Critical Incident Management: Core Elements to Enhance Your Approach

February 25, 2020
TODAY’S DISCUSSION

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

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1. Introduction to Speakers
2. A Quick Refresher on Critical Incident Management
3. Core Elements of an Electronic Incident Management System
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:
  o Abuse, Neglect, and Exploitation
  o Unexpected Deaths
  o Unexpected Hospitalization
  o Serious Injury
  o Criminal Activity/Legal Involvement
  o Loss of Contact/Elopement
  o Suicidal Behavior
  o Medication Errors
  o 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:
  o The state must demonstrate on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.
  o 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.
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.
1. Introduction to Speakers
2. A Quick Refresher on Critical Incident Management
3. Core Elements of an Incident Management System
CORE ELEMENTS OF AN INCIDENT MANAGEMENT SYSTEM

1. Policy
2. Reporting
3. State Review
4. Investigations
5. Outcomes
6. Analytics
7. Quality Improvement
• 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.
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.
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?
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.
DETERMINE WHO WILL INTERACT WITH THE SYSTEM

ADRC (No-Wrong Door)

OAA System

Waiver CM System(s)

Critical Incident Management System

Adult Protective Services

Child Protective Services

Web Incident Form

Public

Guardianship

State Plan Providers

Aging/OAA Providers

Medicaid MCOs

PD/ID/DD Providers

State Hospitals

SNFs ICFMR

Cong. Living Providers

WellSky

1 Policy

2 Reporting

3 State Review

4 Investigations

5 Outcomes

6 Analytics

7 Quality Improvement
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

- What is the person’s current status? (Choose one)
  - Stable with no serious changes noted
  - Stable with no serious changes noted who could benefit from facility placement (specify location and date below)
- Other, briefly describe:

- Could this incident have been prevented? (Choose one)
  - Yes
  - No
  - Unknown

- If yes, then how could the incident have been prevented?

- Ensure timely implementation of current Crisis Support Plan
- Other, briefly describe:

Colorado – Subcategories for Incident Types

- Serious Injury/Illness Type
  - Serious Burn
  - Scoliosis
  - Fracture
  - Dislocation
  - Loss of Limb
  - Other

- Cause of Injury/Illness
  - Accident
  - Medical Condition
  - Poor Care
  - Undermined
  - Other

- Did Serious Injury/Illness Result in Hospitalization? (Choose one)
  - Yes
  - No

- If Yes is selected, where was client hospitalized?

Massachusetts – Body Part of Injury

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

- Toe
- Genital
- Finger
- Arm
- Foot
- Front Torso
- Eyebrow
- Elbow
- Ankle
- Back Torso
- Nose
- Wrist
- Knee
- Internal Organs
- Ear
- Hand
- Leg
- Neck
- Mouth
- Finger
- Hip
- Head
- Shoulder
- Other
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.
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
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
2. Establish policies and procedures for investigators.
3. Consider whether joint state agency investigations are needed.
4. Determine how to share results with other relevant state agencies.
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
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.
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.
Provider Compliance 24 Hour Reporting by Region

Compliant  Non-Compliance
% of Critical Incidents with Investigations Initiated within 48 Hours

Investigations Initiated within 48 Hrs

- 2018-Q1: 65%
- 2018-Q2: 62%
- 2018-Q3: 70%
- 2018-Q4: 66%
- 2019-Q1: 44%
- 2019-Q2: 68%
- 2019-Q3: 62%
- 2019-Q4: 71%
TYPE OF DEATH 2011-2019

- NC-Anticipated
- NC-Unanticipated
- Accidental
- Homicide
- Suicide
- Undetermined
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.

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

<table>
<thead>
<tr>
<th>Critical Incident Report Card</th>
<th>Incidents</th>
<th>Preventable</th>
<th>Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Incidents</td>
<td>36</td>
<td>13</td>
<td>↑</td>
</tr>
<tr>
<td>Number of Falls with Injury</td>
<td>6</td>
<td>2</td>
<td>↓</td>
</tr>
<tr>
<td>Number of ED Admits</td>
<td>12</td>
<td>3</td>
<td>⇔</td>
</tr>
<tr>
<td>Unexpected Deaths</td>
<td>4</td>
<td>1</td>
<td>⇔</td>
</tr>
<tr>
<td>Medication Errors</td>
<td>10</td>
<td>4</td>
<td>↓</td>
</tr>
<tr>
<td>Use of Restraints/Seclusion</td>
<td>4</td>
<td>4</td>
<td>↑</td>
</tr>
</tbody>
</table>
"If you can't measure it, you can't improve it."
Peter Drucker
QUALITY IMPROVEMENT SHOULD REGULARLY IMPACT YOUR APPROACH
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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