Improvements and Challenges: How States Address the Challenges of Incident Management Information

NASDDDS 2018 Director’s Forum & Annual Conference
November 8, 2018
Agenda

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Best Practices
Outstanding State Practices: Massachusetts and Tennessee
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Challenges, Issues and Risks
The statistics are sobering for the 53 million adults (one out of every five adults) in the United States that live with a disability.¹

- In one recent study, more than 70 percent of individuals with disabilities report they have been victims of abuse and more than 90 percent of those said they had experienced such abuse on multiple occasions.²
- Among individuals with disabilities who reported being victims of abuse, nearly two-thirds (63 percent) did not report it to the authorities.²
- In most cases, when victims with disabilities reported incidents of abuse to authorities, nothing happened.²


Challenges

Incident management and reporting has evolved in a piecemeal manner, agency by agency and provider by provider:

- It is common for states to maintain different processes and systems to manage incidents.
- In trying to identify and prevent abuse and neglect, many state human service agencies are hindered by fragmented processes and insufficient information technology (IT) systems.

States, providers, and officials directing these programs can improve services and decrease risks by:

- Improving incident management business processes.
- Developing standardized, automated protocols for reporting and tracking incidents within existing IT systems.
- Upgrading IT systems to improve information sharing.
Ideally, all states would have a comprehensive system or systems that are fully integrated to ensure that all incidents are appropriately managed regardless of incident jurisdiction. This could allow integration provider, individual, demographic and medication data.

Many states struggle with the following issues:

- Agencies and providers do not have access to comprehensive incident management and reporting systems
- Use of multiple, customized legacy systems/databases, often resulting in additional costs
- Variation in data collection and consistency resulting in a lack of standardized information or reporting
- Troubleshooting and reconciliation of various systems, spreadsheets and data
Risks

Disparate systems of incident management and reporting can result in:

- Inhibited progress towards individual-centric, integrated human services delivery
- Inability to identify trends that drive preventative measures, strengthen responses, and improvement incident management
- Risks to individuals, no single agency has a full picture of incidents occurring a the individual or provider level
- Risk to agencies – can be help responsibility for injury or death
Best Practices
Business Objectives

States and providers can proactively improve their incident management systems before circumstances beyond their control force a reactive response to an adverse event.

High-level business objectives for improving incident management include:

• Increase safety of vulnerable individuals
• Reduce incident management processing time and errors
• Decrease number of incident management systems/databases
• Reduce staff effort (business and technical) required to maintain multiple applications and troubleshoot/reconcile transactions between agency systems
• Standardize provider information, data collection, and reporting capability
Improving Incident Management

The success of any endeavor, incident management included, is not solely dependent upon a technology solution.

Modernizing technology without first reviewing and redesigning business practices and policies will not solve all problems.

The following slides outline incident management best practices that yield positive outcomes in cost, process efficiency, quality assurance, and program and performance improvements.
### Best Practices

#### Executive Sponsorship

Identify a neutral champion to establish directive and sponsor the project for a unified vision through project implementation.

This initiative typically cuts across agencies and IT responsibilities, so it is recommended that this be a neutral party outside of these entities.

<table>
<thead>
<tr>
<th>Cross-Agency Governance Structure</th>
</tr>
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<tbody>
<tr>
<td>Identify a stakeholder team reporting to the executive sponsor. Includes representatives from all agencies empowered with the authority for key decision making. Critical for continued agency and systems interoperability, especially in agile environment.</td>
</tr>
</tbody>
</table>

Recommend continuation of existing structure for continuity:

- Identify agency representatives
- Define charter
- Confirm workstreams
- Develop plan
Best Practices

Business Process Review and Redesign (BPR)

Using the aforementioned governance structure and authority, perform cross-agency Business Process Redesign for a business process that meets shared and unique agency needs.

- Confirm the core incident management model
- Consider enterprise initiatives that can resolve current business problems, such as developing common data elements, master provider and client indices, business rules engines, and web services
- Identify what other functions should be in/out
- Where possible, establish standardized and consistent terminology
- Consideration of the need for mobile process for field staff and integrate into business processes
Detailed Business Requirements

Based upon a the new business model inclusive of all necessary functions, further elaborate on the business requirements to obtain necessary detail and scope to design a solution.

- Develop and validate detailed requirements for shared and agency specific processes
- Develop reporting requirements
- Develop business data model
- Develop and validate additional use cases for shared and unique needs

Data Management and Governance

This is critical to resolving many business process challenges. A well-planned data management approach eliminates risk of delays in incident assignments, incorrect agency assignments, and privacy concerns with information sharing. A key function needed to meet business needs and processes.

- Define governance structure
- Establish scope of data governance controls
- Inventory data sets
- Develop cross-agency data dictionary and standards
- Perform data clean-up (automated and manual)
- Develop change management procedures
## Best Practices

### Regulation/ Policy Analysis

Identify conflicts in regulations, policies and procedures that drive the business rules of the system(s) across agencies. Policy, procedural and regulatory changes may be needed to address current business problems related to the incident management lifecycle.

