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

PROMOTING HEALTH AND WELFARE FOR PEOPLE RECEIVING HOME AND COMMUNITY-BASED SERVICES

Division of Long Term Services and Supports

Disabled and Elderly Health Programs Group

Center for Medicaid and CHIP Services

Purpose

- CMS will discuss:
  - Key findings from the national Incident Management Survey
  - Health and Welfare Special Review Team observations
  - Other initiatives that fit into a framework that will strengthen states' health and welfare oversight systems

Regulatory Framework for Incident Management

Health and Welfare Assurance in 1915(c) Waiver Program

Requires the state to demonstrate that it has designed and implemented an effective system for assuring waiver participant health and welfare

Health and Welfare Sub-assurances

- The state demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death;
- The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible;
- The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed; and
- The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

A National Overview of Incident Management Systems Training Series

- CMS conducted a three-part training based on a national survey completed by states on incident management systems.
  - Part 1 described systems and processes implemented by the state to assist with the reporting, identification, and resolution of incidents. Available here: https://www.medicaid.gov/medicaid/home-community-based-services/downloads/ims-national-overview-part1.pdf
  - Part 2 identified quality improvement activities states have implemented to assist with preventing or mitigating incidents from occurring. Available here: https://www.medicaid.gov/medicaid/home-community-based-services/downloads/ims-national-overview-part2.pdf
  - Part 3 shared CMS' recommendations for how states can improve their efforts in developing robust incident management systems. Available here: https://www.medicaid.gov/medicaid/home-community-based-services/downloads/incident-mgmt-rec.pdf

Incident Management Survey and Interviews

- Between July to October 2019, CMS issued a survey to the 47 states that operate 1915(c) waivers, requesting information on their approach to incident management.
- From October 2019 to January 2020, CMS conducted interviews with 5 states that demonstrated promising practices to supplement survey results.

The survey consisted of 146 questions across 8 sections:

1. Systems
2. Reporting
3. Incident Resolution
4. Quality Improvement
5. Collaboration
6. Training
7. Prevention
8. Mitigation of Fraud, Waste, and Abuse (FWA)

General Survey Findings

- CMS received 101 survey responses, representing 101 unique incident management systems across 45 states and 237 waivers.
  - To account for the varying systems, states submitted a unique survey response for each incident management system in their state. As a result, states often submitted multiple but unique surveys.
- Findings are presented in terms of numbers of unique state systems to mirror the structure of survey responses.

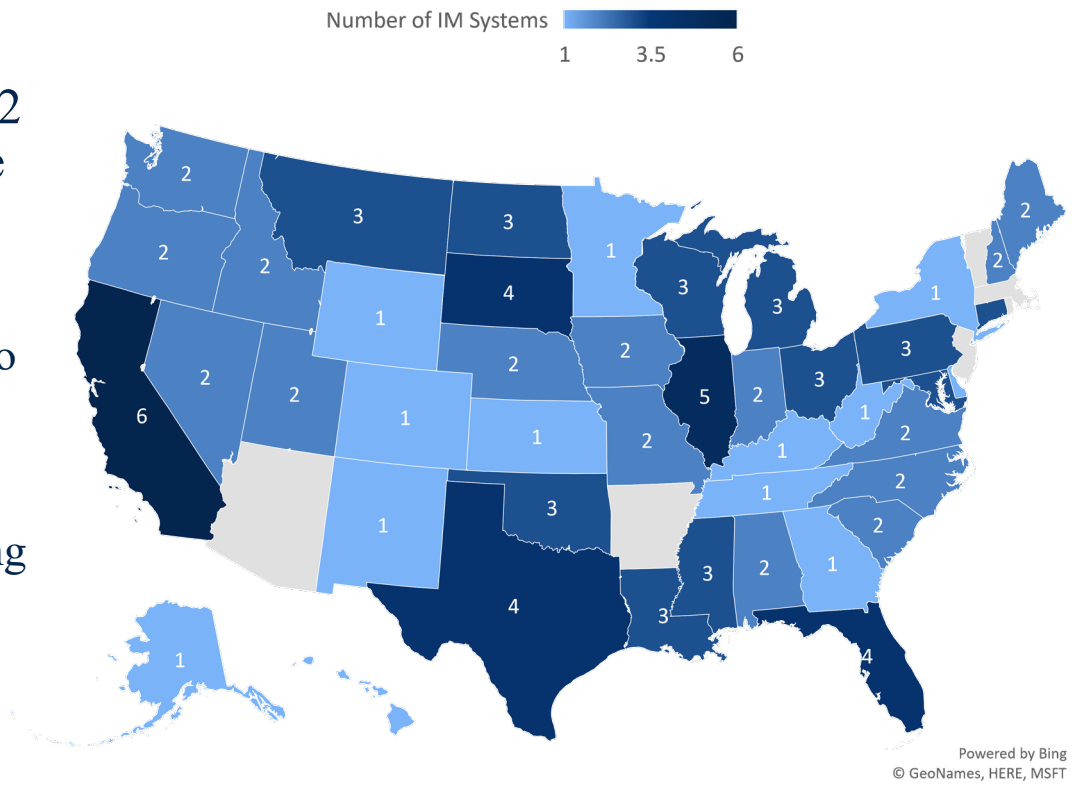
Table 1: General Survey Results

General Survey Results			
Survey Responses			
Total # Survey Responses Received		101	
Survey Response Rates by Level			
	Target Number of Participants	*Number of Respondents*	*Response Rate*
States	47	45	96%
HCBS Waiver Programs	252	237	94%

