DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
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Disabled and Elderly Health Programs Group

January 16, 2020

Maureen Corcoran, Director
Ohio Department of Medicaid
50 West Town Street, 4th Floor
Columbus, OH 43215

Dear Ms. Corcoran,

The Centers for Medicare and Medicaid Services (CMS) is pleased to enclose the summary report of the Special Review Team's (SRT) visit to Ohio in June of 2019 to learn about your health and welfare systems. We appreciate the hard work of your team to pull together meetings with state staff, individuals served by the Home and Community-Based (HCBS) waivers, advocates, investigators and service providers, and to provide extensive documentation regarding incident management and other health and welfare documentation. As you know, Ohio was the first state to have an SRT visit, and your participation and feedback provided important information that CMS has incorporated into the process for subsequent visits to other states.

Please feel free to contact me at Ralph.Lollar@cms.hhs.gov or by telephone at 410-786-0777 if you have any questions or follow up on the enclosed report.

Sincerely,

[redacted]

Ralph F. Lollar, Director
Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services

Ohio Health & Welfare On-site Review

Summary Report for Ohio

I. Executive Summary

The Health and Welfare Special Reviews Team (SRT) conducted a 5-day intensive on-site review (OSR) of Ohio's home and community-based services (HCBS) Medicaid waiver programs from June 3 through June 7, 2019, in collaboration with the Centers for Medicare & Medicaid Services (CMS). Members of the OSR team included Ralph Lollar, Susie Cummins, and Jennifer Maslowski from CMS as well as Teja Stokes, Alissa Halperin, Alex Waddell, and Pat Rivard from IBM Watson Health.

The OSR included multiple meetings with state directors and staff responsible for the administration and operation of Ohio's seven 1915(c) waivers, including staff from the Department of Medicaid (ODM), the Department of Developmental Disabilities (DODD), and the Department of Aging (ODA). The OSR team also held a joint meeting with representatives from Ohio's licensing entity, protective services entities, protection and advocacy entity, HCBS ombudsman, Advocacy and Protective Services Incorporated (APSI) (a guardianship services provider), Ohio Provider Resource Association, the Arc of Ohio, the Ohio Attorney General's Office, ODM, ODA, and DODD. One or two family members of individuals receiving services also were present.

In addition, the OSR team met with case managers, service coordinators, investigators, providers, and participants. The focus of these meetings was to get a sense of how the process for reporting, investigating and resolving critical incidents operates in practice and how health and welfare is assured for HCBS participants in Ohio through the lens of these stakeholders. The OSR team split into two groups—one team focused on the Individual Options (IO) waiver program operated by DODD, and the second team focused on the Assisted Living (AL) waiver program operated by ODA. While State staff offered introductions for the SRT at these meetings they did not remain present for these meetings.

The ODM retains administrative authority in overseeing all the 1915(c) waiver programs. Additionally, ODM is the operating agency for two of the aged and disabled (A&D) waivers, one of which provides services via five managed care entities. The other two A&D waivers are operated by ODA, while DODD oversees operations for all three developmental disabilities (DD) waivers.

ODA utilizes 13 Passport Administration Agencies (PAAs) to provide case management. PAAs also conduct the critical incident investigations. They work with the ombudsmen for investigations in Assisted Living Facilities and Adult Protective Services for people who receive in-home care.

The DODD has Service and Support Administrators (SSAs) and investigators with county boards overseeing critical incidents.

During the OSR, the state identified some areas where technical assistance could assist its efforts. In addition, the OSR team identified challenges in a few areas including–

- Consistency in providers' procedures for reporting incidents, i.e. electronic vs. paper
- Consistency in critical incident investigations across the 12 regions and 88 counties
- Variability in participant knowledge of resources
- Confidentiality rules that constrain information sharing between investigative entities and prevention of further incidents

The team also identified a number of promising practices including—

- DODD's critical incident reporting and management system, mortality review process, and use of "alerts" to educate providers and support staff
- DODD's collaboration with law enforcement around training, prevention, and investigation of critical incidents
- ODA's movement toward a standardized cross-waiver critical incident reporting system
- ODA's collaboration with DODD to build from the successes and troubleshoot issues identified in the DODD critical incident reporting and management system
- ODA and DODD trauma-informed approach in collaboration with Ohio Mental Health and Addiction Services (MHAS)
- DODD's Major Unusual Incidents (MUI) state rule, with its required review and revision every 5 years

Some of these positive policies and practices in the state are not clearly documented in the state's waivers and/or reporting process, such as quality reports included as part of the 372 Report and evidentiary reports to CMS. Overall, Ohio demonstrated that it has a robust system for addressing, tracking, trending, and analyzing critical incidents and that stakeholders are well aware of how to respond to a critical incident.

