

# **INCIDENT REPORTING AND MANAGEMENT SYSTEM (IRAMS) USER GUIDE**

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# 1 IRAMS Purpose and Oversight

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The **Incident Reporting and Management System (IRAMS)** is used by Health Homes, Care Management Agencies, Children's Home and Community Based Services (HCBS) Providers, and Children and Youth Evaluation Services (C-YES) to report critical incidents and complaints/grievances as appropriate for the various populations served to ensure the health, safety, and well-being of members. It is everyone's responsibility to report and ensure issues are addressed.

- **Health Homes (HH)** for both Health Homes Serving Adults (HNSA) and Health Homes Serving Children (HHSC) have oversight of the Care Management Agencies in their network to ensure appropriate reporting and actions are taken according to Health Home policies and standards.
- **Care Management Agencies (CMAs)** for both Health Homes Serving Adults (HNSA) and Health Homes Serving Children (HHSC) will report Critical Incidents and within IRAMS to the lead Health Home (HH). HHSC **will also** report Complaints/Grievances from the member.
- **Children and Youth Evaluation Services (C-YES)** will report Critical Incidents and Complaints/Grievance within IRAMS for children/youth enrolled in the Children's Waiver. Within IRAMS, C-YES reports directly to NYS DOH.
- **Children's Home and Community Based Service (HCBS) Providers** will report Critical Incidents and Complaints/Grievance within IRAMS for children/youth enrolled in the Children's Waiver. Within IRAMS, Children's HCBS Providers report directly to NYS DOH.

IRAMS will take the place of current paper-based processes for HNSA and HHSC. The HHs are already required to report critical incidents (per the [Health Home Monitoring: Reportable Incidents Policies and Procedures HH0005](#)) and grievances/complaints (per the [Complaint and Grievance Policy for Health Homes Serving Children HH0013](#)). Additional information, including definitions of the types of incidents and grievances/complaints, can be found in these policies.

Reporting Critical Incidents and Complaints/Grievances are performance requirements of the Children's Waiver. These are new requirements for HCBS providers and C-YES (per [HCBS Provider Reportable Incidents Policies and Procedures CW0004](#) and [Complaint and Grievance Policy for HCBS Providers CW0008](#)). Additional information, including definitions of the types of incidents and grievances/complaints, can be found in these policies.

Due to the increased number of organizations that are required to report critical incidents and complaints/grievances, as well as additionally reporting requirements, IRAMS was developed to be an automated and trackable system.

At this time Medicaid Managed Care Plans (MMCPs) will not be in the IRAMS due to a reporting structure already in place with additional reporting elements.

IRAMS will assist the State with monitoring and oversight as well as data collection for required federal reporting. The system data will be used as part of the re-designation process for HHSC and HHSA. For HHSC, C-YES, and HCBS Providers, the system data will also be used for the annual Children's Waiver case reviews.

This will also enable HHs, CMAs, C-YES, and HCBS providers to also run their own reports and track complaints/grievances and critical incidents within their own organizations and HH network.

## 2 Responsibilities and Reporting Requirements

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### 2.1 Critical Incidents

Reporting Critical Incidents has been a policy requirement for both Health Homes Serving Children and Adults since 2017. IRAMS will replace the current paper-based process that requires reporting for each incident and quarterly aggregate data reporting. Both HHSC and HHSA will use IRAMS to report critical incidents. Health Homes and Care Management Agencies should maintain internal processes for reporting and monitoring critical incidents based on what works best for their organization and aligns with Health Home Standards.

The **Health Home Care Management Agency (CMA)** must inform the Lead Health Home of a critical incident within 24 hours (or next business day) of notification or discovery (becoming aware of the incident). The Health Home (HH) must inform the Department within 24 hours (or next business day) from the CMA's report. This timeline applies to both HHSC and HHSA.

Please note, that if the Lead Health Home plans to enter Critical Incidents in IRAMS for their network CMAs, then there may be opportunities where the HH will be found out of compliance with the above timeframes due to part of the process being on paper. Additionally, this could impede reporting, tracking, and oversight by the Department, HHs, and CMAs.

The Health Home will provide oversight and direction to the CMA to conclude the critical incident within thirty days (30 days) of receiving the incident report.<sup>1</sup> In IRAMS, *the HH signs off* that appropriate action was taken for critical incidents. The Department will review the incident reported by the HH and make recommendations, if necessary.

**HCBS Providers/C-YES** must inform the Department of a critical incident within 24 hours (or next business day) of notification or discovery (becoming aware of the incident). HCBS Providers and C-YES should maintain internal processes for reporting and monitoring critical incidents as necessary and in alignment with applicable policies. The Department will review the incident reported by the HCBS Provider/C-YES and make recommendations, if necessary. In IRAMS, DOH signs off that appropriate action was taken for critical incidents by HCBS Providers/C-YES.

Additionally, the HCBS Provider must notify the HHSC Care Manager (CM), C-YES family support coordinator (if applicable), and the Medicaid Managed Care Plan (if

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<sup>1</sup> The 30-day resolution is only required if the report is not submitted as final (i.e. not submitted to DOH).

applicable) to ensure the coordination of services, appropriate changes to the Plan of Care if needed, and notification of any changes to the HCBS service plan. If an agency is both a CMA and an children’s HCBS provider, the incident should be reported under their CMA line-of-business to ensure HH monitoring and oversight. If both the CMA and the children’s HCBS provider submits the same incident, DOH will be able to mark one as a duplicate during the review.

