

Community Incident Management & Report System
PCPA Comments
September 19, 2003

General Comments

PCPA supports the development of uniform reporting procedures to establish consistent approaches for providers. The creation of policies and procedures to identify areas of concern and to ensure consumer safety is very beneficial to the system and should be pursued. While we appreciate the intent of the bulletin, we believe there are numerous areas that require revision.

Short Time Frame for Implementation

PCPA is extremely concerned about the time frame proposed in the introductory letter dated August 18 and signed by Office of Mental Health and Substance Abuse Services (OMHSAS) Deputy Secretary Joan Erney. This bulletin, when put into effect, will have an enormous impact on the provision of services in the community. Providers will now be required to complete even more paper documentation and will be forced to do so at the expense of service delivery.

When the equipment needs, training, policy and procedure development, etc. are all considered, to expect that the state, counties, and providers will be ready to implement the bulletin by January 2004 is unreasonable. Additionally, the short timeframe limits adequate and meaningful stakeholder input into this reporting process.

The Office of Mental Retardation (OMR) spent over one year developing an incident management process. After implementation, that office is already drafting changes to their bulletin because of problems that were encountered. To expect that this bulletin can be developed in any shorter timeframe is unwarranted, especially considering that the OMHSAS draft takes very little from the process OMR used to develop their standards and does not appear to utilize the lessons learned by OMR.

Coordination with Multiple Reporting Systems

As was mentioned earlier, PCPA represents multi-service community-based agencies. As such, these agencies must follow the requirements of a number of governing bodies such as OMR, the Office of Children Youth and Families (OCYF), the Bureau of Drug & Alcohol Programs (BDAP), the Department of Health (DOH), the Department of Aging (PDA), the criminal and juvenile justice systems, the Pennsylvania Department of Education (PDE), and others. All of these bodies have their own requirements relating to incidents and, unfortunately, those requirements all differ. The fact that OMHSAS acknowledges that their "reporting format is separate at this point in time from others being used in the Commonwealth" is inadequate. Much more work might

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have been done to streamline and coordinate these processes prior to release of this draft bulletin and needs to be done before the final bulletin is released. We believe strongly that the OMHSAS system for incident management should be fully compatible with other reporting systems used by providers. Creating an inconsistent or incompatible system would add to the confusion, inefficiencies, and reporting errors that already exist between systems.

It is common for counties, BHMCOs, and others to have specific requirements that are more stringent than those of OMHSAS. If a county or BHMCO requires more information than that included in the OMHSAS form, will a provider be required to complete BOTH forms? Obviously this would go against the stated intent to establish a uniform system of incident reporting, and this issue should be addressed in the bulletin.

Level of Detail

The level of detail required by this bulletin would be appropriate for providers to collect, however it is inappropriate for an administrative/oversight body to collect such information. Should a significant incident occur, OMHSAS would investigate further and would then have access to such detail. We do not believe that OMHSAS would not use this information for every single report, and therefore in the spirit of HIPAA's "minimum necessary" requirements, the least amount of private information necessary should be included.

Use of Private Information

We question how OMHSAS will use the information that will be provided to them through these reports and how the state anticipates follow-up of each incident. The Association strongly urges that the privacy of consumers be of the utmost concern when developing an incident reporting system, and that the Health Insurance Portability and Accountability Act (HIPAA) requirements are fully addressed and adhered to. Additionally, we seriously question whether it is the role of any arm of government to maintain a database of citizens who might have threatened to commit suicide.

Medical model language

The language used throughout this bulletin is more appropriate for a medically oriented system, rather than a recovery-oriented system.

Definition of Terms

PCPA recommends including a definition section in the revised bulletin draft, as many of the terms used in this version are ambiguous and unclear. We have identified many of these terms in specific comments that follow. One of the most important clarifications we request is a clear definition of the types of

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incidents being addressed, and the categorization of these incidents. Any such categories must be clearly defined, both in what type of incidents they include and in the specific requirements for reporting them. PCPA believes that such definitions are essential in providing clarity to this draft.

