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Incident Management in 1915(c) Waiver Programs: Incident Management Recommendations

Division of Long Term Services and Supports

Disabled and Elderly Health Programs Group

Center for Medicaid and CHIP Services

Training Objectives

- This training is part three of a three-part training series 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
- This final training will focus on CMS' recommendations for how states can improve their efforts in developing robust incident management systems.

Overview of Incident Management

What is an Incident Management System?

- An “incident management system” includes all technologies and processes implemented within a state to manage incidents.
- According to the 1915(c) Technical Guide, page 225, an incident management system must be able to:
  - Assure that reports of incidents are filed;
  - Track that incidents are investigated in a timely fashion; and
  - Analyze incident data and develop strategies to reduce the risk and likelihood of the occurrence of similar incidents in the future.[1]

Key Elements of Incident Management Systems

- The following are six key elements that states must consider when implementing an effective Incident Management System:

1. Identifying the Incident
2. Reporting the Incident
3. Triaging the Incident
4. Investigating the Incident
5. Resolving the Incident
6. Tracking and Trending Incidents

Overview of the Incident Management Survey

Survey Background

- Incident management has become a focus of the U.S. Health and Human Services (HHS) Office of Inspector General (OIG) and Government Accountability Office (GAO) due to reports of preventable incidents that occur for individuals receiving home and community-based services (HCBS).
- In July 2019, CMS issued a survey to 47 states requesting information on their approach to operating an incident management system under 1915(c) HCBS waiver authority.
- The goal of the survey was to obtain a comprehensive understanding of how states organize their incident management system to best respond to, resolve, monitor, and prevent critical incidents for their waiver programs.

Survey Methodology

- This survey was provided through a web-based platform.
- States self-reported their data and submitted surveys for each unique incident management system.
- 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)

State Interviews

- CMS conducted interviews with 5 states to gain a more in-depth understanding of their incident management systems from October 2019 to January 2020.
- These 5 states were selected for interviews because they demonstrated promising practices in their survey responses.
- CMS developed interview questions tailored to each state's incident management systems. Interview questions sought to clarify responses provided in the survey and to highlight the strengths and lessons learned of each state system.

Overview of Survey Responses

- 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 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%

Waiver Populations

- States often develop differing systems and processes in response to varying waiver program design and population needs.
  - **Example:** One state operates two incident management systems with one pertaining to AD waivers and the other pertaining to ID/DD waivers. This state reported that certification and licensure is different for various provider types. Therefore, referrals and investigations are handled differently for different waiver recipient populations.
- 62 of 101 systems (61 percent) serve one distinct waiver population.

Table 2: Breakdown of Waiver Populations Served*

Population	# of Systems	% of Systems
Aged or Disabled, or Both – General[1]	52	51%
Aged or Disabled, or Both – Specific Recognized Subgroups[2]	41	41%
Intellectual Disability or Developmental Disability, or Both[3]	54	53%
Mental Illness[4]	9	9%

1. This includes: Aged, Disabled (Physical), Disabled (Other)
2. This includes: Brain Injury, HIV/AIDS, Medically Fragile, Technology Dependent
3. This includes: Autism, Developmental Disability, Intellectual Disability
4. This includes: Mental Illness, Emotional Disability

*Note: States had the option of selecting multiple populations. As a result, total response counts do not sum up to 101 systems.

