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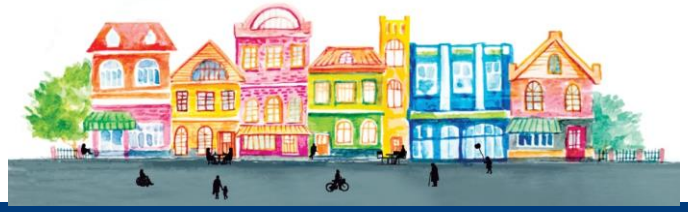
Regional Residential Provider Meetings

July - August 2018

ISAC Update
Aug. 16, 2018



Meetings with Residential Agencies

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Participants: Residential agency CEOs, CFOs, Directors, County Administrative Entities and HCQUs.

Purpose: To discuss recent analysis of available data and recommendations from oversight agencies.

- Publication by HHS, OIG, ACL and OCR - “Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight”;
- What we’ve learned from the Federal OIG investigation of Pennsylvania’s incident management system to date;
- Analysis of incidents of deaths, serious injuries, neglect;
- Analysis of licensing actions;
- Findings from the root cause analysis of residential licensing action.

A Roadmap for States – Compliance Oversight Model Practices

A toolbox for better health and safety outcomes in group homes

Model Practices for State Incident Management and Investigation

- Reporting and notification
- Incident review
- Investigation
- Corrective action and implementation
- Trend analysis

Model Practices for State Incident Management Audits

- Assess incident reporting
- Assess response and review of incidents
- Assess investigations
- Assess corrective actions
- Assess identification and response to incident trends

Model Practices for State Mortality Reviews

- Identify cause and circumstances of beneficiary death
- Where warranted, take corrective action
- Identify mortality trends
- Systemic responses and evaluation of their efficacy
- Reporting

Model Practices for State Quality Assurance

- Oversight of service planning and delivery
- Periodic assessment of performance
- Review network capacity and accessibility
- Compliance monitoring of requirements and outcomes

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Incidents and Hospitalizations

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Findings from an analysis of incidents, hospital claims, mortality reviews and investigations over 2 years or more:

- Between January 1, 2016 and March 31, 2018, ODP received 700 incident reports where people experienced a choking episode while eating.

- Between January 2015 and December 2016, 452 distinct participants receiving services in a 6400 Community Home presented at an emergency room at least once with at least one of the above disorders. The numbers below show the number of emergency room visits by disorder (Note: numbers will not sum to 452 as some participants presented with more than one disorder):
  - Bowel Obstruction / Constipation - 124 participants
  - Aspiration – 23 participants
  - Dehydration – 40 participants
  - Seizure – 158 participants

Qualitative Analysis of Findings

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Qualitative analysis of incidents and regulatory violations found five re-occurring conditions that resulted in or contributed to unexpected death in 6400-licensed residential settings:

- **A documented history of at least one similar event.** Post-event analysis finds that participants who died as a result of an event (e.g. choking) had at least one prior event of a similar nature.

  Example, participants with choking fatalities had at least one choking event before the event that led to death. The event usually does not have health consequences that are immediately apparent (such as the need for hospitalization), which suggests that such events are not recognized as sentinel events.

- **Previous recommendations by medical professionals were not acted upon.** Post-event analysis finds that participants who died as a result of an event or serious medical condition finds evidence that specialized evaluation or treatment was recommended at some point in the past but not acted upon.

  Example: records of multiple participants who died as a result of wandering behavior contained examination results showing the onset or worsening of dementia.

Qualitative Analysis of Incidents

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- **Staff caring for the participant had little-to-no experience working in the home or with the participant.** Staff on duty at the time of fatalities usually did not work in the home before the event, or only did so on occasion, and did not have any experience supporting the participant prior to the day the event occurred.

- **Staff caring for the participant were not trained on the participants' needs.** Investigation of deaths consistently finds that staff were not provided with a copy of the ISP and were not trained to meet the participant's specific needs. To the extent that staff are familiar with the person's needs, it is usually via word-of-mouth, i.e. another staff person provided some sort of nonspecific guidance.

