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Innovation Track: A Comprehensive Critical Incident Management System– A Proposed Best Practice

August 28, 2019

TODAY'S DISCUSSION

1. Introduction to Speakers
2. Overview of Critical Incidents
3. A Brief History of Critical Incident Reporting for Medicaid HCBS
4. Best Practice Guidance for a Comprehensive Incident Management System

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INTRODUCTION OF SPEAKERS

- **Dr. Jay Bulot**
  Vice President for State Markets
  WellSky Corporation
- **Dustin Schmidt**
  Associate Director
  Navigant
- **Brian Bennett**
  Medicaid Section Chief
  Louisiana Department of Health
- **Melissa Ledoux**
  Quality Assurance Manager
  Louisiana Department of Health

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CRITICAL INCIDENT DEFINITION

What is a Critical Incident?

- "Critical incidents" are situations that put the health, safety or welfare of participants at risk. Some states also use the term "adverse", "serious" or "sentinel events".
  - This may include medical (e.g., serious medication error, death, serious injury, etc.) and safety concerns (e.g., missing person, restrictive interventions, etc.).
- There is no standard federally defined term for "critical incident" that outlines the scope of reportable incidents, leading to variation across states [1]

(1) https://www.hhs.gov/sites/default/files/cmcs-informational-bulletin-062818.pdf

Common Critical Incident Types Tracked by State Medicaid Agencies:

- Abuse, Neglect, and Exploitation
- Unexpected Deaths
- Unexpected Hospitalization
- Serious Injury
- Criminal Activity/Legal Involvement
- Loss of Contact/Elopement
- Suicidal Behavior
- Medication Errors
- Use of Restraints/Seclusion

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CMS REQUIREMENTS

- States operating HCBS waivers are required to provide assurances to CMS that necessary safeguards are in place to protect the health, safety, and welfare of participants receiving services. For critical incidents this includes:
  - The state must demonstrate on an ongoing basis that it **identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.**
  - The state must demonstrate that an **incident management system is in place** that effectively resolves those incidents and prevents further similar incidents to the extent possible.

- The state should:
  - Specify the **types of critical events** or incidents
  - **Identify individuals/entities that must report** critical incidents
  - **Define entity responsibilities**
  - Define **timeframes** for reporting and conducting/completing an investigation
  - Define **method(s) of reporting** (e.g., phone, written form, web-based report)
  - Define **notification requirements** (e.g., participants, guardian, etc.)

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THE IMPORTANCE OF CRITICAL INCIDENT REPORTING AND DATA

- **Critical Incident Management not only protects the health and safety of the participants, it also provides data on the state and networks ability and effectiveness to address and mitigate incidents.**

- Incident data is used to:
  - Identify and resolve incidents to support waiver participant safety
  - Mitigate preventable incidents
  - Provide insights into trends and problems to reduce risks and improve quality of services
  - Demonstrate that the state has met or exceeded its waiver assurance performance measures

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PARTIES INVOLVED IN CRITICAL INCIDENTS

Consumers and Other Parties

- Participants / Family Members / Neighbors / Friends / Guardian

Medicaid Waiver Providers

- Direct Service Providers / Case Managers / Support Brokers

State Agencies

- 1915(c) Operating Agency
- Law Enforcement
- State Medicaid Agencies
- Attorney General
- Office of Inspector General
- Adult/Child Protective Services

Federal Agencies

- Centers for Medicare & Medicaid Services (CMS)
- Office of Inspector General

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CMS DEFINITION OF AN INCIDENT MANAGEMENT SYSTEM

What is an Incident Management System? (1)

- Assures that reports of critical incidents are filed;
- Track that incidents are investigated in a timely fashion; and
- Analyze incident data and develop strategies to minimize preventable incidents.

Goals of a Robust System (1)

- Standardizes what incidents are and how incidents are collected.
- Provides guidelines for states in prioritizing what incidents need to be investigated and resolved.
- Allows states to identify, track, trend, mitigate and preventable incidents.

(1) http://www.nasuad.org/sites/nasuad/files/12%20-%20CMS_Managing_Incident_Mgmt_508.pdf

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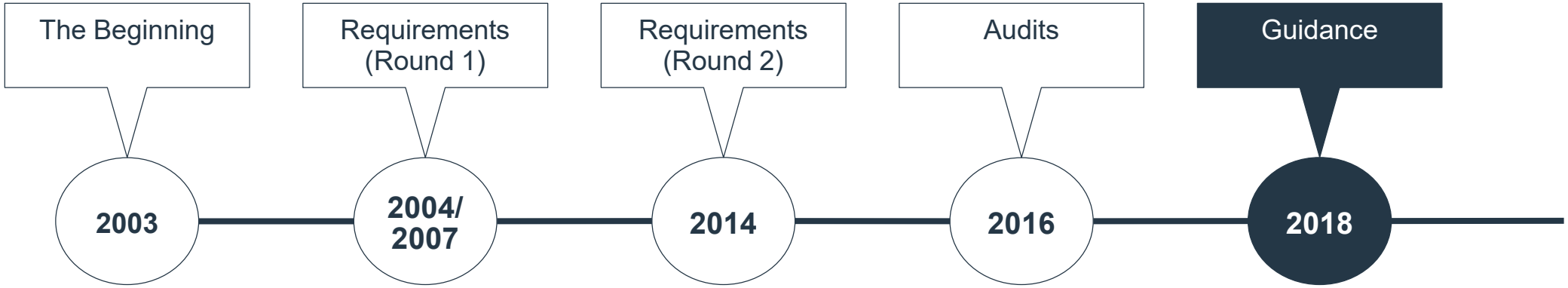
PATH TO NATIONAL REFORMS FOR CRITICAL INCIDENT RESPONSE



GAO issues a critical report about CMS oversight of HCBS waivers.

2004: CMS issues procedural guidance to states regarding site visits and a new waiver quality improvement plan.

2007: CMS updates the process for the Regional Offices to request evidence from states

CMS updates the HCBS regulations and identifies new sub-assurances related to critical incident management.

HHS OIG and CMS audit state critical incident reporting and monitoring processes and find significant gaps.

CMS issues a pilot survey to 7 states to better understand their approach to critical incident management. CMS anticipates issuing a nationwide survey.

OIG/ACL provide a roadmap for states to improve their critical incident management systems.

