Webex Preparation

- During log in, all phones will be muted through the WebEx. We want this training to be interactive so please mute your personal phone to cut down on background noise

VALUE BEHAVIORAL HEALTH of PENNSYLVANIA

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Critical Incident Reporting For VBH-PA Providers

June 20, 2017

Quality Management Department

What is a Critical Incident?

Occurrences that represent actual or potential serious harm to the wellbeing of a HealthChoices member

The following are the 2 types of incidents monitored by VBH-PA:

- **Adverse Incident:** Incidents that may require further analysis
- **Tracking Incident:** Incidents that have no significant outcome or are not related to the provider environment

Incidents That Must Be Reported

Adverse/Critical Incidents

Code	Adverse Critical Incidents	Critical "Tracking" Incidents
01	Completed suicide while in any level of care, attempted suicide while inpatient or if needed emergent care and last discharge was within 7 days.	Attempted suicide at any other level of care than inpatient with no apparent provider culpability
02	Completed homicide while in any level of treatment	Attempted homicide in any level of care with no apparent provider culpability
03	Death by any cause while inpatient for psychiatric /substance abuse treatment or death by an unknown cause while in any other level of care.	Death by any cause while in any other level of care
04	Allegations of sexual or physical abuse/neglect/exploitation by a provider or non-consensual sex between consumers while in a facility	Allegations of sexual or physical abuse/ neglect/exploitation by non/provider and consensual sex between consumers while in a facility
05	Assaults while in a facility that require serious medical treatment	Assaults while in a facility that require minor or no medical treatment
06	Absent without leave and at risk to self or others	Absent without leave with no apparent serious risk
07	Undesirable events inconsistent with routine patient care of a serious nature (adverse medical complications, inebriation, etc.)	Undesirable events inconsistent with routine patient care of a moderate nature
08	Breach of Confidentiality	

Incidents That Must Be Reported (continued)

Adverse/Critical Incidents

Code	Adverse Critical Incidents	Critical "Tracking" Incidents
09	Parents or guardian taking child AMA from any inpatient setting with child at risk due to AMA (kidnapping, etc.)	
10	Serious accidental injuries either in a facility or a providers office	Non-serious accidental injuries either in a facility or in a providers office
11	Medication /treatment errors causing severe or potentially severe harm or distress to consumer	Medication/treatment errors not resulting in severe or potentially severe harm or distress to consumer
12	Adverse reactions to medication/treatment causing severe or potentially severe harm or distress to consumers (NMS, etc.)	Adverse reactions to medication/treatment of a moderate or minor nature
13	Fire setting/Property damage resulting in life threatening risk to self or others, or causing major damage while in a facility or for which fire fighters were summoned to the scene.	Fire setting/Property damage without major risk or damage while in a facility and for which fire fighters were not summoned to the scene
14	Any condition that results in temporary closure of a facility	
15	Possession of a deadly weapon while in any facility at all levels of care	
16	Outbreak of a serious communicable disease	
17	Other	Other
18	ANY real or threatened litigation in a case	

Examples – Adverse Incidents

- Member was discharged from inpatient following a suicide attempt. The following day, member ingested all their prescription medication in another suicide attempt.
- Residents in a facility had to be moved to another unit due to the outbreak of measles on the inpatient MH unit.
- A staff member with direct care services is arrested for distribution of narcotics (undesirable event).
- A visitor brings a resident a knife for self protection from a peer who has threatened them.
- A member receiving outpatient services died from an unknown cause.

Examples - Tracking Incidents

- A member tripped over a carpet at a provider office, was assessed by nursing, but there was no indication of serious injury.
- A member and peer were accidentally given each others medication, were monitored, but had no serious reaction and the error was quickly addressed.
- Member eloped from treatment but returned safely and with no contraband or drug use within two hours.
- A member receiving outpatient services only was sent to the ER via helicopter and placed on a vent following an intentional overdose.

Examples – Non-Reportable Incidents

- The member and his mother are involved in a car accident and the member was hospitalized due to injuries. Not a reportable incident. No provider involved.
- While conducting a visit at the home, a TSS witnesses a 12 year old member get scratched by her cat. Not serious injury, not at a provider location and not potentially related to the providers treatment of member.

