

**Stakeholder Webinar
Panel Discussion
February 2015**



Department of
Developmental Disabilities

Why Stakeholders?



Pick all that apply:

- 1. This requirement can help come up with ideas to enhance individual's lives, improve quality in my community and prevent the reoccurrence of MUIs.**
- 2. All the cool COGs and County Boards are doing it**
- 3. The Department makes me do it**

Rule Requirements for Stakeholders

O.A.C. 5123:2-17-02(L)(6) 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.***

Rule Requirements for Stakeholders

O.A.C. 5123:2-17-02(L)(6)(a) 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.***

Rule Requirements for Stakeholders

O.A.C. 5123:2-17-02(L)(6)(b) The committee shall meet each September to review and analyze data for the first six months of the calendar year and each March to review and analyze data for the preceding 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.***

Required Elements for Stakeholders



O.A.C. 5123:2-17-02(L)(6)(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.

Rule Requirements for Stakeholders

O.A.C. 5123:2-17-02(L)(6)(d) The county board shall ensure ***follow-up actions identified by the committee have been implemented***



Required Elements for Stakeholders

(L)(7) 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.

Stakeholder Composition

- We have a representative from Children Services on our Stakeholder committee. The benefits of that are that the communication has improved between the two agencies and I think it assists Children Services to understand our process better.
- The other Stakeholder addition that we have made is having two nurses on the committee, one a county board nurse and the other is a residential agency nurse. This has been the most beneficial for our committee when discussing hospitalizations, injuries, falls and many other medical issues.
- Their input and knowledge has been a great addition to our committee.

Some Common Mistakes

Not Addressing significant increases and decreases

For example in the last year, there was a 17% increase in Medical Emergencies. The County Board did not drill down to see if there was a certain type of medical emergencies that was increasing like choking incidents

Not addressing identified Trends with action plans

Not following up on Committee Recommendations

Stakeholders Example # 1

Clearwater Council of Governments
Stakeholder Data
2013 Major Unusual Incident
Annual

OVERVIEW

Types and Percentages of Incidents

During 2013, the MUI Unit investigated a total of 486 major unusual incidents compared to 432 major unusual incidents in 2012 and 436 major unusual incidents in 2011. The breakdown of MUIs investigated by type of incident is as follows:

Incident Category	MUIs filed in 2011	Sub.	MUIs filed in 2012	Sub.	MUIs filed in 2013	Sub.
Physical Abuse	17	6	22	8	22	5
Sexual Abuse	2	0	5	2	5	2
Verbal Abuse	13	8	12	7	18	10
Neglect	37	29	39	29	42	29
Misappropriation	42	37	27	26	39	29
Peer / Peer Physical	19	17	19	16	17	13
Peer/Peer Verbal	4	3	7	4	8	7

Stakeholders Example #1

Incident Category	MUIs filed in 2011	Sub.	MUIs filed in 2012	Sub.	MUIs filed in 2013	Sub.
Peer/Peer Sexual	4	1	5	2	3	2
Peer/Peer Misapp.	1	1	2	2	6	1
Prohibited Sexual Relations	1	0	1	0	0	0
Failure to Report	2	2	5	0	1	0
Exploitation	3	1	1	1	6	3
Missing Person	18	-	6	-	4	-
Death	16	-	19	-	25	-
Law Enforcement	35	-	26	-	42	-
Medical Emergency	33	-	21	-	24	-
Known Injury	30	-	52	-	53	-
Attempted Suicide	1	-	1	-	1	-
Unapproved Behavior Support	36	-	33	-	42	-
Hospitalization	111	-	119	-	113	-
Rights Code Violation	3	0	0	0	9	5
Unknown Injury	8	-	10	-	5	-
TOTAL	436	105	432	97	486	106

Stakeholders Example #1

2011 – 34% of all cases reported were protocol cases.
 2012 – 34% of all cases reported were protocol cases
 2013 - 36% of all cases reported were protocol cases

Types and Percentages of Incidents

Percentages for 2011		Percentages for 2012		Percentages for 2013		State Average
Incident Category	Percentage	Incident Category	Percentage	Incident Category	Percentage	
Physical Abuse	4%	Physical Abuse	5%	Physical Abuse	4%	7%
Sexual Abuse	<1%	Sexual Abuse	0%	Sexual Abuse	1%	2%
Verbal Abuse	3%	Verbal Abuse	3%	Verbal Abuse	4%	5%
Neglect	6%	Neglect	9%	Neglect	9%	14%
Misappropriation	10%	Misappropriation	6%	Misappropriation	8%	10%
Peer / Peer Physical	3%	Peer / Peer Physical	5%	Peer / Peer Physical	3%	Combined
Peer/Peer Verbal	<1%	Peer/Peer Verbal	<1%	Peer/Peer Verbal	<1%	Total
Peer/Peer Misappropriation	0%	Peer/Peer Misappropriation	<1%	Peer/Peer Misappropriation	<1%	of peer-to-peer
Peer/Peer Sexual	2%	Peer/Peer Sexual	2%	Peer/Peer Sexual	<1%	12%
Prohibited Sexual Relations	<1%	Prohibited Sexual Relations	0%	Prohibited Sexual Relations	0%	<1%
Failure to Report	0%	Failure to Report	1%	Failure to Report	<1%	<1%
Exploitation	<1%	Exploitation	0%	Exploitation	<1%	<1%

Stakeholders Example #1

Missing Person	5%	Missing Person	1%	Missing Person	<1%	3%
Death	3%	Death	4%	Death	5%	4%
Law Enforcement	8%	Law Enforcement	6%	Law Enforcement	9%	4%
Medical Emergency	5%	Medical Emergency	5%	Medical Emergency	5%	3%
Known Injury	6%	Known Injury	12%	Known Injury	11%	8%
Attempted Suicide	<1%	Attempted Suicide	0%	Attempted Suicide	<1%	<1%
Unapproved Behavior Support	8%	Unapproved Behavior Support	8%	Unapproved Behavior Support	9%	10%
Hospitalization	31%	Hospitalization	28%	Hospitalization	23%	20%
Rights Code Violation	0%	Rights Code Violation	0%	Rights Code Violation	2%	<1%
Unknown Injury	<1%	Unknown Injury	2%	Unknown Injury	1%	2%
TOTAL	100%	TOTAL	100%	TOTAL	100%	

Stakeholders Example #1

Categories Higher than State Average

2012		2013	
Law Enforcement	6%	Law Enforcement	9%
Medical Emergency	5%	Medical Emergency	11%
Known Injury	12%	Known Injury	11%
Hospitalization	28%	Hospitalization	23%
Failure to Report	1%	Death	5%
		Rights Code Violation	2%

Location of Incidents

2011		2012		2013	
Location	Number	Location	Number	Location	Number
CB Operated	43	CB Operated	54	CB Operated	54
School	3	School	2	School	2
Workshop	32	Workshop	42	Workshop	40
Transportation	7	Transportation	10	Transportation	12
SSA	1	SSA		SSA	
Residential	312	Residential	301	Residential	319
Family Homes	22	Family Homes	32	Family Homes	41
Waiver/SL Homes	242	Waiver/SL Homes	235	Waiver/SL Homes	224
Nursing Homes	0	Nursing Homes	4	Nursing Homes	5
ICFs	48	ICFs	30	ICFs	49
Non Board Operated	40	Non Board Operated	39	Non Board Operated	43
Transportation	1	Transportation	1	Transportation	3
Day Programs	18	Day Programs	23	Day Programs	11
Workshop	18	Workshop	15	Workshop	16
After Hours Activities	3	After Hour Activities		After Hour Activities	13
Community	41	Community	38	Community	70
Total	436	Total	432	Total	486

Stakeholders Example #1

INCIDENT SPECIFIC REVIEW

Include Incident Specific Review for all 19 categories.