- Compile library of federal and state policies applicable to the new business model
- Review of jurisdictional ownership of incidents, incident classifications, confidentiality rules, required notifications, timelines, use of social security numbers, required paper forms, ink signatures
- Modify policies as needed

### Funding

Funding options must be evaluated, secured and approved in advance of acquiring or implementing any solution.

- Analysis of potential funding options across all agencies
- Consideration of federal and state funds
- Assessment of alternate funding mechanisms
- Development of a funding plan
Procurement of New or Upgraded Technology

The BPR (fit-gap, cost benefit, or other analyses) resulted in a commitment to pursue IT system upgrades or develop a single incident management system.

- Determine requirements of new IT initiative – scope, statement of work, contract, etc.
- Determine requirements to be developed in-house or contracted out
- Determine procurement timelines, evaluation team, implementation team, etc.
- Determine procurement budget/funding
Outstanding State Practices: Massachusetts and Tennessee
Outstanding State Practices – Massachusetts and Tennessee

Massachusetts and Tennessee have employed innovative strategies for improving oversight and service quality while ensuring the health and safety of individuals.

**Massachusetts**
- Incident reporting and trending
- Mortality review procedures

**Tennessee**
- Protection from harm
- Investigations
Incident Management and Trending: Systems and Improvement

Laney Bruner-Canhoto, PhD, MSW, MPH
Assistant Commissioner of Quality Management
Massachusetts Department of Developmental Services
1. Massachusetts DDS system overview
2. Incident Management System overviews
3. Incident Trending and Reporting
   A. Trigger Reporting
   B. Trigger Reviews
   C. Quarterly risk management reports
4. Recent Improvements to Incident Management Systems
   A. Training and Resources
   B. Data and claims review
   C. Incident reviews
   D. Infrastructure
5. Mortality Reviews
The Department is dedicated to creating, in partnership with others, innovative and genuine opportunities for individuals with intellectual and developmental disabilities to participate fully and meaningfully in, and contribute to, their communities as valued members.
Who We Serve

- 39,584 Individuals
  - 26,406 Adults (22+)
  - 13,178 Children
- Children up to 22 years of age with a Developmental Disability
- Adults over the age of 22 with an Intellectual Disability
- Adults with Autism Spectrum Disorders
- Adults with Prader-Willi Syndrome
- Adults with Smith-Magenis Syndrome
- Adults with Acquired Brain Injury
• The DDS Central Office oversees all of our functions and operations throughout the state and establishes statewide policies and procedures.
• These statewide functions include: Commissioner's Office, Community field operations, Finance, budget and contracts, Human rights, Investigations, Legal, Policy, planning and children's services, Quality management, Volunteers and board membership.
• There are 4 Regional Offices.
• The Regional Office provides management of the area offices and performs the following regional functions: intake and eligibility determination, survey and certification of service providers, procurement and contracts business, legal and administration, abuse and mistreatment investigations, informal conferences to resolve disputes about the identification, prioritization, or provision of services.
Most individuals and families have contact with us through their local Area Office.

These 23 offices are located throughout Massachusetts. Area Offices are responsible for managing and monitoring the services we provide, or arrange for individuals served by us, and their families who live in the towns covered by the respective Area Office.

Functions performed at an Area Office include: information and referral, service coordination/case management, service planning, prioritization and arrangements, complaint resolution; and citizen and family involvement.
• Quality is important to all DDS staff from service coordinators to supervisors to management staff
• The Office of Quality Management is specifically dedicated to developing, implementing and refining all aspects of the Department’s quality management and improvement system.
• OQM staff:
  • Assistant Commissioner of Quality Management
  • Director of Licensure and Certification
  • Director of Health Services
  • Director of Risk Management
  • Director of Waiver Quality Management Systems
  • Regional Quality Enhancement Directors and surveyors for licensure and certification in each of the 4 regions
  • Evaluation, Research and Analysis support through UMASS- Center for Developmental Disabilities Evaluation and Research
• DDS approaches quality from three perspectives:
  • The individual
  • The provider
  • The system
• On each tier, the focus is on discovery of issues, remediation (prevention, where possible) and service improvement.
• Information gathered on the individual and provider level is used not only to remedy situations on those levels, but also to inform overall system performance efforts.
Incident Management Systems

- Investigations of complaints of abuse, neglect and mistreatment
- Incidents or adverse events that can compromise the safety and welfare of persons with a disability
  - Process and practices
  - IT and technological solutions
Per MGL Ch. 19C Sec A, all provider and DDS staff are mandated reporters of any incident, condition, or occurrence where there’s a reasonable cause to believe that an individual has been abused, harmed, exposed to risk, or been subjected to mistreatment due to the actions, the inaction or the negligence of a caregiver or provider.

