

**Report to General Assembly: Reporting Incidents of
Abuse, Neglect, and Misappropriation**

A Report to the 2011 107th Tennessee General Assembly

Tennessee Department of Health

Bureau of Health Licensure and Regulation

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BACKGROUND AND SUMMARY OF THE LAW:

Public Chapter 318 of the 2009 Public Acts of the 106th General Assembly amended T.C.A. §68-11-211 by changing the incident reporting requirements submitted to the Department by licensed facilities. In an effort to make the State law reporting requirements consistent with federal reporting requirements, the law was amended to remove a list of unusual incidents that facilities must report and require facilities to report occurrences of abuse, neglect, and misappropriation. Because the incidents previously contained in the law were already being tracked internally by most facilities to ensure best practices, by focusing the reporting requirement on abuse, neglect, and misappropriation, the law change allowed the Department to reallocate its scarce resources so that it could focus on the serious and potentially harmful violations affecting the health, safety and welfare of the residents. That acknowledgment that data relative to unusual incidents were already being collected and tracked by facilities is contained in the public chapter where the General Assembly recognized the need to collect certain relevant health data to ensure quality patient care, but encourages health care facilities to report such data to patient safety organizations that collect, assimilate and aggregate such data. While the intent of the original law was to collect meaningful health care data to improve resident care, the practical effect was that every incident required an onsite survey resulting in an exponential increase in surveys. The increase in surveys and the demand on surveyor time for an investigation into each incident did not allow surveyors to focus on the more severe incidents of abuse, neglect, and misappropriation and did not provide a greater benefit to the residents.

Not codified, yet contained in the public chapter, is the requirement that the Department of Health submit a written report to the chairs of the Senate Welfare Committee and the House Health and Human Resources Committee that specifically compares and contrasts the 2007 and 2008 annual aggregate data report to the State pursuant to T.C.A. §68-11-211 with the aggregate data available from the produce of surveys performed; this instant report complies with that mandate.

COLLECTION OF DATA:

This report assimilates the annual aggregate data from 2007, 2008, 2009, and 2010 as reported to the State by facilities pursuant to T.C.A. §68-11-211 for the occurrences of abuse, neglect and misappropriation of resident property; the terms “abuse”, “neglect” and “misappropriation” are defined by statute and mimic the federal definitions. The report also contrasts the number of occurrences reported with the results of surveys performed in years 2007 through 2010 by the Department pursuant to T.C.A. §68-11-210 indicating the percentage of incidents reported that were substantiated.

In 2007 (prior to the law change), twenty-eight percent (28%) of the 3,486 reported incidents of neglect were substantiated; thirty-one percent (31%) of the 116 reported

incidents of misappropriation of resident property were substantiated; and twenty-five (25%) of the 1,128 reported incidents of abuse were substantiated upon state onsite survey. Notably, in 2007, the previous law (Health Data Reporting Act of 2002) contained a definition of “abuse”, but did not contain a definition of “neglect”. Arguably, all of the unusual incidents contained in the law that was in effect from 2007 to May 27, 2009, may have been placed under the heading of “neglect” yet may have not constituted “neglect” in accordance with the current statutory definition.

TABLE Description	2007 UIRS		2008 UIRS		2009 UIRS		2010 UIRS	
	Occurrences	%Total	Occurrences	%Total	Occurrences	%Total	Occurrences	%Total
Neglect (Total)	3486	74%	3395	76%	1788	67%	363	23%
% Substantiated	28%		33%		29%		36%	
Misappropriation of Resident Property	116	2%	101	2%	89	3%	82	5%
% Substantiated	31%		36%		18%		39%	
Abuse (Total)	1128	24%	1000	22%	808	30%	1157	72%
% Substantiated	25%		29%		22%		29%	
TOTAL	4730		4496		2685		1602	

In 2008 (prior to the law change), thirty-three percent (33%) of the 3,395 reported incidents were substantiated; thirty-six percent (36%) of the 101 reported incidents of misappropriation of resident property were substantiated; and twenty-nine percent (29%) of the 1,000 reported incidents of abuse were substantiated upon state onsite survey.

In 2009 (law change was effective on May 27, 2009), twenty-nine percent (29%) of the 1,788 reported incidents of neglect were substantiated; eighteen percent (18%) of the 89 reported incidents of misappropriation of resident property were substantiated; and twenty-two percent (22%) of the 808 reported incidents of abuse were substantiated upon state onsite survey.

In 2010 (after the law change), thirty-six percent (36%) of the 363 reported incidents of neglect were substantiated; thirty-nine percent (39%) of the 82 reported incidents of misappropriation of resident property were substantiated; and twenty-nine percent (29%) of the 1,157 reported incidents of abuse were substantiated upon state onsite survey.

COMPARE AND CONTRAST:

In reviewing the aggregate data, the data compiled for 2007, 2008 and 2009 up to May 27, 2009 would be that data collected pursuant to T.C.A. §68-11-211 under the Health Data Reporting Act of 2002. The data collected from May 27, 2009 to date is that which was collected pursuant to the amended T.C.A. §68-11-211 which requires the reporting of occurrences of abuse, neglect, and misappropriation. In comparing and contrasting that data in light of the law change, the percentages of substantiated neglect and misappropriation occurrences has increased and the percentage of substantiated abuse occurrences has remained consistent. Also, in 2010, occurrences of misappropriation comprised five percent (5%) of the total occurrences while abuse comprised seventy-two percent (72%) of the total occurrences. This is a two percent (2%) and forty-two percent (42%) increase respectively in these two occurrences, above these same 2009 occurrences.

Also, a comparison of the data before and after the law change, demonstrates that the number of reported incidents of abuse increased and the number of report incidents of misappropriation remained relatively consistent with only minimal variation. The decreased number of neglect occurrences reported may be attributed to facilities reporting occurrences that meet the statutory definition of neglect as opposed to reporting all of those incidents listed in the previous statute that may or may not constitute neglect. The absence of a definition of neglect in the previous law may have contributed to placing all of the statutorily listed incidents under the heading of "neglect", when now, under the new law, those incidents or occurrences would no longer constitute neglect. By having facilities report those occurrences that constitute neglect as defined by statute, it enables the Department to investigate serious events affording the investigatory process the time required to appropriately determine whether deficient practice did or did not exist. The ability to focus on more serious events produces a quality survey which enhances the quality of patient care. With the Department's better defined goals as a result of the law change, the Department will be using this data to tailor its industry educational sessions to specific areas of focus, with the goal of elevating the quality of care provided to residents in our long term care facilities.