HCBS Providers/C-YES	CMAs	Health Homes	NYS
<ul style="list-style-type: none"> <li>• Submit critical incident or complaint/grievance within 24 hours of discovery date</li> <li>• Take action to ensure safety and wellbeing of the member</li> <li>• Notify the member’s HH or C-YES to determine if the POC may need updated</li> <li>• Retain all documentation related to the critical incident or grievance/ complaint</li> </ul>	<ul style="list-style-type: none"> <li>• Submit critical incident or complaint/grievance (HHSC only) within 24 hours of discovery date</li> <li>• Take action to ensure safety and wellbeing of the member</li> <li>• Work with HH to resolve issue and implement appropriate actions</li> <li>• Retain all documentation related to the critical incident or grievance/ complaint</li> </ul>	<ul style="list-style-type: none"> <li>• Review critical incident and complaint/grievance</li> <li>• Provide assistance to CMA to resolve the issue and implement appropriate actions</li> <li>• Sign-off that appropriate actions were taken by CMA</li> <li>• Submit issue to DOH</li> </ul>	<ul style="list-style-type: none"> <li>• Reviews finalized submissions from HH</li> <li>• Sign-off that appropriate actions were taken by HCBS Provider/C-YES</li> <li>• Coordinate with HH/ C-YES / HCBS Provider on steps toward resolution</li> <li>• Provide technical assistance when indicated</li> <li>• Reports to CMS</li> </ul>

## 2.2 Complaints and Grievances

In the original critical incident reporting policy for Health Homes, complaints and grievance were also included, but then removed in the updated policy. HHSA are no longer required to report complaints and grievances under the updated policy; however, the majority of Health Homes continue to monitor complaints and grievances of members being served.

HCBS Providers, Health Homes Serving Children (only), and C-YES will need to report complaints and grievances for Health Home and Children’s Waiver members as outlined in the Children’s Waiver and issued policies.

Once a member or the member’s representative files a grievance/complaint, the HHCM/C-YES/HCBS Provider enters the issue into IRAMS. The member must be updated within 72 hours of receiving the grievance/complaint as to the status of the of their complaint/grievance. The HHCM/C-YES/HCBS Provider must try to resolve the members complaint/grievance to the member’s satisfaction, otherwise, if the member is not satisfied with the resolution, the member can escalate the complaint/grievance their lead Health Home, the Department, the Medicaid Managed Care Plan Complaint line (if applicable), or to the Medicaid Help Line. The entire process from original complaint/grievance report to resolution/escalation **must be completed within 45 days**. The Department will receive all entered grievance/complaint via IRAMS and will review to ensure resolution for the member is satisfactory. IRAMS currently flags

complaints at 30 days to align with critical incident timeline so users will receive a notification that the timeline for resolution is nearing due date for completion.

Collaboration among the service providers of Health Homes, C-YES, HCBS providers, and Medicaid Managed Care Plans should occur whenever possible. The member's services and Plan of Care should be adjusted accordingly to address the issue raised by the member. If an agency is both a CMA and an children's HCBS provider, the complaint/grievance should be reported under their CMA line-of-business to ensure HH monitoring and oversight. If both the CMA and the children's HCBS provider submit the same complaint/grievance, DOH will be able to mark one as a duplicate during the review process.

All members must be told of their rights to file a complaint/grievance, report an incident, and file a Fair Hearing. Members must be provided with the Medicaid Help Line contact information.

### 3 Who Should Use IRAMS?

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#### 3.1 Health Homes/Care Management Agencies

It is the responsibility of the lead Health Home to ensure that issues are addressed and reported within the compliance timeframes as outlined in policy and have internal processes in place for their network CMAs to follow. The lead Health Home can determine if CMAs will enter issues into IRAMS directly or if the lead Health Home will enter issues into IRAMS on behalf of their network CMAs. If lead Health Homes choose *not* to grant access to CMAs, they must inform the Department of their policy to ensure complete and timely reporting.

Each **HH/CMA** should identify 2-3 users who will have access to IRAMS. Larger agencies may identify additional users but not all care managers will require access. These users will enter issues into IRAMS on behalf of their agency.

**Note:** Each HH/CMA must have policies and processes in place regarding the reporting of critical incidents and complaints/grievance for their staff to follow. The lead Health Home and CMA management should ensure that timely IRAMS reporting is a part of their process and revise internal procedures and/or staff training as needed to meet this requirement.

For agencies that are both CMAs and designated Children's HCBS providers, the agency should consider if it is appropriate to grant IRAMS access to staff that represent both lines of business. If accessing IRAMS as both a CMA and HCBS Provider, the HCS Coordinator will need to enroll the agency as both types of users (see "Accessing the System" below). Granting IRAMS access to administrative staff is permissible.

**Note:** There is not a "read-only" user role within IRAMS. Health Homes/CMAs should ensure that staff overseeing quality assurance or who have oversight responsibility for monitoring issues, have the IRAMS Issue Reporter role in HCS (see "Accessing the System" below).

## 3.2 Children’s HCBS Providers / C-YES

Each **HCBS Provider** and **C-YES** should identify 2-3 users who will have access to IRAMS. These users will enter issues into IRAMS on behalf of their agency; therefore, not all HCBS practitioners/staff or C-YES staff need access.

**Note:** HCBS providers and C-YES must have policies and processes in place regarding the reporting of critical incidents and complaints/grievance for their staff to follow. Management should ensure that timely IRAMS reporting is a part of their process and revise internal procedures and/or staff training as needed to meet this requirement.

For agencies that are both CMAs and designated Children’s HCBS providers, the agency should consider if it is appropriate to grant IRAMS access to staff that represent both lines of business. If accessing IRAMS as both a CMA and HCBS Provider, the HCS Coordinator will need to enroll the agency as both types of users (see “Accessing the System” below). Granting IRAMS access to administrative staff is permissible.

**Note:** There is not a “read-only” user role within IRAMS. HCBS providers and C-YES should ensure that staff overseeing quality assurance or who have oversight responsibility for monitoring issues, have the IRAMS Issue Reporter role in HCS (see “Accessing the System” below).

