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June 6, 2025

MEMORANDUM

MEMO NO
QI-2513

TO: QUEST Integration (QI) Health Plans
Home and Community Based Services (HCBS) Providers
Department of Health Office of Health Care Assurance (DOH OHCA)
Community Ties of America, Inc. (CTA)

FROM: Judy Mohr Peterson, PhD JMP
Med-QUEST Division Administrator

SUBJECT: ADVERSE EVENT REPORT (AER) FORM AND INSTRUCTIONS

This memorandum informs the health plans, HCBS providers, DOH OHCA, and CTA that the DHS Form 519 will be retired and replaced by the AER form, described in this memo. The attached AER form aligns with state and federal reporting requirements and responds to feedback from health plans and healthcare providers about adverse events and adverse event reporting processes. Health plans, Community Case Management Agencies (CCMAs), and other contract providers are required to use the AER form effective July 1, 2025. Health plans must report information gathered in the AER form in their October 31, 2025, AER submission.

The AER form only applies to QI members residing at home and in the community, including residential settings, paid for by QI health plans. This form does not apply to QI members residing in institutional settings paid by QI health plans, nor does it apply to QI members residing in a residential setting not paid for by QI health plans.

Significant revisions include:

1. Additional details on reporting requirements and timelines provided in the instructions.

2. AER form requires additional information in all sections.

a. Section A:
   i. Requirement to report adverse event (AE) Reporter relationship to member
   ii. Requirement to report AE perpetrator, if applicable
   iii. Requirement to report Med-QUEST Provider ID number
   iv. Requirement for AE Reporter to sign AE Form
   v. Additional details required include AE Time reported in 24-hour time scale and AE Setting Name
   vi. New wording pertaining to AEs resulting in extension of hospital stay
   vii. Updated option set for AE Reporting: Adult Protective Services (APS), Child Protective Services (CPS), CTA, QI health plans, Police, Other

b. Section B:
   i. Requirement to report CCMA or Case Manager (CM) Name
   ii. Additional details on AE Type, Level of Harm, and Contributing Factors
   iii. Addition of field: Root Cause Analysis completed (Y/N)
   iv. Addition of field: Was AE related to a service that was Denied or Refused?
   v. Addition of field: Was a site visit conducted by a CM?
   vi. New wording pertaining to action steps taken to safeguard member
   vii. Updated option set for AE Reporting: APS, CPS, CTA, QI health plans, Police, Other

c. Section C:
   i. Requirement to report HP Name, Health Coordinator Name, and signature
   ii. Addition of fields: Written Report Date and Time Received
   iii. Additional details on AE Type, Level of Harm, and Contributing Factors
   iv. Addition of field: RCA completed (Y/N)
   v. Addition of field: Was AE related to a service that was Denied or Refused?
   vi. Addition of field: Was a site visit conducted by CM?
   vii. New wording pertaining to action steps taken to safeguard member
   viii. Addition of field: Was a site visit conducted by CM?
   ix. Addition of fields: Similar AE Setting, Similar AE member
   x. Additional fields: Are there any mitigating factors identified? Y/N, describe mitigating factors identified
   xi. Updated option set for AE Reporting: APS, CPS, CTA, QI health plan, Police, Other

3. New step-by-step instructions pages on how to complete the entire AER form.

Please submit any questions to HCSBInquiries@dhs.hawaii.gov.

Enclosures

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: _____
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: _____

Adverse Event Report (AER) Instructions

General instructions:

- Complete AER Form to report any type of adverse event (AE), including but not limited to medication or treatment-related, neglect, abuse (e.g., verbal, physical, sexual, mental/psychological), suicide/suicide-attempt, exploitation, fall/fall-related injury, elopement/missing person, restraint/seclusion, insect infestation, healthcare-acquired infections, healthcare-acquired conditions, and others (e.g., skin breakdown).
- Use the form to report any adverse event that occurred in member's own home and in the community, including residential settings, where there are services rendered and paid by a QUEST-Integration health plan.