Physical Abuse

Allegation	2011	2012	2013
Family	5	9	6
Guardian			1
Payee			1
Staff	7	7	9
Unknown	2	1	2
Other	3	5	3
TOTAL	17	22	22

Allegations of physical abuse increased from 2011 to 2012. Rate of substantiation is 35% for 2011, 36% for 2012, and 23% for 2013.

*Statewide data indicates the top two PPIs for physical abuse is staff and family.

Sexual Abuse

Allegation	2011	2012	2013
Family	3	1	
Guardian			
Payee			
Staff	1	2	2
Unknown			
Other	1	2	3
TOTAL	5	5	2

*Statewide data indicates that the top two PPIs for Sexual Abuse are friends and family members. The rate of substantiation is 40% for 2011 and 2012 and 0% for 2013.

Stakeholders Example #1

Misappropriation

Allegation	2011	2012	2013
Family	2	1	5
Guardian			
Payee	1		
Staff	11	6	10
Unknown	25	18	16
Other	3	2	8
TOTAL	42	27	39

Misappropriation has remained fairly consistent over the time span reviewed. The substantiation rate is 88% for 2011, 74% for 2012, and 74% for 2013.

2012 Values:

Property	\$4039.00
Cash	\$2367.00
Medication	4 incidents (\$108.00)
Credit Card	0
Identity	0
TOTAL	\$6514.00

**Helpful Comparison:
Statewide data
indicates the top two
things stolen were
cash and property.*

2013 Values:

Property	\$882.00
Cash	\$2115.00
Medication	6 incidents (\$129.00)
Credit Card	\$1950.00
Identity	2 incidents (\$711.00)
TOTAL	\$5787.00

Stakeholders Example #1

CAUSES	2011	2012	2013
Accidents	1		
Adverse Effects			
Alzheimer's Disease		1	
Cancer		3	2
Congenital Syndromes	2		1
Diabetes			
Heart Disease	4	1	5
Homicide			
Infection	2		2
Kidney Disease		1	1
Lung Disease	2		2
Pneumonia	3	3	4
Influenza		1	
Seizure	1	1	
Stroke			
Suicide		1	
Other	1	7	8
TOTAL	16	19	25

The average age for death cases in 2011 was 50 years old, 57 years old in 2012 and 55 years old in 2013.

**Statewide data indicates the life expectancy for the DD population is 50 years old while the life expectancy of the average population is 79 years old.*

**Statewide data indicates pneumonia is the leading cause of death in the DD population.*

**Statewide data indicates the causes of accidental deaths are choking, vehicle accidents, drowning, falls, fire, homicide, suffocation, and suicide.*

Stakeholders Example #1

Stakeholder Meeting Minutes

Semi Annual

September 19, 2014

Reviewed 3/21/14 meeting minutes.

- Multiple county board staff and provider staff attended trainings conducted by the COG regarding Rights Restrictions, Nutrition & Healthy Eating, and Fall Prevention as requested by the committee members from the last review of MUI data.
- The COG nurse has implemented quarterly nursing meetings and is sharing her trainings with county board nurses as requested from the committee members from last meeting.
- Additional Self-Advocates were invited and present at this meeting as requested by the committee members from the last meeting.

Reminded the committee that we were just looking at the first six months of the year, MUIs were up by 30 incidents.

Reviewed the state averages of MUI categories. We were over the state average in deaths, law enforcements, known injuries and hospitalizations. Rights code was down from the last year.

Stakeholders Example #1

Location of Incidents

When looking at location of incidents, we added nursing homes, community, public schools and private day programs as additional locations for occurring incidents. County boards have stayed consistent over the years. We saw a decrease in workshops and an increase in transportation. Residential settings had a slight increase. We saw a significant increase in ICFs due to a 100 bed ICF being in Ottawa county that is now following DODD rules.

Physical Abuse

The substantiation rate increased by 9%

Sexual Abuse

Substantiation rate remained consistent

Verbal Abuse

Substantiation rate increased by 15%, there was a change in the rule which may have contributed to this increase.

Neglect

Decrease in substantiation by 31%.

Stakeholders Example #1

Exploitation

Substantiation rate increased by 30%, discussed what is meant by exploitation where the person is being taken advantage of in some way.

Misappropriation

Substantiation rate increased by 5%, total of allegations have increased as well which shows that people are reporting.

**For next report, IAs will identify what is meant by "Unknown" to show how many PPIs were actually unknown staff as opposed to just not knowing who the PPI was.*

Peer to Peer incidents

For next report, IAs will identify the location as "work", "home", and "community" so that committee knows where incidents are taking place to better identify a prevention plan.

Peer to Peer Verbal

Discussed the rule change and the need for the allegations to be "threatening" or "harassing" and also the ability for the alleged PPI to carry out the threat.

Peer to Peer Misappropriation

Substantiated 2 in the 3 years with these incidents. Discussed allowing the providers a short time to look for property, receipts, etc. that have been reported missing before we file them as MUIs.

Stakeholders Example #1

Rights Code Violation

There was a decrease in the number of allegations. Discussed that when the team is looking at rights restrictions they really should only be put into place because it to protect health and safety.

Failure to Report

Discussed that this is filed when staff fail to report a potential MUI. None were filed during this time span.

Missing Person

Stayed consistent over the 3 years

Deaths

Saw an increase largely due to the ICF and the fact that they have more medically fragile individuals.

Law Enforcement

Slight increase over the 3 years

Stakeholders Example #1

Medical Emergencies

There was a significant decrease in the three years and this was contributed to the committee's recommendation of various trainings over the years.

Known Injuries

Falls were the highest numbers for injuries

For next report, IAs will identify why the person lost their balance and fell and what were the circumstances: uneven surface, slippery surface, etc.

For next report, IAs will identify the location of the injuries work, home, or community.

For next report, IAs will no longer have "other" in the type of injuries and will list what each injury was.

Unapproved Behavior Supports

For next report, IAs will continue to report if the behavior support was necessary and if there were any injuries due to the behavior support being used.

Hospitalizations

Significant increase this is due to the ICF that is in Ottawa County.

