Health Plan Performance Improvement Project (PIP)

MCO Name:
WellCare of Kentucky, Inc.

PIP Title: Preventing Violence, Trauma and the Use of Seclusion and Restraint for the Foster Care Population in Behavioral Health Settings

2020–2023[1]

Project Phase: Proposal/Baseline

[Please utilize the following font colors:
Proposal/baseline: Black font
Revised Proposal/baseline: Blue font for new narrative
Interim Report: Update proposal/baseline narrative/data to Black font and enter new narrative/data in Blue font
Final: Update interim narrative/data to Black font and enter new narrative/data in Blue font]

Submission Date: Click here to enter a date

Submission to:
Commonwealth of Kentucky
Department for Medicaid Services

[1] Insert baseline measurement year and final measurement year

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MCO Contact Information

1. Principal MCO Contact Person

[PERSON RESPONSIBLE FOR COMPLETING THIS REPORT AND WHO CAN BE CONTACTED FOR QUESTIONS]

Lori Gordon, LCSW, MBA
Senior Director, Behavioral Health Operations
1-270-793-7303
Lor.gordon@wellcare.com

Signature for PIP Proposal/Baseline report: Date

Signature for PIP Interim report: Date

Signature for PIP Final report: Date

2. Additional Contact(s)

[PERSON(S) RESPONSIBLE IN THE EVENT THAT THE PRINCIPAL CONTACT PERSON IS UNAVAILABLE]

Leann Magre, MSSW, MBA, LCSW, CCM
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3. External Collaborators (if applicable):

Click here to enter external collaborators involved in this PIP. **If no external collaborators, enter N/A**.

4. For Final Reports Only: If Applicable, Summarize and Report All Changes in Methodology and/or Data Collection from Initial Proposal/Baseline Submission:

Click here to enter text. Examples include: added new interventions, added a new survey, change in indicator definition or data collection, deviated from HEDIS specifications, reduced sample size(s). **If no changes, enter N/A**.

MCO Attestation

Managed Care Plan Name: WellCare of Kentucky, Inc.
Title of Project: Preventing Violence, Trauma and the Use of Seclusion and Restraint for the Foster Care Population in Behavioral Health Inpatient Settings

Required Attestation signatures for PIP Proposal/Baseline and PIP Final Report:
(1) Medical Director or Chief Medical Officer; (2) Quality Director or Vice President for Quality

The undersigned approve this PIP Proposal/Baseline and assure involvement in the PIP throughout the course of the project.

Medical Director Signature — Date
Timothy M. Houchin MD, MHCDS, FAPA

Chief Medical Officer Signature — Date
Howard Shaps, MD, MBA

Quality Director Signature — Date
Laura Betten, BSN, MBA, RN

Vice President for Quality Signature — Date
Printed Name

IS Director Signature (when applicable) — Date
Printed Name

CEO Signature (when applicable) — Date
William A. Jones

The undersigned approve this FINAL PIP Report:

Medical Director Signature — Date
Printed Name

Chief Medical Officer Signature — Date
Printed Name

Quality Director Signature — Date
Printed Name

Vice President for Quality Signature — Date
Printed Name

IS Director Signature (when applicable) — Date
Printed Name

CEO Signature (when applicable) — Date
Printed Name

DMS Review and Approval

MCO Name:

PIP Title:

DMS PIP Proposal/Baseline Report Approval: Date

_____

DMS Staff Signature

DMS Staff Title:

_____

Printed Name

DMS Comments (if applicable):

Revision: Date

DMS PIP Final Report Approval: Date

_____

DMS Staff Signature

DMS Staff Title:

_____

Printed Name

DMS Comments (if applicable):

Abstract

The Abstract should be completed only for the Final Report submission. Should not exceed 2 pages.

Provide an abstract of the PIP highlighting the project topic and objectives, briefly describe the methodology and interventions, and summarize results and major conclusions of the project.

