



# **FINDINGS FROM THE 1915(C) INCIDENT MANAGEMENT SURVEY: IMPROVING QUALITY AND PREVENTING INCIDENTS**

**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 two of a three-part training series based on a national survey completed by states on incident management systems. The survey findings covered in this training focus on how states use their incident management systems to improve quality and prevent incidents. The subsequent training will focus on CMS' recommendations on critical incident management.
- The objectives for this training are as follows:
  - Review findings from a national survey of incident management systems regarding policies and procedures established by states for quality improvement and incident prevention.
  - In the context of the survey findings, identify key components of a robust quality improvement infrastructure within incident management systems.

# Background

# Survey Background

- Incident management became 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 occurred for individuals receiving long-term services and supports (LTSS).
- In July 2019, CMS issued a survey to the 47 states utilizing 1915(c) HCBS waivers, requesting information on their approach to operating an incident management system.
- 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

- 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)**
- This training will cover findings identified in Sections 4 through 8 of the Incident Management Survey.

# Survey Methodology - Continued

- This survey was provided through a web-based platform with some survey logic (e.g., skip patterns). Based on a state's individual waiver criteria, the respondent may not have answered some of the questions in this survey.
- Survey findings are based on an analysis of survey responses received from 45 states:
  - States self-reported their data.
  - States submitted responses for each unique incident management system for their 1915(c) waivers.

# State Interviews Overview

- CMS conducted interviews with 5 states between October 2019 and January 2020 to gain a more in-depth understanding of their incident management systems.
- These 5 states were selected for interviews because they demonstrated promising practices in their survey responses.

# Training 1 Summary

- Part 1 of this training series is available here:  
<https://www.medicaid.gov/medicaid/home-community-based-services/downloads/ims-national-overview-part1.pdf>
- Training 1 focused on the different systems and processes adopted by states to manage incidents. Related survey findings showed that:
  - There is no standard definition of critical incidents across states.
  - States have adopted different systems unique to their needs and objectives as well as their different waiver populations. As a result, most states support multiple incident management systems.
  - The majority of systems use electronic, web- or cloud-based platforms to report, track, and trend critical incidents. However, some states still employ alternative platforms such as manual or email-based systems.
  - While states try to standardize how incidents are reported, there is still wide variation within and across states.



# Incident Management Survey and Interview Findings

# 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**

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

# Creating Trend Reports

**States are using incident management data to create, use, and apply trend reports to improve incident management processes.**

- 97 of 101 systems (96 percent) of IM systems create at least one trend report based on critical incident data.
- The majority of systems aggregate and analyze trends electronically, with 57 of 101 (56 percent) of systems reported using electronic methods.
- Responsibility for producing these trend reports often falls to the Operating Agency (OA) or State Medicaid Agency (SMA) staff.
  - 46 of 101 systems (46 percent) report that the OA is responsible for producing trend reports.
  - 45 of 101 systems (45 percent) report that the SMA is responsible for producing trend reports.

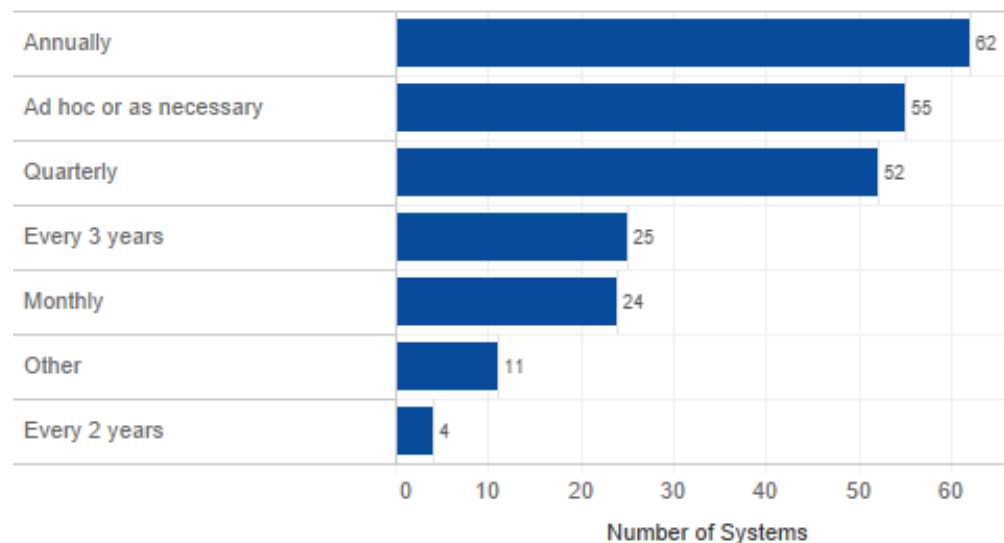
# Frequency of Trend Reports

## States most frequently create trend reports annually.

- 62 of 101 systems (61 percent) produce trend reports annually.
- 55 of 101 systems (54 percent) of systems produce trend reports on an ad hoc or as necessary basis.
- 52 of 101 systems (51 percent) produce trend reports quarterly.

**Figure 1: Frequency of Trend Report Development\***

QI-3. How often are reports produced?



