Okay, it looks like we are at 2 o'clock, so we will get started. Good afternoon, my name is Elaine Sayer, and I am a Policy Associate with ADvancing States. On behalf of ADvancing States, I would like to welcome listeners to today's webinar on Critical Incident Management: Core Elements to Enhance Your Approach. Before we get started, I will cover some housekeeping items. So the slides, audio recording, and transcript from today's webinar will be posted to the ADvancing States website within the next several days. Please visit the website and see our webinar page. The web link is posted in the chat box for your reference. All listeners are muted during the webinar to reduce background noise. We welcome your questions and comments through the Q&A function available on the right-hand side of your screen. Please feel free to submit your questions at any time during today's presentation and we will address questions following the presentation. We also have real-time captioning for today's webinar. On your screen, you should see a multimedia viewer panel on the right where the captioning will appear. You can minimize this panel or have it open, it will not block the slide presentation. You may need to enter the event ID number to see the captioning, so I will give you that number now: 4349823. I will post that in the chat box as well. So, our prsenters today are Dustin Schmidt and Associate Director of Healthcare at Navigant/Guidehouse, and Dr. Jay Bulot, Vice President at WellSky and former board president of ADvancing States. I will turn it over to Dustin and Jay to get started.

Thank you. Dustin will drive the slides for the first portion of this. Thank you everybody for listening into the webinar today on our part two critical incident management. We did a webinar back in November that is on the ADvancing States website. It is kind of a prequel to a deeper dive based on some of the questions that we received. Both of the HCBS conference as well as during and after our last webinar. As Elaine said, I am the former board member and president of ADvancing States, I was also State Director of Aging Services in Georgia as well as Louisiana and worked with a lot of the states throughout the country on critical incident management issues, services, guardianship, and worked through my role at NASUAD with CMS on a lot of these initiatives that were being developed. I will do a quick intro and then we will dive into the core elements as a quick refresher.

Thank you. Excited to speak with everyone today and to share some of my experience on critical incidents. For critical incident management, I have supported several states Medicaid agencies in redesigning and improving their incident management system. Those are the experiences we will speak to today. Glad to be here.

As basics, a lot of you already know some of this information. Back in 2014 or so, CMS started devoting more attention and resources to the health, safety, and welfare of the population through the Medicaid program. ADvancing States as well NASDDDS, NAMD, health associations, all participated early on and some of these discussions about the need to provide better oversight, even insight into abuse, neglect, exploitation, or simply the bad things that happened to the folks we’re responsible for providing care to. Hence started the movement towards data reporting and having to have systems around critical incidents management, and even to date, CMS has not defined what a critical incident is. They defer to

states to define what a critical incident is for that particular state and those waivers that they administer. Suffice it to say their situation to put the health and safety and welfare provider present at risk. Some states use critical incident, some call it adverse events, some include a variety of actions or events that occur for the Medicaid population, including any, unexpected death, hospitalizations, elopement, medication errors, restraint and seclusion's and the list goes on. Again, each state is responsible for defining its own critical incidents.

CMS mandates this for states to have a critical management system in place, and the state has to have a "system" around tracking and improving and reducing incidents of critical incidents within their population. So, I guess the nuance there is a system, in CMS' perspective, does not necessarily have to be an electronic data management system, but you have to have policy and procedures and actions around what your process is to ensure that you are providing and identifying incidents as they happen, and reporting them to CMS. So. it is identifying, seeking to prevent abuse, neglect, and exploitation, and you have systems in place to effectively resolve further incidents from happening.

In your state, likely, if it has not happened already, you have gotten a lot of attention from DC on your critical incident management system. Probably the last three years, we have seen increased oversight leadership, guidance, and even audits of critical management systems. Less than a year ago, we have seen OIG and ACL provide roadmaps for states to improve their systems, OIG released a guide for how states can use diagnosis codes to identify unreported instances of abuse. In 2020, OIG released an audit of Pennsylvania's reports on critical incidents. You go through the OIG website, and do a search for all the different audits that they have done of the states' critical incident management system. Eight or nine audits have been done. Some have been under corrective action around your management process. Even more states have shared with Dustin and I, as well as our federal partners, on the difficulty you have in managing and creating and getting the buy-in across your states to create what is the best practice for a critical incident management system. CMS has stepped in and did a survey of states to see where they were with their reporting on the health and safety welfare measures. They created a special review team that is working directly with states on improving the health and welfare issues among the population, and then CMS has also done three different state visits in the last fiscal year.

So what is next, I know Dustin on my end, we are getting a lot of questions from states on how to start moving and implementing effective systems, quality improvement initiatives around their reporting, oversight. We expect CMS will release high-level results in the next year from the survey that was done of the state Medicaid agency. And then CMS has stated they plan on visiting 15 states in 2020 and providing initial training and support, and then we expect because the findings so far have all found a lack of process, lack of oversight, and in some cases, a lack of entire systems. We expect OIG will continue to do audit around critical incident management.

