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2100 INCIDENT MANAGEMENT

2101 Overview

The purpose of incident management is to assist in promoting the health, safety and welfare of persons with developmental disabilities through active reporting, investigating, tracking and trending of incidents and the implementation of both individual-specific and systemic corrective actions and prevention strategies.

The Division of Developmental Disabilities (Division) has a comprehensive Incident Management System (IMS), which is part of the Focus Quality Management (QM) Incident Management Application. The IMS database; provides the platform for the reporting of incidents; tracking the notification of key personnel and agencies, the assignment of personnel to fact-find incidents, tracking incidents to closure and completing follow-up actions. The IMS is also used for incident trending and analysis.

The IMS captures incidents for all members enrolled with the Division regardless of funding source or whether or not a service was being provided to the member at the time of the incident.

2102 Definitions of Incidents and Serious Incidents

An Incident is defined as an occurrence, which could potentially affect the health and well-being of a member enrolled with the Division or poses a risk to the community. If the incident is determined to be "serious" as defined in this policy, the Serious Incident protocol section of this policy shall be followed.

Incidents

Incidents include, but are not limited to**:**

A. Death of member

B. Potentially dangerous situations due to neglect of the member

C. Allegations of sexual, physical, programmatic, verbal/emotional abuse

D. Suicide threats and attempts

E. Member missing

F. Accidental injuries which may or may not result in medical intervention

G. Violation of a member's rights as stated in this policy manual.

H. Provider and/or member fraud

I. Complaints about a community residential setting, resident or the qualified vendor

J. Allegations of inappropriate sexual behavior

K. Theft or loss of member's money or property

L. Use of emergency measures

M. Medication errors such as:

1. Wastage of a Class II substance

2. Giving medication to the wrong member

3. Wrong method of medication administration

4. Wrong dosage administered

5. Missed medications

N. Community disturbances in which the member or the public may have been placed at risk

O. Serious work related illnesses or injuries (Division employees). (See DES Policy # DES 1-07-02.A, Unusual Incident Reporting [Employee].)

P. Threats to Division employees or state property (See DES Policy # DES 1-07-02.A, Unusual Incident Reporting [Employee]); and accidents on state property involving non-member/non-employees. (See DES Policy # DES 1-07-02B, Unusual Incident Reporting [Client].)

Q. Environmental circumstances which pose a threat to health, safety or welfare of members such as loss of air conditioning, loss of water or loss of electricity

R. Unplanned hospitalization or emergency room visit in response to an illness, injury, medication error

S. Unusual weather conditions or other disasters resulting in an emergency change of operations

T. Provider drug use

Serious Incidents

A *Serious Incident* is an extraordinary event involving a member, facility or employed/contracted worker. A serious incident poses the threat of immediate death or severe injury to a person, substantial damage to individual or state property, and/or widespread interest in the news media.

Serious incidents include, but are not limited to the following:

A. All deaths

B. A circumstance that poses a serious and immediate threat to the physical or emotional well-being of a member or staff member

C. Severe physical injury that:

1. Creates a reasonable risk of death; or,

2. Causes serious or permanent disfigurement: or,

3. Causes serious impairment of a member's or worker's health

D. Property damage estimated in excess of $10,000

E. Theft or loss of a member's money or property of more than $1,000

F. Reporting to law enforcement officials because a Division enrolled member is missing and presumed to be in imminent danger

G. Reporting to law enforcement officials due to possession and/or use of illegal substances by members or staff/providers

H. A 911 call due to a suicide attempt by a member

I. An incident or complaint from the community that could be or is reported by the media.

2103 Incident Management System (IMS) Definitions

The following definitions are used when entering incidents into the IMS database. Incidents are entered by the type which is the main reason for the incident and category which is the main classification for the incident.

A. *Accidental Injury:* a non-intentional or unexpected injury.

B. *Member Missing:* an incident in which a member without planned alone time, is missing, and is at risk of harm; or when a member with alone time as defined in his/her Planning Document is missing longer than the plan provides.

D. *Community Complaint*: a complaint from the community that puts a member or the community at risk of harm.

E. Death: "expected" (natural), "unexpected" (unnatural) or "no provider present".

1. *Expected deaths*: may include deaths from long-standing, progressive medical conditions or age-related conditions, e.g. end-stage cancers, end-stage kidney or liver disease, HIV/AIDS, end-stage Alzheimer's/Parkinson's Disease, severe congenital malformations that have never been stabilized.

2. *Unexpected deaths*: include motor vehicle accidents, suicides, accidental drug overdoses, homicides, acute myocardial infarction or strokes, trauma/abuse, sudden deaths from undiagnosed conditions, or generic medical conditions, (e.g. seizures, pneumonia, falls) that progress to rapid deterioration.

3. *No provider present:* refers to deaths of members living independently or with family and no provider is present at the time of the death. The "expected" or "unexpected" categories shall be used if a provider is present at the time of death.

G. *Emergency Measure*: the use of physical management techniques (Client Intervention Techniques [CIT] level II) or behavior modifying medications in an emergency to manage a sudden, intense or out of control behavior.

