

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
SERIOUS INCIDENT REVIEW COMMITTEE QUARTERLY REPORT
BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

INSTRUCTION: To be completed by the Health Care Integration Agency (HCIA) and submitted to the Bureau of Wavier Management two weeks following the end of each quarter. Attach additional sheets if necessary.

HEALTH CARE INTEGRATION AGENCY REPRESENTATIVE:	HEALTH CARE INTEGRATION AGENCY SIGNATURE: X	DATE:
HEALTH CARE INTEGRATION NAME:		
HEALTH CARE INTEGRATION ADDRESS:	CITY:	STATE: ZIP CODE:

Quarterly report dates <i>(Check one only):</i>	1st Quarter January-March <input type="checkbox"/>	2nd Quarter April – June <input type="checkbox"/>	3rd Quarter July – September <input type="checkbox"/>	4th Quarter October- December <input type="checkbox"/>
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SECTION 1	<p>1. QUARTERLY SUMMARY: Record the number of serious incidents under review during this quarter.</p> <p>2. Identify any trends in Serious Reportable Incidents: _____</p> <p>_____</p> <p>_____</p>
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Complete the following for EACH Closed Serious Reportable Incidents during the quarter.

SECTION 2	<p>1. Report # (from Serious Reportable Incident form, OCFS-8021) :</p> <p>2. Was the Committee's response and that of any involved Waiver Service Provider thorough and complete? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments:</p> <p>_____</p> <p>3. Was the final recommendation and action taken sufficient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Comments:</p> <p>_____</p> <p>4. Was the final recommendation in line with best clinical practice? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Comments:</p> <p>_____</p> <p>5. Is there a need for recommendations for changes that may prevent or minimize reoccurrence of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments:</p> <p>_____</p> <p>6. Were there any identified preventive or disciplinary actions as a result of this Serious Reportable Incident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments:</p> <p>_____</p>
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Complete the following for EACH Closed Serious Reportable Incidents during the quarter. (use for each additional incident).

SECTION 2 Continued	1. Report # (from Serious Reportable Incident form OCFS-802 1):	
	2. Was the Committee's response and that of any involved Waiver Service Provider thorough and complete?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Comments:	
	3. Was the final recommendation and action taken sufficient?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	Comments:	
	4. Was the final recommendation in line with best clinical practice?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	Comments:	
	5. Is there a need for recommendations for changes that may prevent or minimize reoccurrence of the incident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Comments:	
	6. Were there any identified preventive or disciplinary actions as a result of this Serious Reportable Incident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Comments:	