***MUI Discussion: OPRA Rules Focus Group***

* the current MUI system has become one considered punitive and scary. This has led to unintended consequences resulting in negative impact on workforce hiring and retention. DSPs in fear of taking risks (which are greatly increased by community initiatives) and leaving due to MUI process/fear.
* **Policy Committee Members expressed concerns regarding:**
1. It seems that it is now GUILTY until proven innocent-but even when unsubstantiated, it is only because they haven’t dug far enough—“Something had to happen” mentality. The process doesn’t end because even unsubstantiated events are being brought up when there are more than one, going back to past.
2. Even with unsubstantiated events, provider must provide prevention plan, underlying causes, and follow-up.
3. Providers being directed to pull staff from schedule (excessive amounts of time); being directed to fire staff, etc.
4. Community integration and current initiatives in our field requires risk taking. The rule/process does not allow for risks, in fact, supports protections of a congregate facility.
5. There needs to be more awareness of the actual rule and not what others tell us it is.
6. How can you get failure to report substantiation when the MUI itself was not substantiated?
7. Staff getting investigated; families, communities, and others doing same thing-not receiving any scrutiny.
8. Unapproved behavior supports have been an issue with new behavior support changes.
9. MUIs are filed on victim except for peer to peers which are filed on both victim and PPI
10. Why is use of abdominal thrusts (Heimlich) an MUI-if it worked why should it be included as a negative?
11. There is such stigma around incidents and MUI that staff feel threatened and are leaving our workforce-not entering our field

Rules Focus Group Concerns:

1. It is not necessarily in the rule itself-the issues are with the application and implementation---we all want better services, quality and prevention
2. How do we complete true prevention plans when we don’t have the findings in the investigations yet?
3. Providers are not receiving reports until months after incident
4. Communication is lacking between IA, provider, county, etc.
5. When someone dies naturally, how should the provider be responding to preventative measures requests, etc.
6. Serving in multiple counties—every county has different interpretation, process, and even different forms that you have to fill out specific to that county. All aspects are very inconsistent and leads to issues when serving in multiple counties (such as a camp, etc.)
7. The documentation-paper compliance is cumbersome and sometimes repetitive (entering same information in multiple forms, documents)
8. For unknown injuries, the Medicaid requirement to interview all staff working in location for a period of time is very difficult
9. Peer to peer interpretation of rule has been very inconsistent—counties giving instructions that contradict the document DODD MUI provided regarding criminal determination and law enforcement
10. Many counties have a lack of knowledge of what the rule really says
11. The logging and multiple documents is very time consuming
12. What is the actual requirement for sending the UI logs—some counties asking for it weekly, monthly, never???
13. Many times demeanor of IA is a great concern
14. The Attorney General is also now doing reviews after the MUI is closed by county-state, etc.
15. Failure to report has become a huge issue. Providers are reporting an allegation---through the investigation the category is changed and then receiving failure to report (however, the provider did report the allegation as it was known originally)
16. Failure to report should not be applicable when the allegation is unfounded/unsubstantiated.
17. Staff being placed on leave pending investigations (waiver) for 6-8 weeks. Issues with staffing crisis as it is…and then to go without pay for this period of time. Then, unsubstantiated so provider has to back pay (plus pay the Overtime to cover the shifts missed).
18. Even when allegations are unsubstantiated for lack of evidence, there is extreme fear/stigma attached to the situation.
19. Emergency services are upset with the number of times providers have to call them when things do not even meet criminal definitions
20. It depends on who answers the phone for county as to what is filed, how it is handled, etc.
21. When individual is transferred to hospital and then nursing home for extended period of time (over 5 weeks), why would MUI only be questioning the provider who provided services over 5 weeks ago and not the nursing home or hospital in case of death?
22. Families stealing-why not MUI?
23. For ICF, we complete full report in 5 days, sometimes not receiving county MUI report for several months later---when variance in investigation reports, provider does not have their report
24. When individuals are dually served Medicaid State Plan, Children’s Services, DODD, all have different definitions of sentinel events-unusual or major unusual events---systems not consistent and rules do not align. If under CMS umbrella, is there any way for more consistency???
25. For delegated nursing (one time that staff gave incorrect pills)=MUI neglect, put on MAIS (which follows the person). There is no due process and DOES NOT COMPLY WITH LABOR LAWS. (person’s personnel records/actions can be viewed by anyone on MAIS)
26. As a parent, we can’t find good providers and when we do, they make one mistake and are tortured-career ruined forever—even professionals nurses, SW are scared to work in this field because of this rule
27. Unscheduled hospitalizations (with fragile medical population)-becoming a huge issue-hospitals admitting for observation or keeping in ER for observation (does this count?) Providers spending many hours on unscheduled hospitalization paperwork without any true benefit to those served.
28. County often cut and pasting provider reports
29. Clients even telling staff-I will get you fired…I will just tell them that you did something on purpose and you will be gone
30. Hard to train someone new to the field in classroom prior to having any exposure to location/individuals or what it is like to be a DSP (with requirement to be completed prior to direct contact). Can we rethink training after they have seen location, met individuals, etc…
31. Community Employment-Working at Giant Eagle (has become issue- county expecting provider to report-provider fading supports and not on site)
32. Need to capture the true human element (error rate for perfect human around 3%)…must evaluate intent and build in a factor for what a reasonable human can be expected to perform meaning if I put on the seatbelt for 40 years each time I transfer individual (400 times) and one time, I forget to do so…is that really career ending worthy or is this something that could be expected as a normal human being.
33. Prevention plan does not apply to all situations
34. Staff are resigning due to the process and how they are treated by IAs