Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CONNECTICUT DID NOT COMPLY WITH FEDERAL AND STATE REQUIREMENTS FOR CRITICAL INCIDENTS INVOLVING DEVELOPMENTALLY DISABLED MEDICAID BENEFICIARIES

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Daniel R. Levinson
Inspector General

May 2016
A-01-14-00002

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

The Connecticut Department of Social Services did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries residing in group homes.

WHY WE DID THIS REVIEW

A 2012 report issued by the Connecticut Office of Protection and Advocacy for Persons with Disabilities (OPA) stated that 82 of the 1,361 deaths statewide of developmentally disabled individuals from January 2004 through December 2010 involved suspected abuse or neglect. OPA investigated 81 of those deaths. The deaths involved individuals with injuries such as broken bones; safety issues such as choking incidents and burns associated with scalding; car accidents involving unlicensed drivers; and inadequate medical services at private and public group homes, State training schools, regional centers, skilled nursing facilities, and hospitals. Investigators cited abuse, neglect, and medical errors as contributing factors in these deaths. We are performing audits in several States in response to a congressional request concerning the number of deaths and cases of abuse of developmentally disabled residents of group homes.

The objective of this audit was to determine whether the Connecticut Department of Social Services (State agency) complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries residing in group homes from January 2012 through June 2014.

BACKGROUND

Developmentally disabled individuals have chronic mental or physical impairments that must be evident before the age of 22. Residential, institutional, and community providers that serve developmentally disabled individuals must meet minimum standards to ensure the care they provide is free from abuse, neglect, sexual exploitation, and violations of legal and human rights. The State agency administers the Medicaid Home and Community-Based Services Comprehensive Supports waiver (HBSC waiver). This waiver contains safeguards the State agency established to ensure the health and welfare of waiver participants. The Department of Developmental Services (DDS) implements portions of this waiver, including the safeguard provisions, through a memorandum of understanding with the State agency. DDS procedures define a "critical incident" as an incident that includes severe injury and must be reported immediately to the DDS regional director, assistant regional director, or a designee. OPA is responsible for the protection and advocacy of the rights of developmentally disabled persons residing in Connecticut and the investigation of allegations of abuse or neglect of developmentally disabled persons aged 18 through 59.

We limited our audit to 347 emergency room claims for 245 beneficiaries aged 18 through 59 residing in group homes. They had 310 hospital emergency room visits and were diagnosed with at least 1 of 40 conditions that were similar to many of the causes of death identified in OPA's 2012 report.

WHAT WE FOUND

The State agency did not comply with Federal waiver and State requirements for critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically, the State agency did not ensure that

- group homes reported all critical incidents to DDS (14 percent unreported),
- DDS recorded all critical incidents reported by group homes (22 percent unrecorded),
- group homes always reported incidents at the correct severity level (57 percent incorrect),
- DDS collected and reviewed all data on critical incidents, and
- DDS always reported reasonable suspicions of abuse or neglect (99 percent unreported).

The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents because staff at DDS and group homes lacked adequate training to correctly identify and report critical incidents and reasonable suspicions of abuse or neglect, DDS staff did not always follow procedures, DDS lacked access to Medicaid claims data, and DDS did not establish clear definitions and examples of potential abuse or neglect.

The State agency did not adequately safeguard 137 out of 245 developmentally disabled Medicaid beneficiaries because the DDS system of reporting and monitoring critical incidents did not work as expected.

In addition, we noted several issues that while outside the scope of our review are worthy of further discussion and action. These issues involve:

- DDS's revision of its definition of "severe injury,"
- hospital-based mandated reporters' failure to report to OPA all critical incidents, and
- inadequate care contributing to the death of developmentally disabled Medicaid beneficiaries.

WHAT WE RECOMMEND

We recommend that the State agency:

- work with DDS to develop and provide training for staff of DDS and group homes on how to identify and report critical incidents and reasonable suspicions of abuse or neglect,

- work with DDS to develop a data-exchange agreement and related analytical procedures to ensure DDS access to the Medicaid claims data contained in Connecticut's Medicaid Management Information System to detect unreported and unrecorded critical incidents,

- work with DDS to update DDS policies and procedures to clearly define and provide examples of potential abuse or neglect that must be reported, and

- coordinate with DDS and OPA to ensure that any potential cases of abuse or neglect that are identified as a result of new analytical procedures are investigated as needed.

DEPARTMENT OF DEVELOPMENTAL SERVICES COMMENTS AND OUR RESPONSE

In written comments on our draft report, DDS stated that it fully recognizes the need to improve the manner by which critical incidents are reported and reviewed. To that end, DDS agreed that their incident reporting system needs to be revised to ensure the health and safety of individuals who receive services from DDS and DDS-qualified providers. DDS said it has started that process.

DDS further stated that the draft report cites 99 percent (151 of 152) of critical incidents were not reported to OPA as "potential incidents of abuse or neglect." DDS did not agree that all of these critical incidents "rise to the level of a suspicion of abuse or neglect as a contributory factor to the corresponding incident" based on its definition of a critical incident in effect during our audit period. Specifically, DDS said it does not agree that beneficiary visits to the emergency room for known chronic medical conditions create a reasonable cause to suspect abuse or neglect. DDS also noted that some of the information contained in the draft report's figures and table was inaccurate and should be updated.

We have reviewed DDS's comments on our draft report and maintain that DDS did not report 151 of 152 critical incidents to OPA as potential incidents of abuse or neglect involving developmentally disabled Medicaid beneficiaries. All 152 critical incidents in question met the DDS definition of a "severe injury," a determination made by DDS officials at our request. DDS officials agreed that such severe injuries in general should have created a reasonable suspicion of abuse or neglect.

We have clarified that DDS, at our request, made the determination of which emergency room visits were critical incidents, and we clarified the definition of a "severe injury." We maintain that the information contained in the figures and table is accurate, but we have clarified that the data are accurate as of the date we concluded our fieldwork; therefore, the data do not reflect subsequent or ongoing action by DDS, OPA, or the State agency.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

A 2012 report issued by the Connecticut Office of Protection and Advocacy for Persons with Disabilities (OPA)[1] stated that 82 of 1,361 deaths of developmentally disabled individuals from January 2004 through December 2010 involved suspected abuse or neglect. OPA reported that it investigated 81 of these deaths. The deaths involved individuals with injuries such as broken bones; safety issues such as choking incidents and burns associated with scalding; car accidents involving unlicensed drivers; and inadequate medical services at private and public group homes, State training schools, regional centers, skilled nursing facilities, and hospitals. Investigators cited abuse, neglect, and medical errors as contributing factors in these deaths. We are performing audits in several States[2] in response to a congressional request concerning the number of deaths and cases of abuse of developmentally disabled residents of group homes.

OBJECTIVE

Our objective was to determine whether the Connecticut Department of Social Services (State agency) complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries residing in group homes from January 2012 through June 2014.

BACKGROUND

Developmental Disabilities Assistance and Bill of Rights Act of 2000

As defined by the Developmental Disabilities Assistance and Bill of Rights Act of 2000,[3] "developmental disability" means a severe, chronic disability of an individual. The disability of the individual is attributable to a mental or physical impairment, or a combination of both; must be evident before the age of 22; and is likely to continue indefinitely. The disability results in substantial limitations in three or more major life areas, including self-care, receptive and expressive language, learning, mobility, self-determination, capacity for independent living, and economic self-sufficiency.

Federal and State governments have an obligation to ensure that public funds are provided to residential, institutional, and community providers that serve developmentally disabled individuals. Furthermore, these providers must meet minimum standards to ensure the care they

[1] OPA is responsible in Connecticut for the protection and advocacy of persons with developmental disabilities between the ages of 18 and 59. This includes investigating allegations of abuse or neglect.

[2] U.S. Department of Health and Human Services, Office of Inspector General, *Review of Intermediate Care Facilities in New York with High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries* (A-02-14-01011), September 2015. Available at http://oig.hhs.gov/oas/reports/region2/21401011.pdf. States currently under review include Maine and Massachusetts.

[3] P.L. No. 106-402 (Oct. 30, 2000) (the Disabilities Act).

provide does not involve abuse, neglect, sexual exploitation, and violations of legal and human rights (the Disabilities Act § 109(a)(3)).

Medicaid Home and Community-Based Services Waiver

The Social Security Act (the Act) authorizes the Medicaid Home and Community-Based Services Comprehensive Supports waiver (HCBS waiver) program (the Act § 1915(c)). The program permits a State to furnish an array of home and community-based services that assists Medicaid beneficiaries to live in the community and avoid institutionalization. Waiver services complement or supplement the services that are available to participants through the Medicaid State plan and other Federal, State, and local public programs and the support that families and communities provide. Each State has broad discretion to design its waiver program to address the needs of the waiver's target population.

The State agency administers Connecticut's HCBS waiver. The Department of Developmental Services (DDS) implements portions of this Waiver through a memorandum of understanding with the State agency.[4] The HCBS waiver program supports individuals who reside in licensed settings, such as group homes, and require comprehensive services.

States must provide certain assurances to the Centers for Medicare & Medicaid Services (CMS) to receive approval for the HCBS waiver, including that necessary safeguards have been taken to protect the health and welfare of the beneficiaries receiving services (42 CFR § 441.302). This waiver assurance requires States to provide specific information regarding its plan or process related to patient safeguards, which includes whether the State operates a critical event or incident reporting system (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*). In its HCBS waiver, the State agency assured that it has a critical event or incident reporting system that relies on DDS policies and procedures. DDS established certain policies and procedures, which require coordination with other State agencies, including OPA, that have responsibility for responding to critical incidents for developmentally disabled individuals (DDS Procedures I.F. PO. 001, *Abuse and Neglect* and I.D. PR.009, *Incident Reporting*).

Critical Incident Reporting for Group Homes

DDS procedures for group homes and other facilities define a "critical incident" to include death or severe injury. Critical incidents must be reported immediately to the beneficiary's family or guardian and to the DDS regional director, the assistant regional director, or a designee. DDS established a system of reporting and monitoring critical incidents that occur with beneficiaries served by DDS to manage and reduce overall risk and a standardized process for reporting, documenting, and following up on incidents, including those caused by injury, restraint, and medication errors (DDS Procedure I.D. PR.009, *Incident Reporting*). These procedures also require DDS staff to follow up on critical incidents to ensure that corrective actions have been taken and critical incidents have been resolved. Group homes are required to use the DDS

[4] This is known as a "memorandum of agreement," which was in effect for the HCBS waiver period beginning October 1, 2013.

