# Facility Look-Behind

SFY2019 Annual Report

## Background

The Facility Look-Behind (FLB) is an annual review process conducted by the Office of Human Rights (OHR) for abuse cases among individuals in DBHDS state facilities. Facility Human Rights Advocates reviewed a *representative sample of 1,147 cases.* These cases had an incident date in SFY 2019 (between July 1, 2018 to June 30, 2019) and a closed case status.

## Business Processes and Requirements

One goal of the FLB is to assess human rights business processes. OHR uses an *86% threshold* standard for key metrics surrounding reporting timelines and compliance with investigation requirements.

Facilities indicated that 238 individuals experienced an injury related to their allegation of abuse, and 89% of these individuals received care by a licensed medical professional (Table 1). Facilities did not meet the 86% threshold for the 24 hour reporting. This is especially problematic because a closed case status is required in the initial case sampling framework.

***Table 1. Business Requirements for All Cases***

| Business Requirement Question | Count | Percent |
|---|---|---|
| *Did a licensed medical professional provide care?* | 213 | *89% |
| *Incident was reported in CHRIS within 24 hours of being reported to the Director?* | 820 | 71% |

**Out of 238 injuries*

### Non-Investigations

DBHDS facilities are required to investigate all allegations of abuse. For the purposes of this report, a "full investigation" means an Investigation Summary was completed and a Findings Letter was issued to the individual. Further study is required to assess the compliance of the varied investigative actions taken by facilities as compared to DI 201. *Of all 1,147 cases reviewed, there were 748 allegations that did not receive a full investigation (65%).* In these cases, facilities completed an administrative review (555, 74%), filed an incident report (308, 41%), and/or took some other action (160, 22%).



*Created on 1/26/21 by the Office of Data Quality and Visualization in collaboration with the Office of Human Rights.*

## Full Investigations

Of all 1,147 cases reviewed, there were *399 allegations that had a full investigation* (35%). The remainder of this report focuses on results from these full investigations.

Results show that investigations appear to be thorough (Table 2). Investigators interviewed the involved staff (96%), individuals participated in the investigation (87%), and there is documented training for investigators (85%). Most trainings were from Central Office (188, 56%) or from a Certified Investigator Training (145, 44%). Although *trainings could be as old as 2002, over half of all trainings were completed in 2018 alone* (183, 54%).

**Table 2. Business Requirements for Full Investigations**

| Business Requirement Question | Count | Percent |
|---|---|---|
| *Involved staff were interviewed or submitted written statements* | 381 | 96% |
| *Involved individual(s) participated in the investigation?* | 346 | 87% |
| *Evidence that person conducting investigation has been trained to conduct investigations?* | 338 | 85% |
| *CHRIS entry was closed by OHR within 60 days?* | 332 | 83% |
| *Investigation completed within timeframe (10 days)?* | 252 | 63% |
| *Was an extension granted?* | 50 | *34% |

**Out of 147 overdue investigations*

Adherence to process timelines continues to be an issue. Advocates did not meet the 86% threshold for closing cases within 60 days. This is especially problematic because a closed case status is required in the initial case sampling framework.

*Over a third of all investigations were not completed within the required timeframe* (10 business days, not including weekends or holidays, not including extensions). *Out of the 147 overdue investigations, 34% had requested an extension.*

# Data Quality Comparison

Another goal of the FLB is to assess the quality of the data entered into CHRIS compared to the supporting documentation kept on-site at the facility.

## Facility Corrective Actions

Facilities may implement corrective actions, regardless of the outcome of the case. Reviewers assessed on-site documentation for evidence of these actions (Table 3). *If the reviewer found evidence for an action but the facility never entered this into CHRIS, it was labelled as "No data."* Please note this table will not add up to the total number of full investigations because it is possible for the facility to indicate multiple corrective actions across cases.

**Table 3. Evidence of Corrective Action Taken by Facility**

| Corrective Action | Evidence | No Evidence | No Data |
|---|---|---|---|
| *Appropriate Staff Action Taken* | 97 | 42 | 10 |
| *Train Individual Staff* | 15 | 7 | 3 |
| *Reinforce Policy and Procedure* | 14 | 25 | 6 |
| *Train All Staff* | 8 | 15 | 8 |
| *Supervisory/Administrative Staff Change/Action* | 5 | 6 | 6 |
| *Increase Supervision (Change Patterns of Supervision)* | 2 | 0 | 2 |
| *Support Plan Modification* | 1 | 0 | 0 |
| *Individual(s) were Moved* | 1 | 1 | 1 |
| *Increase Staffing* | 0 | 1 | 1 |
| *Environmental Modification* | 0 | 0 | 0 |
| *Improve QA* | 0 | 0 | 0 |

"Appropriate Staff Action Taken" appears to present with the most ambiguity. While there is evidence that appropriate action is taken by the provider in 50 of the cases where this action is selected, it is also the action observed to have been selected most often for which there is no evidence to support it. This is similar to results from the previous year's review. OHR believes that this may be the result of providers misidentifying the action as a justification for not determining a violation as opposed to utilizing the action as intended – as a type of corrective action to demonstrate appropriate behavior followed the violation.

