NEW YORK STATE | Office of Mental Health | Office of Addiction Services and Supports

Community Oriented Recovery and Empowerment (CORE) Services
&
Adult Behavioral Health Home and Community Based Services (BH HCBS)

Incident Reporting & Management Guidance

12/13/21

This document is intended to provide guidance on incident management and reporting for CORE Services and Adult BH HCBS Designated Providers.

Note: Although much of this document follows requirements included in 14 NYCRR Parts 524 and 836, unlicensed providers must follow this document to ensure all mandates are met.

Community Oriented Recovery and Empowerment (CORE) Services and Adult Behavioral Health Home and Community Based Services (BH HCBS) are an unlicensed/uncertified service type and therefore not subject to Title 14 NYCRR Parts 524 or 836. Adult BH HCBS and CORE Services designated providers are required to comply with the incident reporting and management requirements as delineated herein.

I. PURPOSE

The mission and vision of the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) is based on values that promote resiliency, hope, respect, recovery, positive social and emotional development, and an environment free from fear, pain, injury or danger. OMH and OASAS have created safeguards for those served by systems under its jurisdiction, to protect individuals against abuse, neglect, and other dangerous conduct. This includes the ability to review, monitor, and address instances of harm that pose a risk to the health, safety and welfare of an individual receiving services.

This guidance is intended to assist providers in understanding and complying with requirements set forth by the CORE Operations Manual and CORE Services Provider Attestation. This guidance further establishes new incident management and reporting guidelines for Adult BH HCBS designated providers. It explains definitions for reportable incidents and describes steps for reporting to the designated provider's host agency.

II. EFFECTIVE DATE & COMPLIANCE

This guidance is effective immediately for all designated and provisionally designated providers of CORE Services and Adult BH HCBS. Providers may continue to work under existing policies and procedures regarding incident reporting and management while completing systems and training requirements outlined below. Full compliance with this guidance is expected by no later than August 1, 2022. Failure to comply with this guidance on or after August 1, 2022 may result in a termination of the providers designation status under BH HCBS and/or CORE Services.

III. DEFINTIONS

Definition of key terms as used in this guidance:

- ***Custodian*** this term refers to those that have a legal obligation to protect individuals receiving services from harm while they are under their care (or the care of the provider they work for). In the OMH/OASAS system, the following would be considered a "custodian" – a director, employee, or volunteer of a provider designated by OMH/OASAS, or a consultant or contractor with an OMH /OASAS designated provider who has regular and substantial contact with persons served by the provider.
- ***Discovery*** is a term used to identify when a mandated reporter must report an incident. An incident is "discovered" at the time a mandated reporter witnesses a reportable incident, or when another person provides a mandated reporter with

information that gives him/her reasonable cause to suspect a reportable incident has occurred.

- ***Individual (receiving services)*** refers to a HARP member admitted to Adult BH HCBS or CORE Services. For the purposes of this guidance, an individual is considered 'admitted' to Adult BH HCBS or CORE Services upon the initial face-to-face (including telehealth) session with the service provider and until discharge.
- ***First Aid*** refers to one-time treatment, and any follow up, of minor injuries which do not ordinarily require medical care such as, minor scratches, cuts, burns, or other.
- ***Likely to result in injury or harm*** means that the injury or harm is probable or the expected result of the particular conduct.
- ***Mandated Reporter*** means someone who is required to report suspected abuse or neglect of vulnerable persons, as well as "significant incidents", to OMH immediately upon discovery. All Adult BH HCBS and CORE Services staff are mandated reporters.
- ***NIMRS*** refers to the New York State Incident Management and Reporting System, developed and maintained by OMH.
- ***Physical Injury*** means any confirmed harm, hurt, or damage resulting in significant worsening or diminution of a vulnerable person's physical condition.
- ***Reasonable cause to suspect*** means that, based on a mandated reporter's observations of evidence, professional training, and experience, her or she has a rational or sensible suspicion that a vulnerable person has been harmed or placed in danger of being harmed.
- ***Reasonably foreseeable potential*** means that a reasonable person would be able to predict or anticipate that his or her conduct would result in harm or injury to a vulnerable person. It does not mean that given the circumstances involved, it is reasonable or realistic to expect that, likely or not, it would.
- ***Restraint*** means the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.
- ***Serious Injury or Harm*** means: (1) physical injury or harm that requires more than first aid; (2) psychological harm evidenced by negative change in behavior or change in psychotropic medication or intervention; (3) a risk for life threatening physical injury or psychiatric emergency or trauma.
- ***Serious or protracted impairment of the physical, mental, or emotional condition*** means a state of substantially diminished physical, psychological, or intellectual functioning in relation to, but not limited to, such factors as failure to thrive, control of aggressive or self-destructive impulses, or ability to think or reason.
- ***Patient Advocacy*** *for purposes of this document* refers to the OASAS point of contact for the reporting of incidents and ensuring compliance with applicable laws, rules and regulations issued by OASAS.