Reporting Timelines for members residing in Community Care Foster Family Home (CCFFH), Expanded-Adult Residential Care Home (E-ARCH), or Assisted Living Facility (ALF):

- Contract Provider to give verbal report to Community Case Management Agency (CCMA) Case Manager (CM) within 24 hours of the AE.
- 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.
- 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 weekends 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).

This section is to be completed by the Contract Provider (or Member's caregiver) if the Member is residing in a CCFFH, E-ARCH, or ALF. For all other settings, Member or Health Coordinator (HC) may complete this section based on the information provided by the Member or any person who witnessed the AE (i.e., physician's offices, employers, institutional healthcare facilities, family, friends, etc.). An individual may need to complete multiple sections. For example, if the AE reporter is also the CCMA/CM, they should complete both sections A and B.

1. Enter the name (First Name, Middle Initial, Last Name) and phone number of the reporter and the relationship to the Member. This is the person completing section A of the form.
2. Enter the source of AE, if other than number 1. This is the source/person who reported the AE.
3. Enter the date (MM/DD/YYYY) and time (24-hour scale, or military time) of when the AE occurred.
4. Enter the Member's name (First Name, Middle Initial, Last Name) and date of birth (MM/DD/YYYY).
5. Enter the Member's Medicaid (HAWI) identification (ID) number. This is Department of Human Services (DHS) Med-QUEST Division's (MQD) assigned Member ID number.
6. Describe the AE. Include any precipitating factors leading up to the event and other details including, but not limited to, the answers to the following questions:
    a. What happened?
    b. Why did it happen?
    c. How did it happen?
    d. Who is/are involved?

7. Check the appropriate setting where the AE occurred. If it was with a specific provider, then specify the provider's name. If other, specify the type or name of setting.
8. Check the appropriate box to indicate the AE perpetrator, if applicable, or the cause of the AE. Perpetrators may include providers (doctors, nurses, etc.), facility staff, or none (member falls on a slippery floor in a facility hallway). If 'Other,' specify the perpetrator's name and their relationship to the Member.
    a. AE Perpetrator is the person or institution which inflicted or caused AE.
    b. Member is the individual receiving care.
    c. Other is any person or institution not classified as a Member.
    d. Not applicable (N/A) is used when the AE perpetrator is not applicable.
        - Examples when the AE perpetrator is not applicable:
            i. A member falls due to a wet floor from rain.
            ii. A member developed moisture-associated skin breakdown due to incontinence in spite of provider following MD orders and best practices to prevent skin breakdown.
    e. Unknown is used when the AE perpetrator is not known.
9. Enter the Med-QUEST Provider ID number (or HOKU ID number) of the Medicaid-enrolled provider responsible for the AE, if applicable. This may be left blank if unknown or does not apply.
10. Indicate whether the AE led to Member's ER visit and/or hospitalization.
    a. Did AE lead to ER visit? Check the appropriate box.
    b. If yes, did AE lead to hospitalization or inpatient facility stay? Check the appropriate box.

    NOTE: If the Member first went to ER and then was admitted to the hospital or inpatient facility, then select "Yes" for both ER visit and hospitalization or inpatient facility stay.

11. Describe any action steps completed by family/residential setting caregiver/contract provider because of the AE
    a. Action steps: Interventions taken by the provider immediately after the adverse event. Examples include applying first aid, assessing the member for injuries, identifying the cause of the AE and correcting it, calling the doctor for notification or treatment order
    b. If other person(s)/agency(ies) were notified about the AE, include their name and contact information (i.e., police, authorized representative(s), family(ies), guardian(s), PCP, case manager, health coordinator, 911).
    c. If PCP was notified, include the new order, if any.
12. Indicate who AE was reported to by checking the appropriate box(es). If "other" is checked, enter the name of the agency/organization.
13. Include the reporter's signature of reporter and the report date.

Section B: To be completed by the CCMA/CM. This section only applies to members living in CCFFH, E-ARCH, or ALF.