Reporting Methods

The draft bulletin indicates that reports may only be submitted by telephone and fax. In this electronic era, tools are available to assist in reducing duplication of effort, reducing errors, and protecting personal health information of consumers. One such tool is that of the mental retardation system's Home and Community Services Information System (HCSIS), which is also being used by the Office of Social Programs (OSP). OMHSAS should consider the development of, or utilization of similar resources in the creation of any new reporting requirement.

Financial Burden

Finally, in the scope of general comments, the amount of additional time that will be required to comply with this bulletin, from duplicate entry of information by the provider, county, and state, to various reporting requirements of other departments will be considerable. This bulletin becomes yet another unfunded mandate to both counties and providers. In the Commonwealth's current and continuing financial crisis faced by the human services community, it is unconscionable to develop a system, like that proposed in this draft bulletin, that adds to this burden and removes more dollars from care. We strongly recommend that OMHSAS conduct a financial analysis of the true impact any incident management bulletin would have on the state, counties, and providers. PCPA would be happy to assist in the coordination of any efforts to determine the fiscal impact of a proposed bulletin. We expect that OMHSAS does not realize how many reports would be generated by the parameters of this draft bulletin. As such, PCPA believes that OMHSAS and the counties would be unprepared to handle the volume of information they would receive.

Page Specific Comments

Page 1

SCOPE:

It appears that some programs are missing from the list of those covered by this bulletin. For example, personal care boarding homes that are run by behavioral health providers (often utilizing Community Hospital Integration Project Program [CHIPP] funds), Targeted Case Management (of which there are several pilot sites), other CHIPP programs, and other unlicensed programs are not listed.

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PCPA recommends language similar to the draft OMR Incident Management Bulletin language that states:

Providers who receive funds from the mental retardation system, either directly or indirectly, to provide or secure supports or services for individuals authorized to receive services from a County Mental Retardation Program and providers licensed by the Department of Public Welfare's Office of Mental Retardation are required reporters and must file complete incident reports as prescribed within this bulletin. *(Page 1 of draft OMR Incident Management Bulletin – 4/9/03 draft)*

Utilization of similar language would be more adaptable to include new services that are developed and would more clearly define which services are to be included in the scope of the bulletin.

We also question the applicability of this bulletin on programs that are licensed by both the Departments of Health and Public Welfare to treat individuals with co-occurring mental illness and substance abuse (MISA) issues. Currently programs licensed by DOH comply with incident reporting requirements in order to obtain and maintain their licenses. Additionally, the confidentiality requirements governing the release of information are much more stringent than those of OMHSAS as well as HIPAA. With this in mind, we recommend that programs dually licensed to provide services to MISA clients be excluded from the scope of any incident management system developed by OMHSAS. To create a system that does not comply with drug and alcohol (D&A) confidentiality requirements would cause havoc in these programs, and to create a system that does comply with these requirements would be complicated and redundant. We believe that the incident reporting requirements MISA programs are already complying with should be accepted in lieu of any OMHSAS developed requirements.

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REPORTING RESPONSIBILITIES

The three categories specified do not clearly address all of the services identified in the Scope as outlined on Page 1. For example, would psychiatric hospitals and inpatient programs be included under the category "residential providers"?

Where would Intensive Case Management (ICM) and Resource Coordination (RC) fit? ICM and RC are very different programs than the other identified services. Would ICM and RC staff report on incidents only when they are in contact with the consumer? Would they report when they become aware of an incident even though it was completely unrelated to services provided? How do we ensure that

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they don't report an incident already reported by another provider? PCPA recommends that ICM and RC programs only be responsible for reporting incidents while they are in contact with the consumer. Additionally, the term "contact" should be defined as physical contact or while on the telephone.

The bulletin is unclear about when certain programs are required to report incidents, therefore, PCPA recommends that OMHSAS use the language found in the April 4 OMR Draft Incident Management Bulletin, page 4, relating to reporting responsibilities:

After taking all necessary actions following an incident to protect the individual, the provider is to report all categories of incidents and complete an investigation as required whenever services or supports are:

- A) Rendered at the provider's site; or
- B) Provided in a community environment, other than an individual's home, while the individual is under the responsibility of an employee, contracted agent or volunteer;
or
- C) Provided in an individual's own home or the home of his/her family, while an employee, contracted agent or volunteer is providing services in the home.