***\*\*IRAMS does not replace Mandated Reporting requirements or reporting required by programs other than Health Home or the Children’s Waiver (i.e. Justice Center). For agencies licensed by OMH, for example, reporting via NIMRS may also be required if the member is receiving another service (such as PROS or CFTSS). Issues reported for children/youth enrolled in the Children’s Waiver (and not receiving another OMH-licensed service) do not need to be reported via NIMRS.***

## 4 Accessing the System

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IRAMS is accessed through the Health Commerce System (HCS). Users can either search the applications within HCS or navigate to this link: <https://increp.health.ny.gov/>

Each agency/organization’s HCS Coordinator is the person who has the responsibility and authority to request and manage HCS accounts and roles for their agency via the Communications Directory. The HCS Coordinator is by default a user and therefore will have access to IRAMS. The HCBS Coordinator will assign the IRAMS Issue Reporter role to the identified users for their agency and assist users in requesting a valid HCS ID registers with their organization if necessary.

### 4.1 Browser Compatibility

The IRAMS application is **not compatible** with Microsoft Internet Explorer. IRAMS is compatible with Google Chrome, Microsoft Edge and Mozilla Firefox.

## 4.2 Organization Selection

### Organization Select

Select the organization for your session. You may create and view issues for that organization.

	Org Type	Org Name
<input type="radio"/>	CMA	Abbott House (02996490)
<input type="radio"/>	CMA	Northwell Health (03457054)
<input type="radio"/>	CYES	Children and Youth Evaluation Service
<input type="radio"/>	DOH	Department of Health
<input type="radio"/>	HH	Northwell Health (03457054)
<input type="radio"/>	HH	Urban Family Practice dba Greater Buffalo United Accountable Healthcare Network - GBUAHN (03489287)

Continue →

Following the Health Commerce System (HCS) login, the user is presented with an “Organization Select” screen to identify their current organization type **if the user has more than one organization type (line of business) with the IRAMS Reporter role**. User roles are determined by HCS, and affect which issues are viewable in the application. In addition, specific features are available or hidden in accordance with the organization type; for example, a Care Management Agency (CMA) may assign an issue to a Health Home but would be unable to assign an issue directly to the Department of Health (DOH).

## 5 IRAMS Home Page

### 5.1 Issue Queue

The Issue Queue contains summary snapshots of Incidents, Complaints/Grievances.

The screenshot displays the IRAMS Issue Queue interface. At the top, there is a search bar for CIN, Member Name, and Issue ID. Below the search bar is a "Report New Issue" button. The main area shows a list of issues with filters for "All Issues" and "Unread Only". Two issues are visible:

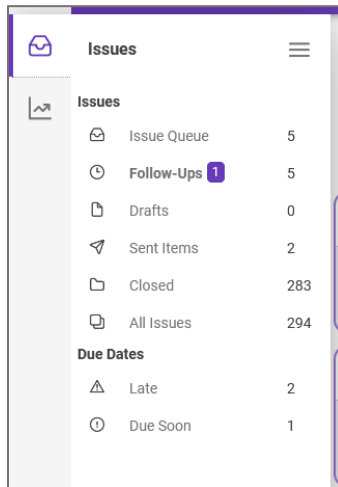
Issue ID	Issue Type	Organization	Status	Member
#1002	Incident	Health Home Serving Adults (HHSA)	New Abuse - Psychological	sdaosdn Isnvosdn
#000102	Complaint/ Grievance	Health Home Serving Adults (HHSA)	Back Up Effectiveness	Yakov Yakovski

Each issue card includes details such as "Current Assignment", "Created" date and time, "Status" (e.g., Follow-Up), and "Due Date" (e.g., Submit to DOH by 04/08/2021).

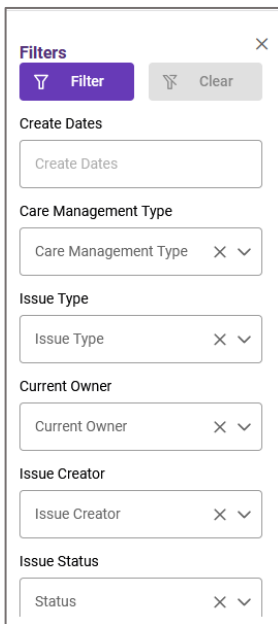


### 5.1.1 Issue Selection

Click the envelope icon to select the desired view. Views will be present or absent according to organizational role.

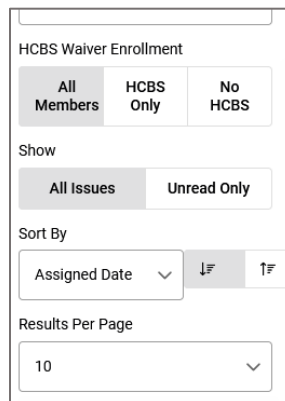


### 5.1.2 Issue Filtering



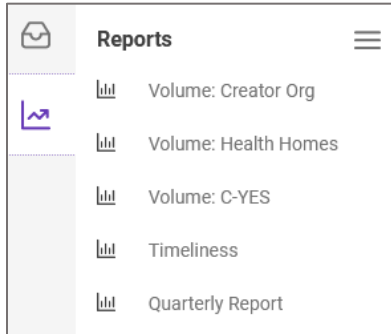
Click the Filter button to apply additional criteria to the Issue Listing, specify a sort order, and/or limit the results displayed per page.

Click "Clear" to clear all filters and revert to the unfiltered results.



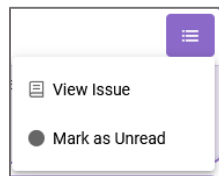
## 5.2 Report List

Click the graph icon to view a list of available reports. Clicking on an individual report will bring the user to the Report Designer; please see section 6.1, “Using the Report Designer,” for additional information.

