Basic MUI Rule Training | ADMINISTRATOR 2019

About the Department

The Ohio Department of Developmental Disabilities (DODD) oversees a statewide system of supports and services for people with developmental disabilities and their families. DODD does this by developing services that ensure an individual's health and safety, encourage participation in the community, increase opportunities for meaningful employment, and provide residential services and support from early childhood through adulthood.

Mission and Vision

The Ohio Department of Developmental Disabilities is committed to improving the quality of life for Ohioans with developmental disabilities and their families. Offering support across the lifespan of people with developmental disabilities, the department oversees a statewide system of supportive services that focus on assuring health and safety, supporting access to community participation, and increasing opportunities for meaningful employment.

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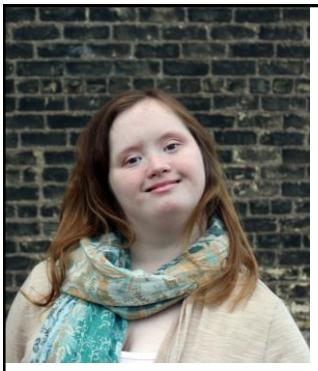
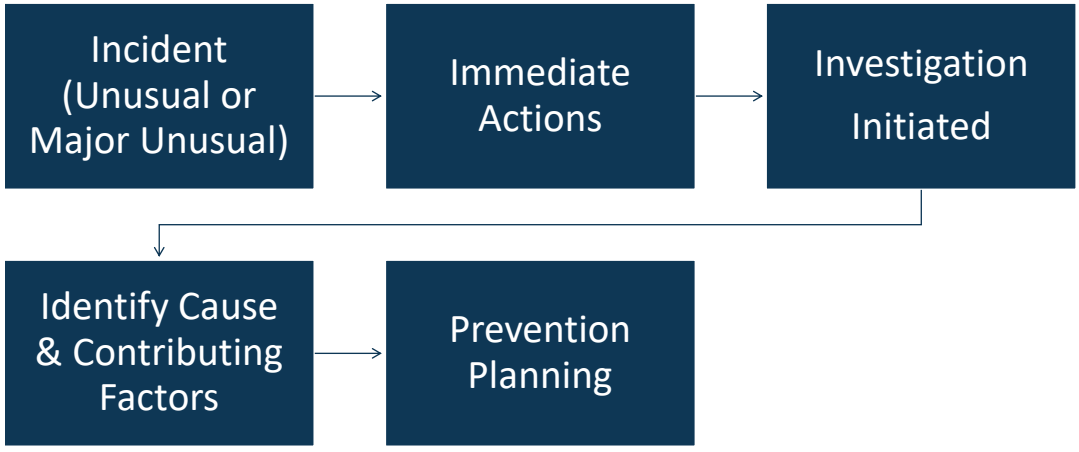


Purpose

This training is intended for any Direct Support Professional and covers the following topics:

- Unusual Incidents
- MUI Rule Definitions
- Reporting Requirements
- Patterns and Trends
- Abuser Registry
- Rights

Protecting the health and welfare of individuals supported in Ohio is of the utmost importance. In that regard, Ohio works diligently to build collaborative working relationships with service delivery partners focusing on reporting, investigation and prevention. The critical incident reporting system in Ohio (MUI System) is a robust, quality improvement process that counts on participation from individuals, families, providers, county boards and other constituents. Working together we can provide services that allow individuals to enhance quality of life outcomes while managing risk and protection from harm. Thank you for the work you do and the lives you change every day.



What can we do to encourage reporting?

1. Follow a system that everyone understands and knows what to do. Start by believing.

2. Build contingencies into the system and test for times/areas of weakness – Weekends, prior to vacations, certain key people not available to report to.

3. Take all reports seriously – including "historical" reports and reports from all witnesses.

What can we do to encourage reporting?

4. Know resources and relationship with law enforcement/children's services prior to crisis. Safety planning.
5. Maintain, as much as possible, confidentiality and anonymity. Support witness.
6. Red Flags of Non-Reporting – investigate.
7. Take Immediate Action.

What can we do to encourage reporting?

8. Prevention measures for failure to report. Criminal charges, Removal, Registry, Provider Certification, Training.
9. Individual First – Think about the worst case scenario.
10. Leadership.

Inspect what you expect!

Unusual Incidents

"Unusual incident" means an event or occurrence involving an individual that is not consistent with routine operations, policies and procedures, or the individual's care or service plan, but is not a major unusual incident. Unusual Incident includes but is not limited to;

- Dental injuries;
- Falls;
- Injury that is not a significant injury;
- Medication errors without a likely risk to health and welfare;
- Overnight relocation due to fire;
- Natural Disaster
- Mechanical Failure
- Incident involving two individuals served that is not a Peer-to-Peer act that is not a major unusual incident;
- Rights code violations
- Unapproved behavioral support without a likely risk to health and welfare.
- Emergency room or urgent care treatment
- Program implementation incidents

Incident Report Requirements

- Any person who provides any type of service to an individual with developmental disabilities.
- Your report should be clear, legible and easy to read.
- It should answer address 5 W's
- 13 required elements to an incident report. They include but are not limited to name, date, location, and description.

Unusual Incident Requirements

- Make preventative measures most important part
- Providers are required to investigate all unusual incidents.
- Always document what actions were taken to ensure the health and welfare of **any** at risk individual(s).

Immediate Actions

Always document what actions were taken following the incident:

Checked for Injuries	Called 911	Initiated First Aid	Contacted the Doctor	Secured the money
Made sure individual had food	Picked up needed meds	Notified Law Enforcement for criminal acts	Contacted County Board/IA	Separated the individuals
Removed the PPI when appropriate	Nursing Assessment	Taken to E.R.	Called Poison Control	Provided additional staffing

Major Unusual Incidents (MUIs)

- MUI means the alleged, suspected, or actual occurrence of an incident when there is reason to believe the incident has occurred.
- 19 categories

Reporting Responsibilities

Take immediate actions to protect all at risk individuals which shall include:

a. Immediate or ongoing medical attention as appropriate;
b. Removal of an employee from direct contact with any individual when the employee is alleged to have been involved in physical abuse or sexual abuse until such time as the provider has reasonably determined that such removal is no longer necessary;
c. Other necessary measures to protect the health and welfare of at-risk individuals.

The Department shall resolve any disagreements

Reporting Responsibilities

Immediate to 4 Hour Reports

- Accidental or suspicious death;
- Exploitation;
- Misappropriation;
- Neglect;
- Peer-to-peer act;
- Physical abuse;
- Prohibited Sexual abuse;
- Verbal abuse
- Inquiry from the media about a MUI

Reporting Responsibilities

- Submit Written Incident Report by 3:00 p.m. the Next Working Day
- Notify Law Enforcement of Criminal Act
- Notify Children's Services for abuse and neglect under the age of 21

What should you expect?

- Your role in the incident process
- What if I am a Primary Person Involved?
- Do I have to cooperate?
- What does substantiation mean?

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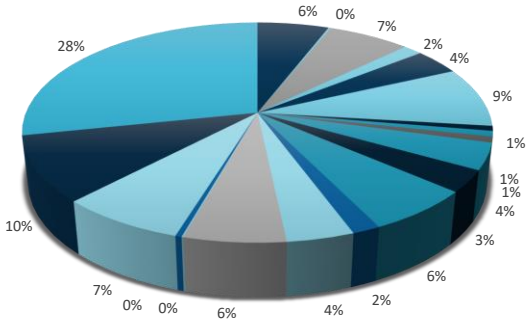
A review of the 19 MUI Types



- Undecided
- Accidental/Suspicious Death
- Alleged Abuse - PHYSICAL
- Alleged Abuse - SEXUAL
- Alleged Abuse - VERBAL
- Alleged Neglect
- Attempted Suicide
- Exploitation
- Failure To Report
- Law Enforcement
- Medical Emergency
- Misappropriation
- Missing Individual
- Non Accidental/Suspicious Death
- Peer-to-Peer Acts
- Prohibited Sexual Relations
- Rights Code Violation
- Significant Injury
- Unapproved Behavior Support
- Unscheduled Hospitalization

Ohio Department of Developmental Disabilities

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Physical Abuse

Physical force and reasonably be expected to result in harm.

Examples: Hitting, slapping, pushing, dragging or throwing an object when the allegation indicates that it could reasonably result in harm.

Cause/Contributing Factors:

- Control
- Unrealistic expectations and retaliation
- Care giver burn out and exhaustion
- Scheduled excessive hours
- Lack of coping skills
- Ineffective training to deal with aggression

2017 Physical Abuse MUI Data		
Total Allegations	1374	
Total Substantiated	426	
Percentage Substantiated	31%	
PPI Breakdown		
PPI Description	Sub #	%
Family	92	22%
Guardian	2	0%
*Other	145	34%
Payee	0	0%
Staff	128	30%
Unknown	59	14%

Sexual Abuse

- Unlawful sexual contact
- Unlawful sexual conduct
- Public indecency, voyeurism, importuning, etc.

