EXHIBIT W(1)

CRITICAL INCIDENT REPORTING AND MANAGEMENT AND

PROVIDER PREVENTABLE CONDITIONS/PREVENTABLE SERIOUS ADVERSE EVENTS REPORTING

All CHC-MCO staff and staff of providers in their networks are mandatory reporters under both the Adult Protective Services Act (APS) and the Older Adult Protective Services Act (OAPSA). Reporting requirements can be found at:

- APS- http://www.dhs.pa.gov/citizens/reportabuse/dhsadultprotectiveservices/
- OAPSA- http://www.aging.pa.gov/organization/advocacy-and-protection/Pages/Protective-Services.aspx

CHC-MCOs must train or educate its Network Providers and ensure they comply with the reporting requirements established in the OAPSA and APS. In addition, CHC-MCOs must ensure that Network Providers comply with the following critical incident and adverse event reporting requirements outlined in this Exhibit.

Critical Incident Reporting to the Department

A. Network Providers and Subcontractors must report critical events or incidents to the CHC-MCOs.

B. Using the Department's Enterprise Incident Management System (EIM), the CHC-MCOs must investigate critical events or incidents reported by Network Providers and Subcontractors and report the outcomes of these investigations. CHC-MCOs must require all information entered in EIM to be written in English. To report the ongoing monitoring of incident reports and compliance with CMS' requirements, the Department has established an Operations Report for critical incidents (OPS 30: CHC Waiver Assurance Performance Measures – Health & Welfare). This reporting requirement is in addition to any other reporting requirements that may exist under the law.

C. CHC-MCO must establish a process to receive and manage critical incident reports that:

1. Safeguards the health and welfare of the participant involved in a critical incident, including seeking emergency medical services if needed.
2. Determines if an incident is reportable based on the definition of a critical incident.
3. Requires the CHC-MCO staff person or Network Provider to submit a critical incident report in EIM within forty-eight (48) hours of discovery of the incident, excluding weekends and holidays. The forty-eight (48) hour clock begins at the time that the incident was discovered. If the incident was discovered on a weekend or holiday the clock would start at 12:00 a.m. on

the first business day following the discovery of the incident.

4. Ensures all required fields are completed in EIM.
5. Requires the CHC-MCO to notify the Participant involved in the incident and the Participant's designated representative (unless the representative is suspected to be involved in the incident) within twenty-four (24) hours that a critical incident report was filed.
6. Requires CHC-MCO staff and Network Providers to report critical incidents even if the Participants involved choose not to report.
7. Respects the right of a Participant involved in a critical incident to: not report the incident; decline further interventions; refuse involvement in a critical incident investigation; and have an advocate present during any investigation resulting from a critical incident report.
8. Provides the number and percentage of substantiated cases of abuse, neglect and exploitation where potential issues related to health and welfare were addressed.

D. The following are critical incidents:

1. Death (other than by natural causes);
2. Serious injury that results in emergency room visits, hospitalizations, or death;
3. Hospitalization except in certain cases, such as hospital stays that were planned in advance;
4. Provider or staff misconduct, including deliberate, willful, unlawful, or dishonest activities;
5. Abuse, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse include, but are not necessarily limited to:
6. Physical abuse, defined as a physical act by an individual that may cause physical injury to a participant;
7. Psychological abuse, defined as an act, other than verbal, that may inflict emotional harm, invoke fear, or humiliate, intimidate, degrade or demean a participant;
8. Sexual abuse, defined as an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant; and
9. Verbal abuse, defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant;
10. Neglect, which includes the failure to provide a participant the reasonable care that he/she requires, including, but not limited to, food, clothing, shelter, medical care, personal hygiene, and protection from harm. Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect;
11. Exploitation, which includes the act of depriving, defrauding, or otherwise

obtaining the personal property from a participant in an unjust, or cruel manner, against one's will, or without one's consent, or knowledge for the benefit of self or others;

12. Restraint, which includes any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions, which are actions or procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights;
13. Service interruption, which includes any event that results in the participant's health and/or safety being at risk because of their inability to receive services. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization; and
14. Medication errors that result in hospitalization, an emergency room visit or other medical intervention.

For the purposes of Critical Incident reporting an emergency room visit is defined as the use of a hospital emergency room. This includes situations that are clearly emergencies, such as a serious injury, life-threatening medical conditions, medication errors, as well as those when an individual is directed to an emergency room in lieu of a visit to the PCP or as the result of a visit to the PCP. The use of an emergency room by an individual, in place of the physician's office, is not reportable.

A serious injury is defined as an injury that:
1. causes a person severe pain; or
2. significantly impairs a person's physical or mental functioning, either temporarily or permanently.

Critical Incident Investigation and Management

The CHC-MCO must ensure that the investigation of critical incidents begins within twenty-four (24) hours after the CHC-MCO discovers the incident.

The CHC-MCO must conclude critical incident investigations and provide the results of their investigations in EIM within thirty (30) calendar days of discovery of the incident. If the CHC-MCO is unable to conclude an investigation within thirty (30) days, the CHC-MCO must document the need for an extension and the reasons for the delay in EIM.

For any participant with more than three critical incidents within a 12-month period, the CHC-MCO must perform an analysis and take action as necessary to prevent or mitigate further incidents. The CHC-MCO must commence the analysis and implement the actions to address potential issues related to the health and welfare of the Participant within the

30-day investigation period. If additional time is needed to investigate and to implement any necessary actions to address potential issues related to the health and welfare of the Participant, the CHC-MCO must document an extension in EIM.

For critical incidents reportable under APS and OAPSA, including those involving suspected abuse, neglect, exploitation or abandonment, the CHC-MCO is responsible to report the incident to APS or OAPSA but not to investigate. CHC-MCO staff and service coordinators are required to provide information to and cooperate with APS and OAPSA staff who are conducting the investigation. In addition, the CHC-MCO shall fully cooperate with APS and OAPSA staff in the coordination of any services provided by the CHC-MCO. Upon being notified by APS and OAPSA staff that a case has been closed, or upon being notified by OLTL, the CHC-MCO will resume full responsibility for subsequent critical incident reporting and investigation for that Participant.

As part of its quality management plan, the CHC-MCO shall have a means to identify Participants who may be at risk of abuse or neglect and take steps to minimize those risks while balancing the right of the Participant to live in his or her community or place of choice.

The Department retains the right to review any incident reports or internal documentation, to conduct its own investigations and to require further corrective actions by the CHC-MCO.

Critical Incident Reporting Requirements for Providers

Providers must report in accordance with applicable requirements.

The CHC-MCO must require providers to cooperate with its investigation of critical incidents. The CHC-MCO must include critical incidents training in its annual training plan and quarterly updates to demonstrate all applicable CHC-MCO staff, Network Providers and their staff and contractors have received the training.

Provider Preventable Conditions/Preventable Serious Adverse Events (PSAE)

The CHC-MCO must require all Network Providers to identify provider preventable conditions as defined in 42 C.F.R. § 447.26 and may not pay for services related to provider preventable conditions unless the condition existed prior to the initiation of treatment for the patient. The CHC-MCO must submit all identified Provider Preventable Conditions in a form or frequency as required by the Department.

The CHC-MCO is prohibited from making payment to a provider for provider preventable conditions that meet the following criteria:

a) Is identified in the State Plan;
b) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by the evidence-based guidelines;
c) Has a negative consequence for the Participant;
d) Is auditable;
e) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

The CHC-MCO must develop and disseminate policies and procedures that prohibit payments for inpatient services related to treating provider preventable conditions.

The Department will recoup any funds expended by the CH-MCO for payments related to inpatient services for provider preventable conditions.

Please refer to the Department's website for additional information regarding PSAE http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_101648.pdf