Adverse Event Report (AER) Form

INSTRUCTIONS: Use this form to report any type of adverse event (AE) occurred in home and community settings paid by a QUEST Integration health plan. Please print clearly and legibly without using cursive writing.

If member resides in a Community Care Foster Family Home (CCFFH), Expanded-Adult Residential Care Home (E-ARCH), or Assisted Living Facility (ALF), the contract provider (or Member's caregiver) must report the AE to the Community Case Management Agency (CCMA) or the Case Manager (CM) and sections A and B shall be completed. If Members reside in their own home or are homeless, then the Member, a witness, or other contract provider must report to the Health Plan (HP) and Health Coordinator (HC), get a copy of this AER form, complete sections A and C and return to the Health Plan.

Reporting Timelines for members residing in CCFFH, E-ARCH, or ALF:

1. Contract Provider to give verbal report to CCMA within 24 hours of the AE.
2. Contract Provider to complete AER Form Section A and submit to CCMA within 72 hours of the event, excluding weekends and holidays, following the verbal report.
3. CCMA to send a copy of the completed Section A and Section B to HP within 72 hours after CCMA receives Section A from the Contract Provider, excluding weekend and holidays.

Section A: To be completed by the Contract Provider or other AE reporter (i.e., Member, witness, or HC receiving the verbal report).

1. Name of reporter: _____ Phone number: _____
   Relationship to the Member: _____
2. Source of AE, if other than #1: _____
3. Date AE occurred (MM/DD/YYYY): _____ Time AE occurred (24-hour scale): _____
4. Member name (First Name, Middle Initial, Last Name): _____ Date of birth (MM/DD/YYYY): _____
5. Medicaid (HAWI) ID number: _____
6. AE description (Include all relevant information including answers to i) What happened? ii) Why did it happen? iii) How did it happen? iv) Who is/are involved?):

7. Setting name:
   - ☐ 01 = Member's residence
   - ☐ 02 = Community
   - ☐ 03 = Provider's clinic, specify: _____
   - ☑ 04 = Other, specify: _____
8. AE perpetrator, if applicable: ☐ Member ☐ Other, specify: _____ ☐ N/A ☐ Unknown
9. Med-QUEST Provider ID number: _____

10. The AE led to: a) ER visit ☐Yes ☐No
    b) Hospitalization or inpatient facility stay ☐Yes ☐No

11. Action steps as a result of this AE, if any:

12. AE reported to: ☐ APS ☐ CPS ☐ CTA ☐ Police ☐ CCMA ☐ Other, specify: _____
    Date reported (MM/DD/YYYY): _____
13. Signature of reporter: _____ Date: _____

Section B: To be completed by the CCMA/CM.

1. CCMA name: _____
2. CM name: _____
3. Name, phone number, and physical address of residential provider/setting, if applicable:
   _____
4. Date and time AE verbal report received (MM/DD/YYYY, 24-hour scale):
   _____
5. Date and time AE written report received (MM/DD/YYYY, 24-hour scale):
   _____
   Reports received within required timeframes: Verbal - ☐ Yes ☐ No Written - ☐ Yes ☐ No
6. AE Type: ☐ 01 = Medication-related ☐ 02 = Treatment-related ☐ 03 = Neglect
   ☐ 04 = Abuse ☐ 05 = Suicide/suicide-attempt ☐ 06 = Exploitation
   ☐ 07 = Fall/fall-related injury ☐ 08 = Elopement/missing person ☐ 09 = Restraint/seclusion
   ☐ 10 = Insect infestation ☐ 11 = Healthcare-acquired infection
   ☐ 12 = Healthcare acquired condition ☐ 13 = Other, specify:
   _____
7. Harm Level: ☐ Unsafe condition or near miss ☐ No harm ☐ Harm ☐ Death
8. Root-cause analysis (RCA) completed. ☐ Yes ☐ No
9. Contributing factor(s) (must complete if "yes" is checked to question #8):

10. Was AE related to a service that was: ☐ Denied ☐ Refused ☐N/A
    Specify: _____
11. Were the immediate action steps taken appropriate to safeguard the member? ☐ Yes ☐ No
    If no, list remediation plan:

12. Was a site visit conducted by CM? ☐ Yes ☐ No
    If yes, site visit date (MM/DD/YYYY):_____

Site visit recommendation or action steps, if any:

13. AE Reported to: ☐ APS ☐ CPS ☐ CTA ☐ QI HP ☐ Police ☐ Other, specify: _____
14. CM Signature: _____ Date: _____

Submit copy to appropriate Health Plan:

AlohaCare: Upload via the provider portal: Alohacare.org >Providers>Forms >General Forms>Adverse Event

HMSA: Fax to 808-944-5604

Kaiser: Email to Emily Kauha'aha'a: Emily.ch.kauhaahaa@kp.org, Bernadette Cabilao: Bernadette.R1.cabilao@kp.org

Ohana: Email to Ohana-HPQM_Dept@centene.com

United HealthCare: Email to reportaconcern@uhc.com

Section C: To be completed by the HP HC.

1. HP name: 'Ohana Health Plan
2. HC name: _____
3. Date and time verbal report was received (MM/DD/YYYY, 24-hour scale):
   _____
4. Date and time written report was received (MM/DD/YYYY, 24-hour scale):
   _____
5. AE Type: ☐ 01 = Medication-related ☐ 02 = Treatment-related ☐ 03 = Neglect
   ☐ 04 = Abuse ☐ 05 = Suicide/suicide-attempt ☐ 06 = Exploitation
   ☐ 07 = Fall/fall-related injury ☐ 08 = Elopement/missing person ☐ 09 = Restraint/seclusion
   ☐ 10 = Insect infestation ☐ 11 = Healthcare-acquired infection
   ☐ 12= Healthcare-acquired condition ☐ 13 = other, specify:
   _____
6. Harm Level: ☐ Unsafe condition or near miss ☐ No harm ☐ Harm ☐ Death
7. Root-cause analysis (RCA) conducted: ☐ Yes ☐ No
8. Contributing factor(s) (must complete if "yes" is checked to question #7: _____
9. Was AE related to a service that was: ☐ Denied ☐ Refused ☐N/A
   Specify: _____
10. Were the immediate action steps taken appropriate to safeguard the member? ☐ Yes ☐ No
    List remediation plan, if any:
11. Was a site visit conducted by HC? ☐ Yes ☐No
    If yes, site visit date (MM/DD/YYYY): _____
    Site visit recommendation or action steps, if applicable:

12. Similar AE in this setting: ☐ Yes ☐ No

13. Similar AE to this member: ☐ Yes ☐ No
14. Are there any mitigating factors identified? ☐Yes ☐No ☐N/A
15. Describe mitigating factors identified:

16. AE Reported to: ☐ APS ☐ CPS ☐ CTA ☐ Police ☐ Other, specify: _____
17. HC Signature: _____ Date: _____