1. Enter the name of the CCMA (First Name, Middle Initial, Last Name).
2. Enter the name of the CM assigned to the Member.
3. Enter the name (First Name, Middle Initial, Last Name), phone number, and physical address of the residential provider/setting (CCFFH, E-ARCH, ALF), if applicable.
4. Enter the date **(**MM/DD/YYYY) and time (24-hour scale) verbal report was received. This must be

on or after the date the AE occurred.

5. Enter the date (MM/DD/YYYY) and time (24-hour scale) written report was received. This must be on or after the date the AE occurred.
   Indicate whether the date and time verbal report and written report were received within the required timeframes by checking the appropriate box.
6. Indicate the AE type by checking the appropriate box. If other is checked, specify the AE. Refer to Table 2 – Definitions for additional guidance.
7. Indicate the level of harm by checking the appropriate box. Harm shall be assessed using a method adapted from the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Index. Refer to Table 3 – Harm Description and Categories for additional guidance.
8. Indicate whether a root-cause analysis (RCA) was conducted by checking the appropriate box.
9. Describe the contributing factors identified during RCA. This must be completed if "yes" is checked to question #8.
10. Indicate whether the AE was due to a service that the Member was denied, refused, or N/A by checking the appropriate box(es). If denied and/or refused is checked, specify the service that was not received.
11. Indicate whether the immediate action steps taken are appropriate to safeguard the member. If not, list any remediation plan.
    a. Action steps: Interventions taken by the provider immediately after the adverse event. Examples include applying first aid, taking vital signs, assessing the member for injuries, identifying the cause of the AE and correcting it, calling the doctor for notification or treatment order
    b. Remediation plan: Corrective actions taken by the case manager to identify areas for improvement to educate and support provider and to prevent the same AE from reoccurrence.
12. Indicate whether a site visit was conducted by CM by checking the appropriate box. If "yes" is checked, enter the date of the site visit.
    Enter any recommendation or action steps made during site visit, if any.
13. Indicate whether the CCMA/CM reported the AE to other entities by checking the appropriate box(es). If "other" is checked, enter the name of the agency/organization. Check only the entities that the AE was reported to by the HP/HC. If the AE was reported to the same group in another section, the CCMA/CM does not need to report to the same group again unless the situation requires it.
14. Include the CCMA/CM's signature of and the report date.

CCMA/CM to submit a copy to the 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 and Bernadette Cabilao: Bernadette.R1.cabilao@kp.org
Ohana: Email to HPQM_Dept@centene.com
United HealthCare: Email to reportaconcern@uhc.com

Section C: To be completed by the HP/HC on all QI members.

1. Enter the name of the HP.
2. Enter the name (First Name, Middle Initial, Last Name) of the HC assigned to the Member.
3. Enter the date (MM/DD/YYYY) and time (24-hour scale) verbal report was received. This must be

on or after the date the AE occurred.

4. Enter the date (MM/DD/YYYY) and time (24-hour scale) written report was received. This must be on or after the date the AE occurred.
5. Indicate the AE type by checking the appropriate box. If other is checked, specify the AE. Refer to Table 2 – Definitions for additional guidance.
6. Indicate the level of harm by checking the appropriate box. Harm shall be assessed using a method adapted from the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Index. Refer to Table 3– Harm Description and Categories for additional guidance.
7. Indicate whether a root-cause analysis (RCA) was conducted by checking the appropriate box.
8. Describe the contributing factors identified during RCA. This must be completed if "yes" is checked to question #7. Do not rewrite the CCMA/CM has already identified in their section.
9. Indicate whether the AE was related to a service that the Member was denied, refused, or N/A by checking the appropriate box(es) If denied and/or refused is checked, specify the service that was not received.
10. Indicate whether the immediate action steps taken are appropriate to safeguard the member. If not, list any remediation plan.
    a. Action steps: Interventions taken by the provider immediately after the adverse event. Examples include applying first aid, assessing the member for injuries, identifying the cause of the AE and correcting it, calling the doctor for notification or treatment order
    b. Remediation plan: Corrective actions taken by the case manager to identify areas for improvement to educate and support provider and to prevent the same AE from reoccurrence.
11. Indicate whether a site visit was conducted by HC by checking the appropriate box.
    If "yes" is checked, enter the date of the site visit.
    Enter any recommendation or action steps made during site visit, if any.
12. Indicate whether a similar AE occurred in this same setting within the past 12 months by checking the appropriate box.
13. Indicate whether a similar AE occurred to the same member within the past 12 months by checking the appropriate box.
14. Indicate whether there were any mitigating factors identified by checking appropriate box.
15. Describe any mitigating factors identified.
    If AER is an unexpected death or if there are suspicious circumstances, further review should be conducted, first through an initial deep review by the CCMA and HP, and if appropriate, through further review, such as a mortality review committee. Health Plans should indicate any further review here.
16. Indicate whether the HP/HC reported the AE to other entities by checking the appropriate box(es). If "other" is checked, enter the name of the agency/organization. Check only the entities that the AE was reported to by the HP/HC. If the AE was reported to the same group in another section, the HP/HC does not need to report to the same group again unless the situation requires it.
17. Include the HC's signature and the report date.