1. Project Topic/Rationale/Aims

Title of Project: Click here to enter text.
Rationale for Project: Click here to enter text.
Project Aims: Click here to enter text.
Project Objectives: Click here to enter text.
Baseline Data: Click here to enter text.
Benchmark Data: Click here to enter text.
Goals for Improvement: Click here to enter text.

2. Methodology

Population: Click here to enter text.
Performance Indicators (Numerators and Denominators): Click here to enter text.
Sampling Method: Click here to enter text.
Baseline, Interim and Final Measurement Periods: Click here to enter text.
Data Collection Procedures: Click here to enter text.

3. Interventions

Barriers Identified: Click here to enter text.
Interventions: Click here to enter text.
Interventions' Target Groups: Click here to enter text.
Interim Results from Plan-Do-Study-Act (PDSA) Method: Click here to enter text. If PDSA Cycle was not used, enter N/A.

4. Results

Baseline Eligible Population: Click here to enter text.
Interim and Final Measurement Eligible Population: Click here to enter text.
Denominator, Numerator and Rates for Each Performance Indicator: Click here to enter text.

5. Conclusions

Indicate if Project Goals were Met: Click here to enter text.
Interpretation of Major Project Findings: Click here to enter text.
Study Design Limitations: Click here to enter text.
Lessons Learned and Next Steps: Click here to enter text.

Project Topic

1. Describe Project Topic and Rationale for Topic Selection

- **Describe how PIP Topic addresses your member needs and why it is important to your members:**

Nationally approximately 428,000 children are in the U.S. foster care system. Many of these children have experienced abuse, neglect or serious traumatic events that required their removal from their homes by a court decision for their own safety (KVC Kentucky, 2018).

According to the Kentucky Cabinet for Health and Family Services (CHFS, 2019), as of June 2, 2019, 9,875 children in OOHC had active placements. Of those:

- 3,775 (38%) are placed in foster homes;
- 959 (10%) are placed in residential treatment facilities;
- 3,163 (32%) are placed in DCBS Basic and Advanced Foster Homes;
- 2,677 (27%) are placed in DCBS Care Plus or Medically Complex Homes;
- 150 (2%) are placed in DCBS Care Plus or Medically Complex Homes;
- 245 (2%) are placed in Independent Living or Education Setting;
- 138 (1%) are placed in psychiatric hospitals.

In addition, as of June 2, 2019, the age breakdown of first entry into the foster care system in Kentucky is as follows:

- 1,945 (20%) entered into foster care < 1 year
- 1,380 (14%) entered into foster care between 1 to < 3 years of age
- 1,624 (16%) entered into foster care between 3 to < 6 years of age
- 2,499 (25%) entered into foster care between 6 to < 12 years of age
- 2,419 (24%) entered into foster care between 12 to <18 years of age (CHFS, 2019).

The average age of a child in foster care in Kentucky is 9 years of age, there are slightly more boys than girls and the median amount of time a child is in foster care is just over one year. Currently, WellCare of Kentucky, Inc. manages 8,233 children and adolescents in Kentucky's foster care program.

- **Describe high-volume or high-risk conditions addressed:**

Aggressive behavior is defined as "actual physical violence toward self, others or property, or making specific imminent verbal threats." Historically for actively aggressive patients the response to aggressive behavior has involved either seclusion (defined as the involuntary placement of a patient in a locked room or area from which he/she is not permitted to leave), or restraint (defined as the involuntary administration of mechanical, pharmacologic, or physical interventions, which is viewed as more restrictive than seclusion) (AHRQ, 2015). In the late 1990's the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) have required that seclusion and restraint must be used only for a behavior that "jeopardizes the immediate physical safety of the patient, a staff member, or others" (including other patients) and when less restrictive measures have failed. However, despite advocating limitations on the use of seclusion or restraint as much as possible, these interventions continue (JCAHO, 2009).