For next report, IAs will identify if a case of pneumonia was bacterial or aspirational.

Louise Terry, Ottawa RN, is going to give information for a Hot Topic on choking and the importance of follow up medical care and monitoring to ensure that the individual does not develop aspiration pneumonia.

Stakeholders Example #1

Discussions:

Verbal abuse – discussed with the committee what can be done when we have these substantiated allegations as far as retraining with staff. Discussion of Good Life, disability awareness training that is being developed by the COG to be used. Kelli Grisham will check DSPATH's training to see if this is addressed in that training.

Exploitation – discussed with the committee about educating the individual will continue to see what happens with this category.

Known Injuries – discussed with the committee about the adaptive equipment that is used and if the individual knows how to properly use it. The committee then decided that we needed to break out why the individuals are falling and where they are falling before we can come up with better prevention plans.

Discussed getting new members for the committee as the current committee would like to see more self-advocates and family members be invited to the SH meeting. It was decided that when self-advocates/family members attend, they will be paid \$40.00 by the COG for their service since all other committee members are in paid positions.

Ability Works is going to have some direct support professionals attend the next meeting.

Stakeholders Example #1

Wyandot CB is going to invite a self-advocate and a home provider.

Huron CB is going to invite First Choice of Ohio as a residential and day program provider.

Marion CB is going to invite OSS as a transportation provider.

Renaissance House is going to have some direct support professionals attend the next meeting.

Crawford CB is going to invite a residential provider.

If still need a provider maybe ask RVI from Ottawa who does both day programming and residential.

The next meeting will be March 20, 2015 at 10:00am the place has yet to be determined. There will be notice sent out when that has been set.

Stakeholders Example #2

2014 Semi-Annual Stakeholder

Meeting Agenda

September 18, 2014



- Introductions
- Review Purpose of Committee
 - ✘ To review and analyze MUI data prepared by the county.
 - ✘ To identify trends, patterns, or areas for improving the quality of life for individuals supported in the county.
 - ✘ To discuss possible causes of the trends/ patterns.
 - ✘ To develop follow-up actions to address the trends and patterns and improve the quality of life for individuals supported in the county.

Stakeholders Example #2

- Review of Data/Identifying Trends/Identifying Likely Causes of Trends (Highest categories, areas of increase/decrease, areas of concern, etc.)
- Discussion of Prior Action Plans/Updates
- Create Action Plan

At the end of the meeting, we want to be able to answer the following questions:

- **What trends has the committee identified? What are some likely causes for those trends?**
- **What actions does this committee recommend to address these trends?**

Stakeholders Example #2

List of Acronyms used in Stakeholder Meeting:

- BCBD-Butler County Board of Developmental Disabilities
- BCCS- Butler County Children Services
- BSP- Behavior Support Plan
- COG- Council of Governments (The Southwestern Ohio Council of Governments (SWOCOG) includes Butler, Clermont, Hamilton and Warren County and is a way to collaborate and share resources.)
- DODD- Ohio Department of Developmental Disabilities
- HRC- Human Rights Committee

This is a helpful tool for Committee Members

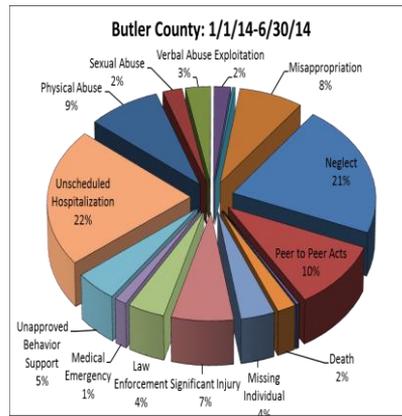
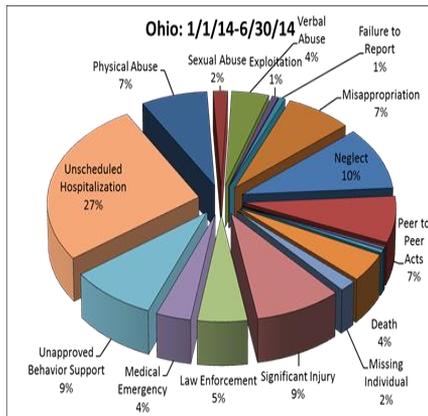
- IDS- Individual Data System (A statewide system in which county boards enter basic demographic information about individuals receiving services).
- IEP- Individual Education Plan
- IR- Incident Report
- ISP- Individual Service Plan
- ITS- Incident Tracking System (The statewide system that tracks Major Unusual Incidents)
- MUI-Major Unusual Incident
- PPI- Primary Person Involved (The alleged perpetrator in a Major Unusual Incident)
- SC/SSA- Support Coordinator/Service and Support Administrator
- UBS- Unapproved Behavior Support
- UI- Unusual Incident

Stakeholders Example #2

Incident Category	MUIs filed in 1/12-6/12		Substantiated	MUIs filed in 1/13-6/13		Substantiated	MUIs filed in 1/14-6/14		Substantiated
	Count	%		Count	%		Count	%	
Alleged Abuse - PHYSICAL	19	6%	3	14	5%	7	26	9%	6 (3 pending)
Alleged Abuse - SEXUAL	3	1%	2	4	1%	0	7	2%	1
Alleged Abuse - VERBAL	7	2%	5	11	4%	2	9	3%	4
Alleged Neglect	51	16%	36	45	15%	31	63	21%	32 (1 pending)
Attempted Suicide	0	0%	N/A	0	0%	N/A	0	0%	N/A
Death	12	4%	N/A	7	2%	N/A	6	2%	N/A
Exploitation	5	2%	3	3	1%	2	6	2%	2
Failure To Report	7	2%	5	3	1%	2	1	0%	1
Significant Injury	15	5%	N/A	20	7%	N/A	20	7%	N/A
Law Enforcement	4	1.5%	N/A	8	3%	N/A	12	4%	N/A
Medical Emergency	4	1.5%	N/A	9	3%	N/A	4	1%	N/A
Misappropriation	35	11.5%	20	31	10.5%	17	23	8%	9 (3 pending)
Missing Individual	3	1%	N/A	9	3%	N/A	11	4%	N/A
Peer-to-Peer Acts Misappropriation	1	0%	1	1	0%	0	1	0%	1
Peer-to-Peer Acts Physical	24	8%	13	31	10.5%	24	7	2%	7
Peer-to-Peer Acts Sexual	3	1%	1	1	0%	0	4	1%	2
Peer-to-Peer Acts Verbal	4	2%	4	18	6%	16	19	7%	18
Prohibited Sexual Relations	0	0%	0	1	0%	0	0	0%	0
Rights Code Violation	1	0%	0	0	0%	0	1	0%	1
Unapproved Behavior Support	29	10%	N/A	11	4%	N/A	14	5%	N/A
Unscheduled Hospitalization	68	24%	N/A	68	23%	N/A	66	22%	N/A
TOTALS	299		93	294		101	298		84

Stakeholders Example #2

TOTAL MUIs
1/1/2012-6/30/2012 : 299 total cases, 160 (54%) were protocol cases. 93/160 were substantiated (58%).
1/1/2013-6/30/2013 : 294 total cases, 162 (55%) were protocol cases. 101/162 were substantiated (62%).
1/1/2014-6/30/2014 : 298 total cases, 166 (56%) were protocol cases. 84/155 were substantiated (54%).



