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MEMORANDUM

To: DBHDS Licensed Providers

From: Taneika Goldman, State Human Rights Director

Date: November 28, 2023

RE: Provider Investigations

The following information is intended to provide an overview of the Community Look-Behind process, a summary of data from recent reviews, and **important reminders for providers to ensure 1) trained investigators conducts investigations 2) investigators interview or collect statements from all involved staff *and* individuals, and 3) investigations are completed within timeframes.** The impetus for this memorandum is based on information collected from the most recent Community Look-Behind reviews and the detailed requirements for providers regarding complaints alleging abuse, neglect, and exploitation outlined in the Human Rights Regulations (see 12VAC35-115-175).

Key Findings Related to Investigations:

- 82% were completed within 10 days,
- 63% were conducted by a trained investigator,
- 77% had evidence that involved staff were interviewed or provided statements,
- 45% had evidence that involved individuals were interviewed or provided statements

Key Reminders for Providers:

- A detailed and systematic investigation must be completed within 10 working days from the date the abuse/neglect complaint is made known to the provider, or the date the potential abuse, neglect or exploitation is discovered by the provider themselves.
- Investigations must be done by a person trained to conduct abuse/neglect investigations.
- OHR Abuse/Neglect Investigation training as well as industry best-practice guidelines indicate all parties including provider staff and individuals receiving services involved or implicated in a complaint should be interviewed and/or asked to provide a written account of what occurred. These perspectives provide important facts and context to be considered when deciding whether the complaint is substantiated.

- Providers must maintain accurate and complete documentation related to the services they provide. This extends to include accurate and complete investigation summaries, witness statements (or notes indicating why a statement was not obtained), copies of notifications to individuals and guardians about the outcome and any other evidence collected or documents produced during the abuse/neglect complaint investigation.

Background:

In 2016, the Office of Human Rights (OHR) established the Community Look-Behind (CLB) to identify areas where training or follow-up technical assistance are needed in order to improve the investigative methods used and outcomes reported by providers to OHR. The CLB is a retrospective review of closed abuse, neglect, and exploitation (ANE) investigations among individuals receiving services for developmental and intellectual disabilities in licensed community provider settings. Due to data quality issues preventing sampling, the CLB was put on hold in September 2021. By January 2023 these issues had been corrected and OHR resumed the CLB review process in June 2023.

CLB Review Process:

The following criteria was utilized to identify a randomized sample of Abuse Reports (or "cases") for review in this recent round of study:

- Incident date in Q3 and Q4 of FY23, and Q1 of FY24, (1/1/23 – 9/30/23)
- Service Type of DD, as listed on the CHRIS Abuse Report (DD refers to "developmental disability" and is inclusive of intellectual disability),
- Abuse Report submitted by a Community Services Board (CSB) or licensed private provider, and
- Abuse Report deemed "closed" by the assigned OHR Advocate.

All CLB reviews are conducted remotely by the five OHR Regional Managers. Reviews include a desk audit of the associated CHRIS Abuse Report, a comparison review of information submitted by the provider and a follow-up virtual meeting or telephone call with the provider to debrief on the outcome of the review. Discrepancies identified during the review are discussed during the debrief session with the provider. For example, when documentation of specific corrective actions that were indicated by the provider in CHRIS as having been completed are not observed in the documents submitted for the desk audit. Reviews are focused on identifying opportunities for systems-improvement, and deficiencies identified during the review of closed cases will not result in a licensing citation.

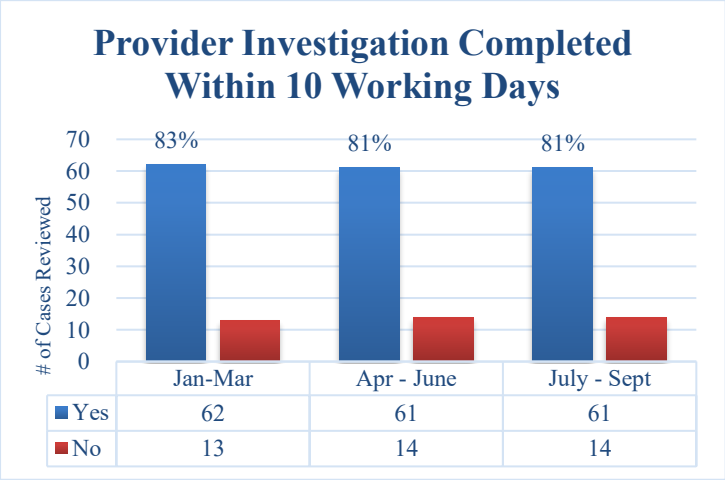
As part of the review, providers are notified and asked to submit via email the following investigation documentation relating to the identified case(s) within 5 working days of the request:

- Full investigative report,
- Corresponding internal incident report,
- Witness statements,
- Accused staff statements,
- Evidence of notification of incident made to AR/guardian (if applicable),
- Written notice of findings,
- Evidence of the investigator's investigation training (ex. Copy of training certificate),
- Evidence of corrective action(s) taken (for substantiated cases).

OHR Regional Managers complete a CLB Review Form for each review. The Form contains Yes/No questions to assess different elements of the ANE investigation process as contained in the Abuse Report and provider documentation. Some of these elements evaluated assess provider requirements such as timeliness of the initial Abuse Report in CHRIS, completion of required notifications, and evidence of identified corrective actions etc. While other elements evaluated assess OHR processes such as whether the assigned OHR Advocate agreed with the provider findings, issued a licensing citation, and verified corrective actions for substantiated cases, and closed the case according to OHR Protocols etc. Reviews are conducted monthly (5 cases per region totaling 25 cases reviewed each month). The goal is to review a sample of 300 cases per year, with the time between case closure and case review structured to average less than 30 days. A copy of the CLB Timeline for 2023 and 2024 is available for review here.

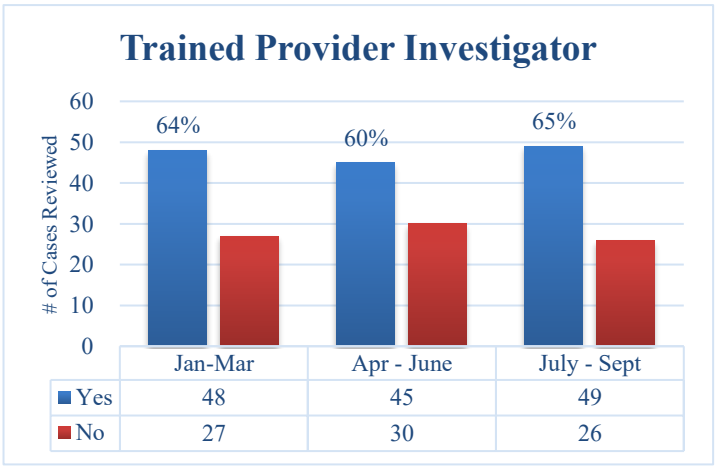
2023 Year-to-Date Review Results:

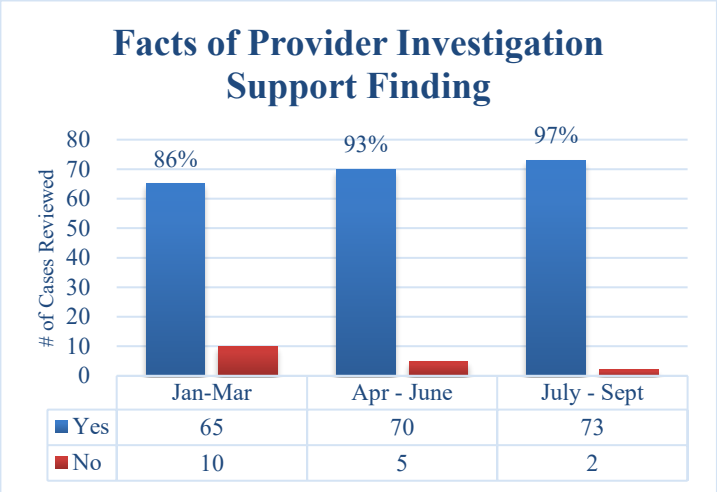
OHR uses an 86% standard based on "Yes" responses to discrete questions in the CLB Review Form to evaluate compliance among key metrics assessing provider requirements and OHR processes. The following data is based on the 225 reviews completed between June and September 2023. Note that a comprehensive report of results and recommendations will be published in early 2024, following a full year of reviews (to include cases closed in October, November, and December 2023). Remarkably, the following key metrics that correspond with best-practice guidelines and requirements in the Human Rights Regulations are below or significantly below the 86% standard.