States Support Multiple Incident Management Systems, Often to Reflect Differences in Population Need

- 32 of 45 surveyed states (71 percent) operate more than one system.
- According to survey responses, 62 of 101 systems (61 percent) serve only one distinct waiver population.
  - **Example:** One state operates two incident management systems with one pertaining to APD waivers and the other pertaining to ID/DD waivers. Due to varying certification and licensure requirements of providers, referrals and investigations are handled differently for unique waiver populations.

Figure 1: Number of Systems Implemented Within a State*



*Grey states either did not provide a survey in time for the creation of this training or currently do not operate 1915(c) HCBS waiver programs.

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Key Finding: Incident Management Involves The Coordination of Processes, People, and Technology

Findings from the survey highlight the importance of the coordination of processes, people, and technology to manage incidents.

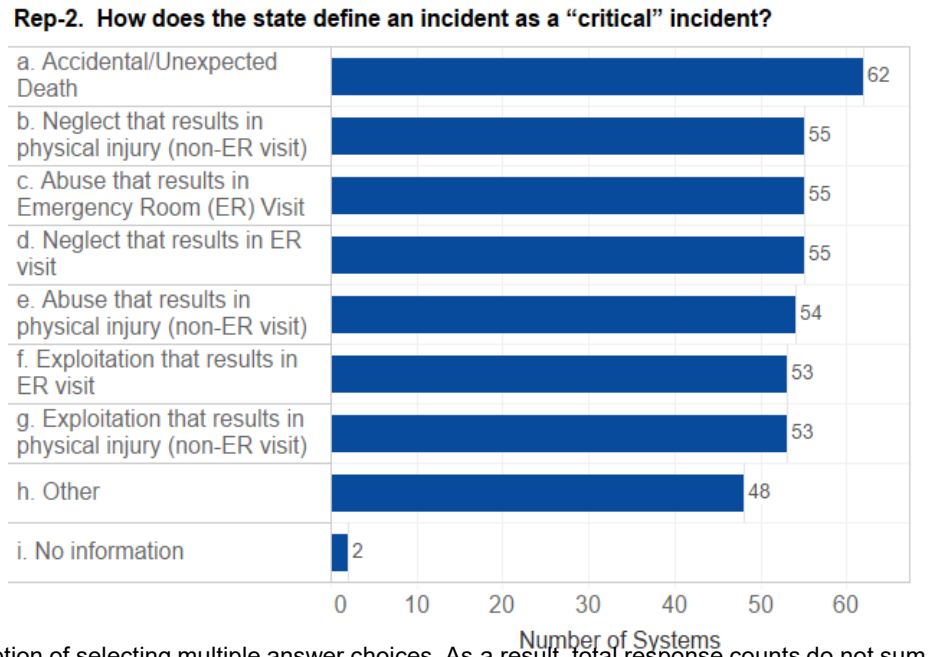
- These variables work in conjunction with one another and share equal responsibility for the success of the incident management system.
  - For example, a strong technology platform is limited if incidents are not adequately defined or stakeholders do not collaborate in sharing information.
- States with more advanced incident management systems consider incident management as a cohesive system rather than siloed processes and activities aimed towards managing incidents.

Key Finding: Definitions of Critical Incidents Varied Within and Across States

Survey responses showed that while most states stratify incidents by risks, definitions for critical incidents varied.

- According to survey responses, 74 of 101 systems (73 percent) identify incidents by risk (i.e., critical vs. non-critical).
- Of those state systems that identified incidents by risks, states defined "critical" differently.

Figure 2: State Definition of Critical Incidents*



*Note: For this question, states had the option of selecting multiple answer choices. As a result, total response counts do not sum up to 101 systems.

