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
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)