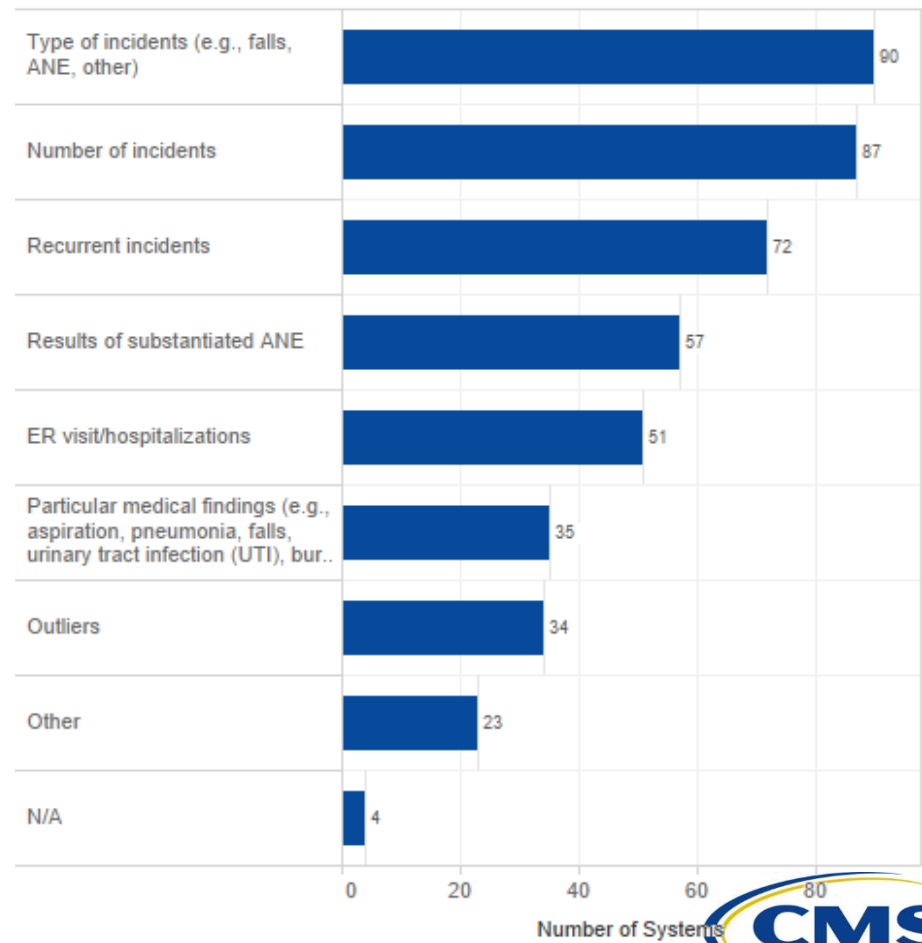
# Types of Trend Reports

States report creating a variety of trend reports.

- States most commonly create trend reports on types of incidents, number of incidents, and recurrent incidents.

Figure 2: System Trend Reports\*

QI-1. Do you create trend reports for any of the following?



13 \*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.

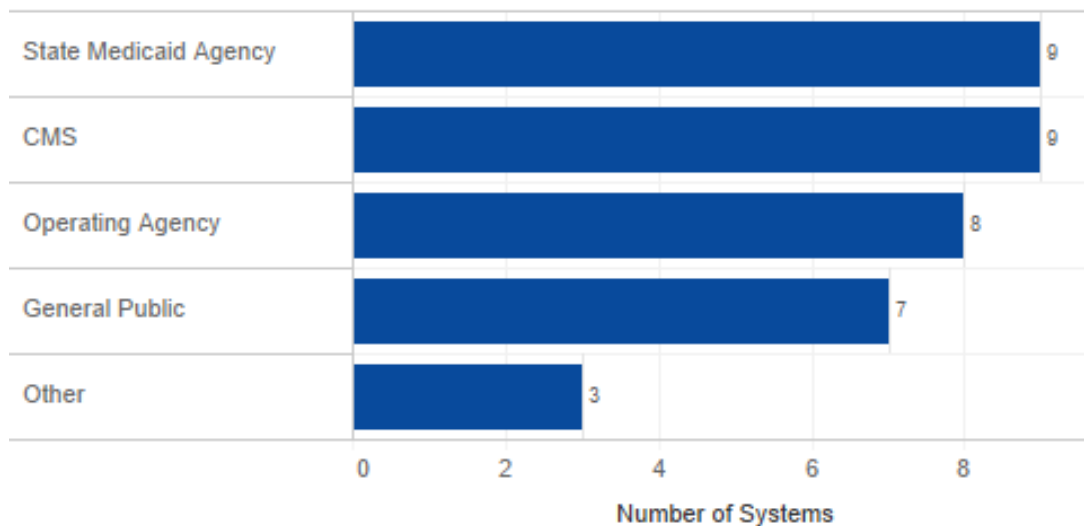
# Publishing Trend Reports

## Most systems do not publish a report on incidents.

- Only 16 of 101 systems (16 percent) report publishing a formal report on all incidents.
  - Of the 16 systems that publish a formal report, 11 (69 percent) issue reports to two or more stakeholders, while five systems (31 percent) issue reports to one stakeholder.
  - Systems most frequently issue these reports to the SMA and CMS.

**Figure 3: Trend Report Recipients\***

QI-9. To whom are these reports issued?



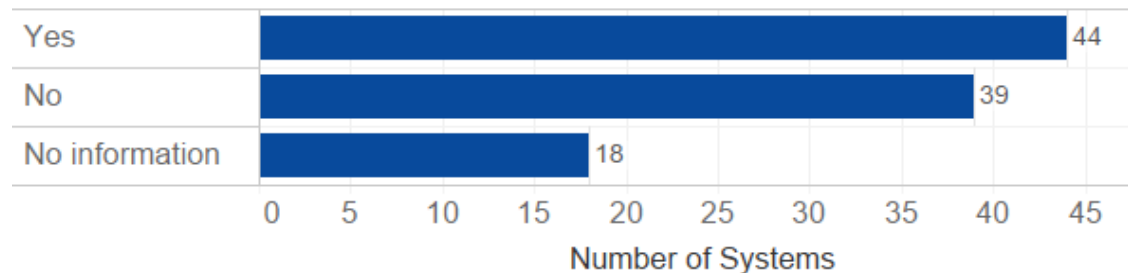
# Using Trend Reports: Implementing Interventions

**Less than half the systems reported using trend reports to develop systemic or operational interventions.**

- 44 of 101 systems (44 percent) have implemented a systemic or operational intervention in response to trend reports.

