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**DEPT. OF HEALTH AND HUMAN SERVICES** 

# Incident Reporting AD and TBI



#### Agenda

**Introduction to the Liberty Critical Incident Management Team** 

**Entering/approving Incident Reports and Required Notifications/Timelines** 

**Liberty Quality Review Process** 

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#### MEET THE CRITICAL INCIDENT TEAM









**Betty Smith** 

Susan Mackstaller

Rosie Newell

**Tammy Coffey** 

Role: Incident Manager

Role: Incident Specialist

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#### MEET THE CRITICAL INCIDENT TEAM









Jennifer Montag

Keesha Godel

**Erin Davis** 

Tara Balvin

Role: Incident Specialist

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Role: Administrative Assistant



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## **Entering and Approving Incident Reports Required Notifications and timelines**

\*This is process Training. Therap training is posted to the website and more will be coming.





#### **Purpose**

Intended for all Providers of Medicaid Home and Community Based Waiver Services (HCBS) through the AD and TBI Waivers

- Outlines who is responsible for reporting incidents
- Provides timelines for required reporting
- Only covers incidents that must be reported to the Division of Developmental Disabilities (DDD), in Therap, Via General Event Report (GER)

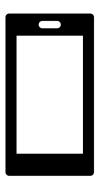
Definitions will be presented at a later meeting





#### Who is Responsible for Reporting Incidents?





Service Providers both Agency and Independent are responsible for reporting incidents to Services Coordination as well as entering a General Event Report (GER) into Therap.



#### **Reporting Requirements**



| Required Notification/                                                                                                           | How Notification/Report is                                                                                                                         | Required Timeframe for                                                                                  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--|--|--|
| Report                                                                                                                           | Completed                                                                                                                                          | Notification/Report                                                                                     |  |  |  |
| participant's Service Coordinator (SC)                                                                                           | Phone call/voicemail  **If unable to reach SC by phone and unable to leave voicemail, notification can be made by secure email or SCOMM in Therap. | As soon as possible but no more than 4 hours after observing or discovering the reportable incident     |  |  |  |
|                                                                                                                                  | **Do <b>not</b> use text messages, as it is not secure communication.                                                                              |                                                                                                         |  |  |  |
| Verbal notification to the participant's legal representatives(s)                                                                | Phone call/voicemail  **When the provider cannot reach the legal representative, a voicemail is                                                    | Preferred: As soon as possible upon observing/discovering the incident Required: Within 24 hours of the |  |  |  |
| **Only applicable when participant has a legal representative.                                                                   | sufficient to meet notification requirements.                                                                                                      | verbal report to the SC                                                                                 |  |  |  |
| **When there are multiple legal representatives, at least 1 must be notified, and provider must attempt to notify all guardians. | **When the provider cannot<br>reach/leave a voicemail for the<br>guardian, all attempts are recorded in<br>the GER.                                |                                                                                                         |  |  |  |
| Verbal notification to the participant                                                                                           | In person                                                                                                                                          | Preferred: As soon as possible upon observing/discovering the incident                                  |  |  |  |
| **Not applicable when the participant was present or is aware of the incident.                                                   | **Document any contact/non-contact within the GER.                                                                                                 | Required: Within 24 hours of the verbal report to the SC                                                |  |  |  |
| Written report to DDD – All incidents identified in this guide                                                                   | GER submitted in Therap                                                                                                                            | Within 24 hours of the verbal report to the SC                                                          |  |  |  |





#### Verbal Notification to the Participant's Service Coordinator

When making the verbal report to the participant's Service Coordinator, the provider must give **all** the following information:

- The name of the person making the verbal report and the provider agency they work for (when applicable)
- The Participant's name
- The type of incident being reported
- A brief summary of the incident
- A brief summary of any action taken immediately to ensure the safety of the participant and others

Must occur within 4 hours of Observation/Discovery of the incident via phone call or voice mail.





### Verbal Notification to the Participant's Legal Representative(s) or Power of Attorney if applicable

- Phone Call/Voicemail
  - A voicemail can be left when the provider cannot reach the guardian.
  - If the provider cannot reach the guardian via phone and cannot leave a voicemail, the provider needs to document all attempts in the GER.
  - Required timeline for Notification/Report is within 24 hours of the notification to the Service Coordinator.