IV. INCIDENT REPORTING

CORE Services and Adult BH HCBS are unlicensed/uncertified and therefore are not subject to the Justice Center's jurisdiction. For OMH-hosted providers, Adult BH HCBS and CORE Services incidents must be reported to OMH only. Such reporting is done through the NYS Incident Management Reporting System (NIMRS), a secure, web-based, quality management tool. For OASAS-hosted providers, Adult BH HCBS and CORE services

incidents must be reported to OASAS only. Such reporting is done by contacting Patient Advocacy. Additional information regarding how to report incidents is found in sections V and VI of this guidance.

V. INCIDENT CATEGORIES

Reportable Incidents

Allegations of Abuse and Neglect, as defined below, must be reported to the designated provider's Host Agency (OMH or OASAS) *regardless of severity*.

Allegations of Abuse and Neglect: An allegation of abuse or neglect must involve an act (or failure to act) by a custodian that causes or was likely to result in, injury or harm to an individual receiving services. All allegations of abuse or neglect must be reported to OMH or OASAS. This category includes: Physical Abuse, Psychological Abuse, Sexual Abuse, Neglect, Restraint/Seclusion, Obstruction of Reports of Reportable Incidents, Unlawful Use or Administration of a Controlled Substance, and Aversive Conditioning.

Definitions of Abuse and Neglect

Incident Type	*Definition*
Physical Abuse	Intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental, or emotional condition of an individual receiving services or causing the likelihood of such injury or impairment; such conduct may include, but is not limited to slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, or the use of corporal punishment, provided, however, that it shall not include reasonable emergency interventions necessary to protect the safety of any person.
Psychological Abuse	Intentionally or recklessly causing, by verbal or nonverbal conduct, a substantial diminution of an individual receiving services emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker, or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include, but shall not be limited to, intimidation, threats, the display of a weapon or other object that could reasonably be perceived by an individual receiving services as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments, or ridicule.

Sexual Abuse	Conduct that subjects an individual receiving services to any offense defined in Article 130 (sex offenses) or Section 255.25 (incest, 3rd degree), 255.26 (incest, 2nd degree), or 255.27 (incest, 1st degree) of the Penal Law, or any conduct or communication that allows, permits, uses or encourages an individual to engage in any act described in Articles 230 (prostitution offenses) or 263 (sexual performance by a child) of the Penal Law.
Neglect	Any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of an individual receiving services. Neglect shall include, but is not limited to: (1) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse if committed by a custodian; and (2) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, provided that the custodian has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from appropriate individuals.
Restraint or Seclusion	Any use of restraint or seclusion.
Obstruction of Reports of Reportable Incidents	Conduct that impedes the discovery, reporting or investigation of treatment of an individual receiving services by falsifying records related to safety, treatment or supervision of an individual, actively persuading a Mandated Reporter from making a report of a reportable incident to the Statewide Vulnerable Persons' Central Register with the intent to suppress the reporting or the investigation of an incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report in accordance with OMH or OASAS policies and procedures; intentional failure of a supervisor or manager to act upon such a report, or failure by a Mandated Reporter to report a reportable incident upon discovery
Unlawful Use or Administration of a Controlled Substance	Any administration to a patient of a controlled substance (e.g., codeine, Oxycontin, Ambien, cocaine, etc.), as defined by article 33 of the Public Health Law without a lawful prescription, or other medication not approved for any use by the Federal Food and Drug Administration, and/or unlawful use or distribution of a controlled substance as defined by article 33 of the Public Health Law at the workplace or while on duty.

