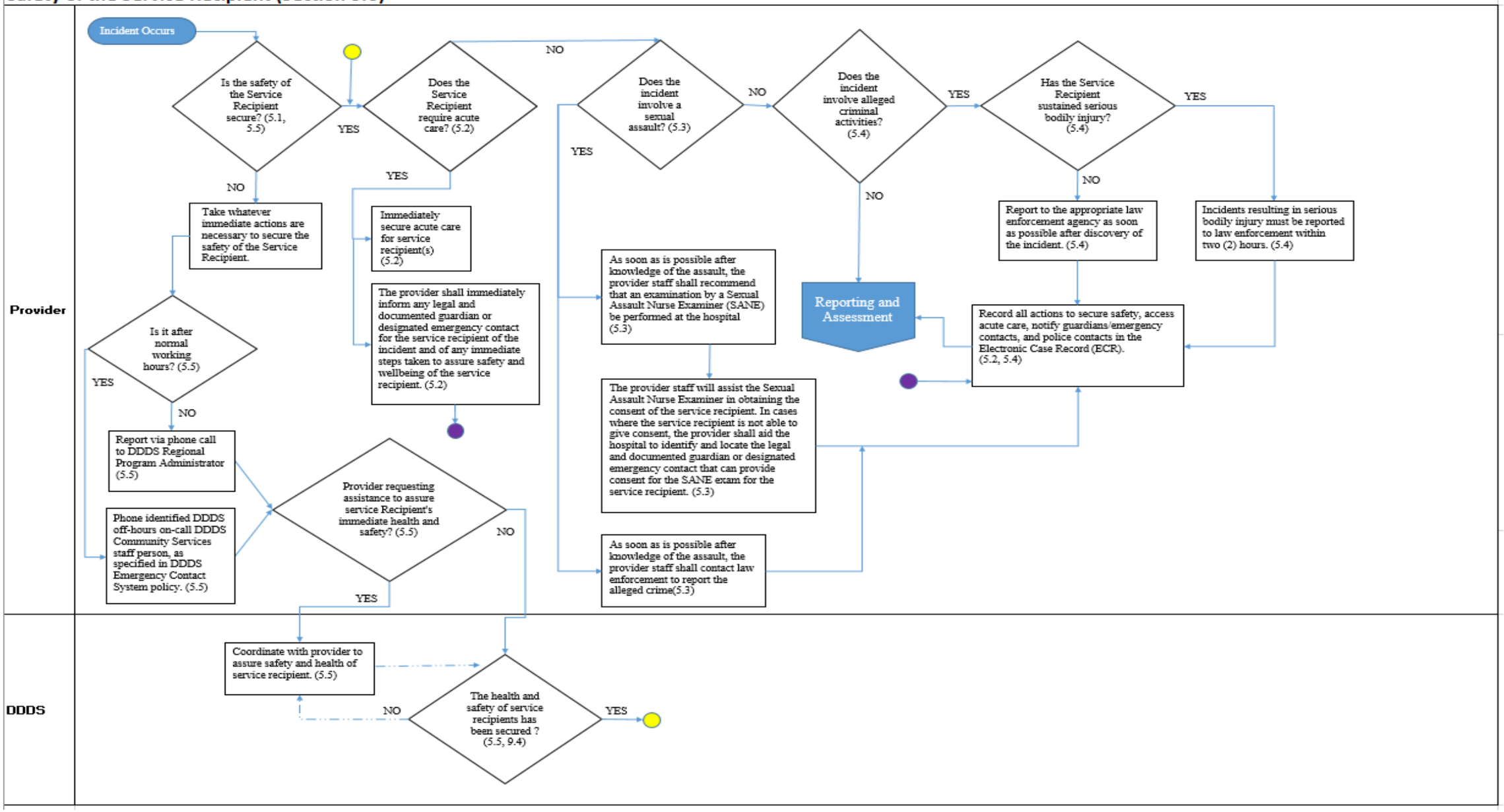
Division of Developmental Disabilities Services * September 18, 2019

Flowcharting for Proposed regulation Title 16, 2103 Reportable Incident Management and Corrective Measures

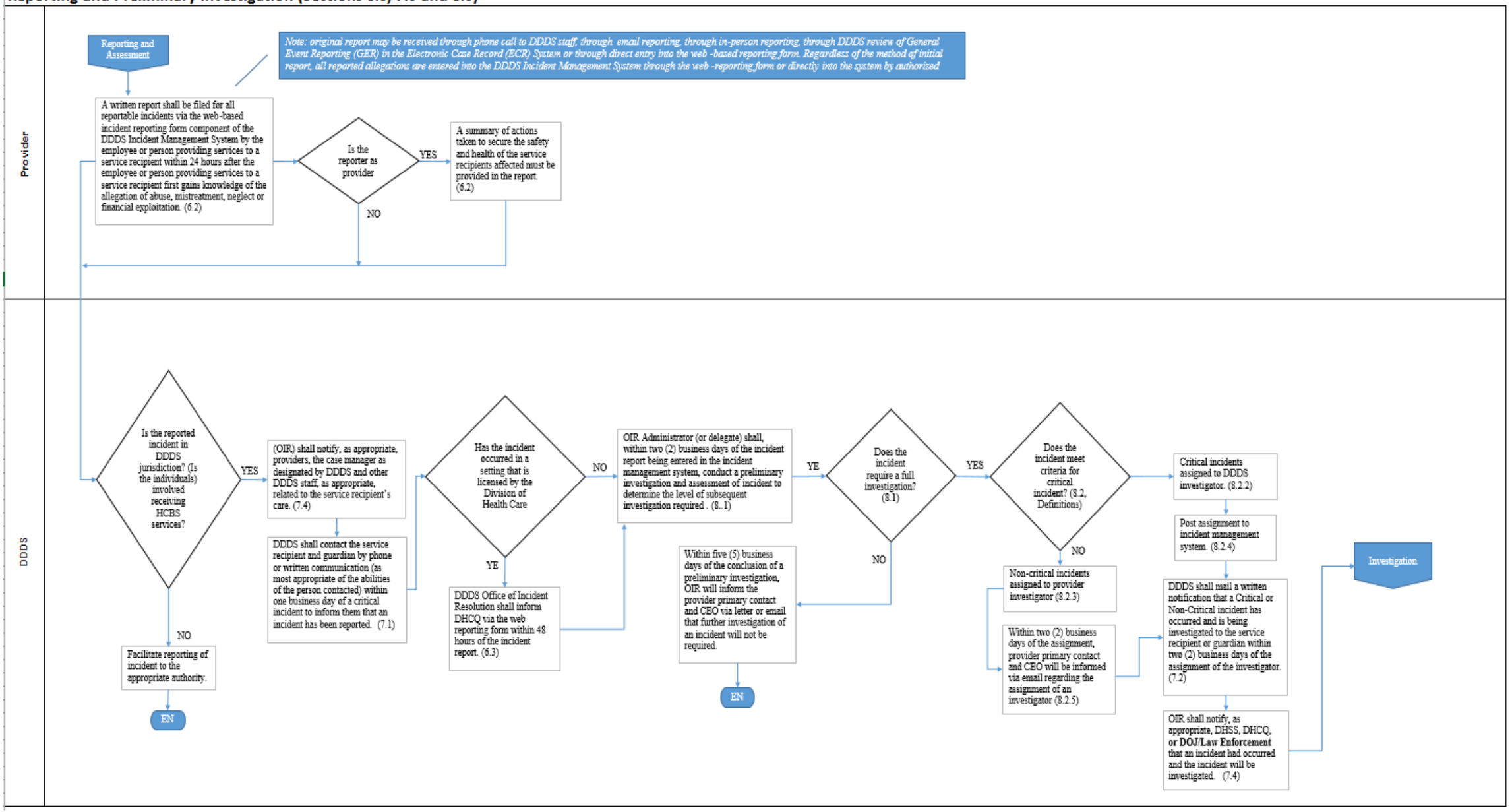
Safety of the Service Recipient (Section 5.0)



Division of Developmental Disabilities Services * September 18, 2019

Flowcharting for Proposed regulaiton Title 16, 2103 Reportable Incident Management and Corrective Measures

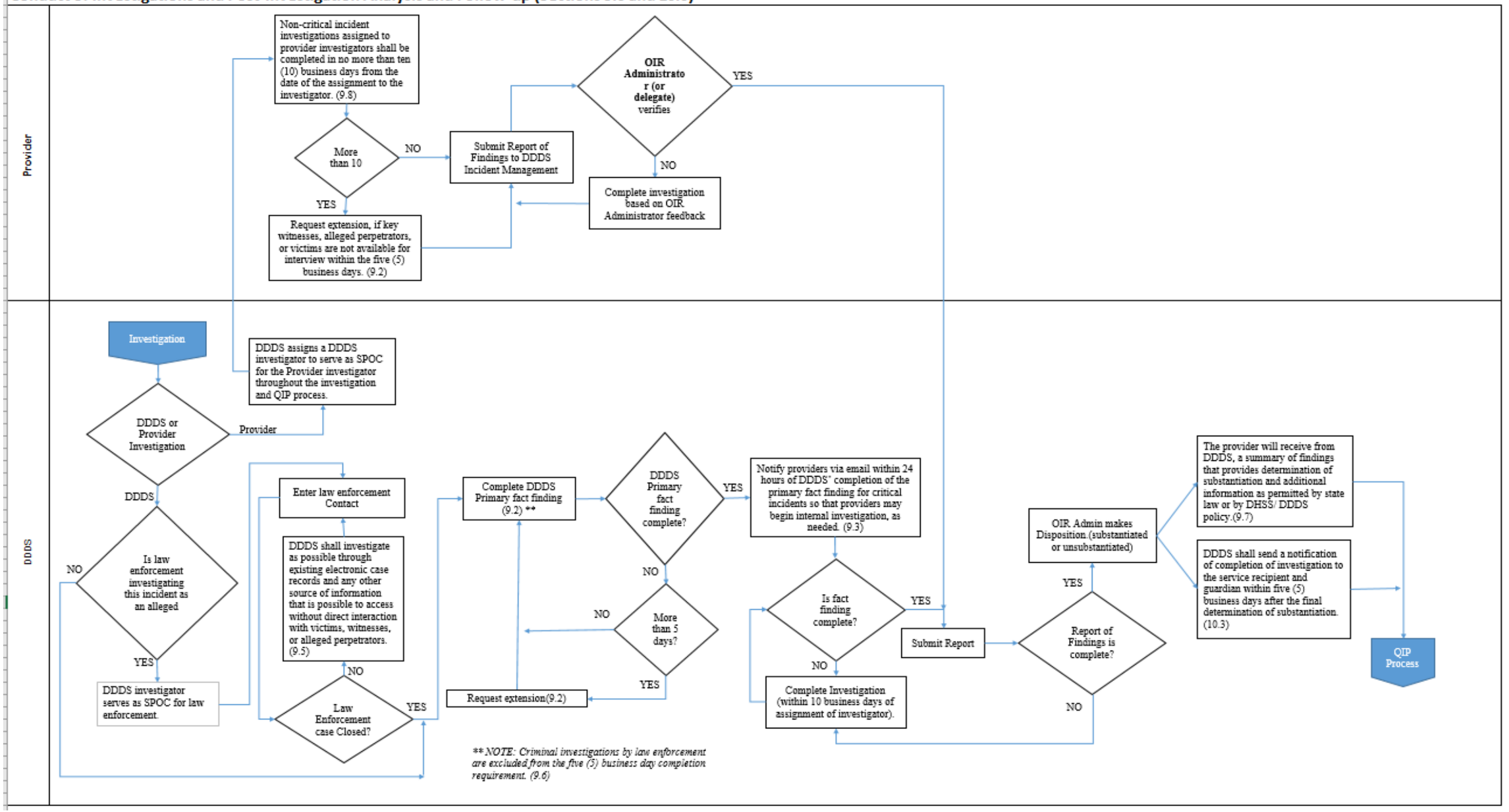
Reporting and Preliminary Investigation (Sections 6.0, 7.0 and 8.0)



