

The 3 R's of HCBS Incidents

Recognize, Report, Respond

Annual Refresher Training for Reporters of HCBS Critical and Minor Incidents

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Pre-Test Link:

[https://www.surveymonkey.com/r/
CIR26-Pre](https://www.surveymonkey.com/r/CIR26-Pre)





Learning Objectives

1. **Recognize** critical incidents and distinguish between incident types.
2. **Report** critical incidents accurately, completely, and within required timelines.
3. Identify and document key reporting elements, including incident details, responsible parties, root causes, and resolutions.
4. **Respond** appropriately through immediate resolutions and long-term remediation planning.
5. Collaborate with the interdisciplinary team to prevent future incidents and improve outcomes.

Who Reports and What to Report

Who Reports

- ▶ First to discover an incident occurred
- ▶ HCBS waiver and Habilitation providers (with some exceptions)
- ▶ Case managers including CBCM, TCM, MFP Transition Specialists.

What to Report

- ▶ Occurrences involving a member enrolled in an HCBS waiver or Habilitation program.
- ▶ Not just during service provision.
- ▶ Occurrences meeting the definitions of critical (major) and for HCBS providers, minor incidents.

Critical Incident Reporting & Management System

- ▶ Critical incidents must be reported through Iowa's Critical Incident Reporting (CIR) and Management System.
- ▶ The CIR Management System is accessed through Iowa Medicaid Portal Access (IMPA).
- ▶ CIR may **NOT** be faxed, emailed, or uploaded in any other way.

Minor Incidents

Recognizing, Reporting, and Responding to Minor Incidents

Recognizing Minor Incidents

An occurrence involving a member that is not a major incident and:

- Results in the application of basic first aid
- Results in bruising
- Results in seizure activity
- Results in injury to self, to others, or to property
- Constitutes a prescription medication error





Reporting Minor Incidents

- ▶ HCBS providers must have policies and procedures for recognizing and reporting both major and minor incidents.
- ▶ Minor incidents may be recorded on any format designed by the provider.
- ▶ When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved must submit the provider's minor incident report to the staff member's supervisor within 72 hours of the incident.
- ▶ The completed report must be maintained in a centralized file with a notation in the member's record.

Responding to Minor Incidents

- ▶ **Immediate Resolution:** Address the issue in the moment to ensure the member's safety.
- ▶ **Long-Term Remediation:** Identify and address factors contributing to repeated incidents.
- ▶ **Centralized Tracking & Trending:** Supports monitoring patterns across the organization and for individual members. |
- ▶ **Role of the IDT:** Patterns of minor incidents must be addressed and brought forward.



Major (Critical) Incidents

Recognizing, Reporting, and Responding to Critical Incidents

Recognizing Critical Incident Types

-  Physical Injury
-  Medication Error
-  Abuse Report
-  Emergency Mental Health Treatment
-  Law Enforcement Intervention
-  Location Unknown
-  Death
-  Use of Restraint
-  Medical Treatment

Recognizing & Reporting Physical Injury

Physical Injury

An occurrence resulting in physical injury requiring (physician's) treatment or admission to a hospital.

Kind of Physical Injury (Check all that apply)*

- ☐ Burn
- ☐ Fracture or break
- ☐ Dislocation
- ☐ Loss of consciousness
- ☐ Concussion
- ☐ Poisoning or toxin ingestion
- ☐ Bite (human or animal)
- ☐ Adverse reaction to medication
- ☐ Laceration
- ☐ Puncture wound
- ☐ Other

Cause of physical injury (check all that apply)*

- ☐ Use of a restraint or physical intervention of any kind
- ☐ Assault
- ☐ Removal or failure to use a mobility aid
- ☐ Intentional action by member
- ☐ Self-harm
- ☐ Unintentional action by member
- ☐ Physical aggression by member
- ☐ Intentional action by staff or another person
- ☐ Physical aggression to member
- ☐ Unintentional action by staff or another person
- ☐ Accidental fall
- ☐ Medication error
- ☐ Aspiration or choking
- ☐ Vehicular accident
- ☐ Other

Did this incident result in? (check all that apply)*

Recognizing & Reporting Medication Error

Medication Error

An occurrence that constitutes a medication error or pattern of medication errors leading to physical injury, death, or emergency mental health treatment.