RESIDENTIAL PROVIDERS

Who is responsible for reporting and investigating (when appropriate) when a consumer lives in a residential program, but an incident occurs while he or she is participating in a treatment program (such as partial hospitalization)? Is the partial hospitalization provider responsible because the incident occurred when the consumer was participating in the program? Is the residential provider responsible if and when they learn about the incident? Are both providers expected to report on the same incident?

PCPA recommends use of the language found on page 4 of OMR's draft bulletin:

In situations where multiple providers learn of an incident, the provider responsible for the individual at the time the incident occurred is to report the incident and conduct any required investigation. If it cannot reasonably be determined which provider had responsibility at the time of the incident, all who are aware of the incident are to report the incident and investigate.

Use of the language suggested in the previous comment under "Reporting Responsibilities" would address the following definitional issues, however they still need to be identified should the recommended language not be adopted.

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“On leave from the program” needs to be clearly defined. A distinction needs to be made between when a consumer is on a planned leave (such as on vacation with their family) and when a consumer is participating in a program (such as attending an outpatient therapy session. Providers have no ability to force family members or community businesses to correct hazards.

NON-RESIDENTIAL TREATMENT, SUPPORT AND REHABILITATION SERVICE

“While in their program” needs to be defined. Does this mean while the consumer is physically at the program site or at any time during which the consumer is registered in the program?

Housing support services pose another question. Is the provider responsible for reporting an incident while the housing support staff is present in the home? What about when an incident occurs while the staff is not present? Is there a distinction between the level of incident that would or would not be reported in each situation?

INCIDENT TYPES AND TIME FRAMES FOR REPORTING

Reporting Time Frames

Two-hour notification is unreasonable and unnecessary. What response and action would OMHSAS plan to do upon receiving the two-hour notification that would require such a short time frame? If an incident occurred that would, according to the bulletin, require the two-hour telephone notification, the staff should be spending their time attending to the incident, working with police, talking with consumers, etc. Unless OMHSAS will be staffing the telephone 24 hours each day, 356 days each year, it would be superfluous to have this two-hour requirement.

If OMHSAS plans to use an answering machine during the times that the phone lines are not staffed, how would confidentiality and security of information be maintained? PCPA understands the intent of this requirement – that significant incidents need to be reported right away so that investigations or corrective measures can be taken to protect other consumers. However, the Association believes that it would be more than adequate to report these incidents within 24 hours of their occurrence. Please refer to the OMR Incident Management Bulletin for different and effective timelines.

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Incident Type: Deaths

A report of death due to natural causes or "sudden, unanticipated or accidental" should only apply to residential providers unless the death occurred at the program site.

"Natural Cause" needs to be defined and it should be noted that it is not always possible to know if a death is of natural causes until some time after the death.

Incident Type: Verbal Threat to Commit Suicide

According to the draft bulletin, "A verbal threat to commit suicide" would be reportable. The OMR Incident Management bulletin limits reporting requirements to include only suicide attempts and specifically states on page 9: "A suicide attempt is limited to the actual occurrence of an act and does not include suicidal threats." PCPA recommends such language in the OMHSAS bulletin, also including in the definition that the suicide attempts to be reported should be those that require medical intervention or hospitalization. A large portion of consumers in treatment have suicidal thoughts and may express this on a very regular basis, both verbally and through minor self inflicted injuries, during the course of treatment.

Any threat to commit suicide is taken seriously by the provider and requires clinical action. If threats to commit suicide were to be reported, the following should be considered. Through the relationship established between the clinical professional and the consumer, the clinician is able to determine the level of imminent danger to that consumer at that time. Another point to consider is that a physical attempt of suicide or verbal suicide threat that is serious will prompt a 302 involuntary commitment, which requires the completion of Form MH-783 and thus would be reported to the State. The decision to report such an incident should be limited to the clinical judgment of treatment personnel regarding intent and the perceived lethality of the threat, reporting only those incidents where significant actions must be taken by staff to assure the safety of the consumer.

