QUARTERLY PERFORMANCE IMPROVEMENT REPORT

Q4 Fiscal Year 2016,
February 22, 2016

Anthony Ng, MD, CMO
Chair, Medical Executive Committee
Daniel Coffey, CEO

Executive Summary

The Quarterly Performance Improvement Report summarizes the status of performance and quality of Acadia's inpatient care.

Regulatory Measures (pages 5-6)

- The Inpatient Psychiatric Facility Quality Reporting System (IPFQRS) measures are required by the Centers of Medicaid and Medicare and The Joint Commission (Acadia's accrediting agency).
- Five measures are new to IPFQRS for 2017: SUB 3 and 3a, Metabolic Screening, Transition Record, and Transmission of Transition Record. The January 2017 results will be available shortly.
- Variation in compliance with screening patients for unhealthy alcohol use resulted when Acadia changed from one screening tool to another. Consistency has been reestablished.
- Performance is good on most measures with the exception of the tobacco use related measures for patients identified as heavy tobacco users being offered or provided cessation counseling and FDA-approved medication during their admission (TOB 2 and TOB 2a) and those accepting same (TOB 3 and 3a).

Patient Restraints (pages 7-8)

- In general, Acadia's inpatient restraint rate is lower than the national average. Acadia continues to have a higher proportion of its patients restrained that its national benchmark. In addition, the proportion has increased since August 2016.
- When stratified by age group, the restraint rate for children (1-12 years) is consistently higher than the NRI rate and the CMS rate. Acadia's rates for the other age groups: adolescents (13-17 years), Adults (18-65) and Older Adults (over 65), are all similar or below both NRI and CMS rates.

Medication Errors (pages 9-10)

- January, March, and December 2016 had spikes in error rate resulting from one error event causing multiple doses in error reaching the patient. While errors during the administration phase occur most frequently, they tend to be single dose errors, while ordering errors result in multiple dose errors.
- Electronic Medication Reconciliation was implemented in both inpatient and outpatient areas and should result in a reduction of ordering errors.
- No medication errors have resulted in significant patient injury. In looking at the events causing doses in error reaching the patient (a single error event can result in one or more doses in error reaching the patient), two error events resulted in severity level higher than D during calendar year 2016.

Executive Summary (cont'd)

Patient Falls (pages 11-12)

- The fall rate continues to be somewhat erratic, but very rarely do patients suffer injury from a fall and most patients who fall have been identified as high risk and are on fall precaution interventions.

- Most falls occur with adult inpatients on the adult inpatient unit. Patients who fall have almost always been identified as at risk for fall and have fall prevention interventions in place, but do not follow the direction of staff caring for them.

30-day Readmission Rate (page 13)

- Readmission rates have been less variable over the most recent 12 months of data and statistically, do not differ from our national benchmark.

Staff Injury (page 14)

- The majority of staff injuries continue to be related to restraints and assault by patients. Pediatric inpatient Psychiatric Technicians are the group most frequently injured.

- During calendar year 2016, Acadia's DART Rate was below the goal, 4.5.

Patient Injury (page 15)

- Patient Injury is defined as any temporary or permanent harm to a patient that required intervention more than just minor first aid (band aid, icepack.) while on the Acadia Hospital campus.
- Patient injury is most often a result of patient assault to peers, self-harm, or incidental injury during restraint. Very few injuries require more than diagnostic services.
- The overall rate of injuries for the inpatients has declined during 2016 with the exception of June.

Patient Satisfaction (pages 16)

- Year-to-date patient satisfaction scores continue to be above the nation on all domains except Outcome of Care.
- One of the four items making up the Outcomes of Care Domain, "I do better in social situations" was identified as the lowest scoring item for all units. Inpatient units have implemented two interventions in an attempt to improve care and affect the Outcome of Care Domain score: utilizing the Youth/Outcome Questionnaire more consistently in psychotherapy to help inform patient's perception of progress and outcomes, and standardizing an electronic version of the Master Treatment Plan template.

Executive Summary (cont'd)

Environment of Care (page 17)

- A Table top exercise and a Disaster Drill were completed in December 2016. The Emergency Management Plan was tested for a Blizzard with unexpected power outage and computer system outage. The drill involved personnel from EMHS Emergency Management department and the American Red Cross.
- Multiple attempted and successful elopements by patients climbing over the fence outside in 2016 resulted in a decision to extend the top of the fence surrounding the outside area by several feet.
- New internal signage was installed during November.

Risk Management Highlights (page 18)

- A Sentinel Event occurred in November 2016. It was reported and the root cause analysis submitted within the 45-day timeline required. The event involved an adult inpatient who was found unresponsive. The patient was revived, sent to Eastern Maine Medical Center, and discharged the following day.
- A sentinel event occurred in February 2017 when a pediatric adolescent Day Treatment patient took an overdose while at Acadia. She disclosed the overdose to Acadia staff and was transported to EMMC where she was admitted. The event has been reported to the State and Acadia is in process of completing the root cause analysis.
- An adult inpatient with persistent, severe schizophrenia fell and hit his elbow, sustaining a fractured elbow. An orthopedic surgeon opted not to perform surgery due to likelihood of patient being unable to follow post op behaviors (refusing medication and not participating in physical therapy). Although permanent loss of function is one criterion for a Sentinel Event, the incident was not deemed such due to the decision not to operate was depended on his severe schizophrenic behaviors, not the fracture itself.
- A significant event occurred in November that Acadia completed a root cause analysis on and also participated in EMMC's root cause analysis process. It involved an adult outpatient sent from Acadia to EMMC for medical clearance and evaluation as there were no inpatient or observation beds available at Acadia. The patient completed suicide in EMMC's emergency department.
- The Maine Sentinel Event Team visited Acadia in January and reviewed the Sentinel Event program for compliance with the law. Some new employee education was found missing from the program, but otherwise the feedback was very positive. The required education has been added to new employee on-boarding.

Inpatient Psychiatric Facility Quality Reporting System (IPFQRS)

- The Inpatient Psychiatric Facility Quality Reporting System (IPFQRS) measures are required by the Centers of Medicaid and Medicare and The Joint Commission (Acadia's accrediting agency). Although performance does not yet affect CMS reimbursement for services provided, results are publically reported and fiscal consequences are anticipated in the near future.

- Five measures are new to IPFQRS for 2017: SUB 3 and 3a, Metabolic Screening, Transition Record, and Transmission of Transition Record. The January 2017 results will be available shortly. For detailed description of measures, see Appendix A, page 19.

- Variation in compliance with screening patients for unhealthy alcohol use resulted when Acadia changed from one screening tool to another. Consistency has been reestablished.

- Performance is good on most measures with the exception of most the tobacco use related measures. These measures relate to patients identified as heavy tobacco users being offered or provided cessation counseling and FDA-approved medication during their admission (TOB 2 and TOB 2a) and those accepting same (TOB 3 and 3a).