Stakeholders Example #2

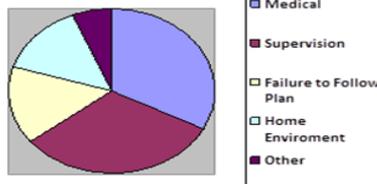
Comparison to Other Counties

	County	Enrollment as recorded by DODD in 2014	Population from 2010 Census Data	Total # of MUIs 1/1/14-6/30/14	Reporting per 1000 enrolled
	1 Butler	2,300	368,130	298 <i>*7th in state</i>	130 <i>*25th in state</i>
Similar Size	2 Clark	1,156	138,333	156	134.94
	3 Delaware	2,345* <i>*closest to Butler</i>	174,214	83	35.39
	4 Lorain	1,745	301,356	117	67.04
	5 Richland	1,052	124,475	155	147.34
	6 Stark	3,317	375,586* <i>*closest to Butler</i>	467	140.78
COG	7 Warren	1,632	212,693	186	113.97
	8 Clermont	2,028	197,363	109	53.75
	9 Hamilton	6,236	802,374	613	98.30
	All of Ohio	90,817	11,536,504	9,797	107.87

Stakeholders Example #2

NEGLECT

- 20 of the 64 (31%) of Neglect MUIs were related to supervision.
- 21 of the 64 (33%) of Neglect MUIs were related to medical issues.
- 10 of the 64 (16%) of Neglect MUIs were related to failure to follow the plan.
- 9 of the 64 (14%) of Neglect MUIs were related to an alleged inappropriate environment (cleanliness, drug use, domestic violence).

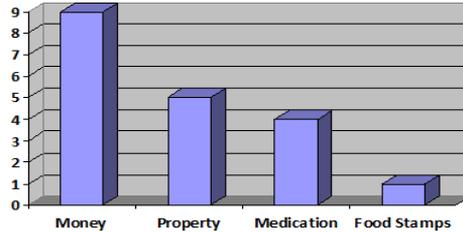


Important to Note:

- 5 incidents were related to the individual being transferred inappropriately.
- 12 were for failure to follow through with doctor appointments/orders.

Stakeholders Example #2

MISAPPROPRIATION



Important to Note:

- Although cash was more frequently stolen, the largest amounts stolen can be attributed to thefts from access to bank accounts.
- There was a significant decrease in theft and/or alleged theft by staff.
- Problems in the IT applications prevented review of all misappropriations.

Stakeholders Example #2

Individuals with 5 or more MUIs in 6 months

Client	MUI Number (only 1 st listed if multiple incidents)	Category	Create Date
Individual # 1	2014-009-0088	Misappropriation	3/4/2014
	2014-009-0222	Alleged Neglect	5/19/2014
	2014-009-0224	Missing Individual	5/21/2014
	2014-009-0249	Unscheduled Hospitalization	6/5/2014
	2014-009-0289	Peer-to-Peer Acts	6/25/2014
Individual #2	2014-009-0045+	Peer-to-Peer Acts (4)	2/4, 2/13, 3/20, and 6/13/2014
	2014-009-0175	Unscheduled Hospitalization	4/22/2014
	2014-009-0265	Law Enforcement	6/13/2014
Individual #3	2014-009-0068+	Unscheduled Hospitalization (4)	2/19, 2/26, 5/13, and 6/16/2014
	2014-009-0092	Alleged Neglect	3/5/2014
Individual #4	2014-009-0038	Alleged Neglect	1/30/2014
	2014-009-0054+	Peer-to-Peer Acts (3)	2/11, 3/11, and 4/29/2014
	2014-009-0123	Unscheduled Hospitalization	3/25/2014
Individual #5	2014-009-0024	Alleged Abuse - PHYSICAL	1/16/2014
	2014-009-0063+	Alleged Abuse – VERBAL (2)	2/18 and 6/17/2014
	2014-009-0191	Alleged Abuse – SEXUAL	5/1/2014
	2014-009-0192	Alleged Neglect	5/1/2014
	2014-009-0223+	Missing Individual (2)	5/20 and 6/30/2014

STAKEHOLDER MINUTES**Stakeholders Example #2**

2014 Semi-Annual Stakeholder Meeting Minutes, 9/18/14

Please see sign-in sheet for those in attendance.

Meeting started with introductions and review of the purpose of the committee.

The group first reviewed overall data by category for the past three years. The group noticed an increase in filing of physical abuse (although substantiated cases remained about the same). There was also a large increase in filing of neglects, but again the substantiated cases were similar.

Misappropriation cases decreased both in the number filed and number substantiated. There was an increase in Missing Person cases which is especially concerning considering the definition to file is more strict now than in prior years. There was also an increase in law enforcement cases.

The group then compared statewide data to that of Butler County. Statewide neglect cases comprise 10% of all MUIs, but in Butler County they are 21%. Peer to peer acts are 7% of cases statewide but are 10% in Butler County. Statewide there are 9% unapproved behavior support, but that is lower in Butler County at 5%. Overall, the biggest concern in this area was the neglect difference. Committee did wonder if having a more extensive nursing staff and more nursing involvement made us more likely to catch and report potential medical neglects.

The group then compared the total MUIs and reporting rates of Butler County to counties similar and size and also to COG counties. Butler County is 7th in Ohio in terms of total MUI numbers. The reporting rate is 25th in the state. It was noted in one county, the reporting rate and total were significantly lower than Butler County even though the number of people served was similar. The group discussed that the county being compared had a high number of individual budgets and many of the providers selected through those budgets are not DODD providers which may impact reporting.

Stakeholders Example #2

Action Plan:

Develop more of a "treatment approach" when serving individuals dually diagnosed with mental health conditions. Colleen is leading these efforts.

Share a "cheat sheet" used by providers (aka Resident at a Glance) that can be used as a snapshot of the most important health/wellness related needs of a person. Leia is still gathering samples from providers and will send out an example.

Teresa Brand will take concerns to team supervisors regarding inconsistency of including health/safety information in person-centered plans. Some SCs are referring to assessed needs rather than including in the plan itself and sometimes the assessments are not being sent with the plan.

Break down fall data by age, cause, diagnoses, medications, etc. This has been completed and will be attached to the minutes.