Key Finding: States Can Benefit from Standardizing the Definition of Critical Incidents

States should include, at a minimum, the following incident types in their definition of critical incidents:

- Broadly defined allegations of physical, psychological, emotional, verbal and sexual abuse, neglect, and exploitation (ANE)
- Accidental/Unexpected Death[1]

States commonly included the following "Other" definitions in their survey responses, which we also recommend considering:

- Fiscal exploitation resulting or not resulting in law enforcement or intervention
- Medication error
- Use and/or improper use of restraints
- Mental health treatment/ psychological injury (e.g., emotional trauma, suicide attempt, etc.)
- Criminal activity/ law enforcement intervention
- Missing person/elopement

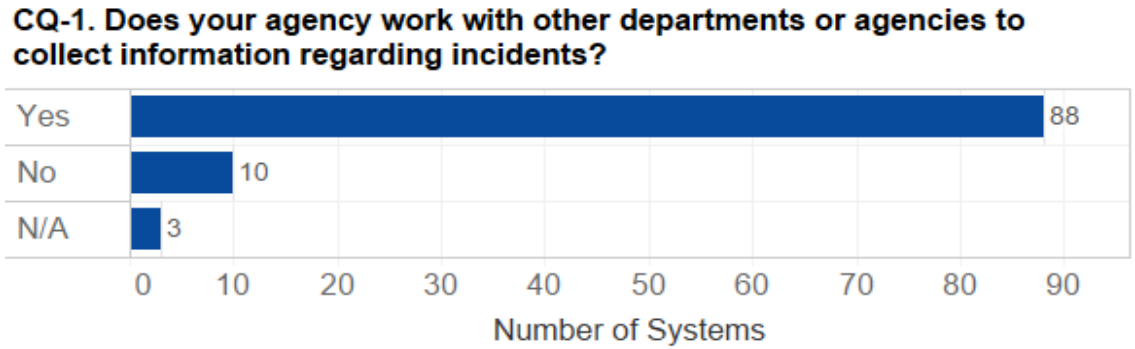
A clear, standardized definition reduces ambiguity with regard to what qualifies as an incident and leads to more efficient identification of incidents throughout all levels of the care delivery system.

1.) U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *CMCS Informational Bulletin: Health and Welfare of Home and Community Based Services (HCBS) Waiver Recipients* (June 2018), Available online: https://www.medicaid.gov/federal-policy-guidance/downloads/cib062818.pdf

Key Finding: Shared Responsibility Can Result In Coordination Challenges

- Responsibility for incident management activities is typically passed from agency to agency, resulting in a complex system that requires interagency collaboration and clearly defined roles and responsibilities.

Figure 3: Department Collaboration to Collect Information on Reported Incidents



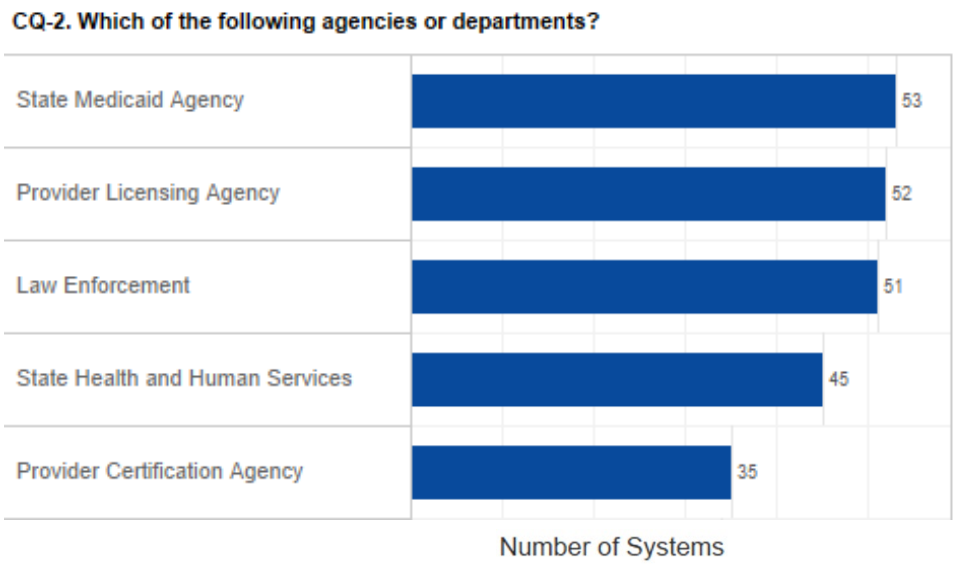
- Findings from the surveys showed states often experience communication challenges, especially when there is no formal structure for coordination.
  - Many states have Adult Protective Services (APS) programs that are involved in identifying and investigating the ANE of adults. Survey respondents commonly stated that APS does not always disclose report outcomes to the oversight agency.

Key Finding: There is Potential for SMAs to Establish Stronger Oversight of Their Systems

As the authority responsible for 1915(c) waiver programs, the State Medicaid Agency (SMA) can provide authoritative support for incident management.

- SMAs should ensure that incident management systems are operating effectively, regardless of whether SMAs manage these systems or delegate management to operating agencies.