Legal Representatives include but are not limited to: Full/Partial Guardians, Power of Attorney, Conservator, Representative Payee, etc.

A person recognized by law with respect to another's property or interest.





#### **Verbal Notification to the Participant**

- In person notification/report
  - Document any contact/non-contact within the GER
- Required timeline for Notification/Report is within 24 hours of verbal report to Service Coordinator



#### **Abuse Neglect, or Exploitation Reports**



When an incident involves suspected or alleged abuse, neglect, or exploitation, the provider must immediately report the incident to law enforcement or the DHHS Children and Family Services Abuse and Neglect Hotline at:

1-800-652-1999

The hotline is toll-free and is available 24 hours a day, 7 days a week.

All providers of HCBS services are mandatory reporters of abuse, neglect, and exploitation.



#### **Therap General Event Report (GER)**





| Basic Information                          |                                         | ٦ |
|--------------------------------------------|-----------------------------------------|---|
|                                            |                                         | l |
| Individual                                 | JOHN SMITH                              |   |
| Program                                    |                                         |   |
| Site                                       |                                         |   |
| * Event Date                               | <b>=</b>                                |   |
| * Report Date                              | · =                                     |   |
| * Reported By                              |                                         |   |
| ,                                          | •                                       |   |
| * Reporter's Relationship to<br>Individual | - Please Select - ▼                     |   |
| Event Basics                               |                                         |   |
| * Event Type                               | ○ Injury                                |   |
|                                            | Medication Error                        |   |
|                                            | Emergency Safety Intervention           |   |
|                                            | Restraint Other                         |   |
|                                            | O Death                                 |   |
|                                            | Other                                   |   |
| * Notification Level                       | - Please Select -                       |   |
| Location                                   | - Please Select - ▼                     |   |
| Address                                    | Street 1 Street 2                       |   |
|                                            | City ZIP State ✓ USA →                  | 7 |
|                                            |                                         | J |
| Phone                                      | Phone                                   |   |
| Fax                                        |                                         |   |
|                                            | Fax                                     |   |
| Describe what happened                     |                                         |   |
| before the event                           |                                         |   |
|                                            |                                         |   |
|                                            |                                         |   |
|                                            |                                         |   |
|                                            | About 3000 characters left              |   |
| Abuse/Neglect/Exploitation                 |                                         |   |
| * Abuse Suspected?                         | ○ Yes ○ No                              |   |
| * Neglect Suspected?                       | ○ Yes ○ No                              |   |
| * Exploitation Suspected?                  | ○ Yes ○ No                              |   |
| promanon outpotted:                        | - · · · · · · · · · · · · · · · · · · · |   |

