Summary of December 2023 Abuse Prevention Committee Meeting

The Justice Center's internal abuse prevention committee is charged with identifying preventative actions that address conditions that cause or contribute to incidents of abuse and neglect. The committee met in December 2023. During this meeting, committee members working in different business units across the Justice Center received updates on National Alliance for Direct Support Professionals (NADSP) E-Badge Academy as well as trends from the Justice Center's mortality review, investigation and case closure units.

E-Badge Academy

NADSP received $10 million in federal American Recovery Plan Act (ARPA) funds over three years to provide bonuses to direct support staff and frontline supervisors working in OPWDD settings who earn "E-Badges" that demonstrate their knowledge, skills, and experience. In addition, providers receive up to 100 hours of training time reimbursement for staff who achieve certification. As of the date of the prevention committee meeting in December, over 1,500 direct support professionals and front-line supervisors were participating. The plan is to certify over 2,000 direct support staff and over 200 front-line supervisors. The University of Minnesota will conduct an evaluation of the program. The evaluation will be looking at the impact the E-Badge has on staff retention and competency among other things. Staff who have participated have completed surveys and over 90% of those responding say that the skills identified by the E-Badges are directly related to the work they do and that because of going through this process they have a better understanding of how to provide high quality support.

Mortality Review Trends

The Protection of People with Special Needs Act requires the deaths of all individuals receiving services from a residential facility or program licensed, certified, or operated by OPWDD, OMH, OASAS or OCFS to be reported to the Justice Center. In addition, the death of any individual who received services from these facilities or programs in the 30 days prior to their death must also be reported. All deaths reported are reviewed by investigators with program experience as well as health care professionals, including registered nurses. Through these reviews, the Justice Center can make recommendations to providers on how to improve quality of care. Letters are sent to both providers and the appropriate state agency for monitoring of recommended corrective actions. Any time a death is reported to the Justice Center where there is an allegation of abuse or neglect, a separate notification is sent to both the district attorney and the medical examiner.

In 2022, the Justice Center received over 1,600 reports of death; 75 of those reports were referred and investigated for allegations of abuse or neglect. Approximately 57% of those reports were substantiated and most were substantiated for a Category 2 level of neglect. All corrective action plans developed by provider agencies for these substantiated cases are audited and reviewed by the Justice Center. Inadequate and/or untimely medical care and inadequate supervision were the leading offenses in substantiated cases.

Mortality assessment closure letters of concern are sent to providers with recommendations to improve the quality of care and the state agency that licenses, certifies, or operates the program receives a copy of the letter. The issues identified in 2022 included a failure to follow up on referrals for mental health services, poor documentation , not implementing needed changes in treatment plans and training deficiencies.

The Mortality Review Unit also summarized findings from all mortality reviews conducted that involved the death of a person who was 21 years of age or younger between 2013 and 2022. During that nine - year time period a total of 179 deaths of people under the age of 21 were reported to the Justice Center. The primary causes of death for young people differed by state oversight agency. Deaths reported by OASAS providers were primarily due to opiate overdoses; in OCFS accidents, suicides, and homicides (post discharge) were the leading causes of death; in OMH it was suicides and complications from medications; in OPWDD the leading causes were complications from congenital conditions, respiratory illness, and bowel obstructions.

Trends from Investigations and Case Closure

The trends reported included:

- Inadequate staffing at IRAs, mostly overnight shifts
- Staff not aware of supervision levels
- Float and contract staff not trained on plans of care, boundaries, etc.
- Mandated overtime leading to burnout
- Failure to de-escalate, follow plans of care before physical interventions