- **Inconsistencies in participants' care plans.** Medical and support records of participants who died are frequently unclear or inconsistent. In cases of choking fatalities, terms such as "pureed," "soft," "mechanically soft," etc. are used interchangeably and supervision needs are vague (e.g. "needs supervision while eating," "needs to be reminded to chew slowly," etc.) or in conflict at different points (e.g. "Jane is independent at mealtimes / Jane needs supervision while eating / Jane cannot have lunchmeat").

High-Risk Regulatory Violations

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ODP has identified four regulations that pose the highest risk of harm:

§ 6400.16. Abuse / § 6400.33(a) - Abuse of an individual is prohibited / an individual may not be neglected, abused, mistreated or subjected to corporal punishment.

§ 6400.62(a) - Poisonous materials shall be kept locked or made inaccessible to individuals who cannot safely use them.

§ 6400.68(b) - Hot water temperatures in bathtubs and showers may not exceed 120˚ F.

- 139 violations for hot water above the allowable maximum.
- For most adults, a second-degree burn will occur after 24 seconds of exposure to water that is 130˚ F; in 54 cases, the water temperature was 130˚ F or higher.
- For most adults, a second-degree burn will occur after 5 seconds of exposure to water that is 140˚ F; In 11 cases, water temperature exceeded 140˚ F.

§ 6400.144. - Health services, such as medical, nursing, pharmaceutical, dental, dietary and psychological services that are planned or prescribed for the individual shall be arranged for or provided.

Conditions that Increase Risk

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- Behavioral health
  - Trauma
  - Mood/Anxiety Disorder
  - Psychotic Disorder
  - Neurodiversity/Autism Spectrum
- Physical disabilities
  - Mobility Impairment
  - Dysphagia – Swallowing difficulties
  - Neurologic – low muscle tone, seizures
- Health Conditions
  - Diabetes
  - Respiratory
  - Heart Disease
  - Age related conditions – falls, dementia, changes in metabolism

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The Fatal Four

- **Constipation**
- **Dehydration**
- **Aspiration**
- **Epilepsy**

See Fatal Four Power Point

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Service Definition
Residential Habilitation
Behavioral Support

ODP Improvement Strategies

ODP Improvement Strategies

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- Service definition and rates allow for hiring clinical professionals
- HCQUs training and technical assistance including on the Fatal Four
- Instituting, through county agreements, a county routine risk assessment in conjunction with support coordination organizations.
- Licensing Standards of Practice for licensing staff
- Interpretive licensing guidelines that target at risk residents
- Developed mortality review process
- Modifications to Speech Language Therapy service to allow for swallowing assessments, education and treatment

Speech and Language Therapy

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- Services provided by a licensed and American Speech-Language-Hearing Association (ASHA) certified speech-language pathologist to participants with a wide variety of speech, language, and swallowing differences and disorders. Communication includes speech production and fluency, language, cognition, voice, resonance, and hearing. Swallowing includes all aspects of swallowing, including related feeding behaviors. Speech and language therapy includes:
  - Counseling participants, families and caregivers regarding acceptance, adaptation, and decision making about communication, feeding and swallowing, and related disorders.
  - Prevention and wellness activities that are geared toward reducing the incidence of a new disorder or disease, identifying disorders at an early stage, and decreasing the severity or impact of a disability associated with an existing disorder or disease.
  - Screening participants for possible communication, hearing, and/or feeding and swallowing disorders.
  - Assessing communication, speech, language and swallowing disorders. The assessment process includes evaluation of body function, structure, activity and participation, within the context of environmental and personal factors.
  - Developing and implementing treatment to address the presenting symptoms or concerns of a communication or swallowing problem or related functional issue. Treatment establishes a new skill or ability or remediates or restores an impaired skill or ability.

ODP Improvement Strategies

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- ISP revisions – to include risk assessment/mitigation
- Orientation Package for new providers
- Require residential providers to complete the dual diagnosis training
- Establish a Learning Collaborative for Residential Agencies
- Development of a Framework for a Successful Residential Program
- Adoption of the Health Risk Screening Tool (HRST) - a web-based screening instrument designed to detect health destabilization early and prevent preventable illness, health related events and even death http://hrstonline.com/

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Provider Strategies Discussion