Incident Type: Medication Error

The Incident Type "medication error" needs to be defined. Do medication errors include medications for which the provider has no responsibility? For example, if a consumer has diabetes and an error occurs in a self-injection, would the provider be responsible for reporting it if they learned of the error? Medication errors should be limited to situations where the staff are directly responsible for the administration of the medication. Many of the consumers in the mental health system have co-occurring health problems requiring numerous

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medications, therefore this requirement could easily become overwhelming, especially considering the frequency of forgotten doses, etc.

"Adverse consequences" also needs to be more clearly defined.

Reporting Multiple Incidents

How will a provider report multiple incidents? In a natural disaster, would individual reports need to be made on each consumer if no medical intervention is needed? Also, telephone and electric service are often disrupted when a natural disaster occurs, thereby prohibiting the provider from submitting the report as currently required in the draft bulletin language. We recommend that language be included that will address these issues.

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INCIDENT TYPES AND TIME FRAMES FOR REPORTING (cont.)

Incident Type: Emergency Services Involvement

The Incident Type "Any event requiring the services of the fire department, law enforcement agency or other emergency services" needs to be defined more clearly. There can be frequent false alarms that resulting in the arrival of fire department or police personnel at the agency, without an actual incident having occurred. In some areas of the state, consumers are often transported for medical treatment by fire rescue or the police. Many 302 commitments involve a police presence. In many rural areas, the consumer can only go to the emergency room because there is no doctor available elsewhere, however the incident may be something minor such as a common cold. This category should be narrowed or there will be a very high volume of reports. Alternatively, PCPA recommends that the decision to submit a report be left to the judgment of the provider so as not to inundate OMHSAS with unnecessary information.

Incident Type: Abuse

OCYF has a form (CY-47) that is required to be submitted in the case of child abuse. Has OMHSAS reviewed this form? Would submission of the OCYF form be acceptable in those incidents, thus reducing the amount of paperwork the provider must do and allowing for more treatment time?

Clarity is needed around the definitions of abuse, neglect, etc. OMR's draft bulletin provides such definitions on pages 6 – 10. As well, state law mandates specific definitions of these terms for individuals under the age of 18.

Frequently in the course of treatment, a consumer may share stories of abuse that have occurred in the past. Would providers be responsible for reporting

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such abuse histories as they are learned, even if that information has not previously been shared or addressed by the professional community? This may have an adverse effect on the willingness of the consumer to disclose such information if they believe it will cause a report outside of the therapeutic relationship. OMHSAS should also consider the impact of reporting abuse to the family, as there are times when the abuse involves a family member.

After looking at the proposed Incident Types, PCPA believes that OMHSAS is overlooking the fact that many identified incidents are common occurrences in every day clinical practice. For example, one PCPA member is an outpatient psychiatric clinic that serves victims of domestic violence who experience various forms of abuse on a frequent basis. Frequently this abuse is a large part of the presenting problem, therefore the provider wouldn't necessarily consider each episode of abuse experienced by the consumer to be a reportable incident. This also raises the question of what OMHSAS will do with this information if it is reported. Follow-up with the consumer by the state could result in further harm if it is done without the collaboration of the provider. In some cases, knowledge that the abuse would be reported could be enough to keep the consumer from talking about the experience or from accessing or continuing treatment. The language of the bulletin requires much more thought in addressing these kinds of concerns.

How are providers to handle threats of abuse or misuse of funds when the consumer is dealing with a diagnosis of paranoia? If the provider is reasonably confident that the abuse is not happening, are they still responsible for submitting a report? Does OMHSAS expect a report each time the alleged abuse is mentioned? Considering some of the symptoms presented by those in the community experiencing mental illness, there could be many false allegations made. Obviously, providers want to ensure that legitimate cases of abuse are reported and investigated and already do so under reporting parameters prescribed by law. However, the determination should be left to the provider, who has the personal relationship with the consumer, on how to evaluate if the incident requires a report.

