

**Addiction and Prevention Services
State Quality Committee**

Final

AGGREGATE ANALYSIS REPORT

Reporting Period **FROM:** July 1, 2010 **TO:** December 31, 2010

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. VO conducts onsite investigations for all 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.

Results: See next page.

**Addiction and Prevention Services
State Quality Committee**

AAPS funded

Adverse Incidents by
Category/Region

Total

	FY08	FY09	FY10	FY11 YTD (includes Q1 & Q2)
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	14
Violent/Assaultive Behavior (physical harm to self or others requiring urgent/emergent intervention)	2	3	3	4
Sexual Behavior (with staff or other patients while in a substance abuse treatment setting)	3	3	10	0
Elopement from Hospital or Residential Setting (when patient is alleged to be a danger to self or others)	6	3	1	0
Injuries in Facility or Provider Office (require urgent/emergent care, accidental)	8	11	8	9
Fire Setting/Property Damage (while in substance abuse treatment setting)	0	0	6	1
Serious Adverse Treatment Reaction (requiring urgent/emergent response, drug interaction)	0	1	1	0
Medication Error (requires urgent/emergent intervention)	0	1	2	0
Human Rights/Civil Rights Violations (neglect/exploitation)	0	1	0	0
Other: Emergent Care Required	X	X	36	19
Other (incidents not listed above which may cause actual or potential harm to the member)	60	30	35	11
Total	92	64	114	62

**Addiction and Prevention Services
State Quality Committee**

Medicaid

Adverse Incidents by
Category/Region

Total

	FY08	FY09	FY10	FY11 YTD (includes Q1 & Q2)
Self-Inflicted Harm (requiring urgent/emergent treatment, suicide attempt)	2	5	4	0
Unanticipated Death (occurring in any setting, suicide, homicide, natural causes)	1	3	10	1
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	0
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	2
Fire Setting/Property Damage (while in substance abuse treatment setting)	0	0	1	1
Serious Adverse Treatment Reaction (requiring urgent/emergent response, drug interaction)	0	0	0	0
Medication Error (requires urgent/emergent intervention)	1	0	0	0
Human Rights/Civil Rights Violations (neglect/exploitation)	0	0	0	0
Other: Emergent Care Required	X	X	14	14
Other (incidents not listed above which may cause actual or potential harm to the member)	10	23	15	16
Total	25	42	57	38

