Welcome to the Division of Healthcare Financing (Division), Home and Community-Based Services (HCBS) Section provider training on incident management and the provider and Division’s roles in reviewing and conducting follow up activities on incident reports. My name is Elizabeth Forslund, and I am the Provider Support Unit Manager. Bethany Zaczek, the Incident Management Assistant Manager, and I will be presenting today’s training.
The purpose of this training is to provide further guidance on the incident reporting process and explain the steps the Division takes related to incident review and investigation.
The Division has received feedback and questions related to the new incident process, so it makes sense to talk more about incidents. In March we addressed incident reporting, but didn’t talk through the “next steps” or “so what” piece of the picture. Today’s training will focus more on some of the next steps in the incident reporting process to give everyone a full picture of the process and answer some of the common questions we have heard. We will cover:

- What happens after the provider submits an incident report through the Provider Portal;
- Who reviews the incident and works with the provider on necessary follow-up activities; and
- The overall process the Division follows when reviewing, investigating, and conducting follow-up on incident reports.

Please note that, for the purpose of this training, providers include provider staff and case managers, unless there is a specific need to make a distinction.
Freedom to make choices is a human right. Participants have the right to make an informed choice about who provides their services.

Even when addressing a topic like incident reporting, it is important to remember that home and community-based waiver services are based on the tenet that people have the freedom to make choices that impact their lives. Whether the choices are related to big decisions such as who provides their services, where they live, or what they want for their future, or small decisions such as with whom they spend time, what and when they eat, and how they spend their day, having choice is paramount to human dignity. Facilitating individual choice is a crucial part of being a Community Choices Waiver (CCW) provider or case manager.

Providers are obligated to respond to incidents in accordance with federal and state regulations and, based on the response, the Division is obligated to conduct follow-up with providers when it is warranted. Providers should use the guidance provided by the Division and the lessons learned throughout the process to improve their systems and ultimately improve the services they provide to participants. Participants have the right to make an informed choice about which providers deliver their services, and a provider’s response to incidents and attitude toward follow-up recommendations is important information for participants to have as they make their choice.
Home and community-based waivers are governed by Title XIX (19) of the Social Security Act, which establishes the laws for Medicaid assistance programs. The federal regulations that are specific to the Community Choices Waiver are found under the code of federal regulations (CFR) 42, which addresses public health.

In order to implement waiver programs throughout Wyoming, the Division must have an agreement with the Centers for Medicare and Medicaid Services (CMS), the federal department with oversight authority for all state waiver programs. This agreement is the Division’s contract with the federal government, and establish details such as the services that will be offered, provider qualifications, costs limits, and health and welfare assurances. This agreement is renewed on a regular basis, and provides the authority for waiver management.

The Division must maintain compliance with this federal agreement in order to receive funding from the federal government - funding that accounts for 50% of the money budgeted for waiver services throughout the state. Information related to incident management can be found in this document. The requirements in this document are what forms the basis of today’s training.

The most current CCW agreement, which has been approved by CMS and went into effect on July 1, 2021, can be found on the Public Notices, Regulatory Documents, and Reports page of the Division website under the Current Waivers tab. The link to the webpage is located on the slide.
Providers are required to utilize the Provider Portal to submit incident reports to the Division.

During the March CCW Provider Support Call training, and during the Incident Reporting Process training that was conducted on June 15, 2021, we discussed the requirements for timely reporting, and the steps involved in reporting an incident through the Provider Portal. These trainings are available on the Training page of the Division website if you would like to review.

Before jumping into some of the detailed information, we wanted to give a quick reminder and link this information back to the big “why” behind our work.
Filing an Incident - A Quick Refresher

- **Requirements established in Appendix G-1-b**
  - Providers, including case managers, must report critical incidents as soon as practicable after assuring the health and safety of the participant.
  - Must use Division’s web-based reporting system - Provider Portal.

- **Critical incidents include:**
  - Abuse;
  - Neglect;
  - Exploitation;
  - Unexpected death; and
  - Use of restraint and restrictive interventions.

As mentioned earlier, the CCW agreement is the Division’s contract with the federal government, and the Division must adhere to the requirements set forth in the agreement. Appendix G-1-b establishes requirements for reporting critical incidents.

According to this appendix, case managers and waiver service providers must report critical incidents through the Division's web-based reporting system as soon as practicable after assuring the health and safety of the participant. The system the Division has designated for incident reporting is the Provider Portal.