Incident Type: Injury or illness

Minor first aid needs to be clarified. OMR defines this on page 8 of their bulletin:

Injury requiring treatment beyond first aid – any injury that requires the provision of medical treatment beyond that traditionally considered first aid. First aid includes assessing a condition, cleaning an injury, applying topical medications, applying a Band-Aid, etc.

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PCPA recommends using this language. An alternative could be to limit reportable injuries to include only injuries or trauma requiring at least outpatient medical treatment.

OMHSAS should clarify the definition of "illness" to include only serious communicable illnesses and illnesses requiring hospitalization. The current language appears to require the reporting of minor illnesses, which, when combined with the phrase "minor first aid," would generate numerous unnecessary reports. An example of such a situation could be a consumer with a sinus infection, who receives medical treatment beyond minor first aid. Does OMHSAS intend for an incident report to be filed in these types of instances?

Included with the draft bulletin is the PA Department of Health list of reportable diseases. It is not clear whether communicable diseases are to be reported or if the list is to be used as a reference. Frequently providers do not learn that the consumer has a communicable disease, especially outpatient providers, as the information is not necessary in order to provide treatment.

How are chronic medical problems to be handled? Would an incident report need to be filed for chronic medical problems that may require medical treatment more than minor first aid?

Incident Type: Out of Contact

The OCYF regulations, Chapter 3800.16, defines a reportable incident as a child's absence from the premises for four hours or more without the approval of staff persons or thirty or more minutes if the child is deemed to be in immediate jeopardy. The Incident Type relating to the consumer being out of contact does not distinguish between how children and adults would be handled. This also points to another governing body to which agencies who serve children must provide incident reports in addition to any that OMHSAS develops.

Clarification is needed regarding the notification of a consumer who is "out of contact" with program staff. Is the two-hour notification to occur after the 24 hours or in the actual second hour that the person is missing? Please note that we continue to believe that two hour reporting is unnecessary.

Incident Type: Unscheduled Hospitalizations

The Incident Type "Unscheduled hospitalization for any psychiatric condition" needs to be defined. Would an involuntary commitment be considered unscheduled? The majority of psychiatric hospitalizations, in our experience, are unscheduled. This could result in a large number of unwarranted reports being

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submitted to OMHSAS. One psychiatric hospital stated that for this incident type alone they could expect to submit 50 to 100 incident reports each day.

Also needing clarity is what provider/program would be expected to complete and file the report. The community-based provider originally serving the consumer (if one existed), the receiving hospital, or the Crisis Intervention service provider facilitating the commitment?

Final Report

What is a final report? If the reporting format is the same (Appendix A) and the incident is resolved by the filing of the first report, does this suffice as a final report or must the same information be submitted twice?

PROVIDERS MUST

What are the requirements for designating an individual with "overall responsibility for quality assurance, risk management"? Is OMHSAS going to allow the provider to inform the state of who that person (or persons) will be, or will the state mandate requirements or training? Is this designated person also the point person?

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PROVIDERS MUST (cont.)

Investigator Training

Small providers have had a very difficult time in complying with the OMR certification training that is required in the March 25, 2002 bulletin. The OMR training is five (5) days long, however attendees felt that 1½ days to cover the information would have been adequate. PCPA cautions OMHSAS that whatever training expectations that will be developed for investigators be reasonable, especially considering rural areas, current staffing shortages system wide, and inadequate funding to address these requirements in addition to others already expected of providers.

When is the provider required to use certified investigators from their own staff vs. requesting them from the county or OMHSAS?

How often will the investigator training be offered? Will it be offered regionally? Will there be ample opportunities for providers to train as many persons as they feel necessary, especially considering the high turnover rates in this field?

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Does OMHSAS expect providers to incur training costs? How will these costs be offset by the state, which is mandating new requirements in a time of especially dire financial hardship?

If an individual works in both the mental health and mental retardation systems and is already a certified investigator within the mental retardation system, must they receive OMHSAS training as well? We would strongly recommend a reciprocal agreement between OMR and OMHSAS.

How is the debriefing to be documented? Where? What if the clinician believes that a debriefing is contraindicated?

