

**Addiction and Prevention Services  
State Quality Committee**

**Adverse incidents:** Occurrences that represent actual or potential harm to the well being of a ValueOptions member or to others by the actions of a ValueOptions member, who is receiving services managed by ValueOptions or has recently been discharged from services managed by ValueOptions.

**Final**

**AGGREGATE ANALYSIS REPORT**

**Reporting Period**                      **FROM:** October 1, 2008                      **TO:** December 31, 2008

**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 quarterly to SRS/AAPS all adverse incidents that have occurred in a given quarter.

**Objectives:**  
To assure the documentation is capturing these 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.

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.

**Results:** See next page.





## Addiction and Prevention Services State Quality Committee

### Medicaid and AAPS Funded:

FY09 Medicaid and AAPS  
funded  
Adverse Incidents by  
Category/Region

	Kansas City				Northeast				South Central				Southeast				West				Wichita				Total				Pct of Total							
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
<b>Self Inflicted Harm</b> (requiring urgent/emergent treatment, suicide attempt)	1																												1	0			5.9%	0.0%		
<b>Unanticipated Death</b> (occurring in any setting, suicide, homicide, natural causes)												1							1					1					2	1			11.8%	5.6%		
<b>Violent/Assaultive Behavior</b> (physical harm to self or others requiring urgent/emergent intervention)						1				1																			2	0			11.8%	0.0%		
<b>Sexual Behavior</b> (with staff or other patients while in a substance abuse treatment setting)		3				1	1																						1	4			5.9%	22.2%		
<b>Elopment from Hospital or Residential Setting</b> (when patient is alleged to be a danger to self or others)		3				1														1									1	4			5.9%	22.2%		
<b>Injuries in Facility or Provider Office</b> (require urgent/emergent care, accidental)	3									1								2				2	1						6	3			35.2%	16.7%		
<b>Fire Setting/Property Damage</b> (while in substance abuse treatment setting)																													0	0			0.0%	0.0%		
<b>Serious Adverse Treatment Reaction</b> (requiring urgent/emergent response, drug interaction)																													0	0			0.0%	0.0%		
<b>Medication Error</b> (requires urgent/emergent intervention)																													0	0			0.0%	0.0%		
<b>Human Rights/Civil Rights Violations</b> (neglect/exploitation)																													0	0			0.0%	0.0%		
<b>Other</b> (incidents not listed above which may cause actual or potential harm to the member)		3								2								2				2	1						4	6			23.5%	33.3%		
<b>Total</b>	4	9			3	1			4	0			1	0			0	5			5	3			17	18			100.0%	100.0%						

### Medicaid and AAPS Funded First Quarter Other Incidents:

*other:	Kansas City	Northeast	South Central	Southeast	West	Wichita
911/ER admission	2				1	1
911/ER urgent care required	1					
left facility and arrested					1	

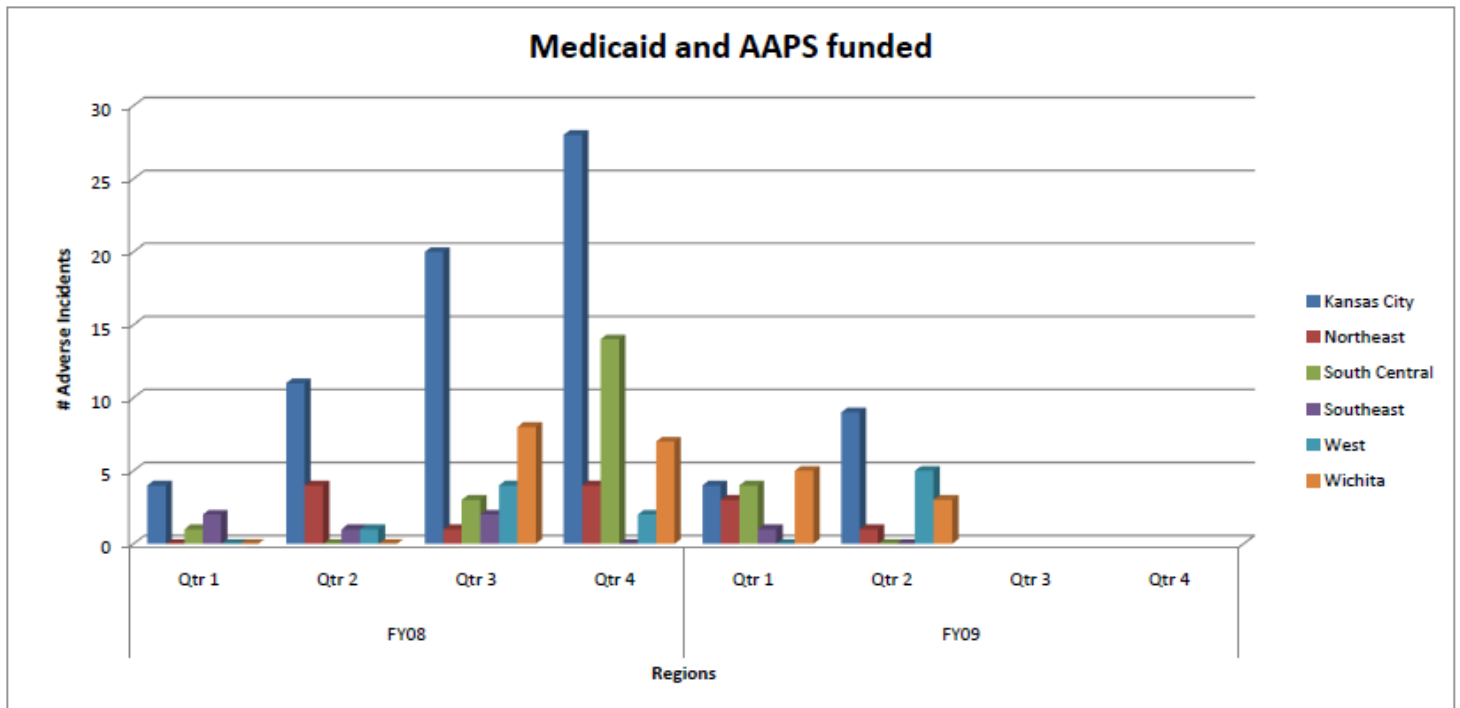
As of Q1 '09, social detox clients who needed medical clearance were not counted as an incident

## Addiction and Prevention Services State Quality Committee

### Medicaid and AAPS Funded Adverse Incidents (FY2008 and FY2009):

	FY08				FY09				FY 08	FY 09
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4		
Kansas City	4	11	20	28	4	9			63	13
Northeast	0	4	1	4	3	1			9	4
South Central	1	0	3	14	4	0			18	4
Southeast	2	1	2	0	1	0			5	1
West	0	1	4	2	0	5			7	5
Wichita	0	0	8	7	5	3			15	8
<b>Total</b>	<b>7</b>	<b>17</b>	<b>38</b>	<b>55</b>	<b>17</b>	<b>18</b>			<b>117</b>	<b>35</b>

Note: As of Qtr 1 FY09, social detox clients who needed medical clearance were not counted as an incident



### Conclusions:

In reviewing second quarter FY2009 data for both Medicaid and AAPS funded, the highest incidents reported with a total of six (6) out of eighteen (18) adverse incidents statewide are in the “Other” category, primarily 911/ER issues. The next highest categories are “Sexual Behavior” and “Elopement from Hospital or Residential Setting” each with a total of four (4).

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Kansas City region reported the most adverse incidents for second quarter FY2009 with a total of nine (9). South Central and Southeast regions did not report any adverse incidents second quarter FY2009. The other regions reported, in decreasing order, West region five (5) adverse incidents, Wichita three (3), and Northeast one (1).

Comparing second quarter FY2009 data to second quarter FY2008 data, total adverse incidents are about the same: FY2008 = 17, FY2009 = 18.

Comparing second quarter FY2009 data to first quarter FY2009, there has been a slight increase in total adverse incidents: first quarter = 17, second quarter = 18.

**As of Qtr 1 FY09, social detox clients who needed medical clearance were not counted as an incident.**

**ValueOptions – Kansas is creating a training document to help providers and regional Provider Relations staff understand adverse incident reporting.**

**Preliminary Recommendations to Committee:**

- It is recommended that trends continue to be monitored and Provider education by ValueOptions of adverse incident definitions and reporting continue.
- It is recommended by the Committee to share this aggregate analysis at the VO Regional QI meetings and be posted on the ValueOptions website for public access.
- It is recommended that ValueOptions do internal staff education. ValueOptions Clinical staff will continue to identify potential adverse incidents, forward to VO Provider Relations staff, who then will follow-up with the Provider. This will be a continuing/ongoing recommendation.
- **It is recommended that ValueOptions – Kansas report next quarter the total number of unique providers statewide who reported an adverse incident and separate the report by residential and outpatient.**

**Date Presented to SQC:** 2/5/2009

**BY:** Kim Brown

**Recommendations from the Committee for action:** Recommendation and changes made by the SQC to the Conclusions and Preliminary Recommendations are noted above in **bold**.

**Person Responsible to follow-up and date due:** Kim Brown Due: 5/7/2009

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