Division of Developmental Disabilities Services * September 18, 2019

Flowcharting for Proposed regulaiton Title 16, 2103 Reportable Incident Management and Corrective Measures

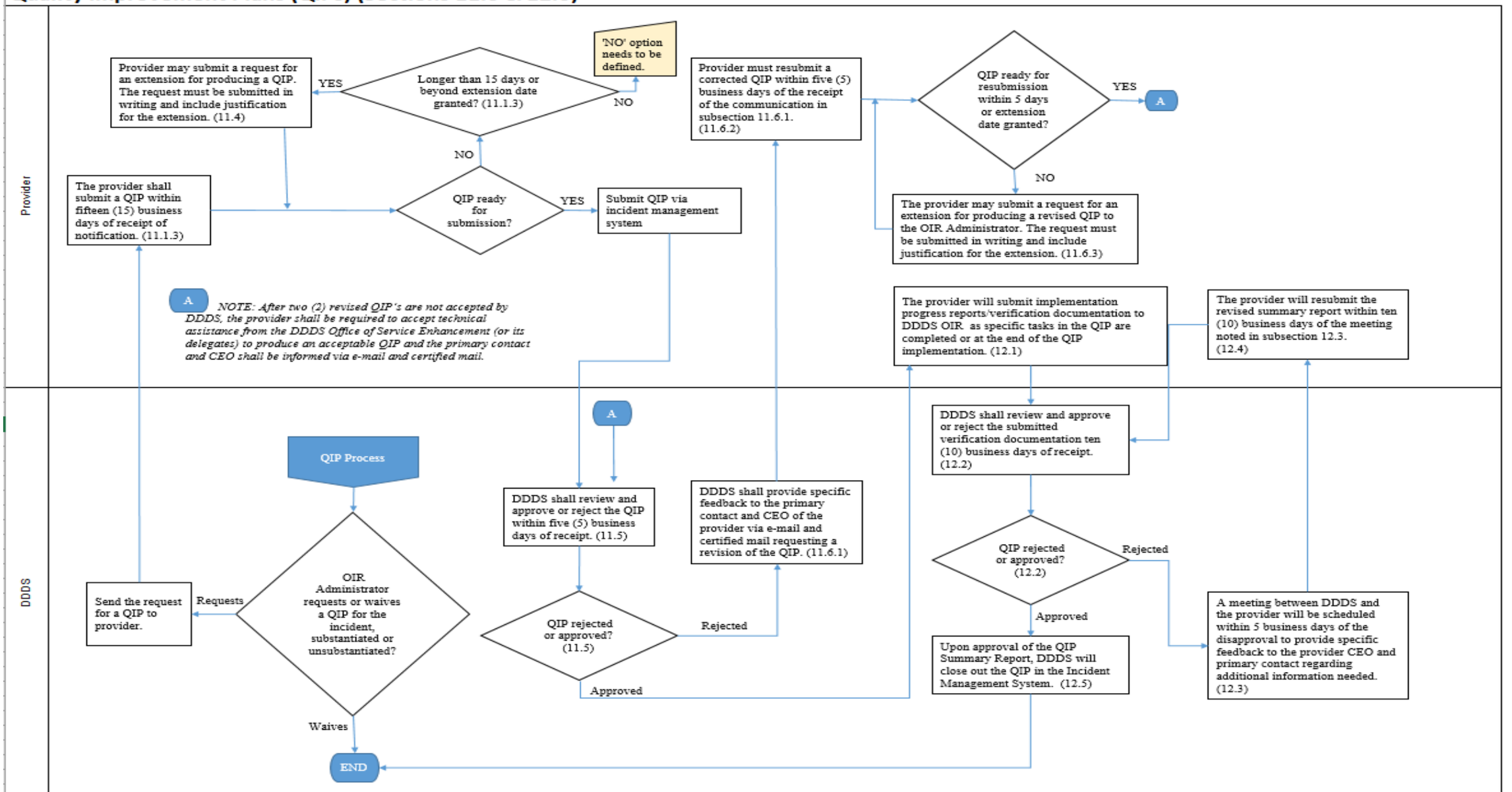
Conduct of Investigations and Post-Investigation Analysis and Follow-up (Sections 9.0 and 10.0)



Division of Developmental Disabilities Services * September 18, 2019

Flowcharting for Proposed regulaiton Title 16, 2103 Reportable Incident Management and Corrective Measures

Quality Improvement Plans (QIPs) (Sections 11.0 & 12.0)



INCIDENT MANAGEMENT 101

Division of Long Term Services and Supports

Disabled and Elderly Health Programs Group

Center for Medicaid and CHIP Services

Training Objectives

In this training we will:

- Review federal regulations that support the health and welfare of Home and Community-Based Services (HCBS) waiver recipients and guide the creation and use of incident management systems;
- Review findings from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) Reports, United States Government Accountability Office (GAO) Reports, and Centers for Medicare & Medicaid Services (CMS) audits beginning in 2016; and
- Describe key elements of a comprehensive incident management system.

Incidents will Happen…

How do you Respond, Report, Resolve, and Remedy?

