Iowa Medicaid Critical Incident Report

Date Received	Incident ID	Staff Reviewer

Instructions: *Submit all pages of this form with as much information as possible within the required reporting timeframes.*

Incident Status:
- ☐ Initial (pending further investigation)
- ☐ Completed (investigation completed)
- ☐ Additional information added

Managed Care Organization:
- ☐ Amerigroup Iowa
- ☐ Iowa Total Care
- ☐ Non-MCO

Provider/Facility Information

National Provider Identifier		Phone Number	
Provider or Agency Name			
Provider Address			
City		State	Zip Code

Reporting Party

Reporter's First Name		Last Name	
Title			
Email		Phone Number	
Point of contact to discuss incident if different from reporter:			
First Name	Last Name	Phone Number	

Medicaid Member

Medicaid State Number	First Name	Last Name	
Address			
City		State	Zip Code
Date of Birth	Age	Member's gender: ☐ Male ☐ Female	

Service Programs

- ☐ AIDS/HIV
- ☐ Brain Injury
- ☐ Children's Mental Health
- ☐ Elderly
- ☐ Habilitation
- ☐ Health and Disability
- ☐ Intellectual Disability
- ☐ Physical Disability
- ☐ MFP
- ☐ Other (non-waiver): Describe: _____

Case Manager (CM)

First Name		Last Name	
Address			
City		State	Zip Code
Email		Phone Number	
Case manager contacted member within 24 hours of discovering incident? ☐ Yes ☐ No			
Date CM Contacted Member		Time CM Contacted Member	

Incident

Date Incident Occurred (***required***)	Time of Incident ☐ a.m. ☐ p.m. ☐ Unknown
Was the incident witnessed? ☐ Yes ☐ No	Date Incident Discovered (***required***)
Person to learn of incident:	
First Name / Last Name	Title

Location of Incident

Select Location Type (If other, specify.)

☐ Member's home	☐ Community	☐ Other location
☐ Living alone	☐ Work	☐ State facility
☐ Living with relatives	☐ School	☐ Correctional facility or jail
☐ Living with unrelated person	☐ Vehicle	☐ Nursing facility
☐ RCF	☐ Day program	☐ Hospital or clinic
☐ Assisted living	☐ Other:	☐ PMIC
☐ Other: _____		☐ Other: _____

Name of Location or Facility		
Location or Facility Address		
City	State	Zip Code

Witnesses

People Present During Incident (Provide name of person, initials if a member, and the person's relationship to the member. If other, specify.)

1.	☐ Another member ☐ Staff ☐ Family ☐ Roommate ☐ Other:
2.	☐ Another member ☐ Staff ☐ Family ☐ Roommate ☐ Other:
3.	☐ Another member ☐ Staff ☐ Family ☐ Roommate ☐ Other:
4.	☐ Another member ☐ Staff ☐ Family ☐ Roommate ☐ Other:
5.	☐ Another member ☐ Staff ☐ Family ☐ Roommate ☐ Other:

Services

Were services being provided? ☐ Yes ☐ No	
Service Name	

Reporting

Case manager informed? ☐ Yes ☐ No ☐ N/A	Date Informed
Guardian informed? ☐ Yes ☐ No ☐ N/A	Date Informed
DHS report made? ☐ Yes ☐ No ☐ N/A	Date of Report
Report Number	DHS report accepted? ☐ Yes ☐ No
Department of Inspections and Appeals (DIA)? ☐ Yes ☐ No ☐ N/A	Date of Report
Law enforcement? ☐ Yes ☐ No ☐ N/A	Date Contacted
Officer Name and Contact Information	
Other Entity Contacted (Specify)	

Incident Description

Description (Include who, what, when, where, and how in a clear concise manner noting the circumstances of the incident.)

Was the incident preventable? ☐ Yes ☐ No

Root Cause (Describe what lead to or contributed to the incident.)

Immediate Resolution (Include action taken to secure the member's safety and proposed prevention plan to address.)

Incident Type

Circumstances (Select one): ☐ Physical injury **to** member ☐ Physical injury **by** member

☐ **Physical Injury** (Injury requiring physician's treatment or admission to a hospital.)

- ☐ Burn
- ☐ Dislocation
- ☐ Concussion
- ☐ Human or animal bite
- ☐ Laceration
- ☐ Puncture wound
- ☐ Fracture or break
- ☐ Loss of consciousness
- ☐ Poisoning or toxin ingestion
- ☐ Other: _____

Injury Is Due To (Check all that apply.)

- ☐ Mechanical restraint
- ☐ Removal of mobility aids
- ☐ Personal harm
- ☐ Aggressive behavior
- ☐ Accidental fall
- ☐ Aspiration or choking
- ☐ Vehicular accident
- ☐ Assault
- ☐ Other: _____

☐ **Medication Error** (Medical intervention sought or pattern of medication errors identified. Check all that apply.)

- ☐ **By staff**
- ☐ **By member**
- ☐ Wrong dosage
- ☐ Wrong medication
- ☐ Missed dose
- ☐ Wrong time
- ☐ Unauthorized administration
- ☐ Overdose
- ☐ Other: _____

Root Cause (Check all that apply.)

- ☐ Staff distracted
- ☐ Not verifying correct member
- ☐ Unknown

Medication Error Lead To (Check all that apply.)