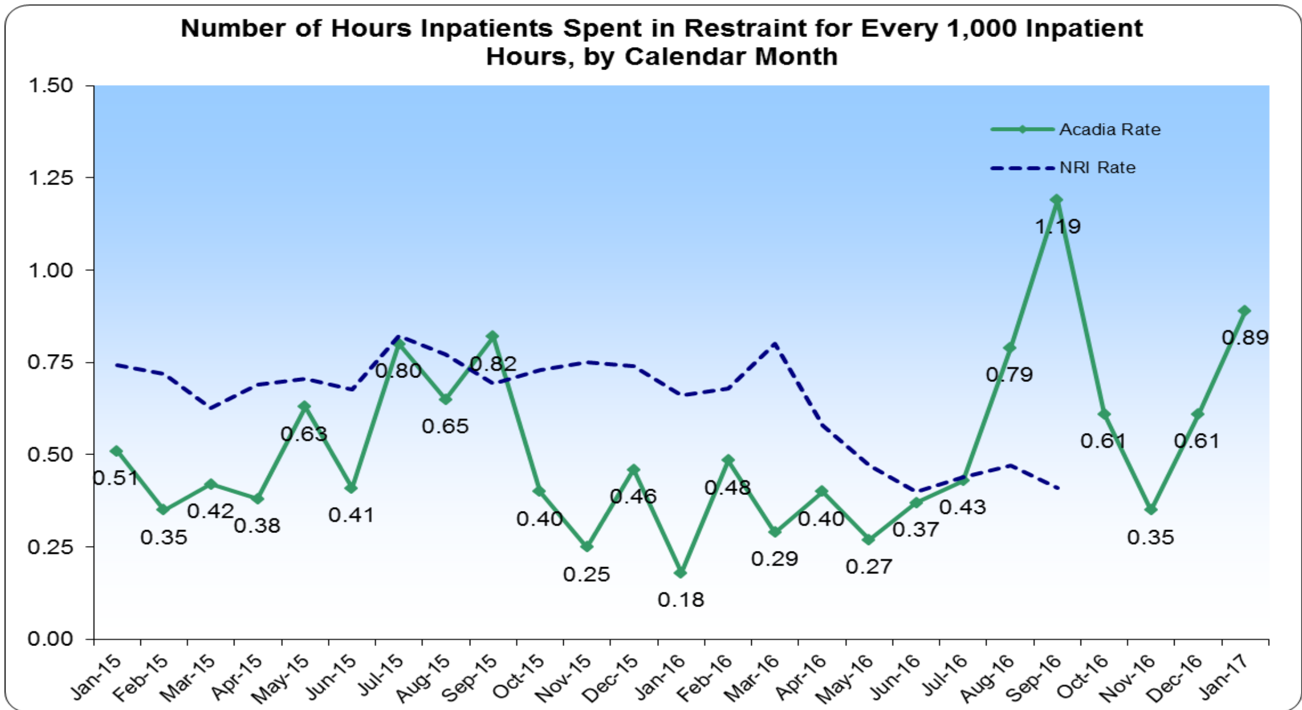
- The following table details the measures and Acadia's monthly performance since July 2016.

IPFQRS Measures	CYTD	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
HBIPS-1: % inpatients with Suicide, Violence, and Comfort Screenings Completed at Admission	89%	77%	91%	83%	96%	96%	91%
HBIPS-2: Hours of physical restraint use per 1,000 patient care hours	0.62	0.40	0.74	1.11	0.58	0.33	0.56
HBIPS-3: Hours of seclusion per 1,000 pt care hrs	0.00	0.00	0.00	0.00	0.00	0.00	0.00
HBIPS-5: Inpatients discharged on more than one antipsychotic with appropriate justification documented	10%	50%		0%	0%	0%	0%
SUB-1: % Inpatients 18 years and older screened for unhealthy alcohol use within 1 day of admission	73%	65%	70%	88%	50%	72%	93%
SUB-2: % Inpatients screened positive for unhealthy alcohol use or alcohol disorder who receive or refuse a brief intervention	50%	0%	0%	0%	100%	100%	100%
SUB-2a: % Inpatients screened positive for unhealthy alcohol use or alcohol disorder who receive brief intervention	50%	0%	0%	0%	100%	100%	100%
SUB-3: % Inpatients identified with alcohol or other drug disorder who receive or refuse a prescription for FDA-approved medication for alcohol/drug disorder at discharge OR receive or refuse referral for additions treatment							
SUB-3a: % Inpatients identified with alcohol or other drug disorder who receive a prescription for FDA-approved medication for alcohol/drug disorder at discharge OR receive referral for additions treatment							
TOB-1: % of Inpatients 18 years and older screened for Tobacco Use within 1 day of admission	49%	0%	0%	0%	95%	100%	100%
TOB-2: % of inpatients identified as "heavy" tobacco users who receive or refuse practical counseling AND receive or refuse FDA-approved cessation medication during their stay	90%				100%	88%	82%
TOB-2a: % of inpatients identified as "heavy" tobacco users who receive practical counseling AND receive FDA-approved cessation medication during their stay	50%				71%	50%	27%
TOB-3: % Inpatients identified as tobacco users who were referred to or refused evidence-based outpatient counseling AND received or refused a FDA-approved cessation medication upon discharge	34%				33%	14%	56%
TOB-3a: % Inpatients identified as tobacco users who were referred to evidence-based outpatient counseling AND received a FDA-approved cessation medication upon discharge	24%				17%	0%	56%
IMM-1: Healthcare Personnel vaccinated for influenza Oct 16-March 17 Flu Season							
IMM-2: % Inpatients vaccinated for influenza	69%				55%	64%	87%
Metabolic Screening: % Inpatients on antipsychotic medication with Metabolic Screening performed (BMI, BP, Glucose or HgbA1c, & Cholesterol w/in 12 months)							
% Transition Record (TR) including 11 required components completed at discharge							
% of TR's transmitted to next provider within 24 hours of discharge							

Patient Restraints

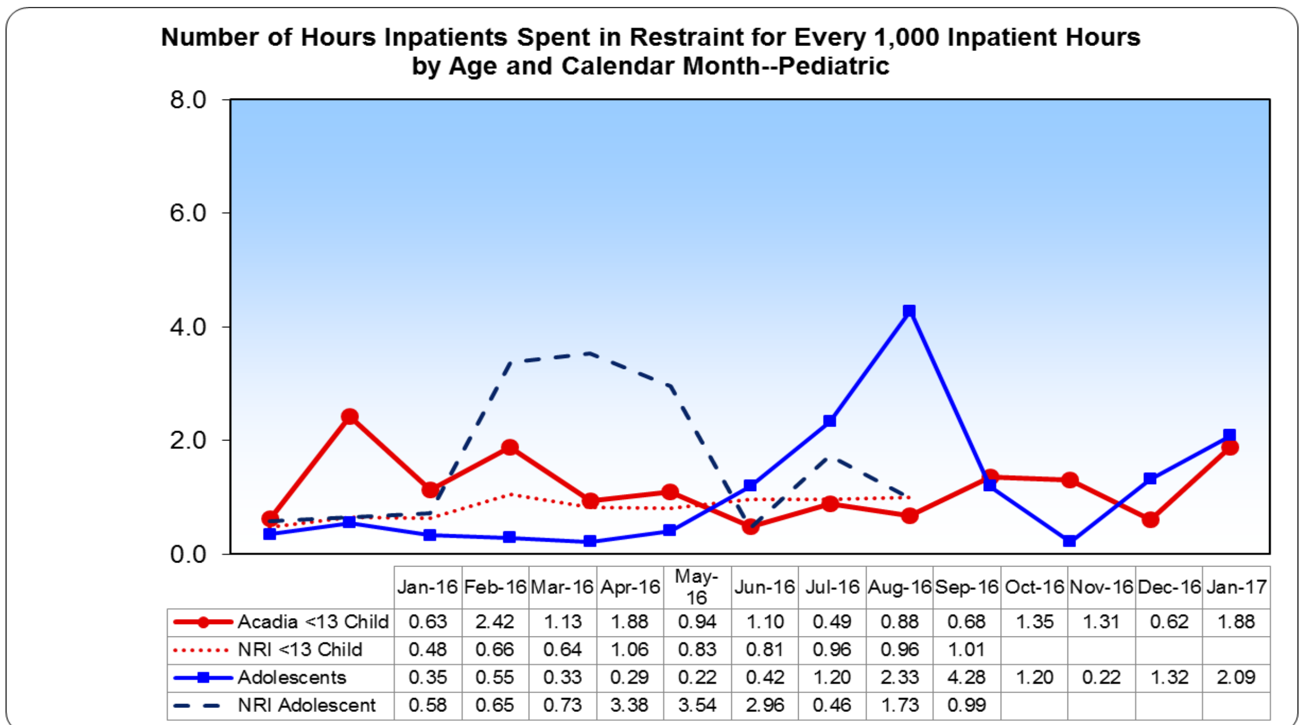
Restraint Rate: number of hours in restraint per 1,000 patient care hours