H. *Fact-finding*: a detailed and systematic collection and verification of facts for the purpose of describing and explaining an incident. The process could include: interviews with the member, Provider and/or Division staff; collection and/or review of member and provider documentation; and coordination with investigatory agencies.

I. *Human Rights Violation*: a violation of a member's rights, benefits, and privileges guaranteed in the constitution and laws of the United States and the State of Arizona. Human rights are defined in A.R.S § 36.551.01. Such as a violation of a member's dignity or personal choice, violations of privacy, the right to open mail, send and receive phone calls, access to one's own money, choosing what to eat.

J. *Member*: a person enrolled with the Division of Developmental Disabilities.

K. *Investigation*: collection of facts/information for the purpose of

describing and explaining an incident. An investigation may be completed by law enforcement, Child Protective Services, Adult Protective Services, or other state agencies.

L. *Legal*: an incident of alleged provider fraud/inappropriate billing, member exploitation through using a member to gain monetary or personal rewards, the possession or use of illegal drugs by provider or state staff.

M. *Medication Error*: the administration of medication in an incorrect manner. This includes: giving medication to the wrong member, administering medication in the wrong method, giving the wrong dosage or not administering the medication.

N. *Neglect*: a pattern of conduct resulting in a deprivation of food, water, medication, medical services, shelter, or other services necessary to maintain physical or mental health. Neglect is an intentional health and safety violation against a member, such as lack of attention to physical needs failure to report health problems or changes in health condition, sleeping on duty or failure to carry out a prescribed treatment plan.

For example: in the case of children, the definition includes the substantial risk of harm due to inability or unwillingness of a parent, guardian or custodian to care for the child. This includes; supervision, food, clothing, shelter or medical care if that inability or unwillingness causes substantial risk of harm to the child's health or welfare, unless the inability of a parent or guardian to provide services to meet the child with a disability is solely the result of unavailability of reasonable services.

O. *Other:* incidents which involve behavioral episodes without the use of physical restraints, hospitalizations or treatment at an emergency medical facility/Urgent care facility due to medical conditions or illness.

Other Abuse: programmatic abuse, verbal/emotional abuse and sexual abuse.

1. *Programmatic Abuse:* aversive stimuli techniques not approved as part of a person's plan. This can include isolation, restraints, or not following an approved plan and/or treatment strategy.

2. *Verbal/Emotional Abuse:* remarks or actions directed at a member enrolled in the Division that are ridiculing, demeaning, threatening, derogatory or profane.

3. *Sexual Abuse:* any inappropriate interactions of a sexual nature

toward or solicited from a member with developmental disabilities.

P. *Physical Abuse*: intentional infliction of pain or injury to a member.

Q. *Property Damage/Theft*: damage or theft of state property in a member-related incident, or the theft or damage of a member's property.

R. *Provider*: any person, entity or person hired by the entity, who is paid, through contract or agreement, to deliver services to any member.

S. *Suicide*:

1. Attempted suicide with medical and/or police involvement

2. Threatened suicide with a statement from a member that they want to commit suicide

T. *A Health Care Acquired Condition (HCAC) inclusive of the Hospital Acquired Condition (HAC):* as described under the Medicare program, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission.

1. Foreign object retained after surgery

2. Air embolism

3. Blood incompatibility

4. Pressure ulcers stage III and IV

5. Falls and trauma (fractures, dislocations, intracranial injuries, crushing injuries, burn, electric shock)

6. Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, and secondary diabetes with hyperosmolarity)

7. Catheter associated urinary tract infections (UTI)

8. Vascular catheter-associated infection

9. Surgical site infection following: after coronary artery bypass surgery (CABG), bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, and laparoscopic gastric restrictive surgery) and orthopedic procedures (spine, neck, shoulder and elbow)

10. Deep venous thrombosis or pulmonary embolism (DVT/PE) after total knee or hip replacement (does not include pediatric and obstetric patients)

11. Other Provider Preventable Conditions (OPPC) means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

    i. Surgery on the wrong member

    ii. Wrong surgery on a member and

    iii. Wrong site surgery

2104 Reporting Requirements

When an incident occurs, take whatever actions are necessary to resolve the emergency and implement protective measures immediately for the person's safety, which may include calling 911 or taking other emergency action.

A. As designated by law, medical professionals, psychologists, social workers, Support Coordinators, peace officers and other people who have the responsibility for the care of a child or a vulnerable adult are mandatory reporters.

   Mandatory reporters who have a reasonable basis to suspect that abuse or neglect or exploitation of the member has occurred are required to report such information immediately to a peace officer or protection services worker, (i.e., Adult/Child Protective Services, Tribal Social Services.) Refer to Support Coordination and Incident Reporting in this Policy Manual for additional information regarding mandated reporting.

B. Serious Incidents, as described in this chapter, are to be reported and written as soon as possible, but no later than 24 hours after the incident.

   Within 24 hours of a serious incident, the following actions must be taken:

   1. The provider shall notify the District of the serious incident.

2. District personnel must enter the incident into the IMS database within 24 hours or the next business day if the incident occurs over a weekend or holiday.