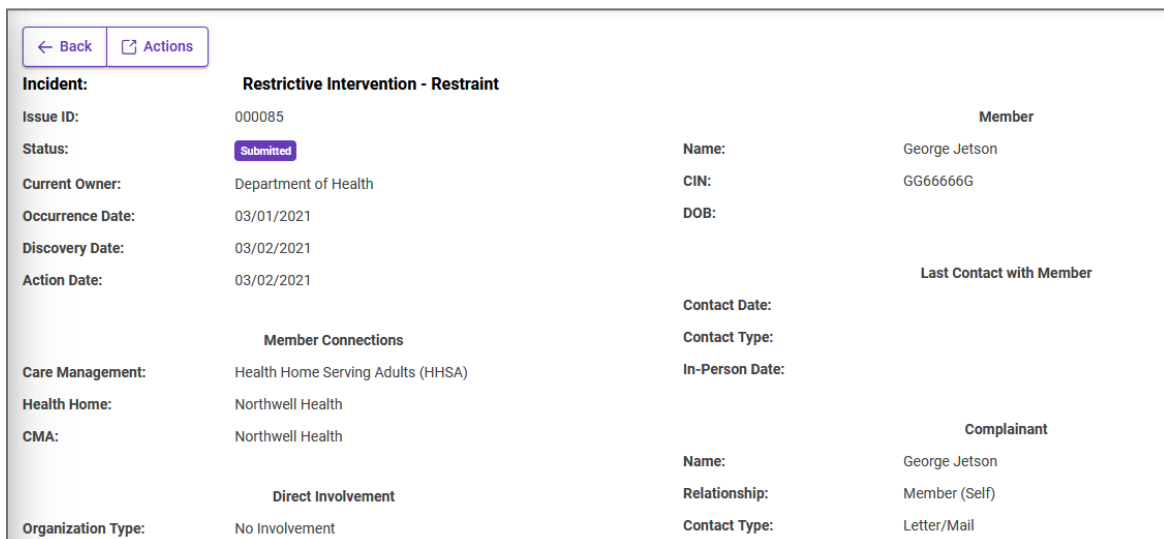


## 5.3 Viewing Issue Details

Click on the information icon on any issue to view the issue details or mark the issue as unread:



Clicking “View Issue” brings up the Issue Details screen to review the issue and to post a public or private comment:

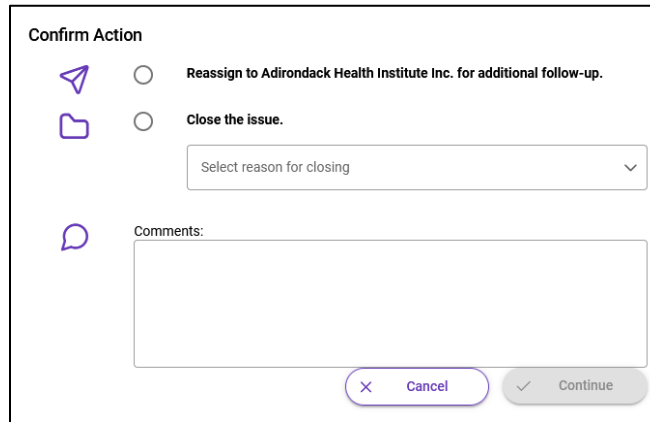


The screenshot shows the Issue Details screen for a 'Restrictive Intervention - Restraint' incident. The screen is divided into several sections:

- Incident:** Restrictive Intervention - Restraint
- Issue ID:** 000085
- Status:** Submitted
- Current Owner:** Department of Health
- Occurrence Date:** 03/01/2021
- Discovery Date:** 03/02/2021
- Action Date:** 03/02/2021
- Member:** George Jetson (Name), GG66666G (CIN)
- Member Connections:** Health Home Serving Adults (HHSA) (Care Management), Northwell Health (Health Home), Northwell Health (CMA)
- Direct Involvement:** No Involvement (Organization Type)
- Complainant:** George Jetson (Name), Member (Self) (Relationship), Letter/Mail (Contact Type)

## 5.4 Acting on an Existing Issue

From the Issue Details screen, clicking “Actions” prompts the user to reassign or close the issue.



The image shows a 'Confirm Action' dialog box. It contains two radio button options: 'Reassign to Adirondack Health Institute Inc. for additional follow-up.' and 'Close the issue.'. Below the second option is a dropdown menu labeled 'Select reason for closing'. At the bottom of the dialog is a text area labeled 'Comments:' and two buttons: 'Cancel' and 'Continue'.

**Note:** that once an issue has been assigned and submitted to a Health Home, the issue cannot be assigned back to the CMA or in the case with HCBS providers or C-YES the issue is submitted to the Department of Health it cannot be assigned back to the HCBS provider or C-YES.

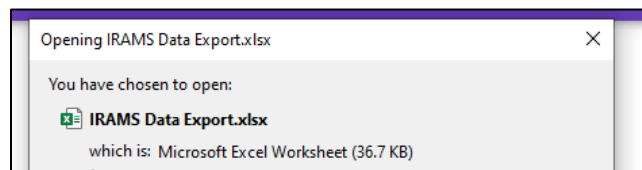
## 5.5 Reporting a New Issue

Click the “Report New Issue” button to create a new Incident, Complaint or Grievance. Please see section 3 for further information.



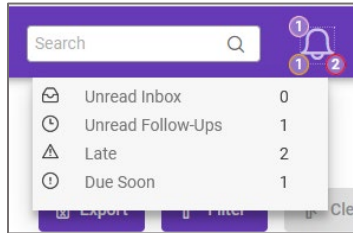
## 5.6 Exporting Data

Click the “Export” button to export the current issue listing to Excel.



## 5.7 Issue Quick View

Click on the bell icon to quickly access a count of Unread, Late, and Due Soon items. The notifications are organization based, so all users within the same organization will see the same alerts.