Figure 4: Top 5 Collaborative Entities*

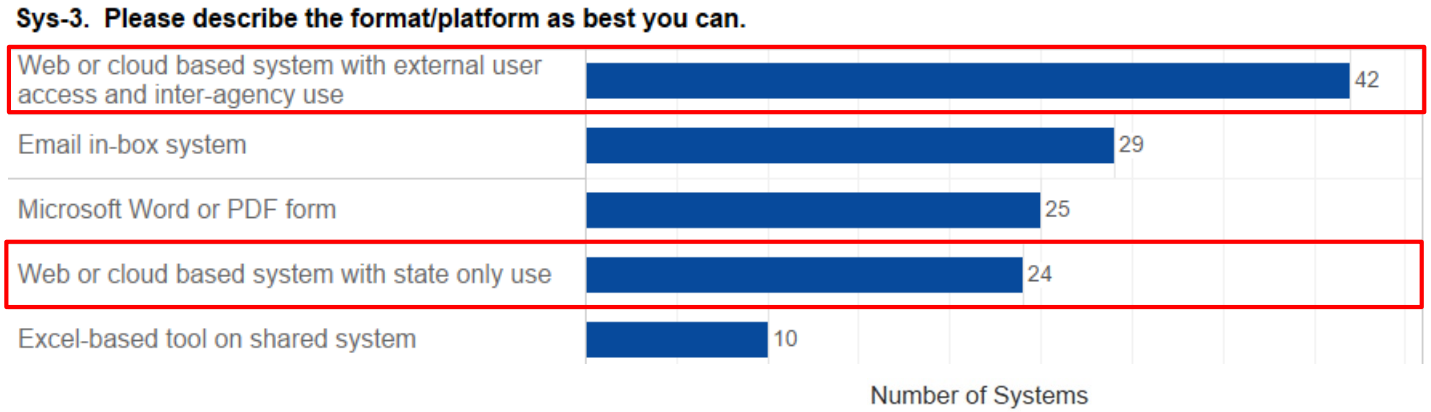


*Note: For this question, states had the option of selecting multiple answer choices. As a result, total response counts do not sum up to 101 systems.

Key Finding: States Can Benefit from Designing Their Systems on Electronic Platforms

Many states are currently using web- or cloud-based systems, which are powerful tools to help improve their incident management systems.

Figure 5: Top 5 Electronic Platforms*



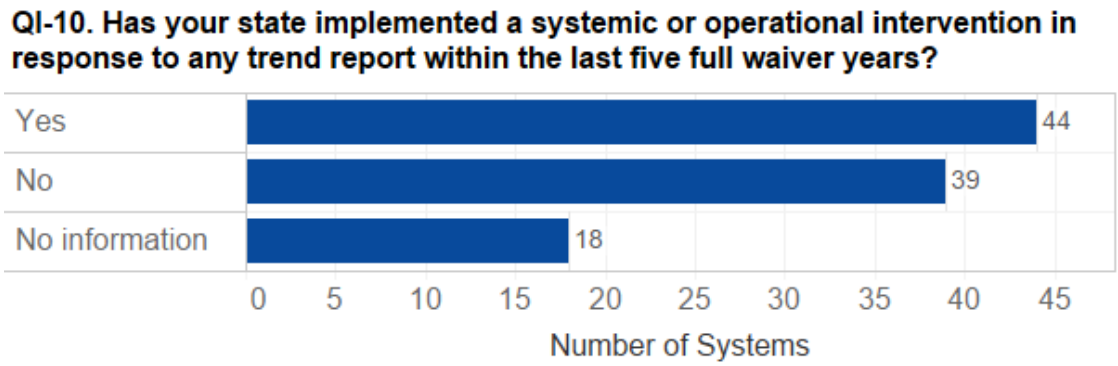
- States face challenges with outdated technology platforms and manual processes.
- Electronic, web- or cloud-based, systems can help states:
  - Streamline data aggregation, compilation and analysis through one central platform.
  - Support data access for multiple stakeholders (e.g., reporter, state agency staff, etc.).
  - Update and adapt to changing needs.
  - Support interoperability.

*Note: For this question, states had the option of selecting multiple answer choices. As a result, total response counts do not sum up to 101 systems.

Key Finding: States Would Benefit From Leveraging Trend Data to Develop Interventions

- Incidents, once reported and recorded in an electronic system, can be continually tracked and used for trend analysis.
- Survey findings show that incident management systems use data to develop trend reports for the state.
  - However, only 44 of 101 systems (43 percent) have implemented a systemic or operational intervention in response to trend reports.