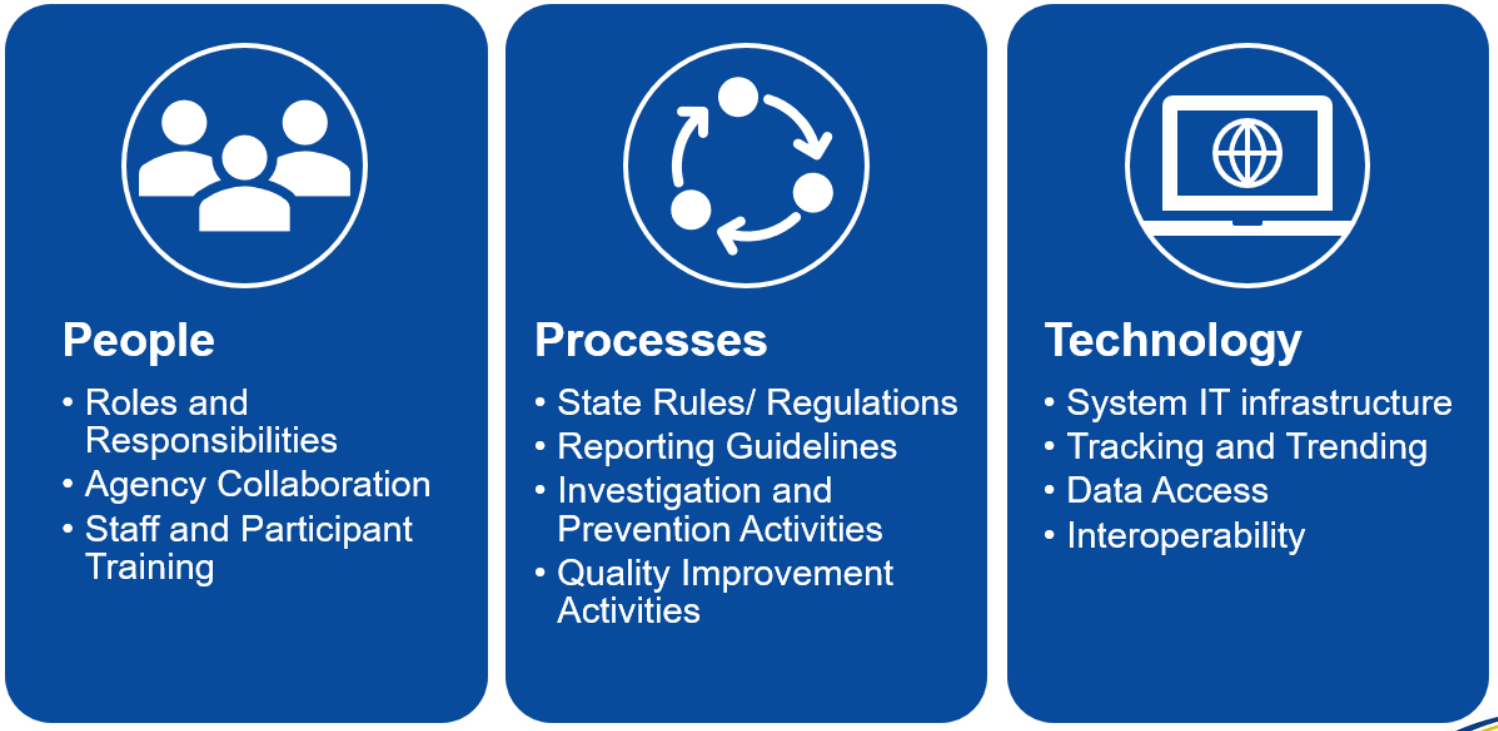
Recommendations based on Findings from the Incident Management Survey

Overview of Findings

- States have adopted different technical and administrative strategies to assist with incident management.
  - Findings from the survey and state interviews demonstrate that states have attempted to identify and implement solutions in response to varying priorities, whether legislative or based on state population needs.
- States with the most advanced incident management systems consider incident management as a cohesive system rather than siloed processes and activities aimed towards managing incidents.
  - Results from the survey and state interviews clearly demonstrate that different variables (people, process, and technology) impact the success of incident management.

Incident Management Requires Coordination of People, Processes, and Technology

- These variables work in conjunction with one another and share equal responsibility for the success of the incident management system.
- For example, the impact of a strong technology platform is limited if incidents are not adequately defined or stakeholders do not collaborate.



Recommendation 1: States could benefit from establishing and uniformly applying a consistent definition of critical incidents for waiver populations within the state.

Definitions of Critical Incidents Vary Across and Within States

There is no standardized, federally defined term for "critical incident" that outlines the scope of reportable incidents.

- This leads to variation across states and across programs within the same state.
- Unique definitions are used within states across different systems. One surveyed state operated four systems with four different definitions of critical incidents.

Table 3: Example of Differing Definitions of Critical Incidents Within a State

System 1	System 2	System 3	System 4

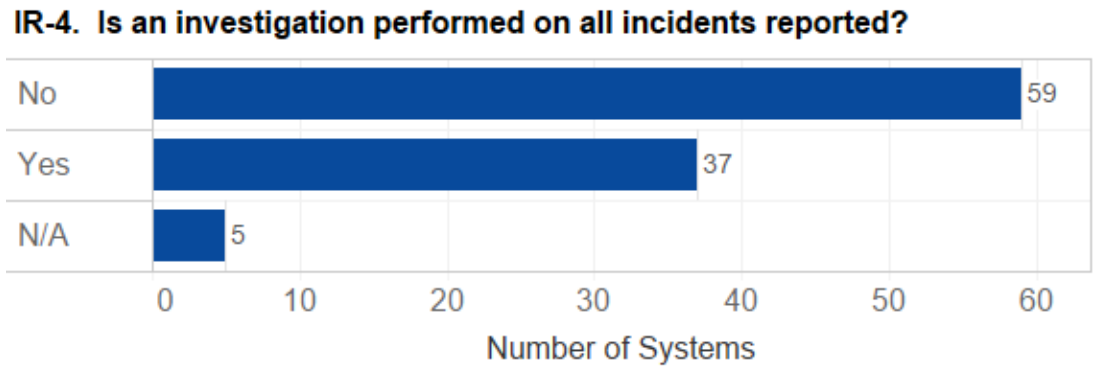
• Abuse resulting in ER visit or physical injury
• Neglect resulting in ER visit or physical injury
• Exploitation resulting in ER visit or physical injury
	• Accidental/Unexpected Death
	• Other:
	  ○ Alleged rape
	  ○ Fire
	  ○ Sprinkler pipe break
	  ○ Flood
	  ○ Extended utility or mechanical outage
		• Abuse resulting in ER visit
		• Neglect resulting in ER visit or physical injury
		• Exploitation resulting in ER visit or physical injury
		• Accidental/Unexpected death
			• Other
			  ○ APS established categories of priority based on possibility of harm

Identifying Incidents by Risk Allows States to Prioritize Investigations

A majority of state systems do not conduct investigations on all reported incidents.