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PATH TO NATIONAL REFORMS FOR CRITICAL INCIDENT RESPONSE

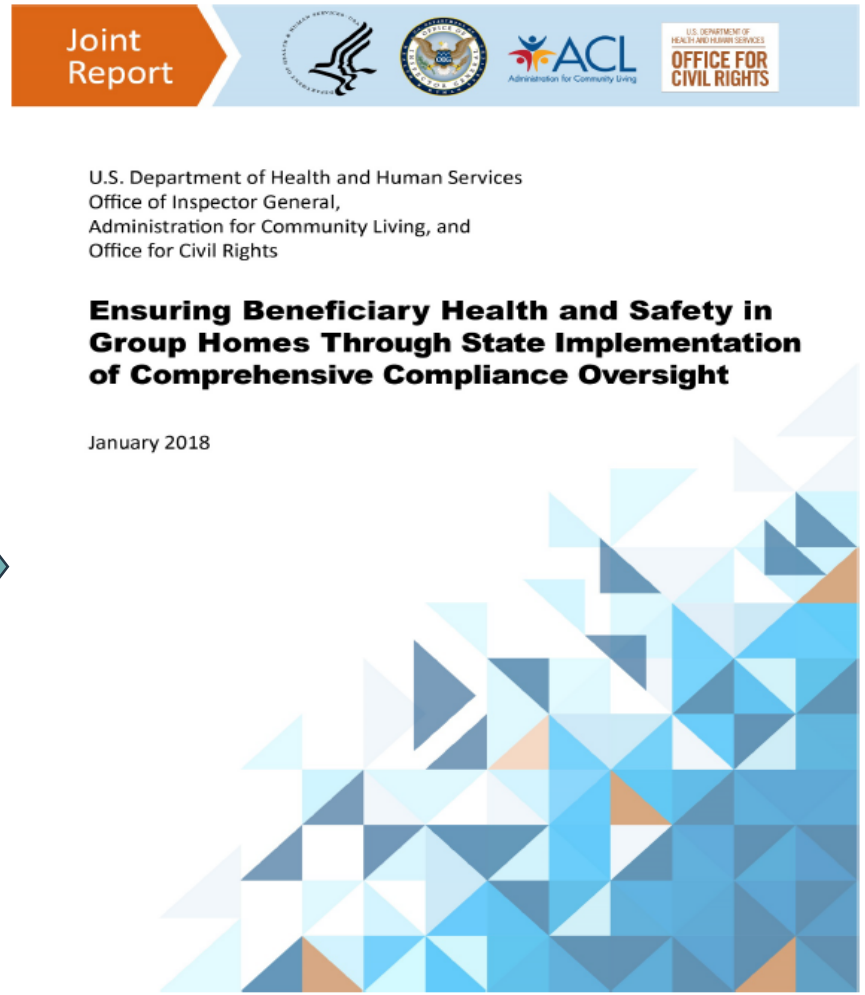
Guidance

2019

GAO/ACL Joint Report: CMS continues to defer to the GAO/ACL report findings as a best practice. CMS does not mandate the adoption of these practices.

CMS Technical Assistance: CMS will create H&W Teams that will work with states during the next 3 years to proactively ameliorate H&W issues and provide technical assistance.

CMS Survey: CMS issued a statewide survey to states on July 13, 2019 to better understand how states approach critical incident management. Responses are due August 28, 2019.



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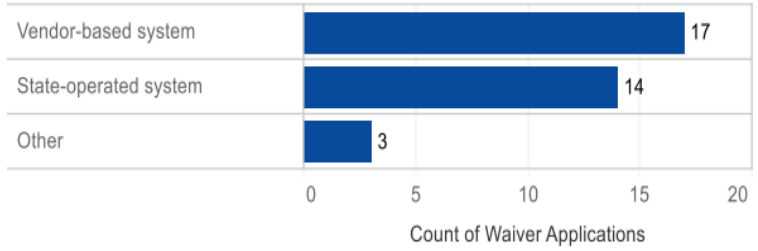
WHAT DID CMS LEARN FROM ITS 2018 CRITICAL INCIDENT SURVEY?

- **States have utilized different approaches to developing and implementing their incident management systems (1)**

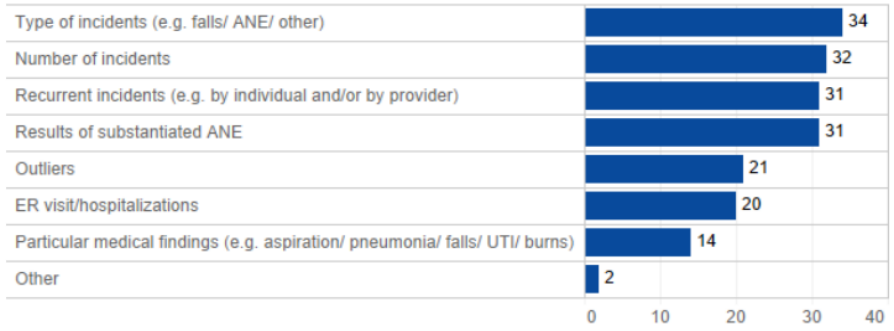
34 out of 38 waivers reported using an electronic system. Half of these waivers had a vendor-based system.

Figure 5: Type of IM System Used



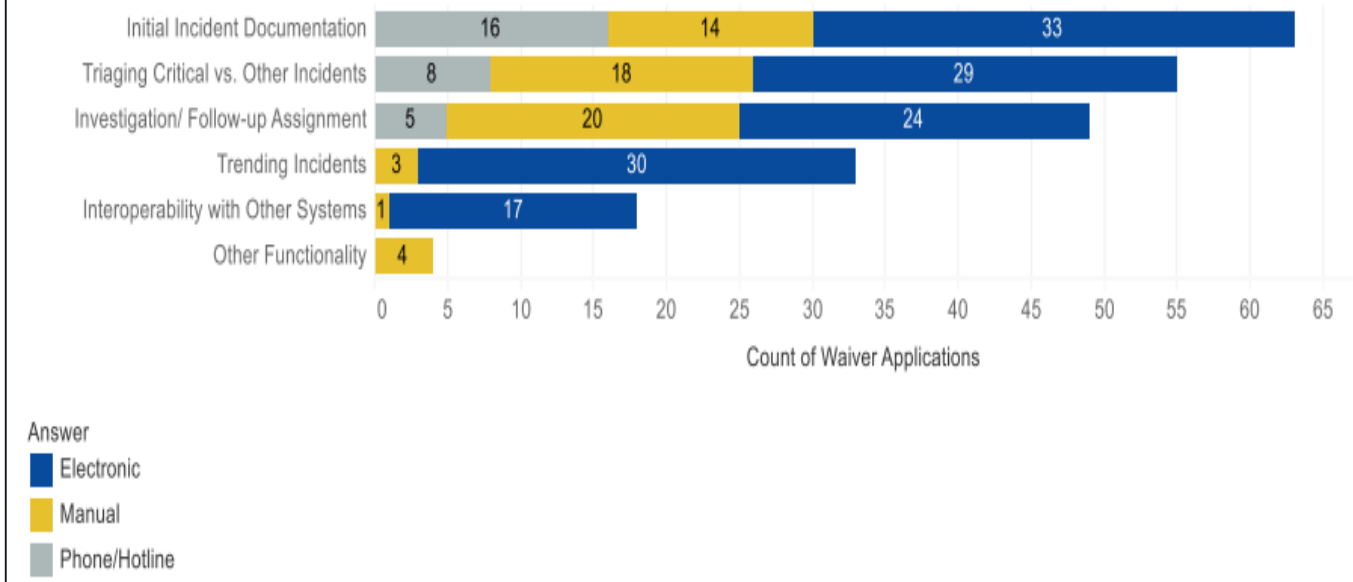
Survey results show that states create one or more of the following trend reports from incident data:

Figure 13: Types of Trend Reports Created*



- Most surveyed waivers record, triage, and trend incidents electronically, but interoperability is not a functionality available for most systems.