Reminders:

1. All reports of abuse and/or neglect of adults (members 18 years or older) must be sent to the APS.
2. All reports of abuse and/or neglect of children (members under the age of 18 years) must be sent to the CPS.

Table 1 – ACRONYMS	
AE = Adverse Event	E-ARCH = Expanded-Adult Residential Care Home
AER = Adverse Event Report	ER = Emergency Room
ALF = Assisted Living Facility	HC = Health Coordinator
APS = Adult Protective Services	HP = Health Plan(s)
CCFFH = Community Care Foster Family Home	ID = Identification
CCMA = Community Case Management Agency	MQD = Med-QUEST Division
CM = Case Manager	N/A = Not applicable, not appropriate
CPS = Child Protective Services	QI = QUEST Integration
CTA = Community Ties of America, Inc.	RCA = Root-Cause Analysis
DHS = Department of Human Services	

Table 2 – DEFINITIONS	
Adverse Events Related to Medical Care	Four types of events are considered adverse events related to medical care, including those related to adverse drug events, treatments, healthcare acquired conditions (HCAC), and other provider preventable conditions (OPPC) including medication errors. Adverse events related to medical care may occur in any setting including in an institution, while the member is receiving residential care, at the member's home, or elsewhere.
Adverse Events Related to Residential Care	Eight types of adverse events may result while the member is in institutional or residential care, including: neglect, abuse, suicide attempt, exploitation, fall/injury, elopement/missing person, restraint/seclusion, and insect infestation. These types of adverse events are reportable if they occur in any types of institutional/residential care settings for which the Health Plan pays, or if they occur while the member is under the care of a provider for which the Health Plan pays.
Events Related to Infection	These types of events include infections that members acquired while receiving surgical or other medical treatment and services. A defined list of HAIs can be found here at https://cdc.gov/hai/infectiontypes.html
Root Cause	A factor which by removal would prevent the occurrence of the AE, other factors that affect the outcome should not be considered as root causes.
Root Cause Analysis	An approach used to analyze serious problems before trying to solve them, by which the main root cause of a problem is isolated and identified.
	TYPES OF EVENTS
Medication-related AE	An unintended act toward an individual either through omission or commission that causes potential for harm or actual harm. Medication administration involving one or more of the following: wrong medication, wrong dose, wrong time, missed dose, wrong route/method, or failure to document or incorrect documentation.
Treatment-related AE	These are adverse events that emerge during treatment, having been absent before or which worsen relative to the pre-treatment state.
Neglect	The failure to provide goods and services necessary to avoid physical harm, mental, anguish or mental illness; neglect that causes, or is likely to cause, harm to a person. Self-neglect is included in this definition. Caregiver – failure to provide adequate food, shelter, clothing, timely health care, personal hygiene, supervision, protection from abandonment, or failure to carry out