In general, Acadia's inpatient restraint rate is lower than the national average. However, five of the past six months have experienced an overall rate higher than usual.



Restraint Rate by Age

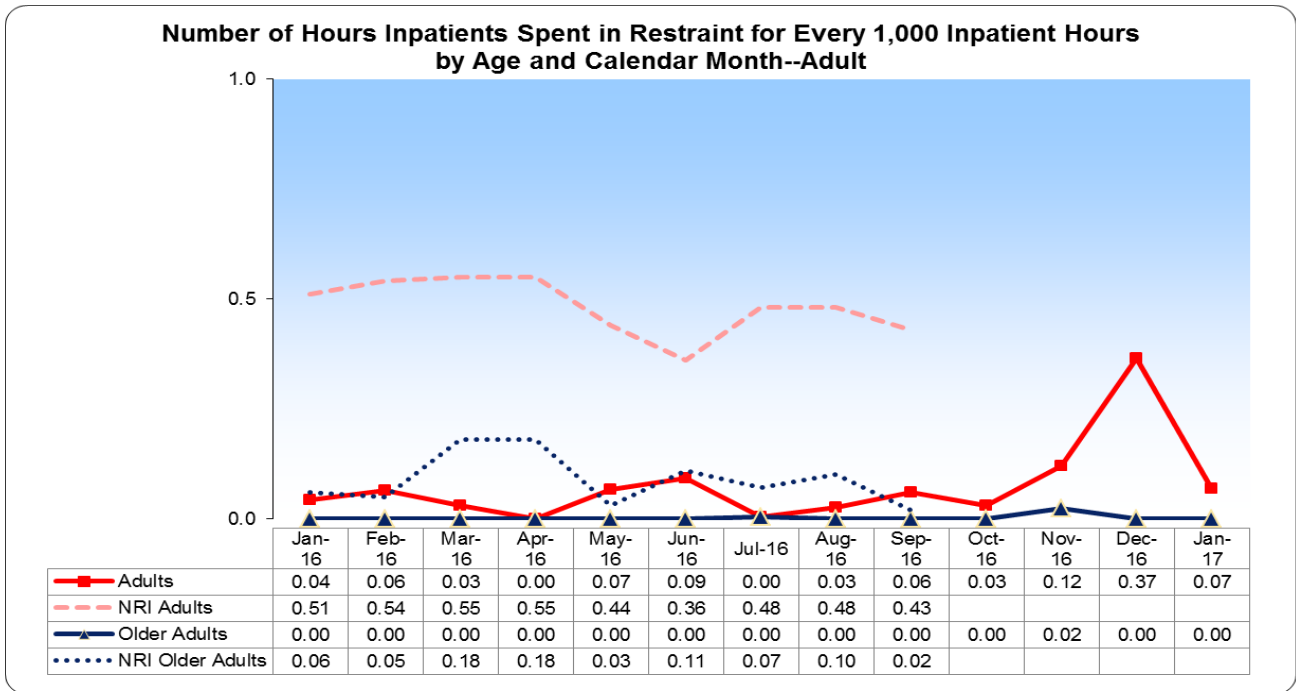
Usually, Acadia's youngest patients, those 12 and under, have the highest restraint rates. Recently the adolescent restraint rate has exceeded the child under 13 rates.



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Acadia <13 Child	0.63	2.42	1.13	1.88	0.94	1.10	0.49	0.88	0.68	1.35	1.31	0.62	1.88
NRI <13 Child	0.48	0.66	0.64	1.06	0.83	0.81	0.96	0.96	1.01				
Adolescents	0.35	0.55	0.33	0.29	0.22	0.42	1.20	2.33	4.28	1.20	0.22	1.32	2.09
NRI Adolescent	0.58	0.65	0.73	3.38	3.54	2.96	0.46	1.73	0.99				

Adults and Older Adults

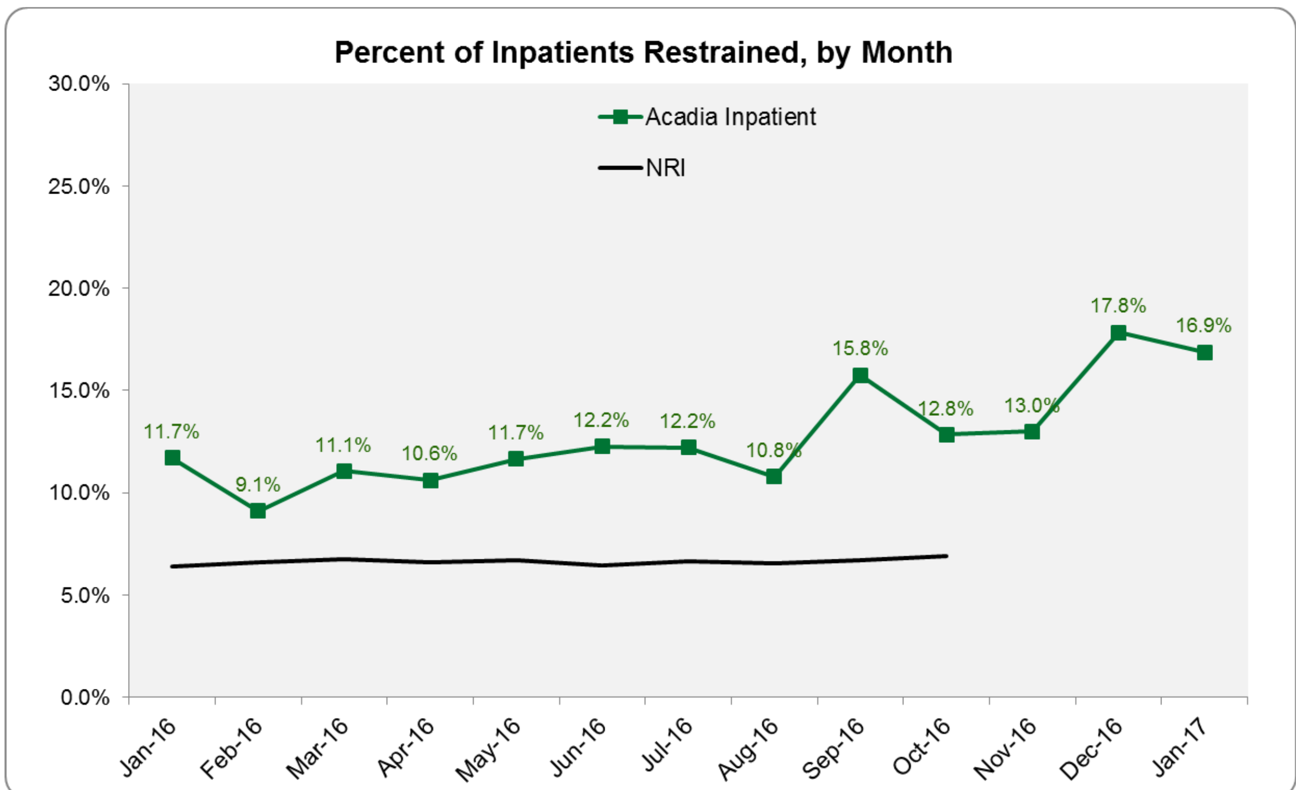
With the exception of the month of December 2016, Acadia's adult patients experience very low restraint rates.