Critical incidents that require review and follow-up action include:

- Abuse, which is the intentional or reckless infliction of injury or physical or emotional harm;
- Neglect, which is the deprivation of, or failure to provide, the minimum food, shelter, clothing, supervision, physical and mental health care, or other care and prescribed medication as necessary to maintain the participant’s life or health;
- Exploitation, which is the fraudulent, unauthorized, or improper acts or processes of an individual who uses the resources of the participant for monetary or personal benefit, profit, or gain or that results in depriving the participant of their rightful access to, or use of, benefits, resources, belongings, or assets;
- Unexpected death, which is the death of a participant when the death is not a result of an expected medical prognosis;
- Use of restraint; and
- Unauthorized use of restrictive interventions.

Waiver service providers licensed by the Wyoming Department of Health, Aging Division must also report incidents and occurrences as required by the applicable licensing regulations.

Additionally, the Wyoming Adult Protective Services Act [W.S. §35-20-101, et seq.] requires that, "any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited, intimidated or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the [Department of Family Services]."
Why is Reporting an Incident Important?

- Identification and remediation of action or inaction that may have caused the incident.
- Facilitation of Division follow-up.
- Implementation of system improvements.
- Better services for those we serve.

So, aside from the fact that providers are required to report incidents to the Division, why is reporting incidents important?

The information submitted in incident reports allows providers and the Division to identify not only what happened during an incident, but also what occurred prior to and after the incident. This information helps the provider identify deficiencies or gaps in their service delivery, as well as training or follow-up that needs to be conducted with their staff members. It can also help the provider to spot patterns with participants, with staff, or with delivery models that may help to make improvements or build on a successful area. It is important for providers to not only report incidents, but also to be thoughtful and analytical when examining the incidents and associated information.

The Division uses information from incidents to ensure that the provider followed federal and state requirements, and that the follow up activities conducted by the provider align with regulations, policies, and reasonable practices. Additionally, the Division analyzes information from incidents to help identify trends within the state system that help to guide improvement efforts.

When concerns are identified, Division staff members are able to follow up with the provider and offer education and assistance when needed. This one-on-one work, called technical assistance, is a primary function of Division staff members. Working together to address such
issues and identify solutions is important for incident reporting and resolution.

The review and follow-up conducted by the provider and the Division ultimately positions the provider to address individual participant concerns and challenges, and better serve participants overall. This process improves provider and Division systems, supports providers in delivering quality services, and assures CCW stakeholders and federal partners that services are being delivered in accordance with established regulations.
Incident Management Team

Identify the Incident Management Specialist in your area at:


When an incident is submitted through the Provider Portal, it is directed to the Incident Management Team. The Incident Management Team is comprised of Incident Management Specialists (IMS) and an Assistant Manager who review every incident that is filed.

Incidents are automatically assigned to an IMS for review based on geographic region, so providers will work with the same area IMS each time they have a question or concern. The IMS can answer incident reporting questions in general, provide assistance with specific incident concerns, and direct you to other resources for help or support on other topics. You can identify your region’s IMS by reviewing the IMS map located on the Contacts and Important Links Page of the Division website.

Our Incident Management Team consists of:

- Bethany Zaczek
- Leigh Holm
- Andrew Horam
- Barb Strasser
- Carol Mitchelson
Division Review

Once the Incident Management Specialist receives an incident report, they are responsible for reviewing the incident.

When the IMS receives an incident report, they review the content of the incident to ensure it meets the requirements established in the CCW agreement.
Criteria from the Waiver Agreement

The Division conducts an investigation of all reported incidents including potential instances of abuse, neglect, exploitation, unexpected death, use of restraint, and/or unauthorized use of restrictive interventions within three business days.

In accordance with the CCW agreement, the Division must conduct an investigation of all reported incidents, including potential instances of abuse, neglect, exploitation, unexpected death, use of restraint, or unauthorized use of restrictive interventions, within three business days. This investigation consists of a desk review of the incident report and other relevant documentation.

The Division reviews the actions taken by the provider agency, case manager, and other responsible parties to assure the health and safety of the participant and to determine if those actions constitute an adequate and timely response that is proportionate to the circumstances of the incident. If those actions are insufficient, the Division will require immediate follow up actions by the provider.
Why Three Business Days?

- First responders are always the first contact!
- Division is reviewing the provider action to the incident.
- Allows time for a thorough review.

The Division requires providers to submit incidents as soon as practicable after assuring the health and safety of the participant. So why does the Division have three business days to review the incident report once it has been submitted?

First, it is important to remember that the Division is not the first responder. While the Division needs to have this information as soon as possible, providers are required to contact the Department of Family Services (DFS), law enforcement, or other entity to assure participant health and safety before contacting the Division. Please be sure to contact the appropriate first responders for emergency situations—we don’t want to be your first contact, or delay necessary support or care.

