Bureau of Developmental Services: He-M 1201
Area Agency Instructions for Completion of Form 1201-C

This form is required by He-M 1201-Administration of Medications in Developmental Services Programs. It is to be completed by area agencies and sent to the Medication Committee two times per year pursuant to He-M 1201.11(c) and (f) (Table 12.1.1). The form is designed to generate summary statements regarding the area agency's oversight of healthcare coordination and safe medication administration. The information entered onto the form will be generated through compilation of all the 1201-A and 1201-B Forms submitted by the rendering service provider agencies.

Please read the following instructions carefully before filling out the form and please complete all items. **Indicate "0", "none" or "N/A" when applicable.**

Note: If errors are identified by a rendering service provider agency outside of the reporting cycle (e.g., during a state certification), they will include the error(s) and circumstance(s) within the 1201-A report under **Other Concerns** corresponding to the reporting period in which the error was found.

- Rendering service provider agencies should not report these **older** errors within the current statistical grid on the 1201-A and 1201-B Forms.
- Area Agencies should not report these older errors in the current statistical grid on the 1201-C Form.
- Area agencies should note the occurrence of the **older** error(s) and circumstance(s) within the 1201-C Form under Corrective Action and /or Plans for Monitoring.
- The Area agency and Med Committee will review the error(s), and if further actions/instructions are needed, they will be provided at that time.

The standard expectation is that these forms will be typed. Illegible reports will be returned for revision and resubmission.

1. **Area Agency Name:** Enter the Area Agency name.
2. **Area Agency Region:** Indicate the region being reported on.
3. **Area Agency Address**: Include the address of the area agency.
4. **Area Agency Contact Person:** Please include a contact name.
5. **Title:** Please include their title.
6. **Contact Email:** Please include the contact email address.
7. **Contact Phone Number:** Please include the contact phone number.
8. **Number of Programs Where Unlicensed Persons Administer Medications:** Please indicate the total number of certified programs providing 1201 medication administration services for individuals supported by the specific Area Agency and classify each program by certification type. Combined programs (e.g., res/day = 1001/507, or 1001 with a 525 bed) should be indicated as an additional entry within the 1001 box.
    - He-M 507 (CPS)
    - He-M 518 (Supported employment)
    - He-M 521* (Home with personal care services for an adult family member)
    - He-M 524* (Home with personal care services for family member under age 22)
    - He-M 525* (Participant-directed and managed services)
    - He-M 1001 (Residential services)

*If He-M 1201 regulation is utilized for training and oversight, then full 1201 reporting is required (occurrence reporting, 1201-A, 1201-B and 1201-C forms).

9. **Number of Current Authorized Providers:** Indicate the total number of providers who are authorized to administer medications for individuals supported by the specific area agency reflected in the report.
    - This should include the total number of authorized providers who were able to administer medications within **<u>any</u>** period of the reporting cycle.
        - Authorized providers who ***remain*** authorized throughout that reporting period,
        - Those providers who were authorized ***in*** that reporting period but no longer authorized, and
        - Newly hired/authorized providers who were added at some point in that reporting cycle
        - Feel free to notate if these numbers include duplications.

10. **Number of Individuals Receiving Medications from Authorized Providers:** Enter the total number of individuals supported by the specific area agency reported on who are receiving services in certified programs and have medications administered to them by licensed or authorized providers from all 1201-B forms.

11. **Number of Medically Frail Individuals:** Enter the total number of individuals supported by the specific Area Agency who are receiving services in certified programs and are indicated to be in frail health from all 1201-B Forms.

~~12.~~ **Number of Medication Errors that Resulted in Medical Treatment (for DD Individuals Only):** Enter the total number of errors that may have contributed to or resulted in harm to individual(s) in the region identified with a developmental disability that required active intervention as a result of the error including monitoring, lab work, or follow-up in Emergency Room, Urgent Care, or medical office visit.

13. **Number of Medication Errors that Resulted in Medical Treatment (for ABD Individuals Only):** Enter the total number of errors that may have contributed to or resulted in harm to individual(s) in the region identified with an acquired brain disorder that required active intervention as a result of the error including monitoring, lab work, or follow-up in Emergency Room, Urgent Care, or medical office visit.

