UnitedHealthcare Community Plan of Iowa

Critical Incident Report (CIR) Form 470-4698 (Rev. 1/17) User Reference Guide

User Reference Guide – Critical Incident Report (CIR) Form 470-4698 (Rev. 1/17)

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User Reference Guide – Critical Incident Report Form 470-4698 (Rev. 1/17)

This reference guide provides instruction on how to complete the Critical Incident Report (CIR) form. All registered Medicaid providers are required to report critical incidents on members receiving Home- and Community-Based Waiver and Habilitation services. Critical incidents are reported as defined by the Iowa Administrative Code (IAC), Chapter 77.

- Critical Incident Report Form 470-4698 is used to report **major** incidents.
- The first individual to witness or discover the occurrence of a major incident completes the form.
- The initial CIR form must be completed and submitted by the end of the next calendar day following the incident or date it was discovered.
- A separate form should be used for each distinct major incident and one for each member involved.
- One CIR form may be used to record multiple incident types if they relate to the same overall incident.
- If the form cannot be completed in its entirety because necessary investigation activities are not complete or resolution activities have not been implemented, submit as much initial information as possible. Additional and/or updated information may be submitted within 5 business days following the incident.
- Detailed guidance will cover the following sections found on pages 1- 5 of the six page CIR form.
    - Incident Status and MCO
    - Provider/ Facility Information
    - Reporting Party
    - Medicaid Member
    - Service Programs
    - Case Manager (CM)
    - Incident
    - Location of Incident
    - Witnesses
    - Services
    - Reporting
    - Incident Description and Root Cause
    - Incident Types
    - Resolution
    - Additional Follow-up and Notes

CIR Form

Key Points:
"When in doubt, fill one out." No matter what program(s), or where a member resides, it's the services they are receiving (HCBS Waiver & Habilitation) that define who needs to have critical incidents reported.

Who Reports?
First to know of the incident (observed or discovered), service providers/workers, Case Managers (CM), Targeted Case Managers (TCM), Community-Based Case Managers (CBCM), Integrated Health Home (IHH) Care Coordinators.

Who does *Not* Report?
Consumer Choice Options (CCO) service providers, home and vehicle modification, and transportation providers or personal emergency response systems.

Accessing and Completing the CIR Form

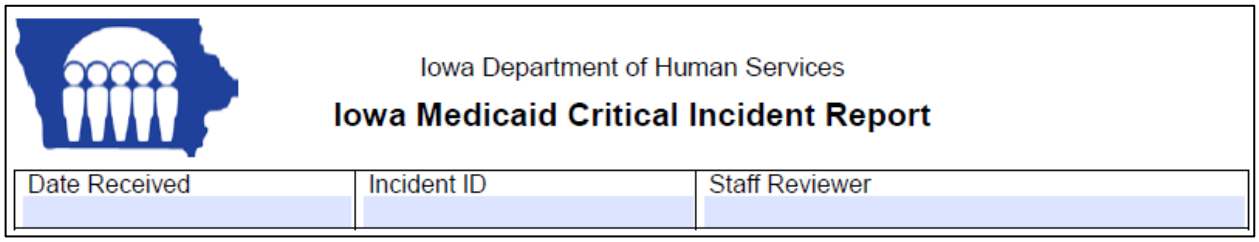
All managed care organizations (MCOs) are using the Iowa Medicaid Enterprise's (IME) standardized Critical Incident Report Form 470-4698. When a member's enrollment is verified, submit a completed CIR form to their respective MCO only.
You do **not** need to send one to the IME as well.

To access the CIR form, proceed to UnitedHealthcare Provider Portal at:
http://www.uhccommunityplan.com/health-professionals/ia/provider-forms.html

This electronic form needs to be saved to a personal device and completed as described. Use "X" for the check boxes. The date and phone number fields do not use a slash (/) or dashes (-).

CIR Form – Page 1

The top section of the form (shown below) will be completed by UnitedHealthcare's Critical Incident Reviewer.



Iowa Department of Human Services

Iowa Medicaid Critical Incident Report

Date Received	Incident ID	Staff Reviewer

Incident Status and MCO – Mark an 'X' in the applicable boxes for the Incident Status and "UnitedHealthcare Community Plan" for the MCO. Incident Status may be your initial report investigation, completed investigation, or additional information as it becomes available.

Instructions: *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)	☐ AmeriHealth Caritas Iowa
☐ Additional information added	☐ UnitedHealthcare Community Plan
	☐ Non-MCO

Provider/Facility Name – Agency or individual associated with the NPI or SSN should be entered, along with the address. The VIN (Vendor Identification Number) is also referred to as the **NPI** (National Provider Identifier) for agency providers. For individual providers, the SSN (social security number) of the provider serves as the VIN.

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

Reporting Party – The person completing/submitting the form. Provide additional point of contact information if different than the individual completing the form.

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 – Complete information on the waiver or habilitation recipient who was involved in the incident.

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 – Check the box to identify the waiver or habilitation **services** the member was receiving.

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

Case Manager – Provide the CM information and if you are aware the case manager has contacted the member. (This section can be completed by either the service provider or CM).