Reports/allegations go to Disabled Person’s Protection Commission (DPPC), which can then investigate or refer complaint to DDS.

DDS can either assign case to DDS investigator, it may resolve the case fairly and efficiently, close it because there is no dispute to the facts, or refer it for an administrative review.
• In all instances where there is substantiated abuse, an action plan is developed by a Complaint Resolution Team (CRT).
• CRTs are comprised of Area Director, other DDS staff and at least one community representative.
• Teams develop and monitor implementation of action plans.

• Web-based system (HCSIS)
Incident Management

- Incidents are reported within certain time limits. Providers and state agency staff enter incidents.
- Review of incidents by provider and determination of immediate actions
- DDS reviews and finalizes incident reports, which include specific details regarding the incident as well as immediate actions taken to protect safety and longer term follow up actions.
- Web-based system (HCSIS)
• Increase awareness & communication
• Track & Monitor
• Identify:
  • People at risk of harm
  • Trends – increasing risk
  • Providers – unusual patterns and trends
  • Regions – issues requiring increased attention
  • State – issues needing special strategies and initiatives
• Guide Improvements
• 10 triggers that include a specific number or combination of incidents in a specified time frame.
• Reports of individuals whose incidents meet the requirements of these triggers are generated monthly for each Area Office for review and follow up.
• Allows for the identification of patterns and trends.
• It uses known patterns of escalated risk to direct proactive risk reviews at early signs of heightened risk for individuals. This system is designed to be an electronic ‘safety net’ to ensure escalated individual risk is identified promptly.
<table>
<thead>
<tr>
<th>Trigger</th>
<th>Description</th>
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<tbody>
<tr>
<td>T1</td>
<td>3 or more unplanned medical hospitalizations, ER visits or psychiatric hospitalizations within 6 months for any reason</td>
</tr>
<tr>
<td>T2</td>
<td>Multiple (2 or more) unplanned medical hospitalizations or ER visits for the same condition or reason that occur within the same calendar month.</td>
</tr>
<tr>
<td>T3</td>
<td>A single unplanned hospital visit for a serious event, including suicide attempts, medication side effects, PICA/choking, bowel obstruction, UTI, or dehydration.</td>
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<tr>
<td>T4</td>
<td>2 or more incidents involving law enforcement that occur within a 3-month time period.</td>
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<tr>
<td>T5</td>
<td>Any incident of alleged arson (fire setting) by the individual within the reporting month.</td>
</tr>
<tr>
<td>T6</td>
<td>Any incident of Aggressive Sexual Behavior within the reporting month.</td>
</tr>
<tr>
<td>T7</td>
<td>3 or more physical altercations or behavioral incidents within a 3 month period, may be either perpetrators or victims</td>
</tr>
<tr>
<td>T8</td>
<td>3 or more alleged incidents of abuse or serious neglect that take place within 3 months.</td>
</tr>
<tr>
<td>T9</td>
<td>Any combination of 5 or more incidents of any type within 6 months, excluding MORs and Restraints. At least once incident must be other than an Unexpected Hospital Visit.</td>
</tr>
<tr>
<td>T10</td>
<td>The use of restraint more than two times within the reporting month. To meet this trigger, the restraints must occur over a span longer than 24 hours.</td>
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### Greater Boston

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<thead>
<tr>
<th>Last Name</th>
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### Metro

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</table>
• **Determine** whether or not the individual situation was carefully reviewed

• **Understand** what actions, if any, were taken to correct, remediate and safeguard

• **Assess** to determine whether or not more supports or service interventions are needed
Quarterly Reviews of Trigger Reviews

- Quarterly review of a sample of individuals who have been triggered to assure that appropriate follow up actions have been taken.
- Regional Risk managers review trigger responses.
• Area Offices review patterns regularly through a monthly report on unexpected hospitalizations, significant behavioral incidents, restraints and investigations.

• This report provides numbers, rates and graphs to help identify patterns and trends over time.
Example of Report

DDS Area-level Monthly Risk Management Report

(\(n\) = count of incidents, rate = count of incidents are per 1000 consumers)

**Significant Behavioral Incidents**

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<tr>
<th>Area</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>July</th>
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<tr>
<td>n</td>
<td>5</td>
<td>7</td>
<td>3</td>
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<td>rate</td>
<td>4.1</td>
<td>5.7</td>
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**Region**

| n    | 12  | 21  | 12  |     |     |     |      |     |     |     |     |     |
| rate | 4.6 | 5.0 | 4.2 |     |     |     |      |     |     |     |     |     |

**State**

| n    | 12  | 21  | 12  |     |     |     |      |     |     |     |     |     |
| rate | 3.1 | 3.6 | 2.9 |     |     |     |      |     |     |     |     |     |

Area change since last month:

**Unexpected Hospital Visits: Any Type**

<table>
<thead>
<tr>
<th>Area</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
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<tr>
<td>rate</td>
<td>18.0</td>
<td>16.4</td>
<td>10.6</td>
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</table>