Are all reportable incidents to have a debriefing with all of the consumer and staff involved? This could mean an enormous amount of time spent on debriefing very minor incidents, or incidents that happen very frequently (such as suicidal threats). Another example is if a consumer believes his or her wallet has been stolen and the police are contacted. Is it necessary to do a debriefing? This determination should be left up to the provider's judgment.

Notification of Family

The consumer must be asked if they want the written notification to be provided to a family member or responsible contact on the closure of an incident investigation. This would also appear to be a violation of HIPAA privacy regulations.

What type of information would be provided to the consumer and family?

What age is OMHSAS considering the age of consent for incident notifications to family members?

Types of Analyses

Root Cause Analysis (RCA) must be defined. True RCA is very complicated and would take a significant amount of time and require a lot of training. Depending on the definition of reportable incidents, it would not be possible to do this every time.

Failure Mode and Effect Analysis (FMEA) must be defined. PCPA believes this might be a requirement of the Joint Commission on the Accreditation of Hospitals (JCAHO), however it is not a term that is familiar to the general provider community.

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Provider Staff Training

It is reasonable that all staff and volunteers who come in contact with consumers have proper orientation and training to respond to incidents and report them to a specified individual or senior level staff member. However, it is not reasonable to expect that ALL staff would be trained to document and report such incidents, nor is it the responsibility of a volunteer to do so. The provider is more than capable of determining what staff is qualified to document and report incidents. Additionally, OMHSAS has not outlined what they consider to be proper orientation and training. Further, agencies cannot be responsible for business associates (as defined by HIPAA?) to have the training and orientation as stated.

Prevention of Future Occurrences

It is recommended that OMHSAS remove the requirements regarding Failure Mode and Effect Analysis. The statement "Identify activities that will be taken to prevent future occurrences of the incident" *as applicable*, is adequate.

Family Notification

The statement that allows the consumer and family member to have the opportunity to provide written comment about the incident must include a provision that the family member would have this opportunity only if the consumer requests this and authorizes the provision of the information. Otherwise we believe this would be a violation of HIPAA privacy regulations.

If a child is 14 years old or above, does the family automatically receive notification of every incident? What if the child is in the care and custody of child welfare or juvenile detention? Are they notified instead? In addition to? Can this notification be by telephone or does OMHSAS expect that written notification be sent to the family?

Investigation files

Investigation files maintained within the agency should be maintained as part of the individual medical record because of the inclusion of protected health information. Providers would be out of compliance with other applicable laws (such as HIPAA) if they were to maintain an "investigation file" with information about multiple consumers.

Alternatively could the investigation files to be de-identified in order to be HIPAA compliant? Will everyone, including the provider, county, and state know the identity of each consumer for whom an incident report is filed? Again, these are very important HIPAA concerns that must be addressed.

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**COUNTY OFFICES OF MENTAL HEALTH AND MANAGED CARE
ORGANIZATIONS MUST
Policies and Procedures**

What guidelines are published to set the standard for the approval of policies and procedures by the county and/or MCO? Will the county AND the MCO approve the policies and procedures? This is a duplication of effort. What if the county approves but the MCO does not? Whose instructions is the provider to follow if this situation were to occur? One entity's approval should be accepted by the other.

The policies and procedures will need to be developed and then reviewed. Considering the amount of time it can take for providers to develop these documents, as well as the large number of providers this bulletin would cover, this cannot possibly occur by the stated deadline of January 1, 2004.

How frequently will this approval occur?

County/MCO Staff Training

As noted earlier in the comments regarding Page 4 under "Providers Must," when is training to be provided by OMHSAS for counties and the MCO regarding certified investigators? Will there be ample opportunities to train all staff members the organization wishes to train? Will this training occur with the frequency necessary to address high turnover of staff?

Investigations

What incidents indicate that a county level investigation should occur (or provider, MCO, or OMHSAS level investigation)? No guidelines have been established and submitted for comment and review. There could be instances when there are dual investigations occurring, which would tax already scarce resources unnecessarily. How does the Department intend to find appropriate staff resources – at the provider, county, MCO and state level – to complete these investigations?