- Survey results illustrate that 59 of 101 systems (58 percent) do not perform investigations on all reported incidents.

Figure 1: Investigations on Reported Incidents



- States reported that they relied on the nature and severity of the incident to determine which incidents to investigate.
- Not all incidents require or would benefit from an investigation. However, incidents identified as critical should trigger an investigation.

Unclear Definitions Can Hinder Systems' Ability to Respond to Incidents

Without clear definitions states may overlook systemic problems.

- The GAO, in their 2018 report on Medicaid Assisted Living Services, found that "Without clear instructions as to what states must report, states' annual reports may not identify deficiencies with states' HCBS waiver programs that may affect the health and welfare of beneficiaries." [2]
- **This finding from the GAO is also supported by findings from the survey.**
  - **Example 1: Lack of Differentiation**
    - One state reports on all incidents of hospitalizations and ER visits, due to a lack of clarity about whether an incident is considered critical or non-critical. Many waiver participants experience chronic health issues, resulting in overreporting of hospitalizations and ER visits, even if not tied to an incident.
    - This is a burden on state resources and often misdirects states from triaging and investigating the most urgent incidents.
  - **Example 2: Lack of Specificity**
    - A state system reported that design issues and a lack of a clear definition led to a majority of incidents categorized as "Other", which has limited the state's ability to identify system level patterns and trends.

Standardized Definitions Reduce Ambiguity and Overreporting

Several surveys noted that the success of their incident management system is dependent on the identification and reporting of incidents.

- To reduce redundancies and potential gaps in what types of incidents are reported, states should begin to clearly define incidents and consistently apply this definition within their incident management system across their waiver programs.
- A standardized definition reduces ambiguity with regards to what qualifies as an incident and leads to quicker identification of incidents throughout all levels of the care delivery system.

States Could Benefit from Applying a Standardized Definition of Critical Incidents

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

- Accidental/Unexpected Death
- Broadly defined allegations of physical, psychological, emotional, verbal and sexual abuse, neglect, and exploitation (ANE) [3]

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 of restraints
- Mental health treatment/ psychological injury
- Criminal activity/ law enforcement intervention
- Missing person/elopement
- General risk to health and welfare

Critical Incident Definitions Codified In State Law Can Enforce Accountability

States should codify definitions in state law or regulation to enforce accountability within an incident management system.

- Definitions outlined in state law promote transparency for all individuals involved with incident management, including beneficiaries, providers, and state staff.
  - One interviewed state emphasized this as a best practice, since all stakeholders are aware of what they need to report.
  - One surveyed state cited a lack of an explicit statutory obligation as a weakness and limitation of their system as it has hindered providers' understanding of which incidents need to be reported.

Recommendation 2: There is an opportunity for State Medicaid Agencies (SMAs) to establish stronger oversight of their systems.

Multiple Entities Are Often Responsible In The Incident Management Process

Incident management is often the responsibility of multiple entities within the state.

- These entities include state agencies involved in the delivery of Medicaid services, Program Integrity staff, state Attorney General/Inspector General, and protective services agencies.
- States report that, on average, 2 to 3 entities are responsible for key incident management activities, such as contacting individuals about the incident report, referring incidents to additional investigative authorities, or following-up with individuals.

Shared Responsibility Across Agencies Can Result In Coordination Challenges

Shared responsibility across agencies often results in disjointed communications across different parties.

- Surveys noted communication challenges, especially when investigations are not conducted by the oversight agency.
  - Survey respondents stated that protective services programs do not always disclose investigation outcomes to the oversight agency, which creates information gaps and hinders follow-up efforts.
- Shared responsibilities without a formal structure for coordination can result in duplicated efforts and inefficient use of state resources.
  - One surveyed state reported that because its Division of Medicaid and Department of Human Services are separate agencies, case managers and providers are required to separately report incidents in both agencies resulting in duplication of effort.

States Could Benefit From Establishing a Governance Structure for Managing Incidents

States could benefit from establishing a governance structure to minimize confusion regarding roles and responsibilities of the incident management process.

- Agencies involved in the incident management process need to collaboratively develop solutions and strategies to support managing incidents.
- Several interviewed states emphasized a need for a champion that prioritizes information sharing across agencies to support the incident management system.
  - One state described how the State Medicaid Agency provides oversight of the incident management system and partners with the Department of Intellectual and Developmental Disabilities to analyze incident data and respond with interventions.

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

As the ultimate authority responsible for 1915(c) waiver programs, the SMA is uniquely positioned to provide authoritative support regarding the incident management system.

