



# **OVERVIEW OF THE PROVIDER PORTAL AND ELECTRONIC SUBMISSION OF ADVERSE EVENT REPORTS**

June 14, 2022

Provider Presentation

# AGENDA



- I. OVERVIEW OF PROVIDER PORTAL
- II. SYSTEMS RESOURCES
- III. ELECTRONIC SUBMISSION OF AERs
- IV. IMPORTANT THINGS TO NOTE
- V. REPORTING AND ANALYTICS
- VI. QUESTIONS



**WHEN?**

**July 1, 2022**

**GOING LIVE**



# AER Submission Dates

6/30/2022

Submit Hard  
Copy AER  
Form 28-3

7/1/2022

Submit via  
Provider  
Portal

# PROVIDER PORTAL OVERVIEW

Secure, web-based system

Real-time communication with DDD

Planned to support:

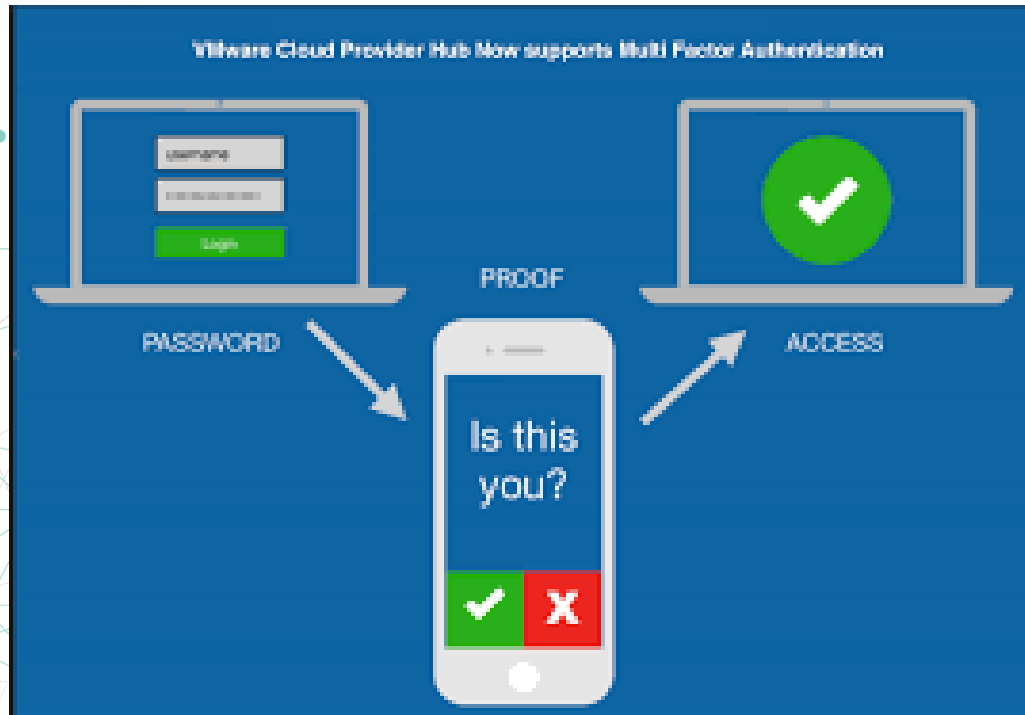
- Adverse Event Reporting
- Service Planning
- Authorizations
- Staff Updates
- Service Capacity
- Referrals

Rolled out in phases

# Systems Resources



# Multi-Factor Authentication



- Set up multi-factor authentication
- This is a required security feature
- Please take the time to familiarize yourself with the process and complete this before July 1
- Instructions will be available from the Provider section of the DDD website



## Training Videos

- Self-Paced training
- Easy to reference
- Accommodates learning with your own schedule



State of Hawaii, Department of Health  
**Developmental Disabilities Division (DDD)**

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## MEDICAID I/DD WAIVER PROVIDERS

Services are provided through the [Medicaid 1915\(c\) Home and Community-Based Services \(HCBS\) Waiver, for Individuals with Intellectual and Developmental Disabilities \(Medicaid I/DD Waiver\)](#).

The purpose of the Medicaid I/DD Waiver is to support people to have a full life in the community.