A *Foster Care Alumni Study*, conducted by the Casey Family Programs in 2003 noted significant disparities in regards to mental health between foster care alumni and the general population. This study, titled *Assessing the Effects of Foster Care: Mental Health Outcomes from the Casey National Alumni Stud*y, compared 1,087 former foster care individuals and 3,547 adults from the general population, matching for age, gender and race/ethnicity. One significant finding was that the foster care alumni experienced post-traumatic stress disorder at a rate nearly 5 times higher than the general population. The use of restraint and seclusion are known to have adverse effects on children (NCSL.org, 2016).

According to Reddy, Hassuk and Azeem (2017), aggressive behavior is seen in 3 to 7% of children and adolescents across all clinical settings. This percentage can be higher in certain populations (i.e., children and adolescents with neurodevelopmental disorders. Aggression is also one of the common reasons for referral to a child and adolescent psychiatric inpatient services because of the significant impact to academic achievement, family and peer relationships, and psychological development. Inpatient clinical settings is where the use of restraint and seclusion can occur for aggressive behavior displayed by children and adolescents.

In addition, according to Renwick, Stewart, and Richardson (2016), the prevalence of aggressive behavior among high school age adolescents is about 28% in boys and 7% in girls. These rates may even be higher in inpatient psychiatric populations. Poggle, Pappalardo, Buccolo, and Harvey (2013) found very few systematic studies of the rates and prevalence of restraint and seclusion in children and adolescents. In addition, they found the rates varied greatly varied depending on the setting and the population. They also noted the prevalence of seclusion was about 26% and was 29% for restraint.

- **Describe current research support for topic (e.g., clinical guidelines/standards):**

The potential harmful effects of the use of seclusion and restraint was initially brought to the attention of public and government attention in the 1998 Pulitzer Prize-winning *Hartford Courant* series of stories. These stories described the use of restraint and seclusion among individuals in psychiatric settings. The stories highlighted incidents of injuries and deaths that occurred in psychiatric settings during the use of seclusion or restraint, in addition to discussing other contributing factors such as, lack of staff training and inadequate staffing patterns (U.S. Department of HHS, 2010). This initial expose' was the beginning of additional investigations resulting in the following timeline of events:

- **1985**: the American Psychiatric Association (APA) published a report on the use of restraint and seclusion discussing regulations, indications for use, contraindications, techniques, and factors to consider especially the use of restraint and seclusion in special populations, such as minors (U.S. Department of HHS, 2010).
- **1999**: The Government Accountability Office (GAO) released two reports titled *Mental Health: Improper Restraint or Seclusion Use Places People at Risk* and *Mental Health: Extent of Risk from Improper Restraint or Seclusion is Unknown*, which confirmed the findings in the *Hartford Courant* series (U.S. Department of HHS, 2010).
- **Late 1999's**: CMS issued a guideline which included stringent standards for the use of seclusion and restraint in residential facilities. In addition, the Joint Commission on Accreditation of Healthcare Organizations developed standards on the use of restraint and seclusion, advocating a nonviolent crisis intervention® training program (JCAHO, 2009) (See **Appendix A** for more detail).
- **2000**: The *Children's Health Act* established standards for the use of seclusion and restraint in all public and private health care settings that receive federal funding U.S. Department of HHS, 2010).
- **2003**: *President's New Freedom Commission Report* stated that the use of seclusion and restraint poses a "risk of serious injury or death, re-traumatizing people who have a history of trauma, loss of dignity, and other psychological harm." In addition the report indicated that the use of seclusion and restraint should only be used as a last resort when there is an "imminent risk of danger." The APA published *Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health* to help administrators and clinicians reduce the use of restraint and seclusion (Recupero, Price, Garvey, Daly, & Xavier, 2011).
- **2007 and 2008**: CMS released new rules prohibiting the use of restraint and seclusion as measures to restore order to a unit and guidelines for training of staff who order the use of restraint and seclusion. The 2008 guidelines requires a face-to-face examination by a physician, nurse, or physician's assistant within one hour of placement in restraint or seclusion and guidelines for staff education requirements (U.S. Department of HHS, 2010).