Kind of Medication error (check all that apply)*

- ☐ Wrong dosage
- ☐ Missed dose
- ☐ Wrong person
- ☐ Administration by unauthorized person
- ☐ Wrong medication
- ☐ Intentional overdose
- ☐ Wrong route
- ☐ Accidental overdose
- ☐ Wrong time
- ☐ Other

Cause of medication error (check all that apply)*

- ☐ Communication failure
- ☐ Documentation error
- ☐ Error by person administering medication
- ☐ Intentional behavior by the member
- ☐ Prescriber error
- ☐ Pharmacy error
- ☐ Other

Did this incident result in? (check all that apply)*

- ☐ Emergency room visit
- ☐ Admission to hospital
- ☐ Urgent care visit
- ☐ Treatment from emergency medical technician (EMT)
- ☐ Consultation with poison control, an on-call medical professional, crisis line, or similar s
- ☐ N/A

Recognizing & Reporting Abuse Report

Abuse Report

An occurrence that requires a report of child or dependent adult abuse.

☐ Member was a victim ☐ Member was a perpetrator

Kind of Abuse report (check all that apply)*

- ☐ Physical abuse of a dependent adult / nonaccidental physical injury of a child
- ☐ Personal degradation of a dependent adult/ Mental injury of a child
- ☐ Exploitation
- ☐ Sexual abuse
- ☐ Self-denial of critical care
- ☐ Other child abuse type
- ☐ Denial of critical care
- ☐ Other

Cause of abuse report (check all that apply)*

- ☐ Suspected abuse or neglect from staff
- ☐ Suspected self-denial of critical care
- ☐ Suspected abuse or neglect from a family caregiver
- ☐ Unknown
- ☐ Suspected abuse or neglect by member to another person
- ☐ Other

Was the abuse allegation founded?*

☐ Yes ☐ No ☐ Unknown ☐ Pending

☐ HHS Abuse Report ☐ Department of Inspection, Appeals, and Licensing (DIAL)

Did this incident result in? (check all that apply)*

- ☐ Emergency room visit
- ☐ Admission to hospital
- ☐ Urgent care visit
- ☐ Treatment from emergency medical technician (EMT)
- ☐ Consultation with poison control, an on-call medical professional, crisis line, or similar service.
- ☐ N/A

Recognizing & Reporting Emergency Mental Health Treatment

Emergency Mental Health Treatment

An occurrence
requiring emergency
mental health
treatment.

Kind of Emergency mental health treatment (check all that apply)*

- ☐ Crisis line or mobile crisis treatment for an emergency mental health crisis.
- ☐ Use of an emergency restraint or physical intervention of any kind as a means of handling an emergency mental health crisis.
- ☐ Emergency room treatment for an emergency mental health crisis.
- ☐ Intentional use of any medication to subdue, sedate, or restrain the member experiencing an emergency mental health crisis.
- ☐ Admission to the hospital, crisis bed or sub-acute mental health facility, or other mental health treatment
- ☐ Other

Cause of emergency mental health treatment (check all that apply)*

- ☐ Member attempted suicide
- ☐ Member expressed suicidal ideation
- ☐ Escalating behavioral health concerns
- ☐ Escalating mental health concerns
- ☐ Aggression by member
- ☐ Medication error
- ☐ Toxic effect of substances/adverse reaction to substance
- ☐ Triggering event or other triggering factor
- ☐ Self-harm/self-injurious behavior
- ☐ Unknown
- ☐ Other

Did this incident result in? (check all that apply)*

- ☐ Emergency room visit
- ☐ Admission to hospital
- ☐ Urgent care visit
- ☐ Treatment from emergency medical technician (EMT)
- ☐ Consultation with poison control, an on-call medical professional, crisis line, or similar service.
- ☐ N/A

Recognizing & Reporting Law Enforcement Intervention

**Law Enforcement
Intervention**
An occurrence
requiring the
intervention of law
enforcement.

☐ Yes ☐ No ☐ NA

Was the member charged?