Services and supports are identified through a person-centered planning process with case managers to develop the [Individualized Service Plan \(ISP\)](#) with the individual's desired outcomes and goals. The case manager assists the individual and family in accessing these services from qualified Medicaid I/DD Waiver providers chosen by the individual.

## SEARCH DDD

Search ...

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## MEDICAID I/DD WAIVER PROVIDERS


- **Provider Portal Modules**
- [I want to be a Medicaid I/DD Waiver Provider](#)
- [I am a Medicaid I/DD Waiver Provider](#)
- [Administrative Hearing for Medicaid I/DD Waiver Providers](#)



**PROVIDER  
PORTAL**

<https://health.hawaii.gov/ddd/waiver-providers/provider-portal-modules/>

## ADVERSE EVENT REPORTS


Posted on Oct 13, 2021 in

 DDD Provider Portal | Adverse Event Reports

 Watch later  Share

Training module:

# Adverse Event Reports

Watch on  YouTube

[Adverse Event Reports – PDF Format](#)

[Interactive Training](#)

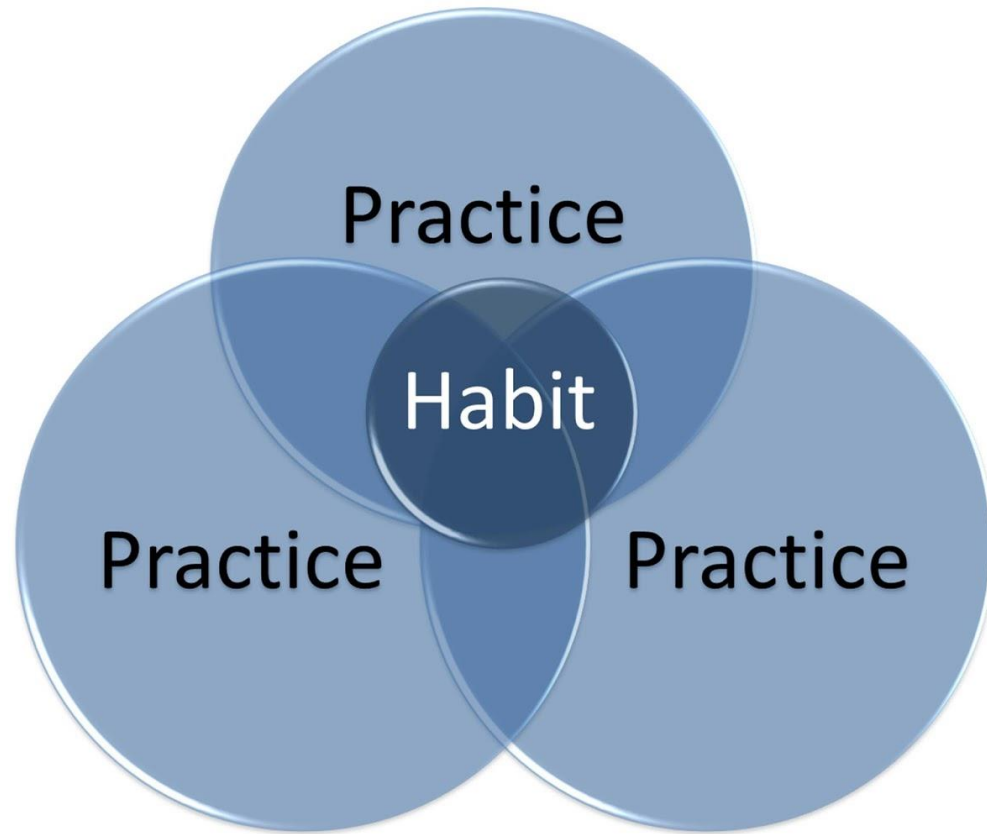
Please click here for the training

## SEARCH DDD

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## DD DIVISION

- [DDD Home](#)
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Wills, Neville (1991). MGT533 Human Resource Management. NZ: NMIT

# Practice Portal

- Practice AER submission in the Provider Portal
- Details on how to access the “Sandbox” a practice environment can be found in Webinar Handout



Send an email to:  
[doh.dddproviderhelpdesk@doh.hawaii.gov](mailto:doh.dddproviderhelpdesk@doh.hawaii.gov)

**SUPPORT**

**Help Desk**



**PROVIDER**  
**inspire** PORTAL

# **ELECTRONIC SUBMISSION OF ADVERSE EVENTS**



# Moving from Manual Processes to a More Effective Incident Management System



- The reporting process will be streamlined by automating the submissions of AERs.
- The Participant/Customer information will be automatically populated in the Provider Portal and INSPIRE.
- The Provider Portal and INSPIRE will have drop-down menus that create more consistent reporting.
- AERs initiated by the provider through the Provider Portal will be transmitted to INSPIRE, allowing immediate notification to the case manager.
- DDD staff at multiple levels across the Division will be notified when specific types of adverse events occur such as suspected abuse and neglect or when there is possible media coverage.
- Analysis of trends and patterns will occur in real-time.
- Timelines will be tracked in real-time.

