**Addiction and Prevention Services**
**State Quality Committee**

**Final**

# AGGREGATE ANALYSIS REPORT

**Reporting Period** **FROM:** July 1, 2010 **TO:** June 30, 2011
***FY2011 Annual Summary**

**Unit/Team/Department:**
PIHP Quality Improvement

**Topic/Project:**
Quality of Services
**Adverse Incident Report (VO # 5, Grid Row #14)**

**Monitoring Standard:**
42 CFR 438.240 Quality assessment and performance improvement program
42 CFR 438.240(c) Performance measurement and improvement

**Goal:**
The PIHP will track and report semi-annually to SRS/AAPS all adverse incidents that have occurred.

**Objectives:**
To assure the documentation is capturing all minimal, moderate, major, and sentinel events.
To evaluate for trends that may require system intervention
To allow data to be presented consistently for Committee evaluation and response

**Data Collection Activities:**
Data was collected from the ValueOptions QualityConnect system. This data is summary information that represents occurrences of actual or potential serious harm to the well-being of a SRS member or to others by the actions of a SRS member, who is receiving services managed by ValueOptions or has recently been discharged from services managed by ValueOptions. The report captures all minimal, moderate, major, and sentinel events.
Timeline:
- The region location is by provider location as requested in the November 2007 SQC meeting.
- As of first quarter FY09, social detox clients who needed medical clearance were not counted as an incident.
- As recommended in the November 2008 SQC meeting, ValueOptions Clinical staff will continue to identify potential adverse incidents as they review each KCPC, forward to ValueOptions Provider Relations staff, who then will follow-up with the Provider.
- As recommended in the November 2010 SQC meeting, the frequency of the report submission by VO and aggregate by the State be changed to semi-annual as longer time frames allow for improved data trending as data can vary significantly from quarter to quarter.
- October 2011: VO-KS has enhanced the adverse incident investigation process. All suicides and suspicious deaths will be investigated by the Clinical Department and all other Major and Sentinel adverse incidents will be investigated by Provider Relations staff. Provider Relations staff can at any point refer an adverse incident investigation to Clinical if necessary. The Adverse incident investigation includes a detailed review of the KCPC medical records, the medical record maintained at the provider

facility, and telephonic interviews with provider staff when necessary. Site visits will occur only if deemed appropriate by the Medical / Clinical Director leading the adverse incident investigation.

**Results:** **See next page**

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**AAPS funded**
Adverse Incidents by Category/Region

| | Total | | | |
|---|---|---|---|---|
| | **FY08** | **FY09** | **FY10** | **FY11** |
| **Self-Inflicted Harm** (requiring urgent/emergent treatment, suicide attempt) | **5** | **1** | **4** | **4** |
| **Unanticipated Death** (occurring in any setting, suicide, homicide, natural causes) | **8** | **10** | **8** | **31** |
| **Violent/Assaultive Behavior** (physical harm to self or others requiring urgent/emergent intervention) | **2** | **3** | **3** | **5** |
| **Sexual Behavior** (with staff or other patients while in a substance abuse treatment setting) | **3** | **3** | **10** | **1** |
| **Elopement from Hospital or Residential Setting** (when patient is alleged to be a danger to self or others) | **6** | **3** | **1** | **1** |
| **Injuries in Facility or Provider Office** (require urgent/emergent care, accidental) | **8** | **11** | **8** | **17** |
| **Fire Setting/Property Damage** (while in substance abuse treatment setting) | **0** | **0** | **6** | **3** |
| **Serious Adverse Treatment Reaction** (requiring urgent/emergent response, drug interaction) | **0** | **1** | **1** | **0** |
| **Medication Error** (requires urgent/emergent intervention) | **0** | **1** | **2** | **1** |
| **Human Rights/Civil Rights Violations** (neglect/exploitation) | **0** | **1** | **0** | **0** |
| **Other: Emergent Care Required** | **X** | **X** | **36** | **30** |
| **Other** (incidents not listed above which may cause actual or potential harm to the member) | **60** | **30** | **35** | **41** |
| **Total** | **92** | **64** | **114** | **134** |

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**Medicaid**

Adverse Incidents by Category/Region

| | | | Total | |
|---|---|---|---|---|
| | **FY08** | **FY09** | **FY10** | **FY11** |
| **Self-Inflicted Harm** (requiring urgent/emergent treatment, suicide attempt) | **2** | **5** | **4** | **2** |
| **Unanticipated Death** (occurring in any setting, suicide, homicide, natural causes) | **1** | **3** | **10** | **3** |
| **Violent/Assaultive Behavior** (physical harm to self or others requiring urgent/emergent intervention) | **1** | **2** | **6** | **4** |
| **Sexual Behavior** (with staff or other patients while in a substance abuse treatment setting) | **2** | **3** | **4** | **2** |
| **Elopement from Hospital or Residential Setting** (when patient is alleged to be a danger to self or others) | **4** | **3** | **0** | **0** |
| **Injuries in Facility or Provider Office** (require urgent/emergent care, accidental) | **4** | **3** | **3** | **4** |
| **Fire Setting/Property Damage** (while in substance abuse reatment setting) | **0** | **0** | **1** | **0** |
| **Serious Adverse Treatment Reaction** (requiring urgent/emergent response, drug interaction) | **0** | **0** | **0** | **0** |
| **Medication Error** (requires urgent/emergent intervention) | **1** | **0** | **0** | **1** |
| **Human Rights/Civil Rights Violations** (neglect/exploitation) | **0** | **0** | **0** | **0** |
| **Other: Emergent Care Required** | **X** | **X** | **14** | **19** |
| **Other** (incidents not listed above which may cause actual or potential harm to the member) | **10** | **23** | **15** | **33** |
| **Total** | **25** | **42** | **57** | **68** |