Figure 6: Interventions Implemented as a Result of Trend Reports



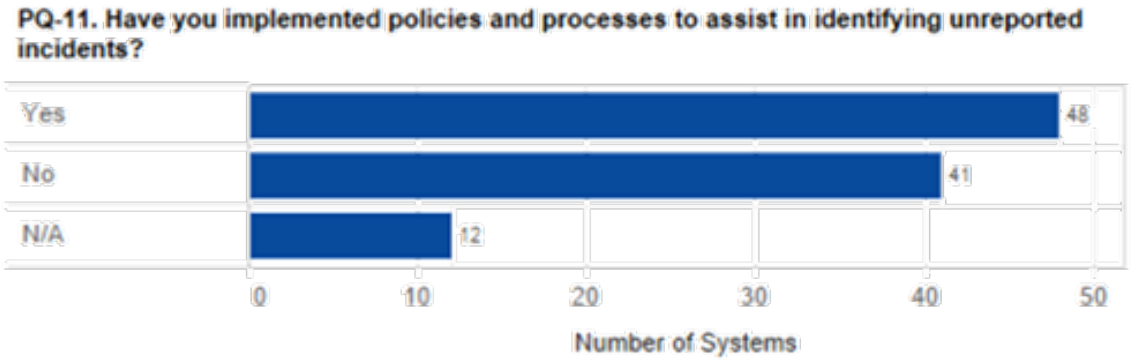
- States should consider implementing data-driven interventions, such as performance measures and trainings.

Key Finding: States Should Consider Tactics that Target Unreported Incidents

Systems can improve upon the identification of unreported incidents.

- Only 48 of 101 surveyed IM systems (48 percent) have implemented policies and processes to assist in identifying unreported incidents.

Figure 7: Identifying Unreported Incidents



- States should further the adoption of tactics that focus on identifying unreported incidents. These tactics include:
  - Additional training sessions
  - Additional check-ins or home visits by providers/case managers
  - Review of service plans
  - Creation of lists identifying individuals with higher risk of incidents

Health & Welfare Special Review Team

CMS created the Health & Welfare Special Review Team (H&W SRT) to support state efforts to assure the health and welfare of individuals receiving home and community-based services (HCBS) as part of a response to a joint report issued by the Office of Inspector General, Administration for Community Living, and the Office for Civil Rights: *Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight.* January 2018.

https://www.hhs.gov/sites/default/files/report_joint_report_hcbs.pdf

Health & Welfare
Special Review Team (cont'd)

The H&W SRT objectives are as follows:

- Assess individual state health and welfare systems
- Identify promising practices related to health and welfare
- Provide technical assistance as needed

Promising Practices for Health and Welfare Systems

- Electronic incident management systems
- Mortality and morbidity review processes
- Medicaid data correlation audits
- Leveraging licensing and certification entities
- Comprehensive training processes on incidents
- Leveraging inherent checks and balances in community service systems to improve the ability to identify incidents

Electronic Incident Management Systems

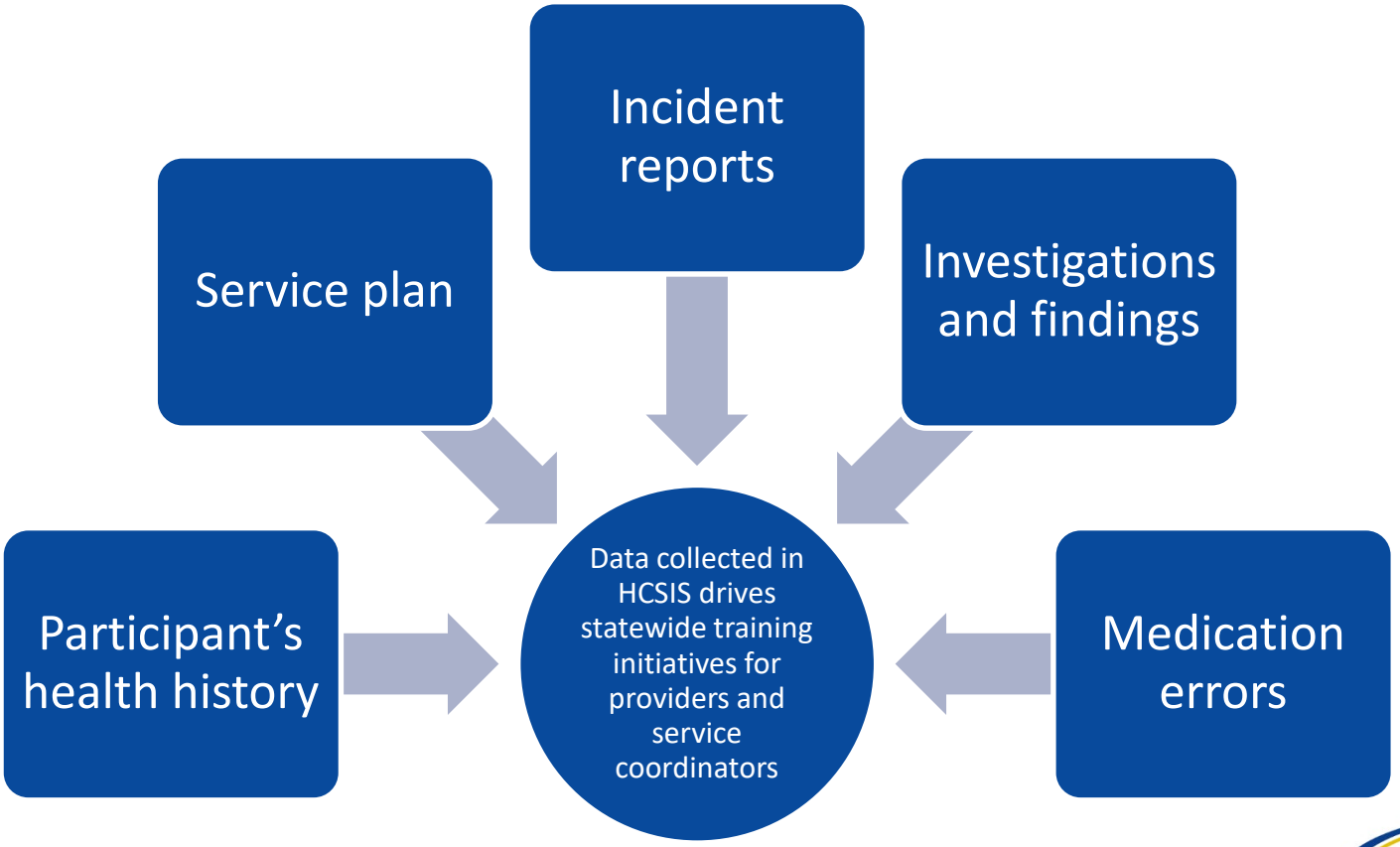
The Joint Report recommended that a critical incident management process include tracking of incident reporting, review, investigation, corrective actions, and trend analysis.