**Region**

| n    | 12  | 21  | 12  |     |     |     |      |     |     |     |     |     |
| rate | 20.1| 19.1| 23.5|     |     |     |      |     |     |     |     |     |

**State**

| n    | 12  | 21  | 12  |     |     |     |      |     |     |     |     |     |
| rate | 23.7| 25.8| 26.0|     |     |     |      |     |     |     |     |     |

Area change since last month:
Area Offices also receive a “by provider” report that notes the number and rate (by month) of the following occurrences:

- unexpected hospitalizations
- significant behavioral incidents
- restraints
- investigations
Recent Improvements - Training and Resources

- DDS and DPPC confirmed and documented the “reasonable cause to believe” standard for reporting
- Developed 2 fact sheets
- Developed and implemented a mandated reporter training (webinar, PowerPoint) - Mandatory for provider and DDS staff (coordinated with DPPC)
- Training for DDS management staff on available reports and how to conduct a thorough review of incidents was completed
Recent Improvements - Training and Resources

• A “Quality is No Accident” brief on ER/Urgent Care has been developed and was disseminated in December, 2016.
• Financial Abuse Training (webinar) developed and disseminated.
• DDS and DPPC support Massachusetts Advocates Standing Strong’s Awareness and Action Training. This is a program that reaches out to individuals supported by DDS to train them on what abuse is and how to stop it and report it. This a joint venture of self-advocates and staff supporters.
• A data exchange agreement was developed and implemented.
• Data analysis ongoing on a quarterly basis from July-September 2016 onward.
• Follow up with area offices and providers for systems improvements.
Recent Improvements - Incident Reviews

• Further guidance was given to DDS managers to aid in the incident report review process
• A question was added to the DDS “trigger” reports related to whether DPPC should have been notified
• A filter has been added to management reports related to whether DPPC has been notified
• Strengthened and revitalized Statewide Committee to focus more globally on Risk, not just incidents.
  • Purpose to conduct reviews of applicable systems to assure the safety and well-being of those served by DDS.
• Indicators as part of licensure and certification process evaluate providers on:
  • Reporting allegations of abuse/neglect as mandated by regulation,
  • Immediate action is taken to protect the health and safety of individuals when potential abuse/neglect is reported,
  • Individuals have been trained and guardians are provided with information in how to report alleged abuse/neglect and
  • Incidents are reported and reviewed as mandated by regulation.
Death Reporting

• All deaths of individuals who are eligible for DDS services and who are 18 years of age or older are required to be reported through the web-based system (HCSIS) within 24-hours of discovery.

• If the individual is a child (under 18), DDS reports the death or injury to the Office of the Child Advocate.

• If the individual is over the age of 55, DDS also reports the death or injury to Elder Services in addition to HCSIS.

• All deaths are also reported to the Disability Law Center (DLC), the Disabled Persons Protection Commission (DPPC), and DDS Investigations.

• Deaths are investigated if there is any suspicion of abuse, neglect or mistreatment related to the death.
Clinical reviews are conducted (usually by Area nurses) on the deaths of persons served by DDS who:

- are at least 18 years of age and
- who was receiving at least 15 hours of residential supports licensed, certified, funded or arranged by DDS, including facilities or
- whose death occurred in a day support program licensed, certified or funded by DDS, or
- whose death occurred in a day habilitation program, or
- who died while in transportation funded or arranged by DDS

A Mortality Review may be requested for an individual that does not meet the above criteria.
• Clinical staff person gathers information from program records, PCP, interviews with staff, hospital discharge summaries and any other source that would enlighten the report
  • to determine cause of death
  • to also identify systemic components that contributed to the death and may need to be strengthened to prevent similar outcomes
• Upon completion of the Clinical Mortality Review, it is forwarded to the Regional Mortality Review Committee for review.
• Mortality Review is either closed at the Regional level or forwarded to the Central Committee for further review based on a defined set of criteria.

• The members of the Central Office Mortality Review Committee are Director of Health Services, Director of Risk Management, RN, NP or risk manager representative from each region, Provider RN, representative from DPPC, representative from DPH, DDS Regional Medical Director, Ethicist, Consulting Psychiatrist and Clinical Pharmacist.
OVERVIEW OF PROTECTION FROM HARM PROCESSES
MAJOR PROCESSES OF DIDD PROTECTION FROM HARM SYSTEM CENTRAL OFFICE AND INVESTIGATIONS
The on-call investigator received a call at 9:53 pm from the provider’s IMC on 6-10-15 regarding Sally Smith. Staff Jane Brown reportedly took Sally to her personal residence to pick up something for dinner. Staff does not have permission to take Sally to their personal residences.

While at Ms. Brown’s home, Sally used the bathroom. When she stood up, Sally fell forward and struck her head. There was no reported observable injury, and Sally stated that she was okay, but her head hurt. Sally requires staff assistance when ambulating due to an unsteady gait.
Sally’s agency management called the Investigations Hotline and reported this allegation of neglect.