Following these reports, the Substance Abuse and Mental Health Series Administration (SAMHSA) began a series of initiatives to reduce the use of restraint and seclusion with children and adolescents. These efforts led to the identification of key elements necessary to reduce the use of restraint and seclusion. These include: adequate and well-trained staff; availability of various treatment options; evidence-based practices; consumer involvement; performance measurement; a quality improvement process; a focus on consumer dignity; and consumer and staff debriefings (U.S. Department of HHS, 2010).

In 2004, SAMHSA launched a three-year grant program involving eight states (including Kentucky) with the goal of implementing and evaluating best practices in preventing and reducing the use of seclusion and restraint in mental health facilities. This resulted, in 2005, the development of a training curriculum titled *Roadmap to Seclusion and Restraint-Free Mental Health Services for Persons of All Ages*. In addition, the National Center for Trauma-Informed Care was established and funded by SAMHSA (U.S. Department of HHS, 2010).

A trauma-informed approach to care is based on recognizing and acknowledging behaviors and responses expressed by individuals are directly related to traumatic experiences that often result in mental health, substance abuse, and physical health concerns. This includes the foster children population (U.S. Department of HHS, 2010).

Finally, in 2006 the National Association of State Mental Health Program Directors (NASMHPD) in collaboration with SAMHSA developed a training curriculum focusing on alternatives to the use of seclusion and restraint in mental health settings titled, *Six Core Strategies© Approach to Reduce the Use of Seclusion and Restraint* based on minimizing conflict and facilitating immediate resolution when conflict occurs to prevent escalation of the behavior. The *Six Core Strategies©* include:

1. Leadership toward organizational change
2. The use of data to inform practice
3. Workforce development
4. Use of prevention tools
5. Supporting consumer and advocate roles in inpatient settings
6. Debriefing tools (NASMHPD, 2006)

See **Appendix B** for more descriptive detail on each of the six strategies. These strategies were developed through an extensive literature reviews and dialogs with experts who have successfully reduced the use of seclusion and restraint in mental health settings for children and adults in the United States.

The discussion concerning the reduction and/or elimination of episodes of seclusion and restraint for patient with behavioral problems continues to be an area of concern and debate among mental health clinicians. However, evidenced continues to show an increased incidence of injury, both physical and psychological occurs to both patients and staff. When restraint or seclusion is used, efforts should be taken to mitigate potential negative consequences that may result from the action taken.

- **Explain why there is opportunity for MCO improvement in this area (must include baseline and if available, statewide average/benchmarks):**

The American Academy of Pediatrics, Healthy Foster Care American Initiative, identified mental and behavioral health as the “greatest unmet health need for children and teens in foster care” (NCSL.org, 2016). In addition, over the past decade, there has been observed a shifting in attitudes and practice regarding the use of seclusion and restraint in mental health treatment settings. The use of seclusion and restraint are being viewed as a crisis intervention technique to be used only as a last resort when less restrictive measures have filed. The use of seclusion and restraint are no longer perceived as “therapeutic” for patients, and there is stronger evidence not only for reducing their use, but to prevent their need by anticipating the needs of patients and by actively engaging them in preventive techniques. There continues to be efforts throughout the United States to raise awareness of the potential harm the

use of restraint and seclusion can cause especially in those patients who have already experienced trauma in their lives (U.S. Department of HHS, 2010).