I think one of the interesting things for this year is it gets on CMS to start providing guidance to states, not only doing these audits, but giving states a better direction on how to move forward with critical incident management. And they are doing that by interviewing and having a deeper dive with states that identify as best practice. The other thing, which I anticipate CMS will send later this year, this is what they shared with us at the HCBS conference last year, was high-level results from their statewide survey so they did a pilot, now it is statewide. I guess my take on that is I think the statewide survey is going to tell them what they found in the pilot, which is every state has different protocols and procedures in place, so it will be an interesting year to see what CMS is able to provide.

Okay.

For the next 40 minutes or so, we will go over from both CMS as well as best practice states, what we found with states who have successfully implemented critical management, what we are calling the elements of the management system and we will start off with discussing policy, why it is important, recording, state review, or the state review process investigations, and quality improvement. I will hand it over to Dustin to start talking about policy around critical incident management.

Thank you. As Jay mentioned, this schematic help us with the entire approach to critical incident management and policy design looks like, from what the policy says reporting to what the state does with that information to support future decision-making and change. For each of these elements or steps, what we will do is provide a basic overview, and provide examples of how other states approach these elements, and then we will provide some of our recommendations as well as some recommendations from CMS and OIG.

So let's jump in. So the first component here in my opinion is probably the most important, since policy is really what dictates how everything should work, and it sets the foundation for what the incident management system is meant to do. I often see and work with states who try to go in to improve their incident management system simply by just trying to plug-in an electronic system and while the electronic solution or system will immediately help the state with tracking and data analytics and so forth, it really the foundational component that the state needs to figure out first is what the policy is because the state does not have good policy, that the state is typically looking at data. We identified 10 key items to include a state policy manual, and I will not touch on all the items in bold, just because we have those items covered. We don't have further discussion on those, I will touch on them briefly.

One thing that is interesting from a policy perspective is how states describe incident reporting in the licensure or certification materials, so a lot of times, the state will use that as a mechanism to issue financial penalties to providers. A lot of times we will see a certification standard or licensure requirement is staff training or requirements that the provider has adequate policies and procedures in place to support incident reporting. Another area of interest that is important for policy is protocols for the state agency review and

investigation. Typically what we will see is the state will have a broader policy that it has externally that shares with the provider community, but it has an internal policy that helps describe its internal processes and mechanisms, and that could be, I think an important element to consider for states is what those key components are that trigger the state to go in and do a review investigation.

Mortality reviews, another hot topic. I will not touch on that one. That one is probably a separate presentation, but the OIG report that Jay mentioned, that they did with ACL, back in 2018, that provided some good structure and guidance for states on what to look at for that.

Rules governing noncompliance, this is an interesting thing that states will do is try to figure out, looking at the requirements that the state has, which of those requirements may trigger a penalty or a corrective action plan, so it is important for the state to a head of time identify what those certain trigger our and penalties and requirements that they do as part of the certification processes. Another important consideration is having a general understanding of how all of this data from your incident management system ties into your 1915c waivers. Within the 1915c waivers, I am sure a lot of you are aware, there are different waivers for performance measures the state has to report on, so it is important for states to look at those measures in comparison to have they have the incident management system structured.

The most important policy decision in my mind is describing which incident types the state would like to request from its providers. The incident types that the state selects is such an important decision because it dictates what information comes into the system and if a state has what I have seen, if a state has too many incidents, this will overwhelm its system, so that means overwhelming the reporters and reporting in the state staff in reviewing the information so it is important to get this step right and to identify where there is balance in the system.

I will give a quick example of maybe not having the right measure. We work with one-state that had, they reported an incident is anytime a referral was made to Adult Protective Services, so the CI team was getting 50-60 reports a day every time APS received a referral, and most of those did not result in an investigation, most of them were individuals who were seeking information on the unmet needs a person might have with a meal, a senior center, and ultimately, the state had to go back and work with their critical incident review team, their waiver team, as well as protective services to narrow that down to those critical incidents that were being investigated or that had a high likely to be substantiated to limit the volume of noise coming into the system.

Another consideration for states when you are trying to figure out which incident types you want to be reported is to look at the incident types that are identified by CMS in its technical guide, and then to also pull your data and look at what the data is telling you. When we went in and look to the incident data for one state, we found that right around 50% of the information that they received was not even information they were

interested in. So it is important to look at what CMS is doing and look at what is actually coming into your system.

And then in this slide, what we are meant to highlight is CMS guidance regarding how to identify incident types and the key recommendations are so define your incident types, it is important to not only identify what the types are, but to include definitions for providers as well as examples that will help support reporters when submitting information back to the state. A second is identifying which incidents are truly critical, so some states communicate this externally and others do this internally, so some states may have separate incident buckets for critical and noncritical and others might do this prioritization internally. My recommendation here is that if the state has limited resources and bandwidth, it should really only ask for what is critical, so when requesting noncritical, it is important, but the state has to go back to what we were referring to, this has to go back to whether it is actually able to review all the information that is submitted. I think the expectation from providers is if they're reporting information to the state, that the state is doing something with that information, so oftentimes what we will see is noncritical incidents are being submitted, the state is not doing anything with it, but it is still requiring providers to take action.