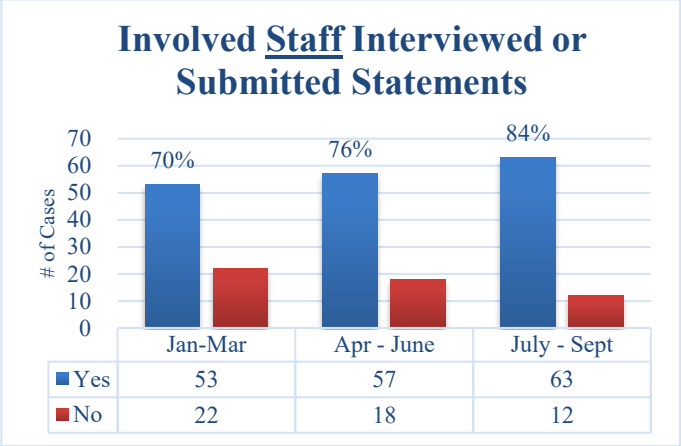
Of the (41) cases reviewed where the provider investigation was not completed within 10 working days, extensions were requested by the provider in 7 cases, but not granted by the Advocate based on "insufficient reasoning". Also, 18 of these investigations were conducted by staff that did not have abuse/neglect investigations training, and in 14 of these same cases the provider investigator also failed to perform other duties such as notify the guardian of the complaint within 24 hours.

Of the 83 cases reviewed where there was no evidence the staff conducting the investigation received proper training, several providers indicated the investigator watched the "OHR Investigator Training YouTube video" but did not have evidence of competency testing, and this was not considered sufficient. Additionally, some providers submitted a certificate indicating "OHR Investigating Abuse and Neglect: The Basics" training had occurred; however, the training date was after the date that the investigation was conducted.



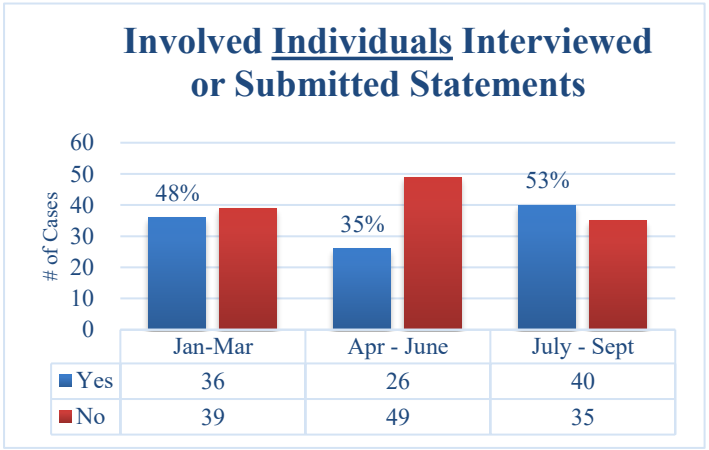


While this key metric is not below 86%, it is significant that in 13 of the 17 cases where the facts identified by the provider did not support the finding, the OHR Manager was unable to decide because the provider failed to submit an investigation summary at all, or the documents submitted lacked information. Of the cases where there were facts to review, witness statements or written notification letters to the individual/guardian indicating a substantiated finding corroborated these violations. Some providers also incorrectly selected "No" to all abuse types under the Investigation Tab in CHRIS in spite of evidence of a violation. In all these cases, the assigned Advocate also identified these violations in real time and the original Abuse Reports reflected that a citation was issued appropriately.



Of the 42 cases where the involved staff were not interviewed, OHR Managers found that in 90% (38) of these cases the individual(s) involved had not been interviewed as well. Of these, nearly all (33) were completed by staff that were not trained to conduct abuse/neglect investigations and most of these cases were not able to be assessed by the OHR Manager, for whether the facts supported the finding because an investigation summary was not provided or, there was not enough information provided in the summary.

There were 123 cases total where the involved individuals(s) were not interviewed as part of the provider investigation. Specifically, the CLB Review Form does allow for a N/A option when providers have appropriate documentation about why a staff or individual did not participate in the investigation. Examples include staff resignation and when an individual refuses. It is not acceptable for a provider to simply indicate that an individual is "non-verbal" without also indicating how they attempted to involve the individual in the investigation process.



Key Takeaways & Reminders for Providers:

- A detailed and systematic investigation must be completed within 10 working days from the date the abuse/neglect complaint is made known to the provider, or the date the potential abuse, neglect or exploitation is discovered by the provider themselves.
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We appreciate your commitment to the health, safety, and rights protections of individuals in our service delivery system, as we continue efforts to build on data collected through quality improvement initiatives like the CLB. If you have questions regarding the information in this memo, please contact your assigned OHR Regional Manager.