H&W SRT observed that:

- HCBS waivers serving participants with intellectual/developmental disabilities (I/DD) have adopted electronic incident management systems more than waivers serving other populations
- Some HCBS waivers serving participants who are aged, who have a brain injury, or who have physical disabilities are relying on lessons learned to develop and implement their own systems

Massachusetts: Electronic Incident Management System

MA Incident management system is a component of the Home and Community Services Information System (HCSIS)



Ohio: Electronic Incident Management System

Ohio has 20 years of experience using an easily accessible incident tracking system

- Capacity to trend by provider, provider type, region, waiver program, and participant
- Data used to evaluate incident investigations and overall incident management process

Mortality and Morbidity Review Process

The Joint Report recommends that states conduct a mortality review process to do the following:

- Report and review all waiver participant deaths
- Complete corrective actions to evaluate, track, and correct circumstances contributing to participant deaths
- Report reviews publicly

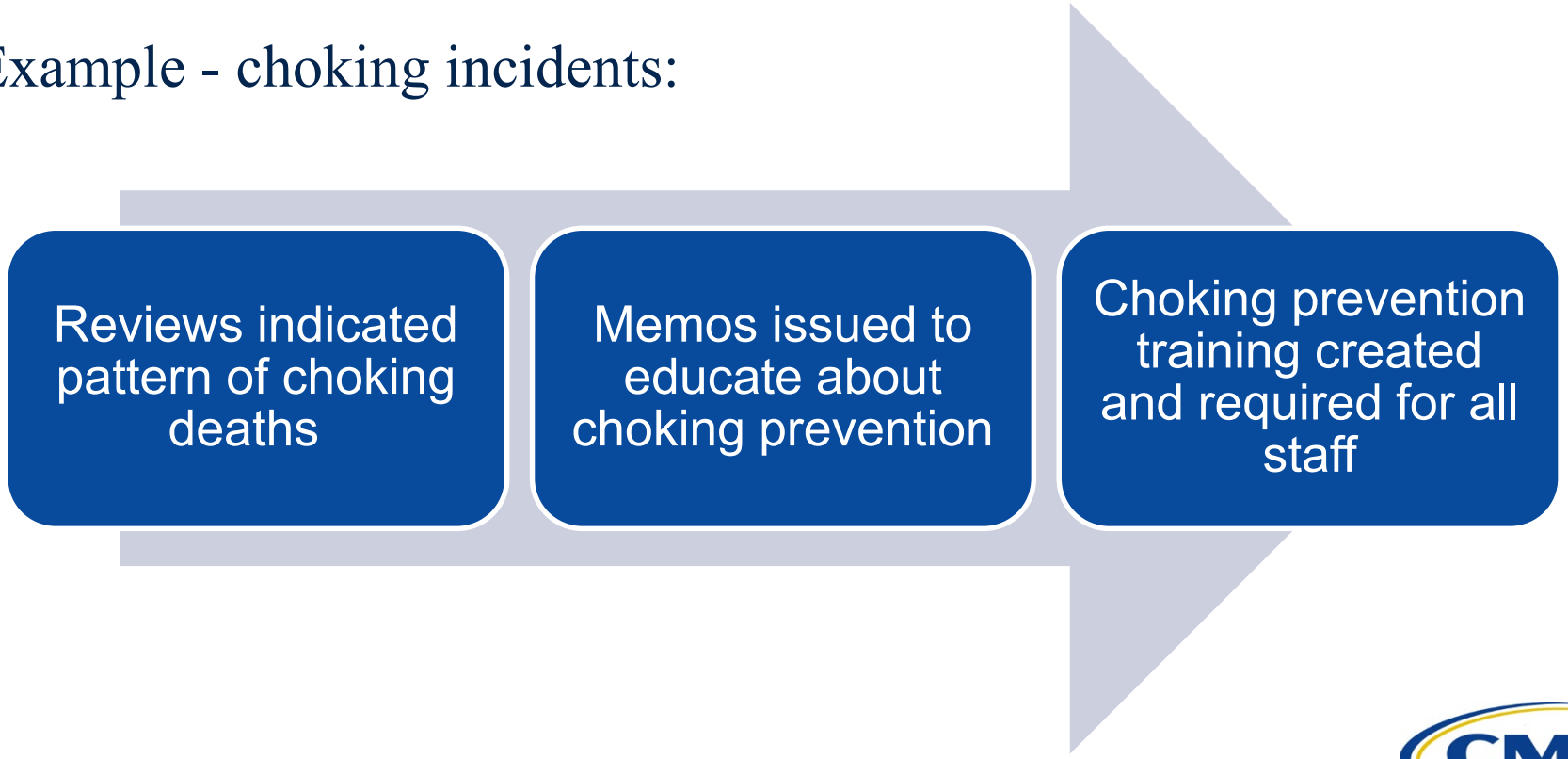
The H&W SRT found that:

- There are more mortality review processes established for waivers that serve participants with ID/DD compared with waivers that serve other populations.
- States may find value in consulting with their ID/DD Agencies when setting up a mortality review process for other populations.

Maryland: Mortality and Morbidity Review Process

Maryland's Developmental Disabilities Administration Mortality Review Committee meets quarterly to review cases, identify patterns and trends, and make recommendations.

Example - choking incidents:



Medicaid Data Correlation Audits

The Joint Report outlined a Model Practice for incident management audits

- Utilization of a Medicaid Data Correlation Audit to determine whether incident reports were filed based on other Medicaid data, usually service claims.
  - Samples of claims are screened for:
    - Allegations of abuse, neglect, or exploitation
    - Emergency department visits
    - Unplanned hospitalizations
    - Ambulance services
    - Urgent care center visits related to accidental injuries
- Claims are then compared with incident reporting data to ensure that incidents were reported as required
- Findings reports should identify any patterns of provider noncompliance with incident reporting

Medicaid Data Correlation Audits (cont'd)

Health and Welfare SRT Observations

- States that engage in data correlation analysis require a data exchange agreement between their Medicaid Management Information Systems (MMIS) and their incident management systems
- Despite electronic tracking systems, much of this analysis remains manual

Massachusetts: Medicaid Data Correlation Audits

Data exchange agreement between the operating agency and the state Medicaid agency, developed and implemented at the recommendation of a 2016 OIG audit

- Allows the operating agency to retrospectively review claims data to "match" emergency department claims to incident reports and to ensure that follow-up activities are conducted (process remains manual)
- Early results: Emergency Department visit claims that do not match an incident report are steadily decreasing
- State's conclusion: Providers are getting better at reporting incidents

Leveraging Licensing and Certification Entities

The Joint Report recommends assessment of service provider and support coordination/case management agency performance at least biennially.

- Assessment could involve a licensure or certification review completed by the licensing entity or other delegated agency

H&W SRT observed:

- States are leveraging licensing and certification to improve provider compliance with ensuring health and welfare

Oregon: Leveraging Licensing and Certification

- Comprehensive licensing information made public and easily accessible: https://ltclicensing.oregon.gov/
  - Includes compliance history and abuse complaints of licensed long-term care providers, such as adult foster homes or assisted living facilities
  - Helps participants make informed choices about care providers
  - Publicly reports any substantiated abuse, neglect, and exploitation findings for providers, level of harm assessed, and sanctions issued
    - Example: Failed to adequately update care plan related to falls

Nebraska: Leveraging Licensing and Certification

- Provider completes training, gains state approval of policies, completes an on-site review, and gains a Provisional License for 6 months.
- Department of Public Health reviews all regulatory compliance items, with a focus on incidents reported and how the provider responded, and provider gains an Initial Certification for 1 year.
- Department of Public Health reviews quality, compliance, and performance in preventing, reporting, and responding to incidents, and provider earns Ongoing Certification for 1 to 2 years.