All ODM, DODD, and ODA staff were extremely prepared and welcoming to the OSR team. The lead staff members for each agency were thorough in their selection of participants for meetings and preparation of meeting materials and presentations. They were flexible in responding to scheduling changes and additional requests from the OSR team. Ohio's hospitality and willingness to be the first state to receive an OSR was appreciated by CMS and the H&W SRT.

II. Background

Before the OSR, the H&W SRT reviewed waiver program documents and other material from the public domain related to the health and welfare assurances of individuals receiving HCBS in Ohio. The H&W SRT reviewed Ohio's seven waiver programs and a selection of CMS-372 Reports, evidence reports, and CMS findings reports for the following:

- Four waiver programs that serve individuals who are aging adults or have physical disabilities:
    - Passport (0198) operated by ODA expires June 2023
    - Home Care (0337) operated by ODM, expires July 2021
    - Assisted Living (0446) operated by ODA, expires July 2024
    - Integrated Care (1035) operated by ODM, expires December 2023
- Three waiver programs that serve individuals with intellectual or developmental disabilities operated by DODD:
    - Individual Options (IO) (0231), expires June 2024
    - Level 1 (0380), expires June 2021
    - Self-Empowered Life Funding (0877), expires June 2020

In preparation for the OSR, the H&W SRT focused on the AL and IO waiver programs, which were both due for renewal this calendar year.

Before the OSR, the H&W SRT reviewed publicly available information about the state's organizational structure and operations. In addition, the H&W SRT reviewed state Office of Inspector General, ombudsman, protection and advocacy, protective services, and advocacy organization websites for information about the health and welfare of participants receiving HCBS. Finally, the H&W SRT reviewed other information in the public domain about HCBS programs and the health and welfare of participants.

In May, Ohio sent the H&W SRT an array of documents that further elaborated on specific elements of the Ohio delivery systems and critical incident processes. Included in the documents were details about the mortality review processes as well as data on critical incidents across all waivers and data specific to each managed care organization. Information about training, use of social media, and alerts also was shared. In addition, the H&W SRT reviewed documents from Ohio that outlined specifics about the ODA/ODM Waiver Alignment Initiative.

CMS and the H&W SRT held a kickoff conference call with Ohio on May 8. The kickoff call consisted of an overview of the H&W SRT, discussion of the OSR schedule, and logistical planning for the OSR. The Ohio OSR Introduction Meeting Summary is attached to this report.

III. Ohio On-site Review

The following is an overview of OSR activities.

Day 1: The OSR team held an entrance conference with Ohio to explain the reason for the H&W SRT and to review the focus of the OSR. The members of the OSR team then split off to meet separately with Medicaid and operating agency program staff from DODD and ODA. Both teams reconvened with state staff to discuss the state's critical incident reporting and management process and the mortality review process for the IO and AL waiver programs.

Day 2: A joint meeting was held with the licensing entity, protective services entities, protection and advocacy entity, HCBS ombudsman, ODM, DODD, and ODA to discuss Ohio's process for addressing critical incidents and to get a sense of how the entities work together to assure the health and welfare of participants. The OSR team split into separate groups to review a sample of critical incident reports along with person-centered service plans.

Day 3: Four focus group meetings were held with case managers/service coordinators from both waiver programs to discuss the critical incident reporting process. The OSR team that focused on the IO waiver program met with one adult day program provider and spoke to eight participants in the adult day program. Additionally, the IO team met with two participants in supported living along with their direct service providers. The OSR team that focused on the AL waiver program met with two providers and four participants. These provider and participant meetings allowed the OSR team to better understand how the critical incident process works and to ensure that participants know whom to contact if there is an incident affecting their health and welfare.