3. Notification to Responsible Person, e.g., guardian or family member - The responsible person shall be notified unless otherwise specified in the Planning Document (Individual Support Plan/Individualized Family Service Plan/Person Centered Plan). The procedures for notification of the responsible person shall be coordinated between the service provider and the Support Coordinator. The Support Coordinator or designated District staff member shall ensure notification of the responsible person of an incident within 24 hours after the incident. The responsible person shall also be notified of any follow up actions that occurs.

C. All other incidents listed in the definitions section of this policy must be reported to the District by close of the next business day following the incident, and be entered by designated District personnel into the IMS database within 48 hours of notification (if applicable).

D. Incidents occurring after normal business hours must meet the above reporting requirements.

2105 Members At-Risk If Missing

The actions in this section are required when a vulnerable member leaves a Division funded setting without planned alone time, is missing, and is at risk of harm; or when a member with alone time as defined in their Planning Document is missing longer than the plan provides.

A vulnerable member is defined as a person who is at potential risk of harm while unsupervised in the community. He or she may be a danger to self or others require medication to control a condition such as diabetes or seizure disorder or lack essential survival skills such as the ability to communicate or move safely about the community. The Individual Support Plan team shall assess the potential risk of a member who may leave his or her service site without supervision and shall note the results of that assessment in the Individual Support Plan. If the member has prescribed medication, the Team shall contact the primary care physician and/or psychiatrist to determine if a potential medical risk may arise if the member goes without prescribed medication for any length of time. This shall be noted in the plan.

Unless approval has been obtained from the Division’s Assistant Director/Designee, the following must occur:

Provider Responsibilities:

A. When a vulnerable member leaves a Division funded setting without planned alone time is missing and is at risk of harm, or when a member with alone time as defined in their Planning Document is missing longer than the plan provides, the provider staff will:

1. Conduct a search of the immediate area.

2. If the member is not located within 15 minutes, provider staff will notify the program supervisor/other staff to assist with the search.

3. If the member is not found within thirty minutes, the provider must notify law enforcement agencies (e.g. Police, Sheriff's Office) in both the immediate and surrounding communities and the parent/guardian.

4. To assist in locating the member, also contact the following entities during the search: hospitals, shelters, jails and bus stations.

5. If the member is not located within one hour, the provider must notify the Division by speaking directly to Support Coordination staff during regular business hours or by calling the District after hours reporting system on evenings and weekends.

6. The provider will report the following information to the Division and submit a written incident report within 24 hours.

   i. Age of member

   ii. General description of the person

   iii. Time and location of disappearance

   iv. Efforts to locate member

   v. Vulnerability

   vi. Means of communication

   vii. Medical or special needs

   viii. Precursors to disappearance

   ix. Time police and parents/guardian notified

   x. Other entities contacted

   xi. Legal status (e.g., foster care, probation)

B. If the member is located within one hour, the provider will notify the parent/guardian immediately and provide notification to the Division within 24 hours.

Media Involvement

The decision to contact the media for assistance in locating a member will be a collaborative agreement between the Division, law enforcement officials, parent/guardian and the provider.

A. Prior to contact with the media, the provider will obtain verbal or written authorization from the parent/guardian. The approval must be documented in the provider and the Division records.

B. As authorized, the provider will work directly with law enforcement officials by providing essential information about the member to be released to the media. Law enforcement will make the request for release of the vulnerable member's information to the media.

C. Support Coordination will immediately notify the District's Program Manager or designee when a media release is requested.

D. District Program Manager/designee will notify the Division's Assistant Director or designee for notification to the Department's Director and Public Information Officer.

Planning Team Responsibilities

The member's Planning Team will meet to discuss the incident within 30 days or as designated in the Behavior Plan to review the appropriateness of the current plan and Risk Assessment Tool.

2106 Incident Reports

The Incident Management System (IMS) is the computerized database for incidents and reports.

A. All incidents meeting the criteria of the IMS including serious incidents must be entered into the IMS as defined in this policy.

B. Reporting an incident

1. Provider's may use the Division's Incident Report Form to report incidents. Or,

2. A provider's own internal incident report form may be used to

record incidents as defined in this policy.

C. Incident Reports shall:

1. Be written clearly, objectively and in order of occurrence, without reference to the writer's opinion. Incident reports may be available to family/guardians and are considered legal documentation.

2. Include demographic information (i.e., full name, address, date of birth and Focus ID number) about the member.

3. Include the names and job titles of staff that witnessed or were involved in the alleged incident.

4. Include a description of the incident including all known facts, location and the date and time incident occurred.

5. Include causes of injury (if applicable).

6. State whether or not the responsible person was notified and, if not, why.

7. Include whether or not law enforcement, Adult/Child Protective Services or Tribal Social Services were contacted.

8. Include signatures and names of the person completing the report and his/her supervisor and any additional comments.

9. Be completed for each individual involved in the incident and reference other individuals by initials only.

10. Be included in the member's primary record maintained by the Support Coordinator and by the provider completing the report.

2107 Fact Finding

The Division may initiate a fact-find of any incident. Except when such action would compromise the legal investigation by law enforcement, Protective Services or another State Agency (i.e., DES Office of Licensure, Certification and Regulation) the Division should notify the service provider of the onset of a fact find.
Service providers shall ensure that any service provider worker alleged to have endangered the health or safety of an individual shall not have direct contact with any individual served by the Division, pending the outcome of the Division's fact finding activities.