Incident Report, Form 255 (Appendix A) to report incidents, and DDS should enter the data from these forms into its incident reporting system.

Connecticut Group Homes

Connecticut is 1 of 18 States that operate a dual system of public and private residential services for the developmentally disabled. During our audit period, approximately 77 percent of Connecticut's developmentally disabled individuals between the ages of 18 and 59 who reside in institutional settings lived in private and public community living arrangements, otherwise known as group homes.[5] The remainder of these developmentally disabled individuals resided independently or in skilled nursing facilities, intermediate care facilities, State institutions, or hospitals.

HOW WE CONDUCTED THIS REVIEW

We extracted 2,963 emergency room claims from the Connecticut Medicaid Management Information System (MMIS) that the State agency paid on behalf of developmentally disabled Medicaid beneficiaries residing in group homes from January 2012 through June 2014. We limited our audit to 347 emergency room claims for 245 beneficiaries between the ages of 18 and 59 residing in group homes who had 310 hospital emergency room visits[6] and were diagnosed with at least 1 of 40 conditions that were similar to many of the causes of death identified in OPA's 2012 report (Appendix B).[7]

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix C contains details of the types of injuries sustained by the 245 beneficiaries who went to the emergency room. Appendix D contains details on our audit scope and methodology. Appendix E contains details of the Federal and State requirements relevant to our findings.

FINDINGS

The State agency did not comply with Federal waiver and State requirements for critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically, the State agency did not ensure that:

- group homes reported all critical incidents to DDS (14 percent unreported),

[5] We determined this percentage from beneficiary data provided to us by DDS.

[6] Some emergency room visits had more than one Medicaid claim.

[7] Appendix B contains a list of the 40 diagnosis codes we reviewed. We refer to these diagnosis codes as "high risk" conditions because they are associated with diagnoses similar to many of the causes of death in OPA's 2012 report.

- DDS recorded all critical incidents reported by group homes (22 percent unrecorded),
- group homes always reported incidents at the correct severity level (57 percent incorrect),
- DDS collected and reviewed all data on critical incidents, and
- DDS always reported reasonable suspicions of abuse or neglect (99 percent unreported).

The State agency did not comply with Federal and State requirements for reporting and monitoring critical incidents because staff at DDS and group homes lacked adequate training to correctly identify and report critical incidents and reasonable suspicions of abuse or neglect, DDS staff did not always follow procedures, DDS lacked access to Medicaid claims data, and DDS did not establish clear definitions and examples of potential abuse or neglect.

The State agency did not adequately safeguard 137 out of 245 developmentally disabled Medicaid beneficiaries because the DDS system of reporting and monitoring critical incidents did not work as expected.

In addition, we noted several issues that while outside the scope of our review are worthy of further discussion and action. These issues involve:

- DDS's revision of its definition of "severe injury,"
- hospital-based mandated reporters' failure to report to OPA all critical incidents, and
- inadequate care contributing to the death of developmentally disabled Medicaid beneficiaries.

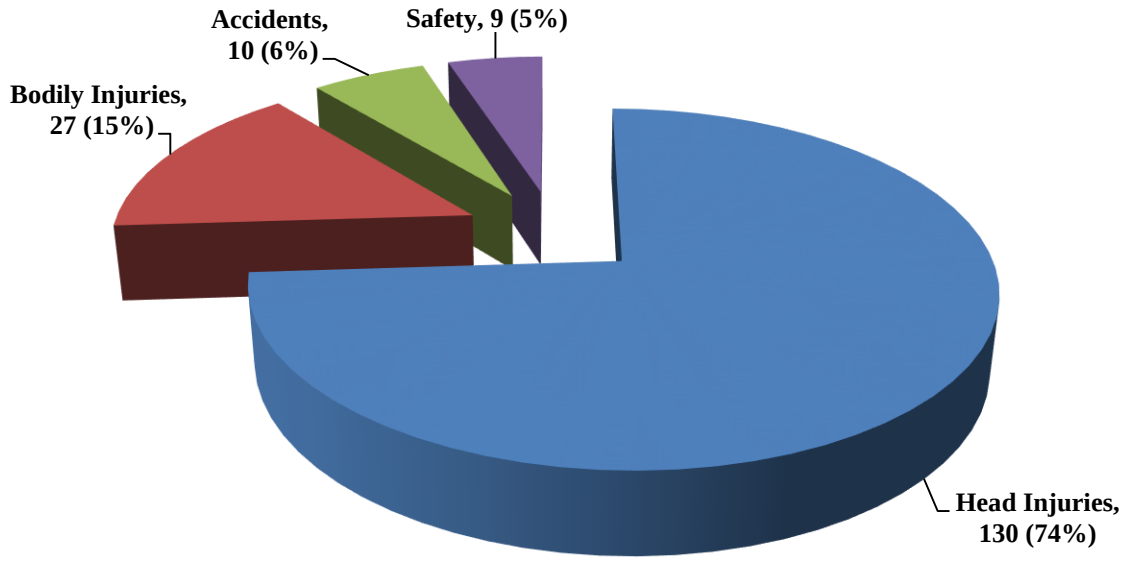
GROUP HOMES DID NOT REPORT ALL CRITICAL INCIDENTS TO THE DEPARTMENT OF DEVELOPMENTAL SERVICES

In accordance with assurances contained in the HCBS waiver, the staff of a DDS-operated, -funded, or
-licensed facility must immediately report all critical incidents to the beneficiary's family or guardian and appropriate DDS regional director or designee (DDS Procedures I.F. PO. 001, *Abuse and Neglect,* (A) "Policy Statement," and I.D. PR.009, *Incident Reporting,* (D) "Implementation" (1)(a)). DDS procedures define a "critical incident" as an incident that involves death or severe injury. Critical incidents must be reported immediately to the DDS regional director, the assistant regional director, or a designee, and DDS procedures define a "severe injury" as an injury that requires treatment at an emergency room or a hospital admission (DDS Procedure I.D. PR.009, *Incident Reporting,* (C) "Definitions").

Group homes did not report to DDS all critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically, of the 310 emergency room visits by 245 developmentally

disabled Medicaid beneficiaries, 176 visits[8] met DDS's definition in effect at the time of a critical incident because they included a severe injury (Figure 1).[9] However, group homes did not report 24 (14 percent) of the critical incidents to DDS.

Figure 1: 176 Critical Incidents by Diagnosis Code Category



Note: These categories do not match precisely those listed in Appendix C because we found no "critical incidents" in the "medical" category.

Group homes did not always report critical incidents to DDS because the State agency did not ensure that group home staff had sufficient training to identify and report critical incidents. DDS officials stated that although DDS offered training to group home staff on abuse or neglect, it did not offer any training on critical incident reporting to Connecticut's 961 public or private group homes that provide residential services to developmentally disabled beneficiaries.

An Example of a Group Home's Unreported Critical Incidents

A group home did not report to DDS a critical incident involving a resident who suffered from Down syndrome and dementia. The resident was encouraged to wear a helmet for protection during seizures and a gait belt when he transferred positions. The resident required one-on-one supervision while walking during a number of specified activities within the group home. The resident had an unwitnessed fall in the group home's kitchen, which was followed by a period of unconsciousness. Hospital emergency room staff evaluated the resident for a trauma to the right side of his head and face with computerized axial tomography.

[8] These 176 critical incidents involved 149 Medicaid beneficiaries.

[9] At our request, DDS made the determination of whether an emergency room visit represented a critical incident.

Because these injuries met the DDS definitions of a "critical incident" and a "severe injury," the group home should have reported the incident immediately.

The Department of Developmental Services Revised Its Critical Incident Reporting Policy To Narrow the Definition of a Critical Incident

This issue was outside the scope of our review; however, it is significant and worthy of further discussion.

DDS revised its critical incident reporting policy in December 2014 while we were conducting our audit. The DDS policy in effect during the period covered by our audit defined a "severe injury" as an injury[10] that requires treatment at an emergency room or admission to a hospital. The participant safeguard provisions of the HCBS waiver reference this definition. The revised policy now defines a severe injury as an injury that requires "a hospital admission" only.

Although we cannot compel DDS to revise its new definition of a critical incident, we plan to refer this issue to State officials for their future followup and action. Only 6 of the 176 critical incidents that we reviewed in our audit would have been required to be reported under DDS's new definition of a severe injury. Therefore, we expect DDS's new definition to significantly reduce the number of critical incidents that group homes are required to report.

THE DEPARTMENT OF DEVELOPMENTAL SERVICES DID NOT RECORD ALL REPORTED CRITICAL INCIDENTS

Each DDS region must identify the staff responsible for entering incident data into the DDS incident reporting system, ensure that the incident report forms are date-stamped on arrival, and ensure that the data on the incident report forms are entered into the DDS incident reporting system within 5 business days of receipt (DDS Procedure I.D. PR.009, *Incident Reporting,* (D) "Implementation" (3)).

DDS did not record all critical incidents reported by group homes. Specifically, group homes reported 152 critical incidents to DDS, but DDS did not record 34 (22 percent) of these incidents into its incident reporting system. Because DDS did not record these incidents, the DDS Division of Investigations and OPA never received notice that these incidents occurred and, therefore, could not determine whether abuse or neglect contributed to these injuries. DDS did not enter all critical incidents into its incident reporting system because it did not always follow procedures. Furthermore, these unrecorded critical incidents were not detected because DDS did not have a way to coordinate with the State agency to facilitate the detection of unrecorded and unreported critical incidents.

DDS officials said they had plans to meet with the State agency to discuss a data-exchange agreement to facilitate the detection of unrecorded and unreported critical incidents.

[10] This includes all fractures (excluding fingers and toes) and other severe injuries, such as severe lacerations, head injury, and internal trauma.