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Adults	0.04	0.06	0.03	0.00	0.07	0.09	0.00	0.03	0.06	0.03	0.12	0.37	0.07
NRI Adults	0.51	0.54	0.55	0.55	0.44	0.36	0.48	0.48	0.43				
Older Adults	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.00	0.00
NRI Older Adults	0.06	0.05	0.18	0.18	0.03	0.11	0.07	0.10	0.02				

Percent of Patients Restrained

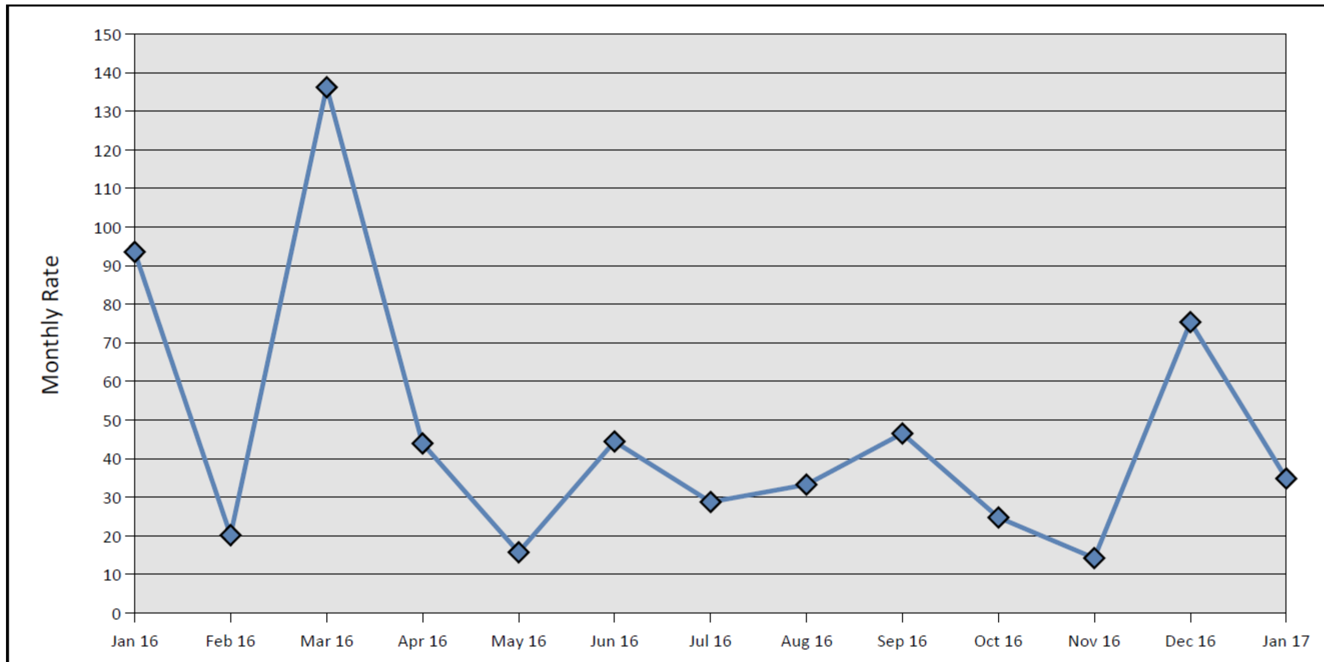
Acadia continues to have a higher proportion of its patients restrained that its national benchmark. In addition, the proportion has increased since August 2016.



Medication Errors

The January and March spikes in rate were both a result of one error event resulting in multiple doses in error reaching the patient. While errors during the administration phase occur most frequently, they tend to be single dose errors, while ordering errors result in multiple dose errors. Unfortunately, there was an ordering error that occurred in December and resulted in multiple doses in error and a spike in the overall error rate.

Medication Error Rate-Doses in Error Reaching Patient per 100,000 Doses Dispensed



The numbers of doses in error reaching patients, by error type, appear in the table below.

Error Type	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017
Count Discrepancy	0	0	0	0	0	0	0	0	0	0	0	0	0
Extra Dose	2	0	39	1	3	1	1	2	1	3	0	3	1
Omitted Dose	2	2	5	4	0	7	5	3	4	2	3	4	2
Wrong Dose Amount	18	0	2	2	0	3	3	4	3	0	1	2	2
Wrong Drug	1	0	0	4	0	0	0	3	1	1	0	5	0
Wrong Patient	0	1	0	2	0	1	0	0	0	0	0	0	0
Wrong Route	2	0	0	0	0	0	0	0	3	0	0	0	0
Wrong Time	4	3	0	1	2	0	0	0	1	1	0	7	4
Totals:	**29**	**6**	**46**	**14**	**5**	**12**	**9**	**12**	**13**	**7**	**4**	**21**	**9**

No medication errors have resulted in significant patient injury. In looking at the events causing doses in error reaching the patient (a single error event can result in one or more doses in error reaching the patient), two error events resulted in severity level higher than D during calendar year 2016.

Medication Errors, Continued

Medication Error Events by Severity Level-through January 2017

Severity Level	CY 2017 YTD	CY 2016	CY 2015	CY 2014	CY 2013
A	0	7	5	5	11
B	2	16	5	17	15
C	4	88	72	81	60
D	1	23	22	17	16
E	0	2	4	5	3
F	0	0	0	1	1
G	0	0	0	0	0
H	0	0	0	0	0
I	0	0	0	0	0
Totals:	**7**	**136**	**108**	**126**	**106**

National Coordinating Council for Medication Error Reporting and Prevention (NCC-MERP) Severity Scale:

A: Circumstances or events that have the capacity to cause an error.

B: An error occurred but the error did not reach the patient.