Division staff is responsible for notifying and assigning appropriate personnel to initiate fact-finding.

The District Program Manager is responsible to assign only qualified Division personnel to complete a fact-finding. Division personnel assigned to conduct a fact finding will meet the following qualifications:

A. Have demonstrated ability to be objective;

B. Can maintain confidentiality;

C. Can complete the task within the assigned period;

D. Have expertise regarding the particular situation; and,

E. Have no conflict of interest involving the situation.

The staff assigned to complete fact finding of any incident must have successfully completed fact-finding training offered by the Division.

When a fact-finding of an incident occurs, the following apply:

A. Protective measures must be taken immediately for the person's safety.

B. Initiation of the fact-finding occurs within 24 hours of notification or the next business day for the following incidents:

1. Allegations of physical abuse which results in medical treatment or police involvement

2. Allegations of sexual abuse

3. High risk incidents of member missing

4. Attempted suicide

5. Unexpected deaths

6. Allegations of neglect that involve imminent danger

7. Accidental injuries involving hospitalization

C. Fact-Findings are initiated within 10 days of notification for:

1. Allegations of physical abuse which do not result in medical/police intervention
2. Allegations of verbal/emotional or programmatic abuse
3. Community complaints
4. State property damage or theft above 100 dollars
5. Member property damage or theft over 25 dollars
6. Expected deaths
7. Allegations of human rights violations
8. Allegations of neglect that involve potential danger
9. Accidental injuries that resulted in medical intervention
10. Legal issues involving allegations of fraud, member exploitation or provider drug use.

The fact-finding may involve a review of the provider's incident reports, as well as a review of other records maintained in the provision of services. A fact-finding will typically include interviewing the person reporting the incident, the service provider, and/or members who might have additional information or insight regarding the incident.

If an external investigation is initiated, the Division may delay its fact-finding until Office of Special Investigations, Department of Child Safety (DCS), Adult Protective Services, Tribal Social Services, law enforcement personnel, or other State Agencies (e.g.,: DES Office of Licensing Certification and Regulation [OLCR]) have completed their investigation, to avoid potential conflicts. If another agency is involved, the assigned Division employee must coordinate efforts with that agency.

Conclusion of the Division’s fact-finding shall be within 30 days from notification date of the incident. A fact-finding can be extended an additional 30 days twice for a total of 90 days if more time is needed to allow DCS, Adult Protective Services, Tribal Social Services, law enforcement or other state agencies to complete their investigation and provide the results to the Division.

2108 Abuse and Neglect

Definitions

Abuse:

A. Intentional infliction of physical harm;

B. Injury caused by negligent acts or omissions;

C. Unreasonable confinement or unlawful imprisonment; and,

D. Sexual abuse or sexual assault.

Abusive treatment:

A. Physical abuse by inflicting pain or injury to a member. This includes hitting, kicking, pinching, slapping, pulling hair, or any sexual abuses;

B. Emotional abuse which includes ridiculing or demeaning an member, making derogatory remarks to an member or cursing directed towards an member; and,

C. Programmatic abuse which is the use of an aversive stimuli technique that has not been approved as part of such person's Individual Support Plan (ISP) and which is not contained in the rules and regulations adopted pursuant to A.R.S. § 36-561(B). This includes isolation or restraint of a member.

Child, youth or juvenile: a member who is under the age of eighteen years.

Exploitation: the illegal or improper use of an incapacitated or vulnerable adult or his/her resources for another's profit or advantage.

Incapacity: an impairment by reason of mental illness, mental deficiency, mental disorder, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication or other cause to the extent that the person lacks sufficient understanding or capacity to make or communicate informed decisions concerning his/her person.

Neglect: a pattern of conduct without the person's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health. Neglect also means:

A. Intentional lack of attention to physical needs of members such as toileting, bathing, meals, and safety;

B. Intentional failure to report health problems or changes in health condition to immediate supervisor or nurse;

C. Sleeping on duty or abandoning work station; and,

D. Intentional failure to carry out a prescribed treatment plan for a member.

Physical injury: the impairment of physical condition and includes but shall not be limited to any skin bruising, pressure sores, bleeding, failure to thrive, malnutrition,

dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ or any physical condition which imperils health or welfare.

Serious physical injury: physical injury which creates a reasonable risk of death or which causes serious or permanent disfigurement, or serious impairment of health or loss or protracted impairment of the function of any bodily organ or limb.

Vulnerable adult: a member who is eighteen years of age or older who is unable to protect himself/herself from abuse, neglect or exploitation by others because of a mental or physical impairment.

Department of Child Safety (DCS)

When a Support Coordinator suspects abuse or neglect, as a mandated reporter, the Support Coordinator must immediately report to DCS. Additionally, any allegation of abuse or neglect must be reported in accordance with A.R.S. §13-3620 as outlined below. Upon reporting, the Support Coordinator should provide sufficient information regarding the alleged abuse and/or neglect to allow the DCS worker to set the appropriate priority to the case. The Support Coordinator shall cooperate during investigations and follow-up as required.