An Example of a Critical Incident Not Recorded by DDS

A group home reported to DDS a critical incident involving a developmentally disabled and wheelchair-bound resident with cerebral palsy and pulmonary disease. The group home's staff reported the resident was dropped while being transferred. This resident suffered a displaced fractured clavicle that required treatment at a local hospital's emergency room. Hospital staff used x-rays in their evaluation of him.

Because the group home reported this incident to DDS, DDS should have entered the incident into its incident reporting system within 5 days. DDS, however, did not record the incident.

GROUP HOMES DID NOT ALWAYS REPORT THE CORRECT SEVERITY LEVEL OF INJURIES

A "severe injury" is an injury that requires treatment at an emergency room or admission to a hospital. To ensure the injury meets the correct level of severity, a group home should not report a severe injury to DDS until after the attending physician has made a diagnosis (DDS Procedure I.D. PR.009, *Incident Reporting*, (C) "Definitions"). DDS requires group homes to select the "highest level of severity" for a reported injury when completing DDS Form 255. The levels of reportable injury are "minor," "moderate," and "severe" (DDS Procedure I.D. PR.009, *Incident Reporting, Attachment B, Instructions for Completing DDS Form 255*).[11]

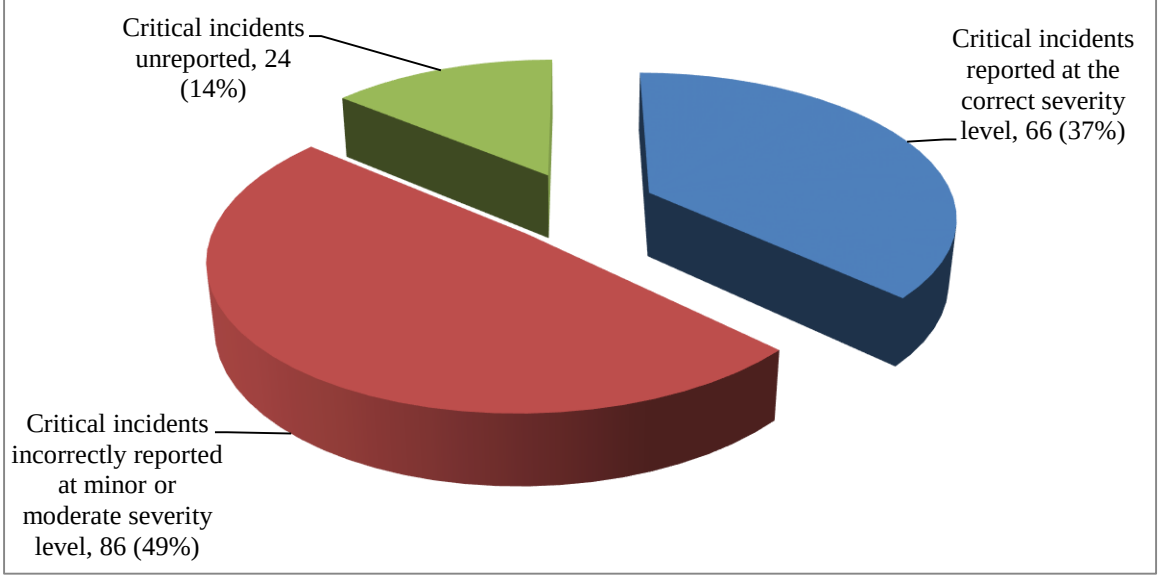
Group homes did not always correctly report to DDS emergency room visits related to severe injuries, which DDS would have treated as critical incidents (Figure 2). Instead, the group homes frequently reported to DDS emergency room visits as involving either minor or moderate injuries. Even though emergency room visits involving minor and moderate injuries are reportable, DDS did not treat them as critical incidents. DDS reviewed the 176 emergency room records we gave to them and they determined that 86 (49 percent) emergency room visits originally classified by the group homes as involving either minor or moderate injuries actually involved severe injuries and would have, therefore, met the State's definition of critical incidents.[12] Accordingly, State agencies could not investigate these 86 critical incidents for potential abuse or neglect.

Group homes misidentified critical incidents in reports to DDS because the State agency did not ensure that DDS provided critical incident report training to employees in group homes.

[11] Group homes use DDS Form 255 to report to DDS all incidents affecting the health and well-being of developmentally disabled beneficiaries residing in group homes. DDS should input the data contained in Form 255 into its incident reporting system and then shred physical copies of the form. The group home maintains the original Form 255 (Appendix A).

[12] DDS officials reviewed the 176 emergency room records during March 2015.

Figure 2: Reported Severity Level for 176 Critical Incidents



An Example of a Group Home Reporting the Incorrect Severity Level of an Injury

A group home reported injuries involving a resident with developmental disabilities, scoliosis, and spastic paralysis of all four limbs at an incorrect severity level. This resident suffered a lacerated upper lip, facial contusions, an acute cervical strain, and a fractured tooth; these injuries required treatment at a local hospital's emergency room. During the resident's treatment, hospital staff evaluated him for additional spine and skull injuries using computerized axial tomography. The group home's staff reported that the resident was injured when he fell from a shower chair, but they also reported that they did not witness his fall.

The group home reported these injuries to DDS, but it reported the severity level of the injuries as only "moderate" instead of "severe." As a result, this critical incident was not investigated by either DDS or OPA for potential abuse or neglect.

THE DEPARTMENT OF DEVELOPMENTAL SERVICES DID NOT COLLECT AND REVIEW ALL DATA ON CRITICAL INCIDENTS

In accordance with assurances contained in the HCBS waiver, DDS must collect and review data quarterly regarding critical incidents to determine the number and percent of critical incidents that were reported and investigated within required timeframes (HCBS waiver, Appendix G, *Participant Safeguards*, *Quality Improvement: Health and Welfare*, subsection (a)(i), *Methods for Discovery: Health and Welfare*). Furthermore, DDS must "review all critical incidents for trends and discussion every 6 months and review medication errors on a quarterly basis" (HCBS waiver, Appendix G-1: *Participant Safeguards: Response to Critical Events or Incidents*,

subsection (d), "Responsibility for Review of and Response to Critical Events or Incidents"). DDS officials stated that these reviews act as detection controls for critical incidents involving potential abuse or neglect.

DDS did not collect and review all data quarterly regarding critical events and incidents. DDS reviewed medication errors quarterly, but it reviewed internal critical incident data only annually. DDS did not have a way to obtain all data regarding critical events and incidents from the State agency. Accordingly, DDS could not review relevant Medicaid claims data for injuries that required emergency room treatment or hospital admission—key elements to detect whether beneficiaries were involved with critical incidents and whether those incidents were reported and investigated within required timeframes.

If DDS had access to relevant Medicaid claims data as contained in the Connecticut MMIS, it could have performed a data match similar to the one we performed. Because it could not, DDS was unable to detect the 24 critical incidents that group homes did not report or the 34 critical incidents that group homes reported but DDS did not enter into its incident reporting system.

THE DEPARTMENT OF DEVELOPMENTAL SERVICES DID NOT ALWAYS REPORT REASONABLE SUSPICIONS OF ABUSE OR NEGLECT

Any employee of DDS or a provider agency must immediately intervene on a developmentally disabled individual's behalf in any abuse or neglect situation and must report the incident immediately (DDS Procedure I.D. PR.009, Incident Reporting, (D) "Implementation" (1)(a) and (b)). DDS employees are mandated reporters, and any employee who has witnessed or has reasonable cause to suspect that there has been abuse or neglect of a developmentally disabled person must make an oral report immediately to the appropriate State agency (DDS Procedure I.F. PR.001, *Abuse and Neglect Allegations,* (D) "Implementation").

Although group homes reported 152 critical incidents to DDS during the period of our audit, DDS did not report 151 of the 152 to OPA as potential incidents of abuse or neglect involving developmentally disabled Medicaid beneficiaries.[13]

[13] DDS maintains that it would not have duplicated the reports to OPA for the 14 critical incidents already reported to OPA by other mandated reporters. DDS was unable to provide any documentation to support its assertion that DDS staff confirmed that these 14 critical incidents were reported to OPA by other mandated reporters.

Table: Actions Taken for 176 Critical Incidents[14]

OPA Action	Number of Critical Incidents
Opened new investigation	24
Updated ongoing investigation	9
Issued immediate protective service order	14
Referred to DDS	33
No further investigation conducted	81
Previously reported and reviewed	15
TOTAL	**176**

We reported to OPA the 176 critical incidents we identified during our audit (Table).[15] OPA stated that DDS should have reported all 176 as incidents with a reasonable suspicion of abuse or neglect.[16] OPA then opened 24 new investigations and updated 9 ongoing investigations—33 critical incidents involving potential abuse or neglect. OPA also issued 8 immediate protective service orders involving 14 critical incidents to protect developmentally disabled group home residents from potential harm. OPA followed up on an additional 33 critical incidents by providing DDS a list of beneficiaries whose emergency room visits did not warrant an investigation at that time; however, OPA officials informed us that they were concerned that the hospital emergency room records documented the need for a DDS review to ensure the ongoing safety of the beneficiaries. OPA did not conduct further investigations of the remaining 81 critical incidents because of their age, nature, or other mitigating factors concerning the critical incidents.

DDS agreed that during our audit critical incidents involving beneficiary visits to emergency rooms in general should have created reasonable cause to suspect abuse or neglect. However, DDS did not report the potential incidents of abuse or neglect to OPA because DDS staff lacked adequate training to ensure that they could properly identify and report reasonable suspicions of abuse or neglect. Although DDS provided abuse and neglect training to its employees once a year, this training included limited examples of potential abuse and neglect. Further, during our audit period, DDS only provided abuse and neglect training to private group homes that requested the training (102 of 961 group homes). In addition, the HCBS waiver did not provide clear definitions and examples of potential abuse and neglect that DDS staff could refer to if needed.

[14] OPA confirmed the data contained in this table on June 4, 2015.

[15] The 176 critical incidents include the 152 critical incidents reported by group homes to DDS plus the 24 critical incidents the group homes did not report to DDS.

[16] OPA was previously notified of 15 of the 176 critical incidents. Of the 15 incidents, 6 were reported by anonymous sources, 5 were reported by group homes, 2 were reported by family members, 1 was reported by a hospital, and 1 was reported by DDS.