C: An error occurred that reached the patient but did not cause patient harm.

D: An error occurred and reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm.

E: An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.

F: An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.

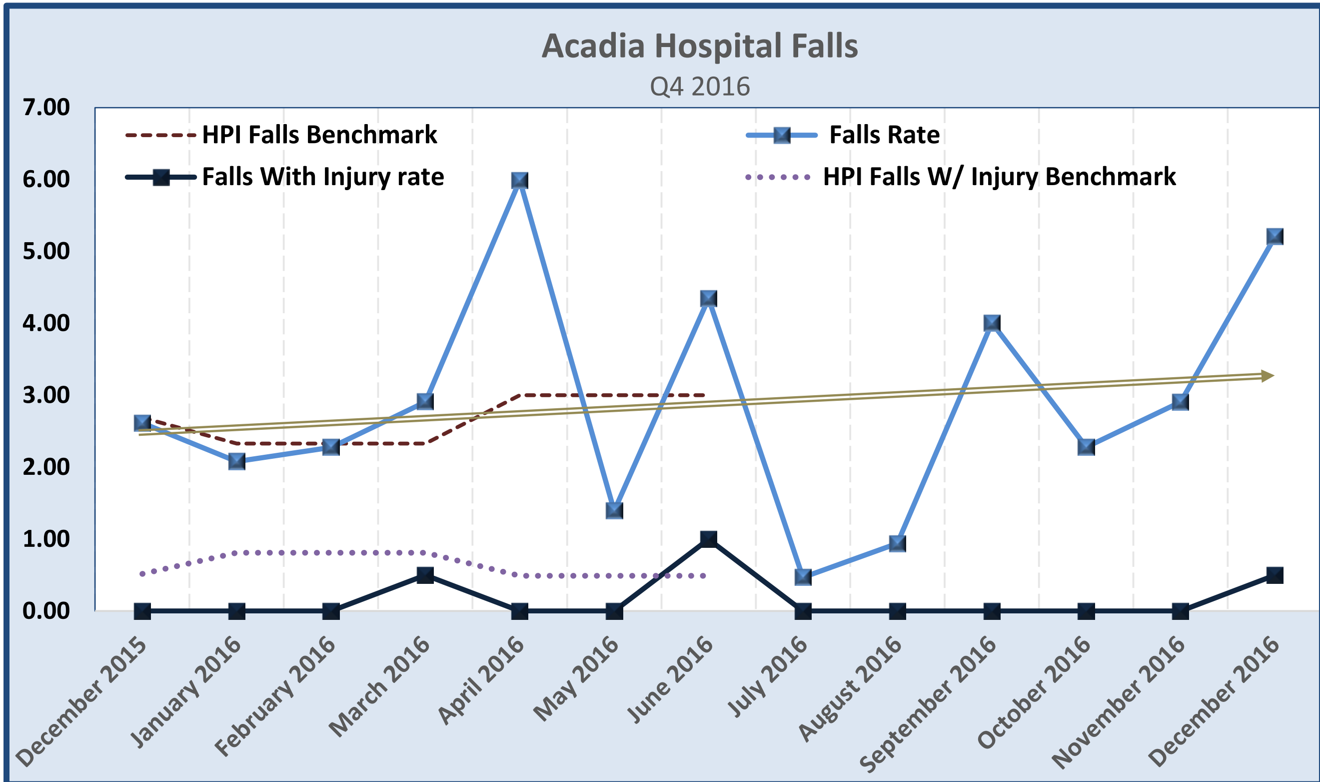
G: An error occurred that may have contributed to or resulted in permanent patient harm.

H. An error occurred that required intervention necessary to sustain life.

I: An error occurred that may have contributed or resulted in the patient's death.

Patient Falls

Number of Patient Falls per 1,000 Patient Days
Fall rates have been variable during 2016, and very few falls have resulted in injury and none have been serious. A new benchmark rate, from the Harbor Performance Initiative (HPI) has been added to the falls report. HPI is a consortium of twelve freestanding psychiatric hospitals, including Acadia, in the HPI benchmark.



Histories of falling and behavioral reasons are the most commonly cited contributing factors in patient falls. The majority of falls occur with patients who have been identified as at high risk and fall mitigation interventions have been implemented.

The table below presents the injury level of falls for calendar year 2016. Scale definitions are on the following page.

A	0
B	1
C	23
D	43
E	2
F	1
G	1
H	0
I	0
Totals:	**71**

NCC-MERP Severity Scale

National Coordinating Council for Medication Error Reporting and Prevention (NCC-MERP) Severity Scale:

A: Circumstances or events that have the capacity to cause an error.

B: An error occurred but the error did not reach the patient.

C: An error occurred that reached the patient but did not cause patient harm.

D: An error occurred and reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm.

E: An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.

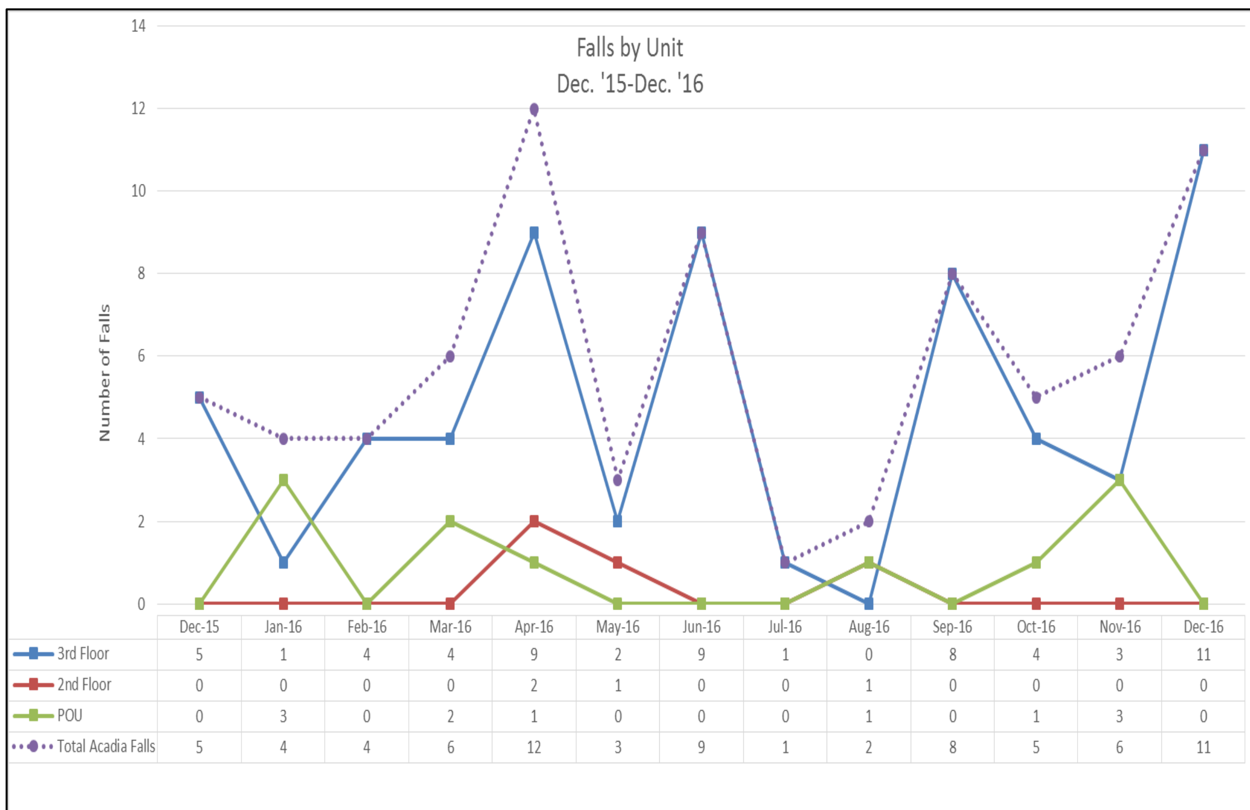
F: An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.