Reports made regarding American Indians will be in accordance with tribal procedures.

Reports

Reports made to DCS shall contain:

A. The names and addresses of the minor and his/her parents or person or persons having custody of such minor;

B. The minor's age and the nature and extent of his/her injuries or physical neglect, including any evidence of previous injuries or physical neglect; and

C. Any other information that such person believes might be helpful in establishing the cause of the injury or physical neglect.

A copy of the Incident Reporter the Child Abuse Reporting Form will be forwarded to the DCS Hotline within 24 hours.

Incident Report

When the Support Coordinator reports alleged abuse or neglect to DCS, the Support Coordinator shall complete an Incident Report (IR) in the Incident Management System.

The District will ensure the DCS Program Manager receives an information copy of all IRs on DCS referrals from Division staff.

When DCS staff reports alleged abuse or neglect made by someone other than Division staff, the Support Coordinator will complete and forward an IR.

Investigative Procedures

It is the responsibility of DCS to determine whether an investigation of the allegation is necessary and to proceed with the investigation. The Support Coordinator shall receive the results of the investigative decision by DCS. If, subsequent to an investigation, DCS opens a case, the Support Coordinator shall participate in a team staffing to develop a collaborative plan.

Working with DCS

The Support Coordinator shall work as expeditiously as possible with the DCS worker to resolve any concerns regarding a report or investigation made to DCS.

Whenever possible, the Support Coordinator shall meet in person with the DCS worker to review all aspects of the report including any information the Support Coordinator could provide regarding important historical information.

The Support Coordinator shall notify his/her immediate supervisor whenever issues cannot be quickly and satisfactorily resolved at the Support Coordination level. Supervisory and/or management staff shall immediately pursue the steps necessary to resolve the issues.

Adult Protective Services

In accordance with A.R.S. §46-454, as a mandated reporter, the Support Coordinator or other Division staff shall immediately report any suspicions/allegations of abuse, neglect or exploitation of an adult to Adult Protective Services (APS). APS responds to allegations of abuse, neglect, or exploitation according to the following requirements the person:

A. Is 18 years of age or older; and

B. Is a vulnerable adult as defined in A.R.S. § 46-451.

Reports

Reports made to APS shall contain:

A. The names and addresses of the adult and any persons having control or custody of the adult, if known;

B. The adult's age and the nature and extent of his/her incapacity or vulnerability;

C. The nature and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property; and

D. Any other information that the person reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property.

A written follow-up report shall be mailed or delivered to the police officer or local adult protective services worker within 48 hours or on the next working day if the 48 hours expire on a weekend or holiday.

When the member resides in his/her own home, a family residence, or an agency not funded by the Division, APS will take the lead for the investigation. APS will work together with the Support Coordinator or other Division staff as appropriate. Specific responsibilities are decided on a case-by-case basis. The APS worker will remain involved until the abuse or problem situation has been resolved.

When the adult resides in a DES/DDD operated or funded program, APS will investigate the complaint. DES/DDD is responsible for coordination with APS and notification of the fact finding process. DES/DDD staff, as appropriate, will conduct a fact- find to determine program and contract compliance issues.

Incident Report

When a report is made to Adult Protective Services, the Support Coordinator shall complete an Incident Report, following procedures established in this policy manual.

Working with APS

The Support Coordinator shall work as expeditiously as possible with the APS worker to resolve any concerns regarding a report or investigation made to APS.

Whenever possible, the Support Coordinator shall meet in person with the APS worker to review all aspects of the report including any information the Support Coordinator could provide regarding important historical information.

The Support Coordinator shall notify his/her immediate supervisor whenever issues cannot be quickly and satisfactorily resolved at the Support Coordination level. The Support Coordinator shall cooperate during investigations and follow-up as required. Supervisory and/or management staff shall immediately pursue the steps necessary to resolve the issues.

2109 Referral to Other Investigative Agencies

The Assistant Director or the Office of Compliance and Review may refer incidents for investigation to the DES Office of Special Investigations. An external investigation request may be made for incidents involving:

A. Potential criminal activity

B. Possible misconduct by a Division or service provider's employee

C. Fraud (this type of incident will also be referred to AHCCCS, as appropriate).

2110 Incident Closure and Corrective Actions

A. An incident is complete when:

1. The fact finding if needed is reviewed and approved by the Division.

2. Recommendations for corrective action are identified and provided to appropriate Division and provider personnel.

3. Corrective action plans, if needed, are requested .and received from the provider and approved by the Division.

4. Designated District personnel have verified the information entered into the IMS database and have verified that all corrective actions have been completed no later than 60 days from the acceptance of for a plan.

B. Corrective actions may be member-specific or systemic.

An example of a member-specific corrective action would be requiring the person's Planning Team to reconvene to discuss the incident and review the need for any changes in the Planning Document (Individual Support Plan/Individualized Family Service Plan/Person Centered Plan) to ensure the health and safety of the member.

Systemic corrective actions may require the provider to rewrite or clarify agency policy, procedure, recommend specialized training of staff, or require other quality improvement actions to increase the ability of the provider to improve the health and well-being of members served.