☐ Yes ☐ No ☐ NA

Kind of Law enforcement intervention (check all that apply)*

- ☐ Response to a medical/injury call
- ☐ Response to mental/behavioral health call
- ☐ Response to a domestic disturbance
- ☐ Response to a crime in progress
- ☐ Response to general report or call
- ☐ Welfare check
- ☐ Unknown
- ☐ Incarceration of any type (jail, prison)
- ☐ Other

Cause of law enforcement intervention (check all that apply)*

- ☐ Member committed a crime/ was engaging in criminal activity
- ☐ A domestic disturbance occurred in the member's home
- ☐ Member was a victim of a crime
- ☐ Member inappropriately contacted emergency numbers
- ☐ Member exhibiting mental or behavioral health issues that put themselves in danger
- ☐ Member location was unknown
- ☐ Member exhibiting mental or behavioral health issues that put others in danger
- ☐ Member was experiencing medical issues or physical injury
- ☐ Other

Law Enforcement contacted?

☐ Yes ☐ N/A

Did this incident result in? (check all that apply)*

Recognizing & Reporting Location Unknown

Location Unknown
An occurrence
involving a member's
location being
unknown by staff who
are assigned protective
oversight.

Approximately how long was the member's location unknown?*

Kind of Location unknown (check all that apply)*

- ☐ Member cannot be located or contacted during times when protective oversight should be provided
- ☐ Member left programming/services against court orders or professional advice
- ☐ Other

Cause of the location being unknown (check all that apply)*

- ☐ Inadequate staffing to provide protective oversight to all members as outlined in their plans
- ☐ Member plan did not adequately address protective oversight needs or supervision not previously identified as a risk for the member.
- ☐ Staff not present when/where expected (i.e. did not arrive to work on time; left during shift; was sleeping when sleeping is not permitted per agency policy or member need)
- ☐ Staff not properly trained on member's plan.
- ☐ Monitoring/Supervision technology failure (i.e. cell phone, GPS, overnight monitoring system)
- ☐ An incident or triggering event occurred resulting in the member's location being unknown.
- ☐ Redirection, de-escalation, and/or monitoring/supervision plan was unsuccessful to prevent the incident.
- ☐ Member not present when/where expected (i.e. did not return to protective oversight at an agreed upon time)
- ☐ Other

Did this incident result in? (check all that apply)*

- ☐ Emergency room visit
- ☐ Admission to hospital
- ☐ Urgent care visit
- ☐ Treatment from emergency medical technician (EMT)
- ☐ Consultation with poison control, an on-call medical professional, crisis line, or similar service.
- ☐ N/A

Recognizing & Reporting Death

Death

The death of a member for any reason.

Cause of death (check all that apply)**

- ☐ On long illness or chronic health problem
- ☐ Homicide
- ☐ Sudden or unexpected illness or injury
- ☐ Medication error
- ☐ Other natural causes
- ☐ Unknown
- ☐ Suicide
- ☐ Other

Was the death unexpected?*

- ☐ Yes ☐ No

Was the death preventable?*

- ☐ Yes ☐ No ☐ Unknown

Was an autopsy requested? *

- ☐ Yes ☐ No ☐ Pending ☐ Unknown

Was an autopsy performed?*

- ☐ Yes ☐ No ☐ Pending ☐ Unknown

Recognizing & Reporting Use of Restraint

Use of Restraint

An occurrence
involving the use of a
restraint of any type.

Incident Type*

- ☐ Authorized (meaning the use of the restraint is or was at the time of its use, authorized by the member or the member's representative and their IDT and justified in the member's person-centered plan)
- ☐ Unauthorized

Kind of restraint (check all that apply)*

- ☐ Physical restraint, intervention, hold, or management technique (any direct contact used to control acute, episodic behavior which is intended to prevent, restrict, or subdue movement of the member's body, or part of the body).
- ☐ Chemical restraint (a medication administered to control behavior, restrict freedom of movement, or sedate the member that is not a standard treatment for the member's medical or psychiatric condition. This does not include as needed medications that the member requests or self-administers as part of their symptom management plan.)
- ☐ Isolation or seclusion (involuntary confinement to any room or area where the member is physically prevented from having contact with others, is not free to leave the room or area or believes they are not free to leave.)
- ☐ Mechanical restraint (mechanical intervention that is used to control acute, episodic behavior and is a device to prevent, restrict or subdue movement or function of the member's body, or part of the body).
- ☐ Other

Cause of restraint (check all that apply)*

- ☐ Redirection, de-escalation or non-aversive techniques were unsuccessful to prevent the incident.
- ☐ Aggression by the member to another person or property that could not be managed using non-aversive methods.
- ☐ Self-harm/self-injurious behavior that could not be managed using non-aversive methods.
- ☐ Emergency mental health crisis that could not be managed using non-aversive methods.
- ☐ Staff not properly trained on the member's plan.
- ☐ Member's plan did not adequately address behavioral intervention techniques to prevent the incident.
- ☐ Unknown
- ☐ Other

Did this incident result in? (check all that apply)*

- ☐ Emergency room visit
- ☐ Admission to hospital
- ☐ Urgent care visit
- ☐ Treatment from emergency medical technician (EMT)
- ☐ Consultation with poison control, an on-call medical professional, crisis line, or similar service.
- ☐ N/A

Recognizing & Reporting Medical Treatment

Medical Treatment
An occurrence
requiring medical
treatment for the
member.