G: An error occurred that may have contributed to or resulted in permanent patient harm.

H. An error occurred that required intervention necessary to sustain life.

I: An error occurred that may have contributed or resulted in the patient's death.

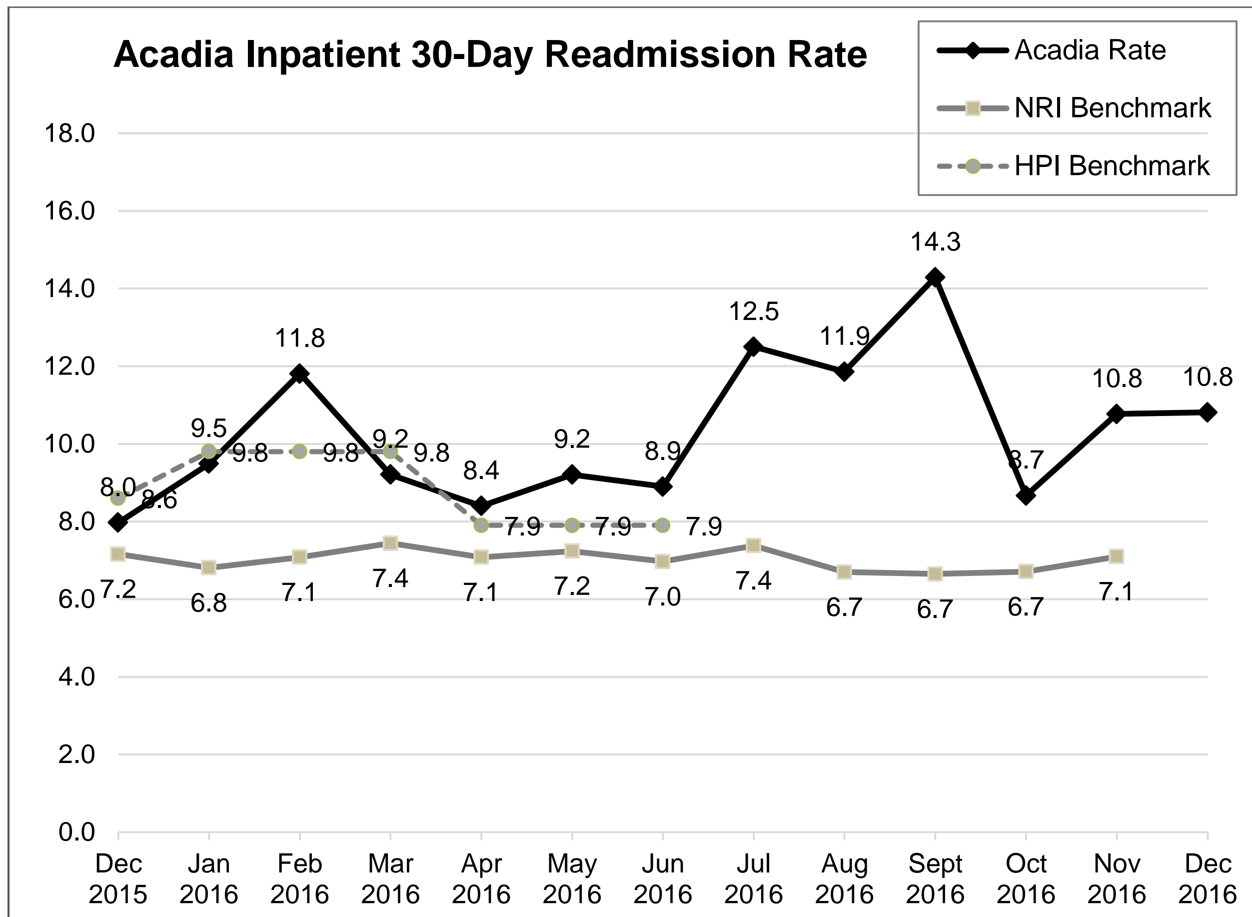
Most falls occur with adult inpatients on the adult inpatient unit. Patients who fall have almost always been identified as at risk for fall and have fall prevention interventions in place, but do not follow the direction of staff caring for them. For example, patients at risk may be given a bell to ring if they need to use the bathroom, but do not ring it.



	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
3rd Floor	5	1	4	4	9	2	9	1	0	8	4	3	11
2nd Floor	0	0	0	0	2	1	0	0	1	0	0	0	0
POU	0	3	0	2	1	0	0	0	1	0	1	3	0
Total Acadia Falls	5	4	4	6	12	3	9	1	2	8	5	6	11

Inpatient 30-Day Readmission Rate

Percentage of discharged patients readmitted within 30 days –Admissions Cohort-Percent of admissions to Acadia that occurred within 30 days of a previous discharge of the same client from Acadia. For example, a rate of 8.0 means that 8% of all admissions were readmissions.