Figure 6: System Functionalities*



(1) http://www.nasuad.org/sites/nasuad/files/12%20-%20CMS_Managing_Incident_Mgmt_508.pdf

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FIVE RECOMMENDATIONS TO IMPROVE YOUR SYSTEM

1. Select critical incident types that are meaningful

2. Create clear policies regarding critical incident reporting requirements

3. Provide sufficient materials to support incident reporting

4. Create a single web-based system to track critical incidents

5. Track and analyze meaningful data points to minimize preventable incidents

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RECOMMENDATION #1: SELECT CRITICAL INCIDENT TYPES THAT ARE MEANINGFUL

States should consider selecting critical incident types that 1) align with CMS requirements and 2) are important based on historical provider performance.

- Key factors to consider include:
  - Critical incidents types outlined by CMS, OIG, and state regulations
  - Provider history and incident trends across the state
  - Administrative burden on both providers to report on and state staff to manage
  - Critical incident types that the state does not want to collect (e.g., scheduled medical procedures/surgeries)

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CMS AND OIG GUIDANCE REGARDING INCIDENT TYPES

CMS Requirements: 7 Incident Types: (1)

- Abuse (including physical, sexual, verbal and psychological abuse)
- Mistreatment or neglect
- Exploitation
- Serious injury
- Death other than by natural causes
- Other events that cause harm to an individual
- Events that serve as indicators of risk to participant health and welfare (e.g., hospitalizations, medication errors, use of restraints or behavioral interventions)

Additional Incident Types Recommended by OIG: 9 Incident Types: (2)

- Events leading to adverse outcomes for participants due to staff misconduct / error
- Events resulting in injury or illness requiring medical treatment beyond first aid
- Choking incidents
- Hospital emergency room visits where the injury or the medical condition could indicate abuse or neglect
- Elopements whereby the individual is removed from staff supervision or placed at risk of serious harm
- Behavioral incidents that result in employee physical intervention, serious risk of harm, or property damage valued at more than $150
- Emergency situations (e.g., fires, flooding, serious property damage)
- Criminal conduct by participants
- Incidents involving law enforcement

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(1) https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf
(2) https://oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf

RECOMMENDATION #2: CREATE CLEAR POLICIES REGARDING CRITICAL INCIDENT REPORTING REQUIREMENTS

- **If you need additional guidance on how to approach policy decisions, ask CMS!**

Key Decision Points	Considerations
1. Does critical incident reporting apply to all incident events or only those that involve a paid Medicaid provider?	State examples: • Pennsylvania: A Critical Incident is an unexpected and undesirable event that has an adverse impact on the outcome of care that **occurs during a Member's term of care funded through PerformCare.** CIR submission should occur to PerformCare only if PerformCare is funding the service. • Kentucky: Critical incidents are serious in nature and pose immediate risk to the health, safety, or welfare of waiver participants or others.
2. Who is responsible for investigating an incident?	Federal OIG recommends: • The **State should ensure independent State investigations of allegations of specified incidents** (e.g., abuse and neglect that results in serious or repeated harm to participants; sexual abuse; unexpected deaths; incidents that result in life-threatening or serious injury or illness that appear to be due to provider misconduct/ANE or due to environmental hazards; etc.). • The **State may delegate investigation for other incident situations to provider agencies or other entities.**

RECOMMENDATION #2: CREATE CLEAR POLICIES REGARDING CRITICAL INCIDENT REPORTING REQUIREMENTS *(CONTINUED)*

Key Decision Points	Considerations
3. Who should be notified when a critical incident occurs?	Kentucky's incident reporting instructional guide describes notification requirements for the following parties: • **Law Enforcement** (For incidents involving criminal activities) • **Family Member**: For adults, a family member is only notified if the waiver participant has provided consent via their PCSP. For children, a family member is always notified. • **Medical Provider**: The medical provider is notified for incidents involving medication errors or hospitalization. • **Direct Service Provider** • **Case Manager or Support Broker** • **State or Private Guardian** (If applicable and if specified in the PCSP)
4. Should the 1915(c) operating agency or APS investigate incidents involving abuse, neglect, or exploitation?	CMS HCBS Technical Guidance: "…if the state's adult protective services (APS) agency has primary oversight responsibility for incident management, there should be processes whereby the **APS agency regularly furnishes the Medicaid agency and/or operating agency with information about critical incidents that involve waiver participants and that the agencies work together to identify strategies to reduce the occurrence of critical incidents.**" (1)

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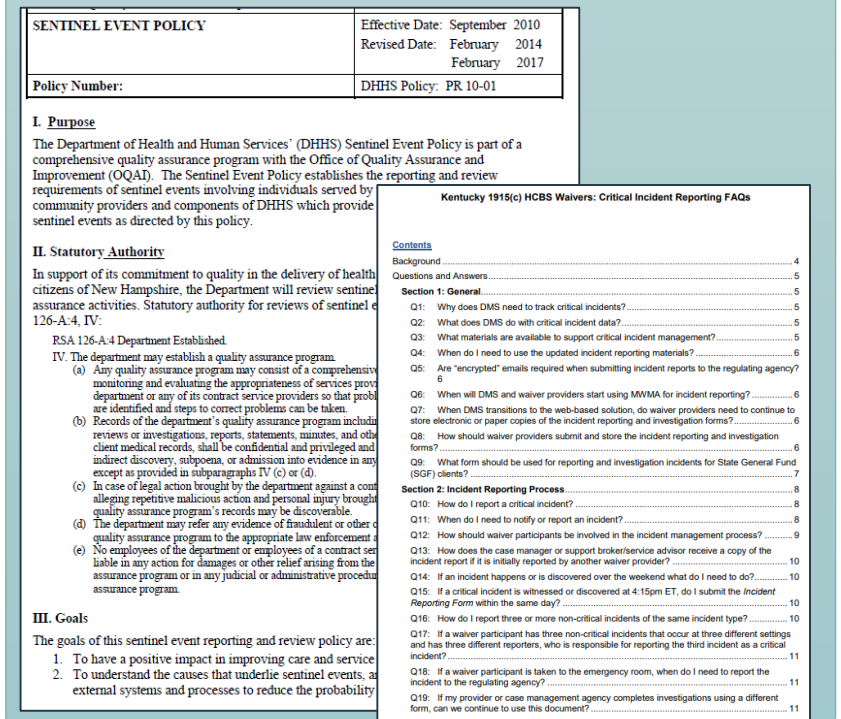
(1) https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf

RECOMMENDATION #3: PROVIDE SUFFICIENT MATERIALS TO SUPPORT INCIDENT REPORTING

Materials Outlining State Requirements



SENTINEL EVENT POLICY	Effective Date: September 2010 Revised Date: February 2014 February 2017
Policy Number:	DHHS Policy: PR 10-01

I. Purpose

The Department of Health and Human Services' (DHHS) Sentinel Event Policy is part of a comprehensive quality assurance program with the Office of Quality Assurance and Improvement (OQAI). The Sentinel Event Policy establishes the reporting and review requirements of sentinel events involving individuals served by community providers and components of DHHS which provide sentinel events as directed by this policy.