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	

CIR Form – Page 2

Incident – Dates are required for the **occurred** *and* **discovered** fields, which may be different. If witnessed, the dates will be the same.

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 a **location category** (Member's home, Community, Other location) *and* a more specific location within that category. Use "other" if needed to provide additional information.

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 – Provide information on **individuals present** during the incident. Enter the names of all provider staff present at the time of the incident or who responded after becoming aware of the incident. When listing names of other members or non-members involved – use only their initials to maintain confidentiality.

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 – Answer whether services were being provided at the time of the incident and write the name of the services in the narrative box.

Services		
	Were services being provided? ☐ Yes ☐ No	
	Service Name	

Reporting – Staff members should notify the following persons by the end of the next calendar day following the incident:

- Staff members' supervisor
- The member or the members' legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the providers service provision. Notification to the guardian is always required.
- The member's case manager

Indicate who was **informed** and if other reports were submitted (i.e. Iowa Department of Human Services, Iowa Department of Inspections and Appeals (DIA) or law enforcement).

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)	

CIR Form – Page 3

Incident Description – Description and root cause should include what happened before, during and after the incident. Include environmental conditions and any noticeable cues, using observable and measureable terms. Select **Yes** or **No** for Preventable Incident. Complete Immediate Resolution.

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

Indicate if incident was injury **to** or **by** the member. Indicate the **type** of injury – select **all** that apply.

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

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

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

Injury Is Due To (Check all that apply.)

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

Incident Type – Medication Error

Select all that apply.

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

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

Root Cause (Check all that apply.)

☐ Staff distracted	☐ Not verifying correct member	☐ Unknown

Medication Error Lead To (Check all that apply.)

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

Incident Type – Death

Regardless of cause, any member death will be reported including those expected by natural causes i.e., terminal illness and/or chronic medical conditions.

☐ **Death** Apparent cause of death:

☐ Accident	☐ Natural causes	☐ Suicide
☐ Homicide	☐ Unknown	
Preventable?	☐ Yes	☐ No
Autopsy performed?	☐ Yes	☐ No
Autopsy requested?	☐ Yes	☐ No
Was there a DNR order?	☐ Yes	☐ No
Hospice involved?	☐ Yes	☐ No

CIR Form – Page 4 (Incident Type cont'd)

Incident Type – Emergency Mental Health

Provide information about mental health factors related to the incident.

☐ **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

Incident Type – Law Enforcement

Provide information that will assist the critical incident reviewer to know the purpose of law enforcement involvement.

☐ **Law Enforcement** Reason involved:

☐ Criminal	☐ Medical		☐ Location unknown/elopement
☐ Mental health	☐ Welfare check		☐ Other (describe):
☐ Behavioral			
☐ Victim	Arrested?	☐ Yes	☐ No
☐ Perpetrator	Charged?	☐ Yes	☐ No

Incident Type – Abuse Report

This section gathers information about child and dependent adult abuse. Select whether the member was the victim or perpetrator. Check the abuse type(s) that apply. For abuse types not listed, please provide detail in the "Additional Follow-Up and Notes" section on page 5 of the CIR form.

☐ **Abuse Report or Restriction**

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

Reports of suspected Child or Dependant Adult Abuse must also be made to the appropriate agencies i.e., DHS, DIA, law enforcement.

Incident Type – Location Unknown/Elopement

Complete this section if the incident included the member's location being unknown.

☐ **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.

Review each of the following sections, check and complete those that apply.

Resolution – Staff Review & Updates

☐ **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:

Resolution – Member Review

☐ **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:

Resolution – Equipment & Supplies Review & Updates

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

☐ Initiated ☐ Completed

Describe:

CIR Form – Page 5 (Resolution – cont'd)

Resolution – Environment Review & Updates

☐ **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:

Resolution – Policy & Procedure Review & Updates

☐ **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:

Resolution – Agency Wide Planning

☐ **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:

Resolution – No Resolution Required

Add narrative to describe how incident was isolated with minimal probability of reoccurrence.

☐ **No Resolution Required** (Indicate how incident was isolated.)

Describe:

ADDITIONAL FOLLOW UP & NOTES

This section is available to submit additional information after the initial critical incident report has been submitted. Be sure to check the incident status box on page 1 with “Additional information added” to coincide with this added information being sent. Additional information should be submitted within five business days of the initial submission.

Additional Follow-up and Notes (Place additional detail regarding incident or resolution as discovered.)

CIR Form – Submission

Submit completed CIR form by fax to 855-371-7638 or email critical_incidents@uhc.com. The critical incident report will be reviewed by UnitedHealthcare Clinical Services Quality of Care Department’s Quality Intervention Services team. The process will be completed within 30 days of receipt including any indicated follow up for the care provider.

Glossary

DNR. Do not resuscitate.

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.

Mental injury. Any mental injury to a child's intellectual or psychological capacity as evidenced by an observable and substantial impairment in the child's ability to function within the child's normal range of performance and behavior as the result of the acts or omissions of a person responsible for the care of the child, if the impairment is diagnosed and confirmed by a licensed physician or qualified mental health professional as defined in Iowa Code section 622.10.

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.

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.

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.