# Policies, Standards and Practices That Have Not Changed



- Individuals responsible for reporting
- Timeline for reporting
- What to report – types of reportable events
- Description of what happened
- Plan of action to prevent recurrence of the event

# Electronic Submission of AERs



## Feature in Provider Portal and INSPIRE

- Required fields with an (\*) must be completed

Event Date and Time \*

M/D/YYYY h:mm A



Reporter's Name \*

Relationship \*

Date of Verbal \*

M/D/YYYY h:mm A



Verbal Report Recipient \*

Island





# Electronic Submission of AERs



## Feature in Provider Portal and INSPIRE

- Comment Section may be used to include documentation that attachments have been uploaded.
- Examples of documents to be attached: Discharge summary, DHS 1640 (APS), DHS 1516 (CWS)

### Comments

Documents attached

File Name: Date of AER (YYYYMMDD)\_Last name of customer\_Document type

Example: 20220614\_Rivera\_DischargeSummary

# Electronic Submission of AERs

## Feature in Provider Portal and INSPIRE



- Drop down menu to select the Primary AER type

Primary AER Type: \*

Suspected Abuse/Neglect/Financial Exploitation

Injury from a Known/Unknown Cause Requiring Medical Treatment

Medication Errors and/or Unexpected Reaction to Meds or Treatment

Behavior Change - May Require New/Updated BSP

Change in Health Requiring Med. Treatment

Death

Participant's Whereabouts Unknown

Any Use of Restraints


Any Use of Seclusion


Any Use of Prohibited Restrictive Intervention or Procedure


# Electronic Submission of AERs


## Feature in Provider Portal and INSPIRE


- Medication Error

Drug Name:  


Drug Name:  

Drug Name:  

Drug Name:  

Drug Name:  

Lookup records ×



✓ **Medication Formulary** ↑

<input checked="" type="checkbox"/>	RISPERDAL - risperidone - SOLUTION - 1 - mg/mL - ORAL
<input type="checkbox"/>	RISPERDAL - risperidone - TABLET - 0.25 - mg/1 - ORAL
<input type="checkbox"/>	RISPERDAL - risperidone - TABLET - 0.5 - mg/1 - ORAL
<input type="checkbox"/>	RISPERDAL - risperidone - TABLET - 0.5 - mg/1 - ORAL
<input type="checkbox"/>	RISPERDAL - risperidone - TABLET - 1 - mg/1 - ORAL
<input type="checkbox"/>	RISPERDAL - risperidone - TABLET - 1 - mg/1 - ORAL
<input type="checkbox"/>	RISPERDAL - risperidone - TABLET - 1 - mg/1 - ORAL
<input type="checkbox"/>	RISPERDAL - risperidone - TABLET - 1 - mg/1 - ORAL

< **1** 2 3 4 5 6 7 8 .. 30 >

Select Cancel Remove value

# Electronic Submission of AERs, cont.

## Feature in the Provider Portal and INSPIRE

- Any Use of Restraint, Seclusions or Prohibited Restrictive Intervention

### Additional Required Information

Describe the intervention procedure

Describe what happened before the behavior that caused the use of intervention or procedure

Other interventions that were attempted and the results of the interventions

Description of injuries that participants sustained

Consequences of restrictive intervention/procedure

How the rights of participant were restored

What did not work that may require a new or updated PBS plan?