**Figure 4: Interventions Implemented as a Result of Trend Reports**

**QI-10. Has your state implemented a systemic or operational intervention in response to any trend report within the last five full waiver years?**



- Of the 44 systems that implemented a systemic intervention, 43 percent reported a decrease in incidents, 21 percent saw no decrease, and 36 percent reported no information.

# State Interventions Example 1

## State Example 1: Development of Targeted Interventions

- One State reported the development of a “Vulnerable Persons Index” based on reportable events, substantiated events, and serious injuries. Clinical teams examine individuals placed on the index to identify patterns and underlying causes, using the following process.

Process	1. Identification of Potential Risk	2. Development of Interventions	3. Continued Monitoring
<b>Example</b>	Clinical team identified individual who was repeatedly admitted to the hospital for pneumonia due to bed positioning.	Clinical team worked with provider agency and community clinician to adjust the positioning and hospitalizations stopped.	Individual developed pneumonia and re-admitted to the hospital. Clinical team identified positioning was no longer being properly followed and retrained staff.



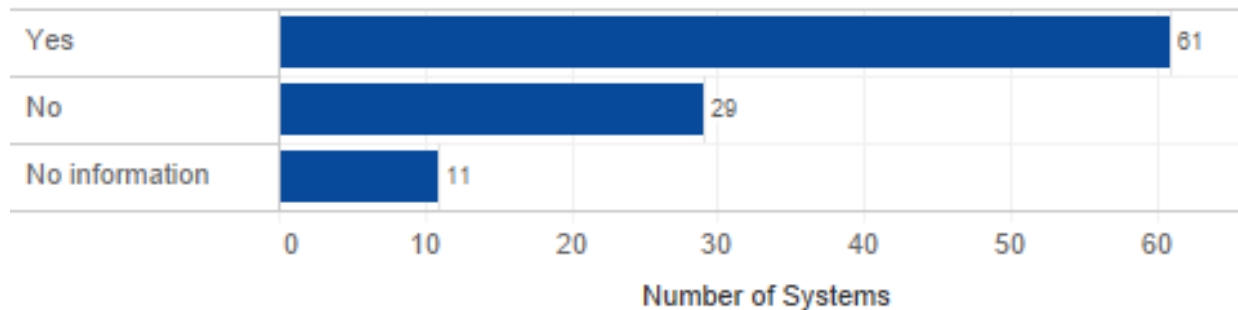
# Using Trend Reports: Creating Trainings

**States report creating new trainings based on findings from trend reports.**

- 61 of 101 systems (60 percent) create new trainings based on findings from trend reports.

**Figure 5: Trainings Created as a Result of Trend Reports**

**QI-12. Has the state created new trainings based on findings from trend reports?**



- States describe using trainings to help individuals, such as state staff, providers, and waiver recipients, recognize and report incidents.

# State Interventions Example 2

## State Example 2: Creation of Trainings

- One State described using patterns and trends to identify training needs and areas where additional monitoring is needed.

<b>Process</b>	<b>1. Identification of Potential Risk</b>	<b>2. Development of Interventions</b>	<b>3. Continued Monitoring</b>
<b>Example</b>	The State's Patterns and Trends Committee identified a spike in the number of choking deaths; reporting 21 choking deaths that year.	The State created choking training modules that involved both face to face trainings and webinars for providers, county boards, and families.	In the following year the State only reported four choking deaths.

# Using Trend Reports: Implementing Performance Measures

**Less than half of the states used trend reports to create new performance measures.**

- 40 of 101 systems (40 percent) implemented performance measures in response to trend reports.
- The following are examples of implemented performance measures identified by states:
  - Timeliness of critical incident reporting by providers
  - Rates of incident closure by agencies
  - Rate of behavioral interventions, such as restraints
  - Percent of mortalities due to specific health conditions
  - Percent of critical incident trends where systemic interventions were implemented

# State Interventions Example 3

## State Example 3: Development of Performance Measures

- One State described how performance measure data is used to develop scorecards so that interventions are designed and organized to be the most effective.

Process	1. Identification of Potential Risk	2. Development of Interventions	3. Continued Monitoring
Example	The State assesses trends related to complaint resolution, incident reporting, investigation results, and provider performance to identify where additional intervention is needed.	The State develops QIS performance measures and analyzes performance measure data to assess systemic performance.	The State compiles scorecards for each of its districts. Each district is ranked on a variety of measures (e.g., timeliness of screening, response, and investigation) to provide a snapshot of areas in which specific facilities and districts are struggling, and areas in which they are succeeding.

# Incident Management Responsibilities

**Survey results show that incident management processes are duplicated across multiple entities or agencies.**

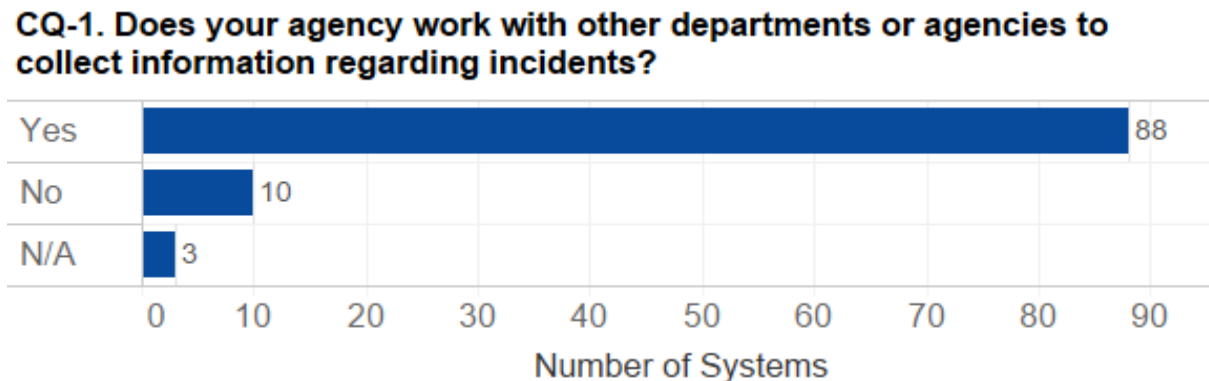
- Responsibility for activities throughout the incident management process often falls on multiple entities within the state.
  - Systems report that, on average, 2 to 3 entities are responsible for key incident management activities, such as contacting individuals about the incident report, referring incidents to additional investigative authorities, or following-up with individuals.
- 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.