II. Statutory Authority

In support of its commitment to quality in the delivery of health citizens of New Hampshire, the Department will review sentinel assurance activities. Statutory authority for reviews of sentinel e 126-A:4, IV:

RSA 126-A:4 Department Established.

IV. The department may establish a quality assurance program.

(a) Any quality assurance program may consist of a comprehensiv monitoring and evaluating the appropriateness of services prov department or any of its contract service providers so that probl are identified and steps to correct problems can be taken.

(b) Records of the department's quality assurance program includi reviews or investigations, reports, statements, minutes, and oth client medical records, shall be confidential and privileged and indirect discovery, subpoena, or admission into evidence in any except as provided in subparagraphs IV (c) or (d).

(c) In case of legal action brought by the department against a cont alleging repetitive malicious action and personal injury brough quality assurance program's records may be discoverable.

(d) The department may refer any evidence of fraudulent or other c quality assurance program to the appropriate law enforcement a

(e) No employees of the department or employees of a contract ser liable in any action for damages or other relief arising from the assurance program or in any judicial or administrative procedu assurance program.

III. Goals

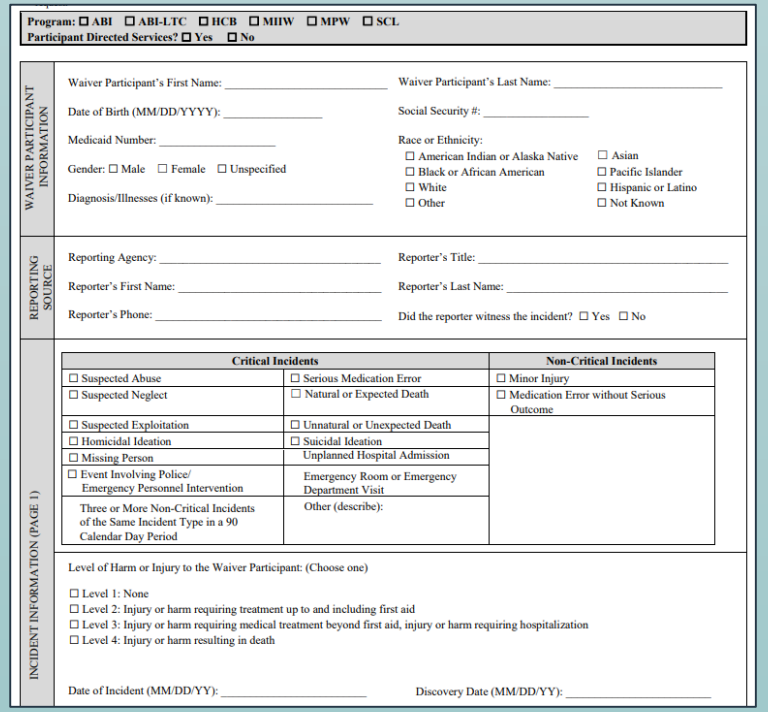
The goals of this sentinel event reporting and review policy are:

1. To have a positive impact in improving care and service
2. To understand the causes that underlie sentinel events, a external systems and processes to reduce the probability

Kentucky 1915(c) HCBS Waivers: Critical Incident Reporting FAQs

Contents

Forms / Reports for Reporting Purposes



Program: ☐ ABI ☐ ABI-LTC ☐ HCB ☐ MIIW ☐ MPW ☐ SCL
Participant Directed Services? ☐ Yes ☐ No

WAIVER PARTICIPANT INFORMATION

Waiver Participant's First Name: _____ Waiver Participant's Last Name: _____

Date of Birth (MM/DD/YYYY): _____ Social Security #: _____

Medicaid Number: _____

Gender: ☐ Male ☐ Female ☐ Unspecified

Race or Ethnicity:
☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ Pacific Islander
☐ White ☐ Hispanic or Latino
☐ Other ☐ Not Known

Diagnosis/Illnesses (if known): _____

REPORTING SOURCE

Reporting Agency: _____ Reporter's Title: _____

Reporter's First Name: _____ Reporter's Last Name: _____

Reporter's Phone: _____ Did the reporter witness the incident? ☐ Yes ☐ No

INCIDENT INFORMATION (PAGE 1)

Critical Incidents		Non-Critical Incidents
☐ Suspected Abuse	☐ Serious Medication Error	☐ Minor Injury
☐ Suspected Neglect	☐ Natural or Expected Death	☐ Medication Error without Serious Outcome
☐ Suspected Exploitation	☐ Unnatural or Unexpected Death	
☐ Homicidal Ideation	☐ Suicidal Ideation	
☐ Missing Person	Unplanned Hospital Admission	
☐ Event Involving Police/ Emergency Personnel Intervention	Emergency Room or Emergency Department Visit	
Three or More Non-Critical Incidents of the Same Incident Type in a 90 Calendar Day Period	Other (describe):	

Level of Harm or Injury to the Waiver Participant: (Choose one)

☐ Level 1: None
☐ Level 2: Injury or harm requiring treatment up to and including first aid
☐ Level 3: Injury or harm requiring medical treatment beyond first aid, injury or harm requiring hospitalization
☐ Level 4: Injury or harm resulting in death

Date of Incident (MM/DD/YY): _____ Discovery Date (MM/DD/YY): _____

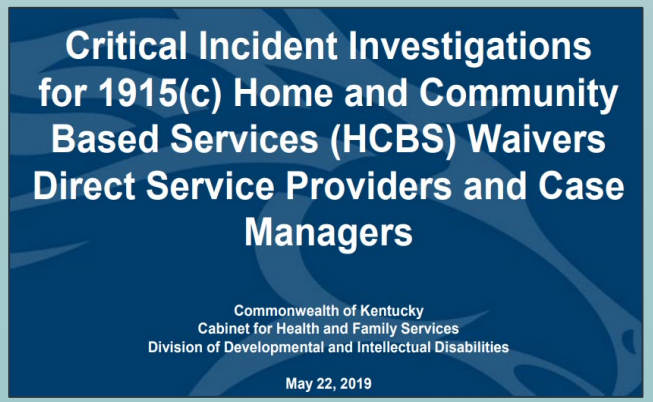
Training Materials

Critical Incident Reporting Requirements

For Community Centered Boards and Service Provider Agencies

DIVISION FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

May 2017



Critical Incident Investigations for 1915(c) Home and Community Based Services (HCBS) Waivers Direct Service Providers and Case Managers