- The SMA is accountable to CMS for implementing an effective system that assures waiver participant health and welfare.
- SMAs should ensure that incident management systems are operating effectively, regardless of whether they directly manage these systems or delegate management responsibility to operating agencies.
- SMAs should maximize their partnerships with the agencies that operate, manage, and implement their incident management systems.

Recommendation 3: States can benefit from designing their incident management systems on an electronic platform that centralizes the reporting, tracking, and sharing of incidents.

States Can Benefit From Designing Systems on a Web- or Cloud-based Platform

The use of web- or cloud-based systems is a powerful tool for states looking to improve their incident management system.

- Reporting, tracking, and sharing data are foundational elements of the incident management process.
- Technology supports real-time data reporting, tracking, and sharing. Web- or cloud-based systems streamline and provide centrality to the incident management process in the state.

Web- or Cloud-based Platforms Support Greater Access to Data

Electronic systems support data access for many stakeholders, ranging from the reporter to state agency staff.

- Typically, more than one entity or individual is responsible for incident management.
- State systems that support electronic functionalities are more likely to provide access to more than one stakeholder.
  - States that reported using no electronic capabilities usually limited system access to their OAs and/or their SMAs.
  - Systems that support electronic functionalities provide access to approximately 4 stakeholders.
- Manual processes or Microsoft tools often limit the use of the information to one individual at a time, whereas electronic systems allow for multiple individuals to access the system concurrently.

Web- or Cloud-based Platforms Support Continual Data Aggregation and Analysis

Web- or cloud-based platforms provide a way for states to capture information from a variety of sources in one location.

- Consolidating multiple databases and reports in a central location can help maintain data integrity and streamline data aggregation, compilation, and analysis.
- Incidents, once reported and recorded in an electronic system, can be continually tracked and used for trend analysis.
  - Of the 78 survey responses indicating the use of trending capabilities, 48 (62 percent) are web- or cloud-based and 30 (38 percent) are non web- or cloud-based.

Web- or Cloud-based Platforms Facilitate Data Sharing Across Different Systems

Web- or cloud-based systems can support interoperability.

- Incidents are nuanced and states can benefit from related information that may be available outside of what is collected in the initial incident report.
  - One state expressed that interoperability between the case management and incident management systems helped inform case managers of any potential investigations when delivering care.
  - One interviewed state is considering developing an integrated incident management and electronic visit verification (EVV) system with a dashboard supporting real-time information that investigators can access.
- Interoperability is an area states can begin to further develop.
  - Survey results indicate that only 33 of 101 systems (33 percent) support electronic interoperability with other systems.

Effective Systems are Updated Based On Changing Needs

States can adapt web- or cloud-based systems to meet their changing needs.

- Incident management is an evolving and often iterative process.
- Many states reported that since implementing an incident management system, they are continually updating and making revisions to address feedback provided from key stakeholders, data from trend analysis, and new legislative requirements.

Legacy Systems and Cost Can Be Barriers to Implementing Web- or Cloud-based Systems

States may encounter challenges when implementing web- or cloud-based systems.

- Older legacy systems struggle to adapt to the changing landscape of incident management and cannot develop necessary trend reports.
- States must factor the costs associated with system implementation as well as ongoing maintenance and/or updates to functionality.
  - Leverage federal participation, such Health Information Technology for Economic and Clinical Health (HITECH) funding made available by CMS through Federal Fiscal Year 2021 via the APD process described in 42 CFR 495. [4]
  - One interviewed state received a grant from the Department of Justice to fund the development of an online reporting system to support online reporting capabilities aimed to prevent elder abuse.

Recommendation 4: States should ensure a comprehensive Quality Improvement Strategy (QIS) that maximizes the use of available data to support systemic interventions.

States Can Benefit From Maximizing the Use of Available Data

Strong incident management systems require a comprehensive QIS that maximizes the use of available data and supports the development of systemic interventions.

- Alternative datasets such as claims data and hospital admissions can be helpful in identifying unreported instances of abuse, neglect, and exploitation (ANE).
  - 27 of 101 systems (27 percent) conduct a cross check between ER admission data and HCBS case management data.
  - Only 8 of 101 systems (8 percent) integrate FWA provider lists with ANE providers.