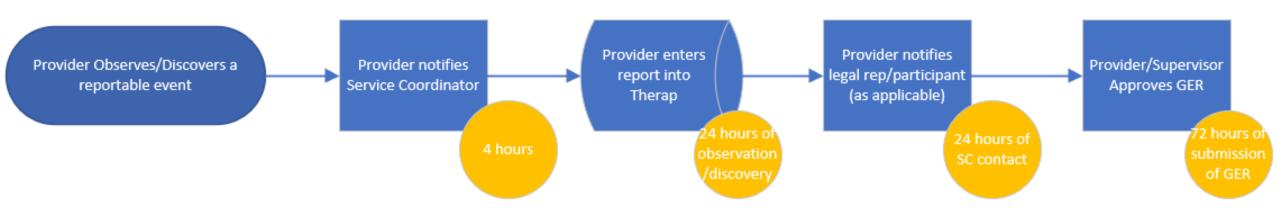
| vent Injury                                  |                                                                  | ?               |
|----------------------------------------------|------------------------------------------------------------------|-----------------|
| * Time of Injury                             | hh:mm a 💮                                                        |                 |
|                                              | Unknown                                                          |                 |
| * This event was                             | Observed Discovered                                              |                 |
| Discovered Date/Time                         | MM/DD/YYYY   iii hh:mm a   iii iii iii ii ii ii ii ii ii ii ii i |                 |
| Specific Location                            | - Please Select -  ▼                                             |                 |
| * Туре                                       | - Please Select -                                                |                 |
| * Cause                                      | - Please Select -                                                |                 |
| * Severity                                   | - Please Select -                                                |                 |
| Color                                        | - Please Select -                                                |                 |
| Size                                         | Length (cm) Width (cm)                                           | Depth (mm)      |
| * Body Part(s)                               | - Please Select                                                  | - Please Select |
|                                              | Body Diagram                                                     |                 |
| Treatment by                                 | - Please Select -                                                |                 |
| Time of Treatment                            | hh:mm a 💮                                                        |                 |
| Treatment date, if different than event date | MM/DD/YYY                                                        |                 |
| Injury Photo                                 | Add Image                                                        |                 |
| tions Taken                                  |                                                                  |                 |
| Corrective Actions Taken                     |                                                                  |                 |
|                                              |                                                                  |                 |
|                                              |                                                                  |                 |
|                                              | About 3000 characters left                                       |                 |
| Plan of Future Corrective<br>Actions         |                                                                  |                 |
|                                              |                                                                  |                 |
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| tification(s)                                | ADOUG SOUT CHARACTERS TOLL                                       |                 |



#### **Liberty Quality Review Process**

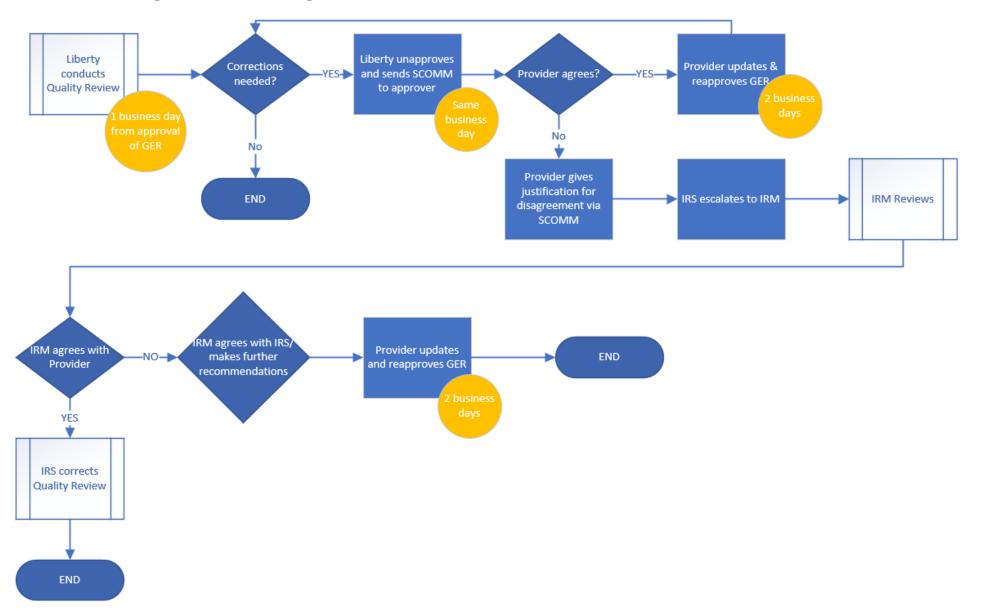


#### **Provider Reporting Process**



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#### **Liberty Quality Review Process**





#### **Upcoming Trainings & Resources**

November 8, 2022 – High-Level Reportable Incident Definitions & How to Respond

November 29, 2022 – Medium-Level Reportable Incidents Definitions & How to Respond Part 1

<u>December 6, 2022</u> – Medium-Level Reportable Incidents Definitions & How to Respond Part 2

Ongoing Therap Trainings and Communication: Please subscribe for updates:

- https://dhhs.ne.gov/Pages/AD-Provider.aspx
- https://dhhs.ne.gov/Pages/Liberty-Partnership-Quality-Project.aspx



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### Questions?

**Email:** 

NeGERHelp@libertyhealth.com