Stakeholders Example #2

Fall Data from January- June 2014							
MUI #	Date	M/F	Age	Circumstances	Injury/Outcome	Diagnoses	Notes
21	14-Jan	M	35	Running and turned to look- fell	laceration above eye	Mod ID, Bipolar disorder, asperger syndrome	
30	21-Jan	M	21	Lost balance, fell in bathroom	7 stitches lower lip	ID, CP, Spastic Diplegia, Complex Partial Seizure, MH diagnoses, Impulse Control	History of falling
34	27-Jan	M	58	Fell out of chair, possible seizure/syncope	laceration to head	Profound ID, Hypertrophy, nuclear sclerosis, esotropia, strabismus, cataracts	NO history of seizures
65	17-Feb	F	43	Bent down in wheelchair to pick something up and fell	fractured clavicle	TBI, spastic hemiparesis, myopia, exotropia, optic atrophy, OCD, bipolar, dementia	
66	14-Feb	M	41	Tried to get out of bed w/o staff	sprained ankle	diabetes, ID, CP, cyclothymia, PTSD	uses a wheelchair
106	14-Mar	M	61	tripped on broken sidewalk	7 stitches to face and wrist injury	diabetes, HTN, COPD, multiple MH diagnoses, Mild ID	
124	7-Mar	M	39	walking in woods, tripped on ice	fractured thumb	Profound DD, Autism, MH diagnoses, Scoliosis, Seizure Disorder	
174	18-Apr	F	58	fell in bedroom	6 stitches to chin	ID, Down syndrome, dementia, astigmatism, myopia, estropia, spontaneous bilateral nystagmus, mild hearing loss	fall not witnessed
195	1-May	F	71	walker slid and she fell and hit face on footboard of bed	bruised jaw and 2 displaced vertebrae	Moderate ID, Osteoporosis, HTN, Hearing Loss, cataracts, CAD, bilateral knee replacement, oostoarthritis, rheumatoid arthritis	
196	1-May	F	63	fell out of bed	foot sprain, fractured toes	Profound ID, MH diagnoses, Seizures,	recent new med (tramadol)
295	26-Jun	M	46	playing football	fractured right ankle	ID, MH diagnoses, Impulse control	
304	28-Jun	F	54	tripped over deck chair	fractured shoulder	Moderate ID, diabetes, HTN, Anemia, multiple MH diagnoses	tendency to shuffle

13 Falls Total

6 outside of home

7 in home (3 related to bed)

Demographics

6 female (age 43-71) average 58

7 male (age 21-58) average 39

Stakeholders Example #3

XX County 2013 Annual Stakeholder Review and Analysis

February 25, 2013]

In attendance:

List of County Board, Providers, and community members for attended by name, title

Review of 2013 Semi Annual Stakeholder Meeting Minutes

The minutes from the September 4, 2013, Semi Annual Stakeholder meeting were reviewed by the committee

XX COUNTY MAJOR UNUSUAL INCIDENT GENERAL INFORMATION

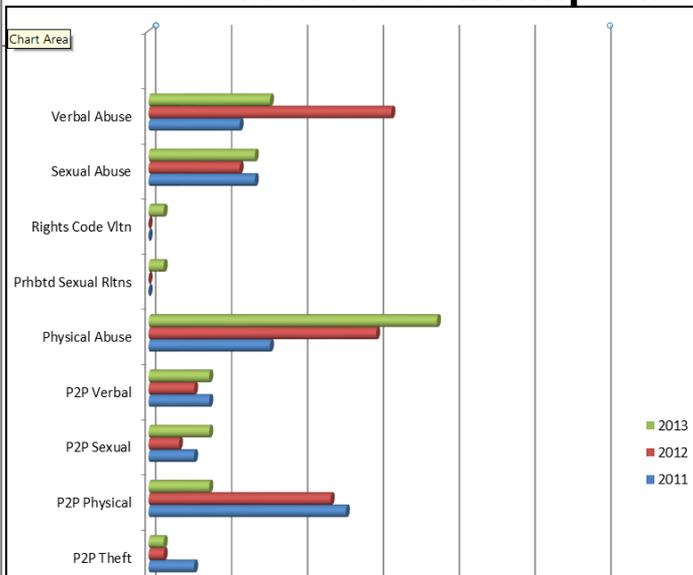
- Over the time period beginning January 1, 2011, through December 31, 2013, a total of 448 mis were filed. The numbers fluctuated from year to year, with the highest reporting year being 2012.
- Protocol/Category A cases peaked in 2012. During the three year period, the percentage of Protocol/Category A cases in relation to the total number of cases filed increased by 19%.
- Category B cases trended downward for the three year period, while Category C cases fluctuated from year to year, with the highest reporting year being 2012.
- For 2013, XX County accounted for 20% of the total MEORC RSC county cases and approximately 0.8% of the total cases state-wide.
- For the three year period, XX County accounted for roughly 30% of the total MEORC RSC county cases.

Stakeholders Example #3

6. The substantiation rate of Protocol/Category A cases peaked in 2012 as during that year, the most Protocol/Category A cases were filed *and* substantiated.
7. Over the course of the three year period, approximately 61% of the cases occurred in provider environments. This location trend was a function of individuals spending the majority of time in provider environments.
8. Per information provided by DODD MUI, XX County provided services to 526 people. This figure represents 17% of the total number of individuals receiving services in the MEORC RSC counties, and slightly less than 0.6% of the people receiving services state-wide.
9. The mui reporting rate per 100 people served exceeded the MEORC RSC county rate by 17% and the state-wide rate by 31%.

Note: This County is a member of a COG and utilizes COG data to make comparisons to other counties in the area.

Stakeholders Example #3



A break down of different types of Protocol A cases is helpful to beneficial for analysis. Here is example of Protocol A cases.

Stakeholders Example #3

Chart Area	2011	2012	2013	TOTAL
CATEGORY A (protocol cases)				
Accidental/Suspicious Death	0	1	0	1
Exploitation	2 (1)	0	0	2 (1)
Failure to Report	0	1 (1)	4 (1)	5 (2)
Misappropriation	11 (5)	15 (12)	20 (9)	46 (26)
Neglect	11 (7)	27 (18)	21 (11)	59 (36)
P2P Exploitation	0	0	0	0
P2P Theft	3 (2)	1 (1)	1	5 (3)
P2P Physical	13 (9)	12 (7)	4 (3)	29 (19)
P2P Sexual	3 (1)	2 (2)	5 (1)	10 (4)
P2P Verbal	4 (3)	3 (3)	4 (2)	11 (8)
Physical Abuse	8 (1)	15 (1)	19 (5)	42 (7)
Prohibited Sexual Relations	0	0	1	1
Rights Code Violation	0	0	1	1
Sexual Abuse	7 (2)	6	6 (3)	19 (5)
Verbal Abuse	6 (2)	16 (9)	8 (3)	30 (14)
Category A totals	68 (33)	99 (54)	94 (38)	261 (125)
CATEGORY B				
Attempted Suicide	1	0	0	1
Death other than accidental/suspicious	4	5	5	14
Medical Emergency	12	13	10	35
Missing Individual	1	0	0	1
Significant Injury	13	11	8	32
CATEGORY C				
Law Enforcement	0	0	0	0
Unapproved Behavior Support	2	7	0	9