Figure 2: Crosschecks Between ER Admission Data and HCBS Data

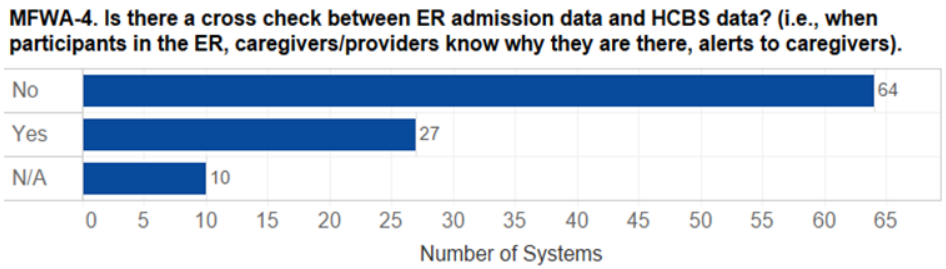
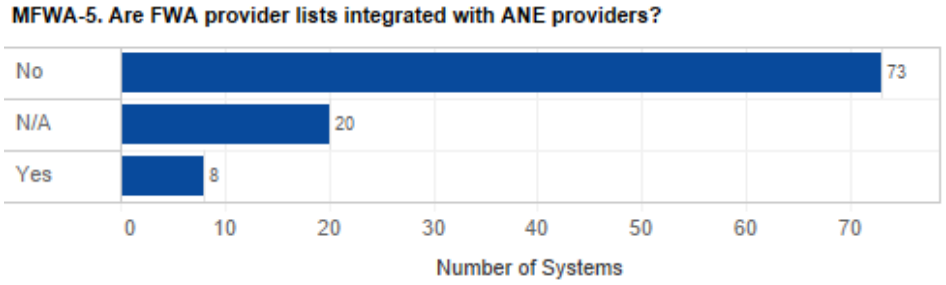


Figure 3: Integrated FWA and ANE Provider Lists



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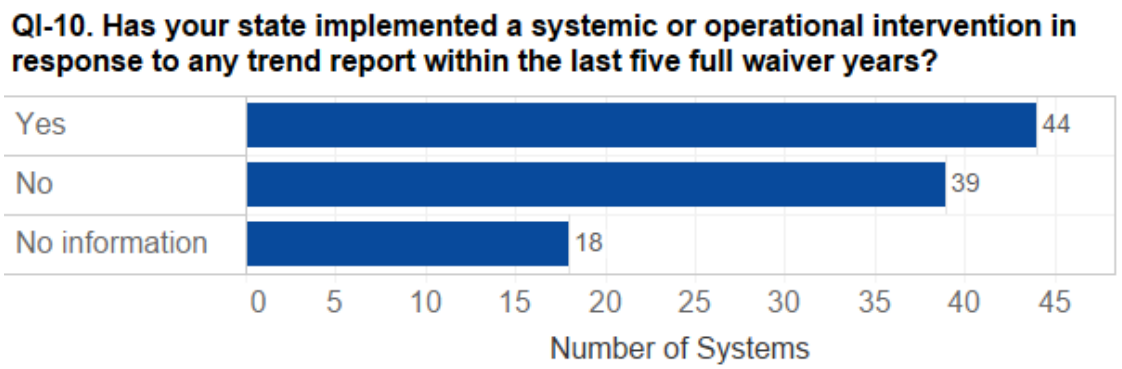
Trend Reports Can Inform Intervention Decisions and Track Their Effectiveness

Data-driven analyses can provide the necessary tools for identifying, understanding, and addressing systemic problems.

- Survey findings show that incident management systems use data to develop trend reports for the state.
  - 97 of 101 systems (96 percent) create at least one trend report based on critical incident data.
  - However, only 44 of 101 systems (43 percent) have implemented a systemic or operational intervention in response to trend reports.

Figure 4: Interventions Implemented as a Result of Trend Reports



Conducting Multi-Level Analyses Can Help States Develop More Targeted Interventions

Trends identified at the local or regional level may not apply universally to all areas in the state.

- States may need to tailor prevention tactics on a more regional basis, as certain state-wide interventions may not be relevant when tackling issues at a local level.
  - One interviewed state identified a spike in the number of reported incidents and isolated this increase to one region, with one provider, impacting three individuals within a specific agency. Rather than a state-wide intervention, the state focused on solutions for the three individuals impacted.

States Must Critically Evaluate Trends When Monitoring Intervention Efficacy

States that perform a multi-level review of data may find that an increase in incidents does not necessarily indicate a failure of preventive efforts implemented in the state.

- An interviewed state reported developing a health alert and additional trainings in response to a surge in number of physical abuse incidents.
- Following the intervention, the state saw a continued rise in abuse reports. The state determined that a rise in incidents could be attributed to an increased understanding of reporting requirements in response to the trainings.
- States need to be careful about drawing conclusions based solely on numbers of reported incidents – increases could be an indicator that there is additional awareness throughout all levels of the system.

States' Prevention Tactics Should Align With Their Greater Quality Goals and Objectives

Incident management systems should consider how their prevention tactics fit in relation to the state's greater quality goals and objectives.

- States should implement data-driven prevention tactics, such as performance measures and trainings. Of the 101 systems surveyed:
  - 61 systems (60 percent) reported creating new trainings based on findings from trend reports.
  - 47 systems (47 percent) reported implementing performance measures in response to trend reports.
- These findings provide insight into how state systems are using incident data trends to create strategies that improve the delivery of care and reduce unnecessary incidents from occurring.

Figure 5: Implementing Trainings in Response to Trend Reports

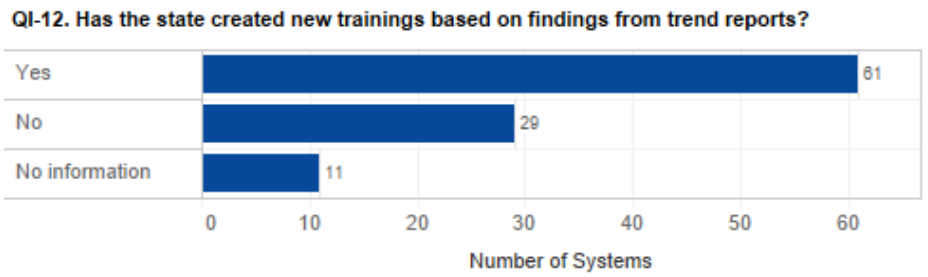
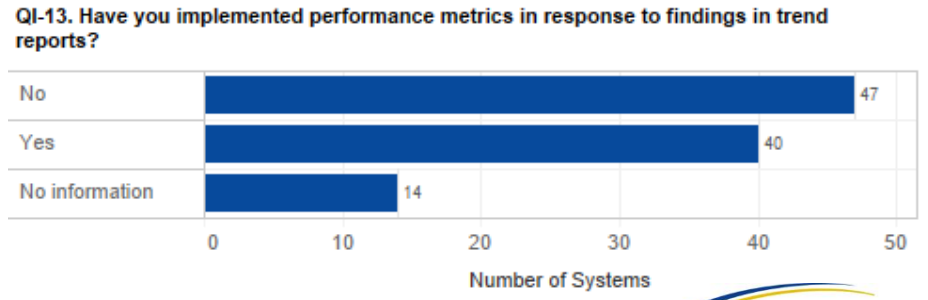


Figure 6: Implementing Performance Measures in Response to Trend Reports



Outcome-Based Performance Measures for Health and Welfare

- States may use outcome-based performance measures to track the rate, prevalence, and/or occurrence of unfavorable participant outcomes.
- Outcome-based performance measures found in Appendix G largely fall in one of two categories:
  - **Incident Prevalence** – quantify the occurrence of specific incidents.
  - **Survey or Interview Result** – quantify the results of surveys or interviews.

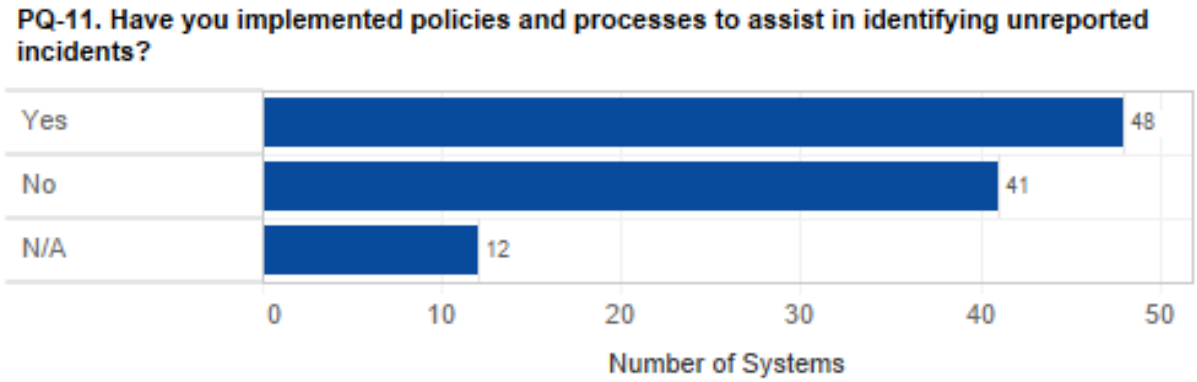
Table 4: Examples of Outcome-Based Performance Measures

Sub-assurances	Examples of Outcome-Based Performance Measures
G-i	• Number and percent of critical incidents requiring investigation, by type • Number and percent of deaths reported by providers • Number and percent of satisfaction survey respondents who reported that someone hit or hurt them physically
G-ii	• The percentage of critical incidents where the root cause was identified. • Number and percent of licensed providers cited for medication errors.
G-iii	• Percentage of restrictive interventions resulting in medical treatment.
G-iv	• Number and percent of those who responded that their overall health is good, very good or excellent on the survey

States Should Consider Prevention Tactics that Target Unreported Incidents

- Some state systems reported implementing policies and processes to assist in identifying unreported incidents.

Figure 7: Identifying Unreported Incidents



- States should further the adoption of prevention tactics that focus on identifying unreported incidents. These 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

Recommendation 5: States can better reinforce interventions and strategies used to manage incidents through the development of a robust training strategy.

Trainings Can Be Effective Tools In Identifying Incidents

Survey findings highlight that many states are using trainings to educate key stakeholders regarding key functions of the incident process.

- 91 of the 101 systems (90 percent) provide initial or ongoing trainings to at least one of the following stakeholders: providers, state staff, investigative staff, waiver participants, individuals with self-directed services, or family/unpaid caregivers.
- 57 of 101 systems (56 percent) reported providing trainings to two or more of the stakeholders identified above.

