DMHA Incident Review Committee

A Quality Review and Improvement Initiative

Incident Review Committee

- Criteria
  - Mortalities in persons age 40 and younger
- Review Process
  - Assessments/treatment plans
  - ANSA/CANS
  - Progress notes (therapy, case mgmt., physician, etc.)
  - Medication list
  - Coroner's Report/Autopsy Report/Toxicology Report
- Goals
  - Understand causes of premature deaths
  - Decrease premature deaths
  - Improve quality of consumer services

Incident Review Committee

DMHA Representatives From:

Youth Services

Adult Services

Suicide Prevention

Addiction Services

Opioid Treatment Program

Quality Improvement

Community Liaisons

Medical Directors

Incident Management

An incident report must be completed for any incident *that* ***can compromise the safety and well-being of an individual***.

We are moving from ***incident reporting*** *to* ***incident management***.

What makes a good incident management system?

- Identifies adverse events, potential jeopardy and factors related to risk
- Notifies key people
- Triggers response to protect individual and minimize risk
- Closes loop with agreeded upon action steps
- Has the ability to collect and analyze information
- Has the capacity to identify patterns and trends to guide service improvement
- Has thresholds for what is important
- Reports important events to key people
- Includes levels of review dependent on the severity of the incident

Incident Reporting Portal

- February 6, 2017 → web-based incident reporting
- https://dmha.fssa.in.gov/dmha_mir/
- Move from hand-written and faxed formats
- More time efficient method of reporting
- Increased security
- Visual tool tips, auto-generated reminders, access to instructions/webinars and answers to frequently asked questions
- Increasing volume
- Improved content
- Positive provider feedback

Trends

Main areas identified to reduce deaths

- Increase therapeutic interventions when client presents with crisis intervention needs: Great need to **triage** high risk patient to prescribers
- Increase administrative responses to **no shows**
- Increase evidenced based therapeutic interventions when clientele present with **substance use disorders**
- Reduce unnecessary **polypharmacy**
- Integrate **CANS/ANSA** in to clinical care/treatment planning

Triage

A number of deaths occurred between the time the client presented for an intake and their scheduled appointment with a prescriber

- All were high risk:
  - Prior suicide attempts
  - Active bipolar disorder/major depressive disorder/psychosis
  - Endorsing suicidal ideation
  - Active substance use

Triage

39 year old male diagnosed with major depressive disorder

- History of suicidal ideation with plans
- 72 hour inpatient stay 9/28-10/1
- Client had rapid med changes during inpatient stay. 3 prescribers: 9/29 start Celexa, 9/30 changed to Strattera, 10/1 back to Celexa
- At discharge the diagnostic assessment notes client "feeling more depressed"
- Outpatient appointments were scheduled for November

Client was brought to the ER with fatal self-inflected gunshot wound 10/12.

Recommendation: have policy/protocol for high risk cases to see a prescriber quickly, ideally immediately

Poll 1

Do you have specific practices to triage high risk clients to a prescriber?

If yes, please describe in the comments.

“No Shows”

Some deaths were preceded by a period of time when patients failed to show for appointments

26 year old male diagnosed with
major depressive disorder, alcohol dependence

- History of self harm, inpatient stay in last 2 months for attempted suicide
- ANSA 3 – all life function and behavioral domains 3 and suicide module 4
- Receiving weekly individual therapy and medication management
- No show for last 3 therapy appointments, no documentation of efforts to engage or reschedule
- Dr. note indicates “doing better” and tx plan updated to reduce therapy to monthly although last 3 sessions missed

Death certificate shows self-inflicted gunshot wound.

“No Shows”

Recommendations

- Assertive outreach approach to better engage individuals with severe mental illness and/or substance use disorders
  - Session follow-up
  - No show policy
    - Phone call
    - Case mgt and/or police wellness/safety check
    - Documentation of efforts
  - Safety plans
- Zero Suicide Initiative: Awareness and Prevention
- Better utilize involuntary commitments

Poll 2

Have you found any practices that have been successful in re-engaging clients after "no shows?"

If yes, please specify in the comments box.

Substance Use Disorders (SUDs)

SUDs, primarily opioids, were a leading cause of death in both SMI and CA cases reviewed.

- Significant lack of thorough SUD assessments for SMI/SED
- Clientele admit to use/abuse of substances; however, SUDs:
  - Are not a part of their diagnosis
  - Are not on their treatment plan
  - Are not addressed by agency
- Drug screens not completed
- INSPECT not reviewed
- ANSA scores
  - Do not reflect adequate scoring of behaviors

Medication Assisted Treatment (MAT)

Virtually no MAT was being provided, only found in 1 out of 192 cases reviewed.

24 year old female diagnosed with PTSD, major depressive disorder, and opioid and cannabis use

- History of childhood trauma and attempted suicide 2x in last year
- ANSA 5 – all life function and behavioral domains 3, suicide module 3, and SUD module 3
- Receiving individual therapy and medication management services for mental health diagnoses only
- Documentation shows attempts to engage in mental health treatment
- No SUD interventions noted or on treatment plan

Coroner report shows heroin overdose.

Medication Assisted Treatment (MAT)

Recommendation: utilize MAT programming, either directly at agency or through partnerships/referrals to external providers.

- Naltrexone (alcohol use and opioid use disorders)
- Buprenorphine products (opioid use disorders)
- Methadone – OTP clinics (opioid use disorders)

Poll 3

Have there been barriers to providing MAT?

If yes, please specify in the comments box.

Polypharmacy

- >90% cases reviewed were on multiple agents, often without clear indications
- The combination of benzodiazepines and opioids occurred often

Recommendations:

- **Limit benzodiazepine use to the treatment of alcohol withdrawal**
- **Monitor routine labs**
- **Utilize Clozaril in treatment refractory psychosis**

CANS/ANSA

- Should reflect client's situation
  - Documentation indicated suicidal risk, but suicide item was rated a '0'
  - Documentation indicated substance use, but substance use item was rated a '0'
  - Documentation indicated trauma history, but trauma item was rated a '0'
- 2s and 3s (actionable needs) should be documented within the record
- Integrate into assessment and treatment planning
- *Note: a discharge assessment (CANS/ANSA/NOMS) should not be done for a deceased client.*

Improving Documentation

Across all charts, documentation can improve, including:

- Rationale for clinical decisions
- Documenting follow-up/no show actions
- Focus more on client's progress/response to treatment versus what the clinician did
- Include evidence-based treatments utilized

Improving Documentation

24 year old female diagnosed with PTSD, borderline personality disorder, opioid dependence, nicotine dependence, and cannabis use

- Assessment recommendations indicate need for individual therapy 3x/mon – tx plan indicates 1x/mon
- No supporting documentation to show why recommendation was reduced
- Client reports being in crisis, overwhelmed and having mental breakdowns during therapy session – no documentation to show how this was addressed
  - Client made commitment to attend group
- Client no show for next appointment – no documentation of engagement activities attempted

Summary

- Provide appropriate intervention for high risk patients at the time of intake
- Assertive outreach strategies to unstable patients who “drop out,” particularly those meeting commitment criteria
- Develop evidence based treatment programming, including MAT, and offer to relevant clients
- Include drug screening and review INSPECT, initially and periodically throughout treatment, for all clients given high rates of co-occurring SUD
- Consider policy to limit benzodiazepine use
- Consider internal review of cases involving polypharmacy
- CANS/ANSA reflects client situation
- Individualize documentation

Questions?