Contact involves touching of an erogenous zone of another, including without limitation the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast, for the purpose of sexually arousing or gratifying either person. Conduct includes oral sex or penetration including digital or with objects.

Causes and Contributing Factors:

- Power
- PPI was a victim of sexual abuse

2017 Sexual Abuse MUI Data		
Total Allegations	316	
Total Substantiated	69	
Percentage Substantiated	22%	
PPI Breakdown		
PPI Description	Sub #	%
Family	16	23%
Guardian	1	1%
*Other	38	55%
Payee	0	0%
Staff	3	4%
Unknown	11	16%

Verbal Abuse

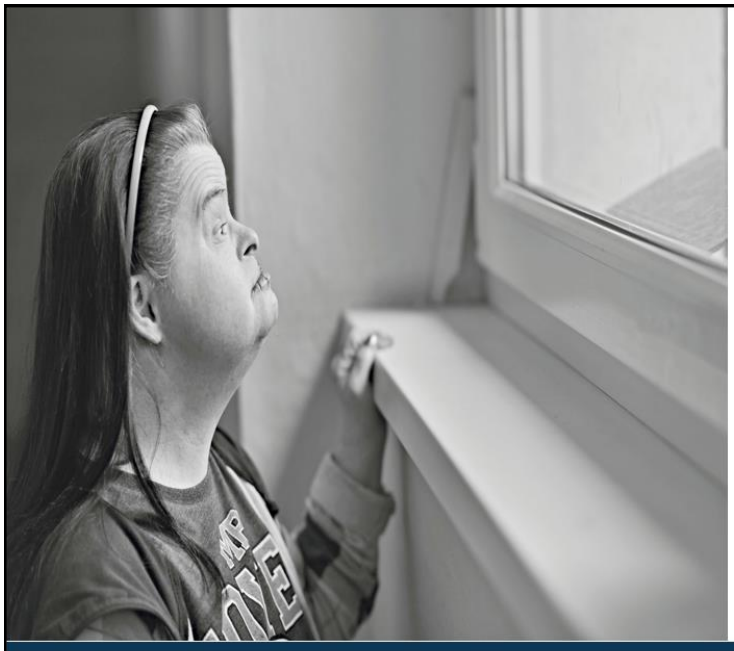
The use of words, gestures, or other communicative means to threaten, coerce, intimidate, harass or humiliate an individual.

Examples: Using social media to post humiliating pictures of someone you serve, threatening to harm a person if they tell on you for sleeping, telling the individual that you will have their roommate beat them up if they don't stop screaming.

Cause/Contributing Factors:

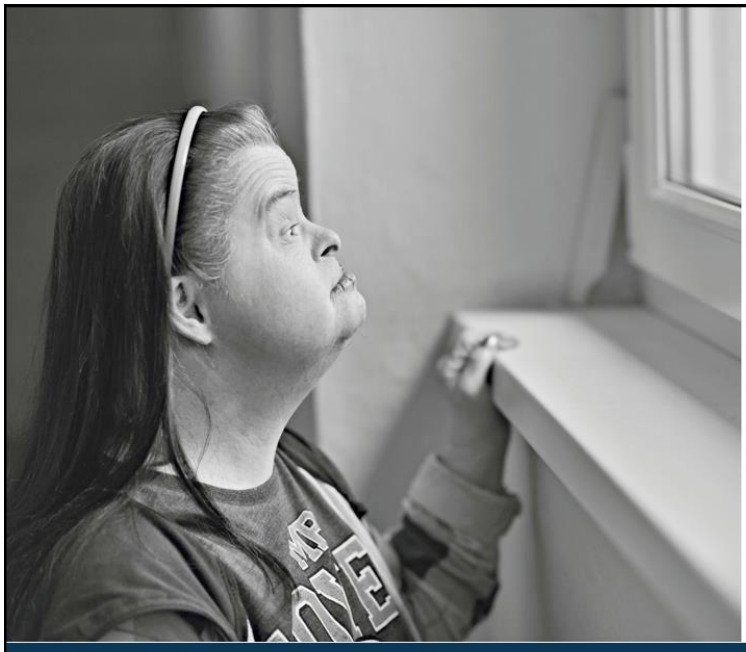
- Control; unrealistic expectations
- Staff are in challenging situation with little support
- Staff don't recognize their own trauma history

2017 Verbal Abuse MUI Data		
Total Allegations	779	
Total Substantiated	315	
% Substantiated	40%	
PPI Breakdown		
PPI Description	Sub.	%
Family	38	12%
Guardian	5	2%
*Other	80	25%
Payee	0	0%
Staff	176	56%
Unknown	16	5%



Know the signs of abuse

- Ongoing unexplained health problems like stomach aches, headaches
- Withdrawal from previously enjoyable activities, places, or persons, suddenly avoiding places or people
- Changes in sleep patterns such as nightmares, trouble sleeping, sudden bedwetting, and other sleep problems
- Dressing in layers of clothing
- Changes in appetite, loss of appetite, weight gain or loss



Know the signs of abuse

- Bruising
- Bleeding, soreness, redness, irritation, itching, and unusual discharges
- Torn or stained underwear or linens
- Sexually transmitted diseases
- New sexual knowledge or sexual behavior
- Sudden difficulty walking or sitting
- Suddenly frightened of certain people or situations

What can you do?

- Help the person feel safe, set judgements aside
- Remember to NOT imply blame on the victim.
- Ask questions like "were you able to?" Instead of "why didn't you?" when talking to the individual.
- Emotionally support the victim.
- Remember to refer the individual for counseling and victim's assistance as appropriate.
- Make a point to talk with the person one on one, repeatedly over multiple visits
- Make unscheduled visits
- Have a plan of response
- Every one deals with trauma differently

Neglect

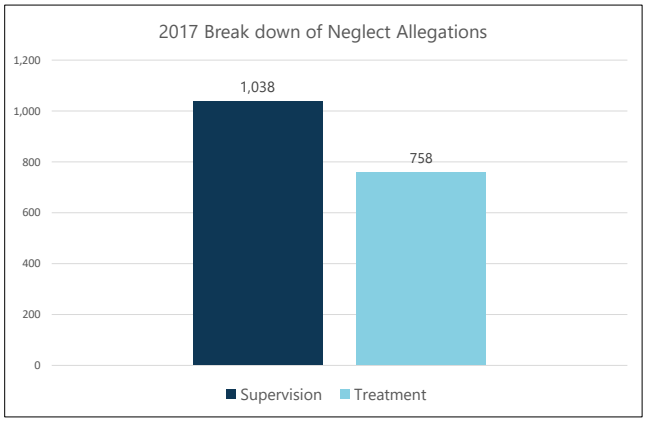
- A duty
- Failing to provide an individual with medical care, personal care, or other support that consequently results in serious injury or places an individual or another person at risk of serious injury.
- Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner.

Examples;

- An individual with a history of eloping is left alone in a vehicle.
- An individual's diet requires that all food is cut into dime-sized pieces and the DSP gives the individual a slice of pizza.

2017 Neglect MUI Data		
Total Allegations	1,797	
Total Substantiated	1,211	
Percentage Substantiated	67%	
PPI Breakdown		
PPI Description	Sub #	%
Family	89	7%
Guardian	21	2%
*Other	82	7%
Payee	0	0%
Staff	1016	84%
Unknown	3	0%

Neglect



What is Systems Neglect?

A substantiated MUI attributed to multiple variables.

Neglect types

Supervision

- An individual requires close supervision when eating and their food must be prepared in a mechanical soft consistency due to history of choking. The DSP working with the individual has not been trained by the employer on the individual's ISP needs and the individual began choking on non-modified food.
- A regular 3rd shift DSP calls off to the on-call manager. The manager does not secure coverage and the 2nd shift DSP left although no one came to replace him. This places individual's at risk of severe injury.

Treatment

- Criminal activity – not feeding or providing medication
- Lack of Medical attention
- Not calling 911
- Dietary Texture-pacing while eating
- Failure to follow ISP
- Failure to follow Doctor's orders
- Lack of training on treatments

Programmatic Implementation UI

An Unusual Incident involving the failure to carry out a person centered plan when such failure causes minimal risk or no risk.

Examples include, but are not limited to, failing to provide supervision for short periods of time, automobile accidents without harm, and self- reported incidents with minimal risk.

Programmatic Implementation UI

Examples;

- An individual is dropped off with no staff present. The individual uses his key and enters the home. The individual is home alone for an hour. There is no known risk to the individual.
- An individual with eyes on supervision walk away from the staff while they are paying for groceries. The individual makes it to the front door before the staff catches up to them.
- An individual's staff is there to provide over night support in case he has a seizure. The staff self- reported she fell asleep for 10 minutes. John was checked on and fine. He suffered no adverse effects.
- An agency staff was involved in a minor car accident while transporting 2 individuals. Staff was sited for failing to assure clear distance. No one was harmed.

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Misappropriation

- With intent
- Deprive, defraud, or otherwise obtain real or personal property
- As prohibited in Ohio Revised Code 2911 and 2913

Examples: Using someone's credit card, taking a person's Ipad, "borrowing" someone's money and paying it back on Friday, withdrawing cash from their personal funds without their knowledge/permission.

Cause and Contributing Factors:

- PPI has a gambling or drug problem
- Multiple people have access to property or funds
- Easy access to individual's financial information

2017 Misappropriation MUI Data		
Total Allegations	1,297	
Total Substantiated	858	
Percentage Substantiated	66%	
PPI Breakdown		
PPI Description	Sub #	%
Family	79	9%
Guardian	6	1%
*Other	134	16%
Payee	22	3%
Staff	175	20%
Unknown	442	52%

Exploitation

- Unlawful or improper or
- Using Individual's resources for personal benefit, profit, or gain

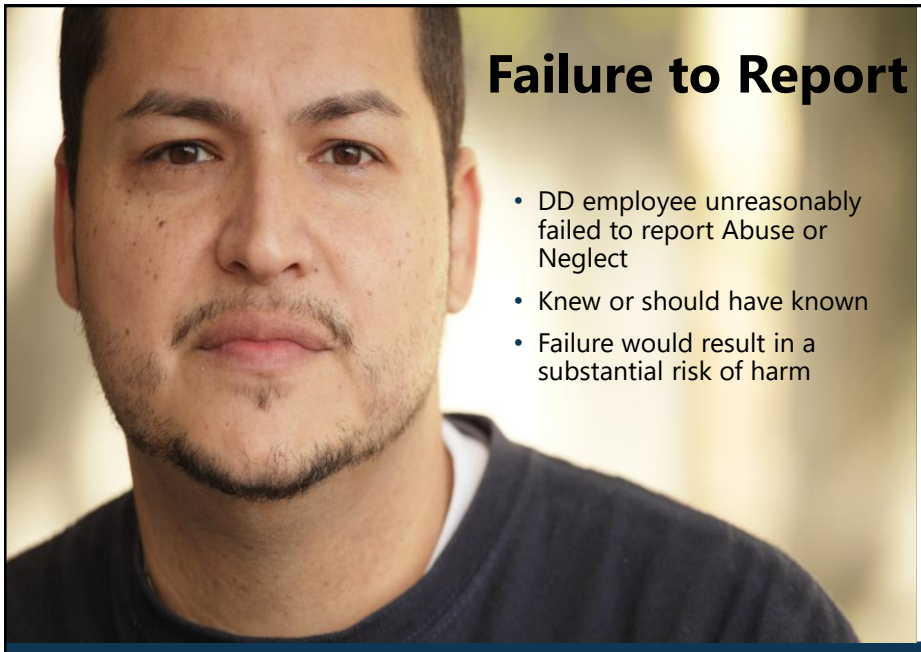
Examples: Selling raffle tickets to individuals for your daughter's sports team, having the individual buy home party items so you can get free stuff, having an individual clean your house, having the individual buy a fax machine for you to use at their home for your business.

2017 Exploitation MUI Data		
Total Allegations	167	
Total Substantiated	87	
Percentage Substantiated	52%	
PPI Breakdown		
PPI Type	Exploitation	
PPI Description	Sub #	%
Family	16	18%
Guardian	1	1%
*Other	22	25%
Payee	3	3%
Staff	19	22%
Unknown	26	30%

Prohibited Sexual Relations

- Developmental Disabilities employee
- Consensual sexual conduct or contact
- With an individual who is not their spouse
- Employed or under contract to provide care to the individual at the time of the incident
- Anyone in the Developmental Disabilities employee's supervisory chain of command

2017 PSR MUI Data		
Total Allegations	17	
Total Substantiated	11	
Percentage Substantiated	65%	
PPI Breakdown		
PPI Type	Prohibited Sexual	
	Sub #	%
Family	NA	NA
Guardian	NA	NA
*Other	NA	NA
Payee	NA	NA
Staff	11	100%
Unknown	NA	NA



Failure to Report

- DD employee unreasonably failed to report Abuse or Neglect
- Knew or should have known
- Failure would result in a substantial risk of harm

2017 FTR MUI Data		
Total Allegations	175	
Total Substantiated	123	
Percentage Substantiated	70%	
PPI Breakdown		
PPI Description	Sub #	%
Family	NA	NA
Guardian	NA	NA
*Other	NA	NA
Payee	NA	NA
Staff	123	100%
Unknown	NA	NA

Rights Code Violation

Rights code violation" means any violation of the rights enumerated in section 5123.62 of the Revised Code that creates a likely risk of harm to the health or welfare of an individual.

Examples:

- Staff takes the individual to a movie, he does not want to go, and he becomes upset and bangs his head against the wall.
- Staff padlocks the refrigerator and the individual sustains a laceration trying to break the lock.
- Staff refuses to take the individual on a scheduled activity for their own convenience or preference. The scheduled activity is a reinforce for positive behavior. Individual is upset due to this rights violation and becomes aggressive. LE is contacted the individual is arrested.

2017 Rights Code MUI Data		
Total Allegations	76	
Total Substantiated	47	
Percentage Substantiated	62%	
PPI Breakdown		
PPI Type	Rights Code Violation	
	Sub #	%
Family	0	0
Guardian	0	0
*Other	0	0
Payee	0	0
Staff	46	98%
Unknown	1	2%

Deaths

Two categories of deaths:

- Accidental or suspicious death. "Accidental or suspicious death" means the death of an individual resulting from an accident or suspicious circumstances (Category A
- Death other than accidental or suspicious death. "Death other than accidental or suspicious death" means the death of an individual by natural cause without suspicious circumstances (Category B)

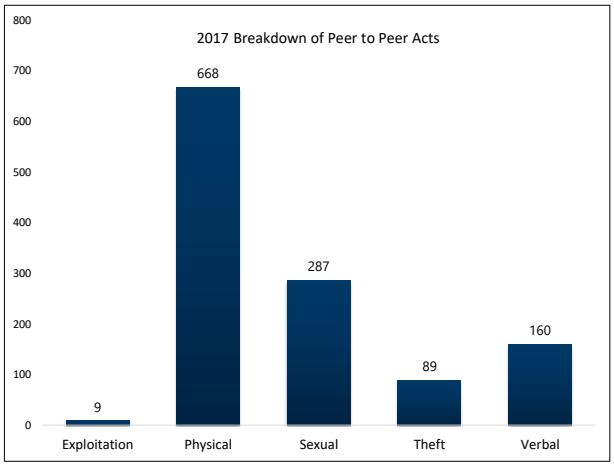
- There were 33 Accidental Deaths and 802 Non Accidental Deaths in 2017 of the 93,000 people served.

- The leading causes of accidental deaths were Choking, Falls, Drownings and Vehicle accidents.

Peer to Peer Acts

- Peer-to-peer act. "Peer-to-peer act" means one of the following incidents involving two individuals served:

- Exploitation
- Theft
- Physical Act
- Sexual Act
- Verbal Act



Peer to Peer Acts

- Theft which means intentionally depriving another individual of real or personal property valued at twenty dollars or more or property of significant personal value to the individual.
- Sexual Act which means sexual conduct and/or contact for the purposes of sexual gratification without the consent of the other individual.
- Verbal Act which means the use of words, gestures, or other communicative means to purposefully threaten, coerce, or intimidate the other individual when there is the opportunity and ability to carry out the threat.
- Exploitation means the unlawful or improper act of using an individual or an individual's resources for monetary or personal benefit, profit, or gain.

Peer to Peer Acts

- Physical Act which means a physical altercation that;
- Results in an injury that is treated in examination or treated by a physician, physical assistant, or nurse practitioner.
- Involves strangulation, bloody nose, a bloody lip, a black eye, a concussion, or biting which causes breaking of the skin; or
- Results in individual being arrested, incarcerated, or the subject of criminal charges.

Examples include;

- An individual reaches in front of a peer who bites him on the arm and causes an open wound.
- An individual is teasing a peer. The peer tells the individual to stop it or he will be sorry. Teasing continues, the peer gets up and starts strangling the individual.

Attempted Suicide

Physical attempt that:

- Results in ER treatment **or**
- Inpatient observation **or**
- Hospital admission

In 2017, there were 146 attempted suicides.

Four people lost their life.

Every attempt is a cry for help.

Suicide Prevention Resources

Crisis Text Line
Text "4HOPE"
to 741741 to be
connected
to a counselor 24/7

Suicide Prevention
1-800-273-TALK

Missing Person

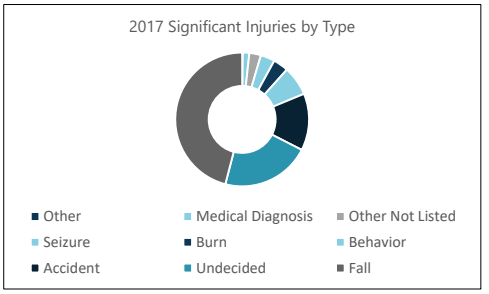
An incident that is not considered neglect and an individual's whereabouts, after immediate measures taken, are unknown and the individual is believed to be at or pose an imminent risk of harm to self or others. An incident when an individual's whereabouts are unknown for longer than the period of time specified in the individuals service plan that does not result in imminent risk of harm to self or others shall be investigated as an unusual incident.

There were 337 Missing Individuals reports in 2017.

Significant Injury

Significant injury means an injury of known or unknown cause that is not considered abuse or neglect and that results in concussion, broken bone, dislocation, second or third degree burns or that requires immobilization, casting, or five or more sutures. Significant injuries shall be designated in the incident tracking system as either known or unknown cause.

Examples: falls, broken finger of unknown origin, scalding burn to hands from faucet.



Type of Significant Injury	Count
Other	2
Medical Diagnosis	24
Other Not Listed	42
Seizure	52
Burn	55
Behavior	107
Accident	207
Undecided	324
Fall	691

Medical Emergency

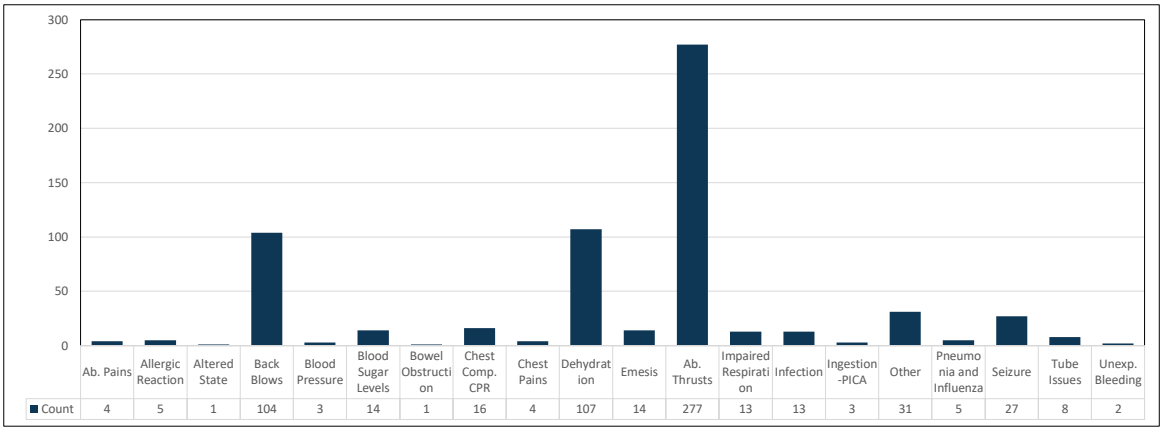
There was 652 Medical Emergencies filed in 2017.

Medical emergency means an incident where emergency medical intervention is required to save an individual's life (e.g. choking relief). Techniques such as back blows or cardiopulmonary resuscitation, use of an automated external defibrillator, or use of an epinephrine auto injector.

Narcan would be considered a life saving technique.

Remember choking prevention:
- Right Diet
- Proper Positions- 90 degree angle during all intake
- Supervision
- Take precaution with foods that are common choking hazards
- Document all choking incidents
- Notify the doctor or nurse of any swallowing concerns

2017 Medical Emergency Data



	Ab. Pains	Allergic Reaction	Altered State	Back Blows	Blood Pressure	Blood Sugar Levels	Bowel Obstruction	Chest Comp. CPR	Chest Pains	Dehydration	Emesis	Ab. Thrusts	Impaired Respiration	Infection	Ingestion -PICA	Other	Pneumonia and Influenza	Seizure	Tube Issues	Unexp. Bleeding
Count	4	5	1	104	3	14	1	16	4	107	14	277	13	13	3	31	5	27	8	2

Unanticipated Hospitalizations

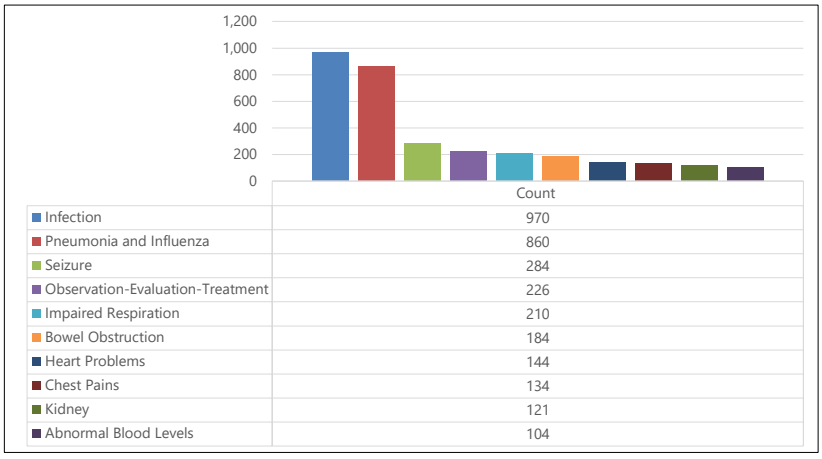
"Unanticipated hospitalization" means any hospital admission or hospital admission exceeding 24 hours that is not pre-scheduled or planned.

A hospital admission associated with a planned treatment or pre-existing condition that is specified in the Individual Service Plan indicating the specific symptoms and criteria which requires hospitalization.

Examples:

- The individual has labored breathing and a rapid heartbeat and is admitted to the hospital with a diagnosis of pneumonia.
- The individual has a history of high blood pressure but was hospitalized unexpectedly due to pneumonia.
- The individual reports severe pain and is admitted for surgery to remove kidney stones.

Top Ten Reasons for Medical Unanticipated Hospitalizations



	Count
Infection	970
Pneumonia and Influenza	860
Seizure	284
Observation-Evaluation-Treatment	226
Impaired Respiration	210
Bowel Obstruction	184
Heart Problems	144
Chest Pains	134
Kidney	121
Abnormal Blood Levels	104

In 2017, there were 5,769 Unanticipated Hospitalizations MUIs filed.

Breakdown:

- 4,930 Medical Hospitalizations MUIs
- 839 Psychiatric Hospitalizations

Unapproved Behavioral Support

Unapproved behavioral support. "Unapproved behavioral support" means the use of a prohibited measure as defined in rule 5123:2-2-06 of the Administrative Code or the use of a restrictive measure implemented without approval of the human rights committee or without informed consent of the individual or the individual's guardian in accordance with rule 5123:2-2-06 of the Administrative Code, when use of the prohibited measure or restrictive measure results in risk to the individual's health or welfare.

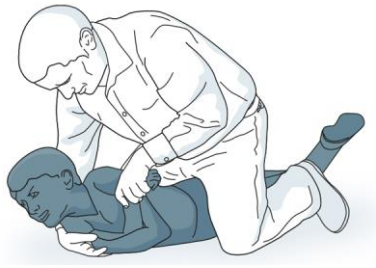
When use of the prohibited measure or restrictive measure does not result in risk to the individual's health or welfare, the incident shall be investigated as an unusual incident.

Prone Restraint

Prone restraint is a method of intervention where a person's face and frontal part of his or her body is placed in a downward position touching any surface for any amount of time. The use of prone restraints in Ohio is prohibited.

Never an Option

- Prone restraints are not to be used at any time, including as a behavioral intervention in any crisis situation
- Prone restraints are not to be written into any support or service plan

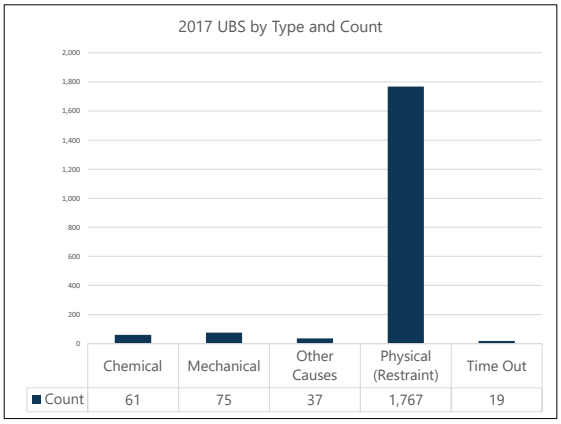


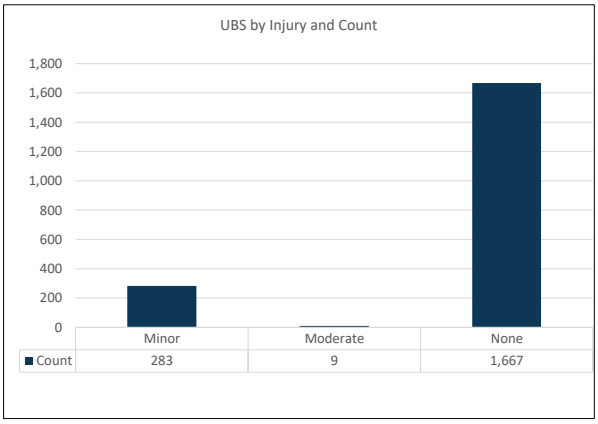
Prone Restraint

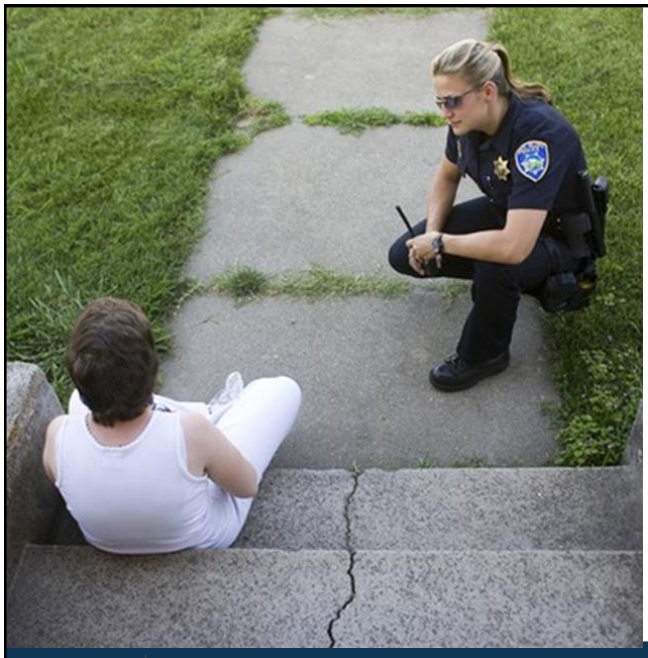
- Placing people in a prone position is a potentially fatal maneuver that reduces a person's ability to breath. The dangers of restraint-related positional asphyxia are well documented.

- Should any person place themselves in a prone position while in a restraint, those applying the restraint shall immediately release their hold or any pressure that was being applied to prevent the application of a prone restraint.

Unapproved Behavioral Support







Law Enforcement

Individual is:

- Charged
- Incarcerated
- Arrested
- Tased even if individual is not arrested

There were 791 law enforcement MUIs in 2017.

(D) Reporting Responsibilities

(D)(1)-<u>All</u> MUIs should be reported for those living in ICFs or receiving around the clock services

(1) All major unusual incidents involving an individual who resides in an intermediate care facility shall be filed and the requirements of this rule followed regardless of where the incident occurred.

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(D)(2)-These MUI Reports shall be filed regardless where the incident occurs:

(2) Reports regarding the following major unusual incidents shall be filed and the requirements of this rule followed regardless of where the incident occurred:

(a) Accidental or suspicious death;

(b) Attempted suicide;

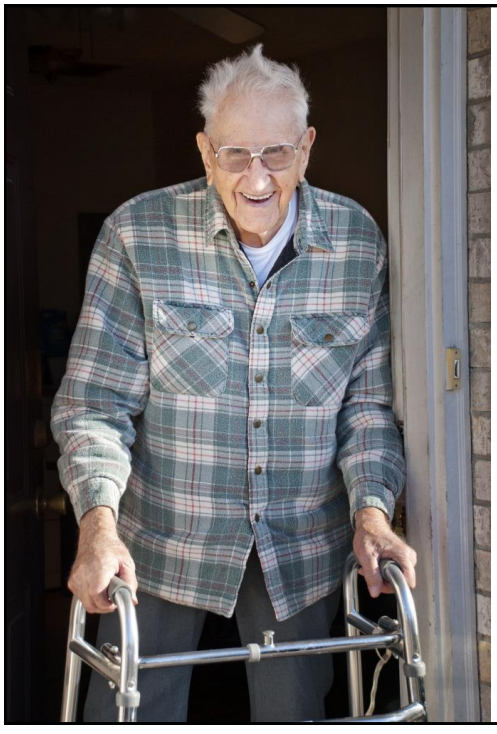
(c) Death other than accidental or suspicious death;

(d) Exploitation;

(e) Failure to report;

(f) Law enforcement;

53



(D)(2)-These MUI Reports shall be filed regardless where the incident occurs

(g) Misappropriation;

(h) Missing individuals

(i) Neglect;

(j) Peer-to-peer act;

(k) Physical abuse;

(l) Prohibited sexual relations;

(m) Sexual abuse; and

(n) Verbal abuse.

54

(D)(3) Reports regarding the following MUIs shall be filed when with provider:

Shall be filed and the requirements of this rule followed only when the incident occurs in a program operated by a county board or when the individual is being served by a licensed or certified provider:

(a) Medical emergency;

(b) Rights code violation;

(c) Significant injury;

(d) Unapproved behavioral support; and

(e) Unanticipated hospitalization.

55

(D)(4) Upon Identification or Notification of MUI, Provider or County Board Shall:

Take immediate actions to protect all at risk individuals which shall include:

a. Immediate or ongoing medical attention, as appropriate;
b. Removal of an employee from direct contact with any individual when the employee is alleged to have been involved in physical abuse or sexual abuse until such time as the provider has reasonably determined that such removal is no longer necessary;
c. Other necessary measures to protect the health and welfare of at-risk individuals.

The Department shall resolve any disagreements

56

(D)(5) County Board Upon Notification shall:

- Ensure reasonable measures to protect **all** at risk individuals, as appropriate
- Determine if additional measures are needed
- Notify the Department if circumstances in Paragraph (I)(1)of this rule are present requiring a Department directed investigation

57

(D)(6) Immediate to 4 Hour Reporting

Provider or county board as a provider, using county board identified system for MUIs, should report incidents or allegations of:

(a)Accidental or suspicious death;
(b) Exploitation;
(c) Misappropriation;
(d) Neglect;
(e) Peer-to-peer act;
(f) Physical abuse;
(g) Prohibited Sexual;
(h)Sexual Abuse;
(i) Verbal abuse; and when the provider has received an inquiry from the media regarding a major unusual incident.

58

(D)(7) Submit Written Incident Report by 3:00 p.m. the Next Working Day

- Agency providers and county boards as providers
- Department prescribed format
- Individual providers notify county board contact person
- Potential or determined MUI

Consider reports that are made to SSA's…Are they allegations?

59

(D)(8) County Board enter reports into Incident Tracking System by 5 p.m.

The county board shall enter preliminary information regarding the incident in the incident tracking system and in the manner prescribed by the department by five p.m. on the working day following notification by the provider or of becoming aware of the major unusual incident.

60

(D)(9) CB/Provider keep appraised of investigation and protective actions

When a provider has placed an employee on leave or otherwise taken protective action pending the outcome of the administrative investigation, the county board or department, as applicable, shall keep the provider apprised of the status of the administrative investigation so that the provider can resume normal operations as soon as possible consistent with the health and welfare of at-risk individuals.

The provider shall notify the county board or department, as applicable, of any changes regarding the protective action.

61

(D)(10) DC notifies the Department

If the provider is a developmental center, all reports required by this rule shall be made directly to the department.

62

(D)(11) CB shall have a system 24- hours for reporting

The county board shall have a system that is available twenty-four hours a day, seven days a week, to receive and respond to all reports required by this rule. The county board shall communicate this system in writing to all individuals or guardians as applicable, providers in the county and to the department.

24 Hour County Contact numbers are available on the Department's website at www.dodd.gov

63

(E) Alleged Criminal Acts

The provider shall immediately report to the law enforcement entity having jurisdiction of the location where the incident occurred, any allegation of a criminal act. The provider shall document the time, date, and name of person notified of the alleged criminal act. The county board shall ensure that the notification has been made.

64

(F) Abused or Neglected Children

- Allegations of Abuse or Neglect per Ohio Revised Code 2151.03 and 2151.031
- Under the age of 21
- Report to local public children's agency
- The county board shall ensure reports have been made

65

(G)(1) Notifications

The provider shall make the following notifications, as applicable, when the major unusual incident or discovery of the major unusual incident occurs when such provider has responsibility for the individual. The notification shall be made on the same day the major unusual incident or discovery of the major unusual incident occurs and include immediate actions taken.

(a) Guardian or other person whom the individual has identified.

(b) Service and support administrator serving the individual.

(c) Other providers of services as necessary to ensure continuity of care and support for the individual.

(d) Staff or family living at the individual's residence who have responsibility for the individual's care.

66

(G)(2) All notifications shall be documented

All notifications or efforts to notify shall be documented. The county board shall ensure that all required notifications have been made.

67

(G)(3) Notification shall not be made

Notification shall not be made if the person to be notified is the primary person involved, the spouse of the primary person involved, or the significant other of the primary person involved.

When such notifications could jeopardize the health and welfare of an individual involved.

68

(K)(1)Senior Management Notifications

Agency providers shall implement a written procedure for the internal review of all major unusual incidents and shall be responsible for taking all reasonable steps necessary to prevent the recurrence of major unusual incidents. The written procedure shall require senior management of the agency provider to be informed within two working days following the day staff become aware of a potential or determined major unusual incident involving misappropriation, neglect, physical abuse, or sexual abuse.

69

(G)(4)Notifications are not required in deaths when family already aware

Notification to a person is not required when the report comes from such person or in the case of a death when the family is already aware of the death.

70

(G)(5)Secondary Notifications

In any case where law enforcement has been notified of an alleged crime, the department may provide notification of the incident to:

- Any other provider;
- Developmental center;
- County board for whom the primary person involved works, for the purpose of ensuring the health and welfare of any at-risk individual.

The notified provider or county board shall take such steps necessary to address the health and welfare needs of any at-risk individual and may consult the department in this regard. The department shall inform any notified entity as to whether the incident is substantiated. Providers, Developmental centers, or county boards employing a primary person involved shall notify the department when they are aware that the primary person involved works for another provider.

71

(H)(1)General Investigations

Each county board shall employ at least one investigative agent or contract with a person or governmental entity for the services of an investigative agent. An investigative agent shall be certified by the department in accordance with rule 5123:2-5-07 of the Administrative Code. Developmental center investigators are considered certified investigative agents for the purpose of this rule.

72

(H)(2)Appendix A, B, and C

All major unusual incidents require an administrative investigation meeting that applicable administrative investigation procedure in appendix A, appendix B or appendix C to this rule unless it is not possible or relevant to the administrative investigation to meet a requirement under this rule, in which case the reason shall be documented. Administrative investigations shall be conducted and reviewed by investigative agents.

73

Appendix A

- Cases in which the police, CSB or IA may be involved in the investigation.
- Good communication and cooperation among investigative entities will be required for these investigations.
- Accidental or Suspicious Death, Exploitation, Failure To Report, Misappropriation, Neglect, Physical Abuse, Prohibited Sexual Relations, Rights Code, Sexual Abuse and Verbal Abuse

74

Appendix B

- Cases investigated by IA
- Attempted Suicide, Medical Emergency, Missing Individual, Death other than an accidental or suspicious, Significant Injury and Peer ti

75

Appendix C

- Cases investigated by IA- Format Requirements
- Law Enforcement, Unapproved Behavioral Supports and Unanticipated Hospitalizations.

76

(H)(2)(a) Elect to complete Category A

(a) The department or county board may elect to follow the administrative investigation procedure for category A major unusual incidents for any major unusual incident.

77

(H)(2)(b) Category could change

(b) Based on the facts discovered during administrative investigation of the major unusual incident, the category may change. If a major unusual incident changes category, the reason for the change shall be documented and the new applicable category administrative investigation procedure shall be followed to investigate the major unusual incident.

78

(H)(3) Gathering Docs for Category C

County board staff may assist the investigative agent by gathering documents, entering information into the incident tracking system, fulfilling category C administrative investigation requirements, or performing other administrative or clerical duties that are not specific to the investigative agent role.

79

(H)(4)IA conducts interviews

Except when law enforcement or the public children's services agency is conducting the investigation, the investigative agent shall conduct all interviews for major unusual incidents unless the investigative agent determines the need for assistance with interviewing an individual.

80

(H)(6)ICF shall conduct investigations in accordance with 42 C.F.R. 483.420

An intermediate care facility shall conduct an investigation that complies with applicable federal regulations, including 42 C.F.R. 483.420 (October 1, 2012), for any unusual incident or major unusual incident involving a resident of the intermediate care facility, regardless of where the unusual incident or major unusual incident occurs. The intermediate care facility shall provide a copy of its full report of an administrative investigation of a major unusual incident to the county board. The investigative agent may utilize information from the intermediate care facility's administrative investigation to meet the requirements of this rule or conduct a separate administrative investigation. The county board shall provide a copy of its full report of the administrative investigation to the intermediate care facility. The department shall resolve any conflicts that arise.

81

(H)(7)ICF's findings due to CB within 14 calendar days

When an agency provider, excluding an intermediate care facility, conducts an internal review of an incident for which a major unusual incident has been filed, the agency provider shall submit the results of its internal review of the incident, including statements and documents, to the county board within fourteen calendar days of the agency provider becoming aware of the incident.

82

(H)(8)All DD employees required to cooperate with investigation

All developmental disabilities employees shall cooperate with administrative investigations conducted by entities authorized to conduct investigations. Providers and county boards shall respond to requests for information within the time frame requested. The time frames identified shall be reasonable.

83

(H)(9)Notifying the individual, guardians, and/or providers of preliminary findings with 14 working days.

Except when law enforcement or the public children's services agency is conducting an investigation, the investigative agent shall endeavor to reach a preliminary finding regarding allegations of physical abuse or sexual abuse and notify the individual, the guardian of the individual, and provider of the preliminary findings within fourteen working days. When it is not possible for the investigative agent to reach preliminary findings within fourteen working days, he or she instead notify the individual or individual's guardian and provider of the status of the investigation.

84

(H)(10)IA submits report into ITS within 30 working days

The investigative agent shall complete a report of the administrative investigation and submit it for closure in the incident tracking system within thirty working days unless the county board requests and the department grants an extension for good cause. If an extension is granted, the department may require submission of interim reports and may identify alternative actions to assist with the timely conclusion of the report.

85

(H)(11)The report shall follow the format prescribed by the department

The report shall follow the format prescribed by the department. The investigative agent shall include the initial allegation, a list of persons interviewed and the documents reviewed, a summary of each interview and documents reviewed, and a findings and conclusion section which shall include the cause and contributing factors to the incident and the facts that support the findings and conclusions.

86

(I)(1)Department Directed Investigations

(1) The department shall conduct the administrative investigation when the major

unusual incident includes an allegation against:

(a) The superintendent of a county board or developmental center;

(b) The executive director or equivalent of a regional council of governments;

(c) A management employee who reports directly to the superintendent of the county board, the superintendent of a developmental center, or executive director or equivalent of a regional council of governments;

(d) An investigative agent;

(e) A service and support administrator;

87

(I)(1)Department Directed Investigations

(f) A major unusual incident contact or designee employed by a county board;

(g) A current member of a county board;

(h) A person having any known relationship with any of the persons specified in paragraphs (I)(1)(a) to (I)(1)(g) of this rule when such relationship may present a conflict of interest or the appearance of a conflict of interest; or

(i) An employee of a county board or developmental center when it is alleged that the employee is responsible for an individual's death, has committed sexual abuse, engaged in prohibited sexual activity, or committed physical abuse or neglect resulting in emergency room treatment or hospitalization.

88

(I)(2)-(3)Department Directed Investigations

(2) A department-directed administrative investigation or administrative investigation review may be conducted following the receipt of a request from a county board, developmental center, provider, individual, or guardian if the department determines that there is a reasonable basis for the request.

(3) The department may conduct a review or administrative investigation of any major unusual incident or may request that a review or administrative investigation be conducted by another county board, a regional council of governments, or any other governmental entity authorized to conduct an investigation.

89

(J)(1) Written Summaries for A, B due within 5 days of recommended closure

No later than five working days following the county board's, developmental center's, or department's recommendation via the incident tracking system that the report be closed, the county board, developmental center, or department shall provide a written summary of the administrative investigation of each category A or category B major unusual incident, including the allegations, the facts and findings, including as applicable, whether the case was substantiated or unsubstantiated, and preventive measures implemented in response to the major unusual incident to the following unless the information in the written summary has already been communicated:

90

(J)(1) (a) Written Summaries to:

(a) The individual, individual's guardian, or other person whom the individual has identified, as applicable; in the case of a peer-to-peer act, both individuals, individuals' guardians, or other persons whom the individuals have identified, as applicable, shall receive the written summary;

(b) The licensed or certified provider and provider at the time of the major unusual incident; and

(c) The individual's service and support administrator and support broker, as applicable.

91

(J)(2)-(4) Written Summaries

(2) In the case of an individual's death, the written summary shall be provided to the individual's family only upon request by the individual's family.

(3) The written summary shall not be provided to the primary person involved, the spouse of the primary person involved, or the significant other of the primary person involved.

(4) When the primary person involved is a developmental disabilities employee or a guardian, the county board shall, no later than five working days following the recommended closure of a case, make a reasonable attempt to provide written notice to the primary person involved as to whether the major unusual incident has been substantiated, unsubstantiated/insufficient evidence, or unsubstantiated/unfounded.

92

(J)(5) Written Summaries

If a service or support administrator is not assigned, a county board designee shall be responsible for ensuring the preventive measures are implemented based upon the written summary.

93

(J)(6) Disputing the Findings

An individual, individual's guardian, other person whom the individual has identified, or provider may dispute the findings by submitting a letter of dispute and supporting documentation to the county board superintendent, or to the director of the department if the department conducted the administrative investigation, within fifteen calendar days following receipt of the findings. An individual may receive assistance from any person selected by the individual to prepare a letter of dispute and provide supporting documentation.

94

(J)(7) CB reviews dispute within 30 calendar days

The county board superintendent or his or her designee or the director or his or her designee, as applicable, shall consider the letter of dispute, the supporting documentation, and any other relevant information and issue a determination within thirty calendar days of such submission and take action consistent with such determination, including confirming or modifying the findings or directing that more information be gathered and the findings be reconsidered.

95

(J)(8) Dispute to the Department

In cases where the letter of dispute has been filed with the county board, the disputant may dispute the final findings made by the county board by filing those findings and any documentation contesting such findings as are disputed with the director of the department within fifteen calendar days of the county board determination. The director shall issue a decision within thirty calendar days.

96

(K)(1) Review, Prevention, and Closure of MUIs

County boards and agency providers shall implement a written procedure for the internal review of all major unusual incidents and shall be responsible for taking all reasonable steps necessary to prevent the recurrence of major unusual incidents.

97

(K)(2) Preventative Measures

The members of an individual's team shall ensure that risks associated with major unusual incidents are addressed in the individual plan or individual service plan of each individual affected and collaborated on the development of preventive measures to address causing and contributing factors to the major unusual incident. The team members shall jointly determine what constitutes reasonable steps necessary to prevent the recurrence of major unusual incidents. If there is no service or support administrator, team, qualified intellectual disability professional, or agency provider involved with the individual a county board designee shall ensure that reasonably possible preventive measures are fully implemented.

98

(K)(3)Department Review

The department may review reports submitted by a county board or developmental center. The department may obtain additional information.

necessary to consider the report, including copies of all administrative investigation reports that have been prepared. Such additional information shall be provided within the time period specified by the department.

99

(K)(4) Dept. Closes the following MUIs

(a) Accidental or suspicious death;
(b) Death other than accidental or suspicious death;
(c) Exploitation;
(d) Medical Emergency;
(e) Misappropriation;
(f) Neglect;
(g) Peer-to-Peer act;
(h) Physical abuse;
(i) Prohibited sexual relations;
(j) Sexual abuse;
(k) Significant injury when cause is unknown;
(l) Verbal abuse;
(m) Any major unusual incident that is the subject of a director's alert; and
(n) Any major unusual incident investigated by the department.

100

(K)(5)The CB closes these MUIs

The county board shall review and close reports regarding the following major unusual incidents:

(a) Attempted suicide;
(b) Failure to report;
(c) Law enforcement;
(d) Missing Individual;
(e) Rights code violation;
(f) Significant injury when cause is unknown
(g) Unanticipated hospitalization; and
(h)Unapproved Behavioral Support.

101

(K)(6) Dept. Review of CB Closures

The department may review any case to ensure it has been properly closed and shall conduct sample reviews to ensure proper closure by the county board. The department may reopen any administrative investigation that does not meet the requirements of this rule. The county board shall provide any information deemed necessary by the department to close the case.

102

(K)(7) Case Closures

The department and the county board shall consider the following criteria when determining whether to close a case:

(a) Whether sufficient reasonable measures have been taken to ensure the health and welfare of any at-risk individual;

(b) Whether a thorough administrative investigation has been conducted consistent with the standards set forth in this rule (based on review in ITS);

(c) Whether the team, including the county board and provider, collaborated on developing preventive measures to address the causes and contributing factors;

(d) Whether the county board has ensured that preventive measures have been implemented to prevent recurrence;

(e) Whether the incident is part of a pattern or trend as flagged through the incident tracking system requiring some additional action; and

(f) Whether all requirements set forth in statute or rule have been satisfied.

103

(L)(1)Analysis of MUIs

Providers shall produce an annual report regarding major unusual incident trends and patterns which shall be sent to the county board.

The annual review shall be cumulative for January first through December thirty-first of each year and include an in-depth analysis.

104

(L)(2)Analysis Requirements

(2) All reviews and analyses shall be completed within thirty calendar days following the end of the review period. The annual report shall contain the following elements:

(a) Date of review;

(b) Name of person completing review;

(c) Time period of review;

(d) Comparison of data for previous three years;

(e) Explanation of data;

105

(L)(2)Analysis Requirements

(f) Data for review by major unusual incident category type;

(g) Specific individuals involved in established trends and patterns (i.e., five major unusual incidents of any kind within six months, ten major unusual incidents of any kind within a year, or other pattern identified by the individual's team);

(h) Specific trends by residence, region, or program;

(i) Previously identified trends and patterns; and

(j) Action plans and preventive measures to address noted trends and patterns.

106

(L)(3)Analysis of MUIs

County boards shall conduct the analysis and implement follow-up actions for all programs operated by county boards such as workshops, schools, and transportation. The county board shall send its analysis and follow-up actions to the department by February twenty-eighth of each. The department shall review the analysis to ensure that all issues have been reasonably addressed to prevent recurrence.

107

(L)(4)CB and COGs required to review for Trends and Patterns

Each county board or as applicable, each council of governments to which county boards belong, shall have a committee that reviews trends and patterns of major unusual incidents. The committee shall be made up of a reasonable representation of the county board(s), providers, individuals who receive services and their families, and other stakeholders deemed appropriate by the committee.

108

(L)(4)(a)Committee's Role

The role of the committee shall be to review and share the county or council of governments aggregate data prepared by the county board or council of governments to identify trends, patterns, or areas for improving the quality of life for individuals served in the county or counties.

109

(L)(4)(b)Committee meets each Sept

The committee shall meet each March to review and analyze data for the previous calendar year. The county board or council of governments shall send the aggregate data prepared for the meeting to all participants at least ten calendar days in advance of the meeting.

110

(L)(4)(c)-(d)Record of Meetings

(c) The county board or council of governments shall record and maintain minutes of each meeting, distribute the minutes to members of the committee, and make the minutes available to any person upon request.

(d) The county board shall ensure follow-up actions identified by the committee have been implemented.

111

(L)(5) Dept. shall prepare a report on patterns and trends of MUIs

The department shall prepare a report on trends and patterns identified through the process of reviewing major unusual incidents. The department shall:

- Periodically, but at least semi-annually, review this report with a committee.
- Appointed by the director of the department which shall consist of at least six members who represent various stakeholder groups, including disability rights Ohio and the Ohio department of Medicaid.
- The committee shall make recommendations to the department regarding whether appropriate actions to:
- Ensure the health and welfare of individuals served have been taken.
- The Committee may request that the department obtain additional information as may be necessary to make recommendations.

112

(M)(1)-(2) Reqs for Unusual Incidents

(1) Unusual incidents shall be reported and investigated by the provider.

(2) Each agency provider shall develop and implement a written unusual incident policy and procedure that:

(a) Identifies what is to be reported as an unusual incident which shall include unusual incidents as defined in this rule;

(b) Requires an employee who becomes aware of an unusual incident to report it to the person designated by the agency provider who can initiate proper action;

113

(M)(2)(c) Requires report be made no more than 24 hours after the UI

(c) Requires the report to be made no later than twenty-four hours after the occurrence of the unusual incident; and

(d) Requires the agency provider to investigate unusual incidents, identify the cause and contributing factors when applicable, and develop preventive measures to protect the health and welfare of any at-risk individuals.

114

The agency provider shall ensure that all staff are trained and knowledgeable regarding the unusual incident policy and procedure.

(M)(4)UI Notifications

The provider providing services when an unusual incident occurs shall notify other providers of services necessary to ensure continuity of care and support for the individual.

116

(M)(5) Independent Provider Requirements

Independent providers shall complete an incident report, notify the individual's guardian or other person whom the individual has identified, as applicable, and forward the incident report to the service and support administrator or county board designee the first working day following day the unusual incident is discovered.

117

(M)(6) Monthly Review

Each agency provider and independent provider shall review all unusual incidents as necessary, but no less than monthly, to ensure appropriate preventive measures have been implemented and trends and patterns identified and addressed as appropriate.

118

(M)(7)Document Trends and Patterns

The unusual incident reports, documentation of identified trends and patterns, and corrective action shall be made available to the county board and department upon request.

119

(M)(8) UI Logs

Each agency provider and independent provider shall maintain a log of all unusual incidents. The log shall include, but is not limited to:

- Name of the individual
- A brief description of the unusual incident
- Any injuries
- Time and date
- Location
- Preventive measures
- Causes and Contributing Factors

120

(M)(9)Trends addressed in Plan

The agency provider and the county board shall ensure that risks associated with unusual incidents are included and addressed in the individual service plan of each individual affected.

121

(M)(10) Documentation requests

The agency provider shall provide the CB or Dept with any and all information regarding an unusual incident and the investigation, upon request.

122

(N) (1) Oversight

The county board shall review, on at least a quarterly basis, a representative sample of provider logs, including logs where the county board is a provider, to ensure that major unusual incidents have been reported, preventive measures have been implemented, and that trends and patterns have been identified and addressed in accordance with this rule. The sample shall be made available to the department for review upon request.

123

(N)(2) CB Programs

When the county board is a provider, the department shall review, on a monthly basis, a representative sample of county board logs to ensure that major unusual incidents have been reported, preventive measures have been implemented, and that trends and patterns have been identified and addressed in accordance with this rule. The county board shall submit the specified logs to the department upon request.

124

(N)(3) Department review of logs

The department shall conduct reviews of county boards and providers as necessary to ensure the health and welfare of individuals and compliance with this rule. Failure to comply with this rule may be considered by the department in any regulatory capacity, including certification, licensure, and accreditation.

125

(N)(4) Department review of administrative investigation complaint

The department shall review and take any action appropriate when a complaint is received about how an administrative investigation is conducted.

126

(O)(1) Access to Records

Reports made under section 5123.61 of the Revised Code and this rule are not public records as defined in section 149.43 of the Revised Code. Records may be provided to parties authorized to receive them in accordance with sections 5123.613 and 5126.044 of the Revised Code, to any governmental entity authorized to investigate the circumstances of the alleged abuse, neglect, misappropriation, or exploitation and to any party to the extent that release of a record is necessary for the health or welfare of an individual.

127

(O)(2) Access to Records

A county board or the department shall not review, copy, or include in any report required by this rule a provider's personnel records that are confidential under state or federal statutes or rules, including medical and insurance records, workers' compensation records, employment eligibility verification (I-9) forms, and social security numbers. The provider shall redact any confidential information contained in a record before copies are provided to the county board or the department. A provider shall make all other records available upon request by a county board or the department.

A provider shall provide confidential information including date of birth and social security number when requested by DODD as part of the Abuser Registry Process.

128

(O)(3) Waive report

Any party entitled to receive a report required by this rule may waive receipt of the report. Any waiver of receipt of a report shall be made in writing.

129

(P)(1) Training

Agency providers and county boards shall ensure staff employed in direct services positions are trained on the requirements of this rule prior to direct contact with any individual. Thereafter, staff employed in direct services positions shall receive annual training on the requirements of this rule including a review of health and welfare alerts issued by the department since the previous year's training.

130

(P)(2)Training Requirements

Agency providers and county boards shall ensure staff employed in positions other than direct services positions are trained on the requirements of this rule no later than ninety days from date of hire. Thereafter, staff employed in positions other than direct services positions shall receive annual training on the requirements of this rule including a review of health and welfare alerts issued by the department since the previous year's training.

131

(P)(3)Training on Alerts

Independent providers shall be trained on the requirements of this rule prior to application for initial certification in accordance with rule 5123:2-2-01 of the Administrative Code and shall receive annual training on the requirements of this rule including a review of health and welfare alerts issued by the department since the previous year's training.

132

Abuser Registry

Established under Ohio law, the Abuser Registry lists the names of people who have committed acts of abuse, neglect, misappropriation, failure to report, and/or prohibited sexual relations. People who have committed a registry offense are prohibited from working with people with developmental disabilities for a minimum of one year.

Prevents persons who were DD employees from working in this field.

As of January 1, 2019 there are 898 people placed on the Abuser Registry.

133

Abuser Registry Process

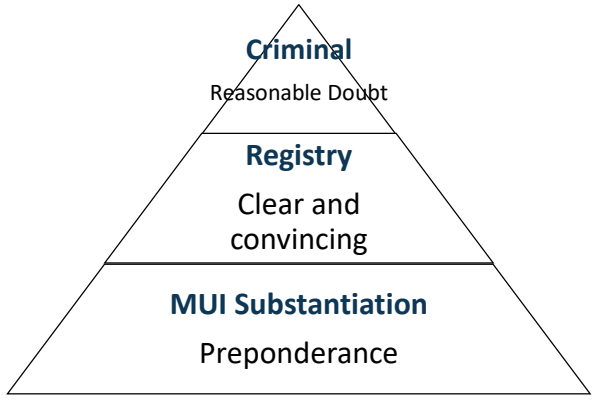
The Abuser Registry is one way Ohio protects it's most vulnerable citizens

1. All Substantiated cases are screened after being closed on ITS. If they meet criteria, they are assigned.
2. Registry Investigators review the entire file to see if it should move forward.
3. If it meets criteria, it goes to External Committee. The Committee makes a decision.
4. If person is to be placed, Notified by certified mail. Opportunity for a 119 hearing
5. Hearing or Affidavit. Finial decision made by Director. If decision is for placement, name goes on the list

Ohio | Department of Developmental Disabilities

Abuser Registry

- Knowingly – Aware that conduct will probably cause a certain result
- Recklessly – Heedless indifference to the consequences.
- Negligently – Substantial lapse in care, failure to perceive or avoid risk



Rights

- Have a clean safe place to live in and a place to be alone
- Have food that is good for you
- Be able to go, if you want, to any church, temple, mosque
- Be able to go to a doctor or dentist when you are sick

Rights

- Be able to complain or ask for changes if you don’t like something without being afraid of getting in trouble
- Not be given medicine that you don't need, or be held down if you are not hurting yourself or others
- To vote and learn about laws and your community

Rights

- Be treated like everyone else
- Be treated nicely at all times and as a person
- Not be hit, yelled at, cursed at, or called names that hurt you
- To say yes or no to being part of a study or experiment

Rights

- Be able to learn new things, make friends, have activities to do, and go out in your community
- Be able to tell people what you want and be part of making plans or decisions about your life
- Be able to ask someone you want to help you, let others know how you feel or what you want
- Be able to use your money to pay for things you need and want with help, if you need it

Rights

- Be able to work and make money
- Be able to have men and women as friends
- Be able to join in activities and do things that will help you grow to be the best person you can be
- Be able to say yes or no before people talk about what you do at work or home or look at your file

Stay Tuned

The new and improved rule is coming soon…

Ohio Department of Developmental Disabilities

Abuse and Neglect contacts

Hotline (866)313-6733

DODD MUI Office
614-995-3810

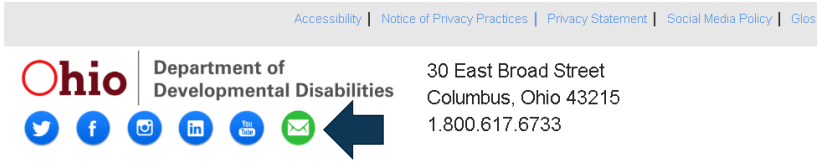
County Board
Emergency Contacts

http://dodd.ohio.gov/reportabuse/Pages/default.aspx

www.dodd.ohio.gov

Helpful Resources on our website

- Subscribe to Health and Welfare Publications like Alerts



- Subscribe for Abuser Registry Updates
  https://its.prodapps.dodd.ohio.gov/ABR_Default.aspx

Helpful Resources on our website

- Check out the Health and Welfare Toolkit for forms, trainings and guidance memos.

- Phone Numbers for MUI Contacts and DODD MUI staff are located here as well.
- You can also find out about upcoming trainings on Training tab.
- The MUI Rule and other rules are also located on the Home page!

MUI Training Contacts

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Connie.McLaughlin@dodd.ohio.gov

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(614)752-0090
Scott.Phillips@dodd.ohio.gov

DODD MUI Office (614)995-3810