

Reportable Incident Reporting Guidance for Health Homes

Upon report/discovery of an incident as defined in the **Health Home Monitoring: Reportable Incidents Policies and Procedures and Reporting Timeframes** effective April 15, 2017, Health Homes should work with contracted CMAs to gather information and respond timely for the protection and support of members and program operations. This includes reporting as outlined, conducting a quality review and implementing timely quality and performance improvement for each identified incident based on Health Home Standards.

24 Hour Report: This submission shall serve as an alert to the Department of an incident/adverse event. The report should represent all known facts of the incident, and the immediate **protections**, actions taken by the provider or on behalf of the member by the provider, **to ensure member safety and well-being**, as well as any action taken to assess the impact on program integrity.

5-day Report: This submission shall include any/all factual updates to the circumstances of the incident, any/all guidance provided to the CMA by the HH to ensure member safety and well-being or program integrity, a preliminary quality review of the care management coordination prior to the incident as well as assurance that plans are in place, in accordance with HH standards, to provide transitional care management services to support the member in light of the incident/adverse event. The 5-day report should document the guidance/direction provided to the CMA by the HH in the current event and the outcome of the HH's preliminary quality review findings and immediate actions taken to address any areas of HH Standards non-compliance or performance improvement opportunities.

30-day (Final) Report: This submission shall include all assurances that the member has care management support and coordination in place to address the circumstances of the adverse event including; transitional support, updates to the plan of care, and linkage and coordination to new or existing providers with the intent of minimizing future adverse events. Additionally, the HH should document the outcome of the comprehensive quality review based on HH Standards, identify performance improvement opportunities, list the actions taken or planned for improvement, and ongoing quality monitoring of actions and improvements.

Health Homes may consider the following questions during the information gathering and review to establish the facts of the incident or event, review of care management activities related to established HH standards, and review of immediate actions to protect and minimize reoccurrence. The questions highlighted below should be considered and documented at the earliest reporting period possible.

Allegation of Abuse, Neglect, Mistreatment, Misappropriation of Member funds, or Sexual Contact between a member and any service provider.

- Review the member's enrollment status, current diagnosis with emphasis on pertinent diagnosis to the current incident, residential setting status, connections to licensed or certified program services and any relevant pre-incident information about the member.
- Does the member have a cognitive impairment or mental health diagnosis that should be considered? Identify any limitations with relation to the current incident.
- If an alleged perpetrator has been identified, provide all relevant information regarding that person's association to the member or the role of the individual in the delivery of care and services to the member.
- If a Health Home or CMA service provider, was routine or specific Human Resource screening conducted on the perpetrator?
- Is the alleged perpetrator a licensed professional or employed by a licensed or certified setting of OPWDD, OMH, OCFS, OASAS, DOH or SED? If so, has the professional licensing authority or the Justice Center been notified of the allegation? By whom? Is there a case # assigned?
- Was a report made to the Statewide Central Register of Child Abuse and Maltreatment or Adult Protective Services?
- Does the individual currently have access to the member?
- Is the identified individual still employed within the network, on suspension or removed from access to this specific member?
- Where did the incident take place?
 1. Was a licensed or certified setting of OPWDD, OMH, OCFS, OASAS, DOH or SED involved? Was the incident reported, **by the appropriate care team member in the licensed or certified setting**, to the Justice Center? By whom? Is there a case # assigned?
 2. Was another regulated setting involved? For example, a nursing home, an adult home, assisted living facility, home care or managed care organization, or an OCFS or DOH program not covered by the Justice Center? If so, was the incident reported to an associated hotline? By Whom? Is there a case # assigned.
- Is there any indication of media attention, for example news personnel contact with the HH, report on the news or in printed or digital media?
- Who reported the incident?