## 5.8 Search Bar

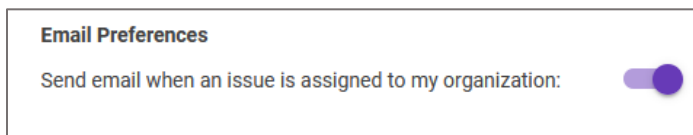
The search bar allows the user to search issues by Client Identification Number (CIN), Member Name or Issue ID.

## 5.9 User Info/Preferences and Logout

Clicking on the User Info icon displays current user information, allows the user to edit their profile, and allows the user to sign out of the application.



Toggle the “Email Preferences” switch to turn on/off email notifications.



### Notifications

Users will receive an alert (under the bell icon within IRAMS and as an email, if that preference is turned on) when a new issue is added to their queue.

## 5.10 Returning to the Home Page

Click the title bar from anywhere in the application to return to the Home Page.

**Incident Reporting and Management System (IRAMS)**

## 6 Reporting an Issue

### 6.1 Member Connections

To report a new issue, begin by selecting the member's care manager from the drop-down listing.

**Note:** that all fields marked with "\*" are REQUIRED.

**Report New Issue**

[@ Connections](#) [Member](#) [Complainant](#) [Detail](#) [Review](#)

**Member Connections**

Select the care manager for the member.

Who is the Member's Care Manager? \*

Select Care Manager Type

- Children and Youth Evaluation Service
- Health Home Serving Adults (HSA)
- Health Home Serving Children (HHSC)

#### 6.1.1 Children and Youth Evaluation Service (C-YES)

For C-YES, fill in the Date of Enrollment, communication details, and whether the member is enrolled in a Home and Community Based Services (HCBS) Waiver. When complete, click "Continue" to access the Member Information screen.

Date of Enrollment

mm/dd/yyyy

**Communication with Member**

Date of Last Contact with Member: mm/dd/yyyy

Last Contact Type: Select a Contact Type

Date of Last In-Person Contact with Member: mm/dd/yyyy

**HCBS Children's Waiver**

Is the child enrolled in HCBS Children's Waiver?

### 6.1.2 Health Home Serving Adults (HHSA)

For HHSA, enter the Health Home, Care Management Agency, Date of Enrollment<sup>2</sup>, and communication details. When complete, click “Continue” to access the Member Information screen.

The screenshot shows a web form for HHSA. It includes a dropdown menu for 'Health Home \*' with the text 'Select the Health Home' and a red error message 'This field is required.' Below this are two more dropdown menus: 'Care Management Agency \*' with 'Select the Care Management Agency' and a red error message 'This field is required.', and 'Date of Enrollment' with a date input field 'mm/dd/yyyy' and a calendar icon. A section titled 'Communication with Member' contains three date input fields: 'Date of Last Contact with Member' (mm/dd/yyyy), 'Date of Last In-Person Contact with Member' (mm/dd/yyyy), and 'Last Contact Type' (a dropdown menu with 'Select a Contact Type').

### 6.1.3 Health Home Serving Children (HHSC)

For HHSC, enter the Health Home, Care Management Agency, Date of Enrollment<sup>3</sup>, communication details, and whether the member is enrolled in an HCBS Waiver. When complete, click “Continue” to access the Member Information screen.

The screenshot shows a web form for HHSC. It includes a dropdown menu for 'Health Home \*' with the text 'Select the Health Home' and a red error message 'This field is required.' Below this are two more dropdown menus: 'Care Management Agency \*' with 'Select the Care Management Agency' and a red error message 'This field is required.', and 'Date of Enrollment' with a date input field 'mm/dd/yyyy' and a calendar icon. A section titled 'Communication with Member' contains three date input fields: 'Date of Last Contact with Member' (mm/dd/yyyy), 'Date of Last In-Person Contact with Member' (mm/dd/yyyy), and 'Last Contact Type' (a dropdown menu with 'Select a Contact Type'). A section titled 'HCBS Children's Waiver' contains a toggle switch and the text 'Is the child enrolled in HCBS Children's Waiver?'.

<sup>2</sup> The segment start date, which should be the month the DOH—5055 Health Home Patient Information Sharing Consent form was signed.

<sup>3</sup> The segment start date, which should be the month the DOH—5055 Health Home Patient Information Sharing Consent form was signed.

## 6.2 Member Information

The Member Information screen contains member demographic details, including CIN, first and last name, preferred name, and the member’s current location. Typing in a member CIN and hitting “Enter” will prompt the system to do a search by CIN and will pre-fill fields for which data can be located.

Once the required fields have been completed, click “Continue” to move to the Complainant page. Alternatively, click “delete” to remove the record.

Important: Completing all fields allows for more information for tracking and data reporting

The screenshot shows a web application interface for 'Member Information'. At the top, there are navigation tabs: 'Connections', 'Member' (selected), 'Complainant', 'Detail', and 'Review'. Below the tabs, the title 'Member Information' is displayed, followed by the instruction 'Enter the information about the member that is the subject of the report.' The form contains several input fields: 'Medicaid CIN \*' with a search icon and the text 'Enter CIN'; 'First Name \*' and 'Last Name \*' each with an 'Enter' placeholder; 'Preferred First Name' and 'Preferred Last Name' each with an 'Enter' placeholder; 'Date of Birth' with a 'mm/dd/yyyy' placeholder and a calendar icon; and 'Location of Member at the Time of Report' with a dropdown menu labeled 'Select Current Location'. At the bottom of the form, there are two buttons: a purple 'Delete' button with a trash icon and a grey 'Continue' button with a right arrow.

**Note:** “Delete” is used to **REMOVE A RECORD FROM THE SYSTEM** and should not be used to clear the fields on the screen.

The screenshot shows a 'Confirm Delete' dialog box. It features a purple trash icon on the left. In the center, the text reads 'This issue will be permanently deleted. Please confirm.' At the bottom right, there are two buttons: a white 'Cancel' button with a close icon and a purple 'Delete' button with a trash icon.

