Session ID: 2131

“LTSS Incident Management:
A Panel from 3 states discuss Best Practices and a National Solution”

Panel Presenters

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November 20, 2017

NASDDDS Issues Report on Incident Management and Mortality Reporting in Select State I/DD Systems

Topics: Announcements, Data and Outcomes, HCBS, Quality,

NASDDDS has recently issued a report on the Incident Management Systems and Mortality Reporting in Select State Intellectual/Developmental Disability Systems. As described in the report, there was a series of issues that arose that prompted attention on the quality of HCBS across the country, which prompted NASDDDS to undertake the study to identify strong state practices, replicable in State I/DD programs across the country.

State DD agencies use multiple approaches to track, measure, and analyze the status of individual and collective health and well-being. More than a compliance exercise, states use multiple approaches towards protecting, preventing and continuously monitoring for indicators of abuse, neglect or mistreatment of their citizens with intellectual and developmental disabilities. This report provides highlights of the activities of twelve states, and a self assessment tool for states interested in assessing the thoroughness of both the design and execution of the system in place for identifying, reporting, intervening, preventing and responding to critical

Current Across the States Incident Management

In the initial findings of the OIG report the states:

- Failed to ensure that group homes reported all critical incidents (CI).
- Failed to ensure that all CI reported were properly recorded.
- Failed to report incidents at the correct severity level.

- Failed to ensure that all data on CI were collected and reviewed.
- Failed to ensure that reasonable suspicions of abuse or neglect were properly responded.

Report Recommendations

1. Reliable incident management and investigation processes;
2. Audit protocols that ensure compliance with reporting, review, and response requirements;

Report Recommendations

3. Effective mortality reviews of unexpectant deaths;

4. Quality assurance mechanisms that ensure the delivery and fiscal integrity of appropriate community based services.

State Panel Discussion

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What was the state process for critical incidents collection or management prior to Therap?

What challenges did you face in deploying a system like Therap, How do you get Provider Buy in...What did you learn, or what would you do different?

What has changed since implementing Therap?

How is the data you are receiving now informing your decision making, training, services?

Q & A

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