Comprehensive Training Processes on Incidents

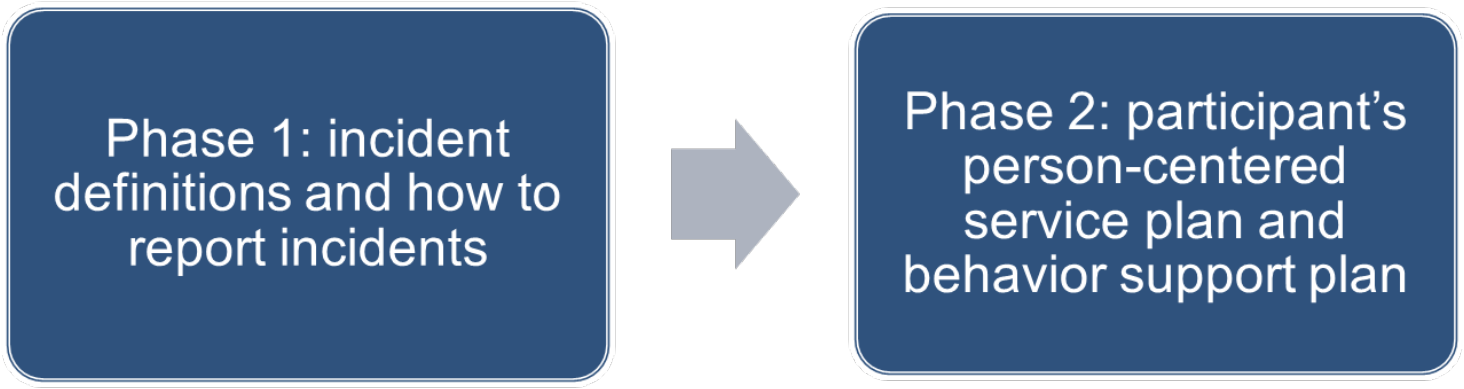
The Joint Report advises that states disseminate and ensure appropriate training regarding definitions of reportable events to service providers and support coordinators/case managers

The H&W SRT observed that states establish training requirements at several levels:

- Direct support staff
- Support coordinators/case managers
- Investigators
- Participants

District of Columbia: Comprehensive Training Processes on Incidents

- District of Columbia completes training of providers, support coordinators/case managers, and incident investigators using Labor Relations curriculum



- Each investigator is partnered with provider agencies to provide an additional training monthly on incident-related topics (e.g., whistleblower protections)

Massachusetts: Comprehensive Training Processes on Incidents

Training options are readily available online

- Standard mandated reporter training
  - Licensing reviews ensure compliance with mandated reporter training
  - Following implementation, incident reporting rates increased
- State and university partnership to data mine incident reports to introduce new trainings
  - Data indicated increase in reported falls
  - Falls Prevention Training Program: falls decreased by 33 percent within 6 months following training

Leveraging Inherent Checks and Balances in Community Service Systems to Improve the Ability to Identify Incidents

The Joint Report identifies importance of assessment of community inclusion outcomes for participants as a component of the Model Practices aimed at State Incident Management systems and state quality assurance. Service recipients, their families, and friends in the community can play a key role.

The H&W SRT observed that some states shared that efforts at community integration had the additional benefit of increasing the individual's support group, reducing isolation of the individual (which increases the risk of abuse and neglect), and providing the individual multiple avenues for support if s/he is experiencing or has experienced abuse and/or neglect.

Ohio: Leveraging Checks and Balances in Community Service Systems to Improve the Ability to Identify Incidents

- Community-based personal care services are provided within an art studio

Montana: Leveraging Checks and Balances in Community Service Systems to Improve Ability to Identify Incidents

A floral shop partnered with a day habilitation program to create employment opportunities for participants with I/DD leading to:

- Steady employment opportunities
- Increased community connections
- Increased reported abuse, neglect, and exploitation

Critical Incident Management Challenges Identified in States

- Differing thresholds for reporting and definitions of critical incidents
- Lack of understanding about how to report
- Potential for underreporting
- Inconsistencies and limitations of investigations
- Workflow challenges with investigative entities (Adult Protective Services(APS)/Child Protective Services (CPS))
- Background/registry checks may not be used to their full potential

Recommendations for States

- Improve partnership with protective services entities (APS/CPS)
- Use the state's data to identify trends and systemic issues
- Use the state's available resources for maximum impact
- Share promising practices across waivers and operating agencies within the state

Key Considerations

- Strengthen partnerships with stakeholders outside of Medicaid, such as licensing and protective services, to improve participant health and welfare
- Follow the data to identify pockets of underreporting, to proactively address trends of incidents with training or other interventions, and to determine whether systemic improvements have any impact
- Identify and use the state's resources to address the issues identified by the data
- Use the resources already developed and implemented to a more meaningful effect
- Borrow lessons learned from other operating agencies and other states as they improve their own incident management policies and procedures

Questions

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