# Adverse Event Report Form

Revised to mirror the Provider Portal  
and INSPIRE

State of Hawaii Department of Health Developmental Disabilities Division ADVERSE EVENT REPORT FORM			
PLEASE PRINT LEGIBLY OR TYPE:			
<b>SECTION A: GENERAL INFORMATION</b>			
1. PARTICIPANT NAME: (Last, First, MI)		2. EVENT DATE: (MM/DD/YY)	
3. EVENT TIME:			
4. DATE OF VERBAL REPORT:		5. REPORTER'S NAME:	
6. VERBAL REPORT RECIPIENT:			
7. RELATIONSHIP TO PARTICIPANT:		8. ISLAND:	
9. NAME OF REPORTER'S AGENCY: (If applicable)			
10. PRIMARY ADVERSE EVENT TYPE: (CHECK ONLY ONE)			
<input type="checkbox"/> SUSPECTED ABUSE/NEGLECT/FINANCIAL EXPLOITATION			
<input type="checkbox"/> INJURY FROM A KNOWN/UNKNOWN CAUSE REQUIRING MEDICAL TREATMENT			
<input type="checkbox"/> MEDICATION ERRORS AND/OR UNEXPECTED REACTION TO MEDICATION OR TREATMENT			
<input type="checkbox"/> CHANGE IN PARTICIPANT'S BEHAVIOR THAT MAY REQUIRE A NEW OR UPDATED BEHAVIOR SUPPORT PLAN			
<input type="checkbox"/> CHANGE IN PARTICIPANT'S HEALTH CONDITION REQUIRING MEDICAL TREATMENT			
<input type="checkbox"/> DEATH			
<input type="checkbox"/> PARTICIPANT'S WHEREABOUTS UNKNOWN			
<input type="checkbox"/> ANY USE OF RESTRAINT			
<input type="checkbox"/> ANY USE OF SECLUSION			
<input type="checkbox"/> ANY USE OF PROHIBITED RESTRICTIVE INTERVENTION OR PROCEDURE			
11. COMMENTS:			
12. <input type="checkbox"/> POSSIBLE MEDIA COVERAGE? If yes, check the box.		13. EVENT LOCATION: <input type="checkbox"/> Own/Family Home <input type="checkbox"/> Community <input type="checkbox"/> Program Site <input type="checkbox"/> Foster Home* <input type="checkbox"/> DOM Home* <input type="checkbox"/> ARCH* <input type="checkbox"/> Other: _____ *Include Name of Licensed/Certified Home: _____	
14. Event occurred during billable service: <input type="checkbox"/> No <input type="checkbox"/> Yes		15. PERSON(S) PRESENT: <input type="checkbox"/> No Persons Present <input type="checkbox"/> Agency Staff <input type="checkbox"/> CD Worker <input type="checkbox"/> Caregiver <input type="checkbox"/> Unknown <input type="checkbox"/> Family <input type="checkbox"/> Other Participants <input type="checkbox"/> Other Person 1: _____ <input type="checkbox"/> Other Person 2: _____ <input type="checkbox"/> Other Person 3: _____	
16. WHO WAS NOTIFIED? (Check all that apply)			
	<u>Name</u>	<u>Date/Time</u>	<u>Report No.</u>
<input type="checkbox"/> Police	_____	_____	_____
<input type="checkbox"/> Adult Protective Services (APS)	_____	_____	_____
<input type="checkbox"/> Child Welfare Services (CWS)	_____	_____	_____
<input type="checkbox"/> DDD Certification Unit	_____	_____	_____
<input type="checkbox"/> Office of Health Care Assurance	_____	_____	_____
<input type="checkbox"/> Case Manager	_____	_____	_____
<input type="checkbox"/> Guardian	_____	_____	_____
<input type="checkbox"/> Caregiver	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____
Form 25-3 (Rev. 01/16) Page			

# Important Things to Note



- Provider agencies of ResHab services will continue to be responsible for AER submission on behalf of caregivers
  - Of the caregivers that submitted AERs in FY21, the number of AERs submitted ranged from 1-8 AERs per year.
  - May upload supporting documents (e.g. discharge summaries)
  - Do not submit handwritten accounts of adverse events
- Consumer Directed (CD) Participants: CD employer will submit to the Case Manager a written account of the Adverse Event. The Case Manager may need to follow-up for additional details.
  - Case Managers to create adverse event record in INSPIRE case management system.