Currently WellCare of Kentucky, Inc. (the Plan) manages the care and services provided to 8,233 children and adolescents in the foster care program in Kentucky. **Table One** displays a breakdown of WellCare's foster care population for the first quarter of 2019. The desire of the Plan is to reduce the use of seclusion and restraint in this population. During the first quarter of 2019, WellCare identified twelve facilities reporting incidents of the use of seclusion or restraint indicating opportunities for improvement. However, there was one additional facility that did not submit information in regards to seclusion or restraint events. **Table Two** shows the number of events reported for the first quarter of 2019. The facilities identified include:

1. ABS LINCS KY, LLC
2. Central State Hospital
3. Eastern State Hospital
4. Western State Hospital
5. Harlan ARH Hospital
6. Lincoln Trail Behavioral Health System
7. Mercy Health – Lourdes Hospital
8. UHS Bowling Green, LLC
9. UHS Ridge, LLC
10. University of Kentucky Hospital
11. The Brook
12. The Brook KMI
13. Our Lady of Peace (No data on seclusion or restraint events submitted by this facility)

While there may be clinical situations for which verbal and behavioral techniques are not effective and the use of seclusion or restraint becomes necessary to prevent harm to the patient and/or staff, the Plan believes measures should be taken to mitigate potential negative consequences that may result when such actions are taken. By partnering with behavioral health facilities in our network providing inpatient behavioral health services to Kentucky's foster care population, the Plan hopes to be able to reduce the incidence of restraint and seclusion through an enhanced behavioral health care management program encompassing the following collaborative efforts: ongoing communication, monitoring, auditing, training, development of prevention tools, and feedback. For this PIP, the Plan will follow the guidelines set forth by CMS, JCAHO, SAMHSA, and NASMHPD.

TABLE ONE: WellCare's Foster Care Population for 1st Quarter of 2019

Kentucky Medicaid Region	Number of New Foster Care Members	Number of Existing Foster Care Members	Number of New Foster Care Members Enrolled into Case Management	Number of Existing Foster Care Members Enrolled into Case Management	Number of New Foster Care Members Enrolled into Active Case Management	Number of Existing Foster Care Members Enrolled into Active Case Management	Number of New Foster Care Members with Completed HRAs	Number of Existing Foster Care Members with Completed HRAs
Region 1	45	534	8	11	0	0	0	0
Region 2	73	604	7	19	0	0	0	1
Region 3	65	462	28	35	0	1	1	1

Region 4	105	1270	32	30	0	1	0	0
Region 5	145	1839	30	45	0	0	0	0
Region 6	55	718	15	9	0	0	0	0
Region 7	73	850	12	10	0	0	0	2
Region 8	98	1297	17	31	0	0	0	1
TOTALS	**659**	**7574**	**149**	**190**	**0**	**2**	**1**	**5**

TABLE TWO: Reported Incidents of Seclusion or Restraint Use During 1st Quarter 2019

FACILITY	QTR 1	PERCENT
1. ABS LINCS KY, LLC	32	7.94%
2. Central State Hospital	24	5.95%
3. Eastern State Hospital	44	10.92%
4. Western State Hospital	38	9.43%
5. Harlan ARH Hospital	14	3.47%
6. Lincoln Trail Behavioral Health System	43	10.67%
7. Mercy Health – Lourdes Hospital	21	5.21%
8. UHS Bowling Green, LLC	19	4.71%
9. UHS Ridge, LLC	46	11.41%
10. University of Kentucky Hospital	30	7.44%
11. The Brook	52	12.90%
12. The Brook KMI	40	9.9%
14. Our Lady of Peace*	0	0.00%
TOTAL	**403**	

*No information submitted in the report by this facility

2. Aim Statement, Objectives and Goals

Aim Statement:

By the final measurement year, the MCO aims to reduce the reported incidents of the use of seclusion and restraint, by behavioral health facilities, by 25 percent compared to the baseline measurement year, among foster care members receiving behavioral health treatment (403 for 1st quarter 2019). (A reduction of 25% = 302.25).

Objective:

Implement an enhanced behavioral health care management educational program targeted toward facilities, providing behavioral health treatment to foster care members, to reduce the percentage of reported incidents of the use of seclusion or restraint by 25 percent compared to the baseline measurement year (403 for 1st quarter). (A reduction of 25% = 302.25).