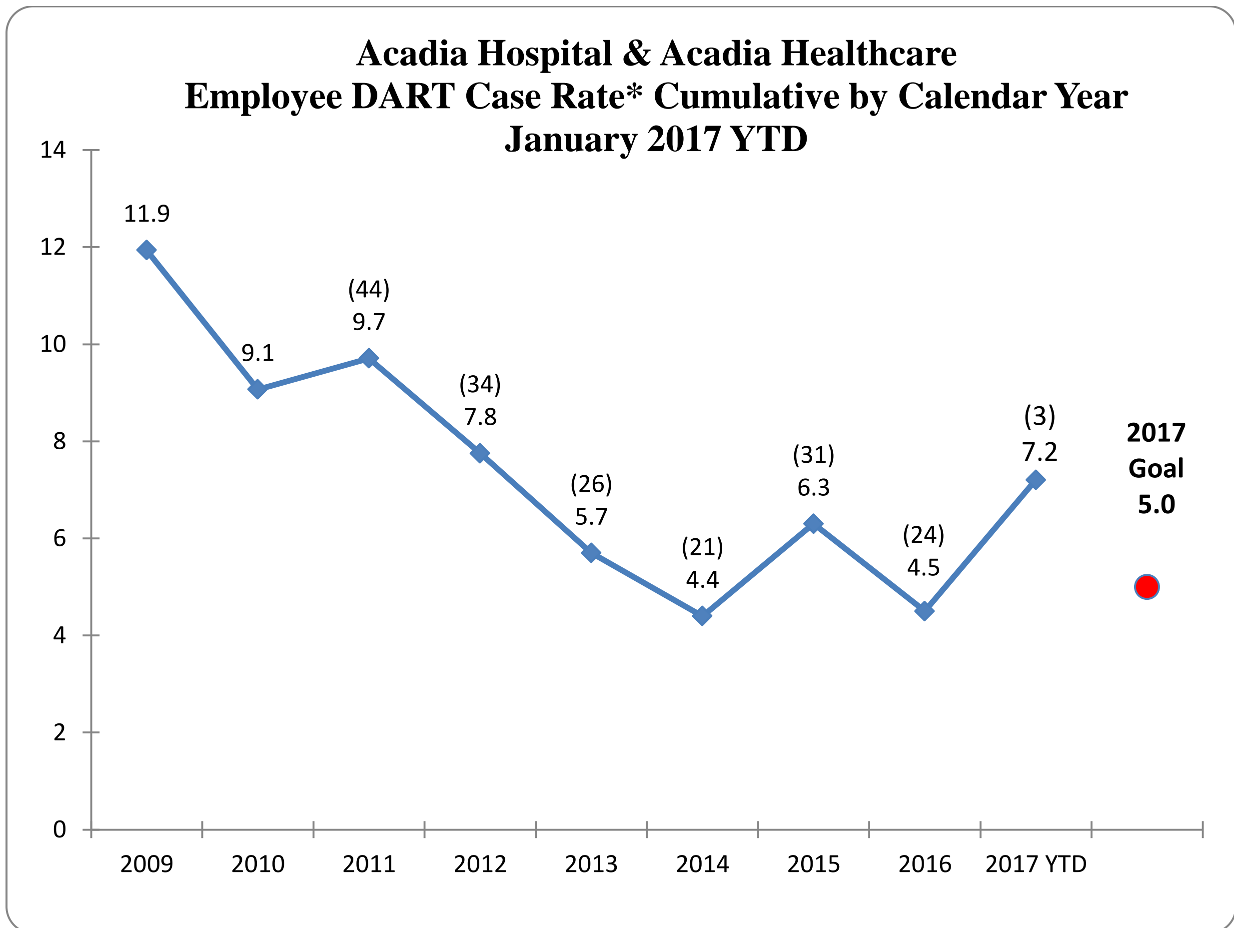


Staff Injury

Days Away, Restricted Duty, and Transfers (DART) due to injury

The Employee DART Case Rate has decreased since 2009. CY2016 achieved a rate below the goal of 4.5, below the goal of 5.0. Increased training and protective equipment for pediatric direct care staff may have helped reduce employee injuries. January 2017 experienced a rate of 7.2 due to three pediatric inpatient staff injuries caused by patients.

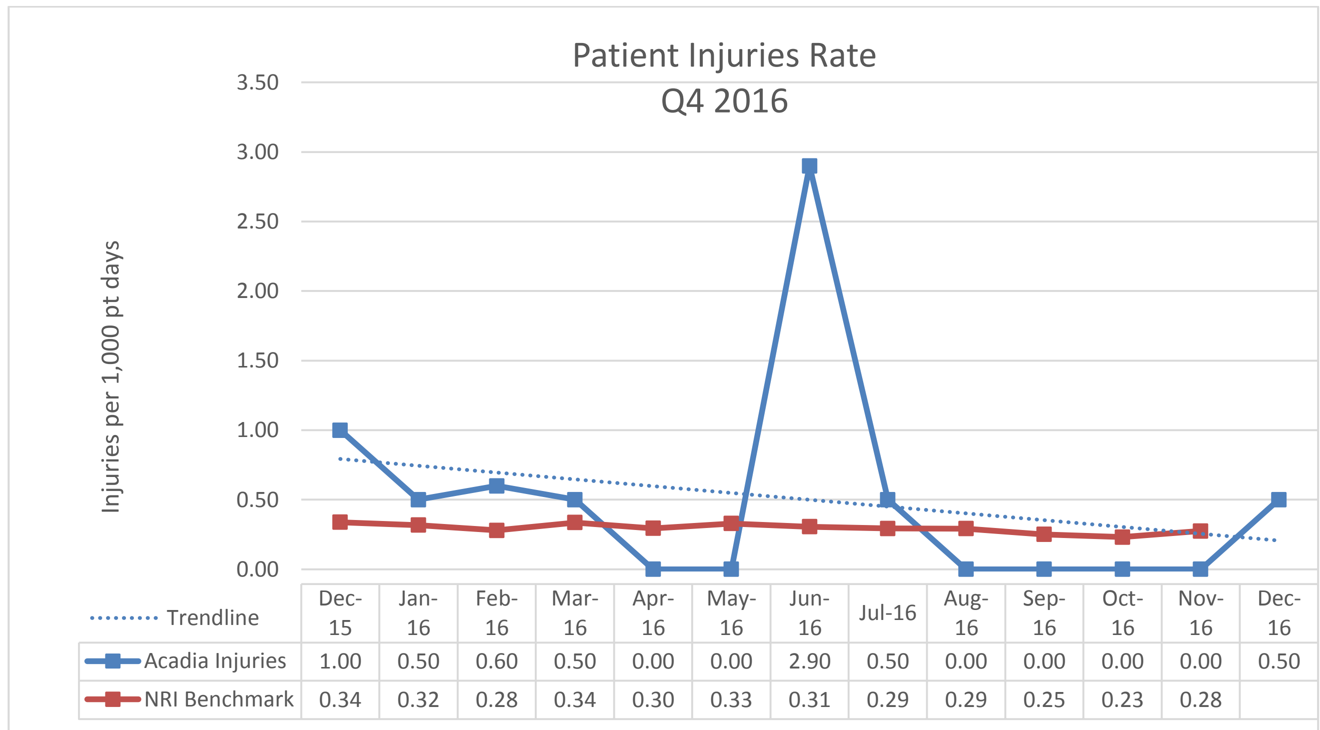
The majority of staff injuries continue to be related to restraints and assault by patients. Pediatric inpatient Psychiatric Technicians are the group most frequently injured.



*Days away from work due to injury per 200,000 hours worked

Patient Injuries

- Patient Injury is defined as any temporary or permanent harm to a patient that required intervention more than just minor first aid (band aid, icepack.) while on the Acadia Hospital campus.
- Patient injury is most often a result of patient assault to peers, self-harm, or incidental injury during restraint. Very few injuries require more than diagnostic services.
- The overall rate of injuries for the inpatients has declined during 2016 with the exception of June.