Day 4: Both teams continued to meet with providers and participants. The OSR team that focused on the IO waiver program met with one provider of day support services and three residential providers. These provider visits included discussions with 12 participants at the day support program and four participants in their apartment or homes. The OSR team that focused on the AL waiver program met with four providers and eight participants. Again, the intent of these visits was to learn how the critical incident process works at the direct service level and to ensure that providers and participants know whom to contact if there is an incident affecting the individual's health and welfare.

Day 5: The OSR team met with case managers from the IO waiver program to understand their role in preventing and responding to critical incidents. The OSR team also met with staff from ODM to learn how the Medicaid agency oversees the management of waivers run by operating agencies in Ohio. Finally, an exit conference was held with staff from ODM, ODA, and DODD to share some initial impressions from the OSR and to discuss next steps.

During the on-site visit, the state also provided the OSR team with multiple documents such as—

- Slide decks/presentations related to the state's critical incident management process and mortality review process
- Flow charts of processes
- Excerpts from regulations
- Information about sites to be visited
- Incident reports
- Copies of handouts and brochures provided to individuals and providers

Additionally, providers shared training materials and reporting forms, among other items.

During the OSR, the team met with the staff identified below as well as others not listed:

- ODM: Kim DeDino, Adrianna Post, Laura Leach, Jackie Rigotto, Hope Roberts, Sue Fredman, Roxanne Richardson, and Patrick Beatty
- DODD: Director Jeff Davis, Scott Phillips, Connie McLaughlin, and Debbie Hoffine
- ODA: Director Ursel McElroy, Matt Hobbs, Christina Miller, and Karen Baker
- DODD investigators: Tanya Hitchens and Matt Costello, Guernsey County; Chuck Davis, Franklin County; Craig Hill, Delaware County; Ruth Watson, Sandusky County; Rob Elston, Northwest Ohio Council of Government; Sam Grisham, Marion County; Jen Walling, Fairfield County; Sarah Diesch, Lucas County; Bambi Zinkon, Coshocton County; Abby Spear, Licking County; and Christine Angora, Mideast Ohio Regional Council
- DODD providers:
    - Goodwill Columbus: Cathy Ramey, Amy Ogden, Jody Dunaway
    - Ali Rahimi Assistive Technology Provider)
    - Open Door Studio/Columbus Center for Human Service (CCHS) : Sean Moore (Gallery Director); Tobi Eitel (CCHS Associate Director); Rebecca Sharp (CCHS Executive Director); Whitney Clark (CCHS Risk Management and Support Living Director); Claire Smith, Haleigh Richards, Gabe George (staff artists); Paige Wooten, Nichole Childs, Britney Trogdon, Lynette Pierce (Community Experience Coordinators)
    - Champaign Residential Services: Michael Smith; Sarah (last name unknown)
    - I Am Boundless: Margaret, Stacy, Carmen, Pam, Zeena; Susie Burke (Director of Quality Assurance)
- DODD participants: Members of the OSR team met with about 24 participants and a few of their direct support staff in their homes or at day programs.
- DODD service and support administrators (SSA) (case managers): Jason Moyer, Logan County; Mary Howell, Athens County; Kelly Meyers, Ross County; Tekissa Graham, Tuscarawas County; Gretchen Ryan, Wayne County; Bessie Cline, Knox County
- ODA service coordinators/case managers from Passport Area Agencies on Aging (PAAs):
    - PAA 6: Jeanette Hamilton, Sue Howson, and Dana Roby
    - PAA 3: Ashley Lehmkuhle and Lisa Hayes
    - PAA 7: Deborah Danner-Gulley and Rebecca Simon
- ODA assisted living providers:
    - National Church Residences Mill Run: Linda Roehrenbeck (Admin), Stephanie Creamer (Director of Nursing (DON), Sally Johnston Kolcun (Life Enrichment Chair), Sue Scheiderer (Memory Care Coordinator), and Sara Saum (Memory Care Director)
    - National Church Residences First Community Village: Judy Wright
    - Ontario Point: Melissa Aherns
    - Country Club Retirement Campus: Tracy Head, Sarah Landis (DON), Whitney Kandel (DON)