Background

Federal Regulations Guiding Health and Welfare

Health and Welfare in the Social Security Act § 1915(c)

- Under section 1915(c) of the Social Security Act, successful waivers must provide assurances to CMS that the state has necessary safeguards to protect the health and welfare of participants receiving services.
- Waiver authority also require states to annually report the following to CMS:
  - Information on the impact of the waiver granted;
  - Types and amounts of medical assistance provided; and
  - **Information on the health and welfare of recipients.**

Health and Welfare in 42 CFR § 441.302(a)

- 42 CFR § 441.302(a) defines the necessary safeguards that will protect the health and welfare of the individual.
- Safeguards outlined in 42 CFR § 441.302(a) include:
  - Adequate standards for all types of providers furnishing waiver services;
  - Assurance that providers are adequately certified or have met the state's licensure requirements to provide the services under the waiver;
  - Assurance that all facilities providing home and community-based services are compliant with state standards and meet the requirements of 45 CFR part 1397 for board and care facilities;
  - Assurance that the state will be able to meet the unique service needs of individuals that are among different target groups under a single waiver, by providing data on an annual basis in the quality section of the CMS-372(s) report; and
  - Assurance that services are provided in home and community-based settings, as specified in § 441.301(c)(4).

2014 Revised § 1915(c) Waiver Guidance

- On March 12, 2014 CMS issued an Informational Bulletin on "Modifications to Quality Measurements and Reporting in § 1915(c) Home and Community-Based Waivers". This document:
  - Revised the guidance on quality assurances related to health and welfare in recognition of the importance of tracking services to prevent future incidents of abuse, neglect, and exploitation;
  - Modified the assurance and sub-assurances related to health and welfare to allow for more extensive tracking of incidents "to benefit the individual receiving services by using data to prevent future incidents"; and
  - Established the following assurance: "The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare."[1]

2014 Revised § 1915(c) Waiver Guidance – *Continued*

- The guidance also created the following four new sub-assurances that the state:
  - Demonstrate on an ongoing basis how it identifies, addresses, and seeks to prevent instances of abuse, neglect or exploitation, and unexplained death;
  - Demonstrate that an incident management system is in place and effectively resolves reported incidents and prevents further similar incidents to the extent possible;
  - Demonstrates that policies and procedures for the use of and prohibition of restrictive interventions (including restraints and seclusion) are followed; and
  - Establishes overall health care standards and monitors those standards based on the responsibility of the service provider as established in the approved waiver.

Importance of Incident Management Systems:
Findings from the OIG Reports, GAO Reports, and CMS Audits

Incidents will happen…

- The goal for states is not to eliminate incidents, but to minimize preventable incidents from occurring.
- A robust incident management system allows states to proactively respond to incidents and implement actions that reduce the risk and likelihood of future incidents.
- States have utilized different approaches to developing and implementing their incident management systems.

Summary of HHS-OIG Report Findings

- In 2016, the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) released several reports on their review of states' compliance with federal or state requirements regarding critical incident reporting.
- The HHS-OIG found that several states did not comply with federal waiver and state requirements for reporting and monitoring critical incidents involving HCBS waiver individuals. The findings included that: [2,3,4]
  - Critical incidents were not reported correctly;
  - Adequate training to identify appropriate action steps for reported critical incidents or reports of abuse or neglect was not provided to state staff;
  - Appropriate data sets to trend and track critical incidents were not accessible to staff; and
  - Critical incidents were not clearly defined, making it difficult to identify potential abuse or neglect.

Summary of CMS Audit Findings

- In 2016, CMS conducted three audits based in part or in whole on concerns regarding health and welfare and negative media coverage on abuse, neglect or exploitation issues.
- CMS found that states have not been meeting their 1915(c) waiver assurances, similar to findings reported by the OIG.
  - In two cases, the tracking and trending of unusual incidents were not present for the incidents of concern.
  - In at least two of the states, the ability to staff at appropriate levels was identified as an issue.
- For more detail on the CMS audits and recommendations resulting from these site findings, refer to the HCBS Quality 201 training: http://www.nasuad.org/sites/nasuad/files/Final%20Quality%20201.pdf
- Please note that CMS is currently working with states and state groups to update the performance measures from the training cited above.

Summary of GAO Report Findings

- In January 2018, the United States Government Accountability Office (GAO) released a report on a study of 48 states that covered assisted living services.[5]
- This study found large inconsistencies between states in their definition of a critical incident and their system's ability to report, track, and collect information on critical incidents that have occurred.
- States also varied in their oversight methods as well as the type of information they were reviewing as part of this oversight.
- CMS conducts oversight using annual state reports for each HCBS waiver; however, almost half of the states had limitations in their data reflected in 372 reports.
- The GAO recommends that requiring states to report information on incidents (e.g., type and severity of incidents, number of incidents, etc.) will strengthen the effectiveness of state and federal oversight.

Summary of Recommendations from Reports

Findings from the HHS-OIG, GAO reports, and CMS audits highlight the need for states to:

- Conduct additional oversight regarding the administration and operation of their incident management systems;
- Provide clarity and transparency on the operation and collection of information from their incident management systems;
- Standardize definitions and processes for:
  - Responding to incidents; and
  - Annual reporting requirements for HCBS waivers.
- Implement promising practices and performance improvements that help maximize resources and improve current incident management systems.

Key Elements of Building an Effective Incident Management System

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

What is an Incident Management System?

The 1915(c) Technical Guide provides guidance:

- According to the 1915(c) Technical Guide (page 225), “an incident management system must be able to:
  - Assure that reports of incidents are filed;
  - Track that incidents are investigated in a timely fashion; and
  - Analyze incident data and develop strategies to reduce the risk and likelihood of the occurrence of similar incidents in the future.” [6]

Goals of an Incident Management System

A robust incident management system:

- Standardizes what incidents are and how incident reports are collected;
- Provides guidelines for states in prioritizing what incidents need to be investigated and resolved; and
- Allows states to identify, track, trend, and mitigate preventable incidents.

