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*.

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<th>What makes a good incident management system?</th>
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<td>• <strong>Identifies</strong> adverse events, potential jeopardy and factors related to risk</td>
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<td>• <strong>Notifies</strong> key people</td>
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<td>• <strong>Triggers</strong> response to protect individual and minimize risk</td>
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<td>• <strong>Closes</strong> loop with agreed upon action steps</td>
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<td>• Has the <strong>ability</strong> to collect and analyze information</td>
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<td>• Has the <strong>capacity</strong> to identify patterns and trends to guide service improvement</td>
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<td>• Has <strong>thresholds</strong> for what is important</td>
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<td>• <strong>Reports</strong> important events to key people</td>
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<td>• Includes <strong>levels of review</strong> dependent on the severity of the incident</td>
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Incident Reporting Portal

- February 6, 2017 → web-based incident reporting
- [https://dmha.fssa.in.gov/dmha_mir/](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
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
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
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.*
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.
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)
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
• 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
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?