- What are the facts of the incident?
- When did the incident take place? Date and time if known?
- How was the incident discovered?
- What is the current location of the member?
- What action did the care manager take upon notification of the incident?
- Was a report made to law enforcement? By Whom? Is there a case # or contact information?
- Were there service needs identified in the member's assessment and plan of care relative to the prevention or protection of the current incident that were being addressed through specific care management activities?
- If service needs were identified and there is a lack of evidence of care management activities related to the need, were there identified barriers to care or services?
- Were interventions in place to address barriers?
- If no barriers were identified but there is a lack of care management activities, what is the identified root cause of the lack of care management services?
- What action(s) has the HH taken, or will take, to prevent reoccurrence?
- If the member has consented to the sharing of information with a legal guardian, family member or friend, has that person been notified of the incident?

Suicide Attempt

- Review the member's enrollment status, current diagnosis with emphasis on pertinent diagnosis to the current incident, residential setting status, connections to licensed or certified program services and any relevant pre-incident information about the member.
- Does the member have a cognitive impairment or mental health diagnosis that should be considered? Identify any limitations with relation to the current incident.
- Who reported the incident?
- What are the facts of the incident?
- What is the current location of the member?
- Where did the incident take place?
 1. Was a licensed or certified setting of OPWDD, OMH, OCFS, OASAS, DOH or SED? Was the incident reported to the oversight agency, **by the appropriate care team member in the licensed or certified setting**? By whom? Is there a case # assigned?
 2. Was another regulated setting involved? For example, a nursing home, an adult home, assisted living facility, home care or managed care organization. If so, was the incident reported to an associated hotline? By Whom? Is there a case # assigned?
- When did the incident take place? Date and time if known?
- How was the incident discovered?
- What action did the care manager take upon notification of the incident?

- Were there service needs identified in the member's assessment and plan of care relative to the prevention or protection of the current incident that were being addressed through specific care management activities?
- If service needs were identified and there is a lack of evidence of care management activities related to the need, where there identified barriers to care or services?
- Were interventions in place to address barriers?
- If no barriers were identified but there is a lack of care management activities, what is the identified root cause of the lack of care management services?
- What actions (referral, linkage, and/or coordination to care and services) has the HH taken, or will take, to minimize reoccurrence?
- Has the member previously attempted suicide? How many attempts? When were the previous suicide attempts? Is there an identified trigger or pattern related to the suicide attempt?
- What is the current location of the member? Has the care manager made contact with the member's current location to be included in the discharge planning for the member?
- If the member has consented to the sharing of information with a legal guardian, family member or friend, has that person been notified of the incident?

Death

Accidental/undetermined

- Review the member's enrollment status, current diagnosis with emphasis on pertinent diagnosis to the current incident, residential setting status, connections to licensed or certified program services and any relevant pre-incident information about the member.
- Does the member have a cognitive impairment or mental health diagnosis that should be considered? Identify any limitations with relation to the current incident.
- Who reported the incident?
- What are the facts of the incident?
- Where did the incident take place?
 1. Was a licensed or certified setting of OPWDD, OMH, OCFS, OASAS, DOH or SED? Was the incident reported, **by the appropriate care team member in the licensed or certified setting**, to the Justice Center? By whom? Is there a case # assigned?
 2. Was another regulated setting involved? For example, a nursing home, an adult home, assisted living facility, home care or managed care organization, or an OCFS or DOH program not covered by the Justice Center? If so, was the incident reported to an associated hotline? By Whom? Is there a case # assigned?
- When did the incident take place? Date and time if known?
- How was the incident discovered?
- What action did the care manager take upon notification of the incident?

- Were there service needs identified in the members assessment and plan of care relative to the prevention or protection of the current incident that were being addressed through specific care management activities?
- If service needs were identified and there is a lack of evidence of care management activities related to the need, were there identified barriers to care or services?
- Were interventions in place to address barriers?
- If no barriers were identified but there is a lack of care management activities, what is the identified root cause of the lack of care management services?
- If the member has consented to the sharing of information with a legal guardian, family member or friend, has that person been notified of the incident?
- Is there any indication of media attention, for example news personnel contact with the HH, report on the news or in printed or digital media?