Kind of medical treatment (check all that apply):*

- ☐ Emergency room treatment
- ☐ Admission to a hospital
- ☐ Treatment from an emergency medical technician (EMT)
- ☐ Urgent care treatment
- ☐ Other

Cause of medical treatment (check all that apply):*

- ☐ Previously known, long-term medical condition or issue.
- ☐ Previously unknown or new long-term medical condition or issue.
- ☐ Acute medical condition or issue.
- ☐ Physical injury
- ☐ Unknown
- ☐ Other

Did this incident result in? (check all that apply)*

- ☐ Emergency room visit
- ☐ Admission to hospital
- ☐ Urgent care visit
- ☐ Treatment from emergency medical technician (EMT)
- ☐ Consultation with poison control, an on-call medical professional, crisis
- ☐ N/A

Reporting Dates Correctly: Incident Date vs. Discovery Date

Incident Date

- ▶ The occurrence date is the date the incident actually happened—to the best of the reporter's knowledge.

Discovery Date

- ▶ The discovery date is the date the required reporter first becomes aware that the incident occurred.

Selecting the Member's Program



Select the programs for which the member is enrolled **at the time the incident is reported.**

Only select one waiver as a member may only be enrolled on one waiver at a time.

You may select one waiver in combination with Habilitation.

If “TCM (Non-Waiver)” or “MFP” is checked, all other service program options are disabled.

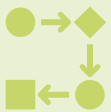
Effectively Reporting Root Cause



Root cause is the initiating event or issue that led to the occurrence (critical incident).



Also known as the “antecedent” or “core issue”.



The highest-level cause in the chain of events—not just what happened, but why it happened.

Root Cause Analysis

Example:

- ▶ A member experiences an occurrence resulting in physical injury requiring (physician's) treatment or admission to a hospital.

Why? Member broke their arm.

Why? The member fell.

Why? They tripped on their front steps while entering their house.

Why? They couldn't see the steps clearly and were not holding the railing.

Why? They were carrying groceries.

Common Root Cause Errors

Writing “Unknown”
or “N/A”

Listing only what
happened—not why

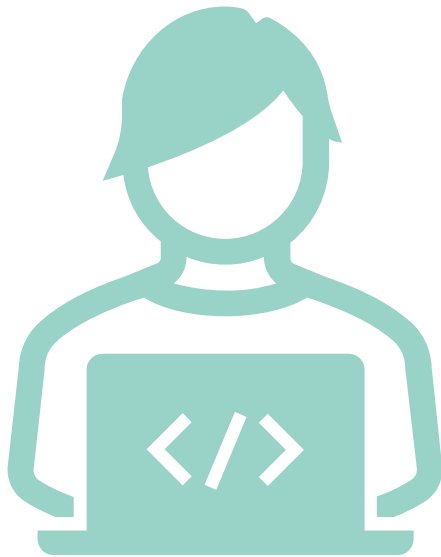
Providing a
superficial cause
(“member fell”)

Giving a cause
unrelated to the
incident type

Entering random
characters just to
complete the field

Root cause
narrative that
contradicts the
selected “kind” or
“cause”

Incident Descriptions



Be detailed.



Be factual.



Be specific.



Be consistent.

Identifying Responsible Provider



Allows the reporter to make a distinction between the organization that reports an incident and the organization that is actually responsible for the member at the time of the incident.

There may be situations when the provider organization responsible for the member at the time of the incident is the same as the reporting party and times when they are different.

There may be situations when there was no provider organization responsible for the member at the time of the incident.

