CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Department for Medicaid Services (DMS) Centralized Quality Management (CQM) Advisory Subpanel

February 6, 2019, 1:00pm-3:00pm

Meeting Summary

Meeting: CQM Advisory Subpanel – Meeting #1

Date: February 6, 2019

Location: Public Health Building, 2nd Floor Board Room, 275 East Main Street, Frankfort KY 40601

AGENDA TOPICS AND KEY DISCUSSION POINTS

I. Introductions and Objectives

a. DMS discussed agenda and objectives

b. Cabinet staff, Navigant, and all panelists shared introductions

II. Subpanel Overview

a. DMS reviewed the subpanel charter and responsibilities for panelists

b. DMS discussed the responsibilities of the chairperson and opened the floor for volunteer nominees

III. CQM Workstream Overview

a. Navigant presented its proposed timeline for CQM activities and CQM subpanel meeting topics by month

b. Navigant introduced the focus areas of the CQM workstream, including the stakeholder input that informed the focus areas and proposed actions. Focus areas include:

i. Interim solution for incident management

ii. Develop and implement a standard tool to certify waiver providers

iii. Web-based solution to support CQM activities

iv. Other quality improvement initiatives, including developing a quality plan/strategy and standardizing participant surveys

c. DMS and Navigant provided a summary of the current incident reporting process in Kentucky, including:

i. Definitions of critical vs. non-critical incidents

ii. Flowchart of incident reporting and responsible parties

iii. Summary of incident data in KY (Fiscal Year 2017 and 2018)

IV. Discussion: Presentation of New Incident Reporting Materials

a. DMS and Navigant facilitated a discussion to receive feedback related to the proposed incident reporting materials listed below. The materials are to be shared with service providers and case managers in March 2019.

i. Incident reporting form

ii. Internal provider investigation summary

iii. Incident reporting instructional guide

iv. Incident reporting email notification

b. Panelists highlighted the following issues with the State's current approach to incident reporting:

i. Additional guidance and instructions are needed in current State policies and procedures.

1. Critical incident definitions are not consistent and available across all waivers.
2. Providers receive differing interpretations from Cabinet staff on critical vs non-critical definitions.
3. For events that are witnessed by several parties, current policies do not state who should report the incident; therefore, there are often multiple incident reports submitted for one incident.
4. Certain waiver vendors (e.g., transportation providers) do not report incidents which makes it difficult to prevent future incidents or resolve the incident.
5. For events that occur in the participant's home, the family or others may not report an incident or report it in a timely manner which makes appropriate intervention difficult.

ii. Incident reporting is administratively burdensome

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1. Providers are currently reporting incidents that should not require submission (i.e., scheduled doctor visits, flu, missed medications that do not cause harm, etc.) resulting in providers spending less time with participants.
2. For staff in the field all day, it is often difficult to meet the critical incident reporting timeframe of "within 8 hours, especially when service providers or case managers accompany the participants to the hospital.

c. Panelists highlighted the following areas where incident reporting can improve:

i. Education and training:

1. The State should stress the importance and benefits of incident reporting with service providers and caregivers. Often, service providers and caregivers do not report incidents due to fear of citation or penalty.
2. Clear and concrete incident definitions and requirements should be used to improve consistency across the entire incident reporting process.

ii. Person-centeredness should be stressed during the incident reporting process. The Person-Centered Service Plan (PCSP) should outline how to handle specific/common incidents as the decision to report should depend on the individual and the location of the incident.

iii. "Falls" should be added as a critical incident type since fall data collection and fall prevention programs have a national and state focus.

V. CQM Subpanel Chairperson

a. The CQM Subpanel voted and selected Catherine Lee as the CQM Subpanel Chairperson.

VI. Next Steps

a. Panelists were instructed to send any feedback regarding the updated draft incident reporting materials to CHFS.IncidentRptWorkGroup@ky.gov by February 15, 2019.

b. The next subpanel meeting date will be on March 6, 2019. *(Please note: The March CQM meeting was later canceled.)*

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