Stakeholders Example #3

SUBSTANTIATION PERCENTAGES

2011	2012	2013	3 Year
48.5%	54.5%	40.4%	48.0%

MUI PROVIDER LOCATION

Location	2011	2012	2013	3 Year Total
Provider	87	97	88	272
County Board	21	32	30	83
No Provider	23	36	34	93

MUI CATEGORY SPECIFIC INFORMATION

UNSCHEDULED HOSPITALIZATIONS

Allergic Reaction	1
Altered State	4
Blood Clot(s)	1
Blood Pressure	2
Blood Sugar Levels	1
Body Temperature Variations	1
Cardiovascular	6

Stakeholders Example #3

- There were 95 unscheduled hospitalization cases over the three year period.
- **For 2013, XX County accounted for 28% of the total MEORC RSC county unscheduled hospitalization cases and 0.8% of said cases state-wide**
- Over the course of the three year period, **XX County** accounted for 41% of the total MEORC RSC county unscheduled hospitalization cases
- **More unscheduled hospitalization cases were filed regarding males than females**
- Discussion and recommendations: It was noted that medication may have been a factor in some of the bowel obstruction cases. With regard to psychiatric admissions, it was noted that services to address psychiatric issues are not readily available. The team did not have a recommendations for further action.

Each MUI type is broken down, reviewed and further analyzed.

Stakeholders Example #3

Types of Primary Person Involved is reviewed by category type to identify any patterns or trends.

PRIMARY PERSONS INVOLVED		
<u>2011</u>		
Category	PPI	Total
Alleged Abuse - PHYSICAL	Family	4
	Other	1 (1)
	Staff	3
Alleged Abuse - SEXUAL	Family	1
	Other	4
	Unknown	1 (1)
	Not Listed	1 (1)
Alleged Abuse - VERBAL	Family	1
	Other	2 (1)
	Staff	1
	Unknown	2 (1)
Alleged Neglect	Family	3 (3)
	Staff	7 (4)
	Unknown	1

Stakeholders Example #3

Category A (Protocol) Cases	# of cases (# substantiated)			
Exploitation	5 (1)	0	2 (1)	7 (2)
Washington County	2 (1)	0	0	2 (1)
Ohio			119	
Failure to Report	2 (1)	1 (1)	12 (6)	15 (8)
Washington County	0	1 (1)	4 (1)	5 (2)
Ohio			176	
Misappropriation	26 (10)	25 (18)	76 (36)	127 (64)
Washington County	11 (5)	15 (12)	20 (9)	46 (26)
Ohio			1528	
Neglect	28 (12)	45 (27)	95 (55)	168 (94)
Washington County	11 (7)	27 (18)	21 (11)	59 (36)

- **A comparison of County to Statewide Reporting is made**

Stakeholders Example #3

Number of Individuals Served:

	2013
Individuals Served for All MEORC RSC Counties	3057
XX County	526
Ohio	88,984

Reporting Rate Per 100 Individuals Served:

	2013
Reporting Rate for All MEORC RSC Counties	24.6
XX County	28.9
Ohio	22.1



Stakeholders Example #4

Highlights from Warren County Board Stakeholder Presentation

This County gives a brief description of each program reviewed and how many people are served. For example:

Adult Services provides community employment services, supported employment, contracted production work in house, leisure, recreation, and retirement opportunities.

Adult Services provided services to approximately 444 Individuals as of December 31, 2013.

Stakeholders Example #4

"Accidental or suspicious death" means the death of an individual resulting from an accident or suspicious circumstances.

"Death other than accidental or suspicious death" means the death of an individual by natural cause without suspicious circumstances.

12 reports total- All Non Suspicious

Ages: 0-2 years old: 0 children
 3-5 years old: 2 people
 6-21 years old: 0 people
 22-30 years old: 1 person
 31-40 years old: 1 person
 41-50 years old: 1 person
 51- 64 years old: 6 people
 65 + years old: 1 person

Stakeholders Example #4

- "Misappropriation" means depriving, defrauding, or otherwise obtaining the real or personal property of an individual by any means prohibited by the Revised Code, including Chapters 2911. and 2913. of the Revised Code
- There were 18 incidents 01/01/13-12/31/13

Stakeholders Example #4

Stakeholder's Committee Meeting Minutes

March 18, 2014

Members present: Names and Titles |

The Committee had received the aggregate and comparison information prior to the meeting. The committee reviewed and compared the MUIs for calendar year 2013 to 2012 and 2011 (January 1 – December 31).

The following trends and issues were noted in the 2013 Annual MUI Stakeholder's meeting:

- **Medical Hospitalization** remains the largest category/number of MUIs for Warren County with 87 incidents from January 1, 2013 – December 31, 2013 compared to 89 incidents in 2012 and 93 incidents in 2011 for the same time period. Committee discussed that, as noted in previous committee meetings, this continues to be a difficult category to prevent due to various individuals' diagnoses and medical needs. Some individuals have chronic illnesses identified in their plans and when those issues cause a hospitalization, they do not constitute an MUI. Also, as trends and patterns arise for new medical concerns, ISP's have been revised when appropriate. The committee also discussed that of the 87 incidents, 47 occurred with the same provider who generally provides care to medically fragile individuals. The committee discussed that this provider is supposed to downsize considerable over the next year and if this occurs, the many individuals could be moved out of county and the number of medical hospitalizations could decrease.

Stakeholders Example #4

2014 ACTION PLAN:

- Committee discussed Medical Hospitalizations and the difficulty with prevention in this category as this continues to be a challenge. Teams will continue to address on-going medical issues in the ISP that lead to hospitalization as relevant. As UIs/MUIs are received with any trends/patterns in providers not following up with medical appointments as required for individuals, provider compliance specialist will follow up. SSA's will bring discuss medical concerns with teams and if a provider is not following up on medical related issues, the SSA will bring concerns to the Support Services division.
- Committee discussed the importance of training with Unapproved Behavior Supports so that least harmful techniques possible are used in each situation. The County Board offers CPI training to independent providers requiring training to work with individuals served. The County Board also offers training in MUI/UI and Individuals Rights to agency and independent providers to ensure that staff are aware of reporting requirements as well as what constitutes an Unapproved Behavior Support. There is a provider support group meeting once a month and a "Good Life" Facilitator is providing learning experiences to the providers during those meetings.

Stakeholders Example #5

2011 Action Plan:

For the first half of 2011, we are noticing an increase in the number of misappropriations that are occurring in Lucas County. There has been an increase in the number of home burglaries, as well as with staff stealing limited amounts of money contained in the homes. We attribute this trend to the economy, but also note that several providers have poor systems for monitoring finances. In response to this trend, the QA newsletter has an article regarding misappropriation for the next issue. I have also initiated a stakeholder group to develop a comprehensive misappropriation training that will be trained to County Board and providers. Beginning in September 2011, the MUI Coordinator is also training all Service and Support Specialists on Financial Monitoring and this same training will be conducted with Quality Assurance staff in October.