Investigations will be opened for the following incident types and a report must be made by phone to the Investigations Hotline as soon as possible but within 4 hours of the incident or discovery.

• Allegations of abuse, neglect or exploitation
• Serious injury of unknown cause
• Suspicious injury
• Unexpected or unexplained death
Abuse: [T.C.A. § 33-2-402 (l)] the knowing infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

Neglect: [T.C.A. § 33-2-402 (9)] failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness, which results in injury or probable risk of serious harm.

Exploitation: [T.C.A. § 33-2-402 (8)] actions including but not limited to misappropriation or wrongful temporary or permanent use of belongings or money with or without the consent of a person using services. The illegal or improper use of a person's resources or status for another's benefit or advantage is considered exploitation.
Serious Injury of Unknown Cause: an injury that requires assessment and treatment beyond basic first aid that can be administered by a lay person, the cause of which is unknown.

Suspicious Injury: an injury that may have been the result of abuse or neglect or is not consistent with the explanation provided. There must be a reason to suspect the injury was the result of abuse or neglect.

Death: a fatality occurring under circumstances that are unexpected or unexplained.
Sally’s agency management properly submitted an incident form for this allegation of neglect.

• Providers must complete and electronically submit the Reportable Incident Form to DIDD and to the ISC within one (1) business day

• When the initial reporter is not the provider responsible for the person supported at the time of the incident, the initial reporter sends a copy to the provider responsible within one (1) business day
Sally’s agency management reported this incident timely and noted the time and dates the appropriate parties were contacted.

• Providers are held accountable for any reporting delays beyond the specified time frame.
• DIDD requires providers to contact local law enforcement to report any alleged criminal conduct or probable criminal conduct. These are acts which lead to or can reasonably be expected to lead to police involvement, arrest or incarceration of a person supported. Providers are required to contact law enforcement and report any suspected criminal activity by staff persons.
• State law requires providers to report certain injuries to, or abuse of, children to the DCS Child Abuse Hotline, and if an adult is the victim, to DHS Adult Protective Services (APS) Division.
Sally’s agency management noted that since the injury required no hospitalization, no contact to the AOD was made.

Each region has an administrator on duty at all times. Providers are required to report the following incidents to the AOD within 4 hours:

- Deaths
- Unplanned hospital admissions (medical or psychiatric)
- Behavioral incidents involving law enforcement (missing person, incarceration, etc.)
- Mobile Crisis Team involvement
- Requests for emergency service approval outside of DIDD business hours
The agency IMC added Sally’s allegation of neglect to the next PIRC meeting agenda.

- Day, residential and personal assistance providers must establish a PIRC with a defined membership and meeting schedule
- The PIRC is responsible for review of all incidents and investigations and the development of corrective, preventive action plans
- The PIRC is required to meet at least every two weeks
Functions of the PIRC include:

• Monitoring of reporting of incidents, including timely notification to entities other than DIDD

• Addressing recommendations relating to incidents in Final Investigation Reports and provider incident reviews

• Identifying individual risk issues for prevention of harm and increasing safety of person supported

• Identifying incident trends and making recommendations as necessary

• Conducting reviews and/or assessments of particular homes, persons, programs, conditions or other factors which can be reasonably identified as presenting risks to persons supported
To Confirm that Incident Type was Reported Correctly

To Confirm that Remaining Report Data is Valid

To Confirm that Injury Level Matches the Injury Described

To Confirm that Narrative Description Matches Incident Reported
The information from the call to the Hot Line about Sally’s incident and the RIF information are entered into the DIDD Incident and Investigation database by DIDD Central Office personnel. It is available for future monthly and quarterly data analysis.

- An **Incident Alert** is created and sent alerting DIDD Central and Regional Office personnel of the incident.

- An **Investigation Initial Notification** is created and sent alerting DIDD Central and Regional Office personnel detailing the allegation and injury.
• Copies of all RIFs sent to DIDD are saved electronically

• After review, RIF information is entered into the Incident and Investigations database (I&I)

• Investigators use information from the I&I database in every investigation to research incidents involving the person supported, the alleged perpetrator, and identification of systemic issues.
Information derived from RIFs is utilized by the Office of Incident Management for a wide variety of purposes, including many types of reports and trend analyses, such as:

• Monthly Protection from Harm Trend Report
• Protection from Harm Profiles
• Vulnerable Persons Index Monthly and Quarterly Reports
• Fatal Five Prevention efforts (aspiration, GERD, dehydration, seizures, bowel obstruction and sepsis)
• Quarterly PFH State Quality Management Committee (SQMC) Data Reviews
• Dashboard Analysis
INVESTIGATORS

- DIDD operates Offices of Investigations in all three regions of the State
- Investigators in each region are supervised by an Investigations Coordinator a/k/a Lead Investigator
- The Investigations Coordinators and a statewide Clinical Investigator are supervised by the Director of Investigations in the Central Office
- There are 47 investigators employed by DIDD statewide, including the Investigations Coordinators
- All Investigators receive training and certification through Labor Relations Alternatives.
- Each new investigator must complete an initial 90 day intensive training period during which they are evaluated while conducting investigations under the direct mentorship of a seasoned investigator.
- All investigators receive ongoing training on a quarterly basis
ON-CALL INVESTIGATOR

• One investigator is designated to answer the Investigations Hot Line in each region – the Hot Line is staffed 24 hours, 7 days a week

• The On-Call Investigator conducts the initial triage of the call to determine the need for any immediate response.

