**Common Goal of MUI/UI rule:**

* Protecting health and welfare of individuals served (Quality service delivery, enhancing lives)
* Identifying cause and contributing factors leading up to the incident to develop prevention plans to reduce likelihood of the incident occurring again

***(We all agree that this is important and that the rule is necessary…we also agree that it is necessary to analyze patterns/trends)***

**And, In order to ensure the success of this system, it requires all of the below:**

1. DODD
2. County Boards
3. Provider
4. Law enforcement, Children’s Services, other external stakeholders

**However, the following unintended consequences have resulted from the current system:**

1. Creating fear/stigma that is forcing DSPs to leave the field in the midst of the largest Workforce Crisis to date
2. Has become another barrier for hiring-fear of ruining any career due to one mistake (particularly the neglect category)
3. Doesn’t align with current community initiatives (community jobs, smaller community settings require more risks)—currently the rule encourages the safety and security found in large settings.
4. Paper compliance vs. Outcome driven care coordination and prevention
5. Burdensome administrative time and processes that, at times, take away from the services of individuals with disabilities.

**Causal factors:**

1. Rule wording
2. Training (method of presentation and that the training must be done before contact with any individual or the work location-which is very overwhelming and confusing to a brand new employee entering field as DSP)
3. Culture of IAs
4. Duplicate processes (separate logs, follow up forms, duplicate IT system entries by all entities requiring repetitive information for DODD, counties, providers)
5. Different interpretation of the rule and different processes for each county in Ohio
6. Requiring additional documentation and or deadlines than the rule states (ie: some counties asking for all UIs, UI logs and full investigative reports weekly/monthly, etc.)
7. Paperwork and report requirements requiring increased administrative staff time
8. Does not apply to all citizens (families, community members, etc.)---prevention and quality affected by those, as well
9. Little consideration of Root Cause Analysis: human factors, human reasonable error factors, environmental factors, training and staffing factors, barriers, etc…

**NOTE: Several resources available discussing Human error factors:** (a few listed below)

All of the research shows that consideration of human error factors play an important role in true quality improvement in many workplaces. Below are a few of the resources:

<https://www.lifetime-reliability.com/cms/tutorials/reliability-engineering/human_error_rate_table_insights/>

<http://www.who.int/patientsafety/research/methods_measures/human_factors/human_factors_review.pdf>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3057365/>

<https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf>

You can find resources on true root cause analysis involving proximate cause, underlying causes, and factors affecting likelihood of reoccurrence of incidents/events, as well.

**What is necessary at this point?**

All of those who are responsible for the success in our field (as listed above) must have open dialog and understanding in order to achieve the desired outcome for quality, care coordination and services within our system. (including, but not limited to, true/clear expectations of each role, consistent application and implementation, consideration of all causal factors)

**Summary of Recommendations/possible proposals for further discussion from provider perspective through OPRA discussions:**

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

Replace INVESTIGATIVE wording-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. **Consideration of causal factors: human error, environmental, etc…**
24. **Shared IT system—information not entered in duplicate process, streamlined reports, data entry, time---identify responsibility and role of each---integrated data collection and reporting**
25. **Other concerns per diagram attached**