**OPRA Rules Focus Group –February 13, 2017**

**Summary of Recommendations/possible proposals for further discussion:**

1. **Rename the rule (**MUI/UI) to something that doesn’t have punitive impact---more quality improvement, risk management related

Repace INVESTIGATIVE-implies criminal offense

1. **Neglect-**
2. Consider human error/reasonable factor
3. Consider intent
4. Consider possibly in different categories tiered with different factors (based on severity, circumstance)
5. Consider consistent definition with criminal/legal definition (and CMS-Childrens Services, state plan, etc…)
6. Consider further clarification (remove ANY) from definition
7. Reconsider car accident automatic determination
8. Consider legal/labor laws
9. **UI-**
10. Require providers to have specific procedure/policy regarding UIs which allows provider systems for follow-up and training (not just paper compliance to have a prevention plan and contributing factors). Documentation systems per the policy of provider which can be produced at request of Department or county.
11. Focus on Pattern/trend and true follow-up to impact quality of service delivery NOT paperwork compliance.
12. Consider removing ANY and BUT NOT LIMITED WORDING in definition
13. Handle med errors through med error reporting form (research how handled in other healthcare settings hospitals-nursing homes, etc.)
14. Handle seizures through seizure reporting/tracking and care coordination.
15. **Unscheduled Hospitalizations**
16. NO true outcome of care coordination resulting from this category—need to focus on Care Coordination and medical outcomes vs. paper compliance-coming up with prevention plan etc…medical care planning and follow-up.
17. Why unscheduled vs. scheduled—is there another way to ensure follow-up and medical care planning with prevention outcomes without this category?
18. Further clarification and consistency surrounding (new standard templates for hospital); waiver provider not provider during hospitalization but requirement to provide all information for MUI, etc.; definition of admission (with new ER admissions or Keeping for observation notes on discharge paperwork)
19. **Peer to peer**
20. MUI DODD clarification is very clear-not being followed by counties (very inconsistent)
21. **Training**
22. Consider allowing DSPs to be trained after having exposure to location/individuals/environment (hard for those never in field to understand without any exposure)
23. **All other categories (refer to suggestions contained on Outline of Concerns document)**