# Interagency Communication

**States recognize the importance of interagency communication and collaboration; survey results show that states collaborate with other entities to manage incidents.**

- 88 of 101 systems (87 percent) work with other departments and agencies to collect information regarding incidents.

**Figure 6: Department Collaboration to Collect Information on Reported Incidents**



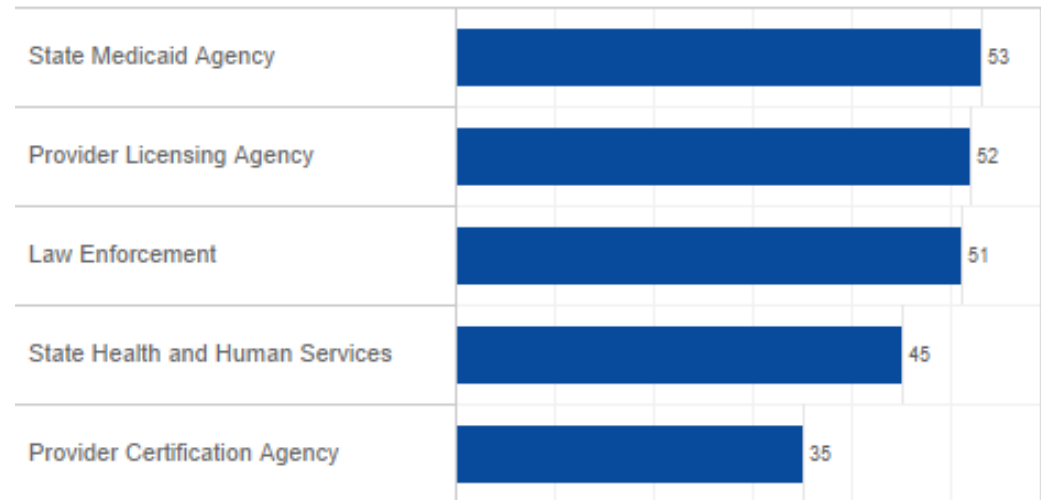
# Collaborative Entities

**88 of 101 (87 percent) systems reported working with other departments or agencies, most commonly collaborating with the SMA, Provider Licensing Agencies, and Law Enforcement Agencies.**

- 53 of 88 systems (60 percent) work with the SMA.
- 52 of 88 systems (59 percent) work with Provider Licensing Agencies.
- 51 of 88 systems (58 percent) work with Law Enforcement Agencies.

Figure 7: Top 5 Collaborative Entities\*

CQ-2. Which of the following agencies or departments?



# Sharing Investigation Results

## **States report challenges closing the information loop on critical incident investigations.**

- Only 52 of 101 systems (51 percent) have oversight agencies that are responsible for closing investigation cases.
- 56 of 101 systems (55 percent) have oversight agencies that are responsible for conducting follow-up care in response to investigation results.
  - For example, if a SMA has primary oversight responsibility of critical incidents but is not directly involved in critical incident investigations, there is a risk that the SMA is not notified of the investigation results. Consequently, this produces information gaps in the system and may hinder follow-up efforts.
  - Many states have Adult Protective Services (APS) programs that are involved in identifying, investigating, resolving, and preventing the ANE of adults. Survey respondents commonly stated that APS does not always disclose report outcomes to the oversight agency. As a result, states may experience information sharing challenges and may turn to other sources to close the information loop.



# Multi-Agency Solutions

**Multi-agency solutions provide an effective means of creating intervention strategies, as they leverage the expertise and skills of staff from multiple agencies within the system.**

- However, only 41 of 101 systems (41 percent) reported that they have developed multi-department or multi-agency solutions with the intent to reduce the number of incidents.
- One interviewed state described leveraging a Serious Event Review Team that consist of APS, regulatory staff, and case management staff.
  - The Serious Event Review team holds two sessions per quarter to conduct a systems-based review of specific critical incidents. Reviews follow the affected individual's journey to identify where improvements can be made, either at the central office, in the field, or systemically, to prevent reoccurrences.
  - Interventions include: policy changes, training for providers, and improvements in data collection.
  - Multi-disciplinary analyses can lead to multi-disciplinary interventions.

# Incident Management Training for Providers

**Most systems reported that new providers were required to receive training on incident reporting before rendering services.**

- 62 of 101 systems (61 percent) require training prior to the delivery of services.
- States also demonstrate continued commitment to providing initial and/or ongoing training, including informal trainings such as public awareness campaigns or state/regional conferences to providers.
  - One interviewed state expressed that critical incident training is a “vital, up-front component for a successful health and welfare system”. The state requires providers to annually review health and welfare alerts developed based on patterns and trends observed throughout the state. These alerts include trainings on topics such as abuse awareness, suicide prevention, and fall prevention.