An Example of the Department of Developmental Services Not Reporting a Critical Incident That Had Reasonable Suspicion of Abuse or Neglect

DDS did not report to OPA any of the three separate critical incidents that occurred in 2012 and 2013 involving a nonverbal group home resident with cerebral palsy and a history of self-injury. This resident suffered from repeated head injuries that required treatment at a local hospital's emergency room. These injuries included contusions with bruising and swelling of the head and face. This resident was evaluated with x-rays and computerized axial tomography.[17]

Because these injuries met the DDS definition of a "critical incident" and there was reasonable evidence to suspect abuse or neglect, DDS should have reported the incidents immediately to OPA. On the basis of the information we provided, OPA issued an immediate protective service order for this beneficiary.

Hospital-Based Mandated Reporters Did Not Report All Critical Incidents to the Office of Protection and Advocacy for Persons With Disabilities

This issue was outside the scope of our review; however, it is significant and worthy of further discussion. Accordingly, we plan to refer this issue to State officials for their future followup and action.

All mandated reporters—such as physicians, interns, registered or licensed practical nurses, police officers, or anyone paid for caring for persons in any facility who have reasonable cause to suspect that any person with an intellectual disability has been abused or neglected—must report the incident to an appropriate State agency (Connecticut General Statutes, Title 46a-11b, *Protection and Advocacy for Persons with Disabilities*).[18]

During the period of our audit, there were 310 emergency room visits involving 428 emergency services provided by 25 hospitals to 245 developmentally disabled Medicaid beneficiaries. Hospital-based mandated reporters reported only one of these incidents for potential abuse or neglect of a developmentally disabled Medicaid beneficiary.[19]

An Example of a Hospital's Unreported Critical Incident

A hospital did not report to OPA a critical incident involving a group home resident with developmental disabilities and behavioral issues that included aggressive outbursts. This resident suffered a lacerated scalp and fractured cervical spine. The hospital's emergency room treated his injuries, which group

[17] Appendix F contains a more detailed example of an unreported critical incident.

[18] Appendix E contains a complete list of mandated reporters.

[19] An additional 14 critical incidents and 4 noncritical incidents were reported to OPA by other mandated reporters.

home staff attributed to falling down a flight of stairs. The resident's medical history indicated that his clavicle appeared to have been fractured in a prior incident.

Because the hospital staff had reasonable cause to suspect abuse or neglect of this resident, the hospital physician and nursing staff, as well as group home staff, should have reported this incident to OPA or an appropriate State agency.[20] OPA officials said they would have investigated this incident if a report had been made.

The Department of Developmental Services Determined That Care Was Not Adequate for Some Beneficiaries Who Died

This issue was outside the scope of our review; however, it is significant and worthy of further discussion. Accordingly, we plan to refer this issue to State officials for their future followup and action.

Connecticut law requires DDS to review the death of anyone for whom it has direct or oversight responsibility for medical care. The review must cover the events, overall care, quality of life issues, and medical care preceding the death to ensure that "a vigorous and objective evaluation and review of the circumstances surrounding untimely deaths takes place" (Connecticut General Statutes, Title 17a, *Department of Developmental Services*, chapter 319b, section 17a-210).

As part of its quality assurance system, DDS has established a three-tiered mortality review process to trigger corrective action and reduce future risk for beneficiaries. The three-tiered system consists of (1) abridged reviews, (2) regional mortality review committees, and (3) the Independent Mortality Review Board (IMRB). The mortality review process includes a medical documentation review by trained nurse investigators and a final review of all IMRB cases by the Connecticut DDS Commissioner and Director of Health and Clinical Services.

DDS conducted 102 death reviews during our audit period, of which 85 involved beneficiaries residing in group homes and covered by the HCBS waiver. DDS conducted 27 IMRB-level death reviews of these 85 beneficiaries[21] and determined that 10 did not receive adequate medical or personal care before their deaths.

Furthermore, DDS seeks to identify systemic mortality issues as part of its death reviews and identified one during our audit period. DDS identified three fatalities over the course of 9 months that involved beneficiaries with food consistency restrictions who were inappropriately provided Jello, which directly led to their deaths. As a result, DDS issued a safety alert directive to highlight adherence to food consistency restrictions for individuals with modified diets.

[20] We did not make an independent assessment that reasonable cause existed. Instead, we asked DDS and OPA for their opinion, and both stated that they believed that reasonable cause existed in this case.

[21] DDS also conducted 46 abridged reviews and 12 regional-level reviews for the remaining 58 beneficiaries.

CAUSES OF NONCOMPLIANCE WITH FEDERAL WAIVER AND STATE REQUIREMENTS

On the basis of our discussions with State agency and DDS officials, we determined the State agency did not comply with Federal waiver and State requirements for critical incidents because:

- DDS and group home staff lacked the training to correctly identify and report critical incidents and reasonable suspicions of abuse or neglect,
- DDS staff did not always follow procedures,
- DDS did not have access to the Medicaid claims data to comply fully with the participant safeguard provisions of the HCBS waiver, and
- DDS policies and procedures did not establish clear definitions and examples of the potential abuse or neglect that must be reported.

The State agency did not adequately safeguard 137 of 245 developmentally disabled Medicaid beneficiaries because the DDS system of reporting and monitoring critical incidents did not work as expected.[22]

RECOMMENDATIONS

We recommend that the State agency:

- work with DDS to develop and provide training for staff of DDS and group homes on how to identify and report critical incidents and reasonable suspicions of abuse or neglect,
- work with DDS to develop a data-exchange agreement and related analytical procedures to ensure DDS access to the Medicaid claims data contained in Connecticut's MMIS to detect unreported and unrecorded critical incidents,
- work with DDS to update DDS policies and procedures to clearly define and provide examples of potential abuse or neglect that must be reported, and
- coordinate with DDS and OPA to ensure that any potential cases of abuse or neglect that are identified as a result of new analytical procedures are investigated as needed.

[22] There were 149 Medicaid beneficiaries involved with 176 critical incidents. Fifteen of these Medicaid beneficiaries had critical incidents reported to OPA. However, 3 of these 15 Medicaid beneficiaries were involved with multiple critical incidents of which at least 1 was not reported to OPA. Therefore 137 (149 – 15 + 3) developmentally disabled Medicaid beneficiaries were not adequately safeguarded.

DEPARTMENT OF DEVELOPMENTAL SERVICES COMMENTS

In written comments on our draft report, DDS stated that it "fully recognizes the need for improvement in the manner by which critical incidents are reported and reviewed." To that end "we fully agree that the DDS Incident Reporting system needs to be revised to ensure the health and safety of individuals who receive services from [DDS and DDS-qualified providers], and have initiated that process."

DDS stated that the report repeatedly finds that DDS did not report reasonable suspicions of abuse or neglect to OPA. DDS said the draft report cites 99 percent (151 of 152) of critical incidents were not reported to OPA as "potential incidents of abuse or neglect." DDS said it does not agree that all of these critical incidents "rise to the level of a suspicion of abuse or neglect as a contributory factor to the corresponding incident" based on its definition of a critical incident in effect during our audit.

In regard to group homes reporting incidents, DDS said that 110 of the incidents shown in Figure 2 were not reviewed as critical incidents. Specifically, 86 incidents reported at the incorrect severity level and the 24 unreported incidents (which make up the 110 incidents shown in Figure 2) were not reviewed by DDS as critical incidents at the time they occurred. Further, DDS stated that the data shown in the Table on page 10 regarding OPA action in response to critical incidents did not match DDS's data to date and further stated it could not interpret the meaning of "No further action"[23] and "Previously reported and reviewed" and therefore could not comment on those sections of the Table.

In addition, DDS disagreed with the following statement in the draft report: "DDS agreed that during our audit, critical incidents involving beneficiary visits to the emergency rooms in general should have created reasonable cause to suspect abuse or neglect." DDS said:

> We respectfully submit that DDS agreed that beneficiary visits to local emergency rooms, during which treatment was provided to the beneficiary (i.e., sutures, diagnostic testing such as MRI or CT scan, etc.) should have risen to the level of a critical incident. We do not agree that every beneficiary visit to an emergency room creates a reasonable cause to suspect abuse and neglect, as illustrated by beneficiary visits to an emergency room for a known chronic medical condition, such as a seizure disorder, the acute onset of symptoms resulting in a diagnosis of pneumonia, or for a precautionary evaluation following a fall or motor vehicle accident where there is no apparent injury to the beneficiary.

According to DDS, the director of OPA's Abuse Investigation Division endorsed DDS's position in a letter to DDS dated June 1, 2015, which said that a substantial portion of our audit had focused on DDS's and OPA's ability to respond to allegations of abuse and neglect "however they arise."

The June 1 letter from OPA went on to say that many of the incidents that our audit identified have since been identified as requiring further investigation, and both DDS and OPA were

[23] We changed this to "No further investigation conducted" in the Table on page 10.

following up. However, some of the incidents that required hospital treatment that our audit identified were not viewed by OPA as warranting further investigation. OPA said these incidents may show a need for "individualized programmatic responses" by DDS to ensure the ongoing safety of the people involved. DDS stated that beneficiary information contained in an attachment to the OPA letter and information received from OIG has been forwarded to DDS regional offices for appropriate followup.

DDS's comments are included in their entirety as Appendix H.

OFFICE OF INSPECTOR GENERAL RESPONSE

We appreciate DDS's agreement that its incident reporting system needs to be revised to ensure the health and safety of individuals who receive services from DDS and DDS-qualified providers, and we also appreciate DDS's commitment to work with the State agency expeditiously to accomplish this.

We reviewed DDS's comments on our draft report and additional information that DDS provided to us. On the basis of this review, we have modified our draft report. Specifically, we noted in footnote 9 that DDS, at our request, made the determination of which emergency room visits were critical incidents, and we clarified in footnote 10 the definition of a "severe injury." However, we maintain that DDS did not report 151 of 152 critical incidents to OPA as potential incidents of abuse or neglect involving developmentally disabled Medicaid beneficiaries. All 152 critical incidents in question met the DDS definition of a "severe injury," a determination that was made by DDS officials at our request. DDS officials agreed in May 2015 that such severe injuries in general should have created a reasonable suspicion of abuse or neglect.

We also agree with DDS that the 86 incidents reported at the incorrect severity level and the 24 unreported incidents (which make up the 110 incidents shown in Figure 2) were not reviewed by DDS as critical incidents at the time they occurred. Only if group homes report all incidents at the correct severity level can DDS determine whether these incidents are "critical" and whether to report potential abuse or neglect to OPA.

We further maintain that the information contained in the draft report's figures and Table is accurate, but we have clarified that the data are accurate as of the date we concluded our fieldwork. The data contained in the Table of our draft report do not reflect subsequent or ongoing actions by DDS, OPA, or the State agency. In addition, the Table's fields titled "No further action" and "Previously reported and reviewed" reflect OPA's actions regarding those critical incidents. Specifically, OPA took no further action on 81 critical incidents and had already reviewed 15 critical incidents that were previously reported.

With regard to DDS's statement that every beneficiary visit to an emergency room does not create a reasonable cause to suspect abuse or neglect, we agree, as evidenced by our acceptance of DDS's determination that only 176 of the 310 total emergency room visits we reviewed met DDS's definition of a critical incident. We then reported those 176 critical incidents to OPA, which determined that DDS should have reported all 176 as incidents with a reasonable suspicion of abuse or neglect.

The letter from OPA to DDS dated June 1, 2015, reinforces our position that critical incidents involving severe injuries should create a reasonable suspicion of abuse or neglect. As noted in that letter, OPA and DDS continue to follow up on many of the critical incidents that we referred to OPA for review. We agree with OPA that some of these critical incidents did not warrant further action once OPA determined whether they involved potential abuse or neglect. However, as OPA stated, these critical incidents may instead show the need for "individualized programmatic responses" by DDS to ensure the ongoing safety of the Medicaid beneficiaries involved. We acknowledge and appreciate DDS's followup on the beneficiaries listed in the attachment to OPA's letter and the information we provided to them during our review.

Although OPA has statutory jurisdiction over abuse and neglect systems for individuals with intellectual disability between the ages of 18 and 59, it cannot exercise that authority unless DDS refers critical incidents to OPA for review.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described actions it had taken or planned to take to address them. The State agency's comments are included in their entirety as Appendix I.

APPENDIX A: THE DEPARTMENT OF DEVELOPMENTAL SERVICES FORM 255, INCIDENT REPORT

State of Connecticut DDS – Incident Report - 255 ***Critical Incident?***: ☐Yes ☐No

1 - Client Name: _____ **DDS#**: _____ **Incident** Date: __/__/____

Responsible **Provider**: _____ Date of this **Report**: __/__/____ **DDS Case Mgr Name**: _____

Responsible **Program**: _____ ☐Res, ☐Day, ☐Other, **Rdid#**: _____

If **not** directly at responsible program: ☐**COM**munity, ☐Fam **H**ome Visit, ☐**REC**reation/leisure, ☐**VEH**icle, ☐**OTH**er: _____

2a – INJURY ☐Observed ☐Discovered at: __:__ ☐Am ☐Pm , Time of **treatment**: __:__ ☐Am ☐Pm
If different than incident date; **Treatment** date: __/__/____

Cause: ☐**AD**aptive Eq ☐**EA**ting Behavior ☐**FO**od Consistency ☐**M**otor Vehicle ☐**SeLF** caused
☐**ASsaUlt** ☐**ENV**ironment ☐**ING**estion of foreign material ☐**RES**traint ☐**SHA**ving
☐**BUM**ped Into ☐**EXP**osure ☐**I**n**S**ect Bite ☐**SCR**atching/picking ☐**UND**etermined
☐**CLO**thing ☐**FALL** ☐**ME**dical Procedure ☐**SEI**zure ☐**OTH**er: _____

Injured **by whom**: ☐**ACC**ident by client, ☐other **CLI**ent, ☐**FAM**ily member, ☐**SIB**, ☐**STA**ff, ☐**UNK**nown, ☐**OTH**er: _____

Type: ☐**ABR**asion/scrape ☐**BLE**eding ☐**CHO**king ☐**FRA**cture ☐**PUN**cture ☐**SPR**ain/strain
☐**AIR**way obstructed ☐**BRU**ise ☐**CUT** ☐indication of **PAI**n ☐**RAS**h/hives ☐swelling/ **EDE**ma
☐**BITe** ☐**BuRN** ☐**DIS**location ☐**POI**son ☐**OTH**er: _____

Severity of injury: ☐**MIN**or (first aid), ☐**MOD**erate (nurse/MD treatment), ☐**SEV**ere (hospital, ER/admission), ☐**DEA**th

Treatment provided, highest level: ☐**NON**e, ☐**SeLF**, ☐**FAM**ily, ☐**STA**ff/LPN, ☐RN **NUR**se, ☐**PHY**sician/other medical, ☐ER/**HOS**pital

Body part(s): ☐**ABD**omen ☐**BUT**tocks ☐**EYE** L☐R☐ ☐**GEN**itals ☐**INT**ernal ☐**MouTH** ☐**SHO**ulder L☐R☐ ☐**TON**gue
(up to 3) ☐**ANK**le L☐R☐ ☐**CHE**st ☐**FAC**e ☐**HAN**d L☐R☐ ☐**KNE**e L☐R☐ ☐**NEC**k ☐**TEE**th ☐ **WRI**st L☐ R☐
and check L or R ☐**ARM** L☐R☐ ☐**EAR** L☐R☐ ☐ **FIN**gers L☐R☐ ☐**HEaD** ☐**LEG** L☐R☐ ☐**NOS**e ☐**THR**oat
☐**BAC**k ☐ **ELB**owL☐R☐ ☐**FOoT** L☐R☐ ☐**HIP** L☐ R☐ ☐**LIP**s ☐**REC**tum ☐**TOE** L☐ R☐

2b – UNUSUAL - All dangerous / life threatening, illegal, police/fire, significant first/rare. Also 'significant behavior not covered by program/guideline'
Time: __:__ ☐ Am ☐ Pm

Type: ☐**ACC**ident no apparent injury ☐**F**ire **N**o Emg Response ☐**PS**ych ER **A**dmit ☐Victim **F**orcible **R**ape
☐accident **VEH**icle no apparent injury ☐medical **ER A**dmit ☐**PS**ych ER **N**o admit ☐Victim **PH**ysical other
☐**A**ggressor **PH**ysical alleged ☐medical **ER N**o admit ☐**R**e**F**used **M**edication ☐Victim **T**heft /**L**arceny
☐**A**ggressor **SeX**ual alleged ☐**PIC**a ☐**S**elf **EN**dangering/sib ☐Victim **SeX**ual other
☐**AWoL / M**issing Person ☐Police **AR**rest ☐Victim **A**ggravated **A**ssault ☐**W**rong **F**ood **C**onsistency
☐**FIR**e Emergency Response ☐**POL**ice no-arrest ☐**BEH**avior other:

2c – RESTRAINT Final **Date OUT**: __/__/____, Either: Time **IN** : __:__ ☐Am ☐Pm, Time **OUT**:__:__ ☐Am ☐Pm
Or, if approved multiple type (see approved list): Total **Hrs**: __**Min**: __ and Total **Occurrences**: ___

Restraint(s): ☐arm **SPL**int ☐**CHE**mical ☐**H**eld **B**y **A**rms ☐**S**afety **CuFf**s
(up to 4) ☐**B-S**afety **B**elt ☐**ESC**ort ☐**HEL**met ☐**SP**ecialized **C**lothing
☐**BeD R**ails ☐**FL**oor control-**P**rone (Face Down) ☐**L**ifted **A**nd **C**arried ☐**VEH**icle/transport
☐**B**ody boa**RD** ☐**FL**oor control-**S**upine (Face Up) ☐**MIT**ts ☐**W**aist **ReS**traint/chest/vest
☐**CH**air & **T**ray/waist ☐**F**our-**PoinT** ☐**PH**ysical **I**solation ☐**N**on-**S**tandard **C**ommissioner ok
☐**N**on-**S**tandard **N**ot-approved

Behavior(s): ☐**ADL** completion ☐**DIS**ruptive behavior ☐**PIC**a ☐**RUN**ning away
(up to 4) ☐**AG**gressor to **C**lient ☐**F**all **O**ut **B**ed prevent ☐**P**roperty **D**estruction ☐**SEL**f-endangering
☐**AG**gressor to **S**taff ☐**F**all **O**ut **C**hair/other prevent ☐**REM**ove sutures,tubes,etc ☐**SIB**

Status: ☐**E**mergency ☐**P**rc/hrc approved
Injury **caused** by restraint: ☐Yes ☐No
Monitoring, at least every 30 min: ☐Yes ☐No
Exercise, at least 10 min every hr: ☐Yes ☐No

Person(s) **Applying**: _____
In-Charge during: _____ **Authorizing** signature:_____
Person(s) **Removing**: _____
Emergency restraint **trauma check** within 24 hrs by: _____

3 – Summary / Comments include events surrounding / interventions:

☐also see attached

Reporter's **Name/title**: _____ ☐entered in log book/notes

Reporter's **Relationship** to client: ☐Family, ☐Self, ☐Staff, ☐Other:

Abuse / Neglect suspected?: ☐Yes ☐No, if "yes"; **Reported**:__/__/____to: _____
Person Completing form **Signature**: _____

4 - Supervisor review: on: __/__/____ Follow-Up:

☐team to review ☐guardian/PRRP notified ☐also see attached

Other review: on: __/__/____ Follow-Up:

Critical Incident?: ☐ Yes ☐ **No**, if "yes" immediate phone call to DDS Regional Administration required. Completed: __/__/____

☐ Client file, ☐ DDS data entry, ☐ DDS case manager CAMRIS entered on__/__/____by:__ (rev 7/24/09 tlh)

State of Connecticut DDS – Medication Error Report - 255m

1 - Client Name*: _____ DDS#: _____ **DDS Case Mgr Name:** _____

Med Error(s) **Initial incident** Date: __/__/____ Time: __:__ ☐Am ☐Pm

Med Error(s) **Corrected** Date: __/__/____ Time: __:__ ☐Am ☐Pm

Responsible **Provider**: _____ Date of this **Report:** __/__/____

Responsible **Program***: _____ ☐Res, ☐Day, ☐Other Rdid#: _____

If **not** directly at responsible program*: ☐**COM**munity, ☐**F**am **H**ome **V**isit, ☐**REC**reation/leisure, ☐**VEH**icle, ☐**OTH**er: _____