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**Medicaid and AAPS funded**

Adverse Incidents by Category/Region

| | Total | | | |
|---|---|---|---|---|
| | FY08 | FY09 | FY10 | FY11 |
| **Self-Inflicted Harm** (requiring urgent/emergent treatment, suicide attempt) | 7 | 6 | 8 | 6 |
| **Unanticipated Death** (occurring in any setting, suicide, homicide, natural causes) | 9 | 13 | 18 | 34 |
| **Violent/Assaultive Behavior** (physical harm to self or others requiring urgent/emergent intervention) | 3 | 5 | 9 | 9 |
| **Sexual Behavior** (with staff or other patients while in a substance abuse treatment setting) | 5 | 6 | 14 | 3 |
| **Elopement from Hospital or Residential Setting** (when patient is alleged to be a danger to self or others) | 10 | 6 | 1 | 1 |
| **Injuries in Facility or Provider Office** (require urgent/emergent care, accidental) | 12 | 14 | 11 | 21 |
| **Fire Setting/Property Damage** (while in substance abuse reatment setting) | 0 | 0 | 7 | 3 |
| **Serious Adverse Treatment Reaction** (requiring urgent/emergent response, drug interaction) | 0 | 1 | 1 | 0 |
| **Medication Error** (requires urgent/emergent intervention) | 1 | 1 | 2 | 2 |
| **Human Rights/Civil Rights Violations** (neglect/exploitation) | 0 | 1 | 0 | 0 |
| **Other: Emergent Care Required** | X | X | 50 | 49 |
| **Other** (incidents not listed above which may cause actual or potential harm to the member) | 70 | 53 | 50 | 74 |
| **Total** | 117 | 106 | 171 | 202 |

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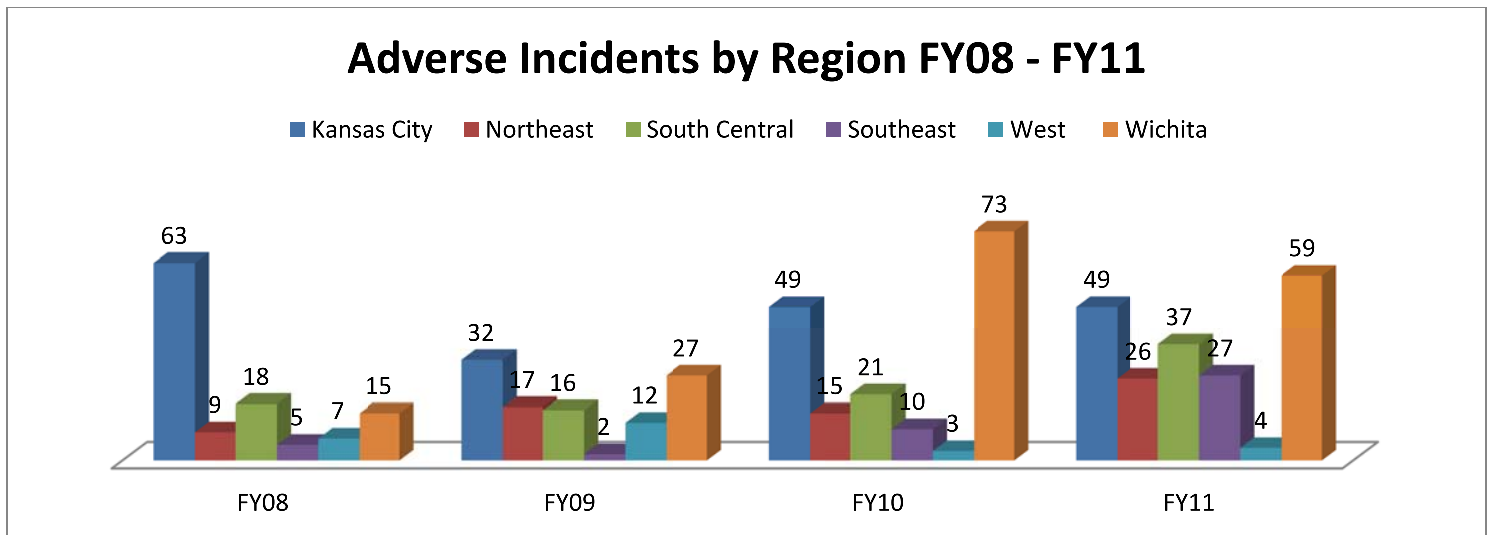
**FY2011 Medicaid and AAPS Other Incidents reported:**

| Other* and Other: Emergent Care Required | Kansas City | Northeast | South Central | Southeast | West | Wichita |
|---|---|---|---|---|---|---|
| 911 called; member refused treatment | 12 | 7 | 8 | 1 | 0 | 14 |
| Contagious illness | 1 | 0 | 0 | 0 | 0 | 0 |
| Ingestion of unauthorized substance | 2 | 1 | 0 | 1 | 0 | 2 |
| Medical attention / discharge | 9 | 2 | 9 | 7 | 0 | 12 |
| Member misconduct | 3 | 1 | 3 | 4 | 0 | 7 |
| Mental health | 1 | 3 | 3 | 1 | 0 | 2 |
| Taken to jail | 2 | 0 | 0 | 0 | 0 | 0 |
| Bugs | 0 | 0 | 0 | 0 | 1 | 2 |
| Allegations of serious crime/duty to warn | 0 | 0 | 2 | 0 | 0 | 0 |




*Total Admissions Higher and Lower Levels of Care by Region FY11:
Kansas City – 7,878
Northeast – 6,777
South Central – 4,426
Southeast – 3,306
West – 3,708
Wichita – 7,831
Other (AAPS) - 25

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## FY2011 Unique Providers Reporting:

| | FY2011 |
|---|---|
| Not in Active treatment | 9 |
| Unique Residential Providers Reporting | 13 |
| Unique Outpatient Providers Reporting | 23 |
| Total Unique Providers Reporting | 31 |

## Conclusions:

## FY2011 Summary (7/1/10 – 6/30/11):

- For Medicaid, the highest number of incidents reported with a total of thirty-three (33) out of sixty-eight (68) adverse incidents statewide are in the "Other*" category. The next highest category is "Other: Emergent Care Required" with a total of nineteen (19).
- For AAPS funded, the highest incidents reported with a total of forty-one (41) out of one-hundred-thirty-four (134) adverse incidents statewide are in the "Other*" category. The next highest category is "Unanticipated Death" with a total of thirty-one (31).
- It was recommended by the Committee that ValueOptions add diagnosis into the summary report for unanticipated deaths. This has been done on the ValueOptions report.
- For both funding sources, Wichita region reported the most adverse incidents for FY2011 with a total of fifty-nine (59). The other regions reported, in decreasing order, Kansas City region forty-nine (49) adverse incidents, South Central region thirty-seven (37), Southeast twenty-seven (27), Northeast twenty-six (26), and the West four (4) incidents.
- In the last Committee meeting, the Committee thought the increase in adverse incidents each fiscal year may be resulting from improved reporting and an increase in violent deaths in the community. It was noted that ValueOptions does investigate all deaths. In reviewing the incidents, it appeared to be a more social issue, rather than a provider issue as the majority of deaths occurred outside of the treatment facilities.
- It is noted again that there is a significant increase in unanticipated deaths for FY2011, primarily for AAPS funded clients. The increase in incidents may be a continued reflection of improved provider self-reporting due to increased education by ValueOptions to providers. Also, providers are now reporting unanticipated deaths after a member is discharged from treatment if they see an obituary. This may also have impacted the increased reporting as well.
- It is noted that there were errors in the report VO originally submitted to the State stemming from the report frequency change from quarterly to semi-annual. After the November State Quality Committee (SQC) meeting, it was discovered that due to a different report process by VO that did not include an annual report to capture late incidents, the report and aggregate presented to the SQC were incorrect. Therefore, a revised report was received by the State and this aggregate has been updated.

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**Preliminary Recommendations to Committee:**

- It is recommended that trends continue to be monitored.
- Due to the significant increase in unanticipated deaths for FY2011, primarily for AAPS funded clients, it is recommended that further investigation into cause for all unanticipated deaths for FY2011 be done by ValueOptions-KS and reported to the State. **VO completed the unanticipated death analysis and submitted to AAPS on 11/29/11. From ValueOptions analysis of unanticipated deaths for FY2011, it is noted that of the 34 unanticipated deaths, 7 members were not in active substance use disorder treatment. Of the 27 members that were in active treatment: 20 were in outpatient, 5 in intensive outpatient, 1 in social detox, and 1 was in a residential treatment center (but the accident was work-related while member on pass).**
- Approval by the Committee is requested to post this aggregate analysis on the ValueOptions website for public access.
- It is recommended that the trends of number of unique providers who report be separated by quarter initially then by fiscal year for comparison purposes in ValueOptions reports. This metric is an attempt to ascertain if more incidents are occurring or if more unique providers are reporting. **The analysis completed and submitted to AAPS on 11/29/11 included unique number of providers reporting incidents.**
- **It is recommended that VO run an annual report of adverse incidents for future reports to ensure that all incidents reported after the report is pulled are captured.**

**Date Presented to SQC:** 11/17/2011 **BY:** Cissy McKinzie

**Recommendations from the Committee for action:** Committee approves of the Preliminary Recommendations as shown above. Enhancements made by the SQC to the Preliminary Recommendations are noted above in **bold**.

**Person Responsible to follow-up and date due:** Kim Brown__Due: 2/10/2012