Incident Management System
Introduction

- **The following are six key elements that states must consider when implementing an effective Incident Management System:**

1. Identifying the Incident	2. Reporting the Incident	3. Triaging the Incident
4. Investigating the Incident	5. Resolving the Incident	6. Tracking and Trending Incidents

1. Identifying the Incident
Definition

- Consider the following when establishing definitions of reportable incidents:
  - Must be clear and understandable so stakeholders can easily identify which incidents are reportable;
  - Whether the same definition will be used uniformly across all waiver populations and, if not, how to account for these variances; and
  - The 1915(c) Technical Guide, in Appendix G – item G-1-b, identifies a list of incident categories that may be considered reportable incidents by the state.
    - Examples include: abuse, neglect or exploitation; serious injuries requiring medical intervention and/or hospitalization; and criminal victimization.
- Identify any guidelines for what is considered reportable
  - The state should determine what types of incidents require follow-up as not to overload the system.

1. Identifying the Incident
Critical vs. Noncritical Incidents

- Identify which reportable incidents are critical or noncritical.
  - This identification allows states to better focus their resources for incidents that cause or have the potential for causing the most harm.
    - Critical incidents may require a more in-depth investigation, requiring an expedited timeline and additional resources.
- Determine if incidents are critical or noncritical by identifying how the state will respond to incidents.
  - Prioritizing incidents based on response helps set expectations and limits over-commitment by the state.
  - For example, if the state defines all missed medications as a critical incident and reviews and investigates all these incidents, then the state runs the risk of delaying a follow-up for incidents that cause potential harm to individuals, such as medication errors for Schedule II drugs.

1. Identifying the Incident
Critical vs. Noncritical Incidents - Continued

- Determine if the frequency of occurrences impacts whether incidents are identified as critical or noncritical.
  - The state may elect to require a more involved investigation on noncritical incidents occurring to the same individual or by the same provider on multiple occasions.
  - States need to clearly indicate the number of times a noncritical incident must occur to elevate it to being critical (e.g., a physician sees the individual for the same reason every month for a specified period of time).

1. Identifying the Incident
Categories of a Reportable Incident

- Group the established list of reportable incidents into applicable categories.
  - For example, the state should clearly define the activities that are considered under abuse, neglect or exploitation as a categorized group.
  - The state may also categorize incidents based on potential or actual:
    - Physical harm;
    - Financial harm; or
    - Environmental harm.
  - Clearly categorizing incidents into these groups will help the state to allocate the appropriate resources and subject matter experts to determine if the reported incident requires further investigation or referral to other agencies.

1. Identifying the Incident
Key Responsibilities

- Determine who is responsible for identifying the incident and their roles and responsibilities.
  - For example, in some states, the person identifying the incident may not directly report the incident.
  - The following are examples of individuals that can identify incidents:
    - Individuals;
    - Family members/guardians/friends;
    - Service provider agencies;
    - Case managers;
    - State officials; and
    - Concerned third parties.
- Ensure that these individuals have received the appropriate training to identify an incident.

2. Reporting the Incident
Method of Reporting

- Determine whether reporting methods will be paper or electronic.
  - Electronic reporting methods provide states with a more efficient method of tracking and trending incidents, e.g., states may track or trend incidents by type of incident, provider, provider type, place of incident, etc.
- Offer multiple avenues for reporting an incident.
  - Provides the opportunity for all stakeholders to report the incident.
  - Examples include email, online form, fax, and call center.
- Recognize and account for the different costs associated with the method and volume of reporting.
  - The administrative and operational costs may vary depending on the reporting method.
  - Some methods may require the set-up of new systems and/or new staff.

2. Reporting the Incident
Identify Information to Report

- Collect information that will assist in the review, triage, tracking, and trending of an incident.
  - States may collect information such as: identifying data (name, date of birth, etc.); alleged perpetrators; date and time of incident; location of the incident; description of incident; provider information; case manager information; and witnesses.
    - Additional training may be necessary to help and encourage individuals to identify incidents.
- Standardize the type of information collected from reports to:
  - Expedite the review of the incident.
  - Maintain transparency about what is collected and the process that occurs after the reporting through public policies and procedure guidelines, training courses, or in provider and program participant handbooks.

2. Reporting the Incident
Key Responsibilities

- Determine who is responsible for reporting the incident and communicate their responsibilities to them.
  - The following are examples of individuals that can report an incident:
    - Individuals;
    - Family members/guardians/friends;
    - Service provider agencies;
    - Case managers;
    - State officials; and
    - Concerned third parties.
  - States often require mandated reporters, based on where the incident took place.
    - For instance, doctors and nurses may be required to report incidents in a hospital setting, case managers and nursing facility staff may be required to report if the individual was in a nursing facility.
- Determine if all individuals that identify incidents have access to the incident reporting system.

2. Reporting the Incident
Timeline for Reporting

- Establish different timelines for reporting incidents based on severity.
  - Critical incidents may require a more aggressive timeframe.
- Ensure that the methods of reporting support the timeline.
  - States need to consider methods that allow for the reporting of incidents on weekends, after-hours, and holidays.
    - One state allows stakeholders to report the incident using a 24-hour hotline.

2. Reporting the Incident
Communicating Reports with Others

- Establish a clear process for communicating to necessary parties within required timelines that incidents have been reported.
  - Consider processes through the incident reporting system or outside the incident reporting system.
- If managed care organizations (MCOs) are managing the incident management process (such as reporting, investigating, and following-up), determine how the state and MCO can share and monitor the reported incidents. Ways to monitor may include:
  - Requiring a summary report of incident management in the MCO RFPs;
  - Regularly reviewing the reports and meeting with MCO special investigative units (SIUs) or other parties performing the incident management.