## 6.3 Complainant Information

The Complainant Information screen contains the contact information for the person reporting the issue. This should be either the member themselves (self-report) or a person acting on their behalf.<sup>4</sup> Additional information captured in the Complainant Information screen includes the date the complaint was reported, and the method used, e.g., Email, In Person, Phone, Letter, Text, or Videoconference.

<sup>4</sup> The Name field is required; however, if the complainant wishes to be anonymous, the report can enter “Anonymous” in the Name field.

**Complainant Information**

Enter the contact information for the person who is reporting the issue. This should be the member (self-reported) or the advocate acting on their behalf.

Complainant's Relationship to Member \*

Select the relationship ▼

This field is required.

<p><b>First Name *</b></p> <div style="border: 1px solid gray; padding: 2px; text-align: center;">Enter First Name</div>	<p><b>Last Name *</b></p> <div style="border: 1px solid gray; padding: 2px; text-align: center;">Enter Last Name</div>
<p><b>Email</b></p> <div style="border: 1px solid gray; padding: 2px; text-align: center;">Enter Email</div>	<p><b>Phone Number</b></p> <div style="border: 1px solid gray; padding: 2px; text-align: center;">Enter Phone Number (555-555-5555)</div>
<p><b>How was the Issue Reported? *</b></p> <div style="border: 1px solid gray; padding: 2px; text-align: center;">Select a Contact Type <span style="float: right;">▼</span></div> <p style="color: red; font-size: small;">This field is required.</p>	<p><b>Date Issue was Reported (Discovery Date) *</b></p> <div style="border: 1px solid gray; padding: 2px; text-align: center;">Select Discovery Date <span style="float: right;">📅</span></div>

Click “Continue” to move to the Issue Details page or click “Delete” to remove the record.

**Note:** The issue is not recording with an identifying number until the Complainant Information screen has been completed. Therefore, if you stop now, you will have to re-enter the information later until a number is assigned.

## 6.4 Issue Details

The Issue Details screen contains information specific to the Incident, Complaint/Grievance, including the date of occurrence, a detailed description of the issue, the impact to the member, actions taken, media coverage, and provider involvement.

At this time, the issue ID and a “draft” notation is assigned:

Issue: #000052
DRAFT



Begin by selecting the Issue Type:

**Issue Details**  
Describe the issue, negative impact to the member, and the actions taken to resolve the issue.

Issue Type \*  
 Incident  Complaint/Grievance

Incident Type \*  
Select an Issue

- Abuse - Misappropriation of Member Funds
- Abuse - Neglect
- Abuse - Physical

Clicking on the Information icon will display a dictionary of Incidents and Complaints to assist with selection. Clicking “Select” in this listing will assign the selection to the Incident Type or Complaint/Grievance Type field.

**Issue Descriptions**

Incidents Complaints

Incident Type	Description	Select
Abuse - Misappropriation of Member Funds	Use, appropriation, or misappropriation by a service provider of a member's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the member of those resources. Examples include the deliberate misplacement, theft, or wrongful, temporary, or permanent use of a member's belongings or money.	Select
Abuse - Neglect	Any action, inaction or lack of attention that breaches a service provider'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 the member.	Select

Continue reporting the issue by noting the date of occurrence\* and a description, as well as the Justice Center Identifier (if known and applicable<sup>5</sup>). The Discovery Date displays what was entered on the Complainant Information page.

**Note:** The date of occurrence must be on or before the Discovery and Action dates. If the exact date of the occurrence is not known, the reporter may use the Discovery date or an earlier date.

Date the Incident/Complaint Occurred \* 03/12/2021

Date Issue was Reported (Discovery Date) 03/14/2021

Justice Center Identifier  
Enter Justice Center ID

Issue Description \*

<sup>5</sup> The Justice Center ID is only used when DOH is sending an issue received from the Justice Center.

### Action Taken:

Following the issue description, continue by selecting the actions taken and noting the date of the first action. More than one action may be selected. This 'action taken' is response from the CMA, HCBS Provider, or C-YES once the discovery of the critical incident or complaint/grievance was made. The action taken should demonstrate that the CMA/HCBS Provider/C-YES is following the standards set forth and is ensuring the safety/well-being of the member.

The screenshot shows two form fields side-by-side. The left field is titled 'Actions Taken' and contains a dropdown menu with the text 'Select Action(s)' and a downward arrow. Below the dropdown is a list of four actions, each with an unchecked checkbox: 'Documentation of incident/complaints', 'Follow-up with Authorities / Obtain Outcome', 'Follow-up with Provider(s) / Collaterals', and 'Mandated Reporter Compliance'. The right field is titled 'First Action Date' and contains a text input field with the placeholder text 'Select Action Date' and a calendar icon on the right side.

Click “Continue” to review the issue details and submit the report, or “Delete” to completely remove the record.

The screenshot shows two sections of a form. The first section is titled 'Media Coverage' and includes the instruction 'Provide link(s) to media coverage. Do not include obituaries.' Below this is a toggle switch for 'Media Coverage' which is currently turned off. Underneath the toggle is a large empty text box. The second section is titled 'Provider Involvement' and includes the question 'Was the Care Manager or HCBS Provider directly involved in the incident?'. There are two radio button options: 'No Involvement' (which is selected) and 'Children and Youth Evaluation Service'. At the bottom right of the form are two buttons: a 'Delete' button with a trash icon and a 'Continue' button with a right arrow icon.

**Note:** Any media coverage and provider involvement. Toggling “Media Coverage” on will require the user to enter information into the Media Coverage text box. Examples of “Media Coverage” include (but are not limited to) crime or missing person information referenced in newspapers, news coverage, or the internet.

## 7 Submitting an Issue

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### 7.1 Review

The Review page displays a complete listing of all information entered.