The third is determine how the state will take action to reportable incidents in which incidents require follow-up. So, this is really about having structure in place that describes what action should be taken when an incident comes in. It is important to know that not all the incidents may require a follow-up. An example is minor injury, and while the state may collect this information, it does not necessarily have to go out and do a separate investigation, but it still finds that the noncritical is still important because a lot of times what it will do is identify if there are systematic issues going on. And a good example of that is one state that I work in, they require a certain noncritical, like minor injury because if that noncritical occurs three or more times in a 90 calendar day period, that then results in a critical, so essentially, what they are doing is asking for a noncritical, but if they are identifying this keeps reoccurring, they are flagging that as critical, which then requires different follow-up actions from the state. Another key consideration is to clearly communicate what you do not want, and so it is important just to look at your incident data and to flag and identify for providers what you all do not considered to be critical incidents, and the one state that I work in, a lot of this information that was coming and that they did not want was related to scheduled medical procedures or surgeries.

Another important policy decision is to define who is involved and this helps reduce duplication of efforts and to improve coordination and there are so many parties involved that it is important to clearly define who is doing what and so just to give you a sense of the parties, it typically involves adult or child protective services, law enforcement, direct service providers to Medicaid, case managers, and the licensure agencies, so there is a lot of folks involved in this process and is important for the state to define who is responsible for doing what. Some key decisions to think about here, who is responsible for completing a

critical incident, this is probably the most fundamental question and it is important to know one thing that completing an incident report is different from notification, so states often have different requirements for notification, and states may have different methods for notifying, which may be verbal versus reporting, which is typically sending in an actual form, which we will talk on in the next slide. Back to the original question, who is responsible for completing a report, in terms of formal reporting, this is often on the direct service provider, or the case manager depending on who witnesses or discovers the incident first. Another key decision point is who is responsible for notifying other parties, so the station have a policy that describes who else needs to be notified when an incident occurs, and so this often includes Adult Protective Services and even the medical provider, if the incident involves medication.

Go ahead.

I was going to say, this is a great opportunity for those states who are still trying to figure out how to involve the other sister agencies in the states, or other partners on the critical incident management process to help define what those roles are and invite those individuals and as you develop policies and procedures around each agency and each type of role and responsibility and discuss what is needed, why it is needed, reflect upon CMS guidance, why is the Medicaid office reaching out to APS or CPS, why are we involved in this, to start building that relationship to let them know this is not something you are doing that causes more work for that agency, but there is a need for others to be involved in this process and to have a formal role in it, which is oftentimes appreciated once the protective service agency understands what is being asked for and how that benefits them in the job that they do.

I think notifications, it is tricky because if a state does not have an electronic system, then it is very manual and it can get really messy. If you have an electronic system, that is where all these different parties can see the system, but if the state is just collecting this information via a fax machine or email, then requiring the provider or reporter to notify all these parties, it gets messy and it is hard to track for the states. Third decision point is who will investigate, so this often involves multiple parties, including the direct service provider, the state Medicaid agency, Adult Protective Services and licensure agencies, so it is important to establish relationships across all these parties to define who will do what. The fourth item is who is responsible for provider action plans and sanctions, so each state agency has different levers that it can pull, but I often see the agency responsible for licensure certification coming into issue penalties because they are able to identify failures and their certification requirements and entitles them to financial penalty. So every agency may have a different point of view and perspective when looking at these things, so it’s important to coordinate across agencies.

It is important to note that not every state will encompass their survey and certification-type agency into their ciritical incident management, there may be a separate process for that. Although, we recommend a comprehensive approach so you have full visibility of what is going on

across the entire state. Some have a critical management just for the waiver population, and something separate for nursing facilities and other healthcare providers.

My last point on this is so we added some screenshots throughout Kentucky and Massachusetts that describe roles and responsibilities. This is to provide a visual regarding what this may look like in the policy manual and I think it is important for states even if you won't have this defined to look at other state examples because it is important to have a perspective on what other states are looking at and they may have some certain entities that they identify that might be helpful what the state is looking at.

Another key policy decision is the timeframes for reporting review resolutions. So, time frames can really be bucketed into three categories: you typically have a verbal notification, which is calling either Adult Protective Services or the state Medicaid agency, then you have a report submission and this is often in either an initial intake form and then a follow-up form, and the follow-up form is usually an investigation form, it informs the state as to what the reporter found as part of its review, and then the third is state reviews. This is the initial intake that the state does as well as any follow-up that it has to do, so states are typically required to provide in their 1915c waivers to CMS what its timeframes are for reviewing the initial incident and then as well as conducting any types of investigations that it determines are needed. We included screenshots from states to help illustrate what this may look like, so Kentucky includes some reporting requirements around notification, which they considered to be verbal or email, and then reporting, which is actual report template that is sent into the state. Go ahead.

I was going to share, the important note is that, in a lot of the OIG audits, or several of them anyway, while the state had effective systems in place, they did not have very good documentation of their process or policies around how they did it, so what often happens is when you receive an audit, whether it is an audit by OIG, or a couple of our state partners are undergoing right now is state audit by the state auditors about their program performance, they are looking at your policies and making sure your policies reflect what your processes are and that they are being followed, and CMS takes the same approach. What you said you were going to do is what they are going to hold you to, so you need to have well fleshed out policies and procedures that are actually being followed.

I think it is important, a lot of states I work with have their process described in their waivers, but I think it is important in the waivers to describe things at a high level, and then kick over the actual details of what you all are doing or what the state is doing in a separate manual. I think there is value, based on what is happening with your data and what you are hearing from providers to have flexibility around what the state’s is able to do because the state should be on a regular basis making changes to its approach based on what is happening, either through incident data or what it is hearing from providers and so forth.

Flexibility is key, and then the state having a separate manual is important.

On this slide, it is important what we are trying to illustrate is to understand who will interact with this system and understand how critical incident reporting for HCBS systems relates to some other requirements for MCOs, hospitals, and nursing facilities, and the state should consider and review these requirements and determine how it interacts with the waivers, so all the reporting requirements may be different, so it is important to look at things holistically and determine if there is opportunities to streamline reporting across provider types and programs. In terms of incident definitions, it is important to see how APS and CPS define abuse and to make sure that does not conflict with the HCBS waiver standards. It does not make sense to have a provider have two different interpretations and have to report two separate times to the state, which can be time-consuming and a burden on state staff and providers. Any other items you wanted to highlight, Jay?

I think that is good. Maybe highlight and reiterate, make it easy for providers, you know, the providers probably have the most difficult job in the critical incident management system, especially when they are working with potentially four, five, six different waivers and each of those waivers may have different language that requires reporting and not reporting, and it is incumbent upon the provider to understand which waiver it is, but when you are balancing and managing that many different potential points of reporting, it becomes really difficult and it is almost like a double jeopardy for the providers where you want to do the right thing, you want to report and you may miss because it was an individual who was 18 on a disability waiver, and you thought there were 18 on a disabled adult waiver, and he did not report it the way you should have an state comes down upon you with corrective action, so as you go through your process, your waiver documents, and your critical management system, look at ways to streamline, simplify and standardize your reporting, so it is easier for you to talk about it to the public, it is easier for the public to understand, easier for providers and then you interpret the data as it is coming in.

Now moving on to the second element, which is reporting, and this is a step where the individual that witnesses or discovers the incident and reports the incident to the state, and at this step, reporting is basically submitting a template back to the state that describes the incident event, and in some cases, what action the reporter took to mitigate future reoccurrence. And all state reporting templates are different, but there are some commonalities across, including the incident type, description of the incident, and reporter information. Our recommendations, which align with some of the CMS recommendations is offer multiple avenues for reporting, so this can be, the best approach to reporting his having an online web-based system that makes it easier for providers, but also have a call center where folks can call in to make the report, but then follow up through the electronic or whatever reporting template the state uses to send in information. Some states will have the option of faxing, but I would not recommend that just given the amount of time that this state spends just having to interpret information that is coming on via fax when all of that stuff can be

streamlined either on a web-based, which is preferable or even email or you can copy and paste certain information into whatever tracking to the state is using.

The second is if the state is using electronic systems to have drop down's, this just makes it easier for the data analytic piece, so if there is a drop-down, the data it is in a format that the state can use to perform different metrics and so forth. So, allowing free tech and time, for the incident description, but I would propose the states to try to limit that whenever possible.

Just some key components to consider in an actual incident reporting templates, the first is the individual impacted, the reporting source, incident information, notifications, so who the reporter told and when, that kind of comes in place with the states policy is around who needs to be notified when an incident occurs. Who the alleged perpetrator or witness is, and then an interesting component, which I think a lot of states are starting to look into is risk mitigation sections, so this helps describe what the reporter did to help mitigate the incident and how it plans on preventing future reoccurrence, so it is important to get the providers take on what it plans on doing to reduce future incidents.

We wanted to highlight three unique fields that we saw from states reporting template, so Kentucky has the risk mitigation section, which I talked about. Colorado, we see a lot of states do this, so they have an additional breakdown of their incident types, which I think is an interesting take and gives this state a little bit more specifics on what happened, and I think the more specifics you on the incident type may reduce the amount of free tech you have for the actual description, so it is an interesting approach to collect information, which obviously, I think you can only ask for this level of detail if you have a web based or electronic system. Massachusetts asked for the body part affected by the injury, I am not sure how the affected body part is used from a data analytic risk perspective, but I think it is an interesting component to capture.

So now we are moving onto when the state receives the report and what action it takes. In this slide, we include some CMS recommendations for reviewing an incoming incident and I will not review all of these, but I will hit on the main takeaways here. The first is staff training is important, so the folks that are reviewing this from the state need to have adequate training to better educate them on what a critical incident is and what actions they need to take when they are reviewing. The state should also have detailed protocols for how it conducts its review, and I think, honestly, a good resource for states to leverage and look into is to look at the materials that adult protective services and child protective services have. A lot of states I have worked in, the state Medicaid agency may not have those detailed protocols, but what they can leverage is a lot of the investigation tools, protocols, Adult Protective Services has in place, so it is interesting and important for states to look at what it already has available and potentially leverage those documents.

I will add, it is important to understand the terminology of language that APS uses because in health facilities and licensing, what might be considered report or investigation may differ somewhat from protective services, so it gives you one more opportunity to understand the processes a little bit better and what standards they used to substantiate an investigation, and what results in follow-up, what results in somebody moving into ongoing services and how that aligns with your waiver operation, and the delivery of home and community-based services.

From a data tracking perspective, so what we recommend that states collect is at the very minimum, so the name of the reviewers who are doing the review, the date the review was completed, and the most important component is tracking the resolution of the incident, so really, this is how the state is closing the incident, so it is good to have an ability to close out an incident and to have clarity and to what action the states have, which could be no action, it can result in an investigation, a corrective action plan was issued, or it could be the state is providing some sort of technical assistance to support the state in better understanding its requirements, and this could even end in termination. And to help with this looks like, we include a shot of what Massachusetts tracks for follow-ups that it does for corrective action, and so I think the key take away here is there is a lot of different areas where the state can go in and start tracking. This can be from the initial review when it does its first review to when the supervisor does its review to when it does its investigation to any type of cap follow-up or corrective action plan follow-up, and there are probably likely other steps the state may want to track from a resolution perspective, but there is a lot of different areas where the state can have tracking mechanisms, all of which are important.

I will add on the state review component, the process may look differently depending upon if you are a state that has managed care and does not have managed care and what you delegate to the health plan around the MLTSS program, but the state should have insight into what is going on in critical incidents, so we have worked with states where I would say 80% of the critical incident review process was delegated to the health plans, and in a particular region of the state, and the state have little insight into what was being done, what was being reported, whether there were these corrective actions, and as you go through and are designing or redesigning or improving your processes, if you have managed-care in your state, that the state has direct insight into the critical incidents going on, reviews, the reviews that have been done by the MCO, may delegate some aspect of the investigations to the plan, but retains a larger role in approving the processes and recommendations.

That ties in nicely to our next slide, which is investigations. Up to this point, the incident report was being submitted to the states, the state does its review, and now we are at the investigation stage, and by investigation, I mean who is responsible for incident follow-up and providing recommendations for how to prevent future reoccurrence, and so as Jay mentioned, some states may actually take on the investigation role in some states may rely on the provider agency's performance on investigation. If the provider agency is performing an investigation as

Jay mentioned, it is important that the state get those results back so that they are able to determine whether any additional follow-up is needed. And one thing that I will highlight here from the joint OIG and ACL report is what they say is if the state, so the state can delegate investigations for other incident situations, but it should do an independent investigation for specific incident types, including unexpected death and sexual abuse, so I think for abuse, neglect, exploitation, that should fall on the shoulders on the state and oftentimes, it is already being investigated from Adult Protective Services and Child Protective Services if it meets their acceptance criteria, but from a state's perspective, it needs to focus on these critical elements.

Some other recommendations around investigation, I think the most important piece is establishing those policies and procedures for the investigators, so that can be the providers they are on the hook to do that as well as the state staff. It is important to have a reporting template or follow-up template. We have seen a lot of states have those, so it is a reporting template that the provider will send typically between 10 to 14 days later that outlines what action steps it took and what its findings and outcomes of the investigation was, so it is important for providers or the state to have some separate standardized template they can use, and to take that data that is flowing into the template and use it for data analytics is key as well.

Another area that I think a lot of states struggle with is how to share results of investigations, so a lot of times, APS and CPS, depending on what the state laws and regulations are, they are limited in what they can share, but I do think it is important from a notification perspective that the participant that is involved from the incident, that they get clear information from the state as to what happens from the results of the investigation the state took, and what outcome it determined. In the last piece, understand how data can be shared. This is complicated, but an important conversation to have with all the parties involved, and it is important to, I see a lot of states do this, they establish a memorandum of understanding with Adult Protective Services and Child Protective Services so that the investigations that they do and the results from that is being shared with the state Medicaid agency, and this obviously is all dependent on what the regulations say in that state, so it is important for the state Medicaid agency to have an understanding of things that are directly impacting its participants as well as the providers involved. A lot of times, the state Medicaid agency will have different levers that it can pull, especially when it is certifying and licensing these providers, if there is an issue identified from an investigation that ties to an actual employee, then it can take different action that adult and child protective services may not be able to. Alright Jay, I think you are taking over.