- The Villas at Bennington Glen: Renee Forester, Jodie (missing last name; Assisted Living Coordinator)
- The Suites at Sarah Moore: Aric Arnett and Tish Hays (DON)

- ODA AL participants: A member of the OSR team met with 12 participants residing in the assisted living facilities noted above.
- Stakeholders (from advocates/agencies/licensing entities meeting): Sylvia Pla-Raith, Attorney General's Office; Beverly Lambert, State Long-Term Care Ombudsman; Robin Miller, Protective Services; Pete Van Runkle, OCHA; Jerilyn George, Beckie Dean and Kristen Henry, APSI; Gary Tonks, the Arc of Ohio; Carolyn Knight, Developmental Disabilities Council; Kerstin Sjoberg and Lauren Kraft, Disability Rights Ohio; Willie Jones, Ohio Association of County Boards; Kim Kehl, MHAS Trauma Informed Care Coordinator; Anita Allen, OPRA; Tim Neville, Echoing Hills Village (provider); Kathy Rader, Champaign Residential Services (provider); Katherine Yoder, Adult Advocacy Centers; Detective Joe Storad, Summit County Sheriff's Office; Dave Donnal, family member; Steve Beha, DODD Licensing; and Jill Shonk , DOH Licensing

IV. State Strengths and Promising Practices

The following is an overview of the state's strengths and promising practices identified by the OSR team regarding the design or practice of assuring the health and welfare of HCBS participants in Ohio.

A. DODD Critical Incident Management Process

The DODD critical incident management process has several promising practices: (1) the level of specificity of the Major Unusual Incidents (MUI) rule, (2) the level of fidelity to which everyone affected by the MUI rule honors its requirements, (3) the electronic Incident Tracking System, and (4) the support that DODD provides to investigators, SSAs, providers, and participants. DODD has been using an electronic incident management system for more than 20 years. CMS found the system to be a promising practice in 2003. Although, the database is dated and due to be updated in the coming years, one particularly useful feature (and piece of the DODD required process) is the system's valuable and easily accessible historical data that investigators use to complete a full evaluation of the history of incidents related to the alleged perpetrator and the victim of a current incident under investigation.

B. DODD Mortality Review Process

For nearly 12 years, DODD has designed and operated a comprehensive mortality review process that includes standardized forms and procedures. Medical professionals are required participants in mortality reviews, and state law supports the process by requiring any death of an individual with an intellectual disability/developmental disability to be referred to the county's coroner for review. The Mortality Review Committee meets quarterly to reviews cases, patterns, and trends and make recommendations for systemic improvement.

C. Collaboration with Law Enforcement Around Training, Prevention, and Investigation of Incidents

DODD is involved in multiple initiatives with law enforcement that cover the spectrum from joint trainings through prevention efforts to investigation processes. Examples include quarterly workgroups with crisis intervention trainings and other periodic cross-training of both law enforcement and those involved in the DODD delivery system/network for preventing escalation of incidents as well as appropriately investigating in a person-centered, trauma-informed, and disability-competent manner. In addition, select counties have a dedicated detective who is solely responsible for working with the county board investigators on investigating allegations of abuse, neglect, and exploitation.

D. Memorandum of Agreement (MOA) between PAAs and Paramedics

One of the PAAs has a MOA with two paramedics for responding to critical incidents. This is beneficial to the health and safety of individuals when there has been a critical incident requiring medical help due to both the paramedics medical experience and the peoples' trust in them.

E. DODD Use of Trending Data and Information to Educate the Field Through Alerts

DODD's process for trending critical incident data at the provider, county, and state levels has led to the use of contemporary social media resources to educate the field on better health and welfare practices. DODD issues "alerts" through newsletters, white papers, and video clips to proactively address the health and welfare of program participants. For example, the state released a video clip regarding mismanagement of medication resulting in a participant's death and a video clip on how firm knowledge of first-aid practices enabled a direct support professional to save a life. This style of provider education is very effective, relevant, and current and is incorporated into annual training requirements statewide.