Aversive Conditioning	The use of unpleasant physical stimulus to modify behavior. ANY use of aversive conditioning is prohibited in facilities/agencies/programs under the jurisdiction of OMH.

Significant Incidents: Significant Incidents are incidents that occur on program premises or when an individual was under the actual or intended supervision of a custodian when the event occurred. These include any incident that, because of the severity or the sensitivity of the situation, results in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of an individual receiving services. Significant incidents do not include those incidents defined as abuse and neglect when committed by a custodian.

In order for a "significant incident" to be reportable, the level of harm must meet the level of "serious injury or harm" unless otherwise indicated in the chart below.

Significant Incidents Reportable to OMH and OASAS

Incident Type	*Definition*
Sexual Assault	A sexual attack including, but not limited to, those that result in vaginal, anal, or oral penetration (i.e., rape or attempted rape and sodomy or attempted sodomy, and/or any sexual conduct between a person who is 18 years old or more and a person who is less than 15 years old, or between a person who is 21 years old or older and a person who is less than 17 years old, or which involves an individual who is deemed incapable of consent).
Severe Adverse Drug Reaction	An unintended, unexpected or excessive response to a medication given at normal doses, which results in serious harm or injury.
Assault	A violent or forceful physical attack by a person *other than a custodian,* in which the person is either the victim or aggressor, which results in serious injury or harm.
Crime	An event which is or appears to be a crime under NYS or Federal Law, which occurs on the program premise or when a person is under the actual or intended supervision of a custodian, and which involves an individual receiving services as a victim or aggressor, or which affects or has the potential to affect the health or safety of one or more individuals of the program or has the potential to have a significant adverse impact on the property or operation of the program.
Crimes in the Community*	An event which is, or appears to be, a crime under New York State or Federal law, and which is perceived to be a significant danger to the community or which involves a person whose behavior poses an imminent concern to the community.
Fight	A physical altercation between two or more people receiving services, in which there is no clear aggressor and no clear victim, resulting in serious injury or harm.

Financial Exploitation	Uses, appropriation, or misappropriation by a custodian of a person's resources (such as, funds, assets, or property) by deception, intimidation, or similar means, with the intent to deprive the individual of those resources.
Fire Setting	Action by a person, either deliberate or accidental, that results in a fire on program premises.
Injury of Unknown Origin	An injury to a person for which a cause cannot be immediately determined because (1) the source of the injury could not be explained by the person or another person; AND (2) the injury is suspicious because of the extent or location of the injury, or the number of injuries observed at one point in time, or the frequency of the incidence of injuries over time.
Medication Error	An error in prescribing, dispensing, or administering a drug which results in serious injury or harm.
Missing subject of AOT order	*For OMH-hosted providers only:* An individual receiving services who is subject to an assisted outpatient treatment (AOT) order who fails to keep a scheduled appointment and/or who cannot be located within a 24 hour period.
Mistreatment	*For OMH-hosted providers only:* Any intentional administration to a patient of a prescription drug or over-the-counter medication which is not in substantial compliance with a physician's, dentist's, physician's assistant's, specialist's assistant's, or nurse practitioner's prescription.
Self-Abuse	Self-inflicted injury not intended to result in death that results in serious injury or harm.
Suicide Attempt*	An act committed by an individual in an effort to cause their own death.
Suicide Attempt, Off Site*	An act committed by an individual in an effort to cause their own death that occurs off program premises, when the individual receiving services was not under the actual or intended supervision of a custodian.
Verbal Aggression by Individual Receiving Services	A sustained, repetitive action or pattern by an individual or individuals of ridiculing, bullying, demeaning, making derogatory remarks, verbally harassing, or threatening to inflict physical or emotional harm on another individual(s), which causes serious injury or harm.