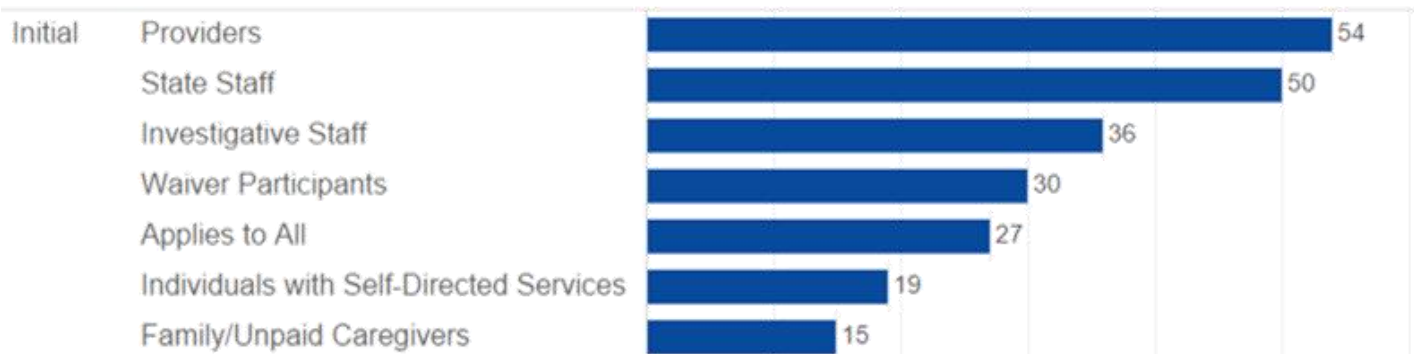
# Initial Training

**Initial trainings are more likely to be delivered to providers and state staff than waiver participants and family/unpaid caregivers.**

- 81 of 101 systems (80 percent) provide initial training to providers.\*
- 77 of 101 systems (76 percent) provide initial training to state staff.\*

**Figure 8: Initial Training Provided by the State\*\***

**TQ-4a. Does the state provide initial and/or ongoing training, including any informal trainings such as public awareness campaigns or state/regional conferences?**



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

\*\* Additionally, states had the option of selecting multiple answer choices. As a result, total response counts do not sum up to 101 systems.

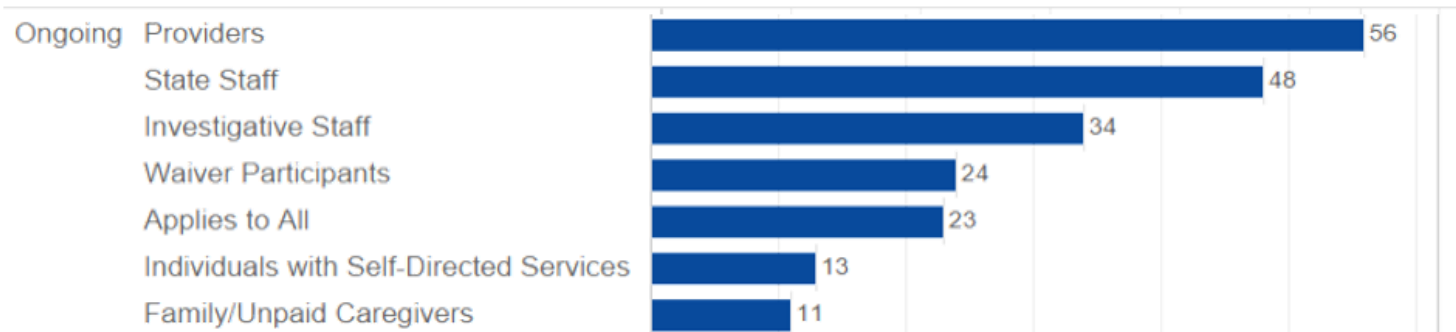
# Ongoing Training

**While states provide ongoing trainings to providers, case managers, and state staff, ongoing trainings for waiver participants and family/unpaid caregivers are not provided as consistently.**

- 79 of 101 systems (78 percent) provide ongoing trainings to providers.\*
- 47 of 101 systems (46 percent) provide ongoing trainings to waiver participants.\*
- 34 of 101 systems (34 percent) provide ongoing trainings to family/ unpaid caregivers.\*

**Figure 9: Ongoing Training Provided by the State\*\***

**TQ-4a. Does the state provide initial and/or ongoing training, including any informal trainings such as public awareness campaigns or state/regional conferences?**



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

\*\* Additionally, states had the option of selecting multiple answer choices. As a result, total response counts do not sum up to 101 systems.

# Training Content

## Topics covered in training sessions differ by role.

- **Providers** – most frequently trained on reporting deadlines and the types of incidents to report.
  - 62 of 101 systems (61 percent) reported that providers are trained on reporting deadlines, and 60 of 101 systems (59 percent) reported that providers are trained on types of incidents to report.
- **Investigative Staff** – most frequently trained on how to perform an investigation.
  - 59 of 101 systems (58 percent) reported that investigative staff are trained on how to perform an investigation.
- **State Staff** – most frequently trained on tracking and trending incidents.
  - 61 of 101 systems (60 percent) reported that state staff are trained on tracking incidents, and 60 of 101 systems (59 percent) reported that state staff are trained on trending incidents.\*

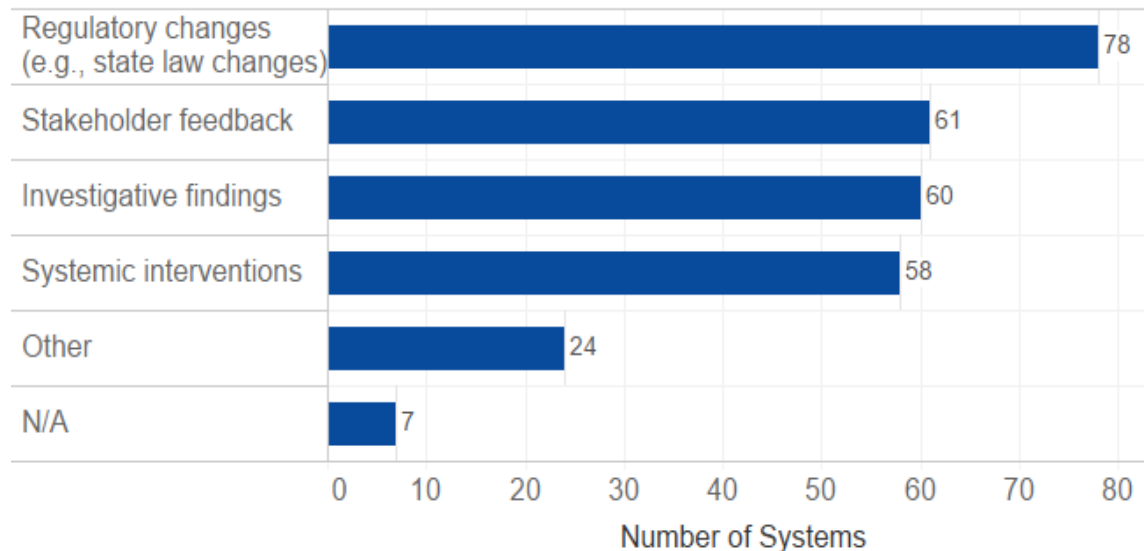
# Training Updates

**Trainings are most commonly updated based on regulatory changes.**

- 78 of 101 systems (77 percent) update trainings based on regulatory changes such as updates to state laws.