Commonwealth of Kentucky
Cabinet for Health and Family Services
Division of Developmental and Intellectual Disabilities

May 22, 2019

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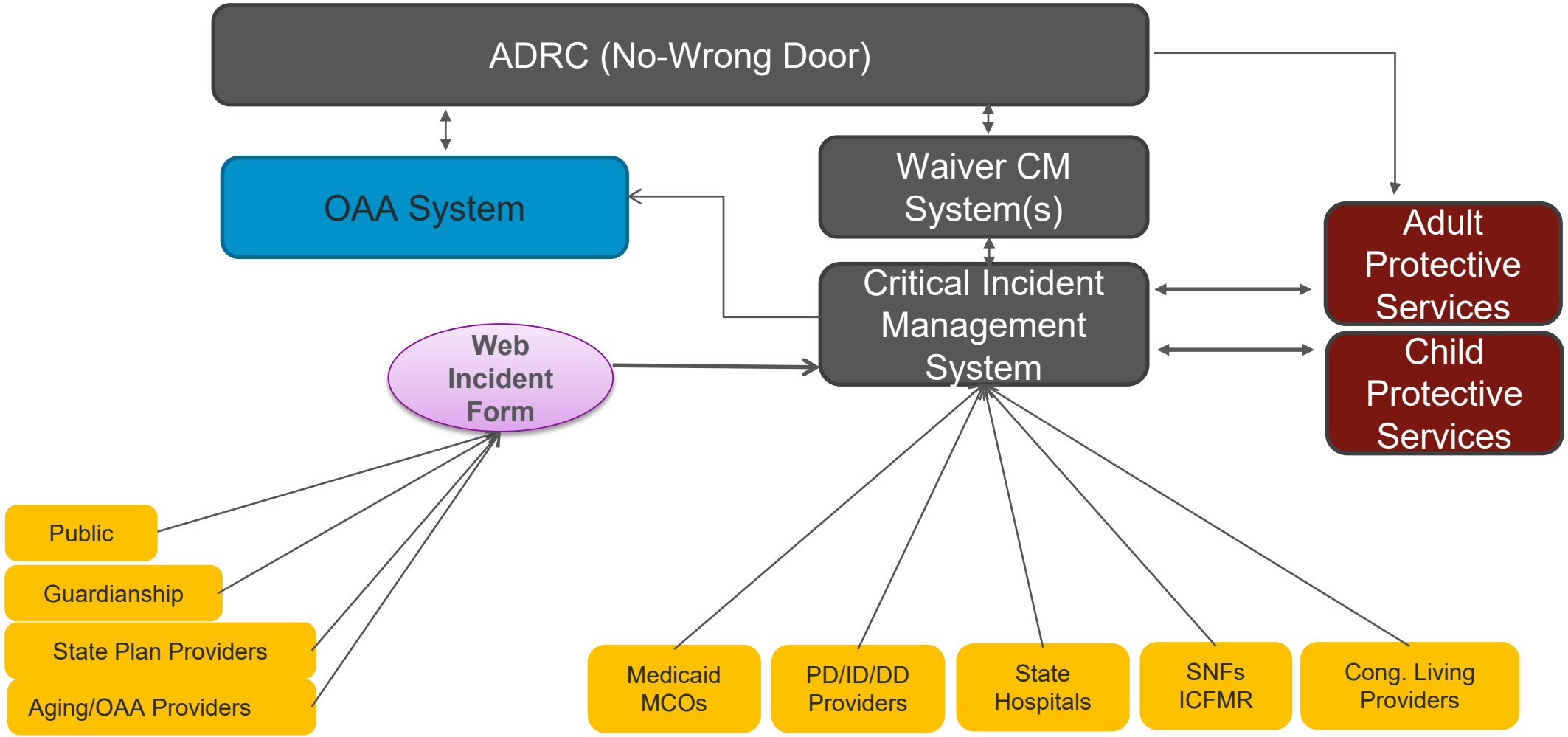
RECOMMENDATION #4: CREATE A SINGLE WEB-BASED SYSTEM TO TRACK CRITICAL INCIDENTS



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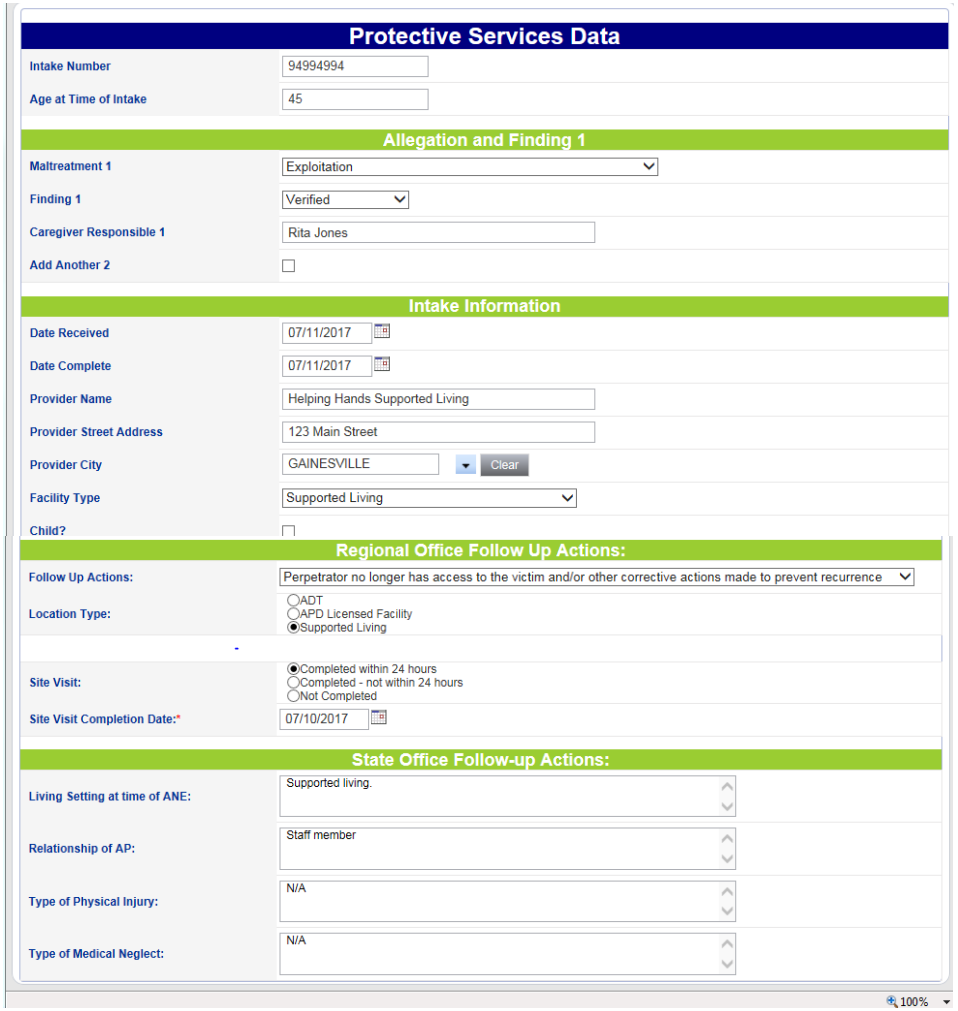
PROTECTIVE SERVICES DATA TO FACILITATE INTERDEPARTMENTAL COMMUNICATION