2 - Unusual: Medication Error Type* (check one only)

☐Med **C**harting **E**rror	☐Med **T**ranscription Wrong **D**ose	☐Med **T**ranscription Wrong **T**ime	☐Med **W**rong **M**edication
☐Med **OM**ission	☐Med **T**ranscription Wrong **M**ed	☐Med **W**rong **C**lient	☐Med **W**rong **R**oute
☐Med **O**rder **E**xpired	☐Med **T**ranscription **O**mission	☐Med **W**rong **D**ose	☐Med **W**rong **T**ime
☐Med **T**ranscription Wrong **C**lient	☐Med **T**ranscription Wrong **R**oute	☐Med **OT**her Error: _____	

3a – Errors Medication/Treatment*	Dose* Time*	Error Description*	Start Date* Last Date*	Total Errors
	: ☐Am ☐Pm		__/__/____ __/__/____	
	: ☐Am ☐Pm		__/__/____ __/__/____	
	: ☐Am ☐Pm		__/__/____ __/__/____	
	: ☐Am ☐Pm		__/__/____ __/__/____	

3b - Reason/Explanation for error:

Copies attached: ☐Medication Administration Record(s), ☐Physician Order(s), ☐Other: _____

	Original Date	Original Time	Rescheduled Date	Rescheduled Time
If Dose **Rescheduled** :	__/__/____	__:__ ☐Am ☐Pm	__/__/____	__:__ ☐Am ☐Pm

Medical **Treatment** Required (due to Med Error)?: ☐Yes ☐No (if yes, a client incident report #255 must also be completed)

Nurse/Medical **Notified**, Name: _____ Date: __/__/____ Time: __:__ ☐Am ☐Pm

☐Name of the **PERSON RESPONSIBLE** for the **ERROR** written on the bottom of the **SUPERVISING RN COPY ONLY**!!

Reporter's **Name/title**:_____

Reporter's **Relationship** to client: ☐Family, ☐Self, ☐Staff, ☐Other: _____

Abuse / Neglect suspected?: ☐Yes ☐No, if "yes"; **Reported**: __/__/____ to: ____

Person Completing form **Signature**: _____

4 - Administrative Review/Follow-Up

Prescriber **Notified**: Name: _____ Date: __/__/____ Time: __:__ ☐Am ☐Pm

Guardian/advocate **Notified** (as appropriate): _____ Date: __/__/____ Time: __:__ ☐Am ☐Pm

Review	Comment	Signature	Date
Primary Care Nurse			
Staff Supervisor			
RN Supervisor			
Other:			

☐Error due to **Staff** Action/Inaction, ☐Omission **Unavoidable** (late returning from family home, etc), ☐**Other**: ____

☐ Client file, ☐ DDS data entry, ☐ Supervising RN (*)=CAMRIS fields, CAMRIS entered on __/__/____by: ___ (rev 7/24/09 tth)

5 – Name(s)/Title(s) alleged to be **Responsible** for error(s), or write "UnKnown":

APPENDIX B: DIAGNOSIS CODES SELECTED FOR REVIEW

Number	Diagnosis Code	Description
1	486	pneumonia
2	79902	hypoxemia—lack of oxygen
3	80701	closed fractured rib
4	81000	closed fractured unspecified part of clavicle
5	81002	closed fractured clavicle (shaft)
6	81342	closed low end fracture to radius
7	81500	closed fracture to hand
8	81601	closed fracture to fingers
9	82525	fractured toes
10	8730	scalp, open wound
11	87342	open wound to forehead
12	87343	open wound to lip
13	87344	open wound to jaw
14	87349	open wound to face and other sites
15	920	contusion of face, scalp, neck (except eyes)
16	92320	contusion of hand
17	92401	contusion of hip
18	92411	contusion of knee
19	92420	contusion of foot
20	92820	crushing injury to foot
21	92821	crushing injury to ankle
22	9331	foreign body in larynx
23	9351	foreign body in esophagus
24	9392	foreign body in vagina
25	94106	burn to scalp
26	94222	2nd degree burns—blisters/epidermal loss to chest wall
27	94406	burn to back of hand
28	94526	2nd degree burns—blisters/epidermal loss to thigh
29	95901	head injury, unspecified
30	95909	injury of face and neck
31	95919	injury of the trunk
32	9592	injury to shoulder and upper arm
33	9597	injury to knee, leg, ankle, foot
34	9623	poisoning by insulin/anti-diabetic agents
35	9778	poisoning by other unspecified drugs and medicinal substances
36	9779	poisoning by other unspecified drug or medicinal substance
37	V714	observation following other accident (car)
38	V715	observation following alleged rape or seduction

Number	Diagnosis Code	Description
39	V716	exam following other inflicted injury
40	V7181	abuse or neglect

APPENDIX C: INJURY CATEGORY STATISTICS

Category	Diagnosis Code	Description	No. of ER Visits	No. of Beneficiaries
Head Injuries				
1	95901	head injury, unspecified	106	86
2	95909	injury of face and neck	40	35
3	87342	open wound to forehead	17	16
4	8730	scalp, open wound	12	12
5	920	contusion of face, scalp, neck (except eyes)	30	25
6	87349	open wound to face and other sites	2	2
7	87344	open wound to jaw	1	1
8	87343	open wound to lip	1	1
Subtotal			**209**	**178**
Bodily Injuries				
1	9597	injury to knee, leg, ankle, foot	18	18
2	9592	injury to shoulder and upper arm	8	8
3	95919	injury of the trunk	10	10
4	92420	contusion of foot	8	8
5	81601	closed fracture to fingers	7	6
6	92401	contusion of hip	5	5
7	81500	closed fracture to hand	3	3
8	82525	fractured toes	4	4
9	92320	contusion of hand	4	4
10	92411	contusion of knee	4	4
11	81002	closed fractured clavicle (shaft)	2	2
12	80701	closed fractured rib	1	1
Subtotal			**74**	**73**
Medical				
1	486	pneumonia	26	24
2	79902	hypoxemia—lack of oxygen	2	2
Subtotal			**28**	**26**
Accidents				
1	V714	observation following other accident (car)	38	38
Subtotal			**38**	**38**
Safety				
1	9331	foreign body in larynx	4	4
2	9392	foreign body in vagina	3	2
3	9779	poisoning by other unspecified drug or medicinal substance	2	2
4	9778	poisoning by other unspecified drugs and medicinal substances	2	2
5	9351	foreign body in esophagus	1	1
Subtotal			**12**	**11**

Category	Diagnosis Code	Description	No. of ER Visits	No. of Beneficiaries
		beneficiaries with more than one diagnosis code		**(81)**
		ER visits with more than one diagnosis code	**(51)**	
TOTAL			**310**	**245**

APPENDIX D: AUDIT SCOPE AND METHODOLOGY

SCOPE

DDS provided services to 2,555 developmentally disabled Medicaid beneficiaries residing in group homes from January 1, 2012, through June 30, 2014. Of the 2,555 beneficiaries, 1,019 had 2,963 claims representing 2,332 emergency room visits for all diagnosis codes. We limited our audit to 245 beneficiaries residing in group homes who had 347 emergency room claims consisting of 310 hospital emergency room visits that included 428 medical services and were diagnosed with at least 1 of 40 conditions that were similar to many of the causes of death identified in OPA's 2012 report.

In performing our audit, we established reasonable assurance that the claims data contained in the MMIS were accurate. We did not review the overall internal control structure of DDS. We limited our internal control review to obtaining an understanding of DDS's policies and procedures related to critical incidents.

We performed our fieldwork at OPA and DDS offices in Hartford, Connecticut, from August 2014 through June 2015.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal waiver and State requirements;
- held discussions with CMS officials to gain an understanding of the HCBS waiver for developmentally disabled beneficiaries residing in group homes;
- held discussions with officials from various State agencies to gain an understanding of State policies and controls as they relate to the mandatory reporting of potential abuse or neglect of developmentally disabled beneficiaries;
- reviewed many of the causes of death contained in OPA's 2012 report and determined the corresponding 40 diagnosis codes contained in the *International Classification of Diseases*, 9th revision;
- reviewed 100 judgmentally selected Medicaid claims that contained at least 1 of the 40 diagnosis codes for developmentally disabled Medicaid beneficiaries for the period January 2010 through December 2011 (Appendix G);
- obtained a computer-generated file from DDS of information on all 2,555 Medicaid developmentally disabled individuals residing in group homes from January 1, 2012, through June 30, 2014;

- extracted a computer-generated file from MMIS containing 2,963 claims for emergency room visits for the 2,555 Medicaid developmentally disabled beneficiaries for the period January 1, 2012, through June 30, 2014;

- reviewed and reconciled the MMIS claims data to the Connecticut Medicaid eligibility records;

- reviewed and analyzed the 347 Medicaid claims that contained at least 1 of the 40 diagnosis codes for the 245 developmentally disabled Medicaid beneficiaries between the ages of 18 and 59 residing in group homes in Connecticut who had 310 emergency room visits[24] during our audit period;

- requested and reviewed the medical records for the 310 emergency room visits;

- obtained from DDS and OPA officials lists of all reported potential abuse or neglect of all developmentally disabled Medicaid beneficiaries during our audit period;

- compared this list to the MMIS data and emergency room medical records to determine which of the 310 emergency room visits were not reported to Connecticut;

- provided a list of the unreported emergency room visits and related medical records to DDS and OPA officials to determine whether the visits should have been reported to Connecticut and what actions State officials planned for each unreported visit;

- contacted the hospitals that provided services to developmentally disabled Medicaid beneficiaries during 30 judgmentally selected emergency room visits to determine whether the hospitals reported these visits to the State and, if so, which State agency they contacted and, if not, why; and

- discussed the results of our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[24] Some emergency room visits had more than one Medicaid claim.