3. Triaging the Incident
Identify Responsibilities

- Determine who is responsible for evaluating incident reports.
  - The state must determine if the agency receiving the incident reports must also review these incidents and if the reviews differ by waiver or population group.
  - Responsibilities of the operating agency and the state Medicaid agency (SMA) may differ based on how the waiver is organized.
- Ensure that reviewers have a firm understanding of what and how to review incident reports (e.g., conduct trainings or encourage use of a standardized checklist).
- Consider potential conflicts of interest when selecting who reviews and/or investigates the incident.
  - Reviewers triaging the incident and investigating the incident should be independent from any apparent conflict of interest from service providers or agency operations.

3. Triaging the Incident
Identify Severity

- Determine and validate the severity of a reported incident.
  - States may determine severity based on whether an incident is identified as critical or noncritical.
    - However, persistent or reoccurring noncritical incidents should also be factored when considering severity as this may indicate a more serious issue.
  - States may also determine that incidents resulting in hospitalization or emergency room (ER) visits are automatically identified as severe.
  - Severity of an incident is a predictor of the type of investigation that is necessary, so states should ensure that incidents are classified correctly.
    - For example, incorrectly reporting and classifying injuries sustained from a fall as moderate rather than severe could deter the state agency from investigating this incident for potential abuse or neglect.

3. Triaging the Incident
Identify Severity - Continued

- Determine if there needs to be follow-up or communication with other affiliated individuals/agencies.
  - For instance, severe incidents may require immediate referral to law enforcement, Adult Protective Services (APS), or Child Protective Services (CPS).
  - Initiating inter-agency collaboration at the point of triage helps set expectations for the investigation stage.
  - Examples of how findings can be communicated are the following methods:
    - Creation of reports;
    - Posted in a centralized system; and
    - Weekly meetings.
- Review any existing licensure or certification actions against providers involved.

3. Triaging the Incident
Timeline for Reviewing Reports

- Identify a timeline for reviewing and triaging incident reports. States should:
  - Determine if critical and noncritical incidents have different review timelines.
    - For example, states can rank incidents based on potential for harm, and require different report and response times for each category.
  - Account for any coordination required with other agencies when establishing the timeline.
    - Licensing and contracting agencies are a primary resource.
    - Utilize other relevant data sources from other agencies that can support or validate the decision to further investigate the incident. Data that may be useful for states are:
      - Claims data;
      - Case management system; and
      - Provider database.

3. Triaging the Incident
Determine Next Steps

- Use the triage process to determine if an investigation is necessary as a response to the incident.
  - For example, an investigation may not be necessary for an individual in a vehicle accident when on an outing with family, resulting in a fracture and a visit to the ER.
  - NOTE: The triage process must be consistent with the waiver language.

3. Triaging the Incident
Follow-up

- Plan on the types of follow-up that must occur during the course of the investigation with the individual, family member/guardian, and provider of service based on incident severity.
  - Critical incidents considered high risk may require immediate, more aggressive follow-up, including:
    - Notifying parent, family member, or guardian;
    - Removing individual from place of incident;
    - Conducting a medical examination of the individual;
    - Taking licensing and certification action; and
    - Taking necessary lawful action.

4. Investigating the Incident
Type of Investigation

- Determine the method of investigation needed for the incident.
  - Incidents may require a combination of desk review (which could include a licensure/credential review), or onsite review.
- Decide the method of investigation by determining the type of information required during the review.

Type of Review	**Description**	**Example of an incident requiring such review**
Desk Review	Document review such as medical records, financial claims, time records, licensure/credential review, person-centered service plans, and/or compliance review.	Reporting of alleged fiscal exploitation.
Onsite Review	Onsite review, which includes, but is not limited to, interviews with staff, confirmation of policies and procedures, and review of systems.	Allegation of abuse leading to fracture treated in the ER.

4. Investigating the Incident
Timeline for Completing an Investigation

- Determine the appropriate length of an investigation.
  - The timeline of an investigation may differ based on severity of the incident, e.g., critical incidents may require a longer period of time due to the need for a more extensive investigation.
- Establish realistic timelines based on required activities of the investigation.
  - The state should consider the time commitment required for different types of investigations, e.g., interviews with stakeholders may require additional time due to availability and other circumstances.
- Establish policies and procedures to follow if an investigation extends beyond the designated timeframe.
- Determine the amount of evidence necessary to take licensing/certification action.

4. Investigating the Incident
Identifying Responsibility

- Identify the agency(ies) responsible for conducting and resolving an investigation.
  - Responsibilities may vary based on how the waiver is organized.
    - For example, the operating agency may be responsible for the waiver, but the SMA may conduct the investigation.
- Establish clear guidelines on next steps to refer cases to law enforcement or external agencies when sufficient level of evidence standards are met for the incident.
  - If the severity of the incident and/or the factors involved in the incident meet the criteria for investigation by an external agency, such as law enforcement officials, coordinate with the referring agencies and understand the role for the investigator versus law enforcement official.
- Minimize conflict of interest by ensuring that the investigator is independent from waiver operations and has no financial interest from service providers.

4. Investigating the Incident
Staff Qualifications

- Ensure that individuals responsible for conducting the investigations are adequately qualified and trained.
  - The state should consider requiring investigators to receive a standard set of trainings so that investigators are adequately prepared to conduct different types of investigations as appropriate and fully understand related policies and procedures.
- Consider requiring individuals conducting investigations to have experience and training and/or have resources immediately available (e.g., nurse consultant, etc.) in areas specific to the incident category.
  - For example, require medical coding and documentation experience or in-depth understanding of such concepts for those who review and investigate any type of physical abuse requiring hospitalization.
  - All investigators should have knowledge of their state's Medicaid system and waiver programs.