2011 Year End Action Plan:

The committee spent time discussing misappropriation cases. The misappropriation training has been developed and is slated to be presented to providers beginning May 2012. The training is geared toward administrative staff with financial oversight/monitoring duties. The training is not slated for direct care staff. The training was conducted 3 times in the year 2012; with great provider participation.

Also, there has been an increase in neglect cases. As a result, one of the QA Newsletter articles focused on neglect and provided information on how to identify, report, and prevent neglect.

Stakeholders Example #5

- **2012 Action Plan:**

- For the first half of 2012, Lucas County has seen an increase in alleged neglect MUIs which involve alarms. Either the alarms not being activated, not being utilized per the individual's plan and/or the alarms listed in the plan but not even present in the home. In response to this trend, the MUI unit developed a Lucas County alert regarding alarms, which was sent to all providers, Service and Support Specialists, and Behavior Management Specialists.

- **2012 End of Year Action Plan:**

- Discussed that Peer to Peer Acts continues to be a gray area for providers. Will develop a training specific to Peer to Peer Acts when the new rule goes into effect, as this will change the definitions of a few categories within Peer to Peer Acts. The training will then be offered to all providers. The committee also discussed health coordination. The SSA department is working on a process for the intake and processing of this information. Once that process is developed, it will be shared with providers.

- **2013 semi-annual action plan:**

- Discussion of 2012 action plan involving alarms. Since only 3 MUIs were alarms related in the first half of 2013, it appears that the Lucas County alert was effective. Group was interested in looking more in depth at misappropriation to determine what amounts are being taken and who the PPI is. Will ensure that this is completed for the annual review to determine if the misappropriation training has been effective and/or if greater emphasis is needed in this area.

- **2013 End of Year Action Plan:**

- The MUI unit will work on tracking neglect cases and law enforcement cases to determine if there are particular training needs for providers and/or individuals for these categories.

Focused Review of Data

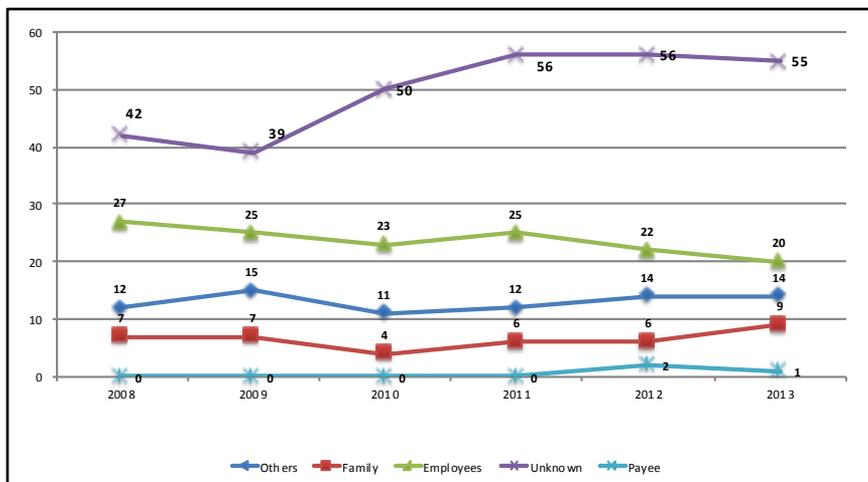
- **Unscheduled Hospitalizations (27%)**
- **Choking due to increased number of choking incidents and deaths**
- **Fatal Five** The Fatal Five refers to the top five disorders linked to preventable deaths of individuals in congregate care settings or in community based residential settings. While the issues can differ in order of frequency depending on the population being represented, the five conditions most likely to result in death or health deterioration for persons with Intellectual and Developmental disabilities are:
 - **Bowel Obstruction**
 - **GERD**
 - **Aspiration**
 - **Dehydration**
 - **Seizures**
- **Falls**
- **Unapproved Behavior Supports**

Statewide Patterns and Trends

- Meets Semi-Annually and Annually
- Committee Membership
- Review of Data
- Makes recommendations for future trainings, Health and Safety Alerts, communication to the field and much more

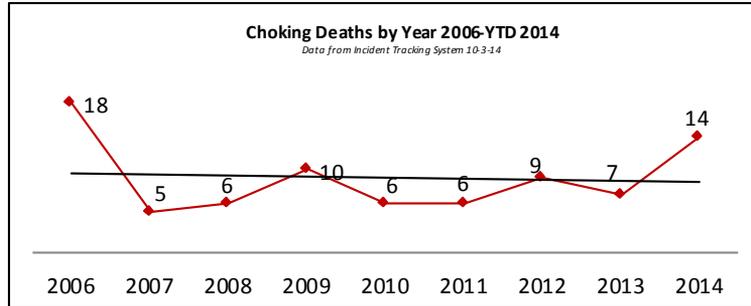


Percentage of Misappropriations by PPI Type 5-Yr Review 2008-2013

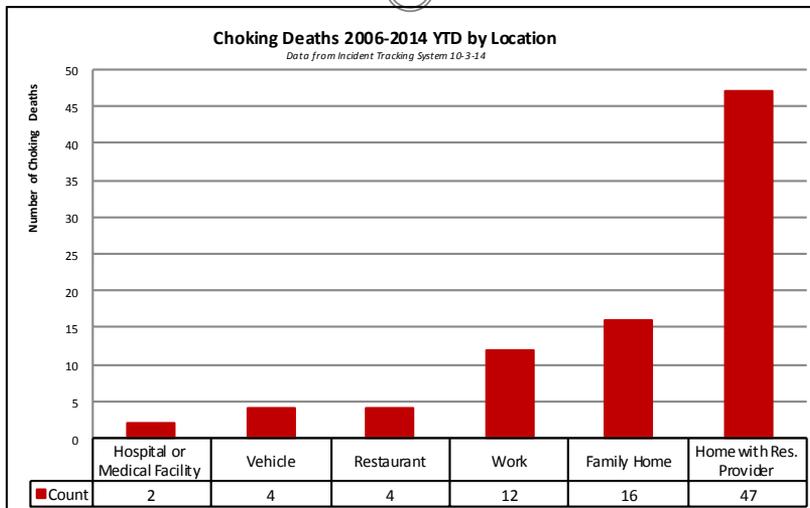


Review of Choking Information

- Each choking death was reviewed for a period of 8 years
- Fact patterns were analyzed for similarities (location, provider type, item choked on)