**Figure 10: Sources for Training Content Updates\***

**TQ-3. What are these trainings based on?**



# Training Methods

## **States reported delivering trainings using a variety of methods.**

- States used in-person trainings most frequently for investigative staff, state staff, and providers.
- For family and unpaid caregivers, states typically delivered trainings in-person or via a self-paced web-based training.
- Other methods of training administration identified by states are:
  - Teleconferences
  - Written materials, including brochures and technical assistance materials
  - Meetings
- Through qualitative responses, states highlighted offering trainings through a variety of methods/ platforms as a strength of their training programs.

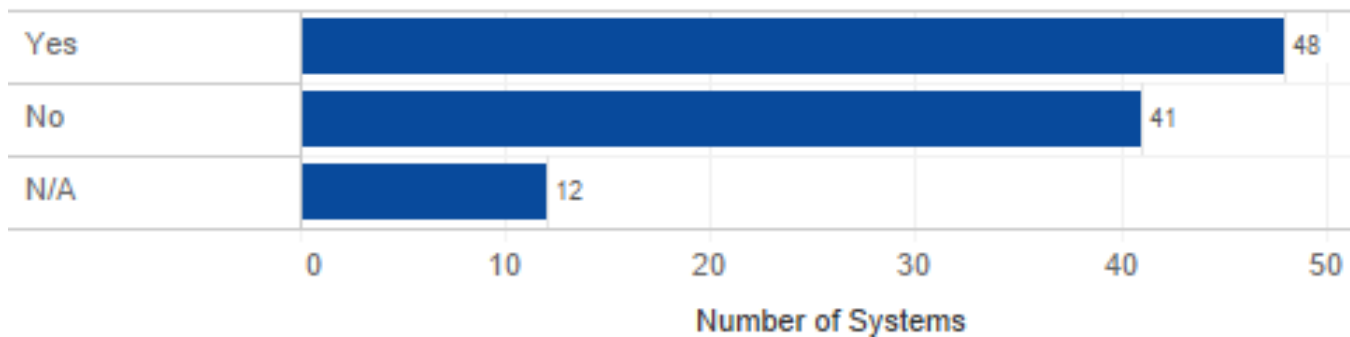
# Identification of Unreported Incidents

**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 11: Policies and Processes to Assist in Identifying Unreported Incidents**

**PQ-11. Have you implemented policies and processes to assist in identifying unreported incidents?**





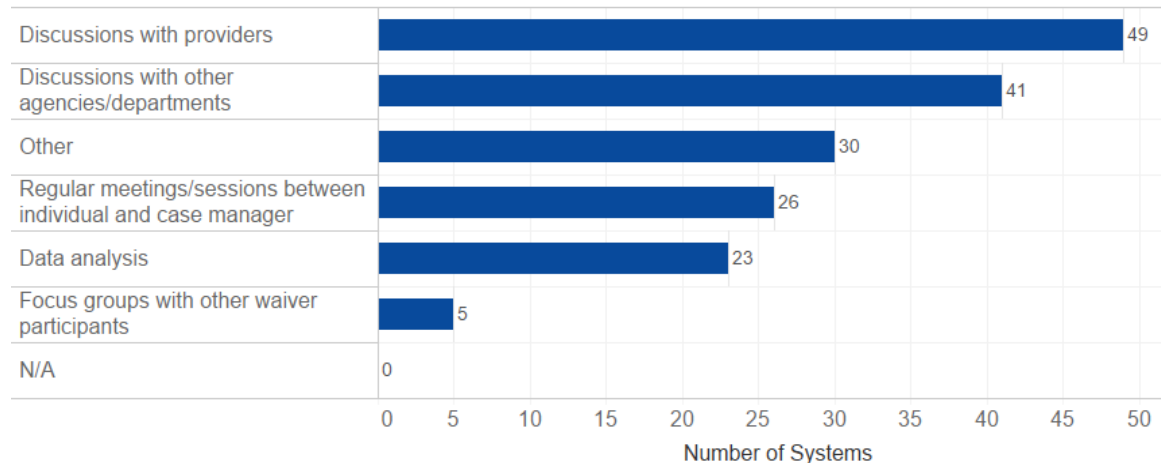
# Methods Used to Identify Unreported Incidents

## States employ multiple methods to identify unreported incidents.

- States most commonly cited discussions with providers and with other agencies/departments as effective methods for identifying unreported incidents.
- “Other” activities reported include record reviews and quality assurance on-site audits with providers.

**Figure 12: How States Identify Unreported Incidents**

**PQ-4b. Which of these activities selected have you found effective in identifying incidents that have not reported?**



# Examples of States' Experiences with Identifying Unreported Incidents

- **Example 1: Use of additional monitoring activities**
  - One state described how certification reviews, monitoring visits, and interviews with people receiving services help identify unreported incidents by provider agencies.
  - When identified, the provider agency is placed on provisional status and required to provide a plan of correction to address the issue. Providers are also required to increase training related to incident identification and reporting.
- **Example 2: Use of organized state workgroups**
  - One state reported how agreements with CPS/APS for sharing reports of ANE have contributed to identifying unreported cases.
  - The state's patient protection agency organizes a workgroup to review trends in reports of serious incidents and identify system-wide opportunities for improvement.