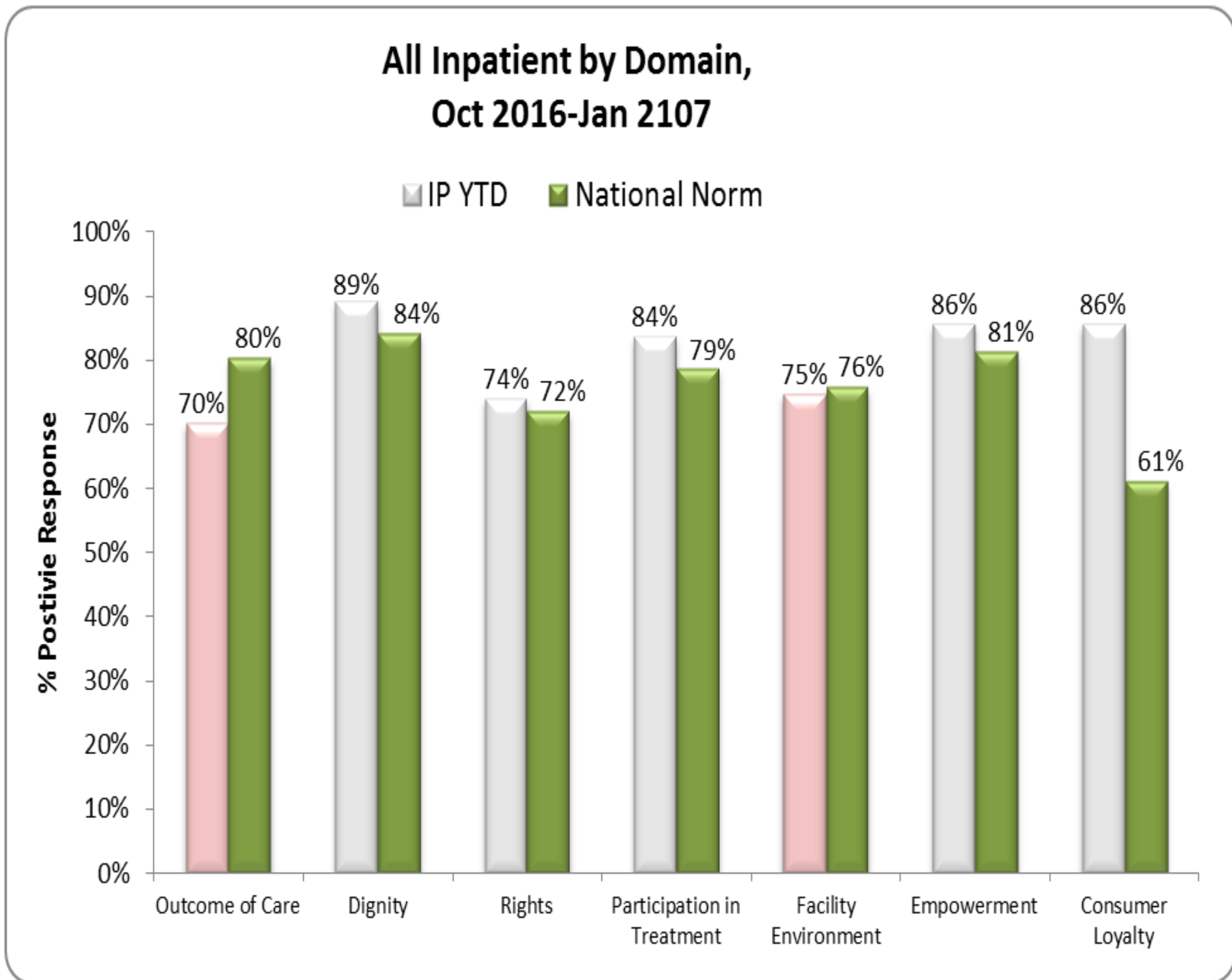
	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Acadia Injuries	1.00	0.50	0.60	0.50	0.00	0.00	2.90	0.50	0.00	0.00	0.00	0.00	0.50
NRI Benchmark	0.34	0.32	0.28	0.34	0.30	0.33	0.31	0.29	0.29	0.25	0.23	0.28	

Patient Satisfaction and Loyalty

Acadia Hospital continues to perform well in comparison to national benchmark in all domains with the exception of Outcome of Care. An attempt to identify a focus area for improvement efforts identified the item, “I do better in social situations” as the lowest scoring item for all units; no other discernable patterns were uncovered.

The other three items that make up the domain are: “I am better able to deal with crisis situations.”, My symptoms are not bothering me as much.”, and “I deal more effectively with daily problems.”

The four items that make up the Outcomes of Care domain are being reported by unit in 2017 to help guide improvement efforts.



Environment of Care Highlights

- A Table top exercise and a Disaster Drill were completed in December 2016. The Emergency Management Plan was tested for a Blizzard with unexpected power outage and computer system outage. The drill involved personnel from EMHS Emergency Management department and the American Red Cross.
- Multiple attempted and successful elopements by patients climbing over the fence outside in 2016 resulted in a decision to extend the top of the fence surrounding the outside area by several feet.
- New internal signage was installed during November.

Risk Management Highlights

- A Sentinel Event occurred in November 2016. It was reported and the root cause analysis submitted within the 45-day timeline required. The event involved an adult inpatient found unresponsive. A code blue was called; the patient was revived, and sent to Eastern Maine Medical Center where he stayed overnight for observation and was discharged.
- A sentinel event occurred in February when a pediatric adolescent Day Treatment patient took an overdose of her mother's medication while at Acadia. She disclosed the overdose to Acadia staff and was transported to EMMC where she was admitted in the Pediatric Intensive Care unit. The event has been reported to the State and Acadia is in process of completing the root cause analysis.
- An adult inpatient with persistent, severe schizophrenia fell backwards with staff present and hit his elbow on a shelving unit, sustaining a fractured elbow. An orthopedic surgeon opted not to perform surgery due to the benefits versus risk of infection risk or limited range of motion. Although permanent loss of function is one criterion for a Sentinel Event, this was not deemed such due to the decision not to operate was depended on his severe schizophrenic behaviors, not the fracture itself.
- Another event occurred in November that Acadia completed a root cause analysis on and also participated in EMMC's root cause analysis process. It involved an adult outpatient sent from Acadia to EMMC Emergency department for medical clearance and evaluation (there were no inpatient or observation beds available at Acadia). The patient completed suicide in EMMC's emergency department. Several items were identified and have been, or are in process of being, implemented that may help prevent future, similar events.
- The Maine Sentinel Event Team visited Acadia in January and reviewed the Sentinel Event program for compliance with the law. Some new employee education was found missing from the program, but otherwise the feedback was very positive. The required education has been added to new employee on-boarding.
- Patient Safety Coordinator participated in the EMHS Risk Management Summit and presented on the operations of the Acadia Significant Event Team. The Summit was well organized and provided claims management education and networking opportunities.

APPENDIX A

Descriptions of Selected New Measures beginning with January 1, 2017 discharges
Metabolic Screening: patients on antipsychotics: have had BMI, Blood Pressure, HbA1c or glucose, and Full Lipid Panel within the last year; if not-order
Transition Record: % patients or caregivers received a Transition Record at discharge that contains, at minimum, the following elements: 1. Reason for admission 2. Principal Diagnosis at discharge 3. Current Medication list (indication & doses) 4. Plan for follow-up care 5. Primary physician/healthcare professional for follow-up care 6. Major procedures and tests performed and summary of results 7. Studies/test results pending at time of discharge 8. Contact info for obtaining results of pending studies/tests 9. Patient instructions 10. 24 hour/7-day a week contact info for including physician for emergencies related to admission 11. Advance Directives or Surrogate decision maker must be documented, or reason for not providing advanced directive documented
Timeliness of Transition Record: % patients who have Transition Record with required elements transmitted to facility or primary physician/healthcare professional designated for follow-up care **within 24 hours**. *Transition Record must be in patient/caregiver-friendly language and be reviewed with the patient caregiver prior to discharge*