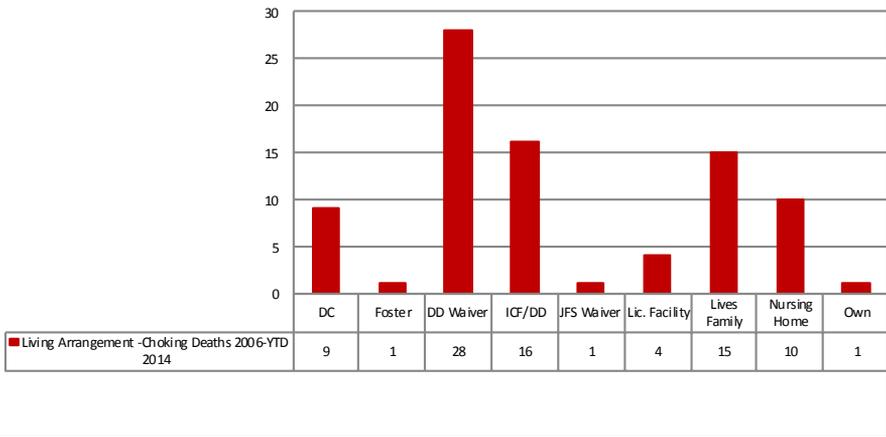


Patterns and Trends Choking Study



Choking Study Data

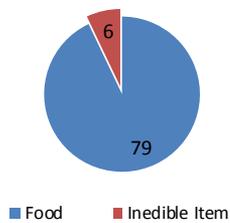
Living Arrangement -Choking Deaths 2006-YTD 2014



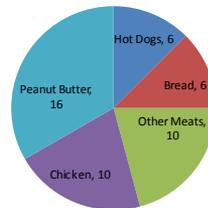
Choking Study Data

- Choking Deaths were also reviewed by gender and age.
- Average Age of person who died was 49.57. The youngest was 1 year old and oldest 79 years of age.

Classification of Item Choked



5 Most Commonly Choked on Foods



Actions to Address Increase in Choking

Ohio Department of Developmental Disabilities
Office of MUI/Registry Unit
John R. Bensch, Governor
John L. Baska, Director

Health and Welfare Alert

Choking #18-04-13

The purpose of this Alert is to provide critical information to caregivers on choking prevention. People with developmental disabilities are at a high risk for choking. Those providing care can help reduce these risks, provide timely care, and potentially save a life. This Alert will provide some signs that may indicate a person is choking and what you can do to help.



In 2013, seven Ohioans with developmental disabilities passed away due to choking related accidents. Unfortunately, there have been more choking related deaths in 2014. We believe prevention is the key to saving lives. While seven people lost their lives, many more were saved by the fast action of others. In over 370 of the

Who is in danger of choking? Anyone can choke, but choking is more likely for someone who:

- Has cerebral palsy or a seizure disorder;
- Has few or no teeth, or wears dentures;
- Has trouble chewing or swallowing;
- Does not sit up while eating;

1. Completed Choking Study
2. Issued an Alert on Choking Prevention
3. Training on Choking Prevention including 4-part Webinar Series
4. Feature in *Well-Informed* Newsletter
5. Plans to include more resources in Health and Safety Tool Kit

More to come...



Let's Reduce Choking Incidents

The Ohio Department of Developmental Disabilities (DODD) and our partners in the field of disability services are committed to reducing the number of choking incidents in Ohio. We believe that through increased awareness, fast action, communication, and diligence we can minimize choking risks and save lives.

Individuals with developmental disabilities are at high risk for dysphagia (difficulty swallowing) which can lead to choking and aspiration. Choking is a major cause of medical emergency Major Unusual Incidents (MUIs) and, unfortunately, some deaths of Ohioans with DD, but it often can be prevented.

In this article we provide specific information so that, together, we can identify risk factors, signs of choking, foods commonly connected to choking incidents, and actions to be taken during an emergency.

When you breathe air through your nose or mouth, it goes down a tube – the trachea – sometimes called the wind pipe, and then into your lungs. Choking is when food or something else gets into your wind pipe and gets stuck, and the air you need cannot get to your lungs.

Aspiration is when you inhale food into your lungs. People with developmental disabilities share a number of common characteristics that may place them at high risk for choking/aspiration.



Take steps to reduce choking hazards.

These characteristics include:

- Decreased or absent protective airway reflexes as occurs with cerebral palsy and some other developmental disabilities.
- Poor or underdeveloped oral motor skills that do not permit adequate chewing or swallowing.
- Gastroesophageal reflux disorder (GERD), which may cause aspiration of refluxed stomach contents.
- Epileptic seizures
- Physical characteristics or wheelchair use which can make proper/safe positioning difficult, and can increase the risk for aspiration.

(continued on p. 2)

Choking (continued from cover)

• Medication side effects that lower muscle tone, causing delayed swallowing or suppression of the protective gag and cough reflexes. This is especially true of some seizure medications, muscle relaxants, and some behavioral intervention medications.

• Individuals may not be able to communicate when they are choking.

Additionally, some medical conditions can increase an individual's risk of choking. They include:

- Cerebral Palsy
- Down Syndrome
- Dysphagia
- Asthma
- Lung disease
- Emphysema
- Sleep apnea
- Allergic reactions that cause throat swelling
- Dental issues (including dentures)
- PICA (swallowing inedible objects)

Common signs of choking include:

- Inability to talk
- Wide-eyed panicked look on face
- Difficulty breathing or noisy breathing
- Inability to cough forcefully
- Skin, lips, or nails turning blue or dusky
- Loss of consciousness

Please see Health and Welfare Alert: Choking <http://dodd.ohio.gov/healthandsafety/Documents/Choking.pdf>

Case Review: Foods

A case review of choking deaths that occurred from 2006-2014, was completed by the MUI Registry Unit in September.

Food most commonly choked on included:

- Peanut butter
- Chicken
- Bread products (toast, sandwich bread, rolls)
- Meats (pot roast, sausage, steak, ham)
- Hot dogs
- Hamburgers
- French Fries

Choking Medical Emergencies-Interventions Per Year

Year	2006	2007	2008	2009	2010	2011	2012	2013	2014
Number of Choking-related Emergencies	285	330	333	362	392	344	344	380	385
Successful First-time Intervention Provided	270	326	323	358	388	338	338	376	376

Each year, caregivers (paid and unpaid) save lives by providing prompt medical interventions to a choking person. And, we always can do better!



In six of the choking-related deaths from 2006-present, the item that was ingested was not edible. Items such as baby wipes, gloves, and thumb tacks were eaten and caused the person to choke.

Case Review: Foods (cont.)

- Crackers
- Fresh fruit (apples, bananas)
- Fresh hard vegetables (broccoli, cauliflower)

(continued on p. 4)

Stakeholder Review

- The Stakeholder Committee shall meet each September and March

Meeting	Time Period Reviewed
March	January 1-December 31 (previous year)
September	January 1-June 30 (same year)

- All participants shall be sent the aggregate data at least ten calendar days in advance of the meeting.
- Stakeholder Information will be reviewed at both Accreditation and Quality Tier Reviews.



Special Thanks to the Panel

- Kelli Grisham, Clearwater COG**
- Leia Snyder, Butler County Board of DD**
- Tonya Hitchens, MEORC COG**

Thanks to Warren and Lucas Counties for allowing their systems to be shared.



THANK YOU!

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1-866-313-6733