KDADS
Behavioral Health / Substance Use Disorders
Quality Committee

AGGREGATE ANALYSIS REPORT

Reporting Period
FROM: January 1, 2013
TO: June 30, 2013

Unit/Team/Department:
Quality Committee

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

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

Goal:
The Quality Committee will track and report semi-annually to KDADS/BHS 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 member or to others by the actions of a 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 QC 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 QC 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 QC 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
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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.

- On July 1, 2012, Addiction and Prevention Services was moved to the Kansas Department for Aging and Disability Services. AAPS merged with Mental Health Services to become Behavioral Health Services.
- On January 1, 2013, Kansas contracted with three health plans, or managed care organizations (MCOs), to coordinate health care for nearly all Medicaid beneficiaries. The KanCare health plans are Amerigroup of Kansas, Inc. (Amerigroup), Sunflower State Health Plan (Sunflower), and UnitedHealthcare Community Plan of Kansas (United). All SUD Medicaid Services are managed under the KanCare MCO contracts.
- On January 1, 2013, Behavioral Health Services created new categories and definitions for adverse incidents.

Results:

<table>
<thead>
<tr>
<th>Adverse Incidents Categories</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventable Death</td>
<td>1</td>
<td>2.4%</td>
</tr>
<tr>
<td>Unanticipated Death</td>
<td>2</td>
<td>4.8%</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Inappropriate Sexual Contact</td>
<td>1</td>
<td>2.4%</td>
</tr>
<tr>
<td>Misuse of Medications</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Psychological Abuse</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Neglect</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Suicide</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Suicide Attempt</td>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>Serious Injury</td>
<td>11</td>
<td>26.2%</td>
</tr>
<tr>
<td>Elopement</td>
<td>6</td>
<td>14.3%</td>
</tr>
<tr>
<td>Law Enforcement Involvement</td>
<td>1</td>
<td>2.4%</td>
</tr>
<tr>
<td>High Profile Event</td>
<td>5</td>
<td>11.9%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>4.7%</td>
</tr>
<tr>
<td>ER Hospitalization</td>
<td>7</td>
<td>16.7%</td>
</tr>
<tr>
<td>Loss/Unauthorized Release of PHI</td>
<td>2</td>
<td>4.7%</td>
</tr>
<tr>
<td>Natural Disaster</td>
<td>1</td>
<td>2.4%</td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
<td>100%</td>
</tr>
</tbody>
</table>
Conclusions:

FY2014 Summary (01/01/2013 – 06/30/13):
- Serious Injury at 26.2% was the highest percentage of Adverse Incidents and ER Hospitalizations being the second highest at 16.7%.
- The West Region had the greatest number of adverse incidents, 35.7%.

Preliminary Recommendations to Committee:
- It is recommended that trends continue to be monitored.
- Approval by the Committee is requested to post this aggregate analysis on the ValueOptions website for public access.

Date Presented to QC: 8/16/2013    BY: Chrisy Khatib

Recommendations from the Committee for action: Committee approves of the Preliminary Recommendations as shown above.

Person Responsible to follow-up and date due: Stacy Chamberlain    Due: