider policies were typically compliant and required internal review of MUIs (82.3%; n=315). Eighty-eight percent (88.3%; n=339) of policies were compliant with Unusual Incident (UI) reporting. Eighty-four percent (84.1%; n=323) were compliant with the 24-hour UI reporting expectation and internal review of UIs for health and safety protection. Inter-rater reliability in the area of policy and procedure review was less than optimal. Reviewers suggest

that this may be a result of the variety of formats representing provider policy and procedure. Providers did not always date their policies, and did not maintain copies of old policies. In general, agency and County Board providers complied more frequently with all components of policy expectation than did independent providers. It is likely that county board compliance with this measure is higher than independent or agency providers because County Board accreditation includes review of MUI compliance, and the ODMRDD’s MUI unit reviews each County Board’s performance annually. Provider compliance review is required at least once during a certification term, which is between one and five years (OAC 5123:2-9-08).

### **Employee Involvement in MUIs**

In the majority (67.0%; n=1240) of the MUIs reviewed, a paid staff person was involved either as witness, reporter or primary person involved (PPI). A chi square analysis of provider type suggested that County Board employees are involved more frequently than expected, and agency and independent employees are involved somewhat less frequently than expected (chi square=17.39; p=.0006). Using a chi square test for significant differences between MUI types, paid staff involvement was significantly higher than expected in Abuse, Neglect and Unapproved Behavior Restraint (chi square=157.7; p<.0001) and less frequent than expected with Death, Hospitalization and Suicide attempts. This result might have been expected, given that staff involvement, observation and reporting are inherent to the identification of Abuse, Neglect and Unapproved Behavior Restraint.

Almost two thousand staff (1944) persons were involved as a witness, reporter or PPI in one thousand two hundred forty (1240) incidents. In twenty eight percent (27.8%; n=516) of all sampled incidents, a second staff member was also involved. In ten percent (10.1%; n=188) of sampled cases, a third staff member was involved. Review of each MUI involved identification of the source of information regarding paid staff. This component intended to evaluate the frequency with which paid staff were formally identified as PPIs. When paid staff were involved, reviewers most frequently identified the PPI from the MUI narrative (55.2%; n=254) or in other documents relevant to the MUI investigation (22.9%; n=266). In twenty-two percent (21.9%; n=254) of cases the paid staff member involved was noted in the specified PPI field in the Incident Tracking System (ITS).

**Table 12. Number of Incidents with Paid Staff Involved**

<b>Number of Paid Staff Involved</b>	<b>Percentage of Total Sample (N=1851)</b>	<b>Percent with Paid Staff as PPI</b>
No Paid Staff Involved	33% (611)	-----
1 or more Paid Staff Person	67% (1240)	21.7% (404)* of Total Sample MUIs identified paid staff as PPI
2 or more Paid Staff Persons	28% (516)	N/A
3 or more Paid Staff Persons	10% (188)	N/A
<b>Total Staff Persons</b>	<b>1944*</b>	<b>20.8 % (404)** of all staff involved are identified as PPI</b>

\* 153 staff persons are duplicated across MUIs \*\*14 PPIs are duplicated across MUIs

Almost a third (32.5%; n=404) of MUIs identifying involvement of a paid staff member also identified this person as the primary person involved (PPI). This represents nearly one quarter (21.7%; n=404) of all MUIs in the sample. No significant differences were identified between provider types for this measure.

In most cases where staff were identified as PPI (62.1%; n=247), this designation was entered in the Incident Tracking System (ITS) PPI field. In a third (30.7%; n=122) of cases, however, the reviewer identified PPI involvement only in the MUI narrative text. Others (7.3%; n=29) were identified outside the MUI report in provider records or other relevant documents. This suggests that the ITS identification field for PPI may not be appropriately utilized, both at the time of initial data entry and when a PPI is identified during the course of an investigation. ODMRDD currently requires the PPI field be completed for Abuse, Neglect, Misappropriation and Rights Code violations.

**Table 13. Paid Staff and PPI involvement by MUI Type**

<b>MUI Type</b>	<b>Number in Sample</b>	<b>Percent with paid staff involved</b>	<b>Percent of MUIs with paid staff as PPI</b>
<b>Hospitalization &amp; Suicide Attempt</b>	521	55.1%	1%
<b>Abuse</b>	275	73.5%	48%
<b>Injury &amp; Medical Emergency</b>	322	64.9%	3%
<b>Neglect</b>	168	87.5%	55%
<b>Misappropriation</b>	161	69.6%	32%
<b>Unapproved Behavior Restraint</b>	119	94.1%	46%
<b>Death</b>	61	41.7%	3%
<b>Series of MUIs</b>	60	58.3%	17%
<b>Law Enforcement</b>	48	60.42%	4%
<b>Missing Person</b>	42	83.3%	17%
<b>Rights Violation</b>	39	84.6%	69%
<b>Relocation</b>	26	30.8%	0
<b>Missing</b>	10	.5%	7
<b>Total</b>	<b>1851</b>	<b>67% (1240)</b>	<b>21.8% (404)</b>

## Involved Staff Description

When paid staff were involved, the average years of employment (n=1791 unduplicated staff) was four (4.0) at the time of the incident. The median length of employment was two (2.0) years and the most frequently occurring number of years was one (1.0). Thus, half of staff involved were employed for a period of between one and two (1-2) years.

Significant differences were identified between MUI types for length of employment (Kruskall-Wallis chi square=38.32; p<.0001). When staff were identified as PPIs (n= 404 MUIs), then the mean service time was slightly shorter (3.8 years) than the average staff involvement in the total sample. No significant differences were identified between MUI types for length of employment for MUIs in which staff are identified as PPI. Table 14 presents the average years of employment for involved and PPI staff by MUI type.

**Table 14. Average Length of Employment for Staff Involved and PPI, by MUI Type**

<b>MUI Type</b>	<b>Average Length of Employment for Staff Involved*</b>	<b>Average Length of Employment when staff is PPI</b>
<b>Hospitalization/Suicide Attempt</b>	4.7 years (n=367)	3.5 years (n=94)
<b>Abuse</b>	3.8 years (n=298)	4.6 years (n=133)
<b>Injury/Medical Emergency</b>	4.5 years (n=292)	4.3 years (n=11)
<b>Neglect</b>	3.4 years (n=238)	3.2 years (n=94)
<b>Misappropriation</b>	2.9 years (n=177)	2.8 years (n=51)
<b>Unapproved Behavior Restraint</b>	5.0 years (n=182)	4.5 years (n=55)
<b>Death</b>	2.7 years (n=31)	2.0 years (n=2)
<b>Series of MUIs</b>	2.8 years (n=55)	2.0 years (n=10)
<b>Law Enforcement</b>	3.0 years (n=37)	.50 years (n=2)
<b>Missing Person</b>	2.6 years (n=48)	1.0 year (n=7)
<b>Rights Violation</b>	4.3 years (n=49)	4.1 years (n=27)
<b>Relocation</b>	3.8 years (n=8)	none
<b>Missing</b>	9	6
<b>Total Average</b>	<b>4.0 years (n=1791)</b>	<b>3.8 years (n=404)</b>

\* Kruskall- Wallis chi square=38.32; p<.0001

County Boards of MRDD (OAC 5123:2-1-05) and MRDD Providers (OAC 5123:2-1-05.1) are required to obtain a Bureau of Criminal Identification and Investigation (BCII) check for new staff at the time of employment. For ten percent (10.3%; n=148) of staff involved and for whom the date of hire was after May 12, 1995 (n=1434), no BCII check was done at the time of employment. When the staff member was identified as PPI (n=390), a similar percentage (11.1%) was not completed. A chi square analysis was not possible to evaluate this component by agency or MUI type, as cell values were too small. Per the same administrative rules, an additional FBI report is required when a new hire has not been a resident of Ohio for a period of 5 years. When an FBI report was also required (this was required in 175 cases) documentation

was not found in the employment file in just over one quarter (27.4%; n=48) of cases. For those employees identified as PPI, only 4% were not compliant with the FBI requirement. Unless there was evidence in the employee file of an out-of-state address within 5 years, reviewers did not look for an FBI report.

Inter-rater reliability was not optimal in the BCII verification component of the review. Date verification was sometimes not available or when a request for BCII had been submitted, the date of receipt was not documented.

**Table 15. Noncompliance with MUI Rule Employment Requirements**

Required Measure	All Staff Involved	PPI Subset
<b>BCII Check</b> (n=1434 and n=390 PPI)	10.3% (n=148)	11.1% (n=35)
<b>FBI Report included when required</b> (n=175 and n=281 PPI)	27.4% (n=48)	3.9% (n=7)
<b>ODMRDD Abuser Registry Check</b> (n=160 and n=40 PPI)	33.8% (n=53)	35.0% (n=14)
<b>Ohio Nurse Aide Registry Check</b> (n=160 and n=40 PPI)	24.7% (n=39)	40.0% (n=16)

The same administrative rules require a Nurse Aide Registry and ODMRDD Abuser Registry check to assure that new hires are not listed on the Ohio Department of Health (ODH) or the ODMRDD offender registries. For individuals whose date of hire was after required implementation of these registry checks (160 were hired after 9/22/02), one third (33.8%; n=53) of employee records contained no documentation that the ODMRDD Abuser Registry check had been performed. Twenty-five percent (24.7%; n=39) of employee records were not compliant with the Nurse Aide Registry check. A chi square analysis produced no significant differences among provider or MUI types. For those staff identified as PPI, slightly more, thirty five and forty percent (35 and 40%) were not compliant with the ODMRDD Abuser and Nurse Aide Registry checks.

Although compliance with the employment requirements specified in the background investigation rule should be improved, the rule does not require the annual re-evaluation of employees. Initial and annual verification of criminal and abuse histories according to the above measures would strengthen the system’s ability to protect waiver enrollees’ health and welfare.

**Involved Staff Training**

Reviewers were asked to identify whether employees involved in MUIs were trained on the MUI rule, when it went into effect or upon hire. For the number of staff (n=1791 unduplicated) involved in MUIs, reviewers found 83.3% (n=1463) compliance with initial MUI training. Because of the data layout, a chi square analysis was not feasible for this measure, so it

is not known whether there are significant differences in performance by provider type. Similar (82.6%; n=313) results were found when the staff person was identified as PPI (n=390 unduplicated). In cases of Abuse, Neglect and Misappropriation, initial training for staff was provided less frequently than expected (chi square=44.2; p=.0033).

Annual training on the content of the MUI rule was also evaluated. In over two thirds (68.7%; n=1199) of cases, staff members had been trained annually. Staff identified as PPI who were employed for more than a year (n=286) were annually trained somewhat more frequently (70.3%; n=201). Chi square analyses were not possible to determine differences in training by provider or MUI type, due to small cell values.

### **Training Specific to MUI Content**

Reviewers were asked to respond to the following, “Based on the circumstances of the MUI...what training would you expect the staff to have had prior to beginning work with this individual?”. A total of 29 training areas were coded; Table 16 presents the frequency of those codes and the frequency of staff having received that training. Overall, training was provided as the reviewers would have expected in 86% of reviewer training recommendations. A chi square analysis (chi square=8.04; p=.0451) suggested that agency providers had complied with the recommended training slightly more frequently than expected, and independent providers did so slightly less frequently than expected. No significant differences among MUI types were identified.

**Table 16. Frequency of Training Need Identified and Provided**

<b>Training Need</b>	<b>Frequency Identified*</b>		<b>Frequency Provided when Identified</b>	
<b>Individual-specific ISP training</b>	1378	21.6%	1109	82.0%
<b>Reporting of Incidents</b>	885	13.9%	817	95.1%
<b>Consumer Rights</b>	745	11.7%	687	93.9%
<b>Identifying Abuse/Neglect/Exploitation</b>	687	10.8%	617	91.5%
<b>First Aid</b>	364	5.7%	328	91.6%
<b>Emergency Protocols</b>	349	5.5%	309	90.6%
<b>Agency Behavior Support Intervention System</b>	337	5.3%	293	88.5%
<b>Individual’s Behavior Plan</b>	240	3.8%	197	83.1%
<b>Signs/Symptoms of Illness</b>	200	3.2%	148	76.3%
<b>Documentation Skills</b>	196	3.1%	166	87%
<b>Communication/Daily Living Skills</b>	174	2.7%	140	82.4%
<b>All Other</b>	822	13.1%	675	82.1%
<b>Total Identifications</b>	<b>6377</b>	<b>100.4%</b>	<b>5486</b>	<b>86.0%</b>

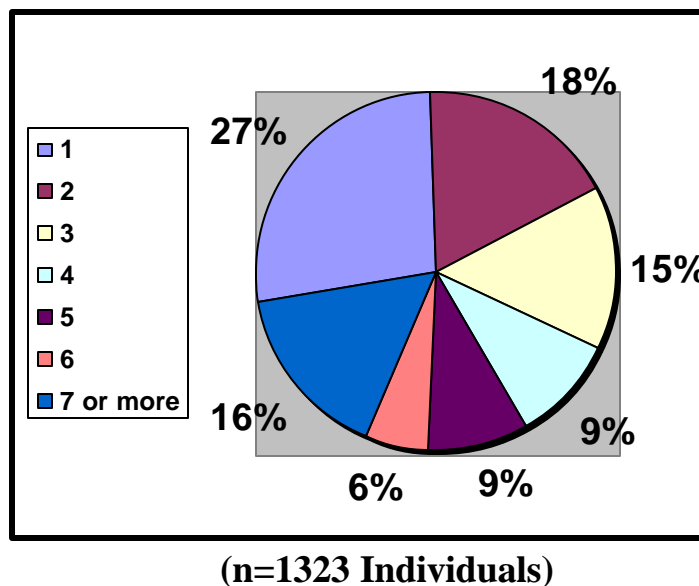
\*percentage of all training needs identified (n=6377)

## Provider Identification and Review of Unusual Incidents

Reviewers were asked to determine whether providers maintained a log of Unusual Incidents, as required in the MUI rule. Unusual incidents are defined by the MUI rule as events or occurrences that involve consumers that are not consistent with the routine care of the individual, but that also do not meet the definition of an MUI. Provider UI logs are intended to document occurrences to prevent further risk of harm to the individuals involved. Of the 401 providers reviewed for this element, less than ten percent were found out of compliance with this requirement (8.9%; n=35). Only thirty-two percent (32.1%; n=9) of independent providers were compliant with this expectation, compared to eighty-two (82.0%; n=223) and seventy-four (74.1%; n=63) percent of agency and County Board providers.

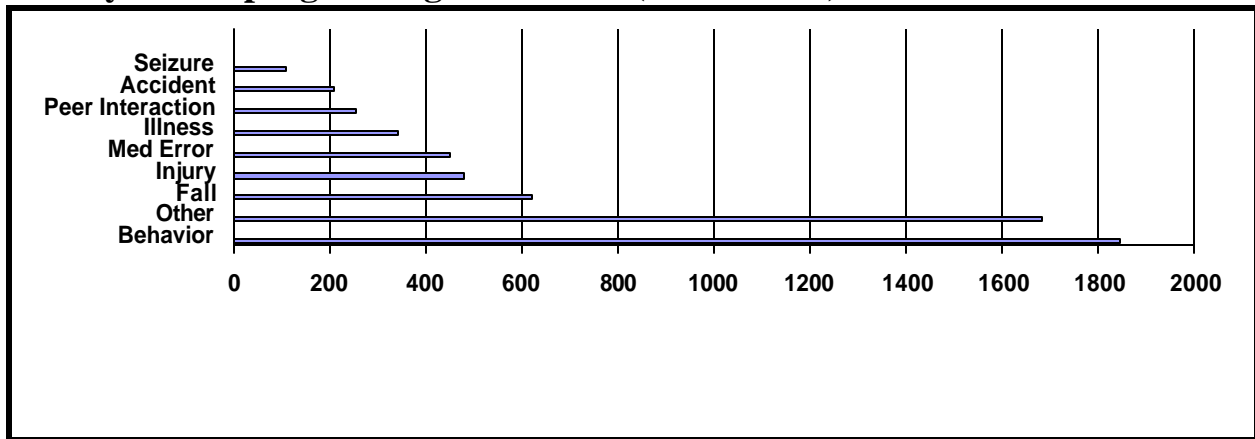
A total of four thousand seven hundred eighty five (4785) UIs within 30 days of the sample MUI were documented by providers for 1323 sampled individuals. This averages to 2.6 UIs per individual. Nearly a third (28.6%; n=531) of all sampled individuals had no UI documented within 30 days prior nor 30 days following. Figure 2 documents the percentage distribution of the number of UIs identified for individuals in the sample from review of provider records. More than half of documented UIs occurred prior to the MUI date (61.1%; n=2925) and just under forty percent (37%; n=1773) occurred after the MUI date.

**Figure 2: Distribution of Provider-logged UIs among sampled individuals**



When county board program logs were also included (n=1242), the total increased to six thousand twenty seven UIs (6027) UIs. Figure 3 presents all documented UIs by type. Behaviors are the most frequently documented UI type, followed by UIs falling outside of available categories, falls, injuries, medication errors, and illnesses. The high volume of UIs for this subgroup suggests the importance of provider action to preventing further UIs and potential MUIs. Targeted review of the relationship of UIs to MUIs may be warranted based on this initial study.

**Figure 3: Number of UIs by type for sampled individuals from Provider and County Board program logs combined (n=6027 UIs)**



Providers are required by the MUI rule to review UIs at least weekly. In the majority of cases in which any UI was documented for the sampled individual (77.3%; n=988), providers were able to document compliance with a weekly review. No statistically significant difference was identified between provider types for this measure. Inter-rater reliability in this area was not optimal; reviewers suggested that documentation of weekly review was inconsistent among providers. It was suggested that standardized provider UI and weekly review documentation would improve reliability of future data collection. Standardization may also help providers to learn to quantify data and evaluate patterns and trends.

Weekly review of UIs is expected to produce information about individuals experiencing a number of lower-risk incidents that could cumulatively threaten their health and welfare or suggest the potential for an MUI. UI “trends” that meet the MUI standard for reporting are defined in the rule as a “series of similar unusual incidents that may have an impact on the health and safety of an individual as determined during the weekly review...”. ODMRDD has produced an interpretive guideline to clarify the definition of “series”, requiring a Series MUI be filed when three (3) or five (5) similar UIs are filed respectively within a one-week or a 31-day period.

Individual UI documentation met the standard for Series MUI in under ten percent (9.7%; n=127) of cases where UIs were present. No significant differences were found between provider types for this measure. Overall, reviewers found that only two percent (1.9%; n=36) of all sampled individuals had UIs meeting the Series MUI requirement that were not reported. This question produced weak kappa agreement on the inter-rater analysis.

Inter-rater kappa values improved, however, when compliance with the UI review requirement for Series MUI was measured for both provider and County Board UI logs combined (kappa=.65). This was evaluated for all individuals for whom the location of the incident was the County Board program. Non-reporting percentages were consistent with the previous result (1.7%; n=25), suggesting that the high level of compliance found with Series reporting may be accurate. The coordination of review of UIs between agency and independent providers and County Board programs, however, was not directly evaluated. Individuals who are

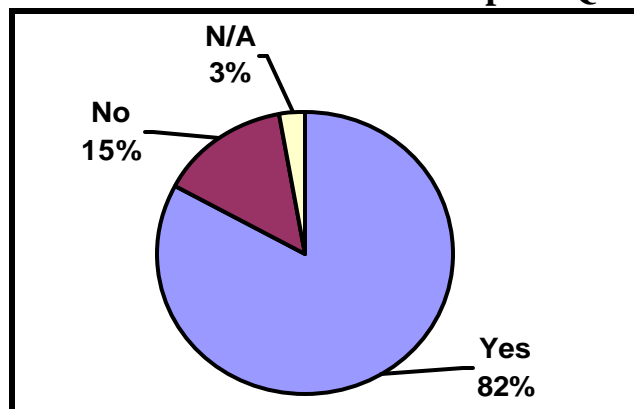
provided services and supports across provider settings may be at risk if documentation and prevention planning relative to the occurrence of UIs is not actively shared.

The volume of UIs for sampled individuals calls for further focus in this area. Although providers are generally compliant with the rule expectations, the weekly, quarterly and annual review requirements are inconsistent with the review’s intent- that trends identified during UI review will identify consumers at risk, and who have experienced events that meet the definition of a Series MUI. A weekly review, unless accumulated over a longer period, does not produce data adequate to document a Series MUI at the monthly threshold defined by ODMRDD. ODMRDD may wish to revisit this review requirement if its intent is to help providers identify individuals at risk.

### **Provider Identification and Review of MUIs**

The MUI rule requires that the provider receive and review quarterly reports of MUIs from the County Board. Among providers for whom there was documentation that county prepares and sends reports, a majority (82.7%; n=210) of providers were able to document receipt of quarterly reports. Less than fifteen percent (14.5%; n=37) were unable to provide documentation of receipt of quarterly MUI reports. Independent providers were not able to document receipt in nearly a third of cases (31.6%; n=6). Figure 4 below presents the percentage distribution.

**Figure 4 : Provider documentation of Receipt of Quarterly Report\***



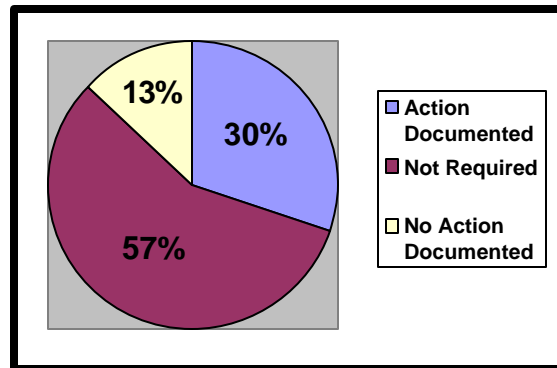
\*Calculated for subset of MUIs occurring in settings other than CB programs, and when reports were sent by the County Board (n=258).

When receipt of the quarterly report was confirmed, provider review was documented in three quarters of cases (75.0%; n=156). There were no significant differences in compliance to the review requirement among provider types. The inter-rater reliability test produced weak kappa agreement on this question; reviewers reported that there is no standardized documentation of this review, and many providers do not maintain documentation over time.

When review of the MUI quarterly report reveals a trend or pattern, providers are required to take action to reduce the reoccurrence of similar incidents. For all cases reviewed (n=1854), over half (56.6%; n=996) showed no identified pattern or trend relative to the sample MUI. In these cases, no intervention would have been required. In one third (30.4%; n=534) of

MUIs, providers were able to document action to prevent future similar incidents for the individual involved or for others potentially at risk. For the remaining thirteen percent (13%; n=229), an action plan would have been required based on trends and patterns in the quarterly report, but none was documented. The inter-rater reliability test produced weak kappa agreement on this question also. The construction of the question may not have produced results that were directly linked to the identification of trends and patterns.

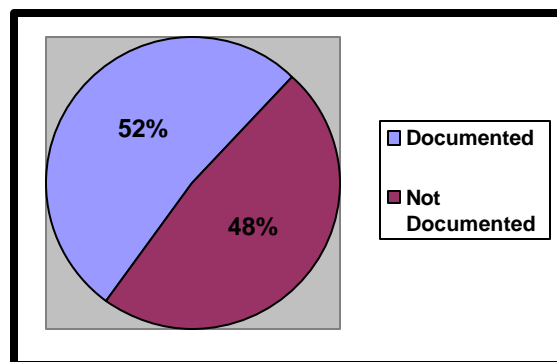
**Figure 5: Provider Action based on Review of Quarterly Report\***



n=1854; 95 missing

Finally, providers are required to conduct annual reviews of MUI trends and patterns. Just over half (52%; n=196) of providers produced documentation that an annual review for trends and patterns had been done. Forty-eight percent (48%; n=181) could not document compliance with this expectation. Independent providers were compliant with this expectation in only fourteen percent (14.3%; n=4) cases, compared to over fifty (51.7%; n=140) and sixty-eight percent (68.5%; n=50) compliance for agency and County Board provider types. Again, reviewers reported a lack of consistency in documentation and maintenance of annual review records, increasing the uncertainty of this result.

**Figure 6: Provider Compliance with Annual Review of MUI Trends/Patterns**

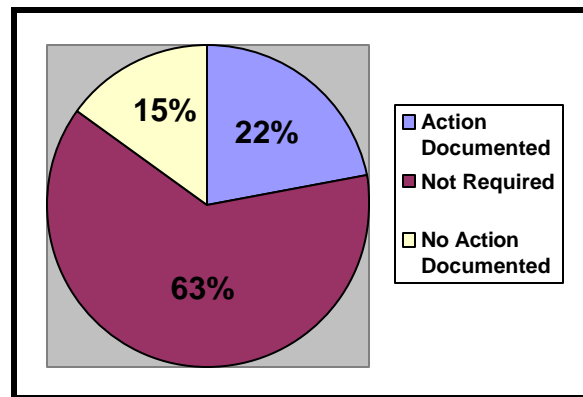


n=409 providers

Similar to the expectation for quarterly reviews, providers are expected to take action based on patterns and trends identified during the annual review, to reduce reoccurrence of similar incidents for the individual involved in the MUI. Similar to the quarterly review results, the majority produced no evidence of a pattern or trend for the individual in question, thus no action would have been expected (63.1%). In nearly a quarter (21.9%) of cases in which the

provider did conduct an annual review, action was taken in response to annual trends and patterns review. In just under fifteen percent (15%) of cases, action would have been appropriate, but was not documented. Inter-rater reliability on this measure was not optimal; like the quarterly review measure, the question's construction was compound and may have contributed to inaccurate results.

**Figure 7: Provider Action Taken based on Annual Review of MUI Trends/Patterns\***



\*for subset of MUIs for which providers documented annual review (n=1709)

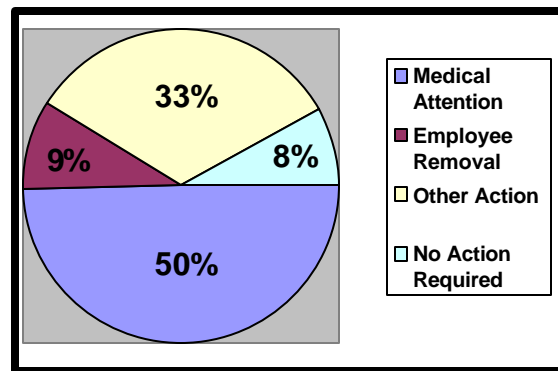
Quarterly review of the report sent by the County Board may or may not include analysis at the consumer level. There also appears to be no individual-specific review of UIs across providers. Thus, individuals might be experiencing UIs in one setting that do not meet the reportable Series MUI threshold, but if data were accumulated and reviewed across providers, actual risk would be identified. It is possible that the SSA, rather than providers should be charged with accountability for an individual-focused review across providers. Again, further review may be warranted to explore UIs as indicators of individuals' higher level risk.

### **Provider Immediate Action**

Reviewers were also asked to document whether providers took immediate action to ensure the individual's health and safety at the time of the incident. In 93% of cases (n=1683) reviewers verified that providers took some form of immediate action. A chi square analysis was not possible to evaluate significant differences by provider and MUI type, again due to small cell values. There was no significant difference identified between calendar quarters during the review period. MUIs involving RFW enrollees were slightly more likely to include evidence of immediate action than IO-enrolled individuals (chi square=6.0789; p=.0137). It is possible that the level of supervision in RFW homes is higher than that provided for IO consumers, and immediate action is therefore more likely for these individuals.

In 52% (n=877) of cases in which immediate action was taken (n=1683), medical attention was provided. Significant differences between provider types were found for this measure (chi square=19.7618; p<.0001). Agency and independent providers were slightly more likely than county boards to provide medical intervention. Predictably, medical attention was provided more frequently than would be statistically expected in combined Injury/Medical Emergency and Hospitalization/Suicide Attempt MUI types (chi square 1149.87; p<.0001).

**Figure 8: Percentage of MUIs by Type of Immediate Action**



(n=1683)

In just under ten percent of cases (9.5%; n=160) employees were removed from contact with the individual. No significant differences among provider types were found for this measure. In Abuse, Neglect and Misappropriation cases, staff removal occurred more frequently than statistically expected (chi square=313.95; p<.0001). This is consistent with the MUI rule requirement that staff be removed from contact when they are accused in these case types.

In Sexual Abuse allegations where immediate action was taken (n=61) staff were removed in just eight percent of cases (8.2%; n=5). It is not clear from this analysis whether the MUI rule requirement that employees be removed in allegations of Sexual Abuse is being met in all cases. Medical attention was provided in thirteen percent (13%; n=8) of Sexual Abuse cases, suggesting best practice in sexual abuse assessment is not being provided in many cases. The majority of cases of alleged Sexual Abuse involved other types of immediate action (65.6%; n=40), likely related to peers or non-employee PPIs, for whom removal from contact is not required.

Reviewers were asked to determine whether providers took steps that prevented reoccurrence of similar incidents for the individual involved in the MUI. The question was designed to evaluate whether similar incidents occurred subsequent to the sample MUI. In the large majority of cases (97.3%; n=1747) there was no evidence that additional related MUIs occurred for the sampled individual. No significant differences were found between provider types. Among MUI types, Neglect, Series and Behavior Restraint re-occurred more frequently than statistically expected (chi square=26.85; p=.0048). No statistically significant differences were identified by waiver enrollment or over the review period's four calendar quarters.

### **Provider Notification**

Reviewers were unable to find documentation that the provider notified the County Board of the MUI in six percent (6%; n=113) of cases. Independent providers documented notification slightly less frequently than would have been statistically expected (chi square=10.09; p=.0064). Timeframes for provider reporting were also evaluated. There was less than optimal inter-rater kappa agreement on this measure; reviewers found no standard for documentation of timeliness, so used a variety of sources to complete this field. In over forty percent of cases, (43.4%;

n=608) reviewers found no documentation of the time of notification to the County Board in the provider records. A second forty percent of cases (39.8%; n=558) were documented within the 24-hour required timeframe. In seventeen percent of cases, reporting was documented beyond the 24 hour expectation (16.8%; n=235). There were no statistically significant differences between provider types with regard to the timeliness of reporting. An analysis by MUI type was not possible due to small cell values.

**Table 17. Timeliness of Provider Reporting to the County Board**

<b>Response Time</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Within 24 Hours</b>	558	39.8%
<b>More than 24 Hours</b>	235	16.8%
<b>Unable to determine- not recorded</b>	608	43.4%
<b>Total</b>	<b>1401*</b>	<b>100%</b>

\*includes only cases for which documentation of County Board Notification was identified during the review

Providers are also required by rule to notify the individual’s guardian or advocate of the occurrence of the MUI within 24 hours of knowledge of the event. In the majority of cases (54%; n=980) notification was not required, as the individual was his or her own guardian or the guardian or advocate was identified as the PPI. In just over six percent (6.5%; n=118) of cases, required notification was not documented and in the remaining forty percent (39.9%; n=728), appropriate notification was found. No significant differences were found between provider types for this measure. In the majority of cases (84%; n=604) where notification was provided, it was done within 24 hours of the provider’s knowledge of the event. No significant differences were found between provider types for this measure.

**Table 18. Provider Notification of Guardian/Advocate of MUI**

	<b>Frequency</b>	<b>Percent</b>	<b>Occurring more frequently than expected for MUI Types</b>
<b>Notification Not Required</b>	980	53.7%	Abuse Hospitalization/Suicide Attempt Death Law Enforcement Misappropriation Relocation Rights Code
<b>Notification not Documented</b>	118	6.5%	Neglect Series MUI Misappropriation
<b>Notification Made</b>	728	39.9%	Injury/Med. Emergency Hospital/Suicide Attempt Behavior Restraint Missing Person
<b>TOTAL</b>	<b>1826</b>	<b>100%</b>	-----

## **County Board Reporting**

Reviewers were asked to determine whether the county board had documentation of receipt of the provider's written MUI report by 5:00 PM the day following the incident, as the MUI rule requires. In over half of sampled cases (55%; n=988) documentation of timeliness was identified. Among provider types, incidents occurring involving County Board programs were more likely to be documented timely than incidents involving agencies or independent providers (chi square=10.92; p=.001). No significant differences were found over the four quarters of the review. Interestingly, incidents for RFW individuals were documented statistically more frequently than expected and those for IO were documented less frequently than expected (chi square=10.9178; p=.001). No significant differences were identified by MUI type. Forty-three (43) counties failed to document receipt of the written report at a percentage higher than the statewide average.

County boards are also required to assure that cases meeting specified requirements be reported to the local Children's Services Board (CSB) or to law enforcement if the individual is over 18. It is important to note that the MUI definitions of Abuse and Neglect do not always meet the standard for reporting to these authorities. In ninety-nine percent (99%; n=1823) of cases, reviewers found that CSB reporting was not required. Less than one percent (.49%; n=9) of cases were identified as having been reported to CSB. For the seven cases in which a timeframe for CSB notification was available, most were compliant with the ODMRDD 24-hour requirement (71.43%; n=5). It should be noted, however, that the MUI rule requirement for 24-hour notification to CSB is not consistent with the immediate reporting requirement established by ORC 2151.421(A)(1)(a).

Generally, reporting to law enforcement was compliant with requirements. Law enforcement was notified in over one third of cases (34.25%; n=150). County Boards failed to assure that Abuse and Neglect were reported to law enforcement in less than three percent of cases (2.51%) when reviewers determined that the case met the criminal standard (ORC 5901.01). In over three quarters of cases (78.1%; n=114) the report to law enforcement was made within 24 hours, in compliance with the MUI rule. Inter-rater reliability was weak for the timeliness measure; reviewers report that the date and time were not always documented. The question's construction also led some reviewers to respond N/A when the report to law enforcement was made by someone other than the County Board.

In ninety percent of cases (89.7%; n=1639) County Boards assured that the Service and Supports Administrator (SSA) was notified of the MUI. During the last two quarters of the review, significant improvement was identified on this measure (chi square=109.37; p<.0001). By the fourth quarter of the review, SSAs were notified in nearly all (96.39%; n=615) cases. No significant difference was present between waivers, MUI nor provider types. Thirty one (31) counties were less compliant (had a higher percentage of "no" responses) than the statewide average for this measure. This notification requirement in the rule may intend to encourage the involvement of the SSA in support of the investigation and prevention planning for the individual. Unfortunately, this review was not able to confirm that notification accomplished these important goals. Further review and consideration will be required to determine whether incident documentation and prevention plans are actively considered part of service and supports

planning and implementation. The MUI rule’s requirement that providers document a prevention plan overlooks the SSA’s role in prevention and service planning.

Among incidents documented with the location County Board program (n=264) eight percent (7.9%; n=21) were found noncompliant with the rule’s requirement that the provider be notified. Sixteen (16) of the sixty-one (61) counties with any MUI occurring at a County Board program showed a deficit higher than the statewide average in notifying the paid provider. As with SSA notification, this component of rule is designed to integrate providers’ sources of information, to optimize coordination among agencies on behalf of the individual. Success with the notification requirement does not assure that prevention planning is actively integrated among providers and County Boards. Further review of assessment and care planning would reveal to what degree the reporting information is used.

Table 19 documents compliance of County Boards to each of the above measures. In general, compliance levels were high. Timeliness documentation was frequently missing.

**Table 19. County Board Notification Compliance**

<b>Reporting Requirement</b>	<b>Statewide Performance</b>
<b>Timely Receipt of Written MUI Report Documented</b>	compliant in 55% of cases
<b>CSB Notified</b>	noncompliant in <1% of cases
<b>Law Enforcement Notified</b>	noncompliant in 2.5% of cases
<b>Provider Notified</b>	noncompliant in 8% of cases

### **County Board MUI Review**

Reviewers sought County Board documentation that County Board reviewed UI logs at least quarterly as required by the MUI rule. In nearly three quarters (73.9%; n=1345) of cases, this documentation was found. Cases in which the County Board was also the provider were statistically more compliant with this requirement (chi square=614.05; p<.0001). Incidents involving RFW consumers were statistically more likely to be out of compliance for this requirement (chi square=15.54; p=.0004). Compliance was significantly less likely than expected for Neglect, Injury/Medical Emergency, Death, Series, Relocation and Missing Person MUI types (chi square=63.59; p<.0001). No significant difference was identified over the review period’s calendar quarters. Notable improvement is apparent over time from the data, although it does not reach the statistically significant threshold. Reviewers reported perceived improvement over time on this measure as well. Twenty (20) County Boards had average compliance as a percentage less than the statewide average. Inter-rater kappa values were less than optimal for this measure. Reviewers cited a lack of standardized documentation as a challenge to consistent measurement.

County Boards are required to prepare quarterly reports of MUIs for providers involved in MUIs to help identify patterns and trends for providers and individuals. In almost ninety percent (89.5%) of sampled MUIs, County Boards were found compliant with this measure.

Again, observable improvement was apparent in the data over the four calendar quarters of the review, but the differences were not statistically significant. No differences were noted between MUI types, and none were expected. Compliance with this standard was significantly more prevalent for the agency provider type (chi square=35.91; p<.0001). Seventeen (17) counties were out of compliance statistically more frequently than the statewide average, as a percent of each county's sample caseload.

County Boards are required by rule to review each MUI upon receipt. In ninety-nine percent (99%) of sampled cases, this documentation was available (n=1819). When timeliness was evaluated, nearly half of cases had no review time documented (47.5%; n=858). As with all of the timeliness measures, reviewers had difficulty evaluating timeliness due to inconsistent documentation sources. Inter-rater kappa values on this measure were less than desirable.

**Table 20. Timeliness of County Board MUI Review**

<b>Documented Time of Review</b>	<b>Number</b>	<b>Percent</b>
<b>Within 0-4 Hours</b>	322	17.8%
<b>Within 5-8 Hours</b>	241	13.3%
<b>Within 9-16 Hours</b>	72	4%
<b>Within 17-24 Hours</b>	136	7.5%
<b>More than 24 Hours</b>	178	9.9%
<b>Unable to Determine- Not recorded</b>	858	47.5%
<b>Missing</b>	12	-----
<b>Total</b>	<b>1819</b>	<b>100%</b>

No significant difference was found over the review period's four calendar quarters. No differences were found between waivers or MUI types. Differences among provider types were significant (chi square=20.39; p=.0257). Incidents for which the County Board or Independent provider were identified as the provider type were more likely than expected to be reviewed in 0-4 hours. Interestingly, these were the same types that were not documented more frequently than statistically expected. Incidents in which an Agency provider was involved were more likely than expected to reviewed in the 5-8, 9-16 and more than 24-hour categories. Thirty-five (35) counties had percentages of cases reviewed in more than 24 hours higher than the statewide average.

## County Board Investigations

In general, County Boards were found compliant with all investigation requirements set forth in the MUI rule. Table 21 documents the percentage compliance with each of the measures evaluated during this review.

**Table 21. County Board Compliance with Investigation Requirements**

<b>Measure</b>	<b>Percent Compliance</b>	<b>Number</b>
<b>Assured Reasonable Measures to Protect Health &amp; Safety</b>	99.9%	1798
<b>Documented Reasonable Measures to Prevent Reoccurrence</b>	97.7%	1756
<b>Separate Investigation Performed When Required</b>	91.6%	11 of 12 cases
<b>Maintain a Copy of Completed Investigation</b>	97.9%	1780
<b>Certified IA performed Investigation</b>	89.6%	1639
<b>Written Summary of Findings to Provider</b>	74.2%	1349
<b>Notification to Provider of Investigation Closure</b>	49%	880
<b>Notification of Written Summary of Findings to Individual or Guardian</b>	68.95%	1248

Reviewers were asked to determine whether there was documentation that the County Board assured that reasonable measures were taken to protect the individual's health and safety. In nearly all cases (99.9%; n=1798) reviewers identified documentation of adequate assurance. No significant differences between waivers, provider types or across review period quarters were identified. Among MUI types, assurance was documented less frequently than expected for Abuse, Neglect and Behavior Restraint MUI types (chi square=19.71; p=.0495). Just fourteen (14) counties had cases for which adequate assurance was not found with percentages higher than the statewide average.

Reviewers were asked to identify whether the MUI involved any party as PPI that would require a separate investigation by ODMRDD. In just twelve (12) cases that meet the MUI rule

definition requiring a separate investigation, (County Board management staff, Board members, individuals with a known relationship to the County Board, or County Board staff member for certain MUI types) was this relationship identified. In all but one of those cases, a separate investigation was done as required.

In nearly all cases (97.9%; n=1780), County Boards were found compliant with the expectation that they maintain a copy of the completed investigation. No differences were found among calendar quarters, waivers, or provider types. Among MUI types, Hospitalizations and Suicide attempts (combined) were less frequently maintained than statistically expected (chi square=22.04; p=.0241). Just fourteen (14) counties produced percentages compliant lower than the statewide average.

In the majority of cases (89.6%; n=1639), a certified Investigative Agent (IA) performed the investigation. In the remaining cases, an SSA (5.85%; n=107) or another individual (frequently a case manager, County Board compliance specialist, or non-certified IA) performed the investigation (4.59%; n=84). Increases in the frequency of IA investigators were significant over the sample period's four calendar quarters, and similar decreases in the SSA and Other categories were found. Marked differences were seen between second and third quarters (chi square=101.46; p<.0001). This may be explained by the IA Certification Rule (OAC 5123:2-5-07) effective date in March 2002. An Information Notice was issued by ODMRDD (June 7, 2002) suggesting the IA implementation should be completed by July 1, 2002).

County Boards are required to provide a written summary of the results of the investigation to the provider, unless that provider is the PPI. In nearly three quarters of cases (74.2%; n=1349) County Boards produced documentation that providers were provided a written summary. In nearly one quarter (23.5%; n=427) of incidents, providers were not given a written summary. In just two percent of cases (2.31%; n=42) providers were not notified because they were identified as the PPI. This figure is much lower than the over four hundred (404) MUIs in which paid staff were identified as PPI. When provider type is considered, agencies were notified in writing more frequently than statistically expected (chi square=50.79; p<.0001). Thus, it is likely that agencies are being notified of the outcome of the investigation in writing when their staff are identified as PPI. The same analysis suggests that independent provider types are not provided a written summary when they are not PPI more frequently than expected. Thirty one (31) counties were compliant with this requirement more frequently than the statewide average percentage of sampled cases. Fifty-seven (57) counties were compliant less frequently than the statewide average.

These written statements are required to include a provider's right to submit comment to the County Board. In ninety-two percent (92%; n=1235) of cases, when written notice was sent, the opportunity to submit comment was included. No differences among waivers or provider types were identified for this measure. Twenty-seven counties (27) counties were identified with percentage noncompliance higher than the statewide average.

Reviewers were asked to determine whether the County Board had documented that it had taken measures to prevent reoccurrence. Documentation of action was identified in almost all (97.7%; n=1756) cases. No significant differences were identified among MUI types or waivers. Twenty-two counties had percentage non-compliance higher than the statewide average for the sample. Reviewers were not trained to evaluate the adequacy of measures taken, thus, the

presence of preventive measures of any type was documented as compliant with this standard. Further evaluation would determine the adequacy of measures to prevent reoccurrence of incidents.

County Boards are required to notify the provider when the incident is closed. In nearly half of all cases (49%; n=880) County Boards documented compliance with this requirement. County Boards notified providers slightly less frequently than expected for Rights Code Violation, Missing Person, Death, Series MUI types (chi square=35.76; p=.0322). In nearly half of sampled cases (47.7%; n=856), no notification of formal closure was documented. Cases for which the provider was PPI or for which no provider was documented were excluded from these figures. Thirty-eight (38) counties were not compliant with this expectation at a percentage higher than the statewide average.

County Boards are also required to provide a written summary of investigation findings to the individual or guardian/advocate. Reviewers documented compliance with this expectation in over half (68.95%; n=1248) of cases. In over another quarter (28.7%; n=519), there was no documentation of a written summary to the individual or guardian when there should have been. No significant difference was found among provider types. Among MUI types, summaries for Death, Rights Code, and Injury/Medical Emergency were sent less frequently than statistically expected (chi square=148.69; p<.0001). ODMRDD advises counties that written summaries to families are not required in Death cases. Compliance with this standard improved significantly over the four calendar quarters of the sample period (chi square=70.04; p<.0001). Thirty-three (33) counties were noncompliant at a higher percentage than the statewide average for this measure.

For those written summaries that were sent, the majority (94.9%; n=1185) did also include the right to submit written comments to the County Board. No significant differences were identified across calendar quarters, provider or MUI types. Just ten counties were noncompliant with this standard at a percentage higher than the statewide average.

Again, it is unfortunate that the rule does not include the SSA as a required recipient of the written summary, as this individual may be the best source for planning and implementation of an effective prevention plan across provider settings.

## **Investigation Outcomes**

Reviewers were asked to identify whether any policy or procedural changes were made as a result of the incident and investigation. Most frequently, reviewers determined that policy revisions were not appropriate or necessary, given the circumstances of the incident (92.3%; n=1693). In a small number of cases (3.3%; n=60) policy changes were identified. In slightly more cases (4.5%; n=82), reviewers found no change in policy or procedure but perceived that such a change would have been appropriate. No differences were identified by calendar quarter, waivers, provider type for this measure.

No additional background screening methods were instituted as a result of MUI investigations. Hiring practices were changed in just seven (7) cases, representing less than one half of one percent (.38%) of all cases reviewed.

Individual Plan (IP) changes occurred as a result of the investigation in nearly a third (27.8%; n=506) of sampled cases. A chi square analysis suggested that Hospital/Suicide attempts, Law Enforcement, Series MUI, Unapproved Behavior Restraint, Missing Person and Rights Code Violations produced changes in IP's more frequently than expected (chi square=127.35; p<.0001). No differences were found among provider types, waivers or across the review's calendar quarters. Twenty-four (24) counties had percentages of "no changes to IP" higher than the statewide average percentage of sampled cases.

**Table 22: MUI Types that produced an ISP change more frequently than expected**

<b>MUI Types that produced an ISP change more frequently than expected*</b>
Unapproved Behavior Restraint
Series MUI
Law Enforcement
Missing Person
Hospitalization/Suicide Attempt
Rights Code Violation

\* in order of statistically significant differences from expected values

IP changes were produced by trend or pattern identification in under ten percent (9.2%; n=168) of cases. In a small percentage of cases, (3.56%; n=65) reviewers determined that a change was warranted, but not made. Series MUIs, Behavior Restraint and Missing Person produced statistically more "yes" responses than expected (chi square=171.53; p<.0001). Differences among provider types, waivers and calendar quarters of the review were not identified. Thirty-three counties had percentages higher than the statewide average for "yes" answers to IP changes produced by individuals' trends or patterns. Reviewers' inter-rater results were less than desirable for this question; the timing of evaluating IP changes after trends identification was unclear and behavior support plans were not consistently identified as IP changes.

Reviewers were asked to seek documentation of IP change implementation. In three quarters of cases (74.7%; n=392) of cases where IP changes were made, implementation of the change was documented in the record. The remaining quarter (25.3%; n= 133) had no documentation that the IP change had been implemented. Implementation occurred slightly more frequently than expected for RFW enrollees and slightly less frequently for IO enrollees (chi square=6.4820; p=.0391). County Board providers documented implementation more frequently than expected and independent and agency providers documented implementation somewhat less frequently than expected (chi square=11.9698; p=.0176).

In fewer than five percent of cases (4.2%; n=76) reviewers found the case to warrant an assessment when one was not done. Just over a third (39.7%; n=720) of investigations recommended any assessment for the individual involved. Table 23 presents the percentage of the total sample that produced the performance of an assessment, by type. It also describes statistically significant differences among provider types, waivers and MUI types.

**Table 23. Assessment Types performed as a result of MUIs**

Assessment	Number	Percent of Sample MUIs	Provider	Waiver
Medical	580	31.3%	Agency, IP (p=.02)	RFW (p<.0001)
Psychological	114	6.2%	None	None
Behavioral	91	4.9%	County Board (p=.01)	None
Environmental	39	2.1%	None	None
Neurological	20	1.1%	None	None
OT/PT/ST	39	2.1%	None	None
Other	81	4.4%	None	None
N/A (none appropriate to incident circumstance)	952	51.4%	None	IO (p=.0434)
<b>TOTAL</b>	<b>1916</b>	<b>-----</b>	<b>-----</b>	<b>-----</b>

Reviewers were asked to determine whether training practices had been changed at the provider or county board agency as a result of the sample MUI. In just under five percent of cases (4.7%; n=85) training practice changes were noted. No difference among provider types was found.

Reviewers were then asked to determine whether any training activities took place as a result of the investigation. Training activity took place more frequently than policy change, in nearly one quarter of MUIs sampled (23.5%; n=426). In just a few cases (4%; n=72) training was merited, but did not occur. In the majority of cases, training was not determined appropriate given the incident’s circumstances (72.6%; n=1316). County Boards were more likely than expected to have documented training activities. They were also more likely than expected to have not provided training when the reviewer perceived they should have (chi square=18.02; p=.0012).

**Table 24. MUI Types for Which Training Activity occurred more frequently than expected**

MUI Type*
Unapproved Behavior Restraint
Neglect
Missing Person
Series MUI
Rights Code Violation
Abuse

\*chi square=272.48; p<.0001

Reviewers were asked to identify any additional measures taken to protect the individual from further incidents. Additional measures were defined as any action taken to protect the individual that was not specifically evaluated in earlier questions. In half of all cases (49.8%; n=904) some additional measure was taken. No differences were identified among provider types. MUI types produced significantly different results than would have been produced by chance, as presented below.

**Table 25. MUI types for which “additional measures” were taken more frequently than statistically expected**

<b>MUI Type*</b>
Neglect
Misappropriation
Unapproved Behavior Restraint
Series MUI
Abuse
Missing Person

\*chi square=131.89; p<.0001

Prevention plans are a required part of each investigation, per the MUI rule. Prevention planning was evaluated for content as part of this review. Inter-rater reliability was not optimal for any of these modification/prevention content types, except environmental modification. Question construction in this area was perceived by reviewers to be unclear. Frequencies of response, however, are presented in Table 26.

**Table 26. Frequency of Prevention Plan Content Type**

<b>Modification/Prevention Content Type</b>	<b>Number/Percent of Sample MUIs</b>
Individual Service modification	682 (37.9%)
Staffing/Supervision modification	540 (29.8%)
Service/Support or QA oversight modifications	216 (11.9%)
Environmental modification	152 (8.3%)

Most frequently, when cross-tabulations were applied, prevention plan content was absent and no change to the ISP was made (chi square=41.59; p<.0001). When ISP changes were found, environmental modification in prevention plans occurred more frequently than expected. The same analysis suggests that environmental modification was identified in prevention plan content and no change was made to the ISP.

Similarly, for individual service modification prevention plan types, the most significant difference between actual and expected results suggests that individual service modification prevention plan content was not identified and no ISP change was made. When this prevention plan content was found, however, changes were made to ISP's more frequently than expected (chi square=451.09; p<.0001).

Staffing/supervision prevention plan content had similar results (chi square=80.99;  $p<.0001$ ) as did Service/support or Quality Improvement oversight needs content (chi square=.129.34;  $p<.0001$ ).

The review did not include verification of the content of the ISP change, only that the change occurred. It is hoped that the change to the ISP was in fact reflective of the prevention plan content. Unfortunately, the strongest results were in the lack of prevention plan content and lack of ISP changes. The link between the investigation and successful service planning can only be effective if the ISP is adapted to reflect the content of the prevention plan. MUIs should be considered sentinel events that invite reconsideration of the ISP. Currently, the MUI Rule requires County Boards to ensure only that patterns and trends are addressed in the individual's ISP. The proposed Service and Supports Administration Rule (SSA) alludes to the need for coordination, but no strong linkage has yet been made.

## **MUI Accuracy**

Reviewers were asked to assess the accuracy of the categorization of the MUI given all the information available. In nearly all cases (96.7%;  $n=1770$ ) reviewers agreed with the categorization identified in ITS. No significant differences were found between provider types, waivers, nor over the review period's four calendar quarters. Among those MUIs for which reviewers disagreed, areas of disagreement occurred more frequently than expected (chi square=25.57;  $p=.0075$ ) among certain MUI categories. Table 27 presents those MUI categories that were disagreed with more frequently than statistically expected, and the categories most frequently recommended by reviewers. Only one county had a percentage disagreement higher than the statewide average.

Reviewers were asked to determine if the PPI was noted on Page 1, from ITS, of the MUI report. In just under twenty percent (19.2%;  $n=354$ ) cases, the PPI was identified in the PPI field from ITS. In another fourteen percent of cases (13.7%;  $n=252$ ) the PPI was not noted in this field, but was identified elsewhere in the report. The majority of cases noted no PPI at all (67.1%;  $n=1237$ ). This field significantly improved during the last quarter of the review (chi square=13.56;  $p=.0348$ ). The PPI field was completed in ITS more frequently when County Board was the provider type than for independent or agency types (chi square=12.84;  $p=.0121$ ). This field was empty more frequently than expected for County Board provider types also. This result would suggest that PPIs were identified more frequently than expected, whether present in the PPI field or otherwise in the narrative.

Reasonably, Abuse, Neglect, Law Enforcement, Series MUI, Misappropriation and Rights Code Violations produced higher than expected volume documentation in the PPI field. Abuse, Neglect, Law Enforcement, Series MUI, Unapproved Behavior Restraint, Missing Person and Rights Code Violation were more frequently than expected not present in the PPI field, but were otherwise in the narrative (chi square=940.01;  $p<.0001$ ). Thirty four (34) counties produced higher percentages of "no" responses, suggesting that PPIs are frequently identified only in the MUI narrative text. Lack of PPI identification in this field will continue to prevent the systematic identification of individuals who are frequently involved in MUIs and who may present future risk to individuals with MR or DD.

Similarly, reviewers were asked to identify whether involved staff were identified in the MUI report by name, when they were not identified as PPI. In just under half (49%; n=897) of cases, involved staff were noted by name. In almost a third (31.6%; n=579) of cases, no staff were involved. Thus, nearly a fifth (19.4%; n=355) of sampled MUIs had no involved staff named, although staff were involved in some way. MUI investigations involving County Boards, again, more frequently than expected identified involved staff by name (chi square=27.79; p<.0001). The same analysis suggests that MUIs involving agencies and County Boards are less frequently identifying staff by name when staff is involved. There is a field in ITS for this which is infrequently used. Tracking this information, although not as significant as PPI names, may help identify staff who are involved in MUIs more frequently than others for further analysis. Thirty-five (35) counties produced higher percentage “no” responses than the statewide average.

A prevention plan descriptive field is required as a component of the ITS database. Reviewers were asked to identify how often a prevention plan was included in the MUI investigation. In the clear majority of cases (86.7%; n=1586) there was a documented prevention plan in the report. In just a few cases (3.5%; n=64) there was no plan documented when one would have been expected. No differences were identified among provider types for this measure. Differences were not found across the calendar quarters of the review. This review did not evaluate the adequacy of prevention planning as a response to the MUI. Twenty one (21) counties had percentages of prevention plans missing higher than the statewide average for this measure.

Prevention plans cannot be effective unless they are implemented. Reviewers were asked to note whether there was documentation of the prevention plan anywhere in the MUI records. In three quarters of cases (75.1%; n=1370) positive documentation was found. In a smaller percentage of cases (12.6%; n=230), no documentation was found, but a prevention plan had been developed. Less than optimal inter-rater agreement resulted for this question. Reviewers cited inconsistent documentation of prevention plan implementation as the source for variation in responses. Differences were not identified among provider types nor across the review’s calendar quarters. MUI categories were significantly different than expected (chi square=432.94; p<.0001). Just twenty (20) counties had percentages with no documentation higher than the statewide average.

**Table 27. Prevention Plans implemented more and less frequently than expected, by MUI Type\***

<b>Implemented more Frequently than Expected</b>	<b>Implemented Less Frequently than Expected</b>
Series MUI	Rights Code Violation
Unapproved Behavior Restraint	Neglect
Missing Person	Misappropriation
Hospital/Suicide Attempt	Abuse
-----	Injury/Medical Emergency

\* chi square=432.94; p<.0001

## **Adverse Outcomes Review Protocol**

Reviewers were involved in a large number of investigative records, each associated with a particular incident and individual waiver enrollee. There are always a number of problems or questions that arise from this level of exposure to consumer information. Thus, as with all programmatic reviews, the ODJFS Adverse Outcomes (AO) process applied. The Adverse Outcome process is designed to evaluate reviewers' concerns that "a sub-recipient has failed to meet basic standards of care resulting in a threat to health and welfare" (See Appendix A). Sixty-nine (69) referrals were made to the AO Committee during this review, in the following categories:

**Table 28: Adverse Outcomes by Level**

<b>Adverse Outcome Reports</b>	
Low	64
Programmatic	5

Low-level AO submissions are defined as those reviewer-identified concerns that are a minimal threat to health and welfare but where failure to correct could result in potential future harm. The majority (92.8%; n=64) of reports during this review met this definition; most involved what reviewers understood was a situation that represented a potential MUI. All low level findings required response from ODMRDD. Six (6) low level submissions resulted in new MUIs, investigated through ODMRDD's process. The majority (90.6%; n=58) required only a plan of correction. Low-level provider issues included the failure to establish policy and procedure for incident reporting and the failure to identify consumer trends and patterns reportable as incidents. Failure to develop policy and procedures was noted more frequently with independent providers. Other issues identified during this process included the failure to integrate preventive recommendations into service plans and a failure to take action to prevent reoccurrence of incidents.

Programmatic AO submissions suggest the need for corrective action to improve the overall quality of Medicaid services. Just five (7.2%; n=5) Programmatic AO reports were submitted to ODMRDD's MUI Unit; for these, no plan of correction was requested. Some of these reports identified patterned failure to implement prevention plans. Others were filed regarding documentation patterns, such as providers' use of unusual incident (UI) reporting in lieu of specific behavior support documentation, or inconsistent documentation of medication administration.

Nearly fifteen percent (14.5%; n=10) of all AO reports were filed in a single county where ODMRDD was previously aware of significant reporting and programmatic issues. The review findings and AO submissions in this county helped ODMRDD to pinpoint areas of noncompliance more specifically for technical assistance.

A total of 62 individuals, 32 counties and 47 providers were impacted by the AO process. AO reports were followed until resolution by the Adverse Outcomes Committee. Regular updates were requested from ODMRDD. All Adverse Outcome Reports resulting in an MUI being filed were also monitored by ODJFS' PFH staff. On average, Adverse Outcome Reports

were open for 56 calendar days. The following outlines the status of reports filed at the end of the review period.

**Table 29: Adverse Outcomes Post-Review Status**

AO Status	
Withdrawn from consideration	13 (18.8%)
Closed with recommendations	10 (14.5%)
Closed with no recommendations	46 (66.7%)

AO Committee recommendations generally suggested that information identified in the MUI investigation be included in an individual’s service plan, prevention plan and provided specific direction regarding the implementation of those plans. The committee was frequently in disagreement with ODMRDD’s decision not to file an MUI based on the circumstances of the AO submission. In many of these cases, AO Committee consensus determined to close these cases with recommendations to ODMRDD. Three (3) cases in which an MUI was filed were closed with recommendations.

**“Alerts” Concurrent Monitoring & Oversight**

Incidents occurring for MRDD waiver recipients that meet certain high-risk criteria are called “Alerts” and are concurrently reviewed by ODJFS Protection from Harm unit staff. This incident review process is part of ODJFS’ ongoing monitoring procedure. For this report, only incidents that occurred during the review period are presented. Incidents meeting these criteria are called “Alerts”. Alerts are identified through referral from ODMRDD or by the ODJFS standard case review process. Circumstances that define an “Alert” include:

- Deaths: suspicious, accidental, or unusual
- Abuse: resulting in hospital admission or removal from the home.
- Neglect: resulting in hospital admission or emergency removal from the home.
- Injury: unknown origin requiring hospital admission, or any resulting from a behavior support technique.
- Serious allegations involving a county board or ODMRDD administrator.
- Incidents that warrant separate investigation by ODMRDD, including incidents that relate to a complaint about another investigation.
- Other accidents/events that result in harm to multiple individuals.
- Publicity: Cases appearing in the media or having contact with CMS.

“Alerts” are concurrently reviewed bi-weekly through ODMRDD’s Incident Tracking System (ITS). If outstanding health and welfare concerns are identified, ODMRDD Regional Managers are contacted to ensure ODJFS oversight concerns have been addressed. A total of fifteen (15) incidents occurred during the sample period for IO and RF waiver enrollees. This represents all cases that met any of the above criteria. A retrospective analysis of these fifteen (15) incidents follows.

**Table 30. Number of Alerts Filed during the Sample Period by Category**

Alert Categories	Number Filed
Suspicious, accidental, or unusual death	8 (53.3%)
Abuse/Neglect resulting in removal from home	3 (20%)
Injury due to behavior support technique	2 (13.3%)
Injury of unknown origin requiring hospitalization	1 (6.6%)
Cases appearing in the media	1 (6.6%)

**Table 31. Alerts by MUI Category Filed**

MUI Rule Categories	Number Filed
Abuse	4 (26.6%)
Neglect	2 (13.3%)
Injury	1 (6.6%)
Death	8 (53.3%)

The “Alerts” filed as Injury due to behavior support technique were filed as Abuse MUIs in the MRDD system. “Alerts” were filed for thirteen (13) county boards and thirteen (13) unique providers, both independent and agency. Thirteen (13) of the incidents occurred in non-county board operated programs.

All “Alerts” are evaluated to determine what, if any, direct harm came to an individual as a result of the incident. Harm is categorized by physical, sexual, mental, or other medical harm, including death. Physical harm includes injuries such as lacerations, fractures, bruising, and burns. Psychological harm includes mental health issues that arise as a result of or related to the incident. Sexual harm may include physical harm to sexual organs indicative of sexual assault. Alerts filed during the sample period indicated the following impact:

**Table 32: Alerts by Type of Harm**

Type of Harm	Individuals
Injury	3 (20%)
Psychological Harm	1 (6.7%)
Other Medical Harm	9 (60%)

Immediate protection is assessed to assure that the health and welfare of waiver recipients is attended to when an incident occurs. Immediate protection includes seeking medical attention by trained personnel, including emergency room visits, hospital admissions, treatment by medical professional (i.e. EMS or nurse) or treatment by other trained staff. Additional areas of immediate protection that are tracked include removal of the PPI, use of aversive behavior procedures, Relocation of the individual harmed, environmental modifications, and law enforcement notification. During the sample period, the following immediate protections were observed:

**Table 33: Alerts by Type of Immediate Protection**

Immediate Protection	Frequency/Percentage
Medical Attention	11 (73%)
PPI Removed	3 (20%)
Behavior Intervention Used	1 (6.7%)
Individual Relocated	2 (13%)
Law Enforcement Notified	4 (27%)

“Alert” cases are assessed for the incident cause and the prevention plan response to the cause. Incidents may have multiple causes and prevention plan components. Causes are categorized by type and include environmental factors, care planning issues, and action or inaction by individual, peer, staff, or family. The following are the causes of incidents that were filed as “Alerts” during the sample period:

**Table 34: Alerts by Type of Cause**

Cause	Number Impacted
Environmental	3 (20%)
Individual behavior and/or action	1 (6.7%)
Staff Action and/or inaction	9 (60%)
Family Action and/or inaction	1 (6.7%)
Lack of care planning and/or management	2 (13.3%)
No identified Cause	1 (6.7%)

Prevention plans were evaluated to determine if an assessment was completed and what the plan included. Assessments include environmental, individual needs, staffing needs, and service planning. Prevention plan content includes service delivery changes, increased supports (i.e. counseling, specialized therapies), environmental modifications, and services plan updates.

**Table 35: Alerts by Type of Assessment Provided**

Assessments	Number completed
Environmental	0 (0%)
Individual Needs	5 (33.3%)
Staffing Needs	3 (20%)
Care Planning Needs	1 (6.7%)

Prevention plans are also evaluated to determine what action resulted from the assessments. This includes a variety of environmental, service, support, or care plan changes based upon the cause of the incident under review. Environmental actions include removing barriers and/or dangerous objects, and home, equipment, and furniture modifications. Individual service changes include medical or psychological services, counseling, behavior supports, or specialized therapies. Staffing changes include increased hours or supervision, retraining, or staff Relocation. Care coordination actions include increased oversight (i.e. home visits), quality reviews, provider reviews, or service plan revisions. During the review period, the following were actions noted as a result of the above assessments:

**Table 36: Alerts by type of Action Taken after Assessment**

Action	Number changed
Individual Service Changes	6 (40%)
Staffing Changes	2 (13.3%)
Care Coordination Changes	1 (6.7%)

It is interesting to note the lack of or ISP changes resulting from prevention plans. Although individual service changes are often indicated, there is rarely documentation of a corresponding service/care plan update. Protocol from ODMRDD indicates that plan updates are recommended when an individual experiences a particular medical condition that would indicate frequent hospitalizations, a trend of anticipated incidents or known behavior issues that may prompt additional MUIs to be filed. Currently, care plans or ISPs are required to be updated whenever a change in condition occurs.

Finally, prevention plans are evaluated to determine whether or not they were implemented, if the plan addressed the needs of the individual, if the plan related to the cause of the incident, and whether or not the plan addressed re-measurement. In the review period, eight (8) cases indicated that a prevention plan was not applicable. By ODMRDD standards, most death cases do not warrant a prevention plan, so many counties choose not to develop prevention plans for death cases, indicating not applicable. Of those alerts with prevention plans, the following are results of the above evaluations:

**Table 37: Distribution of Prevention Plans after evaluation**

Prevention Plans	
Prevention Plan Verified	7 (46.7%)
Prevention plan addressed individual's needs	5 (33.3%)
Prevention plan related to the incident cause	7 (46.7%)
Prevention plan addressed re-measurement	0 (0%)

Due to the nature of the cases involved, alert incidents are very detailed. Below is a summary of the length of time to close these incidents, averaging 187 calendar days. Cases designated as alerts can be understood to take longer if there is law enforcement or child protective services involvement. Also, death cases overall tend to take longer when waiting on autopsy or coroner information.

**Table 38: Average Days to close “Alerts” incidents**

<b>Incident Category</b>	<b>Average calendar days from incident date to close</b>
Abuse	137
Neglect	253
Injury	38
Death	215
<b>Total Average</b>	<b>187</b>

### **Conclusions**

Although ODMRDD had administered a pre-existing consumer incident management process, the development and implementation of ODMRDD’s MUI Rule (OAC 5101:2-17-02) and the Incident Tracking System was primarily a response to CMS oversight concerns. This review was designed to evaluate the ODMRDD delivery system’s compliance with newly-developed rule requirements related to reporting, investigation and prevention of harm for waiver-enrolled individuals experiencing MUIs. The review’s scope was broad and focused primarily on process compliance to rule expectations. Generally, results of this review are positive, and reflect a high level of compliance with the incident reporting, investigation and management rules set forth by ODMRDD. Administration across waivers and among provider types was generally similar, suggesting consistent application of rules in most cases.

Over the three years of implementation, the volume of incident reporting for ODMRDD’s entire service population has leveled to just over 250 MUIs per 1000 enrollees. ODJFS’ calculation of MUI occurrence rates for Medicaid waiver populations during the sample period showed that MUIs for waiver enrollees are reported at rates more than 35% higher than for the general MRDD population. Combined IO and RFW waivers produced an MUI rate of 344 per 1000 individuals for the sample period. This is not a surprising result, as waiver enrollees by their level of care may be more vulnerable to all types of reportable incidents. Their high level of involvement with service providers may also increase the likelihood that incidents that occur are also reported.

Overall, ODMRDD has performed well in establishing a tracking system that accumulates information about incidents occurring for individuals with MR and DD. County Boards of MRDD and provider organizations have responded to expectations and requirements to produce the outcomes presented in this report.

Now that reporting and investigation capacities are in place, focused analysis of those incidents and related trends can begin. Analysis should be designed to target interventions that can successfully reduce future occurrences and improve the system's overall performance. ODJFS and ODMRDD, along with the County Board and provider communities will be called upon to partner in the successful development of these initiatives.

## **Recommendations**

***1. ODMRDD should improve the ITS data system's capacity to perform analysis that distinguishes individuals' enrollment category and providers' unique identifying numbers. It should also require the use of the PPI data field when alleged involvement is identified after initial data entry.***

ODMRDD does not currently calculate waiver-specific prevalence nor incidence rates, so comparison with their general service population has not been possible on an ongoing basis. ODJFS recommends changes to the ITS system that assure ODMRDD can identify rates and trends specific to the waiver populations.

ODJFS has requested the inclusion of an accurate waiver-indicator field to the ODMRDD ITS reporting function. Data system issues were also a factor in developing this review's sample, as the ITS database does not include a unique identifier (SSN or MMIS number) for individuals involved in MUIs. Also, neither an accurate provider number nor provider type is available from the ITS database, so ODMRDD has no ready systems capacity to evaluate incident occurrences among its provider network.

Improved data management capacity will allow ODMRDD to measure the effectiveness of waiver enrollee health and welfare protection in the future. This capacity will allow administrators to evaluate differences between waivers and to compare waiver enrollees' experience with that of the general MRDD population. ODMRDD has a significant amount of information collected about the circumstances of each investigation, but still must develop reporting capacity to distinguish individual enrollment, the frequency of MUIs for individuals and the frequency of specific provider involvement. Specific identification of providers will allow ODMRDD to identify providers whose involvement in incidents exceeds the average and can be further evaluated.

It is also recommended that ODMRDD improve the utilization of the PPI field currently available in the ITS database. Twenty-two percent (21.9%) of MUI cases involved a staff member as the PPI. In over a third of these cases, the ITS field for this identification (38%) was not used. This underutilization of the PPI field in the ITS database represents a missed opportunity to identify staff who may have a pattern of involvement as alleged perpetrator. Required utilization of this field will help identify individuals whose frequent involvement as alleged perpetrator in MUIs can be further evaluated.

Training provider and County Board staff to obtain and analyze improved reports from the ITS database may also improve outcomes across the state.

***2. ODMRDD should evaluate the use of investigation extensions according to its internal procedure, and assess the appropriateness of the 30-working day MUI investigation requirement in its MUI rule.***

The MUI rule directs County Boards of MRDD to complete investigations within 30 working days of incident notification. On average, investigations extended for nearly seventy two calendar days (71.9). Adjusting calendar days to a working day standard averaged 51.3 days. The MUI rule requires that investigations be completed within 30 working days unless an extension is requested; average investigation time had shortened to just over 60 calendar (42.8 working) days at the end of the sample period.

There has been significant improvement in the timeliness of investigations over the rule-implementation period, but the timeliness requirement specified by the MUI rule has not been met. Death cases and rights code violations were among the longest investigative processes. This review did not evaluate extensions issues by ODMRDD. ODMRDD should review internal compliance with its extensions procedure, to evaluate whether the timeliness requirement in rule is met in all cases except those incident types that legitimately meet the extension procedure criteria.

***3. ODMRDD should take steps to improve compliance with the current BCII check, Nurse Aide and Abuser Registry Checks. Consider timeframes for re-verification of employees' criminal histories.***

Almost two thousand staff were identified as a witness, reporter or PPI in one thousand two hundred forty (1240) sampled incidents. Sixty seven percent (67%) of cases sampled involved paid staff.

For ten percent (10.3%) of staff involved and for whom a BCII check was required, none was done at the time of employment. When an FBI report was also required, documentation was not found in the employment file in just over one quarter (27.4%) of cases.

Twenty-five percent (24.7%) of employee records where a Nurse Aide Registry check was expected contained no documentation of compliance. One third (33.8%) of employee records were not compliant with the ODMRDD Abuser Registry check. Improvement in this area is also called for.

Compliance with the initial employment requirements specified in the background investigation rule needs some performance improvement. Initial and re-verification of criminal and abuse histories according to the above measures would strengthen the system's ability to protect waiver enrollees' health and welfare. Annual re-evaluation of BCII and Registry checks might improve current compliance by requiring a more frequent process and would verify a lack of criminal behavior at regular intervals.

***4. Integrate UI and MUI data collection, review and analysis, at the individual and provider levels. Standardize UI and MUI reporting and review processes to improve provider and County Boards' ability to identify consumers and incident categories for improvement and prevention.***

In general, providers were found compliant with the required maintenance of a UI log. Of the 401 providers reviewed, only ten percent were found out of compliance (9%). Weekly review of the UI log was also compliant in over three quarters of cases (77%). Providers' quarterly review was also documented in three quarters of cases (75%). Providers are required to conduct annual reviews of trends and patterns per the MUI rule. Only half (52%) of providers produced documentation that an annual review for trends and patterns had been done. Again, reviewers reported a lack of consistency in documentation and maintenance of annual review records.

The surprising number of UIs occurring within the 30 days of the sample MUI, (4785 and 6027 when County Board UIs were included) suggests further analysis is warranted. This averages to 2.5 UIs per individual within 30 days of the sample MUI.

Providers are expected to take action based on patterns and trends identified during the annual MUI review, to reduce reoccurrence of similar incidents for the individual involved in the MUI. In the majority of cases, action was taken appropriate to the incident circumstances. In just under fifteen percent (15%) of cases, action would have been appropriate, but was not documented. ODMRDD should develop clear standards and technical assistance for data trending and patterning, as the field has not yet developed standards for this important analysis.

Given the surprisingly high volume of UIs for the majority (74%) of the sample population, review of MUIs for individuals will be stronger if UI review is incorporated. The number of UIs documented for individuals experiencing MUIs is evidence that the integration of information about individuals' incident experience (both UIs and MUIs), may better identify opportunity for protective intervention. ODJFS strongly recommends standardized and integrated analysis of UIs and MUIs as measures of individual health and welfare.

***5. Improve County Board accountability for prevention planning and health and welfare protection using the ISP and SSA role.***

The coordination of UI and MUI review between agencies, independent providers and County Board programs was not directly evaluated as part of this review. Individuals who are provided services and supports across provider settings may be at risk if documentation and prevention planning relative to the occurrence of UIs and MUIs is not actively shared. Individuals may be experiencing incidents in one setting that do not meet the reportable Series MUI threshold, but if data were accumulated and reviewed across providers, actual risk would be identified.

The MUI rule directs providers to develop prevention plans that reduce the risk of re-occurrence of incidents. Documentation of action was identified in almost all (98%) cases. County Boards are also directed to take measures to prevent reoccurrence. In order to clarify ongoing accountability, it may be appropriate that the SSA be accountable for an individual-focused review across providers. MUI occurrences are being successfully reported to SSAs in nearly all (90%) of cases, but written summaries of investigation outcomes are reported only to providers, individuals or guardians.

Individual Service Plan (ISP) changes occurred as a result of the investigation in less than a third (28%) of sampled cases. In three quarters of cases (75%) of cases where ISP changes were made, implementation of the change was documented in the record. The remaining quarter (25%) had no documentation that the ISP change had been implemented.

The review recommends that prevention plans be developed across provider settings, with the involvement of the SSA, and integrated with the ISP as appropriate to the incident circumstance. Integration with the ISP will improve accountability to the prevention plan and make it more accessible to all providers involved with the individual's care. The MUI rule's requirement that only providers document a prevention plan overlooks the SSA's primary role in prevention and service planning. The MUI rule was developed prior to ODMRDD's efforts to clarify the SSA function in rule. The link between the investigation and successful service planning can only be effective if the ISP is adapted to reflect the content of the prevention plan. MUIs should be considered sentinel events that invite reconsideration of the ISP. Currently, there is no rule that requires this. The proposed Service and Supports Administration Rule (SSA), alludes to this need for coordination, but no strong linkage has yet been made.

**6. *Standardize documentation for providers' timely notification of the MUI to the County Board.***

Reviewers were unable to find documentation that the provider notified the County Board of the MUI in a small percentage (6%) of cases. Independent providers documented notification slightly less frequently than would have been statistically expected. In over forty percent of cases, (43%) reviewers found no documentation of the time of notification to the County Board in the provider records. Although a large number of cases (40%) were documented within the 24-hour required timeframe. In seventeen percent of cases, reporting was documented beyond the 24 hour expectation (17%).

Reviewers were asked to determine whether the County Board had documentation of receipt of the provider's written MUI report by 5:00 PM the day following the incident, as the MUI rule requires. In just over half of sampled cases (55%) documentation of timeliness was identified. For the remaining MUIs, documentation of timely receipt of the report was not available. Again, standards for documentation would improve the system's ability to evaluate timely receipt of MUI reports.

Generally, notification to County Boards was made, or the MUI would not have been investigated. Standards for documenting the date and time of notification would,

however, improve the system's ability to evaluate compliance with the 24-hour reporting requirement.

***7. ODMRDD should develop specific goals and strategies to reduce risk using statistically valid sampling and continuous evaluation of the cause and effects of MUIs. Implement measurable quality improvement strategies based on these findings.***

ODJFS has recently begun a comprehensive sample-based analysis of incident cases in certain MUI categories. This initiative can be used as a model for ODMRDD's own quality improvement effort to protect individuals with MR and DD. ODJFS will share outcomes of its data to support ODMRDD's development in this area.

ODMRDD should measure the effectiveness of its current efforts to improve system performance, such as its "Information Notices", to assure that the allocation of existing resources is successfully improving individuals' health and welfare.

Focused research on the most frequent causes of certain incident types will clarify what interventions may be effective. Targeted evaluation and intervention will make measurement possible, so that legitimate quality improvement can be documented.

***8. ODMRDD and ODJFS should develop tools to evaluate the adequacy of prevention plans, measurement of incident re-occurrence and integration of prevention plans with ISPs.***

Reviewers were not trained to evaluate the adequacy of measures taken to prevent reoccurrence of incidents. Further evaluation will determine the adequacy of measures to prevent reoccurrence of incidents. ODMRDD and ODJFS, County Boards and providers should consider peer-review or other strategies to evaluate the adequacy of prevention plans as a follow-up to this review.

***9. ODJFS should develop standards for data collection, system performance and individual health and welfare protection that are applicable across populations.***

This review was comprehensive as a rule-compliance process evaluation. ODJFS needs to further its efforts to assure health and welfare in process and outcomes protections across populations. Performance on standardized measures will focus areas for further review and evaluation that are unique to each population. Standardization of measures will allow sub-recipient sister agencies to share interventions and success across systems. Collaboration in times of limited resources can only enhance each system's performance. ODJFS is uniquely positioned to establish this structure and collaboration.

## **Next Steps**

Further review will be required to evaluate the immediate and long-term effects of MUIs on individuals, particularly with regard to the formulation and implementation of legitimate prevention plans and the re-occurrence of similar incidents. ODMRDD should consider case-specific evaluation of incident cause and effects as its focus on improving consumer outcomes develops. Measuring re-occurrence rates and the strategic integration of UIs with MUIs may enhance future evaluations' effectiveness.

Results from this compliance review may be used to develop areas for further focus and quality improvement activity. ODJFS will focus future evaluation efforts on prevention planning, integration with the ISP and re-occurrence of MUIs. Further review and consideration will determine whether incident documentation and prevention plans are linked to the identified cause of the incident and are actively considered as part of service and supports planning and implementation. The development of standards for data collection, system performance and individual protection will improve ODJFS ability to perform adequate health and welfare oversight for all waiver populations.

The active commitment to individual health and welfare protection over the last three years among provider organizations, County Boards of MRDD and at ODMRDD should be acknowledged. Compliance with components of the MUI rule was overall very positive, reflecting the significant effort put forth by all parties involved.

## **Adverse Outcomes Report Protocol**

### **I. Health & Welfare Adverse Outcomes**

All Health & Welfare Adverse outcomes will be documented on the Health and Welfare Adverse Outcomes Report and procedures followed as outlined in this protocol.

### **II. Definitions**

**Adverse Outcome** : A situation in which a sub-recipient has failed to meet basic standards of care resulting in a threat to health and welfare. Adverse outcomes fall into four priority categories and involve an assessment by a reviewer of scope and severity. Scope is defined as an outcome large enough to affect several individuals and/or occur on a frequent basis. Severity is defined as an outcome that is severe enough to have already caused or has the potential to cause permanent damage, irreversible harm, injury, impairment, or death. See Appendix for Triggers of Priority 1 and 2.

**Priority 1** - Imminent: An immediate threat to health and welfare where a failure to correct could result in serious injury, harm to self or others, physical or mental impairment, hospitalization, nursing home admission, and/or death.

**Priority 2** - Serious: A significant threat to health and welfare where a failure to correct could result in the potential for serious injury, harm to self and others, physical or mental impairment, hospitalization, nursing home admission, and/or death.

**Priority 3** - Low: A minimal threat to health and welfare where a failure to correct could result in the potential for future injury, harm, impairment, or negative outcomes.

**Priority 4** – Programmatic: Outcomes based upon an oversight review that results or could result in a need for corrective action to improve overall quality of Medicaid services. Trends and/or patterns of programmatic outcomes could rise to a higher level adverse outcome requiring a plan of correction and/or follow-up.

### **III. Assessment of Adverse Outcomes**

When an adverse outcome is noted, use the following questions and Appendix A and B to determine how to rank as a priority 1, 2, 3, or 4:

1. Is there scope and/or severity to the outcome?
2. Was there an outcome of harm?
  - a. Actual - Does the harm meet the definition of imminent or serious risk? Has the sub-recipient's noncompliance caused serious injury, harm, impairment or

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death to an individual?

- b. Potential - Is there a likelihood of potential harm? Does the potential harm meet the definition of scope and severity? Is the sub-recipient's noncompliance likely to cause serious injury, harm, impairment or death to an individual?
3. Is the harm or potential harm likely to occur in the near future to one or more individuals if immediate action is not taken?
4. Did the sub-recipient know about the situation? If so, when did the sub-recipient first become aware?

Should the sub-recipient have known about the situation?

Did the sub-recipient thoroughly investigate the circumstances?

Did the sub-recipient implement preventative and corrective measures?

Has the sub-recipient re-evaluated the measures to ensure the situation was corrected?

