**MUI Concerns by Category**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| IA and the process | UIs | Neglect | Unscheduled Hospitalizations | Peer to peer | Failure to report |
| * 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. * Even with unsubstantiated events, provider must provide prevention plan, underlying causes, and follow-up. * Providers being directed to pull staff from schedule (excessive amounts of time); being directed to fire staff, etc. * It is not necessarily in the rule itself-the issues are with the application and implementation---we all want better services, quality and prevention * 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. * Staff getting investigated; families, communities, and others doing same thing-not receiving any scrutiny. * There is such stigma around incidents and MUI that staff feel threatened and are leaving our workforce-not entering our field * How do we complete true prevention plans when we don’t have the findings in the investigations yet? * Providers are not receiving reports until months after incident * Communication is lacking between IA, provider, county, etc. * 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.) * The documentation-paper compliance is cumbersome and sometimes repetitive (entering same information in multiple forms, documents) * Many counties have a lack of knowledge of what the rule really says * The logging and multiple documents is very time consuming * What is the actual requirement for sending the UI logs—some counties asking for it weekly, monthly, never??? * Many times demeanor of IA is a great concern * The Attorney General is also now doing reviews after the MUI is closed by county-state, etc. * 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). Lack of care/understanding regarding impact on staff and provider. * Even when allegations are unsubstantiated for lack of evidence, there is extreme fear/stigma attached to the situation. * Emergency services are upset with the number of times providers have to call them when things do not even meet criminal It depends on who answers the phone for county as to what is filed, how it is handled, etc. * Families stealing-why not MUI? * 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 * 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 consistency??? * County often cut and pasting provider reports * 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 * 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… * Community Employment-Working at Giant Eagle (has become issue- county expecting provider to report-provider fading supports and not on site) * Health and welfare alerts not time sensitive (meaning-winter precautions should come out before cold weather-not in spring) * Would be helpful to assign caseloads to IA-agency (specific IAs)? * When discrepancy of County and provider when pulling from schedule (being told can’t get to the investigation for several days)—rule says to call state-is there specific number and how about after hours??? | For unknown injuries, the Medicaid requirement to interview all staff working in location for a period of time is very difficult | 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) | 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 | MUIs are filed on victim except for peer to peers which are filed on both victim and PPI | How can you get failure to report substantiation when the MUI itself was not substantiated? |
| Providers do agree that they should have internal procedures/policies regarding UI—how they use the UI to direct follow up and training. Provides increased awareness for staff. (estimated over 50% of the investigative/admin time is towards UI reports—some providers 3-4 admin staff just for investigations) | 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 | Waiver-very difficult to get info from hospital—no discharge planning or understanding of services when returning home---having to send folks back on many occasions | 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 | 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) |
| Difficulty lies in how to balance burdensome administrative documentation, time, reporting and how that directly benefits or takes away from individual service delivery | 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. | Hospitals-not following medication orders-discharge paperwork is standard template and is 90% of the time totally inaccurate for medication and treatment orders for return home (not followed by DD—Care coordination is very imperative and the provider is not provider while in hospital) Nursing unfunded |  | Failure to report should not be applicable when the allegation is unfounded/unsubstantiated. |
| Med errors should be reported through medication error form-protocol (P/T or adverse should be in MUI category) must be careful to allow for human element error reasonable rate  (hospitals/nursing homes---how are med errors handled with individual staff??) | Has become the catch-all category for when other categories can’t be substantiated (IAs even have said-if we can’t get you for this…we will get you for neglect) | Care plans contain diagnoses…with generic hospital discharge documents…showing cough---for instance, does not count for Pneumonia, COPD, other diagnosis---so being opened |  |  |
| Has become paper compliance---not true outcomes of quality for those served | Need clarification neglect vs. missing individual | Medical definitions of admission, ER, observation not matching this rule –sometimes being discharged with NO diagnosis listed | **UNAPPROVED BEHAVIOR SUPPORT** | **DEATH** |
| Seizures should be handled through seizure reporting and tracking-coordination of care | County to county interpretation is VERY different and the categories are now all resulting in neglect when opened in different category | Hospitalizations not being viewed as part of normal course of life---always if provider messed up? What did provider do to cause it? | Increased due to new behavior rule-causes again documentation-admin time and burdensome process | When someone dies naturally, how should the provider be responding to preventative measures requests, etc. |
|  | HUGE liability concern-neglect substantiated by DODD does not meet legal/criminal definition and providers terminating based on substantiated neglect----EEOC and OCRC conflicts and problems with employment law |  | Doesn’t allow for risk in community | 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? |
|  | Why car accident in this category automatically if at fault? This conflicts with life circumstance—follows staff forever substantiated neglect??? |  |  |  |
|  |  | **MEDICAL EMERGENCY** |  |  |
|  |  | Why is use of abdominal thrusts (Heimlich) an MUI-if it worked why should it be included as a negative? |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |