WellSky

Critical Incident Management: Core Elements to Enhance Your Approach

February 25, 2020

WellSky

TODAY'S DISCUSSION

1. Introduction to Speakers
2. A Quick Refresher on Critical Incident Management
3. Core Elements of an Electronic Incident Management System

TODAY'S DISCUSSION

1. **Introduction to Speakers**
2. *A Quick Refresher on Critical Incident Management*
3. *Core Elements of an Electronic Incident Management System*

WellSky

INTRODUCTION TO SPEAKERS

Dr. Jay Bulot
Vice President for State Markets
WellSky Corporation

Dustin Schmidt
Associate Director
Navigant – A Guidehouse Company

WellSky

TODAY'S DISCUSSION

1. *Introduction to Speakers*
2. **A Quick Refresher on Critical Incident Management**
3. *Core Elements of an Electronic Incident Management System*

WellSky

THE BASICS

Critical Incident Definition

- “Critical incidents” are situations that put the health, safety or welfare of participants at risk. Some states also use the term “adverse”, “serious” or “sentinel events”.
- Common critical incident types tracked by State Medicaid Agencies:
  - Abuse, Neglect, and Exploitation
  - Unexpected Deaths
  - Unexpected Hospitalization
  - Serious Injury
  - Criminal Activity/Legal Involvement
  - Loss of Contact/Elopement
  - Suicidal Behavior
  - Medication Errors
  - Use of Restraints/Seclusion

CMS Requirements

- States operating HCBS waivers are required to provide assurances to CMS that necessary safeguards are in place to protect the health, safety, and welfare of participants receiving services. For critical incidents this includes:
  - The state must demonstrate on an ongoing basis that it **identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.**
  - The state must demonstrate that an **incident management system is in place** that effectively resolves those incidents and prevents further similar incidents to the extent possible.

WellSky

RECENT OIG AND CMS ACTIVITIES

OIG

- Jan. 2018: OIG/ACL provide a roadmap for states to improve their critical incident management systems.
- Jul. 2019: OIG releases a guide for how states can use diagnosis codes in health insurance claims to help identify unreported abuse or neglect.
- Jan. 2020: OIG releases audit findings of PA's reporting and monitoring of critical incidents of Medicaid beneficiaries with developmental disabilities.

CMS

- CMS issued a statewide survey in July 2019, responses were due on or before August 28, 2019.
- CMS created H&W Special Review Teams (SRTs) that will work with states during the next three years to improve H&W issues.
- In FFY 2019, CMS conducted visits in three states.

What's Next?

- We anticipate that CMS will share high-level results of its statewide survey later this year.
- CMS expects to visit another 15 states in FFY 2020.
- CMS anticipates providing additional trainings and educational materials to support critical incident management.
- We may see more OIG audits.

WellSky

TODAY'S DISCUSSION

1. *Introduction to Speakers*
2. *A Quick Refresher on Critical Incident Management*
3. **Core Elements of an Incident Management System**

WellSky

CORE ELEMENTS OF AN INCIDENT MANAGEMENT SYSTEM

1 Policy

2 Reporting

3 State Review

4 Investigations

5 Outcomes

6 Analytics

7 Quality Improvement

WellSky

POLICY WILL DRIVE YOUR SYSTEM

- Without policy, there is no system.

- Key policy elements
  1. **Incident types and definitions**
  2. **Reporting and follow-up timeframes**
  3. Requirements part of provider licensure/certification (e.g., staff training)
  4. **Incident notification requirements (intake and investigation results)**
  5. **State agency and provider responsibilities (e.g., reporting, notifications, investigations, etc.)**
  6. Protocols for state agency review and investigations
  7. Mortality review protocols
  8. Rules governing non-compliance (e.g., when to issue a penalty vs. corrective action plan)
  9. Performance measures
  10. **Approach to continuous quality improvement**

Bold = Discussed in more detail in subsequent slides.

WellSky

SELECTING CRITICAL INCIDENT TYPES IS THE MOST IMPORTANT POLICY DECISION

CMS describes several considerations for states to identify incident types:

Identify reportable incidents which are **clear and understandable so stakeholders can easily identify which incidents are reportable.**

- Consider those which CMS includes in its Technical Guidance to the state.

Identify which reportable incidents are **critical or noncritical**.

- This 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**. Determine **what types of incidents require follow-up** as not to overload the system.

- 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 (i.e., serious and potentially dangerous drugs).

Determine if **frequency of occurrence** impacts whether incidents are critical or noncritical.

- States may require a more involved investigation on noncritical incidents occurring to the same individual repeatedly.

WellSky

DETERMINE WHO IS INVOLVED

Key Decision Points:

1. Who is responsible for completing a critical incident report?
2. Who is responsible for notifying other parties (e.g., the case manager or medical physician)?
3. Who will investigate? This may involve multiple parties
4. Who is responsible for provider corrective action plans/sanctions?

Kentucky – Role of the Direct Service Provider

Entity	Definition/Responsibilities
Direct Service Provider	*Definition:* A direct service provider is any person, agent, or employee of a provider entity who provides a 1915(c) HCBS waiver service. In the case of subcontractors, the responsibility for reporting incidents rests with the contracted direct service provider. *Key Responsibilities Include:* • Notify all appropriate parties as described in Section 3 of this guide. • For critical incidents, direct service providers submit the *Incident Reporting Form* and *Critical Incident Investigation Report* to the appropriate regulating agency. For non-critical incidents, direct service providers complete the *Incident Reporting Form* and store at the direct service providers' location. o The direct service provider is responsible for reporting: ▪ All incidents that occur at the direct service providers' location; ▪ All incidents where the direct service provider is the first person to witness or discover the incident, regardless of location. • Investigate the critical incident with involvement of the waiver participant's case manager or support broker/service advisor. • Participate in case manager and regulating agency investigations.

Massachusetts – Roles and Responsibilities

Role	Role Description
Provider	Responsible for: • Submitting the intial and final incident report via HCSIS • Revising and resubmitting the incident report if necessary
MRC Staff	Responsible for: • Conducting the first and second level of review o *First-Level*: Case Manager o *Second-Level*: Case Manager Supervisor • Revising incident categories if necessary • Returning the incident report to providers if necessary • Approving/ closing the incident
DDS Staff	Responsible for: • Conducting the first and second level of review o *First-Level*: Area Office o *Second-Level*: Regional Office • Revising incident categories if necessary • Returning the incident report to providers if necessary • Approving/ closing the incident

WellSky

DETERMINE TIMEFRAMES FOR REPORTING, REVIEW, AND RESOLUTION

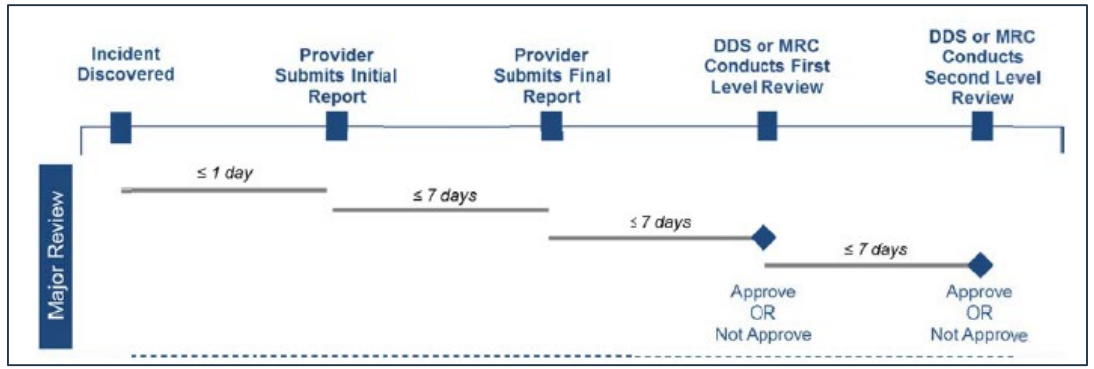
Our Recommendations:

1. Establish clear timeframes for notifying, reporting, reviewing, and investigating critical incidents.
2. Timeframes should consider the type of critical incident (high risk = more aggressive timeframe for follow-up) and staff bandwidth.

Kentucky – Critical Incident Notification and Reporting Timeframes

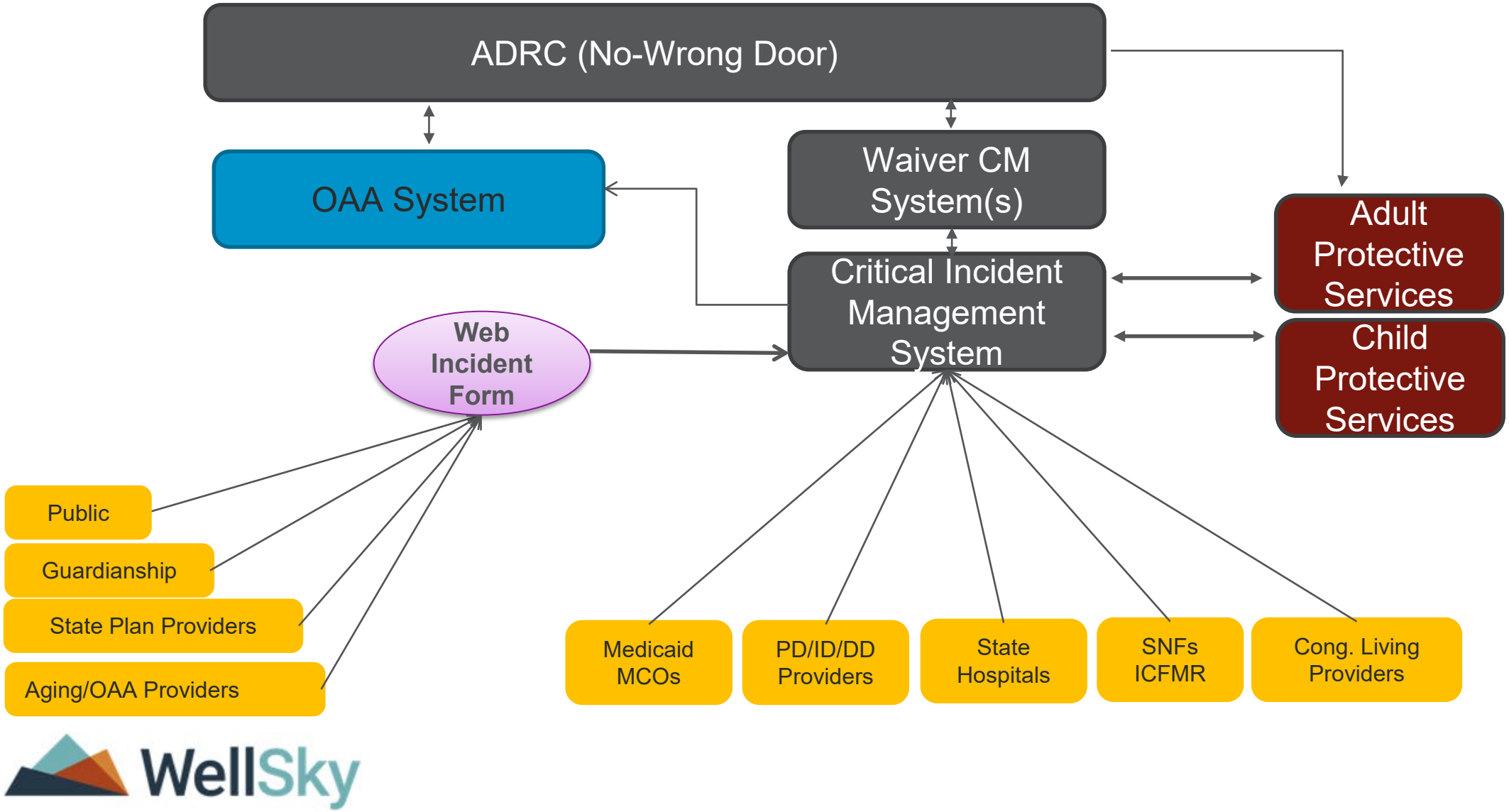
	Notification/Reporting To	Timeframe
Notifications	**Law Enforcement** (For incidents involving criminal activities)	**As soon as possible but no later than eight (8) hours** of witnessing or discovering the incident.
	DCBS – APS and CPS (For incidents involving ANE)	
	Family Member: For adults, a family member is only notified if the waiver participant has provided consent via their PCSP. For children, a family member is always notified.	• *Critical incident*: **As soon as possible but no later than eight (8) hours** of witnessing or discovering the incident. • *Non-critical incident*: **Within 24 hours** of witnessing or discovering the incident.
	Medical Provider: The medical provider is notified for incidents involving medication errors or hospitalization.	
	Direct Service Provider	
	Case Manager or Support Broker/Service Advisor	
	State or Private Guardian (If applicable and if specified in the PCSP)	
Reporting	**Regulating Agency (DMS, DAIL, or DBHDID)**	• *Incident Reporting Form (for critical Incidents)*: Within **same day** if the critical incident is witnessed or discovered during regular business hours (8 am-4:30 pm Eastern Time Monday-Friday, excluding state holidays) **OR next business day** if the critical incident is witnessed or discovered outside of regular business hours. • *Incident Reporting Form (for non-critical incidents)*: Notification to the regulating agency is **not required**. • *Critical Incident Investigation Report*: **Within 10 business days** of witnessing or discovering the incident.

Massachusetts – Major Level Review Timeframes



WellSky

DETERMINE WHO WILL INTERACT WITH THE SYSTEM



1 Policy

2 Reporting

3 State Review

4 Investigations

5 Outcomes

6 Analytics

7 Quality Improvement

WellSky

REPORTING CRITICAL INCIDENTS

Our Recommendations:

1. Offer multiple avenues for reporting (e.g., online, call center)
2. If using an electronic system, use dropdowns whenever feasible.
3. Key components to capture:
   - Individual Impacted
   - Reporting Source
   - Incident Information
   - Notifications
   - Alleged Perpetrator
   - Witnesses
   - Risk Mitigation

Unique Fields Tracked by State Medicaid Agencies

Kentucky – Risk Mitigation

1 What is the person's current status? (Choose one)

☐ Stable with no serious changes noted
☐ Seen by professional and returned home
☐ Seen by professional and admitted to facility (specify location and date below)
☐ Other, briefly describe:

2 Could this incident have been prevented? ☐ Yes ☐ No ☐ Unknown

If yes, then how could the incident have been prevented? (Choose one)

☐ Track/monitor medical treatment (ER, doctor, hospital, etc.) to identify trends
☐ Ensure timely implementation of current Crisis Support Plan
☐ Modification of person-centered service plan
☐ Track/monitor previous incidents to identify trends
☐ Change in environmental factors
☐ Other, briefly describe:

Colorado – Subcategories for Incident Types

SERIOUS INJURY TO OR ILLNESS OF CLIENT

Serious Injury/Illness Type: [check one]

☐ Laceration requiring sutures/staples
☐ Fracture
☐ Dislocation
☐ Loss of Limb
☐ Other
☐ Serious Burn
☐ Skin Wound due to poor care
☐ Suicide Attempt
☐ Brain Injury

Cause of Injury/Illness: [check one]

☐ Fall
☐ Medical Condition
☐ Poor Care
☐ Seizure
☐ Accident
☐ Treatment Error
☐ Undetermined
☐ Other

Did Serious Injury/Illness Result in Hospitalization?

☐ Yes ☐ No

If Yes is selected, where was client Hospitalized?

Massachusetts – Body Part of Injury

(23) Body Part Affected by Injury: *CHECK ALL THAT APPLY*

☐ Toe	☐ Genitals	☐ Face	☐ Arm
☐ Foot	☐ Front Torso	☐ Eye	☐ Elbow
☐ Ankle	☐ Back Torso	☐ Nose	☐ Wrist
☐ Knee	☐ Internal Organs	☐ Ear	☐ Hand
☐ Leg	☐ Neck	☐ Mouth	☐ Finger
☐ Hip	☐ Head	☐ Shoulder	☐ Other

1 Policy
2 Reporting
3 State Review
4 Investigations
5 Outcomes
6 Analytics
7 Quality Improvement

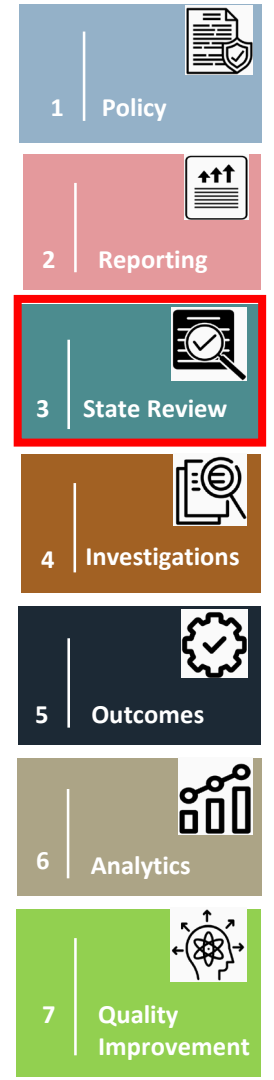
WellSky

STATE REVIEW

CMS describes several elements of **reviewing incoming incidents**. The State should:

- ✓ 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).
- ✓ Determine and validate the severity of a reported incident.
- ✓ Determine if there needs to be follow-up or communication with other affiliated individuals/agencies.
- ✓ Identify a timeline for reviewing and triaging incident reports.
- ✓ Use the triage process to determine if an investigation is necessary as a response to the incident.
- ✓ Plan on the types of follow-up that must occur during the course of the investigation with the individual, family member/guardian, and service provider based on incident severity.

Additionally, OIG recommends that States establish an incident management review committee to review certain serious incidents, review investigation adequacy, collaborate with other agencies, and identify and respond to trends in reported incidents.



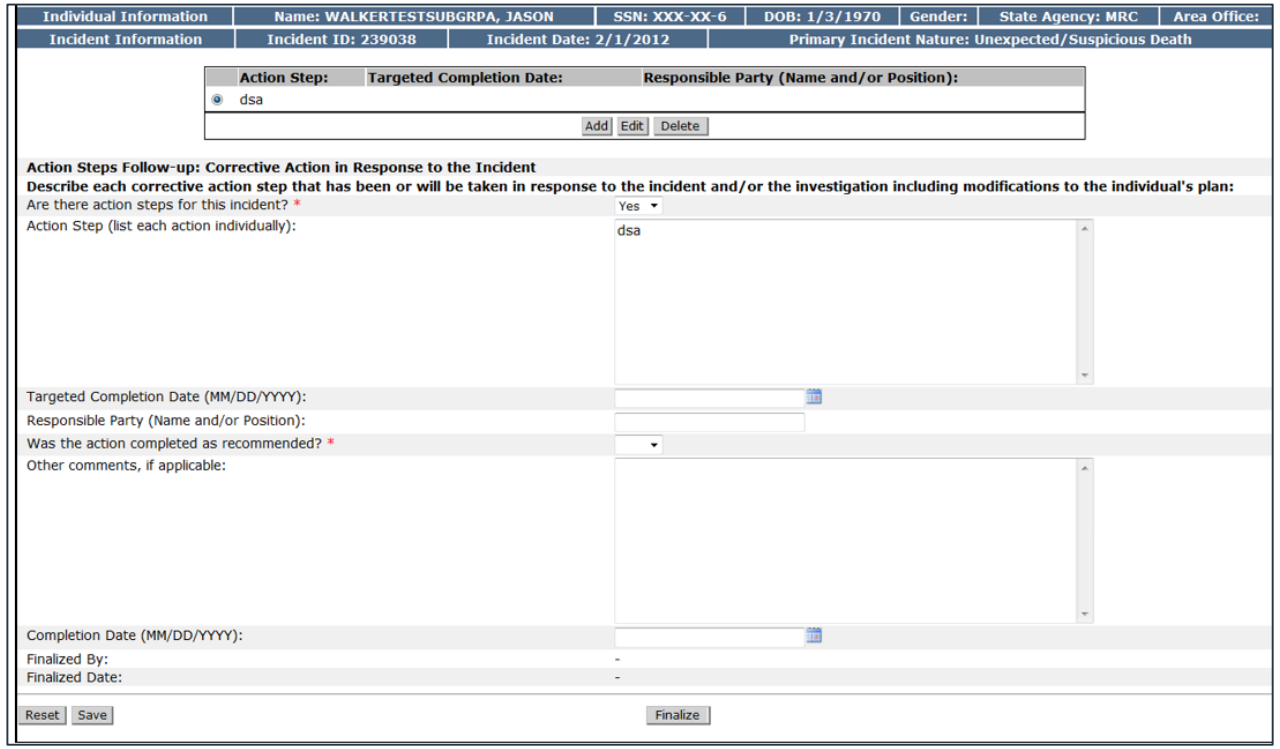
WellSky

STATE REVIEW *(CONTINUED)*

Our Recommendations:

1. The state should have protocols in place that describe its criteria for reviewing critical incidents.
2. Responsibilities across providers and state agencies is key.
3. Key components to capture:
   - Name of the Reviewer
   - Date Review Completed
   - Resolution Type (e.g., no action taken, requires investigation, CAP issued, technical assistance offered, moratorium/termination, etc.).

Massachusetts – State Agency Review Process Management



Individual Information	Name: WALKERTESTSUBGRPA, JASON	SSN: XXX-XX-6	DOB: 1/3/1970	Gender:	State Agency: MRC	Area Office:
Incident Information	Incident ID: 239038	Incident Date: 2/1/2012	Primary Incident Nature: Unexpected/Suspicious Death			

Action Step:	Targeted Completion Date:	Responsible Party (Name and/or Position):
dsa		

Add | Edit | Delete

Action Steps Follow-up: Corrective Action in Response to the Incident

Describe each corrective action step that has been or will be taken in response to the incident and/or the investigation including modifications to the individual's plan:

Are there action steps for this incident? * Yes

Action Step (list each action individually): dsa

Targeted Completion Date (MM/DD/YYYY):

Responsible Party (Name and/or Position):

Was the action completed as recommended? *

Other comments, if applicable:

Completion Date (MM/DD/YYYY):

Finalized By: -

Finalized Date: -

Reset | Save | Finalize

1 Policy

2 Reporting

3 State Review

4 Investigations

5 Outcomes

6 Analytics

7 Quality Improvement

WellSky

INVESTIGATIONS

OIG/ACL Recommendations:

1. The State should ensure independent State investigations of allegations of specified incidents (e.g., abuse and neglect that results in serious or repeated harm to participants; sexual abuse; unexpected deaths; incidents that result in life-threatening or serious injury or illness that appear to be due to provider misconduct/ANE or due to environmental hazards; etc.).
2. The State may delegate investigation for other incident situations to provider agencies or other entities.
3. Investigations of physical abuse / neglect that result in death or serious injury should be reviewed within 14 days. All other incidents should be reviewed within 30 days.

Our Recommendations:

1. Develop a standard template for conducting investigations. Key components to capture:
   - Parties Involved
   - Evidence Collected
   - Findings
   - Outcome of the Investigation
1. Establish policies and procedures for investigators.
2. Consider whether joint state agency investigations are needed.
3. Determine how to share results with other relevant state agencies.

WellSky

INVESTIGATIONS – PRIOR INVOLVEMENT REVIEW

Benefits of a Comprehensive Incident Management System:

1. Person level data allows State identify prior involvement across programs including:
   - Waivers
   - Protective Services
   - Facilities
2. Develop effective correction action plans addressing recidivism by:
   - Victims
   - Perpetrators
   - Providers

	Waiver	Total Closures	Total Non-Compliant	% of Total Compliant	Days Past Compliance			
					1 to 30	31 to 60	61 to 90	91 Plus
Region 1		**24**	**0**	**100.00%**	**0**	**0**	**0**	**0**
	ADHC	5	0	100.00%	0	0	0	0
	OAASCCW	19	0	100.00%	0	0	0	0
Region 2		**53**	**0**	**100.00%**	**0**	**0**	**0**	**0**
	ADHC	9	0	100.00%	0	0	0	0
	OAASCCW	44	0	100.00%	0	0	0	0
Region 3		**16**	**2**	**87.50%**	**1**	**0**	**0**	**1**
	OAASCCW	16	2	87.50%	1	0	0	1
Region 4		**67**	**1**	**98.51%**	**1**	**0**	**0**	**0**
	ADHC	13	0	100.00%	0	0	0	0
	OAASCCW	54	1	98.15%	1	0	0	0
Region 5		**6**	**0**	**100.00%**	**0**	**0**	**0**	**0**

State Agency Prior Involvement Review

Incident Prior Involvement Report

Generated By: Barbara Guglielmo on 02/18/2020 01:53 PM

(People ID: 55973)

7/21/1949 **Social Security Number:**

Contact Type	Relationship	ID	Provider	Report Date	Disposition
InvolvedPerson	Participant	16735	MATTERS OF THE HEART OF N.LA. (14001)	7/11/2019	Incident Closed
InvolvedPerson	Participant	3695	MATTERS OF THE HEART OF N.LA. (14001)	7/17/2019	Pending
InvolvedPerson	Participant	16754	MATTERS OF THE HEART OF N.LA. (14001)	12/17/2019	Incident Closed
InvolvedPerson	Participant	16764	MATTERS OF THE HEART OF N.LA. (14001)	1/14/2020	OAAS Staff Assigned

1 Policy

2 Reporting

3 State Review

4 Investigations

5 Outcomes

6 Analytics

7 Quality Improvement

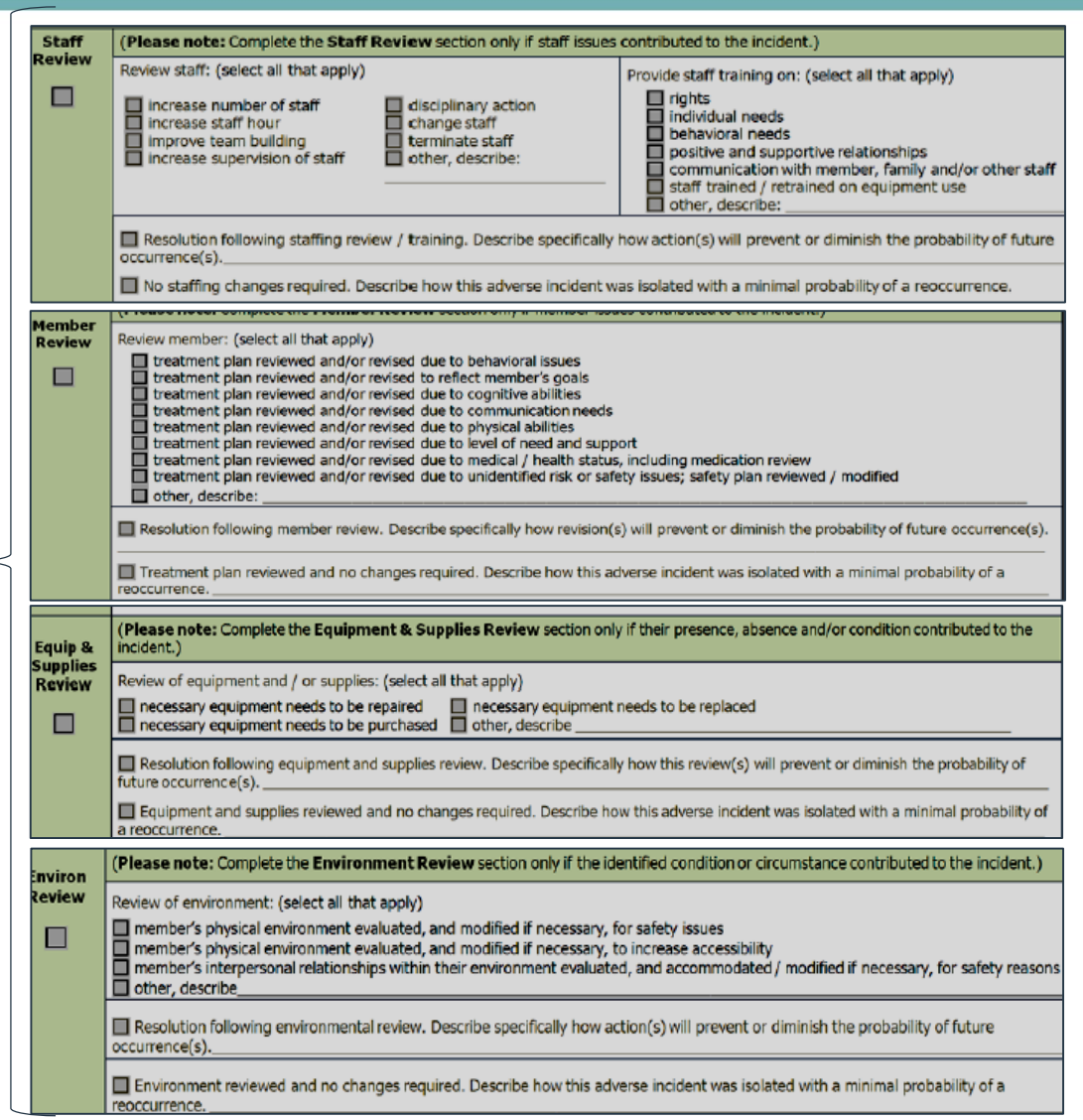
WellSky

OUTCOMES

Our Recommendations:

1. Determine how critical incidents are closed and what fields are used to track outcomes/resolutions.
2. Determine whether additional follow-up is needed and how follow-up actions are tracked.
3. Determine whether recoupment or a financial penalty is needed.

Iowa – Incident-Specific Resolution Reviews:



Staff Review

(**Please note:** Complete the **Staff Review** section only if staff issues contributed to the incident.)

Review staff: (select all that apply)

- increase number of staff
- increase staff hour
- improve team building
- increase supervision of staff
- disciplinary action
- change staff
- terminate staff
- other, describe:

Provide staff training on: (select all that apply)

- rights
- individual needs
- behavioral needs
- positive and supportive relationships
- communication with member, family and/or other staff
- staff trained / retrained on equipment use
- other, describe:

- Resolution following staffing review / training. Describe specifically how action(s) will prevent or diminish the probability of future occurrence(s).
- No staffing changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence.

Member Review

Review member: (select all that apply)

- treatment plan reviewed and/or revised due to behavioral issues
- treatment plan reviewed and/or revised to reflect member's goals
- treatment plan reviewed and/or revised due to cognitive abilities
- treatment plan reviewed and/or revised due to communication needs
- treatment plan reviewed and/or revised due to physical abilities
- treatment plan reviewed and/or revised due to level of need and support
- treatment plan reviewed and/or revised due to medical / health status, including medication review
- treatment plan reviewed and/or revised due to unidentified risk or safety issues; safety plan reviewed / modified
- other, describe:

- Resolution following member review. Describe specifically how revision(s) will prevent or diminish the probability of future occurrence(s).
- Treatment plan reviewed and no changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence.

Equip & Supplies Review

(**Please note:** Complete the **Equipment & Supplies Review** section only if their presence, absence and/or condition contributed to the incident.)

Review of equipment and / or supplies: (select all that apply)

- necessary equipment needs to be repaired
- necessary equipment needs to be replaced
- necessary equipment needs to be purchased
- other, describe

- Resolution following equipment and supplies review. Describe specifically how this review(s) will prevent or diminish the probability of future occurrence(s).
- Equipment and supplies reviewed and no changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence.

Environ Review

(**Please note:** Complete the **Environment Review** section only if the identified condition or circumstance contributed to the incident.)

Review of environment: (select all that apply)

- member's physical environment evaluated, and modified if necessary, for safety issues
- member's physical environment evaluated, and modified if necessary, to increase accessibility
- member's interpersonal relationships within their environment evaluated, and accommodated / modified if necessary, for safety reasons
- other, describe

- Resolution following environmental review. Describe specifically how action(s) will prevent or diminish the probability of future occurrence(s).
- Environment reviewed and no changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence.

WellSky

ANALYTICS

Our Recommendations:

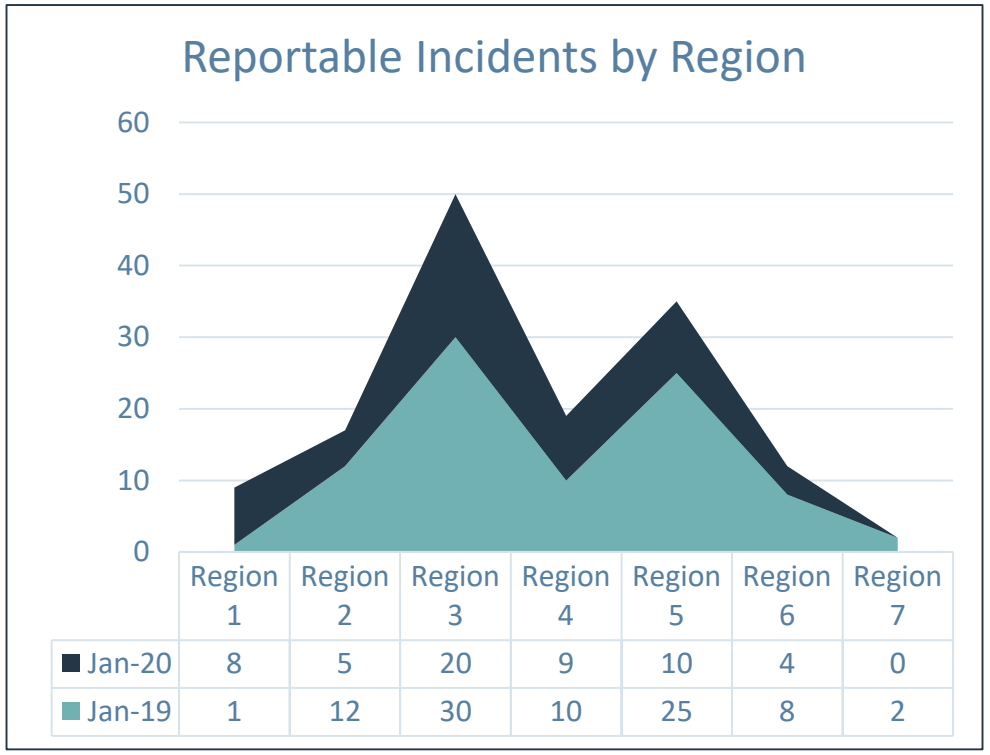
1. Have a regular cadence for collecting and/or analyzing data.
2. Define thresholds or tolerance for critical incidents requiring statewide, regional, or provider level corrective action.
3. Determine if critical incident data correlate with effective risk mitigation or the need for improvement at the individual, regional or system level.

Iowa – Listing of Incident Reports

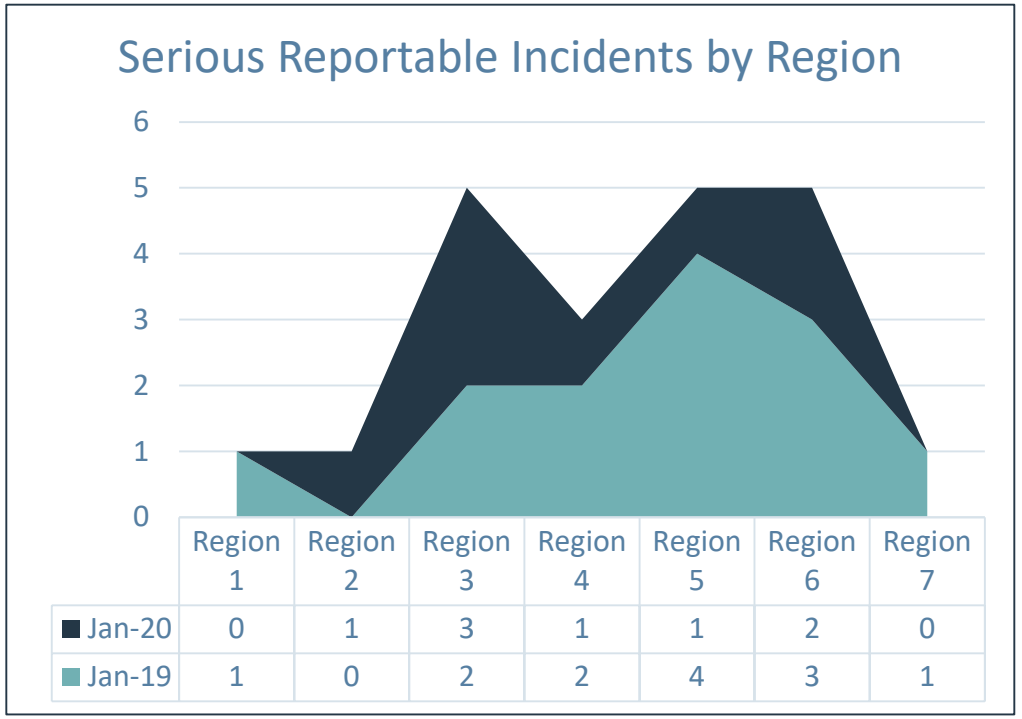
1 Policy
2 Reporting
3 State Review
4 Investigations
5 Outcomes
6 Analytics
7 Quality Improvement

WellSky

ANALYTICS – SAMPLE VISUALS



	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Jan-20	8	5	20	9	10	4	0
Jan-19	1	12	30	10	25	8	2

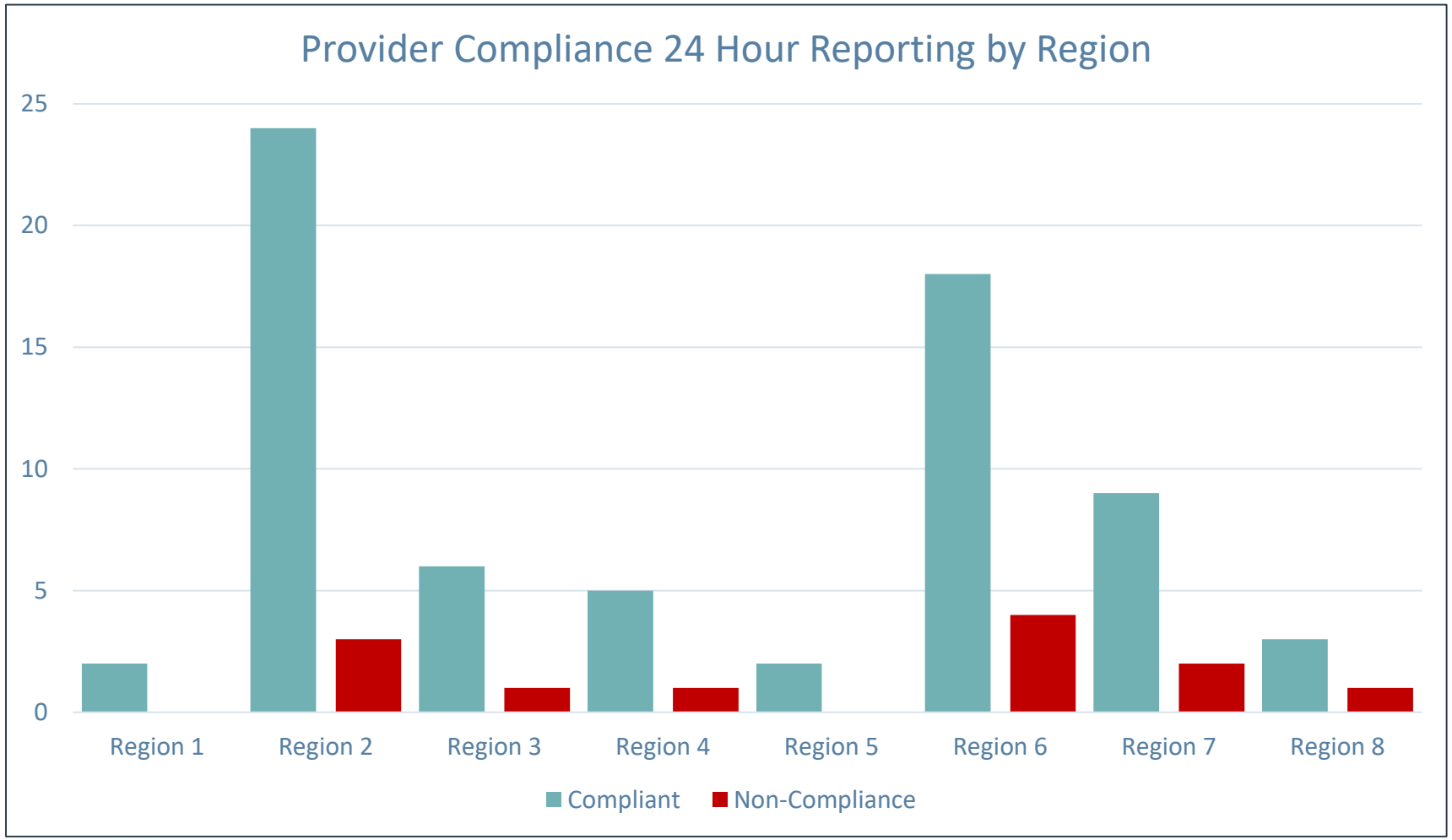


	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Jan-20	0	1	3	1	1	2	0
Jan-19	1	0	2	2	4	3	1

1 Policy
2 Reporting
3 State Review
4 Investigations
5 Outcomes
6 Analytics
7 Quality Improvement

WellSky

ANALYTICS – SAMPLE VISUALS



1 Policy

2 Reporting

3 State Review

4 Investigations

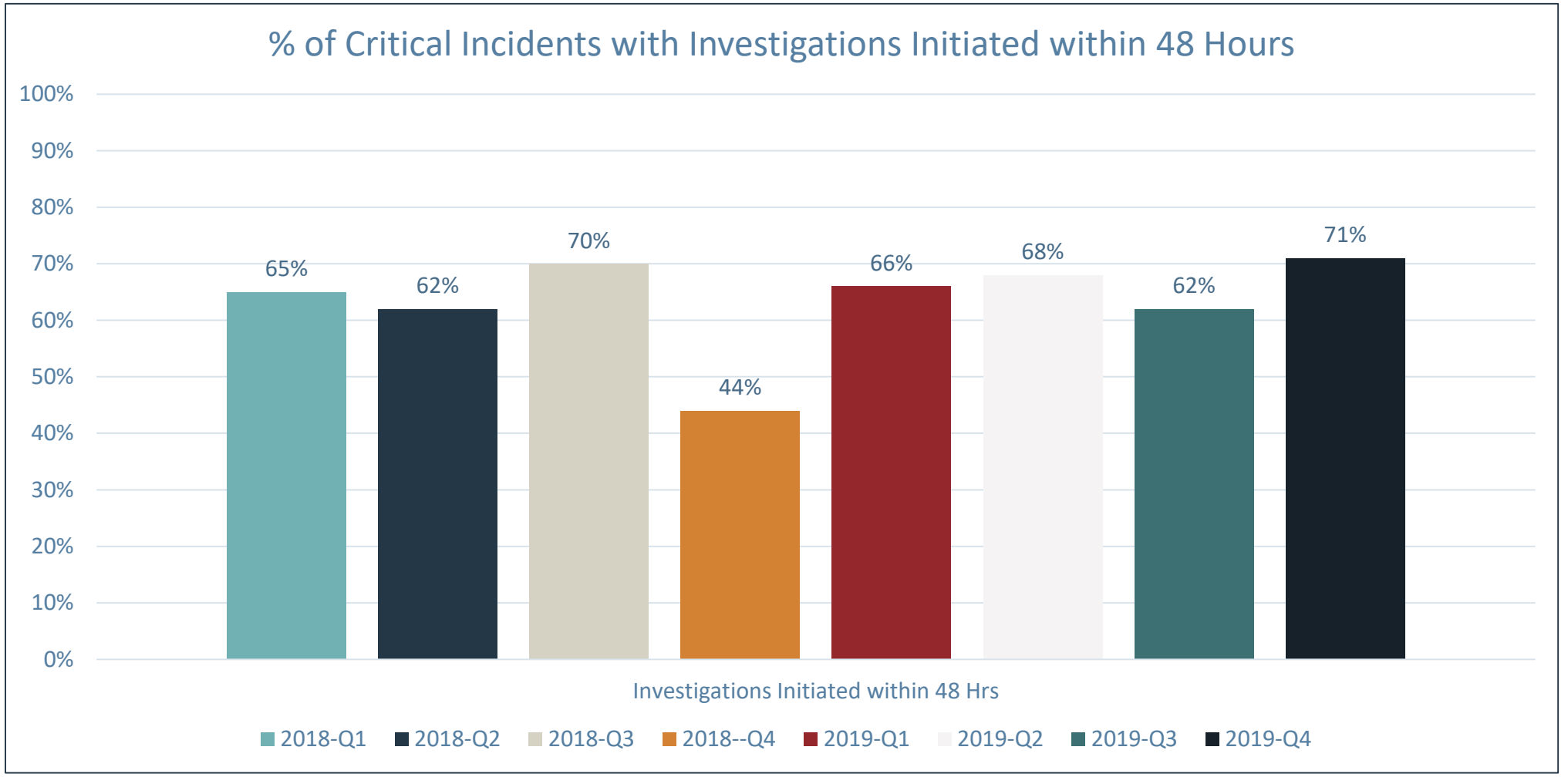
5 Outcomes

6 Analytics

7 Quality Improvement

WellSky

ANALYTICS – SAMPLE VISUALS



1 Policy

2 Reporting

3 State Review

4 Investigations

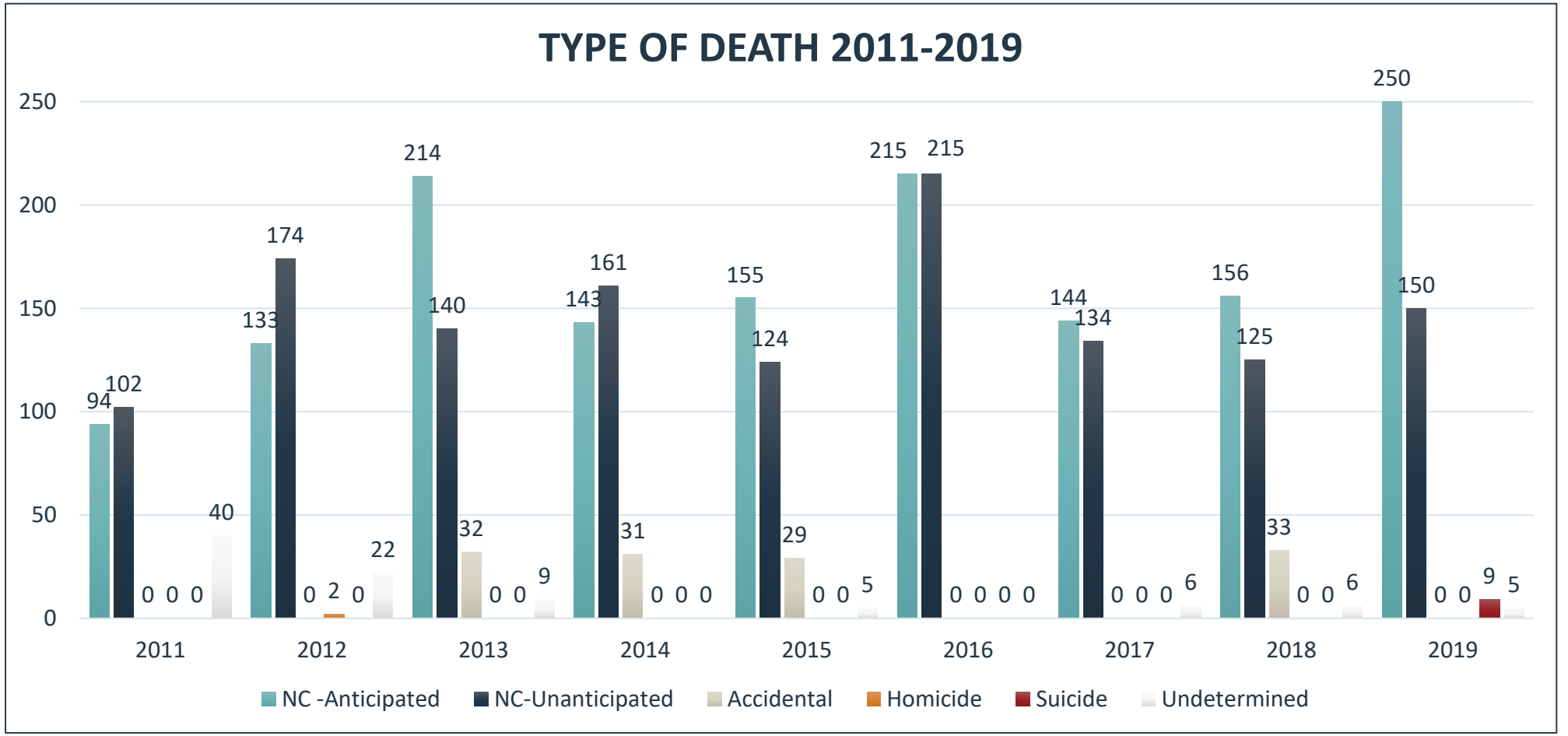
5 Outcomes

6 Analytics

7 Quality Improvement

WellSky

ANALYTICS – SAMPLE VISUALS



1 Policy

2 Reporting

3 State Review

4 Investigations

5 Outcomes

6 Analytics

7 Quality Improvement

WellSky

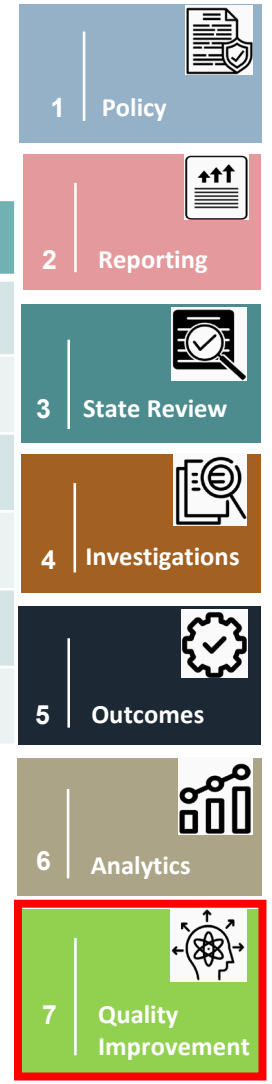
QUALITY IMPROVEMENT

Our Recommendations:

1. Institute multidisciplinary critical incident review teams to review incidents, trends, investigations, and corrective actions.
2. Formalize process for recommending system level changes if the data indicates a need.
3. Develop critical incident report card or dashboard.
4. Determine the need for change in policy or process.

Critical Incident Report Card	# Incidents	# preventable	Trends
Total Number of Incidents	36	13	↑
Number of Falls with Injury	6	2	↓
Number of ED Admits	12	3	↔
Unexpected Deaths	4	1	↔
Medication Errors	10	4	↓
Use of Restraints/Seclusion	4	4	↑

Report Cards and Dashboards make it easy for leadership to see which critical incidents may require attention or mitigation.



WellSky

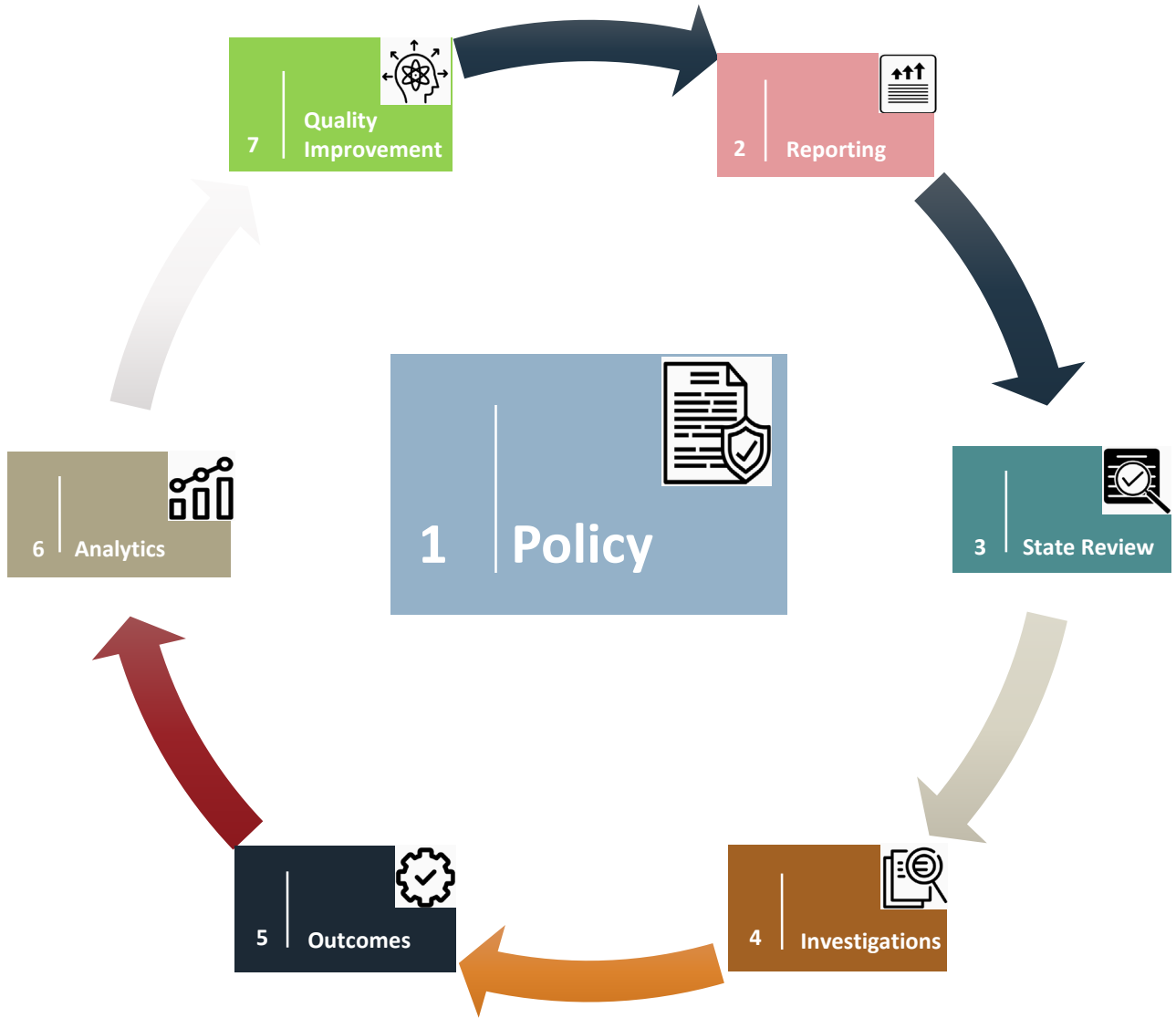
QUALITY IMPROVEMENT *(CONTINUED)*

"If you can't measure it, you can't improve it."
Peter Drucker

1 Policy
2 Reporting
3 State Review
4 Investigations
5 Outcomes
6 Analytics
7 Quality Improvement

WellSky

QUALITY IMPROVEMENT SHOULD REGULARLY IMPACT YOUR APPROACH



WellSky

CONTACTS

Dr. Jay Bulot

Vice President for State Markets

WellSky Corporation

Jay.Bulot@WellSky.com

Dustin Schmidt

Associate Director

Navigant – A Guidehouse Company

Dustin.Schmidt@guidehouse.com

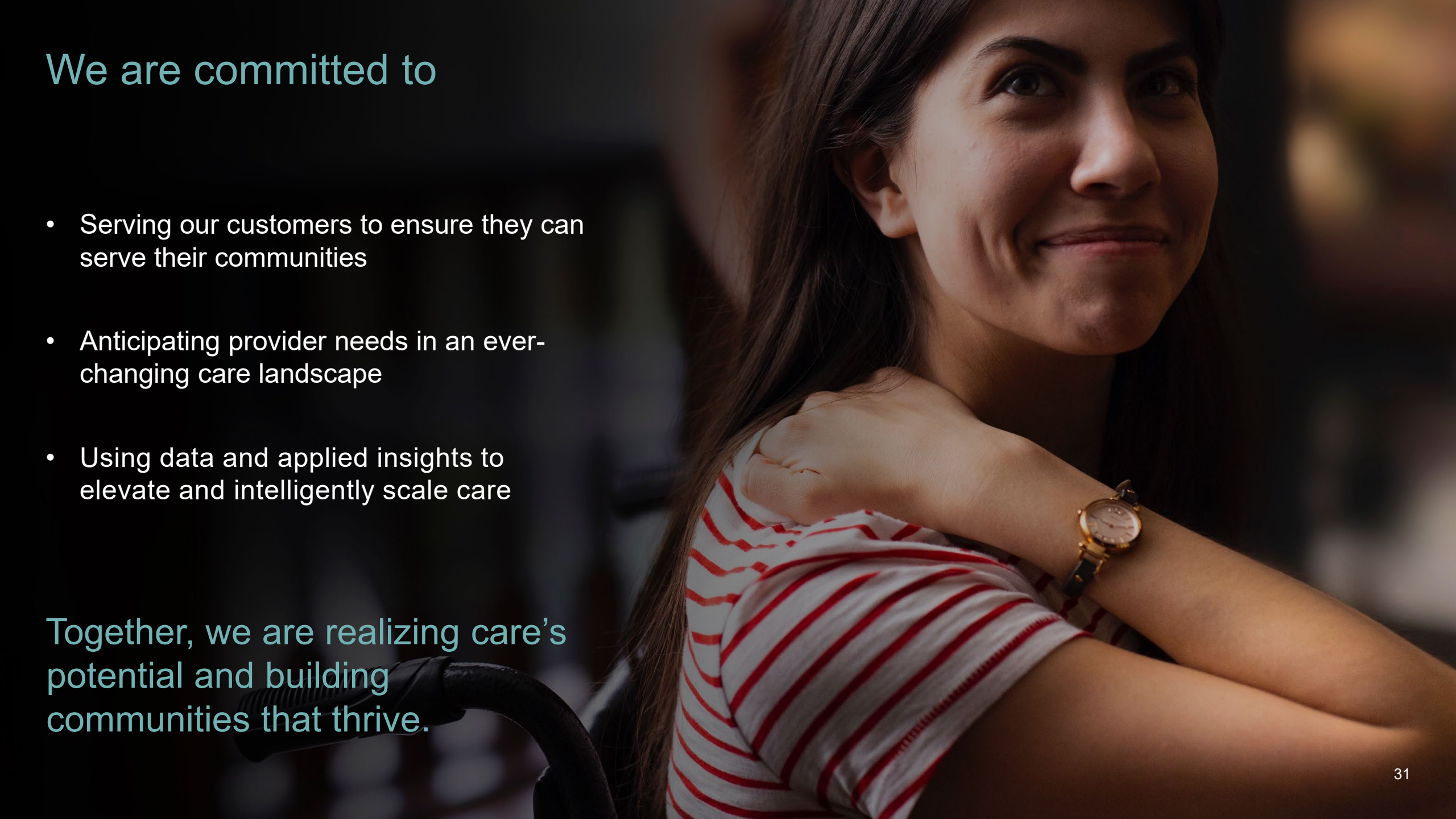
WellSky

About WellSky

WellSky is a technology company advancing human wellness worldwide. Our software and professional services address the continuum of health and social care — helping businesses, organizations, and communities solve tough challenges, improve collaboration for growth, and achieve better outcomes through predictive insights that only WellSky solutions can provide.

We are committed to

- Serving our customers to ensure they can serve their communities
- Anticipating provider needs in an ever-changing care landscape
- Using data and applied insights to elevate and intelligently scale care



Together, we are realizing care's potential and building communities that thrive.

We partner with organizations across the care spectrum

Hospital:
Ensuring hospitals can focus on delivering superior patient care safely and efficiently

Practices & Facilities:
Enhancing providers' abilities to streamline operations and focus on the delivery of care

Home:
Empowering providers to deliver exceptional care while focusing on improving outcomes

Community:
Supporting dynamic communities of care with our diverse set of human services solutions

WellSky

Hospital

- FDA 510(k) cleared system for blood banks
- The blood compliance solution for U.S. Department of Defense facilities worldwide
- + 450 transfusion sites worldwide
- + 20,000 cord blood and tissue donors registered

Home

- +4,500 home health and hospice agencies
- +34 million billable visits in 12 months
- +$11 billion Medicare claims processed
- +200,000 care tasks every day

Practices and Facilities

- +50 million blood donor tests annually
- +22 million rehab treatments in 12 months
- +2.3 million rehab patients served in 12 months
- +135 medication management facilities (including 34 correctional health facilities)

Community

- +35,000 daily users
- + 3,000 agencies providing services
- Used by majority of Area Agencies on Aging
- Used by majority of HUD Continuums of Care
- Customer organizations in 50 US states, Washington D.C., and Canada