Review the reported issue and submit the report.	
<b>Connections</b>	
Care Management:	Health Home Serving Children (HHSC)
Health Home:	BESTSELF BEHAVIORAL HEALTH, INC
Care Management Agency:	Abbott House
Enrollment Date:	03/22/2021
<b>Communication with Member</b>	
Last Contact Date:	03/22/2021
Last Contact Type:	Email
Last In-Person Contact Date:	03/22/2021
<b>Member</b>	
CIN:	AA12345B

Clicking on any previous page allows the user to make changes to individual fields. **Changes will not be saved** until “Continue” is clicked on the page being updated.

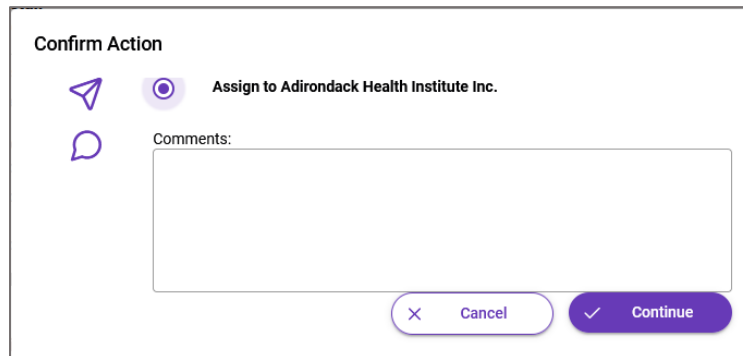
### 7.2 Actions

Clicking the “Actions” button brings up a dialog box that prompts the user to confirm assignment to the appropriate agency and provide comments. Comments provided in this box also populate in the ‘comments’ section for this issue in the Issues Queue on the Home Page.

It is the responsibility of the HH, C-YES, and HCBS Providers to ensure all appropriate actions were taken. For critical incidents, this includes that steps were taken to ensure the safety and well-being of the participant; for complaints/grievances, this includes that the issue was resolved or appropriately escalated. For issues submitted by CMAs, the HH will confirm – via the “Confirm Action” dialogue box – that appropriate actions were taken. For issues submitted by HCBS Providers/C-YES, DOH confirms appropriate actions were taken.

If a CMA enters an issue that does not meet the criteria for a critical incident, the Health Home may select “Not Reportable” and provided appropriate comments. DOH also has the option to mark as issue as “Not Reportable”; therefore, if a CMA/HH, HCBS Provider, or C-YES is unsure if they should report an issue, they should submit to DOH via IRAMS and provide appropriate comments to assist DOH in determining if the issues is reportable or not.

Select “Cancel” to return to the review page, or “Continue” to submit the issue and return to the IRAMS home page.



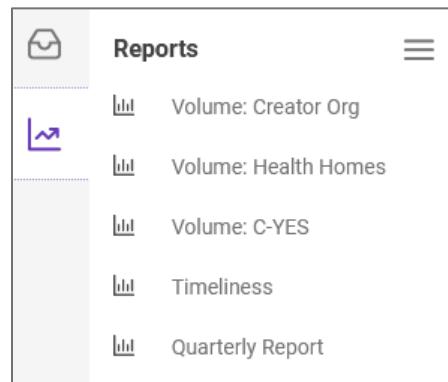
The image shows a 'Confirm Action' dialog box. At the top, it says 'Confirm Action'. Below that, there are three icons in a vertical column: a location pin, a radio button, and a speech bubble. The radio button is selected and has the text 'Assign to Adirondack Health Institute Inc.' next to it. Below the icons is a text area labeled 'Comments:'. At the bottom right, there are two buttons: 'Cancel' with a close icon (X) and 'Continue' with a checkmark icon.

**Note:** For Health Homes, Children’s HCBS Providers, and C-YES selecting “Continue” will submit the issue to DOH. For CMAs, selecting “Continue” will submit the issue to their lead Health Home.

## 8 Reporting

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From the IRAMS home page, select the reporting icon to view a list of available reports:



**Note:** The display reflects reports available for the selected organizational role. The following example displays available reports for the Health Home organizational role.

IRAMS does not generate reports in PDF but issues can be printed from the browser or the details can be selected to copy/paste into a Word document and then converted to PDF if the agency would like to keep a copy of the report outside the system.

## 8.1 Using Quick Filters

Clicking on a report displays a screen containing currently selected rows, columns, and filters:

**Volume: Health Homes**

Column Grand Total Row Grand Total  Expand All  Collapse All

Column Subtotals Row Subtotals

Create Date  Is Reportable?

Care Manager Type  HCBS Enrollment

Health Home Serving Adults (HHSA)

Not Enrolled

Health Home	Care Management Agency	Incident/Complaint	Issue Type	Issues	Same Member within 30 Days	Resolved within 30 Days	Resolved More Than 30 Days	Unresolved Issues
Northwell Health	Abbott House	Complaint/ Grievance		1	0	1	0	0
		Incident		3	0	1	0	2
HHC Health Home - North Central Bronx ACT Case		Complaint/ Grievance		16	0	5	11	0

Users can quickly filter on any category by clicking the filter icon to narrow the display in the report preview screen:

Issue Type

Search

Select All

(Blanks)

Abuse - Misappropriation of Me...

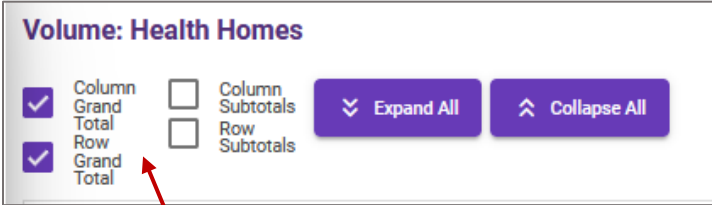
Abuse - Neglect

Abuse - Physical

Abuse - Psychological

OK Cancel

Selecting "Total" options will add Grand and Subtotals to the report.