F. ODA's New Critical Incident Management System

ODA is planning to launch a new cross-waiver critical incident reporting and management system built in part on the successes of the DODD system and lessons learned from that system. Managed care organizations and all waiver program providers will use the same system to report critical incidents. To accomplish this ODA to the action necessary to align incident types across the A&D waivers. These efforts toward consistency in practices and policies programs will help Ohio track and trend critical incidents across all waiver programs that serve individuals who are aging adults and individuals who have physical disabilities.

G. Quality Briefings and Update of Quality Committee

ODM, ODA and DODD conduct internal quality briefing meetings twice a year to review performance and to inform ODM about the operating agencies' quality oversight process. The process includes evaluating performance measures for the waivers on a quarterly basis. In the past, ODM has required the operating agency to submit a quality

improvement plan along with evidence of implementation of the quality plan at subsequent quality briefing meetings. Ohio is also in the process of revamping its cross-waiver quality committee, which will focus on quality improvement for all Ohio waiver programs. The committee will ensure common goals and objectives and serve as a source of best practice sharing.

H. High Level of Specificity of the MUI Rule and 5-Year Revision Process

The DODD MUI rule incorporates all the required steps and time frames of the incident reporting and investigating process into a regulation that is highly specific and that is reviewed and revised every 5 years. Ohio completes this review and revision process every 5 years because of a statutory mandate. The process is regarded as highly, transparent, collaborative, and thorough. It allows the state to be responsive to addressing evidence-based problems or successes and to be sure that its procedures and processes are current and efficacious. A 5-year refresh appears to be invaluable to the state's continued positive relationship with stakeholders.

I. Ohio MHAS Trauma-Informed Trainings and Collaboration with Incident Investigators

Ohio MHAS has a program designed for intra-agency collaboration to ensure that the work of other state offices is trauma informed. By targeting investigators and case managers in helping individuals who have experienced MUIs, the MHAS trauma-informed approach facilitates a person-centered focus that supports the individual while removing harm, investigating the incident(s), and preventing recurrences.

J. Ohio Abuse Registry

Ohio has an abuse registry where a criminal conviction is not required to add a person to it. The registry is a public domain and can be used by anyone. All Medicaid programs use it. See https://dodd.ohio.gov/wps/portal/gov/dodd/health-and-welfare/all-health-and-welfare-resources/abuser_registry/.

V. Challenges

The following is an overview of the challenges identified by the OSR team regarding the design or practice related to assuring the health and welfare of HCBS participants in Ohio.

A. Serving Older Adults with Complex Needs

ODA raised an issue related to serving older adults who are located in settings which are considered to be dangerous both to the individual and the provider delivering services. The state will conduct research to determine the extent of the issue and what strategies have been used to date to address this issue. The OSR team will follow up with the state to provide technical assistance to support its efforts to develop a plan to address this complex issue. The OSR team also informed Ohio about the upcoming H&W SRT training session entitled Balancing Risk and Choice, which may assist the state in its efforts to serve these individuals.

B. Ombudsman Presence in Assisted Living Facilities

During the meetings with participants residing in assisted living facilities, none mentioned contacting the ombudsman if they had any concerns about how they were being treated. Instead, the main response from participants was that they would contact a family member or a staff director. However, when prompted, most responded that they knew that they could contact their case manager or that there was a number that they could call to talk to an ombudsman. It was not clear whether ombudsmen have a regular presence in assisted living facilities, which may depend on staffing capacity.

C. Serving Individuals with Traumatic Brain Injury in Assisted Living Facilities

Multiple providers referenced traumatic brain injury in young people being an issue for the future. They are technically qualified for the AL waiver program, but these facilities do not feel prepared to serve them.

D. Adult Protective Services

Ohio's Adult Protective Services staff members do not investigate reports of abuse, neglect, or exploitation for individuals with disabilities aged 18–59 years and older adults residing in assisted living facilities.

