Joint Report

Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight

Group Home Beneficiaries Are at Risk of Serious Harm

- OIG found that health and safety policies and procedures were not being followed. Failure to comply with these policies and procedures left group home beneficiaries at risk of serious harm.
- These are not isolated incidents but a systemic problem – 49 States had media reports of health and safety problems in group homes.

A Roadmap for States – Compliance Oversight Model Practices

A toolbox for better health and safety outcomes in group homes

Model Practices for State Incident Management and Investigation

- Reporting and notification
- Incident review
- Investigation
- Corrective action and implementation
- Trend analysis

Model Practices for State Incident Management Audits

- Assess incident reporting
- Assess response and review of incidents
- Assess investigations
- Assess corrective actions
- Assess identification and response to incident trends

Model Practices for State Mortality Reviews

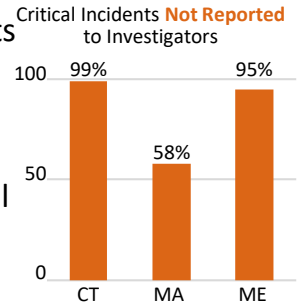
- Identify cause and circumstances of beneficiary death
- Where warranted, take corrective action
- Identify mortality trends
- Systemic responses and evaluation of their efficacy
- Reporting

Model Practices for State Quality Assurance

- Oversight of service planning and delivery
- Periodic assessment of performance
- Review network capacity and accessibility
- Compliance monitoring of requirements and outcomes

OIG Group Home Health and Safety Work

- **Objective:** To determine if group homes complied with Federal and State requirements for reporting, recording, and detecting critical incidents in group homes
- **Where we did the work:** Connecticut, Massachusetts, and Maine
- **Finding:** OIG found serious lapses in basic health and safety practices in group homes.
- **Recommendations:** Connecticut, Massachusetts, and Maine should provide additional training, update policies and procedures, and provide access to Medicaid claims data.
- **Referrals**: OIG made multiple referrals to local law enforcement to address specific incidents of harm.



Examples

Connecticut did not report to investigators three separate critical incidents. A resident suffered from repeated head injuries that required treatment at a local hospital's emergency room. An immediate protective service order was issued for the beneficiary based on information OIG provided.

Massachusetts did not report to investigators two separate critical incidents. A resident suffered head lacerations while being restrained by the group home's aides. The resident required treatment at a local hospital's emergency room. Investigations were opened for both incidents based on information OIG provided.

OIG Reports on Group Home Health and Safety

- *Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries (May 2016 – A-01-14-00002)*
- *Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries (July 2016 – A-01-14-00008)*
- *Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities (August 2017 – A-01-16-00001)*

Government Partnership – OIG, ACL, and OCR

- **Depth of expertise** and **multiple perspectives**
- Developing a set of **Model Practices that provide States with a roadmap** for how to implement better health and safety practices, many of which are already required
- **Coordination with: DOJ, CMS, State stakeholders**

Joint Report Suggestions to CMS:

CMS Guidance

Encourage States to implement compliance oversight programs for group homes, such as the Model Practices, and regularly report to CMS

CMS "SWAT" Team

Form a "SWAT" team to address systemic problems in State implementation and compliance with health and safety oversight

CMS Take Action

Take immediate action in response to serious health and safety findings in group homes, using authorities under 42 CFR § 441.304(g)