- ☐ Physical injury
- ☐ Death
- ☐ Emergency mental health
- ☐ Law enforcement
- ☐ Abuse report

☐ **Death** Apparent cause of death:

- ☐ Accident
- ☐ Homicide
- ☐ Natural causes
- ☐ Unknown
- ☐ Suicide

Preventable?	☐ Yes	☐ No
Autopsy performed?	☐ Yes	☐ No
Autopsy requested?	☐ Yes	☐ No
Was there a DNR order?	☐ Yes	☐ No
Hospice involved?	☐ Yes	☐ No

Location Death Occurred

Location Address

City	State	Zip Code

Incident Type (Cont.)

☐ **Emergency Mental Health** (Check all that apply.)

Suicidal?	☐ Yes	☐ No
Self-injurious?	☐ Yes	☐ No
Aggressive to others?	☐ Yes	☐ No
Member needed to be admitted for treatment?	☐ Yes	☐ No

☐ **Law Enforcement** Reason involved:

☐ Criminal ☐ Medical ☐ Location unknown/elopement
☐ Mental health ☐ Welfare check ☐ Other (describe): _____
☐ Behavioral

☐ Victim Arrested? ☐ Yes ☐ No
☐ Perpetrator Charged? ☐ Yes ☐ No

☐ **Abuse Report or Restriction**

☐ Victim ☐ Physical injury ☐ Sexual abuse
☐ Perpetrator ☐ Exploitation ☐ Denial of critical care
☐ Self-denial of critical care ☐ Mental injury

☐ **Location Unknown/Elopement** (Location unknown by provider responsible for protective oversight.)

Approximate length of time location unknown:

Resolution

Incident-Specific Resolutions

This section includes multiple types of resolutions possible for reported incidents. Check all that apply. Describe the agency course of action, proposed plans, self-corrective actions, measures needed to prevent or diminish the probability for future occurrences or other information needed for each checked resolution.

☐ **Staff Review and Updates** (Complete this section if staff issues will be addressed by the agency or facility. Describe any changes in staffing patterns.)

☐ Initiated ☐ Completed

Describe:

☐ **Member Review** (Complete this section if the member's plan, health, or care needs will be reviewed or revised.)

☐ Initiated ☐ Completed

Member care and treatment plan revised? ☐ Yes ☐ No

Describe:

☐ **Equipment and Supplies Review and Updates** (Complete this section if necessary equipment or supplies need to be purchased, repaired, or assessed.)

☐ Initiated ☐ Completed

Describe:

Resolution (Cont.)	☐ **Environment Review and Updates** (Complete this section if the member's environment will be evaluated, accommodated, or modified for safety or accessibility needs.) ☐ Initiated ☐ Completed Describe:
	☐ **Policy and Procedure Review and Updates** (A review or adjustment of formal written policies, procedures, and guidelines implemented by the agency or facility.) ☐ Initiated ☐ Completed Describe:
	☐ **Agency Wide Planning** (Systemic resolution to include, but not limited to, training or retraining, self-CAP, communication and awareness regarding updates, employee screening, etc.) ☐ Initiated ☐ Completed Self-corrective action initiated? ☐ Yes ☐ No Describe:
	☐ **No Resolution Required** (Indicate how incident was isolated.) Describe:
	Additional Follow-up and Notes (Place additional detail regarding incident or resolution as discovered.)

Critical Incident Submission Guidelines per Iowa Administrative Code Chapter 77

Major incidents require notification by the end of the next calendar day following the incident. Minor incidents are reported to the staff's supervisor within 72 hours of the incident. Cases of abuse require notification to the DHS Abuse Hotline (1-800-362-2178) and the member's assigned MCO. **Note:** Mandatory incident reporting requirements to other entities continue to apply including, but not limited to, Iowa Code Chapter 235B and Iowa Administrative Code Chapter 50.

Submission Instructions

Direct entry of critical incidents can be completed electronically within each Managed Care Organization (MCO) and the Iowa Medicaid Portal Access (IMPA) system. Direct electronic entry is the preferred method. Link information for each MCO and IME electronic systems are provided below. Submit as much information as possible within the required reporting timeframes to the member's assigned MCO or to the IME if not assigned an MCO. If additional investigation is required for full resolution, please indicate this within the report. One will have the ability to return to the original entry in IMPA to add supplemental information regarding the incident and/or resolution.

Definitions

Root cause. A method of problem solving used for identifying the root causes of faults or problems then determining solutions to address those causes to avoid occurrences of the same incident.

Welfare check. A police welfare check takes place when law enforcement is sent out to check the wellbeing of a person. This check is done when the police have a reason to believe someone is harmed or in danger.

Natural causes. Death attributed to a pre-existing illness or disease, old age or an internal malfunction of the body not directly influenced by external forces such as violence or an accident.

Laceration. A break, cut, gash, or tear in the skin or flesh. An incision by a surgeon or physician is not a laceration on a patient.

DNR. Do not resuscitate.

Protective oversight. An awareness of the location of an individual where care is being provided; the ability to intervene on behalf of the individual; the supervision of nutrition, medication, or actual provisions of care; and the responsibility for the welfare of the individual.

MCO and IME Contact and Link Information

Amerigroup Iowa, Inc.

- Fax: 844-400-3465
- Provider Call Center: 1-800-454-3730
- Web: https://providers.amerigroup.com/IA/Pages/welcome.aspx
- Email: IAincidents@amerigroup.com

Iowa Total Care

- Submit completed form by fax to 1-833-205-1251 or email to QOCCIR@IowaTotalCare.com
- Provider Services Call Center: 1-833-404-1061
- Web: www.IowaTotalCare.com

Iowa Medicaid Enterprise

- Submit via the Iowa Medicaid Portal Access (IMPA) system
- Email: hcbsir@dhs.state.ia.us **(Incident reports are not accepted via email per IL 1119. Email is for question or concern submission only.)**