	responsibilities that a reasonable person would exercise as an assumed legal or contractual caregiver. Self – failure to care for one's self thereby exposing one's self to a condition that poses an immediate risk or death or serious physical harm.
Abuse	The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a member. Self-abuse is considered abuse. Types: Physical = Non-accidental injury, pain, or impairment such as from hitting, slapping, improper physical restraint, or poisoning. Mental/Psychological or Verbal – Threats, insults, harassments, humiliation, or other means that profoundly confuse or frighten the member. Sexual – Sexual contact or conduct including pornographic photographing without consent.
Suicide / Suicide attempt	Self-inflicted death or injury that is the result of intentional action by an individual to end their life.
Exploitation	The deliberate misplacement, misuse or wrongful temporary or permanent use of a member's belongings or money without the member's consent.
Fall / Fall-related injury	An unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). It may be witnessed or unwitnessed. Falls are not a result of an overwhelming external force (e.g., a person pushes another person)
Elopement / Missing person	Unauthorized departure. Includes wandering.
Restraint / Seclusion	Any use of prohibited restrictive intervention or procedure that restricts the member's freedom of movement, access to other locations, property individuals, or rights. Types: Physical restraints – Any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to their body. Chemical restraints – Any psychotropic medication prescribed by a licensed health care professional with prescriptive authority. - On a routine basis without an appropriate diagnosis found in the current version of the Diagnostic and Statistical Manual (DSM) for the purpose of behavioral control. - Incidental use of medications, sometimes called as needed or prn medications, to restrict the freedom of movement or temporarily sedate the member. Involuntary Seclusion – Involuntary confinement of a member in a room or area from which the member was prevented from having contact with others or leaving

	by closing the door or using another barrier.
Insect/rodent infestation –	Any widespread incident or detected increase of insects or rodents that may cause inconvenience, discomfort, or spread of disease. Insects/rodents may include bed bugs, cockroaches, flies, mites, mice, rats, or any number of other insect/rodent pests. In the case of bedbugs or mites, ANY presence constitutes an infestation.
Healthcare-acquired Infection (HAI)	These include infections that members acquired while receiving surgical or other medical treatment and services. A defined list of HAIs can be found here at https://cdc.gov/hai/infectiontypes.html Examples include: i) Central line-associated bloodstream infection (CLABSI) ii) Catheter-associated urinary tract infection (CAUTI) iii) Surgical site infection (SSI) iv) Ventilator-associated pneumonia (VAP)
Healthcare-acquired Condition (HAC)	These include conditions that a patient develops while being treated for something else.
Other	Examples: Accidental or unexpected death (i.e., MI or stroke and died), skin breakdowns (i.e., pressure injury)

Table 3 – Harm Description and Categories

Category	Description	Harm Categorization
Category A	Circumstances that have the capacity to cause an adverse event.	Unsafe condition or near miss
Category B	An event occurred that did not reach the patient (an "error of omission" does reach the patient).	
Category C	An event occurred that reached the patient but did not cause patient harm. Harm is defined as "any physical injury or damage to the health of a person requiring additional medical care, including both temporary and permanent injury."	Adverseevent, no harm
Category D	An event occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm. Monitoring is defined as "to observe or record physiological or psychological signs." Intervention is defined as including "change in therapy or active medical/surgical treatment."	Adverse event, no harm, increased patient monitoring needed
Category E	An event occurred that may have contributed to or resulted in temporary harm to the patient but did not require a significant intervention. Significant intervention is defined as "an intervention intended to relieve symptoms that have the potential to be life-threatening if not addressed."	Adverse event, less serious harm

Category F	An event occurred that may have contributed to or resulted in temporary harm to the patient and required a significant intervention. Significant intervention is defined as "an intervention intended to relieve symptoms that have the potential to be life-threatening if not addressed." The types of interventions may include, but not be limited to, an emergency visit, hospitalization, or prolongation of an existing hospitalization or institutional stay.	Adverse event, serious harm or death
Category G	An event occurred that may have contributed to or resulted in permanent patient harm. Permanent harm is defined as "harm lasting more than 6 months, or where end harm is not known ('watchful waiting')."	
Category H	An event occurred that required intervention necessary to sustain life. Intervention necessary to sustain life is defined as including "cardiovascular and/or respiratory support (e.g., CPR, defibrillation, intubation)."	
Category I	An event occurred that may have contributed to or resulted in patient's death.	