I wanted to share several states use different ways in which they do their investigations on the state side when a state is looking at critical incidents among participants or providers and one of the benefits of having a comprehensive incident management system that brings together all different waivers, all different settings of care, nursing facilities, hospitals, case managers, direct service providers is having

a really good, or having really good visibility into what is going on, both at the individual recipient service level, but as well as folks who are providing care. So, several states use something called a prior involvement review where they are able to look at not only the victim or the person who was injured, but also all the other times in which they had a report of some type of critical incident, or if they have integrations with the adult protective services, how many times APS has had some interactions with that individual that are also flowing down to a provider, so the prior involvement report for provider, how many times has that provider been included in critical incident reports, how many consumers were involved with that provider. It gives the state a lot more insight in order to develop really good quality improvement initiatives, both in parts of the region, as you can see are with individual providers when those providers tend to be the ones who may be more than an average of number of reports affiliated with them through a prior involvement review and those states you work with their APS really closely recognize that some of this comes from the NAMRS reporting to get from the personal level on perpetrators, and folks who abuse other adults, whether they be licensed providers, caregivers or just individuals, so you are able to track individuals across the state when they involved in abuse neglect, and exploitation.

So, the next section is the outcomes piece, so we talked about policy, which drives your entire process. Every one of these pieces that we talked about so far, the roles and responsibilities should be defined somewhere within those policies, who is responsible for certain activities, who is responsible for reporting, what's the state's role in delegating and identifying an investigation, once the investigation becomes done, what happens as a result and that is when we start getting to the outcomes piece. As we mentioned earlier, CMS has an expectation that states take an active role in mitigating the risks associated with critical incident, those risks again are the systems themselves defined by the state, what is important to the states they are providing care to, and then there is the process built around measuring incidents, what the outcomes are, what happened as a result of the incident, and then what outcomes are we going to be looking at to improve going forward, so how do we reduce the future risk among this population and how do we determine whether it is a systemic issue, a regional issue, or a provider level issue.

That gets back to the investigation, how to we close the case. How do we define the closure, was it, do we use APS language, do use Medicaid language, do we use some other agency that has some experience in defining what constitutes a critical incident that was addressable, and to reduce those risks, and tracking? Do we determine whether follow-up is needed and how to do those follow-ups attract? So a follow-up investigation, we have corrective action plans. Those plans should have a really well thought out deliverables for the provider or the case manager, or the MCO, with measurable timeframes associated with them. When will certain activities be done, and the folks who are managing the system are following up with the agencies corrective action, the providers or all the providers in the region if it is something going across the entire region, on their corrective action plans, what progress is being made. And then if we do not see the progress and you have the

processes in place, not every state does have processes in place, you determine whether you recoup funds, penalties are applied to those providers, or whether the state has to make a decision to no longer allow that provider to be a Medicaid provider or whether it is in HCBS provider, if it is MCO, whether that MCO can continue to be an MCO for the Medicaid waiver population. Here is a sample in the screenshot there from Iowa where they have specific resolution criteria that they have identified, who reviewed it, what actions were taken, and spend timeframes in which those investigations were closed, and the outcomes as a result of it.

Out of all the states I have looked at, I really like how they bucket these different categories. They have an employee or staff perspective, where there are changes that are needed, things that impact the member involved in some type of environmental issue, equipment and supplies, it is an interesting way to bucket resolutions. I like the level of detail here from a data analytic perspective. Obviously, I think this is something that can only be captured in an electronic solution. I think it is interesting.

Also, here, several states have identified, I guess I will call them sub outcomes within their critical incident management system. For example, one state looked specifically at falls, and they have an entire outcome and assessment system when somebody has a falls as part of the critical incident management system where they are doing an investigation of the fall, what caused the fall, what could have been done to mitigate the fall and recommendations for the family to implement to reduce future risk and that was a trigger that happens is the critical incident was a fall with an injury that resulted in a hospitalization. So, a pull aside, this is extra, not only on our critical incident, but this is a specific protocol be have in place for individuals who are receiving waiver services who had a fall with an injury.

We only have 10 minutes here.

Luckily, we are almost done with the important stuff.

So, the analytics piece. This is one of the most important pieces not only for the state because the state has to have an idea of what it’s managing, and when I talk about the state here, we are talking about the state Medicaid agency because, ultimately, they are the entity responsible. Some state Medicaid agencies had delegated some portions of critical incident management to waiver operating entities or MCOs, but ultimately, it rolls up to the state level to ensure it has a system in place to impact the entire state, individuals who receive home and community-based services and that they are tracking and monitoring critical incidents to identify trends, to identify whether this is a systemic issue across the entire state or whether it is a regional issue, whether it is something happening in one part of the state or with one provider and that is where your reports come into play. The data you are collecting you should be looking at and using on a regular basis. Best practice states have a monthly cadence where they have individuals from different parts of the agencies involved where they are looking at trending the critical incidents, they are analyzing the data, they are

identifying the thresholds internally for what requires corrective action by Medicaid to make some changes on how we deliver services, not in the CMS corrective action, how do we make quality improvements and improve outcomes. Then, with mitigation strategies, talking to providers, sometimes talking to a family member to find out what could have been done to reduce the risk of a fall, whether it was done by a family member or stranger, what could the state have done, and then they push policies, they change policy, they change procedures from the state level to the providers to ensure that going forward we have mitigated this type of risk for the population. You can see in the next slide, here are some examples of how states have used some of the data they are collecting to make some of these improvements.

This is one, looking at regions, this state had regional case managers who had a large role in the critical incident management process, so they were looking at reportable incidents by region and then they also looked at serious reportable incidents by region and that is how they defined these and they looked month to month and they looked year over year to see if they were making progress. As far as their trending for reportable critical incidents. For the next slide is looking at provider compliance, so this is a state, looking at all the providers in a particular region, seeing how many of them when they made a report, they made the report within a 24 hour timeframe as defined in the policy. As you can see, there were eight regions in this state. Region two and region six might be a region the state want to look into because region two had a large number of reports overall and a large number of providers that did not make reports to the policy. Same with region six, and the data would be looked at on a monthly basis, on a quarterly basis, annually, and year over year to see if you are trending in the right direction. You want to see the trend go down as much as possible on provider incompliance.

And this is on the state side on investigations. These are the states who did their own investigations. This is a report that they run on percent of critical incidents with investigations initiated within 24 hours. Their policy indicated that for a critical incident, they had to initiate the investigation within 24 hours of the report. They received the report, assessed whether it was a critical incident, and the investigation was initiated and this is a quarterly report that is run and you can see the trending, 60 to 70% one month, 44%, 2018 and 71% were initiated within the policy.

And this is one on another state looking at the types of deaths. This state tracked natural causes anticipated, natural causes unanticipated, accidental, homicide, suicide, and undetermined and they built quality improvement measures around these data where you expect to see a norm expected death or anticipated death, but when we have these unanticipated deaths, homicides or suicides, the state may need to take additional action. So our recommendation, the multidisciplinary critical incident review team, look at the data that is being collected around your system, around critical incidents to review the incidents, identify trends, do we need to make changes to our investigative techniques, are there corrective actions effecitve? And that team influences the policies that then get changed or modified to mitigate risk for the future. That is a continuous process, one of the statewide quality improvement initiatives.

The state could also formalize the process for recommending system-level changes. If the data indicates there is a need. At what threshold does your state identify that this is a systemic issue? When more than 5% of the population is experiencing this type of critical incident. Is it when a number of providers reporting these incidents and how do you receive approval for those types of system-level changes?

We also recommend that states look at developing a critical incident to report quarter dashboard. Dustin and I have worked with states where we are collecting 90 different variables in their waiver program, and the states essentially in paralysis because they did not know how to look at and use that much data, so figure out what the most important aspects of your critical management systems are, whether it is all the incidents to get an idea of how many are being recorded across the state on a regular basis, and what are the ones that need action by the state? Unless they get above a certain threshold, they are not included in what does your trending look like?

Report cards make it easy for leadership, for managers for supervisors to understand what is happening across the state or across the region, and to drive some of the changes that might be necessary to support some of the changes that might be necessary, but for impact they hold a slew of providers across the state. Based on the data, determine when is the need for a change in policy and process.

Lots of different ways you can implement that component of it. Implementing CQI (continuous quality improvement). The important thing is that you have a process that is used and implemented and informs that cycle of improvement over the course of whether you are looking at it yearly, quarterly, monthly, that you are able to see and use those changes and tweaks and we put the last slide, you know, the core components of a critical incident management system and the cycles, to give you an example of how it works, so policy drives everything, policies is what you are going to select, policy says how you will do it and who does what, what to do with the results of it, and then you have all the different pieces: the reporting, the state review, the investigation, the outcomes, the analytics, and then you have quality improvement initiatives, wear that report team sits down, looks at what happened over the last quarter, what we need to change, let's implement those changes and we will get reports into our investigation. It is a cycle that never really ends. You are constantly trying to improve the welfare of the folks you are serving.

I think another interesting thing aside from data is looking at the types of questions that you are receiving from providers, so often times, the state will do an FAQ or just make direct changes to the policy manual, but I think it is important to look at data and also look at what people are asking questions on. If one person usually has a question on something, it is usually multiple folks have the same question.