**Addiction and Prevention Services
State Quality Committee**

Medicaid and AAPS funded

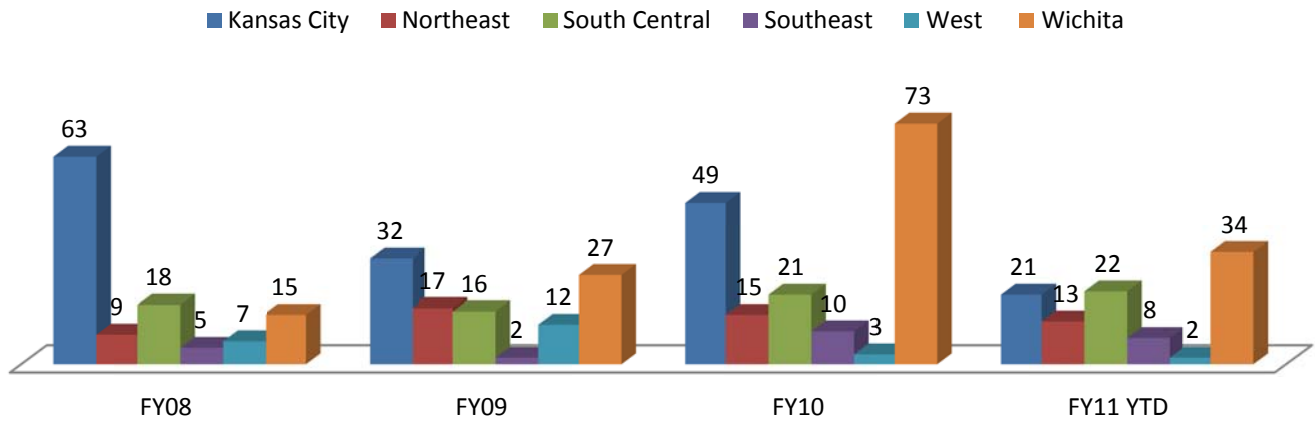
Adverse Incidents by
Category/Region

Total

	FY08	FY09	FY10	FY11 YTD (includes Q1 & Q2)
Self-Inflicted Harm (requiring urgent/emergent treatment, suicide attempt)	7	6	8	4
Unanticipated Death (occurring in any setting, suicide, homicide, natural causes)	9	13	18	15
Violent/Assaultive Behavior (physical harm to self or others requiring urgent/emergent intervention)	3	5	9	8
Sexual Behavior (with staff or other patients while in a substance abuse treatment setting)	5	6	14	0
Elopement from Hospital or Residential Setting (when patient is alleged to be a danger to self or others)	10	6	1	0
Injuries in Facility or Provider Office (require urgent/emergent care, accidental)	12	14	11	11
Fire Setting/Property Damage (while in substance abuse treatment setting)	0	0	7	2
Serious Adverse Treatment Reaction (requiring urgent/emergent response, drug interaction)	0	1	1	0
Medication Error (requires urgent/emergent intervention)	1	1	2	0
Human Rights/Civil Rights Violations (neglect/exploitation)	0	1	0	0
Other: Emergent Care Required	X	X	50	33
Other (incidents not listed above which may cause actual or potential harm to the member)	70	53	50	27
Total	117	106	171	100

**Addiction and Prevention Services
State Quality Committee**

Adverse Incidents by Region FY08 - FY11 YTD



Q1 and Q2 FY2011 Unique Providers Reporting:

	Q1 & Q2
Unique residential providers reporting	11
Unique outpatient providers reporting	16
Total unique providers reporting	21

Q1 and Q2 FY2011 Medicaid and AAPS Other Incidents reported:

*other:	Kansas City	Northeast	South Central	Southeast	West	Wichita
911 called; member refused treatment			1			
Contagious illness	1					
Ingestion of unauthorized substance	2	1		1		2
Medical discharge						1
Member misconduct	1	1	2			4
Mental health	1	3	2			2
Taken to jail	2					

Conclusions:

FY2011 Q1 and Q2 Summary (7/1/10 – 12/31/10):

- It was recommended by the Committee in the November 2010 SQC meeting that the tables and regional graph shown in this aggregate analysis not include quarterly breakouts, but rather a fiscal year to date total. This recommendation has been completed as shown in this aggregate analysis.
- It was also recommended by the Committee in the November 2010 SQC meeting that 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. This recommendation has also been completed.

**Addiction and Prevention Services
State Quality Committee**

- For Medicaid, the highest number of incidents reported with a total of sixteen (16) out of thirty-eight (38) adverse incidents statewide are in the “Other*” category. The next highest category is “Other: Emergent Care Required” with a total of fourteen (14).
- For AAPS funded, the highest incidents reported with a total of nineteen (19) out of sixty-two (62) adverse incidents statewide are in the “Other: Emergent Care Required” category. The next highest category is “Other*” with a total of eleven (11).
- Wichita region reported the most adverse incidents for Q1 and Q2 FY2011 with a total of thirty-four (34). The other regions reported, in decreasing order, South Central region twenty-two (22) adverse incidents, Kansas City region twenty-one (21), Northeast thirteen (13), Southeast eight (8), and the West two (2) incidents.
- What are the committee’s thoughts on the increase in adverse incidents each fiscal year? – **The Committee thought that the increase 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 appears to be a more social issue, rather than a provider issue as the majority of deaths occurred outside of the treatment facilities.**

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.
- 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.
- **It was recommended by the Committee that ValueOptions add diagnosis into the summary report for unanticipated deaths.**

Date Presented to SQC: 5/12/2011

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 and Conclusions are noted above in **bold**.

Person Responsible to follow-up and date due: Kim Brown Due: 8/11/2011