C. The member's Planning Team shall review all incidents for the effectiveness of services and assess risk as part of the Planning Document and update the process.

D. The Division's Program Monitoring staff (at the Central Office and District Level) shall review all incidents for residential placements and day programs to be monitored prior to the visit to identify any areas that may warrant extra monitoring.

2111 Trending for Quality Improvement

Trending is an essential component of the IMS.

District Quality Management lead will compile District specific quarterly data analysis reports and submit to the Quality Management unit. The content will include at a

minimum:

A. Total incidents by type and category, provider and member

B. Trends by provider and member including:

i. Total allegations of abuse, neglect and exploitation,

ii. Information of whether or not the allegation was substantiated

C. A narrative analysis of findings, patterns, areas of concern and recommended actions for quality improvement

The Division's Central Office designee will prepare a Statewide Incident Summary Report monthly and annually and will include at a minimum:

A. Total incidents by type and category by district,

B. Trends by provider and member including:
i. Total allegations of abuse, neglect and exploitation,

ii. Information of whether or not the allegation was substantiated

C. In a narrative format an analysis of findings, patterns, areas of concern, and recommended actions for quality improvement

Incident Summary Reports will be provided to the Quality Administrator, the Assistant Director and to designated personnel.

The Division Management Team and Statewide Quality Management Committee will formally review the summary reports on a quarterly basis.

If the District or Statewide Incident Summary Reports indicate any areas of concerns or patterns, focus studies will be completed by the Central Office designee, District Quality Management leads or designee. If the focus study confirms any areas of concerns or patterns, corrective actions will be recommended for quality improvement.

2112 Information Sharing

Incident reports may be made available to:

A. The Human Rights Committees as prescribed in this policy manual;

B. The member/responsible person(s);

C. Others who are bound by confidentiality on a need to know basis; and,

D. All requests should be directed to the Office of Compliance and Review.

Fact finding reports and action plans are confidential. Fact finding and corrective action plans are summarized in the IMS Fact Finding screens.

2113 Mortality Review Audits

Computer and desk audits will be conducted to determine the timeliness and accuracy of reports, investigations and implementation of corrective actions involving the death of a member. Quality reports of the system will also be used to identify patterns of user concerns, e.g. entering an incident into the incorrect type or category, common data entry errors, that indicate the need for additional training, technical assistance or management information system change.

2114 Mortality Review Process

The purpose of this policy section is to improve quality of care for members by a systematic examination of deaths.

Notification Procedure

When a death is reported to a Support Coordinator, the Support Coordinator will forward the information to their District Quality Unit's IR Central for entry into the IMS database within 48 hours of notification of a death.

Once the Support Coordinator is alerted to an incident, they will notify the responsible person or next of kin, if they have not already been notified. The Quality Assurance manager or designee will also immediately notify the appropriate District Manager or designee within 24 hours of the Division's notification of a member's death. All service authorizations must be closed in Focus with the date of death as the effective date by the Support Coordinator. Support coordination (CMG/CPG) and Bereavement Counseling is offered to the family may remain authorized for days after the Division was notified of the death. If staff becomes aware of any service utilization after the date of the member's death, it should be reported into the Incident Management System.

If Health Care Services staff is notified of a death, they will notify the Central Office on-call person within 24 hours.

The District Manager or designee will notify the Assistant Director/designee or the Division's on-call line within 24 hours of being notified of a death, as well as the Adult or Child Protective Services agency as required by statute. The District Manager or designee will also notify the Human Rights Committee District liaison.

Central Office designees will notify the Department of Administration (DOA) Risk

Management if the death may give rise to a liability claim against the state.

Review Procedure

A. District Review

1. All deaths are to be reviewed jointly by the Support Coordinator and his/her supervisor within 30 days, to identify apparent issues relating to care or cause of death.

2. The Support Coordinator or designee will enter the following information, as applicable, relating to the death into the IMS database:

   i. Member's underlying primary medical conditions

   ii. Detailed circumstances of the death Date of Death? What happened? Where did it happen? Was a provider present? Did providers follow policy such as calling 911 and performing CPR? Had the member been ill? Was the member recently seen by PCP? What symptoms of illness did the member have? What is the suspected cause of death (if known)?

   iii. Was Hospice involved?

   iv. Did the member have an Advance Directive in place?

   v. Had DCS/Adult Protective Services (DCS/APS) been involved within the last year?

   vi. Is there litigation pending?

   vii. Is there further fact-finding pending?

   viii. Was the family/guardian notified?

   ix. Did the Division offer support/grief counseling for the family?

3. The District will send the primary case file to Central Office Health care Services within 60 days after being notified of the death.

B. Health Care Services Quality Assurance Investigative Nurse (HCS QA Nurse) Review

1. The HCS QA Nurse reviews the mortality information documented in the IMS database and requests further information, as

necessary.

2. The Chief Medical Officer assigns the death into one of the following categories:

   Level A These include deaths that are expected and/or anticipated, due to natural causes, such as terminal illness or congenital anomalies. Level A deaths typically would also include members who lived with family or independently and were not receiving any services from the Division at the time of death.