APPENDIX E: FEDERAL AND STATE REQUIREMENTS

States must provide certain assurances to CMS to receive approval for the HCBS waiver, including that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the service to receive CMS approval of the HCBS waiver (42 CFR § 441.302). The State agency must provide CMS with information regarding these participant safeguards in the HCBS waiver, Appendix G, *Participant Safeguards*. A State agency must provide assurances regarding three main categories of safeguards:

- response to critical events or incidents (including alleged abuse, neglect, and exploitation);
- safeguards concerning the restraints and restrictive interventions; and
- medication management and administration.

The HCBS waiver, Appendix G, *Participant Safeguards*, G-1(d), "Responsibility for Review of and Response to Critical Events or Incidents," states that all critical incidents must be reviewed for trends and discussed by DDS every 6 months. All medication errors must be reviewed quarterly.

The HCBS waiver, Appendix G, *Participant Safeguards, Quality Improvement: Health and Welfare*, subsection (a)(i), *"*Methods for Discovery: Health and Welfare," requires that DDS collect and review data quarterly regarding critical events and incidents to determine the number and percent of critical incidents (including incidents of abuse, neglect, and exploitation) that were reported and investigated within required timeframes.

DDS Procedure I.D. PR.009, *Incident Reporting*, (C) "Definitions," defines a critical incident as an incident that includes death; severe injury; vehicle accidents involving moderate or severe injury; a missing person; fire caused by the individual and requires emergency response, involves a severe injury, or both; police arrest; and aggravated assault or forcible rape. Critical incidents must be reported immediately to the DDS regional director, an assistant regional director, or a designee.

DDS Procedure I.D. PR.009, *Incident Reporting*, (C) "Definitions," defines a reportable minor injury as an injury in which no treatment or minimal (first aid) treatment is required. These injuries include bruises, falls, choking from obstructed airways, ingestion of foreign material, eating behavior, and food consistency. It defines a reportable moderate injury as an injury for which more than first aid is required, such as an assessment and/or treatment by a registered nurse or physician. These injuries include broken fingers and toes. And it defines a severe injury as the type of injury that would require treatment in an emergency room or a hospital admission. This includes all fractures (excluding fingers and toes) and other severe injuries, such as severe lacerations, head injury, and internal trauma. A severe injury should not be reported until a diagnosis is made to ensure the injury meets the correct level of severity.

DDS Procedure I.D. PR.009, *Incident Reporting*, *Attachment B, Instructions for Completing DDS Form 255*, requires that the "highest level of severity" for the injury reported be selected when completing DDS Form 255.

DDS Procedure I.F. PR.001, *Abuse and Neglect Allegations*, (D) "Implementation," states that all DDS employees are mandated reporters, and any employee who has witnessed or has reasonable cause to suspect that there has been abuse or neglect of a developmentally disabled person must make an oral report immediately to the appropriate State agency.

Connecticut General Statutes, Title 46a, Human Rights, chapter 813, section 46a-11b, states that mandated reporters include:

> …any physician or surgeon licensed under the provisions of chapter 370; any resident, physician, or intern in any hospital in this State, whether or not so licensed; any registered nurse; any person paid for caring for persons in any facility; and any licensed practical nurse, medical examiner, dental hygienist, dentist, occupational therapist, optometrist, chiropractor, psychologist, podiatrist, social worker, school teacher, school principal, school guidance counselor, school paraprofessional, mental health professional, physician assistant, licensed or certified substance abuse counselor, licensed marital and family therapist, speech and language pathologist, clergyman, police officer, pharmacist, physical therapist, licensed professional counselor, or sexual assault counselor or battered women's counselor.

Connecticut General Statutes, Title 46a, Human Rights, chapter 813, section 46a-11b, further states that any mandated reporter

> …who has reasonable cause to suspect or believe that any person with intellectual disability has been abused or neglected shall, as soon as practicable but not later than 72 hours after such person has reasonable cause to suspect or believe that a person with intellectual disability has been abused or neglected, report such information or cause a report to be made in any reasonable manner to the director or persons the director designates to receive such reports. Such initial report shall be followed up by a written report not later than 5 calendar days after the initial report was made. Any person required to report under this subsection who fails to make such report shall be fined not more than five hundred dollars.

APPENDIX F: CRITICAL INCIDENT DETAILED EXAMPLE

Jane Doe was a group home resident with developmental disabilities and a variety of psychiatric disorders, including self-injury and suicidal ideation. We reviewed Ms. Doe's medical records with OPA officials in January 2015. OPA officials said that they were aware of other incidents involving Ms. Doe. OPA officials said the DDS plan of care required the group home staff to keep Ms. Doe in sight at all times because of her condition and tendencies. Furthermore, Ms. Doe required arm's-length supervision in the community and group home common area when experiencing episodes of suicidal ideation. Furthermore, the group home staff was required to take extra precautions to ensure that Ms. Doe did not have access to any foreign objects.

Two hospital emergency rooms treated Ms. Doe on 19 separate occasions from May 2010 through August 2011, which was a period within our review's preliminary work (Appendix G). In addition, Ms. Doe was treated in a hospital emergency room on three other separate occasions (December 20, 2013; March 1, 2014; and April 14, 2014).

According to the medical records of the 19 emergency room visits from May 2010 through August 2011, Ms. Doe received treatment for violent outbursts, suicidal ideation, the removal of foreign objects from her vagina and rectum, monitoring for swallowing foreign objections, yeast infections, kidney stones, self-inflected burns, and abdominal pain. The records stated that Ms. Doe had inserted razor blades, eyeglasses, pens, push pins, nails, video game cartridges, buttons, zipper pulls, batteries, and a cigarette lighter into her vagina and rectum. On one occasion, Ms. Doe required surgery to remove the plastic eating utensils she had inserted into her vagina. She also swallowed pieces of razor blades, jewelry, and silica gel packets. Hospital staff physically restrained her during some of these emergency room visits. The group home that cared for Ms. Doe reported 6 of the 19 incidents to DDS. However, DDS did not report these incidents to OPA.

Ms. Doe's emergency room visits in December 2013 and April 2014 were for the removal of foreign objects from her vagina. Specifically, according to the medical records, Ms. Doe had inserted a metal can lid into her vagina on both occasions. The group home that cared for Ms. Doe reported these two emergency room visits to DDS as noncritical incidents. During her emergency room visit in March 2014, the hospital treated her for ingesting medication that belonged to another of the group home's residents that the group home's staff had given to her. The group home correctly reported the medication error to DDS. However, DDS did not report any of these three incidents to OPA.

After our meeting with OPA officials, they issued to DDS a request for an immediate protective service order for Ms. Doe on the basis of the information we provided. The group home's inability to properly protect Ms. Doe from further injury was the basis for this order. OPA also initiated an in-depth review of Ms. Doe's care at the group home.

APPENDIX G: RESULTS OF PRELIMINARY AUDIT WORK

We conducted preliminary audit work regarding developmentally disabled Medicaid beneficiaries who resided in group homes from January 2010 through December 2011. We conducted our preliminary audit work from December 2013 through August 2014 in Boston, Massachusetts, and at OPA and DDS offices in Hartford, Connecticut. Our objectives were (1) to determine whether potentially reportable conditions existed regarding DDS's compliance with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries residing in group homes and (2) to develop the appropriate audit steps to conduct a full audit, if warranted.

DDS provided services to 3,836 developmentally disabled Medicaid beneficiaries residing in group homes from January 2010 through December 2011. We limited our review to 100 judgmentally selected beneficiaries residing in group homes who received emergency room services and were diagnosed with at least 1 of 40 conditions that were similar to many of the causes of death identified in OPA's 2012 report. We reviewed the medical records supporting these services and determined that many represented critical incidents that were not reported to OPA.

A typical example of an unreported critical incident noted during our preliminary audit work includes the following:

> Jane Doe was a group home resident with developmental disabilities. She was brought to Hospital D's emergency room for nausea and vomiting over a 3-day period. The hospital determined Ms. Doe suffered from a small bowel obstruction and admitted her to the hospital for treatment and management of her condition. The group home did not report this critical incident to DDS.

We therefore determined that potential reportable conditions existed regarding DDS's compliance with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries residing in group homes.

APPENDIX H: DEPARTMENT OF DEVELOPMENTAL SERVICES COMMENTS

State of Connecticut
Department of Developmental Services

Dannel P. Malloy
Governor

Morna A. Murray, J.D.
Commissioner

Jordan A. Scheff
Deputy Commissioner

November 12, 2015

Mr. David M. Lamir
Office of the Inspector General
Regional Inspector General for Audit Services
Office of Audit Services, Region 1
JFK Federal Building,
15 New Sudbury Street, Room 2425
Boston, MA 02203

Report Number: A-01-14-00002

Dear Mr. Lamir:

I am in receipt of the draft report of the Office of the Inspector General (OIG) audit of services and supports afforded to CT citizens enrolled in the Home and Community Based Comprehensive Waiver, and in particular, a review of the CT Department of Developmental Services'(DDS) Incident Reporting system. I appreciate the opportunity to consider and comment upon the draft report.

The draft report makes repeated findings that the Department of Developmental Services did not report reasonable suspicions of abuse and neglect to the Office of Protection and Advocacy for Persons with Disabilities (OPA). OPA has statutory jurisdiction over abuse and neglect systems for individuals with intellectual disability between the ages of 18 and 60. The section of the draft report section titled "THE DEPARTMENT OF DEVELOPMENTAL SERVICES DID NOT ALWAYS REPORT REASONABLE SUSPICIONS OF ABUSE OR NEGLECT", and elsewhere in the draft report, cites 99 percent (151 of 152) critical incidents were not reported to the OPA as a 'potential incident of abuse and neglect'. The department does not agree that all critical incidents rise to the level of a suspicion of abuse or neglect as a contributory factor to the corresponding incident. The department bases this on DDS Procedure I.D.PR.009, Incident Reporting, and the definition of critical incident and review processes contained therein. This procedure was in effect from January 2012 through June 2014, the period of time of the audit review. On page 7 of the draft report, Figure 2, a pie chart reflects the following: Critical Incidents reported at the correct severity level, 66 incidents or 37%; Critical Incidents incorrectly reported at minor or moderate severity level, 86 incidents or 49% (equaling 152 incidents); Critical Incidents unreported, 24 incidents or 14%. Although the 86 incidents reported at the incorrect level were reviewed by DDS at the time the incident occurred, those incidents and the 24 beneficiary emergency room visits for which a Form 255 was not completed (110 incidents, or 63%) were not reviewed as Critical Incidents.

