Q: Where within the e-CAP Knowledge Exchange can the CMEs locate the presentation on the e-CAP CIR form updates?
A: CMEs can access the resources under the "Critical Incident Management Functionality Update" file in e-CAP.

Q: When will all forms and screens be available for use by case managers and providers so the critical incident reporting process can be fully initiated? Will CMEs and providers have a window to comply with this process?
A: The e-cap system has all required forms to report, track, and manage incidents. After refresher training, reporting incidents according to the leveling processes must be instantaneous. Resource documents are in the e-CAP systems and the CAP/C and CAP/DA webpages on the NC Medicaid website.

Q: Can the submitted incident reports be amended?
A: Yes, reports can be amended. This is a new feature from the past.

Q: Should documentation start based on timelines and save the CIR as not complete while additional notation, research, or investigation is being conducted?
A: Yes.

Q: Does the e-CAP system determine the CIR level?
A: Algorithms are built into the e-CAP system to source the level type based on what the critical incident reporter enters.

Q: When a new CIR is entered, will the e-CAP system prompt the RCA screen after the CIR is saved?
A: No, you will be required to enter RCA information to save the CIR for all level II incidents. The RCA narrative box is under the "Quality of Care Issues Arising from Incident" section within the CIR.

Q: Is COVID still considered a level II?
A: Yes, the highly infectious diseases category encapsulates COVID-19 and other viruses.

Q: Are all falls level II or just falls resulting in an ER or hospitalization?
A: Yes, all falls are now a Level II critical incident.

Q: Does the individual risk agreement (IRA) require a signature by the waiver beneficiary or representative?
A: Yes.

Q: Is an IRA needed for every CIR or only when applicable?
A: Only when applicable based on the consensus of the multidisciplinary team review.

Q: It was stated that the Root Cause Analysis would be required to save the CIR. So, does this mean an IRA would need to be performed every single time?

A: No, an IRA is not needed for every incident. An IRA mitigates risk by allowing the waiver beneficiary/representative to assume risks as identified.

Q: Is there a maximum number of IRAs for one individual?
A: No, there is no maximum number of IRAs.

Q: Is a home visit required for each incident?
A: The need for a home visit is based on the risk level of the incident.

Q: If the waiver beneficiary has an IRA and a level II incident occurs two months in a row, can the first IRA be updated/amended, or does a new IRA need to be initiated?
A: If a critical incident results from a reoccurring situation, amend and update the current IRA and the waiver beneficiary to address the additional steps needed to mitigate risk to ensure their health, safety, and well-being. The updated/amended IRA should be updated in the e-CAP system and include the waiver beneficiary's signature.

Q: What is the timeline for completing a critical incident report?
A: 15 calendar days from the awareness of a CI.

Q: At what point should a decision be made about dis-enrollment when risk cannot be mitigated with a service plan or an IRA?
A: Waiver beneficiaries can assume risks for situations that may jeopardize their health and safety. They are entitled to make person-centered decisions and choices similar to those of non-disabled individuals. When assumed risks result in significant danger to self and others, consult the MDT members to identify a plan and follow the recommendations of that team.

Q: Will every hospitalization or rehabilitation discharge require an IRA?
A: No.

Q: How should a CIR be documented when the waiver beneficiary is hospitalized for more than 15 days for level II unplanned hospital admissions?
A: A critical incident should be completed upon the awareness of the hospitalization. Based on the severity of the hospitalization, a visit can be scheduled shortly after the discharge to update/amend the critical incident to align with the risk mitigation strategies.

Q: The CME is often unaware of an ED visit or hospitalization until the monthly monitoring contact or visit. Given the length of time between the incident and awareness by the CM, are face-to-face visits needed?
A: The timeline to process an incident is within 72 hours of awareness. Once you are aware, follow the steps outlined in the CIR, and when applicable the associated triage checklist.

Q: If the incident report is closed within 72 hours, must the RCA be completed within 15 days?
A: An RCA is required for all level II incidents. If one is required, it must be completed within 15 days.

Q: How do we handle falls for children since they can be related to typical development? What if they are not injured by the fall?
A: Falls for children are different, especially those that result from minor trips due to play or

initially learning to walk or maintain balance. However, falls that result from disability or illness should be documented to assist with identifying trends for preventative measures and risk mitigation.

Q: How do we complete an RCA around natural death?
A: The triage checklist will provide support for completing the modified RCA for natural death and uploading supporting documents.

Q: If an RCA requires an IRA, how would that work with a death?
A: An IRA is not needed for CIRs with death. The triage checklists will provide support around completing the RCA for natural and unnatural death.

Q: Do all level II CIs need a follow-up home visit? So, do staffing concerns/missed shifts need a follow-up home visit?
A: No. Missed shifts should be addressed with the provider(s), and mitigation plans should be identified during the MDT meetings. If missed shifts are reoccurring, the waiver beneficiary should be counseled about other available provider agencies.

Q: Will a home visit be necessary for all incidents or just level II and those requiring the following process?
A: Level II incidents require a home visit. The home visit can be at the next scheduled monitoring contact/visit. The triage checklists outline completing the RCA steps for each level II critical incident.

Q: If the beneficiary has had a Level II Incident and the CM attempts to complete the home visit but cannot do so due to the beneficiary's MD appointments or other prior commitments, what needs to be done?
A: Discuss the incident with the waiver beneficiary/representative and arrange a convenient face-to-face visit to monitor health, safety, and well-being.