  • Notification to agency management for the removal of staff from direct contact with any person supported for allegations of physical or sexual abuse
  • Identify the need for notification of law enforcement
  • Coordination with the medical examiners office. Investigators attend autopsies for unexpected or unexplained deaths
• Immediate response to the location is required under the circumstances for these types of incidents:

  • Alleged physical or sexual abuse or neglect resulting in serious injury or where evidence needs to be collected quickly

  • Alleged abuse or neglect where the person(s) supported are likely to remain at risk without prompt intervention by the investigator

  • Serious injury where abuse or neglect is suspected

  • Unexpected or unexplained death
When conditions are observed by a DIDD investigator, QA survey team members or regional office staff which appear to indicate immediate jeopardy to a person(s) supported. Examples may include:

- Serious environmental hazards
- Serious medication errors
- Identification of major risk factors in absence of a plan to address the risk
- Lack of follow-up for major medical issues
- Failure to follow mealtime staff instructions resulting in choking or imminent risk of choking
- Little or no food in the home or little or no food appropriate to a person’s special diet
- Failure to remove an alleged perpetrator of physical or sexual abuse
• The DIDD investigator or other DIDD staff will contact agency management to provide verbal notice of the immediate jeopardy situation; DIDD’s regional Director of Operations is also notified

• The investigator will remain on-site until agency or operations personnel arrive or the immediate jeopardy situation has been mitigated sufficiently to ensure the person’s health and safety

• The DIDD Regional Director will be notified

• Written notice to the provider including mandated actions to be taken within a specified timeframe will be issued

• The person’s ISC or case manager will be notified

• A Reportable Incident Form (RIF) will be completed and the Investigations Unit will be notified, if necessary

• The provider will notify the person’s legal representatives or authorized primary contact
The investigator contacts Sally’s provider agency and schedules interviews and requests relevant documents. This contact is normally made the day the case is assigned.

- Initial face-to-face contact must be made with a relevant witness (in this case, Sally, the person supported) and a scene visit conducted, within three business days of the case assignment.

- All interviews and written statements should be conducted and documentation received by the 10th business day of the case assignment.
INITIAL PHASES OF THE INVESTIGATION

• During the scene visit, photographs and diagrams are made of the area where the fall occurred. Since the incident happened at Ms. Brown’s private residence, permission for access was requested and obtained.

• When interviewing Sally, photographs of the injury site are obtained with Sally’s permission; subsequent photos shall be taken to show the progression of the injury.
The investigation process includes interviews of witnesses, obtaining written statements, collection of documentary, video recordings and other evidence, review of the background checks and personnel file of the alleged perpetrator and preparation of the Final Investigation Report.
Investigations must be completed within 30 calendar days from notification of the allegations.

Extensions of the 30 day requirement for community providers may be granted under limited circumstances which are beyond the investigator’s control.
• Unless an exception is approved by DIDD Central Office, alleged perpetrators of physical or sexual abuse must be placed on administrative leave or in a position where they do not have direct contact with persons supported or supervision of direct support staff.

• The administrative leave exception process requires
  • Completion and submission of the Exception Request online form by the provider
  • Consent of legal representative or ISC when there is no legal representative
  • An interview with the victim and identified witnesses by a DIDD investigator to ensure that an approved exception is appropriate.
Legal representatives or authorized primary contacts for persons supported, as well as Independent Support Coordinators, are contacted within five days of the initiation of an investigation.

Investigators work with outside entities investigating the same incident, such as Adult Protective Services, TBI and local law enforcement organizations, when circumstances permit.

Final Investigation Reports are confidential under state law unless redacted so that persons supported cannot be directly or indirectly identified.
The investigator interviews witnesses whose statements will be summarized in the *Direct Evidence* section of the investigation report:

- The person supported
- Any person who was present at the time of the incident
- the alleged perpetrator
These witnesses include:
• The attending physician at the emergency room, housemates
• Conservator or legal representative
• The agency clinical coordinator
• Direct care staff and/or supervisor or management personnel on duty at the time of the incident
• Agency incident management coordinator
The investigator may review, as applicable:

- Reportable Incident Form
- Individual Support Plan
- Behavioral Support Plan and Risk Issues Identification Tool
- The Staffing Plan for the home, any applicable clinical Plan of Care
- The Daily Notes for the home for relevant dates
- The agency’s transportation logs
- The agency body check form
- The staffing schedule and time sheets
- Medical records
- A Summary of Reportable Incidents related to the person supported for the past year
The investigator reviews the DIDD Provider Manual Chapter 7 and any additional sections of the Provider Manual relevant to the specific allegations and/or incidental findings made during the course of the investigation.