OHR will consider utilizing its existing training infrastructure/presentations (i.e. CHRIS; Overview of Human Rights; and Community Provider Investigation) to educate about the accurate use of "Appropriate Staff Action Taken" as a corrective action after the identification of a violation as opposed to the justification for not determining a violation.

## Notifications

Another data quality comparison assessed the evidence of any notifications sent by the facility regarding the abuse case (Table 4), with the same rules from Table 3 used again. If a provider

checked a corrective action in CHRIS, reviewers indicated whether they found supporting evidence in the on-site documentation ("evidence"). Reviewers also indicated if documentation could not support the CHRIS data ("no evidence") or if evidence was found on-site but it was never entered into CHRIS ("no data"). *Some notifications only apply to eligible cases, such as when the case warrants notification to police, whereas the final notice of the investigation findings applies to all 392 investigations, regardless of the outcome.*

**Table 4. Evidence of Notifications Sent by Facility**

| Notification Questions | Evidence | No Evidence | No Data |
|---|---|---|---|
| *Initial allegation reported to Authorized Representative (AR)/Guardian?* | 117 | 3 | 17 |
| *Notification to Department of Social Services?* | 302 | 10 | 24 |
| *Notification to Police?* | 13 | 4 | 4 |
| *Investigation findings sent to the individual and/or AR/Guardian?* | 356 | 12 | 17 |

# Validity of Investigation Outcomes

The final goal of the FLB is to assess the validity of the facility investigation and outcomes.

## Facts Support the Findings

*Reviewers indicated that the facts of the facility investigation supported the Investigator's conclusion in 382 cases (96%*). For 17 (4%) cases, reviewers indicated the facts did not support the findings, meaning after reading the rationale the reviewer would have issued a different finding. This could mean the facility substantiated a case that a reviewer would not, or vice versa. Reviewers also indicated that the Facility Director agreed with the Investigator's conclusion in 384 cases (96%). *Every quarter, OHR assesses open-text responses to understand the various reasons why the facts did not support the findings* or why a Director and Investigator disagreed.

## DBHDS Advocate Actions

DBHDS Human Rights *Advocates indicated 829 actions were taken as they monitored 399 facility investigations.* Advocates utilize these actions as a way to document their monitoring processes and communicate with the facility. *The two most popular choices for actions were "Ok to close case" (326, 82%) and "Reviewed Investigation Report" (249, 62%)*. All other actions were used less frequently (15% or less for each).

## Verification of Corrective Actions

Of the 399 investigations, there were 105 substantiated allegations of abuse (26%). OHR defines substantiated as "a preponderance of evidence that abuse or neglect did occur." Reviewers

utilized a text description called 'Remarks' for this assessment. *Among these 105 cases, reviewers indicated that corrective actions taken by the facility were verified by advocates in 71 cases (68%).*

# Differences and Limitations

Determining which cases are eligible to include in the full analysis is complicated by several factors. Unlike community providers, DBHDS facilities do not complete full investigations on all reported cases. Of the 1,147 cases reviewed in this study, 65% did not receive a full investigation. Most of these cases are allegations of neglect on the part of the facility due to peer-to-peer altercations. Peers are typically separated and a full investigation is not conducted, yet the occurrence is documented in CHRIS as an allegation.

Mental health issues among the facility population also contribute to a number of improbable allegations, whereas the Community Look-Behind (CLB) is restricted to DD service recipients. These cases are also documented as an allegation, but do not typically receive a full investigation.

Unlike community providers, state facilities are not licensed by DBHDS. This could inhibit the ability to improve outcomes or affect change.

## After Actions and Next Steps:

- Case closure by the advocate is evidence of verification of corrective actions and replaces the need for an additional statement by the advocate as indication.
- OHR implemented AIM Protocol to ensure ANE case review and closure by the advocate within 60 days. In addition to advocate EWPs, managers have identified oversight tools via Data Warehouse.
- New and Experienced Facility Investigator Training includes overview of process for requesting an extension in addition to existing information about investigation timelines.
- P2P workgroup
- Violation letters – address late reporting (71%), late findings for investigations and when advocate disagrees with facts – namely violation occurred
- Second iteration of FLB (FY20) to further study nuances of full investigations and use of other type of investigative actions.