### **IV. Priority Ratings - Procedure for Reporting**

A. All adverse outcomes will be categorized by the following priority ratings:

#### 1. Priority 1 - Imminent Health & Welfare Risk

a). Situations that are considered a Priority 1 - Imminent Health & Welfare Risk are an immediate threat to the recipient's health and welfare and require *immediate action within, but not longer than, 24 hours from the time of notification*, or sooner as the situation warrants.

b). Issues warranting a Priority 1 - Imminent Health & Welfare Risk rating are where the failure to correct will (or did) result in serious injury, harm to self or others, physical or mental impairment, hospitalization, nursing home admission, and/or death.

c). The BCA Reviewer will, within 30 minutes of the adverse outcome, notify the appropriate entity of the outcome and request immediate corrective action to prevent danger/harm. This corrective action must be accomplished prior to the completion of the on-site review but not longer than 24 hours (in the case of a review expected to last longer than one calendar day) or sooner as the situation warrants.

d). Health and welfare adverse outcomes that fall within the Priority 1 - Imminent Health & Welfare Risk category will need to be *reported to the Ohio Department of Job & Family Services (ODJFS) within 24 hours of discovery*. This will be done via fax or electronic mail. All adverse

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outcomes in this category will be documented on the Health and Welfare Adverse Outcomes Report.

e.) Resolution of the adverse outcome shall be documented to include action to prevent harm in the future to the recipient or recipients of Medicaid Services. The sub-recipient is required to submit such documentation within 30 days of discovery or as specified within the specific Oversight Review Manual. Regulatory entities (i.e. ODH) can submit documentation in accordance with OAC rule provisions which may extend beyond the 30 day timeline.

f.) If unsure of the disposition of an outcome, the BCA Reviewer shall contact the Bureau of Community Access for guidance.

### 2. Priority 2 - Serious Health & Welfare Risk).

a.) Situations that are considered a Priority 2 - Serious Health & Welfare Risk pose a significant threat to the recipient's health and welfare and requires *corrective action within, but not longer than, 7 calendar days from the date of notification*, or sooner as the situation warrants.

b.) Issues warranting a Priority 2 - Serious Health & Welfare Risk rating are where the failure to correct will (or did) result in negative outcomes for the recipient.

c.) Health and welfare adverse outcomes that fall within the Priority 2 - Serious Health & Welfare Risk category will need to be *reported to ODJFS within 24 hours of discovery by the BCA Reviewer*. This will be done via fax or electronic mail. All adverse outcomes in this category will be documented on the Health and Welfare Adverse Outcomes Report.

d.) The BCA Reviewer will notify the appropriate entity of the outcome when determined appropriate by the reviewer and BCA Supervisor.

e.) Resolution of the adverse outcome shall be documented to include action to prevent harm in the future to the recipient or recipients of Medicaid Services. The sub-recipient is required to submit such documentation within 30 days of discovery or as specified within the specific Oversight Review Manual. Regulatory entities (i.e. ODH) can submit documentation in accordance with OAC rule provisions which may extend beyond the 30 day timeline.

### Priority 3 - Low Health & Welfare Risk

a.) Situations that are considered a Priority 3 - Low Health & Welfare Risk are a minimal threat to the recipient's health and welfare but requires corrective action to avoid the potential for future harm. *Corrective action*

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*shall be taken within, but not longer than, 30 calendar days from the notification date, or sooner if the situation warrants.*

- b.) Situations warranting a Priority 3 - Low Health & Welfare Risk rating are instances where failure to correct may result in negative outcomes for the recipient. It is possible to have a trend of low level outcomes that together creates a situation for a serious or imminent health and welfare risk.
- c.) Health and welfare adverse outcomes that fall within the Priority 3 - Low Health & Welfare Risk category will need to be reported to *the ODJFS within **three** days of discovery by the BCA Reviewer. Low health and welfare category outcomes can be reported through an on-going review or as the situation warrants during a review.*
- d.) The BCA Reviewer will notify the appropriate entity of the outcome when determined appropriate by the BCA Supervisor.
- e.) Resolution of the adverse outcome shall be documented to include action to prevent harm in the future to the recipient or recipients of Medicaid Services. The sub-recipient is required to submit such documentation within 30 days of discovery or as specified within the specific Oversight Review Manual. Regulatory entities (i.e. ODH) can submit documentation in accordance with OAC rule provisions which may extend beyond the 30 day timeline.

### 4. Priority 4 – Programmatic Health and Welfare Outcomes

- a.) Situations that are considered a Priority 4 – Programmatic Health & Welfare Outcome rating are outcomes found through oversight reviews that result or may result in a need for corrective action. The need for corrective action would be dictated by the direction and type of Medicaid program under review and could be targeted as a follow-up review by BCA Reviewers.
- b.) Programmatic outcomes requiring corrective action are reported via the “outcomes” reflected at the end of each review tool. Trends and/or patterns of programmatic outcomes may result in the reporting of a Priority 1, 2 or 3 adverse outcome and the procedure followed as indicated within this protocol.

## **V. Reviewer Completion of the Adverse Outcome Reporting Form**

The reporting form is a three-page document used to record specific detail about the consumer/provider and corresponding narrative for the purpose of initiating and tracking

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resolution. The reviewer shall follow the protocol in terms of timeliness of reporting and accurately reflect information on the reporting form.

Page 1 is a quick synopsis of detail surrounding the adverse outcome and shall include the following:

- ✓ Priority Level
- ✓ Completion date
- ✓ Supervisory contact
- ✓ Consumer information
- ✓ Action by the BCA reviewer

The reviewer shall indicate the person/entity notified for all imminent and serious adverse outcomes. The name and date of the person/entity notified shall be reflected in the appropriate box titled "Action by BCA Reviewer".

The reviewer is responsible for completing all areas of the form except the assignment of a form number and the section titled "To be completed by BCA".

Page 2 of the form is an area requiring codes of the adverse outcome. More than one code may be chosen.

Page 3 is the narrative surrounding the adverse outcome. The narrative shall include the following components, at a minimum:

- ✓ Orientation (Who, What, When, Where)
- ✓ Sequence of events and objective facts that led to the reporting of the adverse outcome(s)
- ✓ Impact on health and welfare (actual or potential)
- ✓ OAC Rule/Federal Regulation citations (if applicable)

The reviewer shall attach supporting documentation, as applicable to the reported outcome. Any supporting documentation attached shall be indicated at the bottom of page 3 in the space provided.

## **VI. Supervisory Procedure – Entry into the Adverse Outcomes Tracking System**

1. All completed Adverse Outcome Reports are received via e-mail/fax.
2. The designated supervisor will review the Adverse Outcome Report and enter into the BCA Section the current date as the **Case Opened** date and his / her signature.
3. An individualized folder will be created indicating the consumer / agency name and waiver and review type. A BCA Intervention Form is stapled to the folder and the supervisor will document in narrative the case opening and referral note.

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4. The supervisor who opens the case is responsible for entering electronically the following information into the Adverse Outcomes Database located on the shared drive (R Drive / OM / BCA/ CM Unit / Adverse Outcomes Database). The Supervisor then places the form number on the report and the folder.
  - a) Form year
  - b) Form Review Type
  - c) The priority level
  - d) The County Number
  - e) The Reviewer initial
  - f) The date the case was opened
  - g) Up to two Adverse Codes
  - h) The consumer / agency name
  - i) The applicable waiver program.
  - j) The date the sub-recipient was notified
  - k) The expected response from the sub-recipient

Note: Sub-recipient within this document refers to ODJFS' first point of pass through of Medicaid funding.

### **VII. Supervisory Procedure – BCA Intervention and Referral**

1. All Priority 1 (Imminent) and Priority 2 ( Serious) Level cases are immediately referred to the appropriate entity (direct service sub-recipients) who shall initiate action to ensure health and welfare by the BCA reviewer. BCA management staff contacts indirect sub-recipients to initiate formal corrective action (i.e. Notification to Children's Services, Department of Health, ODMRDD etc.)
2. The case is then placed in the Open Section of the CMU Adverse Outcomes File.
3. All Priority 3 (Low Health and Welfare Risk) and Priority 4 (Programmatic Health and Welfare Outcomes) are referred to the appropriate entity after it is reviewed by the Adverse Outcomes Committee.

### **VIII . Adverse Outcomes Committee**

The Adverse Outcome (AO) Committee is comprised of CMU staff supervisors / managers, protection from harm unit staff and / or others related to entities under review.

The AO meeting is held Biweekly to review all Adverse Outcome Reports and perform all or any of the following:

1. Review all newly opened cases.

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2. Determine if the case is reportable.
3. Identify if the form has complete and accurate information.
4. Identify if the AO has been appropriately categorized and correct if necessary.
5. Determine the referral entity and appropriate BCA Intervention.
6. Withdraw any cases determined to be inappropriate to report per the guidelines of the Adverse Outcomes Protocol.
7. Review resolution and preventative measures submitted and determine if appropriate to close the case.

### **IX . Resolution of Adverse Outcomes / Closing the Case**

An Adverse Outcomes case is considered closed only after the following criteria, at a minimum, have been met:

1. The AO committee has formally met and reviewed the AO case.
2. The appropriate intervention has occurred for each AO case. Intervention should include a follow-up to the referral source (e.g. ODA, ODMH, ODE, ODMRDD, etc) to obtain any necessary supporting documentation as evidence that satisfies the AO committee.
3. In some cases the AO committee may request additional evidence that appropriate follow-up has occurred by sending out a BCA reviewer to the agency site to re-review the case.
4. Once the AO committee has approved the case for closure a closure letter is mailed out from the CMU Section Chief to the agency or person (s) involved in the AO case identifying the case as closed and resolved.
5. CMU supervisors go to the R Drive / OM / BCA/ CM Unit/ Adverse Outcomes Database and mark the case as closed.

### **X . Corrective Action Parameters**

- All low level adverse outcomes (priority 3) require resolution within 30 days of discovery.
- Any imminent or adverse outcomes require resolution within 7 days of discovery.

Corrective action shall follow the below guidelines for all priority levels:

1. An outline of the process/plan for resolution shall be submitted to BCA within 5 days of notification by BCA using the guidelines in section XI.
- 2.)Resolution of any adverse outcome shall be completed within 30 days of notification by BCA including documentation that details process and outcome (i.e. plan of care, prevention plan, etc...). The immediate resolution of imminent and or serious adverse outcomes shall be documented within the overall plan submitted within the 30 day timeline and shall show evidence of correction within the 7 day timeline as specified above.

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Should additional time be needed to correct the adverse outcome, submission of a formal request for an extension is required.

### **XI. Corrective Action Guidelines**

Acceptable corrective action may include the following elements:

- It must contain elements detailing how the sub-recipient will correct the outcome as it relates to the individual(s) found to have been affected by the negative practice.
- It must indicate how the sub-recipient will act to protect individuals in similar situations (how will you identify other individuals who may be potentially affected by the same negative practice, and what action will you take to protect them?).
- It must include the measures the sub-recipient will take or systems it will alter to ensure that the problem does not recur (how will you correct the finding?).
  1. When staff training is the resolution, the specifics of the training should be documented. Who will be trained? When? What? And By Whom?
  2. If increased service is the corrective action taken, specify the change or increase in hours and/or service type.
  3. When corrective action refers to the development of new policies and procedures, a copy of the new policy/procedure should be included
  4. You may wish to consider changes in the following systems or areas in addressing outcomes: in-service training, off-site training, use of consultants, QI teams or process, oversight mechanisms, etceteras.
  5. Avoid vague statements. Corrective action should reflect the specific and realistic action taken.
- It must indicate how the sub-recipient plans to monitor its performance to make sure that solutions to problems are permanent (how will you make sure the adverse outcome does not recur; what quality assurance program will be put into place?).
- It must include specific timelines for correction.

### **XII. Process for Adverse Outcomes Dispute**

Prior to a review with a sub-recipient, specific details shall be outlined and collaboration used to agree on parameters specific to the delivery system under review.

In regard to a specific adverse outcome under dispute between BCA and the sub-recipient, whether as a reporting issue or as a corrective action issue, the sub-recipient may submit, in writing, the rationale for the particular stance on an issue including OAC rule citations/federal regulations/etceteras that support's the sub-recipients position.

The BCA will review submitted information through the AO committee process including the potential inclusion of Medicaid policy and legal staff to determine appropriate response for the disputed issue. Adverse outcomes may be withdrawn, or further clarification provided to the sub-recipient as determined by the AO committee.