The investigator also reviews the agency’s policies and rules that may be relevant to the specific investigation and/or incidental findings made during the course of the investigation.

Documentary evidence is summarized in the Circumstantial Evidence section of the investigation report.
Final reports summarize all witness statements, documentary evidence and other evidence collected during the course of the investigation.

• Within 30 calendar days from opening of the investigation, the investigator completes the Final Investigation Report

• After consideration of all the evidence, the investigator determines, using a ‘preponderance of evidence’ standard, that the perpetrator is substantiated for supervision neglect due to the fact that she took Sally to her personal home, an act which is prohibited by the agency and DIDD, and did not provide assistance to Sally while she was in the bathroom as required within her clinical plan of care.
A detailed analysis is included in the report to explain how the specific conclusions are reached.

The final report is distributed to the appropriate parties and the investigation is closed. Central Office Protection From Harm staff enter information into the I&I database to record the conclusion(s) of the investigation and information related to the substantiated perpetrator.
Any issues noted during the course of the investigation that were not directly related to the incident are listed as *Incidental Findings*.

While interviewing witnesses in Sally’s case, it was discovered that:

- Agency staff had not been trained on Sally’s plan of care for transfers
- Staff reported to investigator that Sally had shown decreased independent mobility issues and a need for increased assistance, though staff had failed to document the issues in the daily notes
- Reportable Staff Misconduct occurred as co-workers were aware that the perpetrator was taking Sally to her personal residence on an ongoing basis but failed to report this to the agency IMC
Providers, ISCs/CMs, persons supported or their legal representatives may request review of a DIDD Final Investigation Report.

Review by the Investigation Review Committee (IRC) may be requested within 15 days of receipt of the Final Investigation Report.

A request must raise genuine and material factual issues affecting the challenged conclusion(s).

The Director of Investigation may reopen an investigation based on the request.

A request may be approved for consideration by the IRC based on the request. Review may be approved for some issues but not others. Incidental findings are not reviewed nor are Reportable Staff Misconduct.

The review process is not an appeal. It is a consideration by the IRC of the conclusion(s) of a DIDD Final Investigation Report when new or additional information or evidence not considered during the investigation is presented, or when a matter raises a question concerning the integrity of the investigative process.
The IRC meets monthly. This committee is comprised of DIDD employees as well as representatives from a DIDD contracted provider, DRT, APS, ARC of Tennessee and Tennessee Council on Developmental Disabilities.

The IRC can uphold, overturn or modify the investigative conclusion(s), or request that further investigation be conducted.

The decision of the IRC cannot be overturned or modified by any DIDD employee, including the Commissioner.
• All Class 1 substantiations (acts or omissions resulting in serious injury to a person supported requiring treatment by physician, physician assistant, FNP and/or BA) are reviewed by the Abuse Registry Review Committee (ARRC) for consideration of placement of the substantiated perpetrator(s) on the State’s Abuse Registry. The ARRC meets monthly and is comprised of DIDD employees as well as persons who are not affiliated with DIDD.

• If the committee’s decision is to refer the perpetrator for placement, the perpetrator has sixty days to request an administrative hearing.

• Providers are prohibited from hiring or retaining anyone whose name appears on the statewide Abuse Registry.
• Persons holding a professional license who are substantiated in an investigation will be referred to the appropriate licensing authority if their case is reviewed by ARRC and referred for placement on the Abuse Registry by that committee.

• The cases of substantiated professionals which are not reviewed by the ARRC or not referred for placement on the Abuse Registry by the ARRC will be reviewed by the appropriate DIDD Central Office director for that discipline, who will decide if the licensing authority should be notified.
VULNERABLE ADULT PROTECTIVE INVESTIGATIVE TEAM (VAPIT)

• By January 1, 2017, the district attorney general of each judicial district established, or caused to be established, a vulnerable adult protective investigative team (VAPIT) for the purpose of:

  • Coordinating the investigation of suspected instances of abuse, neglect, or exploitation of an adult; and

  • Receiving and reviewing information generated by the multi-disciplinary adult protective services evaluation teams.
MAJOR PROCESSES OF DIDD PROTECTION FROM HARM SYSTEM CENTRAL OFFICE AND REGIONAL OFFICES

ANPC → RQMC → SQMC

Investigations Follow-up → Provider
Allegation is reported and case number assigned/opened (Investigation Unit)

Investigations Unit Secretary disseminates Final Report electronically

DIDD Investigator Conducts Investigation (30 calendar days) and completes Final Report

Substantiated

Level 1

Level 2

Unsubstantiated
Allegation is reported and case number assigned/opened (Investigation Unit)

Substantiated

Level 1

Provider must complete Plan of Correction (POC) and submit electronically to DIDD within 14 calendar days of receipt of the Final Report (must include written notification of the outcome of the investigation to the alleged perpetrator(s) and person supported and/or legal representative within 15 days).