# Inter-Rater Reliability

*Seventy-three cases were sampled for review by a second rater* who did not have access to the original reviewer's responses. The sample was stratified so that all facilities would be

represented, with priority given to cases where a full investigation was conducted. While it is not ideal to have an inter-rater process that differs from the original review process or to switch raters half way through, the first inter-rater retired during the review year and the on-site review process for the second inter-rater was replaced with a virtual review due to the COVID-19 pandemic. All reviewers conducted a desk audit of CHRIS documentation followed by an onsite review of the facility's investigation records. Both inter-rater process also involved an initial desk audit of CHRIS; however, the first inter-rater traveled to each facility to conduct the onsite review while the second inter-rater reviewed all the investigation documents reviewed by the reviewer, uploaded into a Teams folder by the reviewer.

The percent agreement between the first and second reviewers was calculated for each question. In addition, Maxwell's random error coefficient (RE) was calculated to adjust for agreement expected by chance alone[1]. Since Maxwell's RE is for binary outcomes only, an extension proposed by Janes (1979) was used for questions with three or more possible outcomes.[2] Another common inter-rater reliability statistic, Cohen's kappa, was considered but not used because the kappa coefficient is reduced when one of the outcomes is highly prevalent.[3]

*The Maxwell RE coefficient ranges from -1 (perfect disagreement) to 0 (no agreement beyond what is expected by chance) to 1 (perfect agreement). Scores in between those values can be interpreted on a spectrum; cutoff scores are arbitrary*, as there is no consequential difference between a value of 0.599 and 0.600, for example. However, for easier interpretation, scores were coded with the following color scheme:

| | |
|---|---|
| No agreement | < 0 |
| Weak agreement | 0.00 to 0.39 |
| Moderate agreement | 0.40 to 0.59 |
| Substantial agreement | 0.60 to 1 |

[1] *Maxwell, A. E. (1977) Coefficients of agreement between observers and their interpretation. British Journal of Psychiatry **130**, 79-83.*

[2] *Janes, C. L. (1979) An extension of the random error coefficient of agreement to NxN tables. British Journal of Psychiatry **134**, 617-19.*

[3] *Feng, G. C. (2013) Factors affecting intercoder reliability: a Monte Carlo experiment. Quality & Quantity **47**, 2959–2982.*

Seven questions related to business processes and compliance with investigation requirements were analyzed for all 73 cases. *Substantial agreement was found for all of these questions except whether the incident was reported within 24 hours. There may be confusion about when exactly to start the clock and/or whether non-business days count* (Table 5).

**Table 5. Inter-Rater Agreement for Compliance with Business Processes and Investigative Requirements**

| Business Requirement Question | Percent Agreement | Maxwell's RE |
|---|---|---|
| *Did a licensed medical professional provide care?* | 85% | 0.70 |
| *Incident was reported in CHRIS within 24 hours of being reported to the Director?* | 73% | 0.45 |
| *Neglect Peer-to-peer: 201 Investigation Opened?* | 84% | 0.67 |
| *Facility incident report* | 97% | 0.95 |
| *Administrative Review* | 88% | 0.75 |
| *Facility took other action* | 90% | 0.81 |

Out of the 73 cases sampled by an inter-rater, there were 58 considered full 201 investigations. Results show *substantial agreement for the business process questions that apply to these reviews, except about whether an extension was granted, which showed about what could be expected from chance alone* (Table 6). This may have to do with inconsistent documentation and/or location of documentation about extension requests and responses.

**Table 6. Inter-Rater Agreement for Business Process Questions (Full Investigations Only)**

| Business Requirement Question | Percent Agreement | Maxwell's RE |
|---|---|---|
| *Involved staff were interviewed or submitted written statements?* | 93% | 0.86 |
| *Involved individual(s) participated in the investigation?* | 86% | 0.72 |
| *Evidence that person conducting investigation has been trained to conduct investigations?* | 81% | 0.62 |
| *CHRIS entry was closed by OHR within 60 days?* | 83% | 0.66 |
| *Investigation was completed within timeframes (10 days)?* | 88% | 0.76 |
| *Was an extension granted?* | 38% | 0.07 |