4. Investigating the Incident
Safeguards for Individuals

- Establish safeguards for individuals in cases of serious allegations of abuse or hospitalization.
  - For example, if an individual was injured from abuse in a residential facility, the provider agency or state agency may remove all individuals from that setting within 24 hours.
- States should develop a registry of providers that have previously-substantiated instances of abuse, neglect or exploitation, and inform individuals of the list during beneficiary selection of service providers.
  - If an allegation of abuse, neglect or exploitation committed by the provider agency was substantiated, then include the names of the responsible owners and not only the agency name.
  - Registry should reflect any license revocations and any criminal conduct that prohibits Medicaid participation in the state.

4. Investigating the Incident
Process of Conducting Investigations

- Establish policies and procedures for investigators when conducting investigations.
- Define the procedures on how to gather and obtain access to other needed data sources (e.g., claims data, medical records, case management notes, etc.), particularly if it requires assistance from other state agencies or private sources.
- Determine ways to keep invested individuals, families, and providers apprised of the investigation process. The state may:
  - Consider requiring routine updates for these stakeholders.
  - Develop a centralized system, with access given to stakeholders, so that the process and results of an investigation are transparent. NOTE: Provider rights and privacy concerns must be considered.

4. Investigating the Incident
Collaboration with Other State Agencies

- Identify if the investigation requires referral to other agencies or external stakeholders. The state should:
  - Determine a clear tracking process if fraudulent activities or other activities require involvement of law enforcement agencies, APS, CPS, Medicaid Fraud Control Unit (MFCU), or licensing/certification agencies.
  - Establish how findings are established and communicated for instances when inter-agency coordination is necessary for the investigation.
    - According to a recent OIG report, 42 out of 50 MFCUs reported that they are not informed of the outcomes of the cases after they refer the complaints to investigative authorities for non-facility-setting abuse, neglect or exploitation complaints.[7]
- Update all relevant agencies on the ongoing investigations.
  - Schedule regular meetings to discuss cases.
  - Allow all relevant agencies to have access to a centralized system to view the investigation status and report summary.

4. Investigating the Incident
Investigation Results – Burden of Proof

- The state should determine the burden of proof threshold that substantiates an allegation. Such as:
  - Preponderance of evidence (over 50%);
  - Clear and convincing (greater than 51% and less than 75%); and
  - Beyond a reasonable doubt (greater than 95%).

5. Resolving the Incident
Other Resolutions from the Investigation

- Determine what types of resolutions are necessary based on findings from the investigation, including:
  - Corrective Action Plan (CAP);
  - Provider suspension/termination after repetitive convictions of abuse, neglect or exploitation;
  - Inclusion in the provider abuse registry; and
  - Legal ramifications.
- Identify safeguards for ensuring that when individuals are the victims of abuse, neglect or exploitation by HCBS providers, additional services are available to:
  - Treat all injuries; and
  - Provide supports (e.g., mental health professional) for any subsequent emotional/psychological trauma.

5. Resolving the Incident
Determining Monitoring and CAPs

- Determine if CAPs are necessary, based on findings from the investigation. The state must:
  - Clearly specify the goals and objectives of the CAP.
    - For example, the state can require direct service providers to implement policies and procedures to clarify how they will identify potential cases of financial exploitation in a CAP.
  - Determine a timeline for the development and implementation of the CAP.
- Determine how to monitor the implementation of the issued CAPs. The state should identify:
  - Milestones to measure success;
  - Timelines for reporting progress of such milestones (e.g., weekly, monthly, etc.) for CAPs that require ongoing monitoring; and
  - Methods in which implementation will be monitored (e.g., the implementation of an electronic tracking system or phone-calls).
- Evaluate to determine if the CAP ameliorated the issues identified.

5. Resolving the Incident
Recouping Costs

- Determine and establish methods of recouping costs from providers if abuse, neglect or exploitation is substantiated.
- Determine if the incident requires:
  - The offer of a provider appeals process;
  - Imposition of fines;
  - Moratorium on admission;
  - Contract termination;
  - Decertification; and/or
  - Other.
- A backup plan may be necessary for providing alternative provider options to waiver enrollees when providers are under investigation or a CAP for abuse, neglect or exploitation.

5. Resolving the Incident
Communicating Results

- Determine how to share results with other relevant agencies or departments in the state.
  - Inter-agency communication and collaboration is integral in monitoring and preventing future occurrences.
- Identify the method of communicating the results of the investigation to relevant stakeholders.
  - A standard method of sharing results allows for transparency and ease of communicating the results of the investigation.
  - Methods of communication may include the state's intranet, letters or memos sent to stakeholders, or an electronic portal, if available.

6. Tracking and Trending Incidents
Data Collection Priorities

- Identify the trends of interest to the state.
  - Determine what data is available and what needs to be collected.
    - Has the state committed to collecting data they aren't?
    - Is the state collecting data, but not trending or using for quality improvement?
- Determine what types of reports are most beneficial.
  - The 1915(c) Technical Guide, on page 228 suggests gathering information for system-wide oversight, including the following:
    - Participant and provider characteristics;
    - How quickly reports are reviewed, investigated, and followed-up; and
    - Results of the investigation.
- Identify how often and who will receive the trend analysis reports (e.g., Ombudsman office, disability office, etc.).
  - Identifying common or reoccurring incidents will help the state prioritize what data to collect.