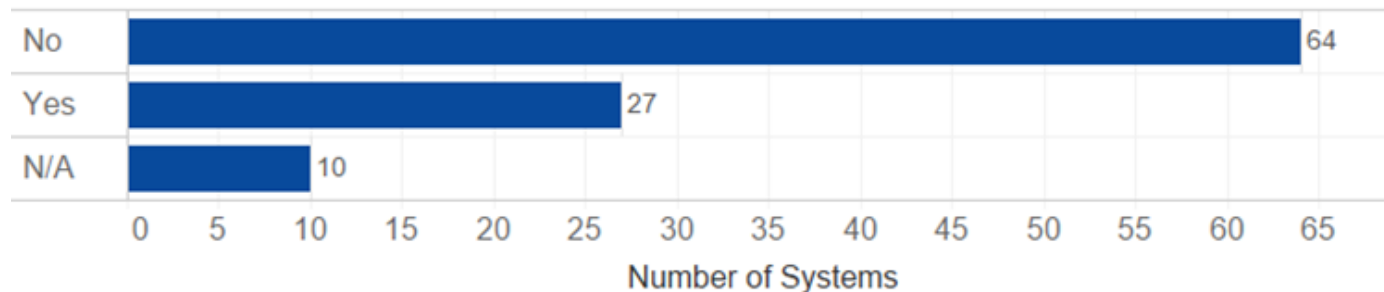
# Using ER Admissions Data to Identify Unreported Incidents

**ER admissions data can be used to retrospectively identify unreported instances of ANE. However, survey data indicates that states are not consistently using this information.**

- Only 27 of 101 systems (27 percent) report conducting crosschecks between ER admission and HCBS data.

**Figure 13: Crosschecks Between ER Admission Data and HCBS Data**

**MFVA-4. Is there a cross check between ER admission data and HCBS data? (i.e., when participants in the ER, caregivers/providers know why they are there, alerts to caregivers).**



# Leveraging Providers to Identify Potential 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) have provided training to providers and case managers to highlight risk factors that help identify the potential occurrence of incidents.
- 56 of 101 systems (55 percent) have provided training to providers and case managers to highlight signs and symptoms that indicate the potential occurrence of incidents.
  - Examples of these signs and symptoms include radial fractures, long sleeve shirts in the summertime, and visits to multiple primary care providers and/or ERs.

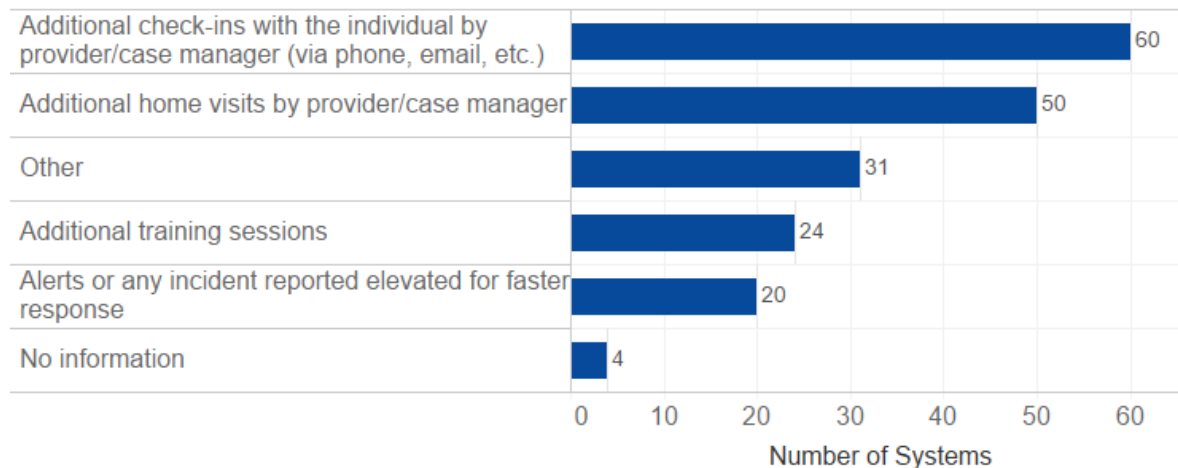
# Prevention Safeguards

**Providers and case managers routinely assess the potential for incidents and identify safeguards to prevent future incidents.**

- States most commonly implemented additional check-ins and additional home visits by the provider/case manager if waiver participants were categorized as high risk for a critical incident.
- Several interviewed states reported that incidents are often discussed as part of an interagency committee meeting, aimed to discuss potential solutions to monitor and prevent incidents from occurring in the future.

**Figure 14: Safeguards Implemented for High Risk Individuals\***

**PQ-9. If an individual is categorized as high risk for a critical incident, what safeguards does the state implement to monitor and prevent these incidents? (select all that apply)**



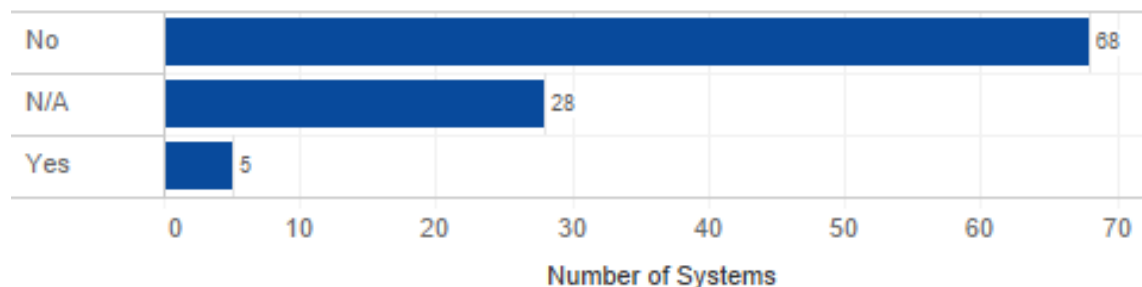
# Prevention Efforts for Self-Directed Service Participants

**Most states respond to reports of ANE for self-directed services using the same system as other waiver services.**

- Most incident management systems do not employ separate processes or tools for managing critical incidents for participants self-directing their services.
  - 68 of 101 systems (67 percent) do not respond differently to reports of ANE on individuals self-directing their services.