*Considering the FLB goal of a data quality comparison, results for the facility corrective actions documented in CHRIS showed perfect agreement was found for five of the items (Table 7). Agreement was strong for all items except "appropriate staff action taken," although agreement was still higher than expected by chance alone for this item.*

**Table 7. Inter-Rater Agreement for Corrective Actions Data in CHRIS**

| Corrective Action | Percent Agreement | Maxwell's RE |
|---|---|---|
| *Environmental Modification* | 100% | 1 |
| *Improve QA* | 100% | 1 |
| *Increase Staffing* | 100% | 1 |
| *Increase Supervision (Change Patterns of Supervision)* | 100% | 1 |
| *Support Plan Modification* | 100% | 1 |
| *Individual(s) were Moved* | 98% | 0.97 |
| *Reinforce Policy and Procedure* | 98% | 0.97 |
| *Supervisory/Administrative Staff Change/Action* | 97% | 0.93 |
| *Train Individual Staff* | 97% | 0.93 |
| *Train All Staff* | 95% | 0.90 |
| *Appropriate Staff Action Taken* | 78% | 0.55 |

For corrective actions with on-site documentation, perfect agreement was found for six items (Table 8). Substantial agreement was found for all items except "appropriate staff action taken" where agreement was lower, but still higher than expected by chance. The result for this item is very similar to what was found in the previous checklist for facility actions documented in CHRIS, suggesting the same reason for disagreement may apply in both sections.

**Table 8. Inter-Rater Agreement for Corrective Actions Documented in Investigation**

| Corrective Action | Percent Agreement | Maxwell's RE |
|---|---|---|
| *Environmental Modification* | 100% | 1 |
| *Improve QA* | 100% | 1 |
| *Increase Staffing* | 100% | 1 |
| *Increase Supervision (Change Patterns of Supervision)* | 100% | 1 |
| *Support Plan Modification* | 100% | 1 |
| *Train Individual Staff* | 100% | 1 |
| *Individual(s) were Moved* | 98% | 0.97 |
| *Supervisory/Administrative Staff Change/Action* | 95% | 0.90 |
| *Reinforce Policy and Procedure* | 91% | 0.83 |
| *Train All Staff* | 90% | 0.79 |
| *Appropriate Staff Action Taken* | 76% | 0.52 |

Substantial agreement was found for data quality comparison questions regarding notifications sent by the facility (Table 9).

**Table 9. Inter-Rater Agreement for Data Quality Comparison for Notifications**

| Notification Questions | Percent Agreement | Maxwell's RE |
|---|---|---|
| *CHRIS shows notification of initial allegation made to AR/Guardian* | 84% | 0.69 |
| *Documentation shows notification of initial allegation made to AR/Guardian* | 79% | 0.69 |
| *CHRIS shows notification made to DSS* | 81% | 0.62 |
| *Documentation shows notification made to DSS* | 71% | 0.61 |
| *CHRIS shows notification made to Police* | 97% | 0.93 |
| *Documentation shows notification made to Police* | 71% | 0.61 |
| *CHRIS shows written notice of investigation findings provided to individual and/or AR/guardian* | 86% | 0.72 |
| *Documentation shows written notice of investigation findings provided to individual and/or AR/guardian* | 84% | 0.69 |

Lastly, questions used in the final FLB goal of validity of investigation outcomes were analyzed. Raters agreed 91% of the time on whether the facts of facility investigation support the Investigator's conclusion (Maxwell's RE=0.83) and agreed 83% of the time on whether the Director agreed with the Investigator's conclusion (Maxwell's RE=0.66).

Substantial agreement was found for the various DBHDS Advocate Actions conducted in support of the investigation, with perfect agreement on seven of the items. One item ("Reviewed Investigation Report") had moderate agreement (78% agreement, Maxwell's RE=0.55).

Agreement was weak on the final question about whether the Advocate Action description in CHRIS verified the corrective actions by the facility (62% agreement, Maxwell's RE=0.24).

## Impact of Having Two Raters

The first rater completed 35 cases (24 with full investigation) while the second completed 38 cases (34 with full investigation). In order to determine whether the switch in raters may have had an impact on the results, percent agreement and Maxwell's RE were calculated for each rater separately and then compared. The results were generally similar with the exception of the results for the question, "Did the Advocate Action Description verify the corrective actions by the provider?" For this question, agreement was substantial for one of the reviewers (Maxwell's RE = 0.65), while for the other reviewer there was so much disagreement that the value was negative (Maxwell's RE = -0.33).

For all other questions, the impact of using two different reviewers for the inter-rater analysis appears to be minor.