

Iowa Medicaid Critical Incident Report

Date Received Incid		Incident ID	Staff Reviewer		
<i>Instructions:</i> Submit all pages of this form with as much information as possible within the required reporting timeframes.					
Incident Status: Managed Care Organization: Initial (pending further investigation) Amerigroup Iowa Completed (investigation completed) UnitedHealthcare Community Plan Additional information added Iowa Total Care Non-MCO Non-MCO					
lity	National Provider Identifier		Phone Numb	Phone Number	
Provider/Facility Information	Provider or Agency Name				
ovider Inforn	Provider Address				
Pro	City		State	Zip Code	
Reporting Party	Reporter's First Name		Last Name	Last Name	
	Title				
	Email		Phone Numb	Phone Number	
Rep	Point of contact to discuss incident if different from reporter:				
	First Name Last Name		Phone Numb		
nber	Medicaid State Number	First Name	Last Name		
i Men	Address				
Medicaid Member	City		State	Zip Code	
Med	Date of Birth	Age	Member's ge	nder: 🗌 Male 🗌 Female	
Service Programs	AIDS/HIV Habilitation MFP Brain Injury Health and Disability Other (non-waiver): Children's Mental Health Intellectual Disability Describe: Elderly Physical Disability			ther (non-waiver):	
(CM)	First Name		Last Name	Last Name	
	Address				
lager	City		State	Zip Code	
Case Manager (CM)	Email		Phone Numb	Phone Number	
Casi	Case manager contacted member within 24 hours of discovering incident?				
	Date CM Contacted Men	nber	Time CM Co	ntacted Member	

lent	Date Incident Occurred (<i>required</i>)	Time of Incident	🗌 a.m. 🗌 p.i	m. 🗌 Unknown
	Was the incident witnessed?	es 🗌 No		covered (<i>required</i>)
Incident	Person to learn of incident:			
	First Name Last Name		Title	
	Select Location Type (If other, specify.)			
Location of Incident	Living alone W Living with relatives So Living with unrelated person Ve RCF Data	ommunity ′ork chool ehicle ay program ther:	 Other location State facility Correctional f Nursing faciliti Hospital or cli PMIC Other: 	- facility or jail ty
Loca	Name of Location or Facility			
	Location or Facility Address			
	City		State	Zip Code
	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 🗌 Fa	mily 🗌 Roommate
SSes	2.	Another member	🗌 Staff 🗌 Fa	mily 🗌 Roommate
Witnesses	3.	Another member	🗌 Staff 🗌 Fa	mily 🗌 Roommate
	4.	Another member	🗌 Staff 🗌 Fa	mily 🗌 Roommate
	5.	Another member	🗌 Staff 🗌 Fa	mily 🗌 Roommate
ices	Were services being provided?	Yes 🗌 No		
Services	Service Name			
	Case manager informed? Yes] No 🗌 N/A	Date Informed	
	Guardian informed?	No 🗌 N/A	Date Informed	
	DHS report made?] No 🗌 N/A	Date of Report	
rting	Report Number	DHS report accepted	J? □ Ye	es 🗌 No
Reporting	Department of Inspections and Appeals (D Yes No N/A	IA)?	Date of Report	
	Law enforcement?	No 🗌 N/A	Date Contacted	
	Officer Name and Contact Information			
	Other Entity Contacted (Specify)			

ription	Description (Include who, what, when, where, and how in a clear concise manner noting the circumstances of the incident.)				
esc	Was the incident preventable?	☐ Yes ☐ No			
Incident Description	Root Cause (Describe what lead to or contributed to the incident.)				
Inci	Immediate Resolution (Include action taken to secure the member's safety and proposed prevention plan to address.)				
	Circumstances (Select one):	Physical injury to m		al injury by member	
	Physical Injury (Injury requir Burn Dislocation	 Laceration Puncture wound 		ning or toxin ingestion	
	ConcussionHuman or animal bite	 Fracture or break Loss of consciousne 	ess		
	Injury Is Due To (Check all th	nat apply.)			
	Mechanical restraint	Aggressive behavio		ular accident	
	Removal of mobility aids Personal harm	 Accidental fall Aspiration or chokir 	lg ☐ Assau		
	Medication Error (Medical intervention sought or pattern of medication errors identified. Check all that apply.)				
	By staffBy member	 Wrong dosage Wrong medication Missed dose 	Unaut		
ype	Wrong time				
dent Type	Root Cause (Check all that apply.)				
Incide	Staff distracted	Not verifying correc member	t 🔄 Unkno	own	
l	Medication Error Lead To (Check all that apply.)				
	Physical injury	 Emergency mental Law enforcement 	health 🗌 Abuse	report	
	Death Apparent cause of death:				
	Accident Homicide	Natural causes Unknown	Suicid	e	
	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	S	State	Zip Code	

	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		
t.)	Law Enforcement Reason involved:				
Cont			Location unknown/elopement		
Incident Type (Cont.)	Mental health	Welfare check	Other (describe):		
cident	 Victim Perpetrator 	Arrested? Yes Charged? Yes	□ No □ No		
lne	Abuse Report or Restriction	• —			
	VictimPerpetrator	 Physical injury Exploitation Self-denial of critical care 	 Sexual abuse Denial of critical care Mental injury 		
	Location Unknown/Elopement (Location unknown by provider responsible for protective				
	oversight.) Approximate length of time location unknown:				
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.)				
	Describe:				
uo					
Resolution	Member Review (Complete this section if the member's plan, health, or care needs will be reviewed or revised.)				
Res	Initiated	Completed			
	Member care and treatment pla	an revised?	No No		
	Describe:				
		Equipment and Supplies Review and Updates (Complete this section if necessary			
	equipment or supplies need to		sessed.)		
	I Initiated	Completed			
	Describe:	Completed			

	 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		
(Cont.)	Describe:		
Resolution (Cont.)	 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, lowa Code Chapter 235B and lowa 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 lowa, 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

UnitedHealthcare Plan of the River Valley, Inc.

- Submit completed form by fax to 1-855-371-7638 or email to critical incidents@uhc.com
- Provider Services Call Center: 1-888-650-3462
- Web: http://www.uhccommunityplan.com/health-professionals/ia.html

Iowa Total Care

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

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.)