The three day time frame also allows time for the Division to conduct a thorough review of the incident. Sometimes a review of an incident will indicate that there is no further follow-up needed, and the Division can close it right away. Other times, though, the Division will need more time to gather information. Our three day review period gives us time to work through our initial review of incidents from around the state.
Evaluation of Provider Response

- Was the response appropriate?
  - Met CCW requirements
  - Aligned with service plan and needs of the individual
  - Was consistent with program direction

- Were the necessary parties notified?
  - Law enforcement, DFS, Protection and Advocacy
  - Licensure oversight entities, State Ombudsman

- Did the response address the situation?
  - The participant’s safety and well-being have been addressed

During the review of the incident, the IMS evaluates the response of the provider to ensure the response was appropriate and aligned with program regulation and philosophy. In order to make that determination, the IMS reviews the service plan, the requirements outlined in the Waiver document, and any other relevant documentation in the Electronic Medicaid Waiver System (EMWS). The IMS must then determine if other parties such as the licensure board, DFS, or law enforcement may need to be notified and involved. Most importantly, though, the IMS must evaluate if the participant’s safety and well-being have been addressed.

In order to fully determine if these areas have been addressed, the IMS may contact involved parties, ask providers, case managers, participants, and others for additional information, collaborate with other agencies, and make referrals to appropriate entities if necessary.
The Incident Management Specialist will follow up with the provider, as appropriate.

After reviewing the incident report and evaluating the provider’s response, the IMS may close the incident, or may determine that provider follow-up is necessary. This follow-up may include just gathering more information, or progressing to technical assistance or corrective or adverse action.
Technical Assistance: What is it?

- Help from the Division
- Advice on CCW matters
- Discussing problems or concerns
- Providing information about additional resources

Technical assistance is a broad term, but simply refers to the support the Division gives to providers and others stakeholders in making sure actions align with program regulations and philosophies. Technical assistance is focused on regulation and can help support best practices.

Most interactions that providers have with Division staff count as technical assistance. Often providers will email or call Division staff asking for guidance or information—that counts as technical assistance. Division staff LOVE providing technical assistance; that is our job!
Technical Assistance: What Does it Look Like?

- **Informal**
  - Phone calls;
  - Emails;
  - Support calls;
  - Division website; and
  - Division guidance.

- **Formal**
  - In writing; and
  - Typically issued on Division letterhead

Informal technical assistance comes in many forms, such as:
- Phone calls;
- Emails;
- Information on support calls;
- Documents and announcements on the Division website; and
- Information or guidance from the IMS or any other person within the Division.

Technical assistance is also connecting providers with information that the Division has previously offered. Division staff may provide links or documents for your review, and point you in the right direction. These links and documents are resources for you to keep and reference; please be sure to review and keep for future reference.

The Division issues informal technical assistance on a daily basis. The technical assistance offered in response to incident reports can be informal, but it will be maintained for documentation purposes. The technical assistance in response to incident reports can also be formal technical assistance. Formal technical assistance is typically issued in writing, and is often on official letterhead. Formal technical assistance can be provided in more serious situations to ensure that providers have an understanding of the Division’s response or suggestion to a particular situation. Either informal or formal technical assistance can also come from any person within the Division.
Technical Assistance: What Does it NOT Look Like?

- How to run your business.
  - Business decisions unrelated to compliance with rule and regulation.

- Navigating personal conflict.
  - Be professional, courteous, and focused on the participant.

- Providing the same level of support for the same or similar situations.

As much as Division staff love offering technical assistance, there are a few limitations to keep in mind. Division staff are focused on the “technical” part of the technical assistance—and that technical knowledge is focused on CCW requirements and regulation. The Division is not an expert in running your business or making personal decisions, and instead will focus technical assistance on how come into and stay in compliance with program rule and regulation. Within those confines, you have freedom to develop and manage your own business as you see fit.

Waiver services, particularly when dealing with incidents, can be complicated and involve lots of emotions. However, the Division is not able to intervene in personal or professional conflicts. If you request technical assistance in these situations, we will advise everyone involved to be professional, courteous, and focused on serving the participant. We can also provide feedback on rule and regulation compliance.