Trainings Can Be Effective Tools In Preventing Incidents

- Providers and case managers regularly interact with participants and can be trained to detect potential signs of abuse, neglect, and exploitation.
  - 62 of 101 systems (61 percent) provide training highlighting risk factors that help identify potential occurrences of incidents.
  - 56 of 101 systems (55 percent) provide training highlighting signs/symptoms that could indicate the potential occurrence of incidents. Examples include radial fractures, visits to primary care providers, etc.

Figure 8: Trainings on Risk Factors

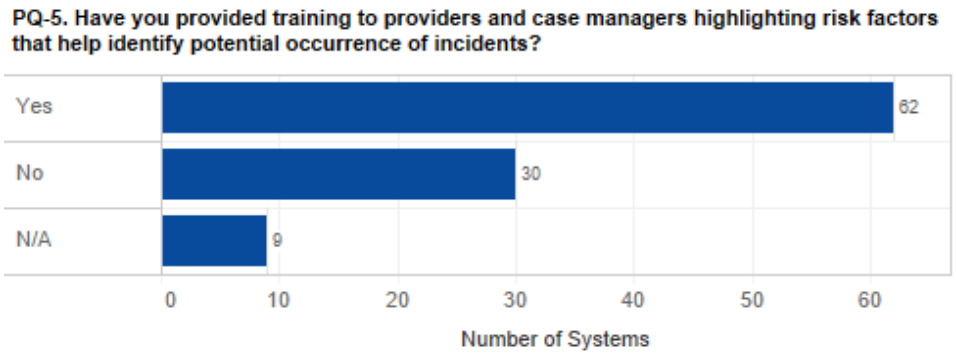
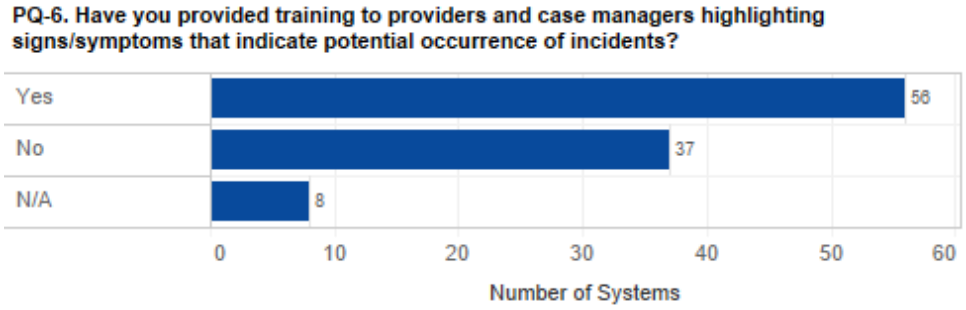


Figure 9: Trainings on Signs/Symptoms of Incidents



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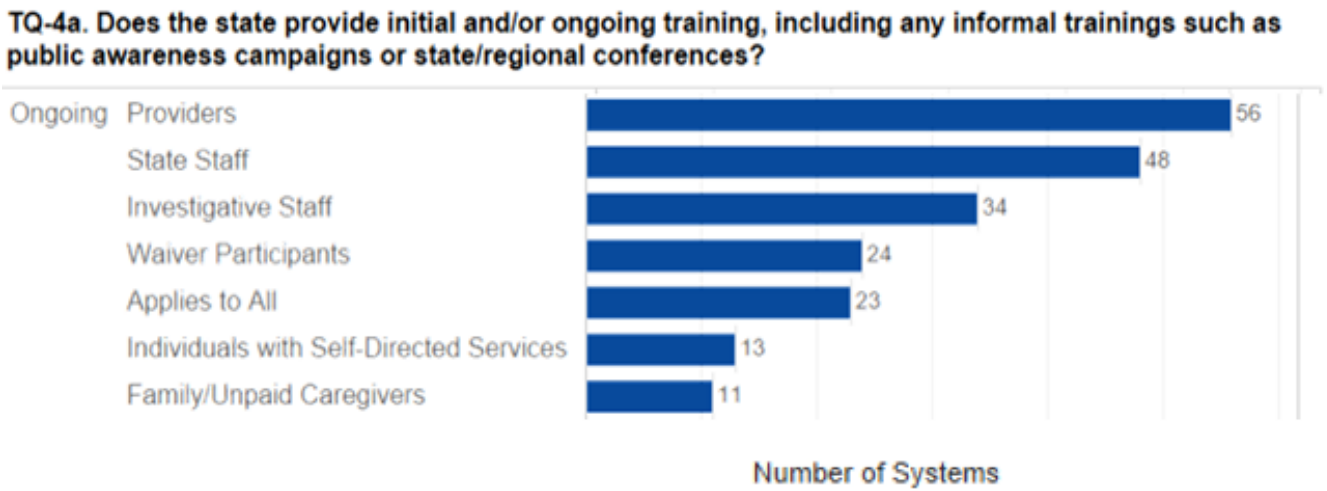
Some States Do Not Consistently Offer Trainings to All Stakeholders

States would benefit from developing a training strategy that is consistently applied across stakeholders.