- **Determine when to contact protective services.**
  - Severe Incidents may require immediate referral to protective services.
  - Early identification helps set expectations for the investigation
- **Data sharing may happen:**
  - Through creation of reports and triggers
  - Posted in centralized system
  - Weekly meetings
- **All protective service calls are critical incidents, but not all critical incidents will rise to the level of a protective services investigation.**



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CRITICAL FUNCTIONALITY FOR ELECTRONIC REPORTING/MANAGEMENT OF CRITICAL INCIDENTS

- Multiple mechanisms for submitting incident reports
- Ability to compare incident occurrence date/time to incident submission date/time as a performance indicator
- Workflow automation to allow for different workflow for different incident types
- Mechanisms to ensure that incident reports flow through often complex, multi-tiered review/approval process
- Tracking of incident review, follow-up and when necessary, investigation
- Ability to report on critical incidents to detect providers in need of additional training and/or sanction, detect trends, etc.

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RECOMMENDATION #5: TRACK AND ANALYZE MEANINGFUL DATA POINTS TO MINIMIZE PREVENTABLE INCIDENTS

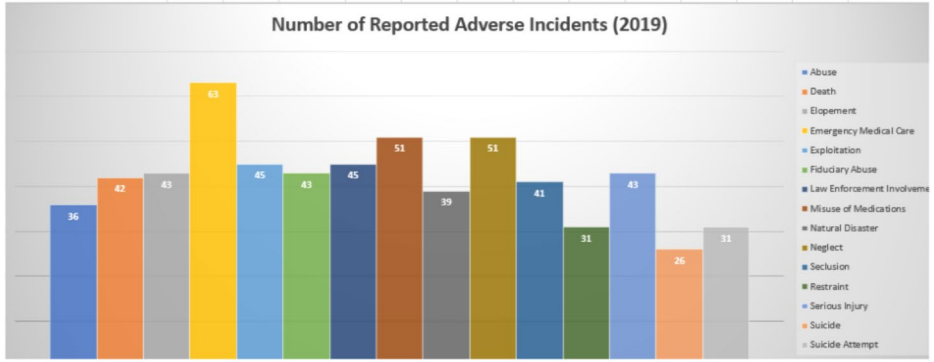
States should consider tracking at least the following data points:

- **Waiver Measures**: Performance measures that are described in the state's 1915(c) waivers (e.g., # of critical incidents resolved within 30 days of the date of the critical incident report date)
- **Reporting Timeframes**: Number of critical incidents reported within required timeframes
- **Severe Cases**: Status/outcome of reported abuse, neglect or exploitation (ANE) cases
- **Member Specific Dashboard**: Number and type of incident reports for a member during a specified timeframe
- **Provider Specific Dashboard**: Number and type of incident reports for a provider during a specified timeframe
- **Emergency Room (High Cost Claims)**: Usage of ER visits.

RECOMMENDATION #5: TRACK AND ANALYZE MEANINGFUL DATA POINTS TO MINIMIZE PREVENTABLE INCIDENTS (CONTINUED)

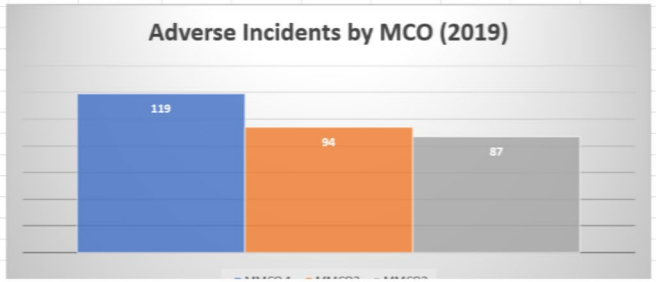
Number of Reported Adverse Incidents-Statewide

Type of Adverse Incident	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Annual Total
tal	63	57	43	46	53	54	58	53	47	48	55	53	
use	1	2	1	5	1	5	5	2	5	1	6	2	
ath	5	3	3	2	3	4	1	5	1	5	5	5	
opement	6	4	5	1	5	2	3	1	4	6	2	4	
ergency Medical Care	4	5	4	4	7	8	5	6	6	1	7	6	
oloitation	2	2	2	5	5	6	6	4	3	4	3	3	
luciary Abuse	5	1	6	3	2	4	4	2	5	2	4	5	
w Enforcement Involvement	1	6	2	6	6	2	7	5	5	3	1	1	
suse of Medications	4	4	4	4	3	5	5	5	4	3	5	5	
tural Disaster	5	4	2	2	4	6	4	4	2	2	2	2	
glect	6	6	3	5	2	3	1	6	4	5	6	4	
clusion	8	5	2	2	3	1	3	2	1	6	3	5	
straint	7	2	1	2	4	1	5	1	1	3	1	3	
rious Injury	2	4	5	1	5	2	6	7	3	2	4	2	
icide	3	7	2	1	2	1	2	1	1	4	1	1	
icide Attempt	4	2	1	3	1	4	1	2	2	1	5	5	



Number of Reported Adverse Incidents-By MCO

iver Population	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Annual Total
tal	63	57	63	57	63								3
MCO 1	25	22	25	22	25								1
MCO2	20	17	20	17	20								
MCO3	18	18	18	18	15								



	Performance Measures	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
PM 1	Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures	95%	98%	95%	98%	95%	98%	95%	98%	95%	98
PM 2	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	93%	71%	93%	71%	93%	71%	93%	71%	93%	71
PM 3	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	100%	100%	100%	100%	100%	100%	100%	100%	100%	100
PM 4	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	100%	100%	100%	100%	100%	100%	100%	100%	100%	100
PM 5	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	50%	50%	50%	50%	50%	50%	50%	50%	50%	50
PM 6	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken	100%	100%	100%	100%	100%	100%	100%	100%	100%	100
PM 7	Number and percent of waiver participants who received information on how to report suspected										

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RECOMMENDATION #5: TRACK AND ANALYZE MEANINGFUL DATA POINTS TO MINIMIZE PREVENTABLE INCIDENTS (CONTINUED)