14. **Number of Individuals on ≥ 4 Psychotropic Medications:** Enter the total number of individuals who are receiving four or more psychotropic medications from all 1201-B Forms.

15. **Select Date:** Enter the full reporting period dates by using the drop-down calendar. Reporting period dates are identified within He-M 1201.11(f). The reporting period remains the same for every setting within that region's reporting cycle. The full reporting period dates must be indicated in this section to ensure the information provided reflects data from the entire reporting period.
    - Excerpt from C Form:
      Dear Dr. McLaren,
      *Enclosed are the semi-annual medication administration review He-M 1201-A, -B, and –C Form(s) for the period of **(select date)** through **(select date)**, each provider agency and/or area agency entity's performance summarized, and this corresponding area agency's plan for monitoring, oversight and quality improvement. In addition, from this area agency's perspective:*
    - The only time reporting period dates may differ is if you are doing a 1201-C form in conjunction with an ***interim*** 1201-A and/or 1201-B report.

16. **Medication Errors Occurrences for This Area Agency:** Enter the total number of medication errors by category (wrong med, time, dose, person, route, omission, or documentation errors) by utilizing the data provided on the 1201-B forms and then add those numbers for each error type. Enter "0" if none.

Medication Errors Occurrences for this Area Agency	
Wrong Medication	
Wrong Time	
Wrong Dose	
Wrong Person	
Wrong Route	
Omission of Medication	
Documentation Error	

17. **Summary of Medication Errors:**

    - **Total Errors:** Enter the total number of medication errors for all individuals supported by the specific area agency by adding the total number of errors from all 1201-B Forms**.**
    - **Total Number of Prescribed Doses:** Enter the total number of doses administered for all individuals supported by the specific area agency by adding the total number of doses administered from all 1201-B Forms.
    - **Error to Dosage Ratio:** Divide the total number of errors by the total number of prescribed doses to calculate the error to dosage ratio.
        - Note: This is not a percentage (e.g., 0.001109).

Summary of Medication Errors	
Total Errors	
Total Number of Prescribed Doses	
Error to Dosage Ratio	

18. **Summary of Significant Changes in Individual's Health Status and Associated**

Actions Taken: Please describe significant health changes individuals have experienced and actions taken by the area agency (or rendering service provider agency) to ensure individual's health care needs are met. Please comment on individuals who have been identified to be in frail health, including changes in functional abilities and how support has been adjusted to meet those needs.

19. **Positive Regional Trends:** Please identify any positive trends within the region which will assist or illustrate improved medication administration practices and lower error rates. Please note any specific initiatives or proactive measures that have been taken or proposed to help improve regional trends.

20. **Negative Regional Trends**: Please identify any trends within the region negatively impacting the ability to provide safe, accurate and efficient medication administration for individuals. Please indicate if there are patterns of medication administration errors that have become evident within the region and/or with a specific rendering service provider agency. Include any actions taken to correct or prevent reoccurrence of the errors to help improve regional trends.

21. **Regional Patterns of Non-Compliance:** Please comment on any patterns of non-compliance identified by the Nurse Trainers and rendering service provider agencies, and any plans for correction or increased oversight.

22. **Corrective Action and/or Plans for Monitoring:** Please indicate the area agency's plans for continued oversight of medication errors and compliance issues. Include any specific corrective action plans to correct or prevent reoccurrence of errors.

23. **Quality Improvement Initiatives:** Summarize the area agency's plan for ensuring that the corrective actions taken by the Nurse Trainers and rendering service provider agencies are appropriate and designed to address trends/systemic issues or breaches in medication administration systems such that individuals' risk for future errors is minimized or eliminated. Also summarize the area agency's plan for healthcare oversight. Please indicate which quality improvement plans are being enacted.

24. **Name:** Provide the name of the person completing the form.

25. **Date:** Provide the date that the form was completed.

26. **Signature or Electronic Signature**: Provide signature of person signing report. Either an electronic signature or handwritten signature are acceptable on this form.

27. **Contact Phone Number:** Provide contact phone number.