Finally, it is important for providers to keep important links, documents, and other information provided by the Division. Technical assistance can be given, but if the same technical assistance is given on multiple occasions to the same provider related to the same or similar situations, we may need to discuss a higher level of support.
When an IMS issues technical assistance, either formal or informal, it means that they have identified a deficiency or concern with the provider’s response to the incident, or that there is something in the report that has raised a red flag or caused concern. The technical assistance that is provided is intended to help the provider improve their systems or response in order to better handle similar situations in the future. The provider needs to follow the guidance and recommendations provided by the Division. If the provider fails to implement the necessary changes, they will be subject to a more formal follow up action if they repeat the insufficient incident response.

Providers must retain any documentation they have on the incident, including evidence that they have implemented recommendations made during technical assistance. Please be sure to ask questions to clarify what you don’t understand.
Corrective Action

- Formal action imposed to correct an identified deficiency.
- Provider is required to submit a plan (CAP) that explains how they will make necessary corrections.
- Corrective action is not an adverse action.

Corrective action is a formal action that the Division imposes on the provider to correct an identified deficiency or violation. If a provider does not make changes after technical assistance is given, or if the issue is considered serious enough to warrant immediate action, the Division may issue corrective action. Please note that corrective action is not considered an adverse action, so a provider does not have the right to a fair hearing if the Division imposes corrective action.

When the Division imposes corrective action on a provider, the provider must develop and submit a plan within the specified time frame that explains the steps they will take to make the necessary corrections. This corrective action plan (CAP) must adequately address the area of non-compliance, and include detailed action steps the provider will take to ensure the correction is made now and in the future, the person responsible for ensuring the correction is made, the date by which the correction will be made, and the actual date of completion.

The purpose of the corrective action plan is not only to ensure the provider complies with regulations, but also to assist the provider in making systemic improvements to their practices in order to address underlying issues that decrease the effectiveness or safety of the services they provide. Making a correction that fixes the immediate problem isn’t always enough.

For example, if a provider has a fire in a service setting, putting the fire out is a correction. This action eliminates the immediate problem. But what started the fire? That is the root cause the
provider needs to address in the CAP. If the fire started due to faulty wiring or other safety hazard, the provider needs to have a plan to ensure that the faulty wiring is fixed, but must also address how they will assure that wiring will be inspected regularly to avoid faulty wiring in the future.
<table>
<thead>
<tr>
<th>Area of Non-Compliance</th>
<th>Action Step</th>
<th>Responsible Party</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>The service setting is free of significant health or safety concerns</td>
<td>ABC Services will ensure inspections from an outside entity, including wiring inspections, are completed on all settings owned or operated by ABC Services.</td>
<td>Firestorm, Maintenance Technician</td>
<td>August 2021</td>
</tr>
<tr>
<td>Ongoing inspections</td>
<td>ABC Services will use Google tasks to schedule ongoing inspections. ABC Services will document inspections and review annually to ensure completing</td>
<td>Ghost Rider, Safety Coordinator</td>
<td>October 2021 Ongoing</td>
</tr>
</tbody>
</table>

When writing a CAP, the provider should remember the concepts of a SMART goal.

- Objectives should be **Specific** - explain what will be accomplished.
- Objectives should be **Measurable** - explain what will be measured, and what success will look like.
- Objectives should be **Achievable** - ensure the action is doable.
- Objectives should be **Realistic and relative** - ensure the action addresses the problem, and doesn’t promise something that can’t be delivered.
- Objectives should be **Timely** - establish the time frame for accomplishing the action, and how often progress will be measured.

In this example, the provider plans to schedule an external inspection for all of the settings it owns or operates. Additionally, the provider is addressing how it will ensure that external inspections are conducted in the future. The action steps address the concern, are specific, and success can be demonstrated.
Ensuring Compliance With A CAP

- Provider is responsible for ensuring actions have been completed within specified timeframes.
- Division may review the provider’s compliance with the CAP.

The provider is responsible for completing appropriate follow-up monitoring to assure that the actions identified in their CAP have been completed within the specified time frames. In some cases an action may take longer or be ongoing. In our example, the provider planned to have inspections completed on all of the service settings they owned or operated by August 2021, which is a one time thing. However, scheduling ongoing inspections is anticipated to take a couple of months, and ensuring that inspections occur on an annual basis is an ongoing activity.

The Division may review the provider’s compliance with the CAP at any time to assure the provider has fully implemented and evaluated the CAP, and that participants remain safe during its implementation. The Division and the provider will work together to ensure that the CAP is completed and can be closed out in the appropriate time period.

Remember - corrective action and the provider’s obligation to develop, submit, and implement a CAP is intended to help the provider improve their systems and avoid ongoing issues that may result in an incident. Once the CAP is implemented and closed, the provider is obligated to ensure that the deficiency addressed in the CAP is not repeated. However, the provider should also be able to move on, continue to provide services, and know that the CAP experience improved their services and systems.
Adverse Action

An adverse action is the termination, suspension, or other sanction of a provider, the denial or withdrawal of admission certification, the determination of a per diem rate, or the denial or reduction of a Medicaid payment to a provider.