Why Must a Provider Report a CI?

- Contractual requirement for credentialing and re-credentialing as a network provider
- Continuous Quality Improvement (CQI) for the identification of trends and/or improvement opportunities
- Monitoring of VBH-PA network and members to help ensure member safety and the provision of high quality of services

When and How Must a Provider Report a CI?

When do I report?

- Within the next business day from the incident date

Should I use a particular reporting form?

- VBH-PA prefers you use the critical incident log located on http://vbh-pa.com/provider/prv_forms.htm
- It is located under Quality Management Forms

How do I report?

- Risk Management Fax: 1-855-287-8491
- Risk Management Email (encrypted only): Criticalincident@beaconhealthoptions.com
- Contact a Quality Management Staff:
  - Corky Blackburn 724-744-6365 (NW3, SW6)
  - Cindy Andrews 724-744-6589 (GR, FA)
  - Nicole Brown 724-744-6327 (BE)

What Do I Report?

- Initial Summary of Event (Facts Only)
  - Don’t use pronouns
  - Don’t state opinions
  - Include factual incident details
  - Safety issue(s)-current status or action taken

- Example:
  - Patient reportedly ingested 20 .5 mg Xanax in a suicide attempt. Family called EMS for transport to ER where patient was treated with …….. Patient voluntarily admitted to inpatient mental health. Patient reports event occurred during argument with mother. Patient states……

What if I am a Substance Use Disorder Provider?

- OMHSAS issued a policy clarification regarding Code 255.5 as it relates to Critical Incidents and disclosing member information.

  Section II. 5. G. (b) of the HealthChoices Program Standards and Requirements states that as part of the Quality Management Plan the BH-MCO should report adverse incidents. However, the information shared must be congruent with current PA State Regulation 4 Pa. Code 255.5. Therefore, D&A providers should report incidents but not provide any client names or other data which reasonably may be utilized to identify the client.

Substance Use Disorder Providers

- Should continue to report Critical Incidents
- The report should contain the name of the provider, a detailed description of the incident, and member's county of residence
- If VBH-PA determines that the incident requires a more thorough investigation, the provider may be asked to submit the member's redacted clinical record to VBH for review.

Will I Be Penalized If I Report Too Much Or Not At All?

- Incidents happen all the time at every level of care
- Reporting all incidents helps VBH-PA and providers reduce the risk of potential litigation
- Every provider should have their own internal reporting process, along with a Policy and Procedure
- Patterns of non-reporting may be referred to Provider Relations or the Quality of Care Committee to determine if further action is necessary

What Happens After I Report a CI?

The VBH-PA Risk Analyst will take the following next steps:

- Triage for Risk Severity
- Notify the appropriate County/Oversight Entity
- You may be contacted for additional information
- VBH-PA tracks and monitors all critical incidents
- Redacted reports and adverse events are reviewed by Quality Management Committees
- Corrective Action Plans (CAP's) may be required of the provider
- VBH-PA may conduct a site visit or request a copy of the clinical record

What Is a Corrective Action Plan?

A Corrective Action Plan (CAP) is a written plan that identifies steps to correct the circumstances that led to the critical incident and to prevent a recurrence.

If you are asked to complete a corrective action plan and you have never completed one before, VBH-PA can provide you with some report templates.

Risk Management

The Risk Management process is a collaborative process to strengthen the alliance between behavioral health managed care organizations and network providers to assure the members receive the highest quality of professional services.

High Priority Incident Alert

- A new **High Priority Incident Alert** notification was established in 2016.
- High Priority includes any of the following that occur at a provider facility:
  - Suicide/Completed Death
  - Physical Assault requiring emergent care
  - Completed/Attempted Homicide
  - Alleged Sexual Assault/Non-Consensual Sex
  - Media Event
- VBH will contact each county via email to alert them to the incident and that it will be investigated.
- VBH will send a follow up email once the outcome is established as substantiated/unsubstantiated

Thank you


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