### 8.2 Exporting a Report to Excel

Clicking the icon below will export the report to Excel .xlsx format.



## Appendix

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### Appendix A: Definitions

**Abuse:** Any of the following acts:

- **Physical Abuse:** any non-accidental physical contact with a participant which causes or has the potential to cause physical harm. Examples include, but are not limited to, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, or the use of corporal punishment.
- **Psychological Abuse:** includes any verbal or nonverbal conduct that is intended to cause a participant emotional distress. Examples include, but are not limited to, teasing, taunting, name calling, threats, display of a weapon or other object that could reasonably be perceived by the participant as a means of infliction of pain or injury, insulting or coarse language or gestures directed toward a participant which subjects the patient to humiliation or degradation; violation of participant rights or misuse of authority.
- **Sexual Abuse/Sexual Contact:** includes any sexual contact and a participant. Examples include, but are not limited to, rape, sexual assault, inappropriate touching and fondling, indecent exposure, penetration (or attempted penetration) of vagina, anus or mouth by penis, fingers, or other objects. For purposes of this policy, sexual abuse shall also include sexual activity involving a participant and a service provider; or any sexual activity involving a member that is encouraged by a service provider, including but not limited to, sending sexually explicit materials through electronic means (including mobile phones, electronic mail, etc.), voyeurism, or sexual exploitation.
- **Neglect:** any action, inaction or lack of attention that breaches a service provider'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 the participant.
- **Misappropriation of Member Funds:** use, appropriation, or misappropriation by a service provider of a participant's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the participant of those resources. Examples include the deliberate misplacement, theft, or wrongful, temporary, or permanent use of a participant's belongings or money.

**Children and Youth Evaluation Service (C-YES):** C-YES is the State-designated Independent Entity who develops and manages the HCBS plan of care for children and youth enrolled in the 1915(c) Children's Waiver who elect to opt out of Health Home care management but still want to receive HCBS. The 1915(c) Children's Waiver of HCBS requires that each participant receives care coordination for HCBS. Health Home care management provides this care coordination unless the participant opts-out and are managed by C-YES.

**Complaint:** Dissatisfaction expressed verbally or in writing by or on behalf of a member, other than an appeal or Fair Hearing Rights. Such expressions may include dissatisfaction with the provision of services or other services identified in the member's

plan of care. For example: a customer service issue; lack of/dissatisfaction with coordination of care; a long wait in doctor's office; Health Home Care Manager (HHCM) not returning phone calls; HHCMs lack of response to member request for changing HHCM or Care Management Agency (CMA); etc.

**Complainant:** the person reporting the issue or filing the complaint; this could be either the member themselves (if they are self-reporting ) or a person acting on their behalf (such as a family member).

**Crime Level 1:** An arrest of a member for a crime committed against persons (i.e. murder, rape, assault) or crimes against property (i.e. arson, robbery, burglary) AND is perceived to be a significant danger to the community or poses a significant concern to the community.

**Grievance:** A wrong or hardship suffered (real or perceived), which is the grounds of a complaint.

**Death:** The death of a member resulting from an apparent homicide, suicide, or unexplained or accidental cause; the death of a member which is unrelated to the natural course of illness or disease.

**Exploitation:** taking advantage of a [participant] for personal gain through the use of manipulation, intimidation, threats, or coercion.

**Fair Hearing:** A Fair Hearing is a chance for an individual to have an eligibility or service decision reviewed by an Administrative Law Judge from the New York State Office of Temporary and Disability Assistance (OTDA), when the individual does not agree with the decision made or thinks it is wrong.

**Incident:** A reportable or critical incident is an event involving a participant, which has, or may have, an adverse effect on the life, health, or welfare of the participant

**Issue:** within the IRAMS system, "issue" is used to refer to either an incident or a complaint/grievance.

**Member:** For the purpose of this document, whenever 'member' is used it refers to the child or youth and their parent(s), guardian, or legally authorized representative, unless stated otherwise.

**Missing Person:** When a member 18 or older is considered missing AND the disappearance is possibly not voluntary, or a Law Enforcement Agency has issued a Missing Person Entry, OR when a child's (under the age of 18) whereabouts are unknown to the child's parent, guardian or legally authorized representative.



**Restrictive Interventions** – According to the CMS Final Rule 42 CFR Part 482 (Federal Register/Vol 71, No. 236, pg. 71427):

- A **restraint** is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition; a restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
- **Seclusion** is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

**Suicide Attempt:** An act committed by a member in an effort to cause his or her own death.

**Violation of Protected Health Information:** Any violation of a client's rights to confidentiality pursuant to State and Federal laws including, but not limited to, 42 CFR Part 2 or the Health Insurance Portability and Accountability Act (HIPAA), and Article 27F. The CMA has a responsibility to review to determine whether the incident is a breach of security vs. a breach of privacy.

## Appendix B: Types of Complaints/Grievances

### Complaints/Grievances

- Any violation of rights: for example, a participant's plan of care being shared with a provider that is not listed on their consent form
- Availability of service or ability to receive service: for example, a participant being placed on a waitlist to receive a service for more than 1 month
- Quality of care received and/or whether services are meeting the member's needs: for example, services provider are not addressing the needs/goals identified on the participant's plan of care
- Afforded choice of providers: for example, a participant being told they must receive care management and services from the same agency
- Whether back up plans are effective: for example, participant is not able to reach provider during a crisis
- Program eligibility and/or qualifications: for example, participant believes their eligibility assessment was conducted incorrectly
- Whether health and welfare are being maintained: for example, participant does not receive required care management visits to ensure health and welfare
- Dissatisfaction with services or providers of services: for example, provider cancelling meetings/sessions or a long wait in a doctor's office