Wyoming Medicaid Rules - Chapter 1

Chapter 1 of Wyoming Medicaid Rules defines an adverse action on a provider as the termination, suspension, or other sanction of a provider, the denial or withdrawal of admission certification, the determination of a per diem rate, or the denial or reduction of a Medicaid payment to a provider. An adverse action may be issued by the Division when there are serious concerns that have not been addressed by the provider. An adverse action is a higher level of follow-up by the Division, but is still typically intended to allow the provider to come into compliance. Adverse actions are more rare than technical assistance and CAPs, and can range in severity.

Chapter 16 of Wyoming Medicaid Rules provides some examples of adverse actions, including:

- Educational intervention;
- Recovery of overpayments;
- Suspension of payments;
- Suspension or termination of the provider agreement;
- Placing conditions on the provider;
- Imposing a monitor;
- Imposing civil monetary penalties; or
- Imposing an immediate suspension.

If a provider receives an adverse action, they must follow the instructions they receive from the Division. They must also communicate with Division personnel on a regular basis during the
time that the adverse action is in effect.
Right to a Fair Hearing

- Provider may dispute an adverse action pursuant to Chapter 4.
- Must be requested within twenty (20) business days after the mailing of the notice of adverse action.
- Not all actions are considered adverse, and are therefore not subject to a fair hearing.

Providers have the right to dispute an adverse action. To request a hearing, the provider must send the request by certified mail, return receipt requested, or personally deliver the request to the Division offices on the 4th floor, west wing of 122 W. 25th Street in Cheyenne, within twenty business days after the mailing of the notice of adverse action. Other rules related to adverse actions are found in Chapter 4 of Wyoming Medicaid Rules.

Not all actions are considered to be adverse actions that are subject to a fair hearing. According to Chapter 1 of Wyoming Medicaid Rules, the following terminations, suspensions, or other sanctions are not considered adverse actions.

- A termination, suspension, or other sanction based on the provider's loss of or failure to provide documentation of required licensure or certifications.
- A termination, suspension, or other sanction based on a provider's exclusion by the Office of the Inspector General (OIG) or termination by Medicare; and
- A termination, suspension, or other sanction based on a finding of fraud, abuse, or other prohibited activities by a judicial or administrative process where the provider was afforded notice and the right to a hearing.

Additionally, the following reductions, denials, or recoveries of overpayments are not adverse actions:

- A reduction, denial, or recovery described in Section 12(c)(d) and (e) of Chapter 16 of Wyoming Medicaid Rules;
• A reduction, denial, or recovery due solely by a change in federal or state law; or
• An appeal of a rate setting methodology.
 Incident Resolution and Closure

- The Division determines when an incident is resolved.
- Associated documentation is retained electronically for seven years.

It is the Division’s responsibility to determine when an incident has been resolved. The Division may determine that an incident can be closed immediately after the initial review, or may determined that it needs to remain open until an investigation or work with other agencies has been completed.

Once the incident is closed, any associated notes, documents, or information is retained electronically in the incident reporting system. Incidents and associated documents are kept for at least seven (7) years in accordance with the State of Wyoming document retention policies.
Email: Incident reporting benefits the participant and the provider.
2. All incident reports are reviewed by the Division.
3. The Division offers technical assistance as its primary support. Providers should not ignore technical assistance offered by the Division.
4. Additional follow-up may be required by the Division.

As we end this training, we’d like to review some of the key items that providers need to remember:

1. Incident reporting is important because it benefits the participant and the provider. This incident reporting processes improves provider and Division systems, supports providers in delivering quality services, and assures CCW stakeholders and federal partners that services are being delivered in accordance with established regulations. Better systems allows for better services.
2. An Incident Management Specialist reviews all incidents to ensure the provider’s response was appropriate and aligned with program regulation and philosophy, and conducts follow-up as necessary.
3. Technical assistance is the primary support offered by Division staff members, and is focused on regulation and supporting best practices. Providers should not ignore technical assistance offered by the Division.
4. Finally, the Division may require additional follow-up by the provider. Providers should keep in close contact with the area IMS to ensure all follow-up activities are conducted in a timely and appropriate fashion.
Thank you for participating in this training. If you have questions related to the information in this training, please contact the Incident Management Specialist based on your county. The Incident Management Specialist assignments can be found on the Contacts and Important Links Page of the Division website.