Homicide

- If the perpetrator is a service provider, provide all relevant information regarding that person's role in the delivery of care and services to the member.
- If a Health Home or CMA service provider, were routine or specific Human Resource screening conducted on the perpetrator?
- Is the alleged perpetrator a licensed professional or employed by a licensed or certified setting of OPWDD, OMH, OCFS, OASAS, DOH or SED? If so, has the professional licensing authority or the Justice Center been notified of the allegation? By whom? Is there a case # assigned?
- Where did the incident take place?
 1. Was a licensed or certified setting of OPWDD, OMH, OCFS, OASAS, DOH or SED? Was the incident reported, **by the appropriate care team member in the licensed or certified setting**, to the Justice Center? By whom? Is there a case # assigned?
 2. Was another regulated setting involved? For example, a nursing home, an adult home, assisted living facility, home care or managed care organization, or an OCFS or DOH program not covered by the Justice Center? If so, was the incident reported to an associated hotline? By Whom? Is there a case # assigned?
- Did the incident occur during the course of business or outside of routine appropriate contact with the member?
- Is the identified individual still employed within the network, on suspension or has the individual been removed from access to members?
- If the perpetrator is known, identify the name(s) and was there a relationship or connection to the member prior to the incident?
- Is the perpetrator in custody?
- Was a report made to law enforcement? By Whom? Is there a case # or contact information?
- If the member has consented to the sharing of information with a legal guardian, family member or friend, has that person been notified of the incident?

- Is there any indication of media attention, for example news personnel contact with the HH, report on the news or in printed or digital media?

Suicide

- Review the member's enrollment status, current diagnosis with emphasis on pertinent diagnosis to the current incident, residential setting status, connections to licensed or certified program services and any relevant pre-incident information about the member.
- Does the member have a cognitive impairment or mental health diagnosis that should be considered? Identify any limitations with relation to the current incident.
- Who reported the incident?
- What are the facts of the incident?
- Where did the incident take place?
 1. Was a licensed or certified setting of OPWDD, OMH, OCFS, OASAS, DOH or SED? Was the incident reported to the oversight agency and/or the Justice Center **by the appropriate care team member in the licensed or certified setting**? By whom? Is there a case # assigned?
 2. Was another regulated setting involved? For example, a nursing home, an adult home, assisted living facility, home care or managed care organization. If so, was the incident reported to an associated hotline? By Whom? Is there a case # assigned.
- When did the incident take place? Date and time if known?
- How was the incident discovered?
- What action did the care manager take upon notification of the incident?
- Were there service needs identified in the members assessment and plan of care relative to the prevention or protection of the current incident that were being addressed through specific care management activities?
- If service needs were identified and there is a lack of evidence of care management activities related to the need, were there identified barriers to care or services?
- Were interventions in place to address barriers?
- If no barriers were identified but there is a lack of care management activities, what is the identified root cause of the lack of care management services?
- Has the member previously attempted suicide? How many attempts? When were the previous suicide attempts? Is there an identified trigger or pattern related to the suicide?
- If the member has consented to the sharing of information with a legal guardian, family member or friend, has that person been notified of the incident?

Crime Level 1

- Review the member's enrollment status, current diagnosis with emphasis on pertinent diagnosis to the current incident, residential setting status, connections

to licensed or certified program services and any relevant pre-incident information about the member.

- Does the member have a cognitive impairment or mental health diagnosis that should be considered? Identify any limitations with relation to the current incident.
- Is there any indication of media attention, for example news personnel contact with the HH, report on the news or in printed or digital media?
- Who reported the incident?
- What are the facts of the incident?
- Where did the incident take place?
 1. Was a licensed or certified setting of OPWDD, OMH, OCFS, OASAS, DOH or SED? Was the incident reported to the oversight agency, **by the appropriate care team member in the licensed or certified setting**? By whom? Is there a case # assigned?
 2. Was another regulated setting involved? For example, a nursing home, an adult home, assisted living facility, home care or managed care organization? If so, was the incident reported to an associated hotline? By Whom? Is there a case # assigned?.
- When did the incident take place? Date and time if known?
- How was the incident discovered?
- If there is a victim(s), are the name(s) known and is/was there a relationship or connection to the member prior to the incident? What is the status of the victim?
- When was the member arrested? By what law enforcement agency?
- Is the member currently in a correctional setting? When is the next court appearance? Is there a planned release date?
- What action did the care manager take upon notification of the incident?
- Were there service needs identified in the members assessment and plan of care relative to the prevention or protection of the current incident that were being addressed through specific care management activities?
- If service needs were identified and there is a lack of evidence of care management activities related to the need, were there identified barriers to care or services?
- Were interventions in place to address barriers?
- If no barriers were identified but there is a lack of care management activities, what is the identified root cause of the lack of care management services?
- What action(s) has the HH taken, or will take, to re-engage the member?