Responding to Critical Incidents

Immediate Resolutions

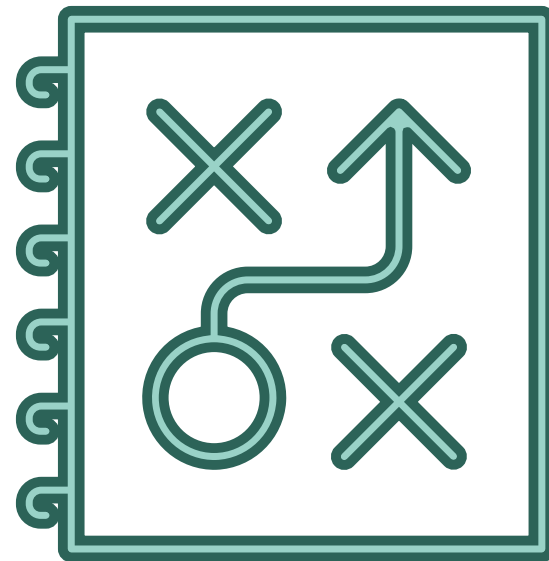
Action taken immediately following the incident of discovery of the incident to ensure the member's immediate safety and to initially resolve the situation.



Responding to Critical Incidents

Long-Term Remediation

Long-term remediation is action that will be taken/has been taken to prevent future similar incidents from occurring to the extent possible.



Tracking and Trending

Provider Responsibilities for Tracking, Trending, & Remediation



Maintain a centralized incident tracking system for all minor and critical incidents.



Review incidents regularly to identify patterns and emerging risks.



Incorporate incident tracking and trending into the agency's Quality Improvement (QI) plan.



Analyze trends across members, programs, shifts, locations, staff performance, and environmental factors.



Address negative trends with appropriate follow-up, including staff training, policy updates, process changes, or environmental improvements.



Communicate relevant patterns to the IDT when they affect individual member safety or support needs.

IDT Responsibilities for Member-Level Follow-Up

Review	Review incident patterns for individual members.
Determine	Determine whether incidents signal changes in needs, risks, or supports.
Update	Update the member's PCSP, risk assessments, or support strategies when needed.
Coordinate	Coordinate follow-up actions across all team members.
Ensure	Ensure prevention strategies are person-centered and implemented.

Incident Quality Assurance Activities

Errors and Corrections

QA Activities

MCO & QIO (for FFS Members)

What Reporters Can Expect

- MCO (managed care) and QIO (FFS) conduct QA reviews on all CIRs.
- They monitor for:
 - Errors or missing information
 - Incorrect incident types
 - Trends and patterns
 - Timeliness issues
- Corrections are sent through the CIR Management System; the reporter must complete them.
- Some fields (e.g., member identifying information) cannot be corrected—CIR must be deleted and resubmitted.

QA Projects That Identify Unreported Incidents

What Reporters Should Know

- The MCO and QIO complete routine projects to identify potentially unreported incidents.
- If an unreported incident is identified, the reporter may be asked to complete a CIR.
- The reporter should cooperate with CIR submission when contacted.



We did it!

Today, We...

Recognized critical incidents and distinguished between each incident type.

Reported incidents accurately, completely, and within required timelines, using correct occurrence and discovery dates.

Identified and documented all key reporting elements, including incident details, responsible providers, root cause, immediate resolution, and long-term remediation.

Responded appropriately by separating immediate actions from long-term remediation and understanding when to involve the IDT.

Collaborated effectively with the IDT to address member-specific patterns, update plans, and support improved outcomes.



Health and
Human Services

Questions

Michele Baughan, HCBS Senior Operations Manager, Iowa
Medicaid's Quality Improvement Organization (QIO)

Lisa Roush, HCBS Incident & Complaint Specialist, Iowa
Medicaid's QIO

Thank You for Attending

Additional Questions & Assistance

LTSS/HCBS Iowa – Training Technical Assistance (TTA)

- **Email:** HCBSTTA@hhs.iowa.gov
- **Phone:** 515-325-1557
- Please Allow up to **2 Business Days** for a Response

Upcoming CBTs

- **Root Cause Analysis (RCA)**
 - Thursday 11/12, 1:00 – 3:00pm
- **New - CCO 101: Getting Started with the Consumer Choice Option**
 - Tuesday 11/24, 12:30 – 2:00pm
- **Listening Beyond Words: Understanding and Supporting Diverse Communication Styles**
 - Thursday 12/3, 1:30 – 3:30pm
- **Foundations of Caring for Youth with Complex Behavioral Support Needs**
 - Thursday 12/17, 1:30 – 3:30pm