**Figure 15: Incident Management of Self-Directed Service Participants**

IR-15. Does the state respond differently to reports of ANE on self-direction individuals?



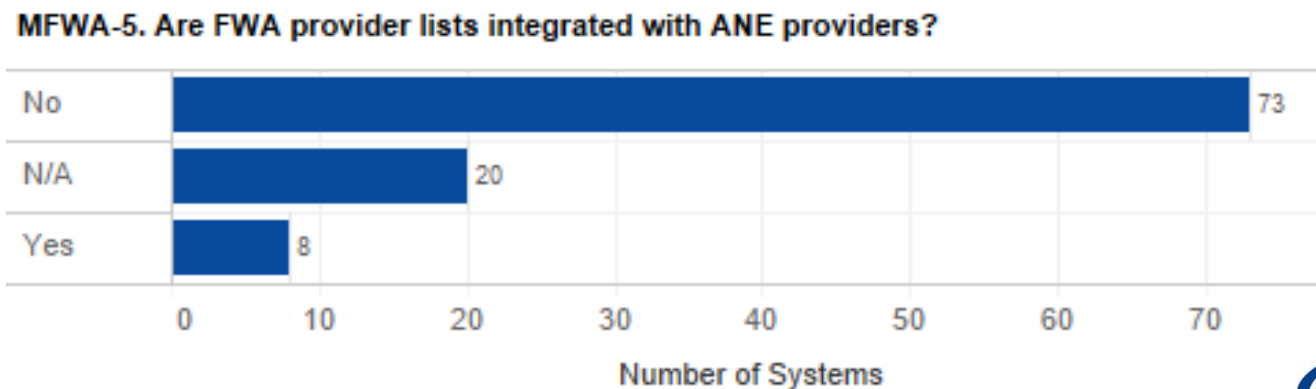
- Systems did not list prevention safeguards that were unique to self-directed services.

# Tracking Fraud Waste and Abuse

**Claims data and provider lists can be used to identify unreported ANE. State systems reported limited and ad-hoc use of claims analyses as a means of verifying incidents.**

- Most states report that they do not cross check ANE and FWA reports when performing post-payment reviews. Only 29 of 101 systems (29 percent) report having such a process in place.
- Survey findings show that only 8 of 101 systems (8 percent) integrate FWA provider lists with ANE providers.

**Figure 16: Integrated FWA and ANE Provider Lists**



# Common Challenges and Promising Practices: Tracking and Trending

**Common challenges and promising practices highlighted in state survey responses demonstrate the need to emphasize tracking capabilities, streamline agency collaboration, and expand training efforts.**

Areas Highlighted	Challenges	Promising Practices
Tracking and Trending Analyses	<ul style="list-style-type: none"><li>• Manual incident management system or limited IT capabilities</li><li>• Siloed databases create challenges in producing comprehensive trend reports</li><li>• Lack of dedicated personnel to accomplish analysis</li></ul>	<ul style="list-style-type: none"><li>• Proactive identification of potential trends</li><li>• Multi-level analysis of trends (state, region, county, and individual level) provides a more holistic view of incidents</li><li>• Data driven quality improvement interventions and performance measures</li></ul>



# Common Challenges and Promising Practices: Communication and Collaboration

**Common challenges and promising practices highlighted in state survey responses demonstrate the need to emphasize tracking capabilities, streamline agency collaboration, and expand training efforts.**

Areas Highlighted	Challenges	Promising Practices
Communication and Collaboration	<ul style="list-style-type: none"><li>• Lack of communication by the investigative agencies, such as law enforcement or APS</li><li>• Information sharing challenges with staff and external stakeholders</li><li>• Staff turnover creates uncertainty in roles and responsibilities</li></ul>	<ul style="list-style-type: none"><li>• Clear processes outlined for reporting, including timelines and responsibilities for individuals with access to the incident management system (e.g., SMA/OA staff, APS, etc.)</li><li>• Communication and cooperation between multiple entities through multidisciplinary committees, data sharing, and formal agency partnerships</li></ul>

# Common Challenges and Promising Practices: Training and Education

**Common challenges and promising practices highlighted in state survey responses demonstrate the need to emphasize tracking capabilities, streamline agency collaboration, and expand training efforts.**

Areas Highlighted	Challenges	Promising Practices
Training and Education	<ul style="list-style-type: none"><li>• Difficult to measure the effectiveness of trainings</li><li>• Limited resources and data available for training development</li><li>• Lack of “buy-in” by providers</li><li>• Trainings not offered in a consistent and ongoing basis for all stakeholders</li></ul>	<ul style="list-style-type: none"><li>• Trainings developed based on trend reports</li><li>• Creation of a designated team to meet provider training needs</li><li>• Individualized targeted training for providers</li><li>• Multiple methods/ platforms used to disseminate training materials</li></ul>

# Summary

- Continuous quality improvement shifts systems from a reactive “crisis management” mentality to a proactive “prevention planning” approach.
- Most state systems create trend reports from their incident management data. However, not all states implement systemic or operational interventions in response to the findings of trend reports.
- Effective incident management is a collaborative effort, involving multiple agencies and entities. States often face challenges with interagency communication.
- While states provide ongoing trainings to providers, case managers, and state staff, ongoing trainings for family/unpaid caregivers and waiver participants are not provided as consistently
- States can improve upon prioritizing identifying unreported incidents.

# Upcoming Trainings

- Part 3 of this series will focus on CMS' recommendations for how states can improve their efforts in developing robust incident management systems.

**Questions?**

# For Further Information

**For further information, contact:**

[HCBS@cms.hhs.gov](mailto:HCBS@cms.hhs.gov)