   Level B These include deaths that are not expected and/or are sudden, such as trauma or pneumonia that progresses to respiratory failure. These deaths require a closer inspection into the circumstances surrounding the death and assessment of any systemic issues which should be addressed. Other situations where Level B is indicated include: aspiration, coroner cases, law enforcement/911 calls, decubitis, methicillin-resistant staphylococcus aureus (MRSA), unexpected circumstances, unusual or suspicious circumstances, and problems with emergency or other medical care.

C. The HCS QA Nurse requests death certificates and when indicated, autopsy reports.

D. The HCS QA Nurse gathers additional medical records for review when indicated.

E. The HCS QA Nurse tracks mortality information in a database specifically designed to collect information related to member deaths.

F. The Chief Medical Officer communicates via IMS the status of the mortality review and when the case is considered closed. The Chief Medical Officer shares any recommendations in the summary.

G. Based on the information reviewed by the Chief Medical Officer, cases will be selected from the Level B deaths to present to the Mortality Review Committee at their next quarterly meeting. The selected cases warrant additional review by the Committee and demonstrate situations where systemic improvement may be made**.**

Mortality Committee Review

A. The Committee shall discuss each case selected and identify changes to

practice, training, or processes that may positively affect care and treatment. The Committee shall report in writing their recommendations to the Management Team.

B. Within 30 days of receiving a recommendation from the Committee, the Management Team shall report their disposition and intended steps to respond to recommendation(s).

C. Following the Mortality Review Committee review, the case shall be closed unless it is referred for Level C review.

Review Level C – Root Cause Analysis Review

A. Root Cause Analysis, which will follow the general protocols recommended by the Joint Commission on Accreditation of Health Care Organizations, will be arranged by the Chief Medical Officer and will be conducted on cases recommended to the Assistant Director by the Mortality Review Committee or as requested by the Assistant Director.

B. No more than 3 Root Cause Analyses shall be conducted in a fiscal year.

C. The HCS QA Nurse shall monitor the implementation of recommendations from a Root Cause Analysis.

Process

A. The Mortality Review Committee shall meet at least quarterly.

B. The Chief Medical Officer shall issue annually a Mortality Review and Analysis, which will aggregate, analyze and summarize mortality data and actions taken for system improvements.

C. The HCS QA Nurse is responsible for monitoring the mortality review process and conducting integrity checks, including protecting any privacy rights of the deceased.

D. Autopsies should always be requested for children in foster care. For all other deaths, requests should be made whenever it is possible that something can be learned about the death. Consent for an autopsy rests with the responsible person or next of kin, unless the county attorney or coroner is involved. A request for an autopsy should follow these steps in priority order:

1. Arizona Revised Statute 11-597 (www.azleg.gov/) provides for County Medical Examiners to complete an autopsy and outlines when this is required.

2. When the Medical Examiner does not identify a need for an autopsy, the Division can request the family to authorize an autopsy, at the expense of the Division, when the Division's Chief Medical Officer believes there are unanswered questions surrounding the death.

3. Autopsy reports will be requested by the HCS QA Nurse.

E. Death Certificates will be requested by the HCS QA Nurse.

F. Reviewers and all others involved with these processes shall in all cases exhibit compassion and sensitivity to next of kin, caregivers, and others who cared about the member.

2115 Fraud and False Claims

Overview

This section defines fraud and describes the procedures for prevention, detection and reporting of fraud, false claims and abuse within the Division.

Policy Objectives

The objectives of this policy are to:

A. Prevent or detect fraud and abuse

B. Delineate reporting requirements

C. Define investigative procedures

D. Explain corporate compliance

E. Describe training requirements

F. Specify policy requirements for providers

Definitions

Abuse: related to this section, practices which are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Division or in reimbursement for services which are not medically necessary or which fail to meet professionally recognized standards for health care.

Fraud: "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or

another person. It includes any act that constitutes fraud under applicable federal or state law." (42 CFR 455.2)

An act of fraud has been committed when a member or provider:

A. Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment.

B. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government.

C. Conspires with others to get a false or fraudulent claim paid by the Federal Government.

D. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the Federal Government.

42 CFR 455.2 www.gpoaccess.gov/cfr
ARS §§13-1802; 13-2002; 13-2310; 13-2311; 36-2918, www.azleg.gov/

Potential: based on one's professional judgment, it appears as if an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

Preliminary Fact--Finding Investigation: when the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practices, it may conduct a preliminary fact-finding to determine whether there is sufficient basis to warrant a full investigation by the Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity.

Prevention: keep something from happening.

Primary Contact: the central person within the Division who is charged with the responsibility to report potential incidents of fraud and abuse to the Arizona Health Care Cost Containment System (AHCCCS) in the manner prescribed in this policy.

Provider: a person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers must meet the specific qualifications outlined in the Division's Policy Manual, All providers of Arizona Long Term Care System (ALTCS) services must be registered with AHCCCS. Health Plans under contract with the Division are responsible for credentialing acute care providers.

A.A.C. Title 6, Chapter 6, Articles 8, 10, 11, and 15
www.azsos.gov/public_services/rules.htm

Remit Advice: a document detailing the status of each line item in a provider claim, by member specificity. It reports the resolution for each line as paid, denied, or pended. Reason codes are attached and summarized for those lines denied.