- Family/unpaid caregivers and waiver participants are less likely to receive routine or standard trainings.
- States provided ongoing trainings to **providers** in 79 of 101 systems (78 percent). In comparison, states provided ongoing trainings to **waiver participants** in 47 of 101 systems (47 percent).*

Figure 10: Ongoing Training Provided by the State**



* Note: Counts are inclusive of states that selected "Applies to All".

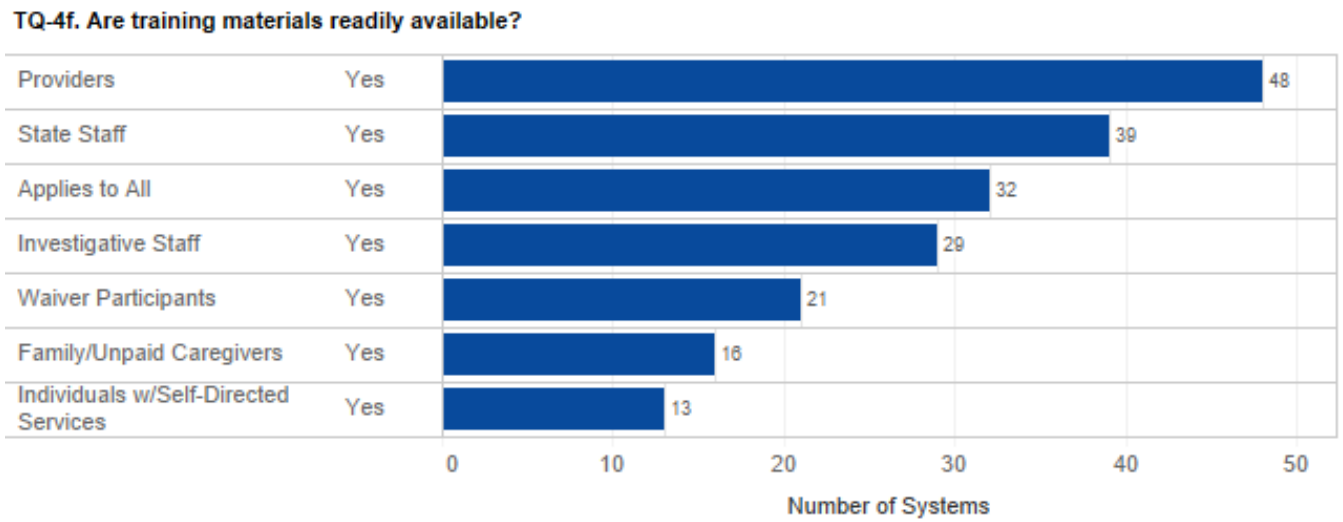
**Note: For this question, states had the option of selecting multiple answer choices. As a result, total response counts do not sum up to 101 systems.

Trainings Should Be Accessible To All Individuals Involved In Incident Management

States should support the availability and accessibility of training materials to all impacted stakeholders.

- Training materials are often more readily available to providers and state staff (81 of 101 and 71 of 101 systems, respectively) than to waiver participants or family/unpaid caregivers (53 of 101 and 48 of 101 systems, respectively).
- Only 13 of 101 systems (13 percent) reported having trainings readily available for individuals with self-directed services.

Figure 11: Stakeholders' Access to Training Materials**



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**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.

States Should Administer Trainings Through a Variety of Methods

States should administer trainings through a multitude of platforms to reach all individuals within their incident management systems.

- States should continue to adopt a variety of methods for how training is administered, including in-person training, self-paced web training, and web-based live training.
- State systems benefit from exploring new platforms to widen access to their training materials.
  - For example, one state adopted social media campaigns on key topics, distributed through a variety of channels such as Facebook, Twitter, and Instagram. The state also created a YouTube channel which houses short health and welfare trainings for providers and the general public.
  - Social media and alerts efficiently deliver information regarding incident management training and prevention to a broader population.

States Can Use Data to Drive Training Initiatives

- States should create trainings based on issues identified through data analysis. One of the ways states can do this is through the use of alerts to providers, individuals, and family/unpaid caregivers.
  - Once trends highlight an area of concern, states can create an alert via the incident management system, case management system, or social media.
  - Alerts spread awareness of identified issues and inform stakeholders on proactive measures that can mitigate or support the monitoring of these issues.

Conclusion

- Critical incident management is a priority for states.
- States adopt different systems that are unique to their needs and objectives, and often states support multiple incident systems to reflect the nuanced differences in the populations served.
- Such differences underscore the complexity of incident management and highlight the potential challenges states have in making sure that incidents are adequately reported, tracked, investigated, and analyzed.
- Incident management is a continually evolving process, necessitating upgrades to technologies, clarification of roles or responsibilities, and review of challenges and/or best practices.

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Questions?

For Further Information

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