Wrongful Conduct	Actions or inactions on the part of a custodian that are contrary to sound judgment or training and which are related to the provision of services, the safeguarding of an individual's health, safety, or welfare, or individual rights, but which do not meet the definition of abuse or neglect, including but not limited to: (1) any non-accidental physical contact with an individual receiving services which causes minor injury or has the reasonably foreseeable potential to cause injury, provided however that this shall not include the application of restraint, when such application is necessary and performed in accordance with applicable laws and regulations, or reasonable emergency interventions necessary to protect the safety of any person; (2) intentional verbal or nonverbal conduct that is meant to cause an individual emotional distress, but which does not result in harm, or results in only minor harm, to the patient. Examples include taunting, name calling, issuing threats, using insulting, disrespectful, or coarse language or gestures directed toward an individual; violating an individual's rights or misusing authority; (3) activity of a sexual nature (physical or non-physical) involving an individual receiving services and a custodian; or activity of a sexual nature involving an individual receiving services that is encouraged by a custodian. Examples include inappropriate touching or physical contact, sending sexually explicit materials through electronic means (including mobile phones, electronic mail, etc.), voyeurism, or sexual exploitation; or (4) conduct that falls below the standards of behavior established in guidance or facility policies and procedures for the protection of individuals receiving services against unreasonable risk of harm (*e.g.*, sleeping while on duty).
Death*	*For OMH-hosted providers only:* The death of an individual receiving Adult BH HCBS or CORE Services at the time of death, including any death of an individual receiving services within 30 days after discharge from Adult BH HCBS or CORE Services.
Other	An event, other than one identified in this section, which has or creates a risk of, a serious adverse effect on the life, health, or safety of an individual receiving services.

***** *Incident must be reported regardless of resulting, perceived or actual, injury or harm OR regardless of setting, whether the event occurs while in the care of a custodian or not.*

Please note: Although Adult BH HCBS and CORE Services reporting categories follow those outlined by Incident Management Programs Regulation (Title 14 NYCRR Part 524), due to inapplicability of specific categories; the following reportable or significant incident categories have been omitted as required to be reported to OMH:

- Falls by patients in an inpatient or residential setting
- Sexual contact between children

VI. HOW TO REPORT FOR OMH-HOSTED PROVIDERS

NIMRS

NIMRS is a web-based application that is available on the browser 24 hours a day, 7 days a week. Access to NIMRS is granted through the Security Management System (SMS). Each designated provider will assign an SMS Administrator who will grant and remove access to applications such as NIMRS. For more information, please see the NIMRS FAQ. For training on the use of NIMRS, see the NIMRS Learning Center.

Reporting an Incident

Incidents are reported into NIMRS immediately upon discovery of the incident (no later than one business day).

Designated providers are responsible for incident reporting in an effective and timely manner. To ensure proper protocols and procedures are being maintained, the organization must maintain the following responsibilities:

- The designated provider is responsible for incident reporting after being made aware of an event within one business day.
- Individuals receiving services, and their guardian or personal representative when applicable, are made aware of the organization's incident reporting procedures.
    - This includes providing the individual with information on incidents that are as reportable to ensure that they inform the service provider of such incidents, as applicable.
- If the incident constitutes an emergency, employees must initiate their organization's emergency procedures and also report the incident in NIMRS.
- Providers must clearly indicate what actions took place on behalf of the organization in response to the incident including, but not limited to, contacting law enforcement, coordinating information with other related service providers, immediate resource/ support provided to the individual receiving services, assessment(s) administered and, the review and subsequent updates made to the ISP, where appropriate.

Incident Reporting Follow-up

The designated provider is responsible for investigating incidents at a level commensurate with the seriousness of the incident. The organization should be in contact with the individual receiving services to determine if there is any new information regarding the incident(s) and report this new information in NIMRS along with any action that has been taken since the initial reporting or the last follow-up, until the incident is resolved.

When providing follow-ups/updates in NIMRS, providers must clearly indicate their actions in addressing the incident and any continued actions and/ or plans to ensure the safety of the individual receiving services, where applicable.

This information should be updated in the Investigation Conclusions area on the

Investigation Findings & IRC (Investigation Review Committee) Sub Tab. For example: if an individual is reported missing, the organization will need to keep in contact with any identified collaterals and report updates in NIMRS until the individual is found. The incident should not just be entered into NIMRS and closed with no follow-up with collaterals on status of the incident.

VII. HOW TO REPORT FOR OASAS-HOSTED PROVIDERS

Patient Advocacy

Patient Advocacy is available Monday-Friday during business hours and can be reached by phone at 1-800-553-5790. Each OASAS-hosted Adult BH HCBS and CORE provider shall designate at least one staff person responsible for reporting incidents to Patient Advocacy. Such staff person shall also be responsible for the follow-up and resolution of the incident as directed by OASAS. Reporting of incidents shall be completed immediately upon the discovery of the incident or, at the latest, on the next business day, unless otherwise advised by OASAS.

Policies and Procedures for Incident Reporting

OASAS-hosted Adult BH HCBS and CORE providers shall develop policies and procedures to address incident reporting in accordance with this document and any other guidance issued by OASAS.

Providers shall designate and train staff responsible for incident reporting. Incidents shall be reported immediately or at the latest on the next business day. Providers shall inform individuals receiving services of incident reporting requirements and procedures.

VIII. OVERSIGHT FOR ALL DESIGNATED PROVIDERS

Designated Provider Agency

The designated provider agency establishes a Reportable Incident Review Committee to review all Reportable Incidents to determine if incidents are handled properly and to the satisfaction of the individual receiving services and any regulatory body including, OMH and OASAS.

1. Care and Safety of an Individual Involved in an Incident:

Provider agency administrators of Adult BH HCBS and CORE Services must ensure that their incident management policy(ies) requires any staff person who observes or is informed that a Reportable Incident of any type has occurred, is to immediately provide assistance and secure appropriate care for the involved individual(s). Such administrators must provide OMH/OASAS with contact information for administrators (director, supervisor) who can be contacted by OMH/OASAS, for the purpose of ensuring that such measures have been taken. This information may be included in the incident report narrative.

(a) If an allegation of abuse or assault has been made, appropriate care must include separating the alleged perpetrator from the alleged victim, in circumstances where it

appears the allegation is credible and sufficient staff coverage can otherwise be maintained. In all cases, the welfare of the individual receiving services is paramount.

(b) Reasonable actions must be taken to ensure that an individual who has been harmed receives necessary treatment or care. If an individual has been injured, such actions must include a medical examination commensurate with the acuity of the injury. The provider should note the location where medical treatment was sought and if there is an identified course of treatment that must be followed up on. The name of the examiner, the written findings of the examiner, and a copy of any other medical record associated with such examinations must be retained by the organization, if available.

(c) In addition, designated providers must review their activities in response to reportable incidents to ensure corrective actions will be taken, as necessary, to address system and personnel issues that may pose a continued risk to other individuals receiving services.

2. Organization and Membership of the Incident Review Committee

The committee may be organized on an agency-wide, multi-program or program-specific basis. Agencies may use a current incident review committee if one has been established. It is recommended that the committee contain at least five individuals drawn from a cross-section of staff, including professional, direct care, quality management and administrative. It is recommended that the committee also include a peer advocate who is a former recipient of services.

The committee must meet at least quarterly and within 45 days of a Reportable Incident report involving an individual receiving CORE Services.

3. Responsibilities of the Incident Review Committee

This committee is responsible for reviewing the inquiry of every Reportable Incident. The committee evaluates the response of the agency and any involved provider for thoroughness. The committee determines whether the final recommendations and actions taken are sufficient, in line with the best clinical practice and in compliance with the Adult BH HCBS and CORE Service Standards and other guidance.

In addition, the committee:

- makes certain that the agency's Incident Reporting Policies and Procedures comply with the OMH or OASAS Incident Reporting Policy,
- determines if its response and that of any involved provider have been thorough and complete,
- ascertains that necessary and appropriate corrective, preventive and/or disciplinary action has been taken in accordance with the committee's recommendations and OMH or OASAS guidelines. If different or additional actions are taken, the committee must document the original recommendations and explain why the recommendations were revised,
- develops recommendations for changes in provider policies and procedures to prevent or minimize the occurrence of similar situations. These recommendations must be presented to the appropriate staff, and

- identifies trends in Reportable Incidents (by type, individual receiving services, site, employee, involvement, time, date, circumstance, etc.) and recommends appropriate corrective and preventive policies and procedures.

4. Documentation

Incident management must include procedures for documenting the occurrence of incidents and the results of all related examinations, investigations, and reviews. Incident-related documents are confidential quality assurance documents which must be maintained separately from the individual's CORE Services case record. However, a description of any clinical impact which an incident may have on an individual must be recorded in the case record.

5. Notifications

In addition to reporting requirements, designated providers must have procedures to assure the following notifications occur:

(a) Notifications to Individual Receiving Services, and Guardian/Personal Representative (as applicable): Individuals receiving services may be notified of the outcome of incidents involving them, if and as clinically appropriate, and in accordance with applicable federal and state laws. Any applicable guardian or personal representative, as identified in the individual's ISP or case record and by consent, must be notified immediately of allegations of abuse or neglect, missing person or incident involving an individual's death or injury.

New York State

OMH and OASAS may track and monitor all aspects of Reportable Incidents and uses the data collected and included in reports to determine if there are systemic issues that need to be addressed and plan a strategy for preventing Reportable Incidents from occurring or recurring. OMH and OASAS reserves the right to review incidents at any time and may request additional information in NIMRS or through Patient Advocacy and/or the Regional Office, if not updated accordingly.

In the event that any designated provider is found to be non-compliant with these policies and procedures, the State may take appropriate action. This may include requesting corrective action and suspending or terminating the provider's designation to provide CORE Services. OMH and OASAS work cooperatively with other state agencies that provide services to individuals with disabilities, informing them when shared providers experience significant or numerous Reportable Incidents.

IX. TRAINING REQUIREMENTS

Training for all Mandated Reporters

Designated providers must ensure that all employees who are Mandated Reporters receive training in the following areas on at least an annual basis:
1) Abuse prevention, identification, reporting, and processing of allegations of abuse,
2) Laws, guidance, and policies/procedures governing protection from abuse; and,

3) Incident reporting and processing.

Online and in-person training resources are available through the New York State Justice Center.

Designated providers must ensure that there is a mechanism for monitoring the type, frequency, and amount of such training employees receive and that:
1) The records are current; and,
2) There is documentation establishing that employees have received the specified training.

Investigation Training for OMH-Hosted Providers

Each designated provider must have trained staff available to complete incident investigations. The State has identified 4 training modules available in the New York Statewide Learning Management System (SLMS) that are required for staff conducting investigations:

Course Code	Course Name
OMH-99-SI-002-V1	Special Investigation Process, Version 1
OMH-99-SI-003-V1	Interviewing and Interrogation, Version1
OMH-99-SI-004-V1	Assembling Evidence and Report Writing, Version 1
OMH-99-SI-005-V1	Incident Review Committee and Corrective Action Plans, Version 1

Providers will need to contact the OMH Division of Quality Management (DQM) to register staff in the SLMS. Instructions can be found on the OMH DQM website.

Immediate Actions Training for OASAS-Hosted Providers

Each designated provider must have trained staff available to respond to the discovery of a reportable incident. The following archived training is available on the OASAS website: Immediate Actions Following the Discovery of a Reportable Incident.

X. QUESTIONS

For questions regarding this guidance, please see mailboxes below.

OMH-Hosted Providers may contact: dqm@omh.ny.gov

OASAS-Hosted Providers may contact: picm@oasas.ny.gov