E. H&W Practices Across Programs

Despite strong oversight by ODM of each of the programs operated by ODA and DODD and similar management of quality structures, there are significant differences between some of the health and welfare practices of ODA and DODD. DODD's use of alerts for immediate education to the field and subsequent measure of the success of the alert on reducing the number of such incidents is a successful and effective practice that could be adopted by ODA. ODA has been developing a new critical incident management report system. ODA is encouraged to continue collaborating with DODD on the data elements for this new system and processes for trend analysis to inform a proactive response to provider education. ODM is encouraged to continue to work together to harmonize practices across ODA and DODD programs to continue to improve overall operations.

F. Nonuniformity in Application of MUI Rule Across County Boards

There was some inconsistency reported to the OSR team in the operation of the county boards as it relates to MUI processing. The OSR team heard about or observed inconsistent processes, time frames, policies, and more—from the boards' role in determining whether an incident is an MUI or a UI to the scope of MUI investigations (and the level of detail included in MUI reports). In one case, a county board rejected an MUI report and refused to accept a reported staff no-show as an alleged neglect MUI because the individual periodically was permitted to have alone time. Instead of investigating the alleged neglect and potentially concluding that the alone time justification mitigated the potential harm caused by the neglect, the county refused to even accept the report from the provider who felt strongly that it should have been investigated as an MUI.

G. Inconsistency in Application and Process Across DODD Providers

The team identified inconsistencies in the level of sophistication of the providers and their reporting procedures (electronic vs. paper). There were also inconsistencies in the provider processes for determining whether an incident is an MUI or a UI. In some cases, the provider office staff were significantly more knowledgeable about abuse, neglect and exploitation, including the reporting process and follow up than the direct care staff who are the first level of reporting and intervention.

H. Rigidity of Scoring of Violations

Some stakeholders noted the failure of the MUI rule to aggregate lower level violations and considered it to be a significant weakness in the DODD system. Concern was expressed that a provider could deliver substandard services based on unusual incidents that don't reach the level of a MUI throughout the entire course of their career. They would like to see a more holistic approach in which multiple MUIs that individually do not meet the criteria for a perpetrator to be added to the abuser registry are aggregated and result in entry in the registry. The same suggestion was made to aggregate multiple UIs to equate to MUI-level sanctions.

I. Variability in Participant Knowledge of DODD Resources

Participants reported critical incidents to a variety of individuals, including direct support staff, SSAs, or family members. They all clearly would tell a trusted person and knew what MUIs and UIs are. Of interest is the fact that while a number of individuals where confused regarding critical incidents, when the SRT member mentioned UI or MUI all individuals were able to share knowledge regarding the process. That said, more information could be provided to inform participants of exactly whom to call and what to do if a MUI or a UI occurs. Additionally, one blind participant who reads braille was not provided MUI handbook information in her preferred form of written communication.

J. Absence of Licensure/Certification to Impose Any Intermediate Sanctioning

It did not appear that county boards have imposed (and/or have the authority to impose) any penalties or adverse licensure/certification actions such as a provisional licensure on providers performing poorly in the area of participant health and welfare. The OSR team heard several times about ways in which county boards responded to problems only by providing technical assistance, but never by imposing any penalty or consequence.

K. Confidentiality Rules That Create Conflict in the Resolution of Investigation and Prevention

Confidentiality rule exceptions do not exist for sharing of information in instances where the alleged perpetrator is funded by the waiver provider—either to ensure thorough investigation (e.g., adult/child protective services investigation dispositions) or to prevent additional risk of harm to others (e.g., county board cannot contact new employer of substantiated perpetrator).

VI. OSR Team Outstanding Questions

The OSR with Ohio was very thorough. The state's policies and practices are evident. No additional information is needed from the state at this time.

VII. OSR Team Recommendations and Next Steps for Follow-up Technical Assistance

The following is an overview of the OSR team's recommendations:

A. As described in one of the challenges above, the H&W SRT may, at the state's request, follow up with the state to provide technical assistance to support its efforts to develop a plan to address issues related to addressing the needs of individuals when providers are at risk providing in-home services.

B. The OSR team recommends that Ohio continue its efforts to align DODD's and ODA's approaches to assuring the health and welfare of waiver program participants. This includes the process for addressing critical incidents and conducting mortality reviews.

VIII. Areas for Further Inquiry or CMS Follow-up

The OSR team did not identify any areas for further inquiry related to HCBS participant health and welfare.