Q: Should a case management visit occur in the hospital to monitor an incident?
A: The CME's internal processes (policies) would determine how they would meet the beneficiary's needs in that instance.

Q: What are "unplanned hospitalization" and "true emergency"?
A: An unplanned hospitalization occurs when a beneficiary is admitted to the hospital for a procedure that was not scheduled. The CAP policies do not define a true emergency. However, a true emergency can be equivalent to a sudden and severe incident that could potentially be life-threatening.

Q: If an identified piece of equipment is necessary to mitigate risk, and the timeline to procure the equipment is extended, what steps should be taken?
A: It is important to consider a waiver beneficiary's immediate HSW and provide alternate mitigation strategies or contingency plans.

Q: What is considered a grievance?
A: A grievance is a complaint made by a waiver beneficiary or representative regarding their Medicaid services or the administration of waiver services.

Q: Private duty nursing (PDN) is on the POC, but we don't manage it. So, we are not always aware of their missed shifts. Do we still create a CIR, and do we do so for each missed shift?
A: The CAP case manager must oversee all Medicaid services the beneficiary is authorized to receive to ensure their health and well-being. The PDN provider should keep the CM informed of service utilization and attend MDT meetings to ensure the monitoring of the service plan. If PDN is not rendered, it must be documented because it impacts the beneficiary's HSW. CIRs are completed when there are consistent, ongoing, unmet services.

Q: Can direct service providers complete CIR in the e-CAP system to report missed appointments or other incidents?
A: Direct care providers can initiate a CIR in the e-CAP system for missed shifts or other incidents. However, the case manager is responsible for completing the CIR initiated by a direct care provider.

Q: When a Wavier service is not being provided, for example, unstaffed hours by an agency, who is responsible for the CIR, the DSP aide agency, or the CME?
A: The CME.

Q: Can you quantify when to file an incident report for missed IHA hours? It is not uncommon to lose a shift here and there.
A: Missed shifts may be common. Documenting those missed shifts is important to identify trends and strategies to mitigate risks and prevent future incidents.

Q: If the POC is reviewed after an incident and no changes are required, how should that be documented?
A: Documentation should be made in the case notes.

Q: If abuse, neglect, or exploitation is suspected, should a CIR be completed before we know the results (substantiated or non-substantiated) of the CPS or APS investigation?
A: Yes, the CIR may be amended to include protective service investigation results if they occur outside the 15-day window.

Q: Should an IRA be completed when there are no risks to mitigate?
A: No.

Q: The CAP population is prone to experience many incidents listed as Level I or II. Must an incident report be completed for each incident occurrence?
A: Incidents that fall within the outlined categories need to be documented to ensure that every effort is taken to assist with the HSW of the waiver beneficiary.

Q: How do we handle instances when waiver beneficiaries disagree with risk mitigation strategies?
A: Document all risk mitigation strategies identified and declined by the waiver beneficiary.

Q: If a suggestion for safety is provided to the waiver beneficiary, such as removing a slippery or torn rug, but a choice is made to keep the carpet. What steps should be taken to mitigate the identified risk?
A: The beneficiary and the MDT should discuss (additional/alternative) risk mitigation strategies to avoid further incidents for the beneficiary. Documentation of all efforts to mitigate risk and the beneficiary's refusal is required.

Q: It is difficult to "enforce" recommendations for safety when a beneficiary is competent to make their own decisions and chooses to remain in an unsafe environment or live alone with no caregiver outside of CAP/DA waiver services
A: A waiver beneficiary has the autonomy of choice and person-centered decisions. When unsafe living habits are identified, and mitigation strategies are refused, document those along with recommendations from the MDT to show efforts to mitigate risks.

Q: What do you do when the Beneficiary refuses to sign an IRA?
A: Document the refusal.

Q: If a beneficiary has COPD and is 100% compliant with their service plan and mitigation strategies to maintain their health but is hospitalized every three months, would these occurrences be considered a level II incident and warrant an IRA?
A: If it is a planned hospitalization, it would be a level I incident. If it is an unplanned hospitalization, it would be a level II and may need a review of the current IRA following recommendations of the interdisciplinary team.

Q: Can we avoid doing the risk agreement if there is nothing to mitigate? Can we just document it in the root cause analysis or somewhere on the incident report after investigation if it is not deemed necessary?
A: An IRA is only needed if there is something to mitigate.

Q: When should the CM begin entering CIR based on the CIR refresher training?
A: Immediately.
Q: Where will the FAQs be located?
A: FAQs will be located in the Knowledge Exchange in e-CAP and on the CAP/C and CAP/DA webpages on NC Medicaid's website.

Q: What is the contact information for asking additional questions about critical incidents?
A: The contact email addresses are CAP/DA: medicaid.capda@dhhs.nc.gov & CAP/C: Medicaid.capc@dhhs.nc.gov).
Q: Can CAP/DA Consultants answer questions about critical incidents?
A: You can contact your service area's assigned CAP/DA Consultant.

Q: Are mitigation strategies needed for a new beneficiary who may not have a designated caregiver, live alone, or be unsafe in their home alone?
A: Risk mitigations are only needed when an incident or occurrence puts the waiver beneficiary's health in jeopardy. If the waiver participant can manage their care needs independently with support, living alone and not having a designated caregiver may not put the person at risk, thus not warrant mitigation strategies.

Q: What do we do when APS does an investigation, and the person doing the investigation says the environment is safe when it is not?
A: Document the investigation results in the CIR and case notes.