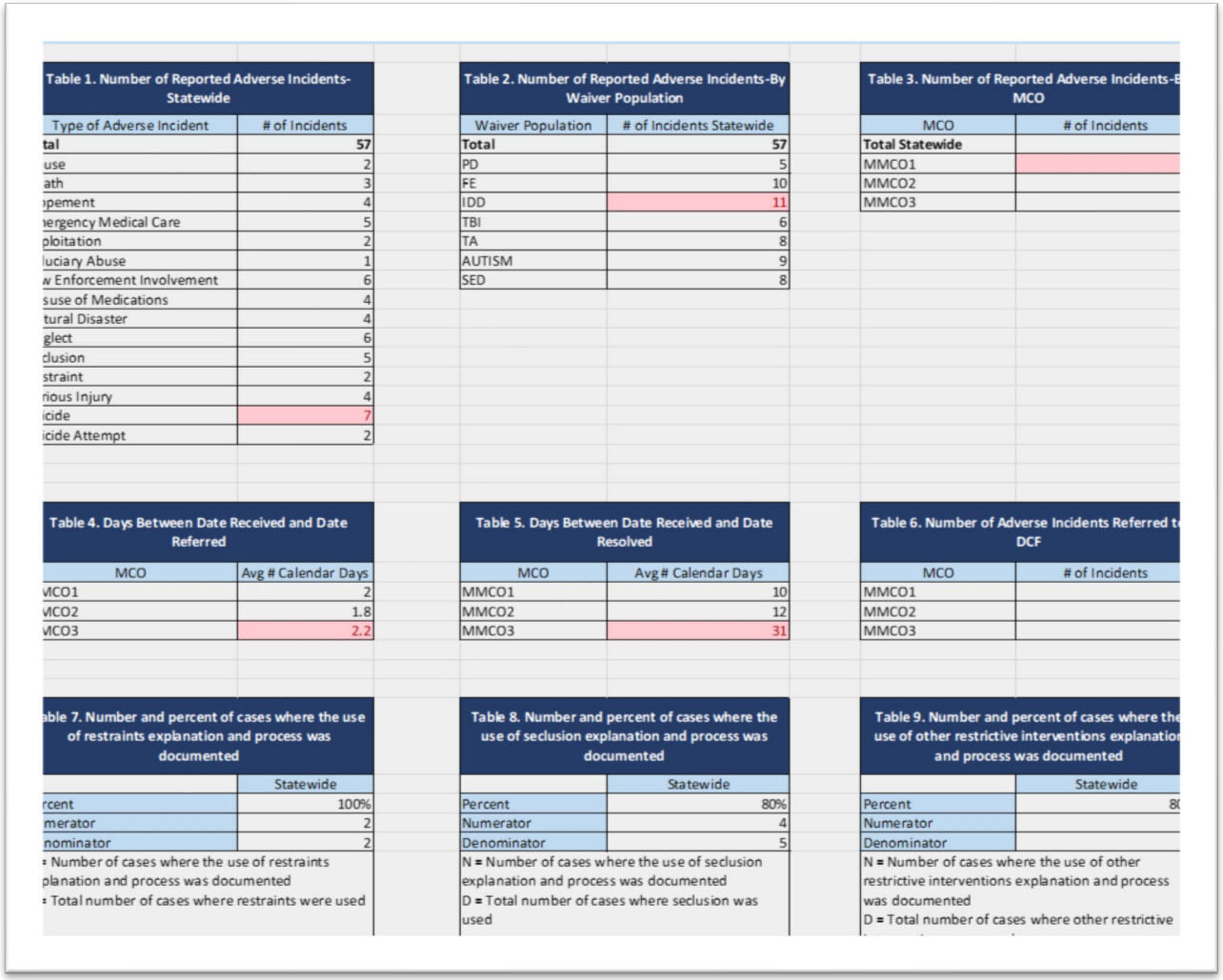

Table 1. Number of Reported Adverse Incidents-Statewide

Type of Adverse Incident	# of Incidents
tal	**57**
use	2
ath	3
pement	4
ergency Medical Care	5
ploitation	2
luciary Abuse	1
w Enforcement Involvement	6
suse of Medications	4
tural Disaster	4
glect	6
clusion	5
straint	2
rious Injury	4
icide	7
icide Attempt	2

Table 2. Number of Reported Adverse Incidents-By Waiver Population

Waiver Population	# of Incidents Statewide
Total	**57**
PD	5
FE	10
IDD	11
TBI	6
TA	8
AUTISM	9
SED	8

Table 3. Number of Reported Adverse Incidents-B MCO

MCO	# of Incidents
Total Statewide	
MMCO1	
MMCO2	
MMCO3	

Table 4. Days Between Date Received and Date Referred

MCO	Avg # Calendar Days
MCO1	2
MCO2	1.8
MCO3	2.2

Table 5. Days Between Date Received and Date Resolved

MCO	Avg # Calendar Days
MMCO1	10
MMCO2	12
MMCO3	31

Table 6. Number of Adverse Incidents Referred t DCF

MCO	# of Incidents
MMCO1	
MMCO2	
MMCO3	

able 7. Number and percent of cases where the use of restraints explanation and process was documented

	Statewide
rcent	100%
merator	2
nominator	2

= Number of cases where the use of restraints planation and process was documented
= Total number of cases where restraints were used

Table 8. Number and percent of cases where the use of seclusion explanation and process was documented

	Statewide
Percent	80%
Numerator	4
Denominator	5

N = Number of cases where the use of seclusion explanation and process was documented
D = Total number of cases where seclusion was used

Table 9. Number and percent of cases where the use of other restrictive interventions explanation and process was documented

	Statewide
Percent	8
Numerator	
Denominator	

N = Number of cases where the use of other restrictive interventions explanation and process was documented
D = Total number of cases where other restrictive

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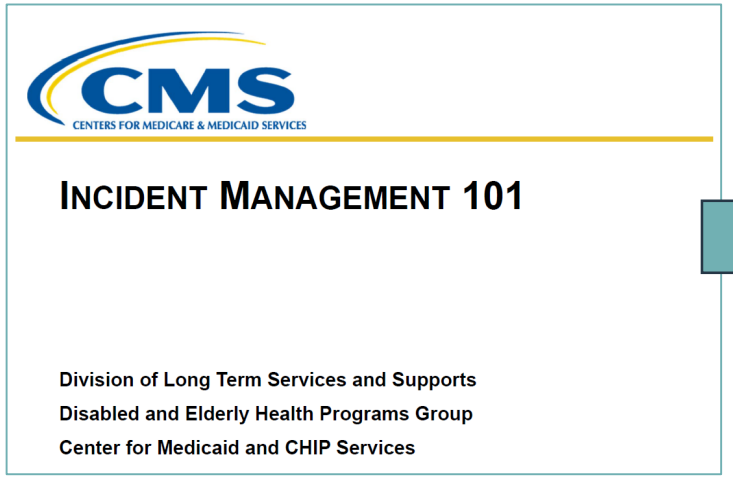
CMS GUIDANCE IN ANALYZING CRITICAL INCIDENT DATA



https://www.medicaid.gov/medicaid/hcbs/downloads/training/incident-management-101.pdf