# Reporting and Future Analytics

DDD is the state agency responsible for conducting oversight of the reporting and follow-up of critical incidents and events

Electronic submission aids with real-time data collection

Effective oversight requires data systems that identify trends and patterns of critical incidents or events

- To identify opportunities for improvement
- Aids in development of strategies to reduce incidents in the future

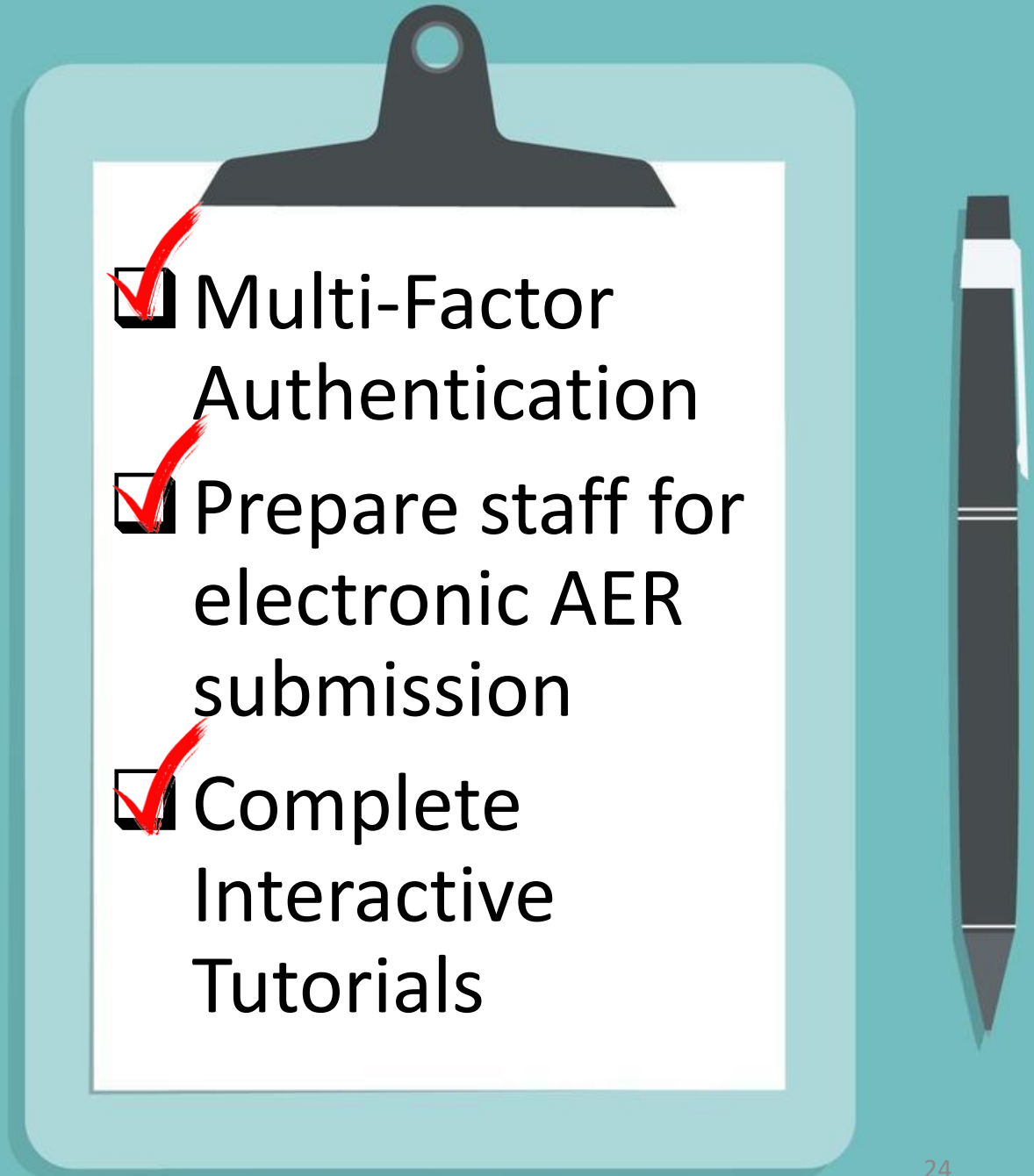
Predictive Analytics Solution

- Using multiple sources of data to detect trends and patterns of adverse events
- May predict and ultimately prevent future adverse events

PROVIDER



# Go-Live Checklist for Providers

- 
- ☒ Multi-Factor Authentication
  - ☒ Prepare staff for electronic AER submission
  - ☒ Complete Interactive Tutorials