Prevention and Detection

The Division has established internal controls on the member payment system including claim edits and prior authorization requirements. The Division produces reports to review high utilization by members (CLT_0060), underutilization by members (CLT_0150), service cost, and units by service title, month by month over the fiscal year and other reports for analysis. The Business Operations Unit as outlined below conducts a post-payment review process.

A. Claims Edits

All claims are edited through a computerized system. When a claim is entered in the system for payment the system checks to ensure that a completed authorization is in place. System edits prevent payment for incomplete or absent authorizations and/or duplicate claim submittals.

The Division also segregates the functions of service authorization and claims processing.

B. Post Processing Review of Claims

The Division reviews detailed "remit advices". Additionally, the Auditor General performs an annual audit of the ALTCS program including claims processing and payment.

C. Prior Authorization

All services are prior authorized. Prior authorization occurs within the guidelines set forth in this policy manual and the AHCCCS Medical Policy Manual.

D. Utilization/Quality Management

The Division complies with the requirements set forth in the AHCCCS Medical Policy Manual.

E. Contract Provisions

All providers shall comply with the "Uniform General Terms and Conditions" and the "Special Terms and Conditions" of the Qualified Vendor Agreement or the terms of the Independent Provider's "Individual Service Agreement".

F. Reporting

The Division enters all reports of suspected fraud or false claims into the Incident Management System (IMS). The incidents are reviewed, trended and reported as required.

The IMS is the tracking system for any suspected fraud or false claims reported by providers, members, or staff. Fraud can be reported to the Division by anyone in writing or by phone reports can be made by calling the appropriate District Office. The Office of Compliance and Review can be contacted directly to report fraud as well as by calling

1.866.229.5553 or submitting information to:

Division of Developmental Disabilities
Office of Compliance and Review
1789 W. Jefferson Ave.
Phoenix, AZ 85007

All the Division employees and providers shall comply with this chapter. The Manager of the Division Office of Compliance and Review shall report potential incidents to AHCCCS utilizing the AHCCCS prescribed form.

False Claims Act (FCA)

The False Claims Act (FCA) covers fraud involving any federally funded contract or program, with the exception of tax fraud. Liability for violating the FCA is equal to three times the dollar amount that the government is defrauded and civil penalties of $5,500 to $11,000 for each false claim.

An individual can receive an award for "blowing the whistle" under the FCA. In order to receive an award the person must file a "qui tam" lawsuit. An award is only issued if, and after, the government recovers money from the defendant as a result of the lawsuit.

The amount of the award is generally between 15 and 30 percent of the total amount recovered from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government's participation in the suit and the extent to which the person substantially contributed to the prosecution of the action.

The "whistle blower" is protected under the FCA. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the Act is entitled to any relief necessary to make the employee whole.

Any provider receiving at least $5,000,000 in annual payments through the Division; shall establish written policies for all employees regarding Fraud and the FCA requirements.

Corporate Compliance

The Corporate Compliance Officer implements, oversees and administers the Division's compliance program including fraud and abuse control. The Corporate Compliance Officer shall be an on-site management official, available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCS Office of Inspector General.

The Division reviews, analyzes and trends fraud and false claims through the monthly Corporate and Quality Data Analysis Committee. The committee includes the Chief Medical Officer, Quality Management Administrator, Quality Assurance staff, Office of Compliance and Review Manager, Consumer Resolution Unit, ALTCS Administrator

and Business Operations Administrator. The monthly agenda includes a review of all Incident Management System data for the past month (including suspected fraud); Consumer Resolution System data for the past month; Program Monitoring reviews for the past month; claim disputes, appeals and state fair hearings for the past month; and any other data available, including results from post-payment reviews. The committee will make recommendations for improvement of the compliance program as identified through the analysis and review of reports. The Office of Compliance and Review Manager also meets quarterly with the Assistant Director to review any pending litigation, including a review of all fraud or false claim reports. The Office of Compliance and Review Manager reports any suspected fraud or false claims incidents to the appropriate AHCCCS entity as required by contract and/or AHCCCS policy.

Training

The Division has available training through both the continuous core curriculum as well as Computer Based Training regarding the False Claims Act. In addition, the Office of Compliance and Review provides on-going standalone training to each District regarding compliance issues including the False Claims Act. The Division has contract language requiring Qualified Vendors to comply with the Deficit Reduction Act including providing training to their employees.

2116 Health Care Acquired Conditions (HCAC)

Identification and Reporting

Any HCAC occurrence that has been identified and verified will be entered into the Division's Information Management System (IMS) by the Health Care Services (HCS) Quality Assurance Registered Nurse/designee who has the final determination of confirmed HCAC occurrence and will enter each confirmed HCAC as an Incident Report (IR) within twenty-four (24) hours of confirmation. These IR's will be reviewed on a daily basis for reporting to AHCCCS by the Division's HCS Quality Assurance Registered Nurse. In addition, a report could be made to the appropriate regulatory boards and agencies (Arizona Department of Health Services, Arizona Medical Board, and Arizona State Board of Nursing).