So, we have one minute left for questions. If you have any. If not, Dustin and I have our email addresses up here. We are more than happy to answer any questions you might have and point you in certain directions if you want to talk to some of your peers on how they are doing their

critical incident management system. Or if you just want some insight on best practices, we are happy to share our time with you. Elaine, do you want to go over the questions.? Just so people are aware, there is a quick poll that should appear on your screen, so if you want to take a second and answer a few of those questions, that would be great.

Our first question says can you speak in a little bit more detail about examples of how a waiver agency can document attempts to prevent incidents that arise to reporting to APS, so cases involving abuse, neglect, and exploitation could be complex with many contributing factors.

And I think we mentioned it a little bit earlier where depending upon the type of critical incident, you may determine there is an opportunity for what we call a "joint investigation" where APS and the waiver management entity, whether that is the operating agency or Medicaid agency, they jointly conduct an investigation. What happened, they participate and support each other. Some of that requires MOUs between the agencies to allow that to happen. The other way that you can ensure there is some communication back and forth, it tends to be a lot easier when you have electronic systems that can communicate and share data with each other, is again, this is where you need to know what your rules are around the APS side of it on data sharing, but there are pieces of an investigation that may be able to be shared with the Medicaid agency: what was found, what the recommendations were, you know, the case manager or the person who is reviewing it on the state side can look at the results of the investigation, see what some recommendations are, informed case management. There are lots of different opportunities to develop those relationships with APS and you know, frankly, APS, and this has been my experience, that they would love to have more involvement and communication with Medicaid because they are so dependent upon Medicaid as a resource for the folks that they are doing investigations for, so more often than not, they are happy to spend time with the Medicaid agency. I have facilitated several different meetings between Medicaid and APS where the end result was they wanted to meet monthly to go over investigations that they have initiated for people who are on waivers, and the Medicaid agency wanted to meet to talk about their investigations that they did not know about, so they were constantly informed of what the other was doing and how they can improve.

The key thing I would highlight with any type of joint efforts is I think the MOU, memorandum of understanding, needs to be in place just to establish some of those parameters around who is doing what and even describe how both agencies will work together, I think one of the things that I have noticed with working with APS is even some of the basic information like a lot of times APS will not know whether someone is on a waiver, so it is important for Medicaid to work with them and identifying opportunities to make that identification so that they know that they have to send in the results back to Medicaid, so there are a lot of details to work there and it is important to have all those details in some type of agreement.

You know, the collaboration happens when you start having those meetings. I was in a meeting not long ago where APS was getting daily referrals

from the MLTSS plans to open up investigations, but the state had no idea APS was getting those referrals, and one of the takeaways from that was no longer accept those and to make those referrals to us (the state Medicaid agency). That was a critical incident that should have been reported to the state. The MCOs and LTSS plans were reported that APS because you know, not going to go into my hypothesis around why some of that that reduced the number of referrals they were getting probably by 15% per day because the Medicaid agency was able to enforce the rules and policies around critical incident reporting and they just learned that by meeting regularly with protective services.

Great, thank you. We have one more question that is kind of a combination two questions. Is there a way for people to get copies of other state policies and along with that, are there states that are considered implementing best practices by CMS and OIG?

So I may be wrong, but I believe most states have at least some components of their policies online, and part of that is because they need to be able to communicate with providers whether it is always publicly acceptable or not varies. I do not know that there is any directory or database of state policies around critical incident management, but you could always do a Google search with quotations around the "state critical incident management system".

I would say from the research we have done, I think most states have all of this information available publicly, most states will have -- there is different terminology that states use, so keep that in mind, but most states have to have this information online so that providers have it and can use it, but that includes like the manual as well as reporting templates, but I think it is important for states to look at you know, multiple states because each state kind of has a different take on what it includes in its manual.

I don't know that CMS has come out with a reference state or OIG on a best practice state. I know we wanted to have one of our state partners who has done a lot of work around this, they were under a corrective action, and even though I am a Louisiana native, I forgot that today is Mardi Gras. So, everything is closed in Louisiana today, so they were not able to participate, just to share some of their perspectives on how they went about implementing a comprehensive system, but you know, Dustin, have you heard CMS or OIG refer to a best practice state?

I guess in terms of best practice, I think it is important that the OIG and ACL report considers what it considers to be best practice. CMS has special review teams now and it is looking at states flagged as best practice based on I believe the information they received from that statewide survey, so we should expect, I would assume this year where CMS provides some additional guidance for states based on its review of those states that it identified as the practice. In terms of other states to look at, I would look at some of the states we included screenshots for, I think they have a robust policy documentation in place, so those are I think go to states if you are looking for policy materials.

Okay, it looks like we do not have any more questions. Thank you for sticking around and answering a few and thank you for everyone else who stayed with us and I hope you will have a good day.

Thank you, have a good day.

Thank you.

Happy Mardi Gras.

[Event concluded]