Phone: 860 418-6000 ◆ TDD 860 418-6079 ◆ Fax: 860 418-6001
460 Capitol Avenue ◆ Hartford, Connecticut 06106
www.ct.gov/dds ◆ e-mail: ddsct.co@ct.gov
An Affirmative Action/Equal Opportunity Employer

On page 9 of the draft report, there is a table titled 'Actions Taken for 176 Critical Incidents'. Respectfully, after our review of the data to date, the Department submits the following table showing both the draft OIG findings (in black), and DDS corrected findings (in blue). We would appreciate your consideration of these discrepancies in our findings.

Table: Actions Taken for 176 Critical Incidents

OPA Action	Number of Critical Incidents
Opened new investigation (DDS interprets this to mean a new allegation of abuse or neglect was generated by OPA based on their review of medical records)	24 (DDS: 28)
Updated ongoing investigation (DDS interprets this to mean a previous allegation/investigation existed and OPA requested additional investigation based on review of hospital records.)	9 (DDS:7)
Issued immediate protective service order	14 (DDS: 6)
Referred to DDS	33 (DDS:40)
No further action*	81*
Previously reported and reviewed*	15*

**DDS cannot interpret the meaning of "No Further action" and "Previously reported and reviewed". Therefore, we cannot comment. Additionally, DDS data reflects a total of 177 versus 176 Critical Incidents noted in the table in the draft report.*

On page 9, the following statement is made:

> "DDS agreed that during our audit, critical incidents involving beneficiary visits to the emergency rooms in general should have created reasonable cause to suspect abuse and neglect."

We respectfully submit that DDS agreed that beneficiary visits to local emergency rooms, during which treatment was provided to the beneficiary (i.e. sutures, diagnostic testing such as MRI and CT scan, etc.) should have risen to the level of a critical incident. We do not agree that every beneficiary visit to an emergency room creates a reasonable cause to suspect abuse and neglect, as illustrated by beneficiary visits to emergency rooms for a known chronic medical condition, such as a seizure disorder, the acute onset of symptoms resulting in a diagnosis of pneumonia, or for a precautionary evaluation following a fall or motor vehicle accident where there is no apparent injury to the beneficiary.

To endorse the above statement, I received a letter from Peter Hughes, Director of the OPA Abuse Investigation Division, dated June 1, 2015. In his letter, Mr. Hughes stated:

> "A substantial portion of this federal review has focused on the ability of the Department of Developmental Services (DDS) and the Office of Protection and Advocacy Abuse Investigation Division (AID) to receive and respond to allegations of abuse and neglect however they arise. OIG auditors also identified several incidents that occurred during the last three years where DDS clients received hospital treatment for various injuries but no follow-up report of suspected abuse or neglect related to these injuries were ever initiated. Many of those incidents have since been identified as requiring further investigation and both DDS and OPA are now in the process of following up in that regard.
>
> However, some of these hospital treatment incidents as identified by the OIG were not viewed by AID as warranting further investigation at this time. Nevertheless, these incidents may evidence a need for individualized programmatic responses by DDS to ensure the ongoing safety of the people involved."

Attached to Mr. Hughes' letter was a table containing the names of 40 individuals with an associated summary of each hospital record reviewed by OPA and the OIG auditors and represent cases, in OPA's determination, which did not rise to the level of a suspicion of abuse or neglect but which may require individualized programmatic review. Beneficiary information gleaned from the OPA and OIG review of hospital records has been forwarded to the DDS Health and Clinical Services Directors in each of our three regions for appropriate follow up.

The Department fully recognizes the need for improvement in the manner by which critical incidents are reported and reviewed. To that end, as I have stated to you, we fully agree that the DDS Incident Reporting system needs to be revised to ensure the health and safety of individuals who receive services from the department and DDS Qualified Providers, and have initiated that process. We look forward to working with the Department of Social Services, with expediency, to accomplish this very important and essential task.

Sincerely,

Morna A. Murray

Morna A. Murray, J.D.
Commissioner

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

RODERICK L. BREMBY
Commissioner

TELEPHONE
(860) 424-5053
TDD/TTY
1-855-470-3767
FAX
(860) 424-5057
EMAIL
commis.dss@ct.gov

March 30, 2016

David Lamir
Regional Inspector General for Audit Services
Office of Inspector General
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

Dear Mr. Lamir:

The Connecticut Department of Social Services (DSS), the dedicated state agency for the administration of the Medicaid program, has reviewed the report issued by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) Audit Number A-01-14-00002.

The audit's objective was to "determine whether the Connecticut Department of Social Services (State agency) complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries residing in group homes from January 2012 through June 2014." DSS appreciates the opportunity to provide comments concerning this serious matter.

We note that the report has the benefit of comments from the Connecticut Department of Developmental Services (DDS), which has group homes under its purview in service to individuals with developmental disabilities through a Medicaid waiver.

DSS is committed to ensuring that there are safeguards in place to protect the health and welfare of the beneficiaries of the Connecticut Medicaid program. We have discussed the OIG audit report and findings with DDS and other parties as needed. We are working collectively to solidify existing protocols and to incorporate new strategies to ensure that all cases of alleged abuse and neglect are reported and investigated, and that proper action is taken. The Memorandum of Agreement (MOA) between DSS and DDS, and relevant waivers are being revised, as necessary, to reflect this process.

As noted in the OIG report, §46a-11b of the Connecticut General Statutes, Annotated, identifies a broad range of professionals; including, but not limited to, physicians, nurses, nursing home administrators, police officers, caregivers affiliated with community-based organizations, and emergency medical technicians; as mandated reporters of incidents of suspected abuse or neglect.

55 FARMINGTON AVENUE • HARTFORD, CONNECTICUT 06105-3730
An Equal Opportunity / Affirmative Action Employer
Printed on Recycled or Recovered Paper
www.ct.gov/dss

That statute section requires mandated reporters to follow detailed procedural guidelines for investigations of such complaints, including timing. Reports of this nature require immediate investigation. Page ii of the Executive Summary of the OIG report notes, however, that, "hospital-based mandated reporters failed to report to OPA all critical incidents..." While DSS clearly acknowledges its ultimate responsibility as the Connecticut Medicaid agency for appropriate administration of Connecticut's Home and Community-Based Services Comprehensive Supports waiver, failure by hospital-based individuals to report as they are legally required to do is beyond the direct control of this department. Nonetheless, it is clear that this should and must be addressed. While DSS agrees with OIG that review of Medicaid claims data for emergency room visits represents an important tool in helping to identify potential cases of neglect or abuse that have not been reported by mandated reporters, there is no substitute for timely and proactive compliance with the mandatory reporter law. In addition to working with DDS to ensure that claims data is being appropriately reviewed for this purpose, DSS will address this significant finding with the Connecticut Hospital Association (CHA) so that CHA can take steps with its member hospitals to remedy failure to adhere to the requirements of the law. Further, DSS will discuss this finding with the Connecticut Department of Public Health (DPH), request that DPH engage with mandated reporters who did not timely report, and take needed action to ensure that this will not reoccur.

***

Provided below are the Department of Social Services' comments to each of the four recommendations that were included in the report.

- **DSS concurs with the recommendation for further training on identifying and reporting critical incidents, as well as reasonable suspicion of abuse and neglect.** DSS has discussed this aspect of DHHS OIG audit report with DDS and will be **revising our MOA with DDS to affirmatively require DDS to develop, provide and monitor the efficacy of training to all involved staff.**

- **DSS concurs with the recommendation to develop a data-exchange agreement and related analytical procedures to ensure that DDS has access to the Medicaid claims data contained in Connecticut's MMIS. Access to this data will enable DDS to detect critical incidents that may not have been reported and recorded by group homes.** We will enable DDS staff access, and will provide needed training on, DSS's data warehouse, which houses MMIS claims data. In particular, we will equip DDS to run reports of diagnosis codes that have been defined by the OIG as indicative of "high risk" conditions, permitting DDS to more affirmatively identify abuse or neglect.

- **DSS concurs with the recommendation that policies and procedures should clearly define and provide examples of the types of abuse or neglect that must be reported. We will work with DDS to review the same, and to make any needed revisions.**

- In its role as the Connecticut Medicaid agency, **DSS will review with DDS and the Connecticut Office of Protection and Advocacy (OPA) their responsibilities to investigate the cases of abuse and neglect, and will assess ongoing the efficacy of use of Medicaid claims data.**

***

Thank you for the opportunity to respond to these recommendations. The Connecticut Department of Social Services remains committed to maintaining the integrity of all aspects of the Medicaid program, from the health and well-being of our beneficiaries to the proper utilization of funds in support of this vital program. Further, we have confidence in the dedication and commitment of our sister agency, the Department of Developmental Services, in addressing and remediating the relevant findings of the DHHS OIG report. In partnership, we will ensure that individuals with developmental disabilities served by our Medicaid program are safeguarded by the most thorough and professional standards possible.

If you have any questions or comments or require any additional information from the Department, do not hesitate to contact my office. In my absence you should feel free to contact Deputy Commissioner Kathleen Brennan at kathleen.brennan@ct.gov; (860) 424-5693; John McCormick, Director, Office of Quality Assurance at john.mccormick@ct.gov; (860) 424-5920 or Frank LaRosa, Director, Office of Quality Assurance-Audit Division, at frank.larosa@ct.gov; (860) 424-5855.

Sincerely,

Roderick L. Bremby
Commissioner

cc: Morna A. Murray, J.D., Commissioner, CT Department of Developmental Services
Jordan A. Scheff, Deputy Commissioner, CT Department of Developmental Services
Kathleen Brennan, Deputy Commissioner, Programs & Administration, DSS
John McCormick, Director, Office of Quality Assurance, DSS
Kate McEvoy, Director, Division of Health Services, DSS
Brenda Parrella, Director, Office of Legal Counsel, DSS
Frank LaRosa, Director, Audit Division, Office of Quality Assurance, DSS