What is the intent of OMHSAS in requiring these investigations for incidents that occur in the community and not at a licensed facility? OMR has concluded after experiences reported by providers, that providers have no jurisdiction to investigate in community locations or private homes.

How often must certified investigators take refresher training and receive recertification?

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High Risk/At Risk

What is meant by identifying programs "engaged in high-risk activities" and consumers who are "at risk"?

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**THE OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
WILL** (continued)

It is noted that OMHSAS "reserves the right to issue provisional licenses/apply appropriate sanctions to an agency based on the outcome of an investigation." Does OMHSAS plan to submit applicable licensing regulations to the Independent Regulatory Review Commission (IRRC) for the addition of this language for it changes existing state regulation? Providers should be informed of any specific outcomes that will trigger the issuance of provisional licenses or the application of sanctions in advance.

OMHSAS will "coordinate with other agencies as necessary to investigate special incidents." Please define special incidents.

PROVIDERS MUST

Point Person

The definition OMHSAS is proposing for the point person is different from the OMR definition of point person. This will only serve to confuse providers who deliver multiple services. The first responsibility identified by OMHSAS is for the point person to take prompt action to protect the consumer's health or safety. The OMR draft bulletin requires that the point person discuss with the reporter what actions were taken and suggest other actions if they are necessary. This is more realistic as the point person may not be at the scene of the incident. Depending on how the role is assigned, the point person might not know the person as well as the reporter of the incident does. Since the bulletin does not provide a time frame for the witness of the incident to report, the point person may not learn of the situation for some time. Hopefully the health and safety issues will have already been addressed by then.

The third responsibility of the point person is to call the county within two (2) hours or fax a report within 24 hours of learning of the incident. This is confusing because the bulletin doesn't state the time frame for the witness or first person learning of the incident to contact the point person. For example, a staff person could be aware of an incident at 3:00 p.m. and not call the point person until the next week.

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Will providers be allowed to identify more than one point person? If only one point person were identified, that person could literally be consumed with managing incidents. One provider reported that they dedicate around 30 hours each month to mental retardation incident management alone. This provider estimates that the current mental health incident management responsibilities will be double the amount of time necessary for mental retardation requirements, due to both the increase in incidents as OMHSAS has defined them and the increased requirements for reporting, investigating, etc.

Telephone/Fax Staffing

County mental health offices and OMHSAS offices are not currently staffed to receive telephone and fax reports after hours, on weekends, and on holidays. How does the state expect providers to telephone reports of incidents during those times?

It seems appears to be duplicative for providers to report the same incidents to both the county/BHMCO. There is no indication of which entity providers are to report to in HealthChoices areas where the county and the BHMCO are separate entities. PCPA recommends that the state, counties and BHMCOs agree upon how to best unify this data collection process.

Contacting Law Enforcement

Law enforcement agencies are to be notified when there is "suspicion that a crime has occurred." How does this requirement interface with consumer/clinician confidentiality? Does this requirement change depending upon the seriousness of the alleged crime? Murder vs. shoplifting or violation of a protection from abuse order?

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PROVIDERS MUST (cont.)

Is the point person also the certified investigator? This draft states that the point person will investigate the incident, so does this mean that there are to be two investigations done by the provider? One by the point person and one by the certified investigator?

Final Report

To whom does the final report get submitted? The County? The State? The MCO? All three?

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COUNTIES MUST

The county identified point person is responsible to “notify the appropriate OMHSAS Field Office according to the established time frame and fax follow-up reports to OMHSAS within 5 working days.” If the county will complete this requirement, why then, is the provider also required to do so?

PROVIDER ROLE

There is a statement that trend analysis involves reviewing the incident data after it has been entered into a database. What database? It is not clear whether providers are to develop a database or if the county would input data into a system that would provide reports. The bulletin mentions providing forms and fax machines to staff for reporting, but there is nothing about electronic submission, nor does it speak to the county or OMHSAS having any electronic requirements.

While the bulletin says it will not direct any specific procedure for the review of incident data by providers, the requirement to conduct RCA and FMEA appears to be doing just that.