- Commit to a **regular schedule** for aggregating and **analyzing findings and trends (no less than annual basis)**
- Identify areas of **improvement**, **interventions** to address adverse trends and patterns, and **training opportunities** for stakeholders to help prevent and mitigate incidents
- Gathering information for system-wide oversight, including:
  - Participant and provider characteristics
  - How quickly reports are reviewed, investigated, and followed-up
  - Results of investigations
- Determine the **types of analysis** to conduct, which may include:
  - Recurring deficiencies;
  - Types of incidents;
  - Types of providers/provider analysis;
  - Location of incidents;
  - Alleged perpetrators;
  - Investigation findings of: Outlier incidents; Abuse, neglect or exploitation; ER visits/hospitalizations;
  - Incident resolution timelines; and
  - Other medical findings

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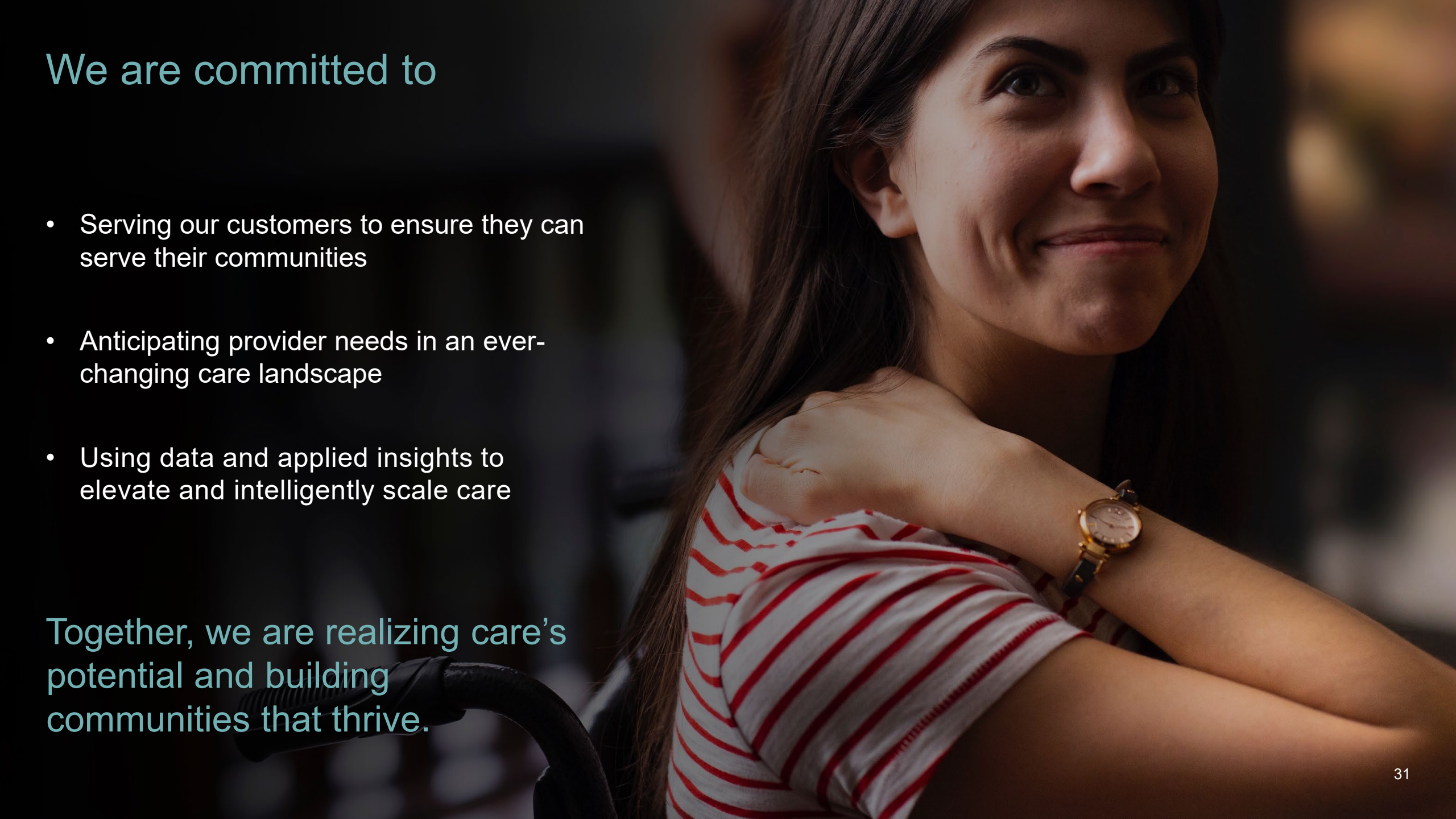
About WellSky

WellSky is a technology company advancing human wellness worldwide. Our software and professional services address the continuum of health and social care — helping businesses, organizations, and communities solve tough challenges, improve collaboration for growth, and achieve better outcomes through predictive insights that only WellSky solutions can provide.

We are committed to

- Serving our customers to ensure they can serve their communities
- Anticipating provider needs in an ever-changing care landscape
- Using data and applied insights to elevate and intelligently scale care



Together, we are realizing care's potential and building communities that thrive.

We partner with organizations across the care spectrum

Hospital:
Ensuring hospitals can focus on delivering superior patient care safely and efficiently

Practices & Facilities:
Enhancing providers' abilities to streamline operations and focus on the delivery of care

Home:
Empowering providers to deliver exceptional care while focusing on improving outcomes

Community:
Supporting dynamic communities of care with our diverse set of human services solutions

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Hospital

- Blood Transfusion
- Hospital Donor Program
- Biotherapy Clinics
- Inpatient Rehabilitation
- Outpatient Rehabilitation
- Acute Respiratory & Rehabilitation
- Enterprise Scheduling
- Medication Management
- International Medication Management

Home

- Home Health
- Hospice
- Home Infusion
- Specialty Pharmacy
- Home Medical Equipment
- Private Duty
- Home Health Therapy
- OASIS Review & Coding
- Billing & Revenue Cycle Services
- DDE & Payer Connection

Practices & Facilities

- Behavioral Health & IDD Providers
- Donor Testing Services
- Biotherapy Labs
- Private Practice Rehabilitation
- Scheduling
- Long-Term Care
- Correctional Medication Management

Community

- Payers
- IDD Payers
- Aging & Disability
- Protective Services
- Incident Management
- Information & Referral
- Community-Based Organizations
- Housing & Homelessness
- Blood Centers

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Hospital

- FDA 510(k) cleared system for blood banks
- The blood compliance solution for U.S. Department of Defense facilities worldwide
- + 450 transfusion sites worldwide
- + 20,000 cord blood and tissue donors registered

Home

- +4,500 home health and hospice agencies
- +34 million billable visits in 12 months
- +$11 billion Medicare claims processed
- +200,000 care tasks every day

Practices and Facilities

- +50 million blood donor tests annually
- +22 million rehab treatments in 12 months
- +2.3 million rehab patients served in 12 months
- +135 medication management facilities (including 34 correctional health facilities)

Community

- +35,000 daily users
- + 3,000 agencies providing services
- Used by majority of Area Agencies on Aging
- Used by majority of HUD Continuums of Care
- Customer organizations in 50 US states, Washington D.C., and Canada