Missing Person

- Review the member's enrollment status, current diagnosis with emphasis on pertinent diagnosis to the current incident, residential setting status, connections to licensed or certified program services and any relevant pre-incident information about the member.
- Does the member have a cognitive impairment or mental health diagnosis that should be considered? Identify any limitations with relation to the current incident.

- Is there any indication of media attention, for example news personnel contact with the HH, report on the news or in printed or digital media?
- Who reported the incident?
- What are the facts of the incident?
- Where did the incident take place?
 1. Was a licensed or certified setting of OPWDD, OMH, OCFS, OASAS, DOH or SED? Was the incident reported to the oversight agency **by the appropriate care team member in the licensed or certified setting**? By whom? Is there a case # assigned?
 2. Was another regulated setting involved? For example, a nursing home, an adult home, assisted living facility, home care or managed care organization? If so, was the incident reported to an associated hotline? By Whom? Is there a case # assigned?
- When did the incident take place? Date and time if known?
- What action did the care manager take upon notification of the incident?
- Was a report made to law enforcement? By Whom? Is there a case # or contact information?
- Were there service needs identified in the members assessment and plan of care relative to the prevention or protection of the current incident that were being addressed through specific care management activities?
- If service needs were identified and there is a lack of evidence of care management activities related to the need, were there identified barriers to care or services?
- Were interventions in place to address barriers?
- If no barriers were identified but there is a lack of care management activities, what is the identified root cause of the lack of care management services?
- What action(s) has the HH taken, or will take, to support the member to prevent reoccurrence?
- If the member has consented to the sharing of information with a legal guardian, family member or friend, has that person been notified of the incident?

Violation of Protected Health Information

- Was the incident reported to the DOH Privacy Officer? If not, immediate notification is required.
- Review the member's enrollment status, current diagnosis with emphasis on pertinent diagnosis to the current incident, residential setting status, connections to licensed or certified program services and any relevant pre-incident information about the member.
- Does the member have a cognitive impairment or mental health diagnosis that should be considered? Identify any limitations with relation to the current incident.
- Is there any indication of media attention, for example news personnel contact with the HH, report on the news or in printed or digital media?

- If a person responsible has been identified, provide all relevant information regarding that person's role in the delivery of care and services to the member.
- Was routine or specific Human Resource screening conducted on the perpetrator?
- Is the person a licensed professional?
- Does the individual currently have access to the member?
- Is the identified individual still employed within the network, on suspension or removed from access to this specific member?
- Who reported the incident?
- What are the facts of the incident?
- Where did the incident take place?
 3. Was a licensed or certified setting of OPWDD, OMH, OCFS, OASAS, DOH or SED? Was the incident reported to the oversight agency **by the appropriate care team member in the licensed or certified setting**? By whom? Is there a case # assigned?
 4. Was another regulated setting involved? For example, a nursing home, an adult home, assisted living facility, home care or managed care organization, If so, was the incident reported to an associated hotline? By Whom? Is there a case # assigned.?
- When did the incident take place? Date and time if known?
- How was the incident discovered?
- Was there a business system in place to prevent the incident? If so, identify the systemic gap that allowed for the incident to occur.
- What action did the care manager, CMA, and/or the HH take upon discovery of the incident?
- What action has been taken to prevent reoccurrence?

Other

- Provide a detailed description of the incident including all facts that have had, or has the potential to have, a negative impact on member health and wellbeing or Health Home systemic integrity.
- Is there any indication of media attention, for example news personnel contact with the HH, report on the news or in printed or digital media?
- Does the CMA require assistance from the Health Home, or does the Health Home require assistance from the State to mitigate the current situation? If so, define the assistance requested.