Pages 7 – 8

PROVIDER ROLE

OMHSAS indicates that providers should do trend analysis and possibly build a database of incidents to manage such analysis (if this is indeed required. See previous comment.) Does OMHSAS intend to prescribe what kinds of analyses are to be provided? If so, this needs to be done quickly so excessive staff time and resources are not spent creating databases that will not “work” or meet the needs of the Department.

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PROVIDER ROLE (cont.)

Summary Reports

Providers and counties are to file summary reports either quarterly or semi-annually. It would appear to be most efficient to place these additional duties on one level of the system, instead of on each level. For example, once the report is made, just one level could be responsible for trend evaluation and each level would be accountable for follow-up of reduced risks related to each incident as appropriate.

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COUNTY ROLE

Does OMHSAS expect that the BHMCO will follow all statements applicable to counties? It is unclear exactly what is being expected of the BHMCO throughout this document.

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APPENDIX A

PCPA believes it may be prudent for OMHSAS to look at the forms OMR is using for incident reporting, to see how some of the desired information may be simplified. The forms OMHSAS is proposing appears to be overly complicated, confusing, and time consuming.

What is the "Provider Seq#"? "Provider MPI #"? "DOW Code (Sun=1)"?
"CIS#"?

Please define the difference between "final" and "closure."

Will counties also use this form? It is not clear who is to use the form. The fields ask for provider identifying information but do not ask for county identifying information. If the counties are also supposed to complete reports, perhaps the fields such as "Provider Name" should be changed to "Reporting Entity."

What should be entered into the field "MA#" if the consumer does not receive Medical Assistance?

Is it necessary to indicate that the consumer is under 18 when the date of birth is clearly indicated in an earlier field?

Please define "prime incident type" and "2nd incident type."

When would there be more than one closure?

In the block that asks if the family was notified about the incident, if the selection is "no" then the ability to indicate that the consumer did not want the family to be notified should be included. The form might be improved by adding the question: "Consumer was asked if they want family notified."

The race codes do not match those used in HealthChoices. They should be coordinated for ease in reporting and to reduce potential confusion and errors.

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The location of the incident (if applicable) should be included in the report form, as well as a section that identifies what the immediate action or response was and what will prevent future incidents.

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CONSUMER'S REPORT ABOUT THE INCIDENT

There is no discussion of how the consumer's report is to be handled. When is the report to be completed, every time there is a reportable incident? In certain circumstances? Is the consumer to complete the report? What if they are illiterate or otherwise unable to do so? Is it adequate to have the consumer sign the report? Can the report be completed with the assistance of staff if requested? With the assistance of family? If multiple consumers are involved in the incident, does each consumer complete a report? Does the consumer have access to the report after the provider, county, and OMHSAS review and comments are added to the report? What if, in the assessment of the treating clinician, sharing the report with the consumer is contraindicated?

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COMMUNITY INCIDENT REPORT CODE SHEET

Numbers 8-10 in the Incident Type Codes section all relate to seclusion and restraint. These are not listed as reportable incidents, therefore it is unclear why these are included.

Several providers reported to PCPA that this is a very confusing form.

There is no code for Verbal Threat of Suicide.

Shouldn't the Race Code "American Indian" be changed to "Native American"?

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ADDITIONAL REPORTING

Why is the incident to be reported to OMHSAS if the individual's treatment needs are not funded through the Commonwealth or county Mental Health systems? How would HIPAA privacy requirements be met if this were required? Will the private insurance companies be informed that they will be receiving these reports? What if they already have their own reporting requirements and do not want the reports developed by OMHSAS? What if the person is a self-pay client? Where would the report go in that situation? Why should OMHSAS be entitled to information on privately funded individuals? This whole paragraph generates

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much concern about the privacy of the consumer, unless changes are made to de-identify such reports.

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PA DOH LIST OF REPORTABLE DISEASES

There is no mention of how behavioral health providers are to report these. It is not always possible that the provider will be aware of these diseases. Is the provider expected to ask every consumer if they currently have or have had an illness identified in the list of reportable diseases?

Act 148 of 1993 states that it is illegal to reveal confidential information, such as test results, associated with a person's HIV infection. How then can OMHSAS expect the provider to report HIV/AIDS information?