DIDD Investigation Follow-Up Unit Staff conduct an on-site visit to ensure stated actions in the POC have been implemented

DIDD Investigation Follow-Up staff process POC and complete closure letter. Regional Director signs closure letter. PFH Unit Secretary disseminates and logs closure letter (within 45 days of release of Final Report)

PFH Unit Secretary disseminates and logs closure letter (within 45 days of release of Final Report)

Provider and R.O. retain copy of closure letter

Sample provided to Quality Assurance Unit for Domain 3 follow-up during Survey
DIDD INVESTIGATION FOLLOW-UP PROCEDURES

Allegation is reported and case number assigned/opened (Investigation Unit)

Substantiated

Level 2

Provider must complete Plan of Correction (POC) and submit electronically to DIDD within 14 calendar days of receipt of the Final Report (must include written notification of the outcome of the investigation to the alleged perpetrator(s) and person supported and/or legal representative within 15 days).

Provider must submit supporting documentation with the POC to validate that stated corrective actions were implemented or provide target date of completion

DIDD Investigation Follow-Up staff process POC and complete closure letter. Regional Director signs closure letter. PFH Unit Secretary disseminates and logs closure letter (within 45 days of release of Final Report)

PFH Unit Secretary disseminates and logs closure letter (within 45 days of release of Final Report)

Provider and P.O. retain copy of closure letter

Sample provided to Quality Assurance Unit for Domain 3 follow-up during Survey

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DIDD INVESTIGATION
FOLLOW-UP PROCEDURES

Unsubstantiated

Allegation is reported and case number assigned/opened (Investigation Unit)

Alleged perpetrator(s) and person supported and/or legal representative must be notified of the outcome of the investigation in writing (within 15 days)

All Incidental Findings and Late Reporting (if applicable) must be internally addressed and documented in the provider’s Incident Review Committee Minutes

DIDD Investigation Follow-Up staff may inquire regarding what actions the agency took to address Incidental Findings

DIDD Investigation Follow-Up staff complete closure letter. Regional Director signs closure letter.

PFH Unit Secretary disseminates closure letter and logs (within 45 days of release of Final Report)

Provider & R.O. retains copy of closure letter in records
As part of the DIDD Quality Management system, each region maintains an RQMC which meets monthly

• RQMC reviews provider performance and determines the need and frequency of Provider Support Team follow-up

• Results of each QA Provider Performance Survey are reviewed along with information from other components of the Quality Management System, such as complaint information, I&I data, PFH profiles, recommendations for the ANPC, provider support team follow up information, etc.
STATEWIDE QUALITY MANAGEMENT COMMITTEE (SQMC)

- The SQMC membership is comprised of management level staff of all units within the Central Office and includes representation from each Regional Office.
- SQMC meets monthly and reviews statewide data to determine trends and initiate follow up actions if warranted.
- Information regarding actions taken by the RQMC in response to specific provider performance or other issues is reported to and reviewed by the SQMC.
- The SQMC ensures statewide consistency and maintains oversight of regional QM activities.
- Both the RQMC and SQMC may take a variety of actions to improve provider performance. Only those involving provider termination, moratorium and MTA must go through SQMC prior to implementation.
Each region has an Abuse & Neglect Prevention Committee (ANPC)

The mission of the regional ANPC is to advocate for, and to protect and enhance the rights, well-being and quality of life of persons supported

The functions of the ANPC are to:

- Review report summaries, reports and analyses by the Office of Incident Management
- Utilize available resources to request additional information deemed necessary for evaluation
- Make recommendations for changes and improvements for the reduction and prevention of A/N/E with respect to particular individuals and providers
- Make recommendations for systemic change or improvement and submit to DIDD management
• Recommendations for statewide or systemic policy or procedural changes are submitted to the Commissioner, Deputy Commissioner for Program Operations, Regional Director and the SQMC

• Recommendations concerning regional operations which would affect multiple providers in the region are submitted to the Deputy Commissioner for Program Operations, the Regional Director and the SQMC

• Recommendations regarding a particular person supported or provider are submitted to the Chief Officer or Executive Director of the provider, the DIDD Regional Director and the RQMC
- See more at: http://www.tn.gov/didd/article/incidentmanagement#sthash.MOBQwEri.dpuf
- http://www.tn.gov/didd/article/investigations
- Reportable Incident Form - Middle Region
  http://www.tn.gov/assets/entities/didd/attachments/RIF-Middle.doc
- http://www.tn.gov/assets/entities/didd/attachments/Provider_Manual.pdf: Refer to Chapter 7
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