6. Tracking and Trending Incidents
Data Collection and Analysis – Part 1

- Determine the types of analysis to conduct from the collected data such as:
  - Recurring deficiencies;
  - Types of incidents;
  - Types of providers/provider analysis;
  - Location of incidents;
  - Alleged perpetrators;
  - Investigation findings of:
    - Outlier incidents;
    - Abuse, neglect or exploitation;
    - ER visits/hospitalizations;
  - Incident resolution timelines; and
  - Other medical findings

6. Tracking and Trending Incidents
Data Collection and Analysis – Part 2

- Identify the types of data that need to be collected and tracked.
  - Sources of data:
    - Findings and recommendations from previous investigations;
    - Previous unsubstantiated incidents;
    - Current CAPs and status of CAPs, if applicable; and
    - Clinical claims review.
  - Types of data to collect from the incidents include:
    - Initial incident reports;
      - Type of incident;
      - Alleged perpetrator and victim;
      - Treatment;
      - Timeframe; and
      - Other.
    - Findings and recommendations of investigations;
    - Unsubstantiated incidents;
    - CAPs and status of CAPs, if applicable; and
    - Clinical claims review.

6. Tracking and trending Incidents
Data Collection and Analysis – Part 3

- Determine how often data is aggregated and analyzed.
  - States should commit to a regular schedule for aggregating and analyzing findings and trends of the incident management system that is no less than annual.
  - This will require the training of staff to conduct the analysis of the findings and identifying trends from the incident reports.

6. Tracking and Trending Incidents
Interventions and Safeguards – Part 1

- Identify areas of improvement to address adverse trends and patterns.
  - Page 228 of the 1915(c) Technical Guide states that “a critical element of effective oversight is the operation of data systems that support the identification of trends and patterns in the occurrence of critical incidents or events to identify opportunities for improvement and thus support the development of strategies to reduce the occurrence of incidents in the future.”
  - The state may need to implement corrective actions to address adverse trends and patterns.
- Consider establishing interventions that are proactive.
  - For example, an alert sent to all providers at the beginning of summer to remind providers to not leave individuals alone in vehicles.

6. Tracking and Trending Incidents
Interventions and Safeguards – Part 2

- Identify performance metrics as benchmarks that guide incident management activities. The state can:
  - Use the Quality Improvement System (QIS) Appendix G standard requirements highlighted in the 1915(c) Technical Guide to develop metrics that are appropriate for their waiver program.
  - Update the CMS-372(s) report with any performance metrics related to incident management and Appendix G that demonstrate deficiencies.
- Regularly conduct audits of the incident management process to determine the efficacy of implemented activities.
  - Results of the audits should be made available to CMS at least annually.
  - CMS will offer technical assistance upon request.

6. Tracking and Trending Incidents
Interventions and Safeguards – Part 3

- Use the data to identify training opportunities for stakeholders to help prevent and mitigate incidents from occurring, including:
  - Trainings around risk factors to help individuals identify and mitigate situations that could potentially lead to an incident.
  - Trainings to help state agencies address any adverse findings from trend analysis and reports.
  - Trainings to assess proper compliance with trend analysis findings and CAPs issued to address adverse patterns.
    - For example, training providers who render services to elderly individuals of appropriate interventions to prevent falls. NOTE: Ensure you complete a follow-up analysis to determine if the training adequately addressed the issue.

6. Tracking and Trending Incidents
Interventions and Safeguards – Part 4

- Conduct outreach to stakeholders based on findings from the data, strengthening collaborations in identifying, reporting, tracking, trending, and preventing incidents.
  - The 1915(c) Technical Guidance provides an example on page 228, that if the state's APS agency has primary oversight responsibility, the state's APS agency is responsible for sharing and communicating incident information shared with the SMA and/or operating agency.
  - Stakeholder participation is necessary for ensuring a comprehensive approach to gathering data regarding incidents.

Summary

- A robust incident management system will help ensure the health and welfare of waiver individuals.
- States should reference this training and the 1915(c) Technical Guide when considering improvements to their incident management system.
- States should identify clear definitions, policies, and responsibilities for parties involved in the incident management process and provide continued training to prevent future incidents.
- It is CMS' intent to provide further guidance on this topic.

References

1. Department of Health & Human Services CMS. “Modifications to quality measures and reporting in 1915(c) home and community-based waivers.” March 12, 2014. Available online: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/3-cmcs-quality-memo-narrative.pdf
2. Department of Health & Human Services Office of Inspector General. “Connecticut did not comply with federal and state requirements for critical incidents involving developmentally disabled Medicaid beneficiaries.” May 2016. Available online: https://oig.hhs.gov/oas/reports/region1/11400002.pdf
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5. Government Accountability Office. “Medicaid assisted living services – improved federal oversight of beneficiary health and welfare is needed.” January, 2018. Available online: https://www.gao.gov/assets/690/689302.pdf
6. CMS Disabled and Elderly Health Programs Group. “Application for a 1915(c) home and community-based waiver – instructions, technical guide and review criteria.” January 2015. Available online: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf
7. Department of Health & Human Services Office of Inspector General. “Medicaid fraud control units: investigation and prosecution of fraud and beneficiary abuse in Medicaid personal care services.” December 2017. Available online: https://oig.hhs.gov/oei/reports/oei-12-16-00500.pdf

Additional Resources

- Copies of the HCBS Training Series – Webinars presented during SOTA calls are located in below link: https://www.medicaid.gov/medicaid/hcbs/training/index.html.
- 42 CFR § 441.302 is located here: https://www.gpo.gov/fdsys/pkg/CFR-2002-title42-vol3/pdf/CFR-2002-title42-vol3-part441.pdf
- Social Security Act § 1915(c) is located here: https://www.ssa.gov/OP_Home/ssact/title19/1915.htm
- The 1915(c) Technical Guide is located here: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf

Questions & Answers

For Further Information

For questions contact:

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SOTA Feedback Survey

- Please go to the following survey in the link and give us your feedback on this SOTA call:
  - https://www.research.net/r/IncidentManagementSystem101