Goal:

Baseline to final measurement goal:

Reduce the number of reported incidents of the use of seclusion and restraint by behavioral health facilities by 25 percent compared to the baseline measurement year, among foster care members receiving behavioral health treatment (403 for 1st quarter 2019). (A reduction of 25% = 302.25)

Methodology

1. Performance Indicator[2]

Indicator #1

Data Source(s): Behavioral Health JCAHO Report on Use of Seclusion and Restraint

The percentage of reported incidents of the use of seclusion and restraint by behavioral health facilities among foster care members receiving behavioral health treatment.

Eligible Population:

Foster care members receiving behavioral health treatment in a behavioral health facility during the measurement year.

Exclusion Criteria:

None.

Numerator Definition:

Foster care members receiving behavioral health treatment in a behavioral facility during the measurement year, and who had an incident of seclusion or restraint during their treatment period.

Denominator Definition:

Foster care members receiving behavioral health treatment in a behavioral facility during the measurement year.

2. Data Collection and Analysis Procedures

Is the entire eligible population being targeted by PIP interventions? Yes

If sampling was employed: No sampling methodology will be used

Data Collection:

Data collection will be performed internally by members of WellCare's Behavioral Health Care Management Team and by the Plan's corporate analytics team according to the specifications developed and established for this performance improvement project (PIP).

TABLE THREE: Outcome Variables to be Included in the Analysis

	OUTCOME VARIABLE	DEFINITION
SECLUSION	1. Seclusion hours per 1,000 treatment hours	Hours of seclusion as a proportion of all treatment hours in the pre-and stable phase
	2. Percent of consumers secluded	Proportion of all individuals in the facility during the pre-and stable phase who had a seclusion event.
RESTRAINT	3. Restraint hours per 1,000 treatment hours	Hours of restraint as a proportion of all treatment hours in the pre-and stable phase.
	4. Percent of consumers restrained	Proportion of all individuals in the facility during the pre-and stable phase who had a restraint event.

Validity and Reliability:

To determine content validity of the specified performance indicator, which is the extent to which the performance indicator measures the universe of claims and encounters for the eligible population that should have been included in order to evaluate intervention effectiveness, WellCare Behavioral Health Care Management Team and the corporate analytics team will initially perform the data collection, run the data based on the specifications, review the results, and then will review the results with the Plan's Senior Manager of Foster Care and Adult Guardianship, the Senior Director of Behavioral Health Operations and the Plan's Behavioral Health Medical Director. This team reviews the results and compares the findings to those of previous data runs to determine any outliers or significant variations from previous data collection. Results will be compared to those previously obtained for the indicator for similarity/consistencies in findings. Any discrepancies and/or concerns will be discussed and revisions made to the data collection process if needed (Results reported in the Results/Discussion Sections of this PIP). Queries will be re-run as needed, and the results compared again. The data collection and analysis will be performed monthly, quarterly and annually as another method to ensure content validity. The Plan's Senior Medical Director and members of the Quality Improvement Team may also review and participate in the analysis. The results will be presented to the Plan's QI Committees annually. This additional Team is comprised of associates with several years of experience with quality improvement as well as experience with quality improvement methodology, data collection, analysis and critique.

Reliability for the performance indicator is tested using a test/re-test methodology to determine if the established queries performed yield consistent results for the specified performance indicator) when repeated using the same universe of claims and encounters for the eligible population and following set protocols. To determine intra-query/intra-analyst reliability, queries for the performance indicator are re-run by the Plan to determine if the results can be accurately repeated, and then will be compared to those results previously obtained. This is important to establish since a specific/established query is used for the specified performance indicator. Adjustments/corrections will be made to the queries as needed (Reported in the Results/Discussion Sections of this PIP) and the above stated testing process is repeated. This testing process is performed monthly, quarterly and annually as another method to ensure reliability.

Data Analysis:

The project topic selected for this collaborative Performance Improvement Project (PIP) is *Preventing Violence, Trauma and the Use of Seclusion and Restraint for the Foster Care Population in Behavioral Health Settings* with the goal reducing the number of reported incidents of the use of seclusion and restraint by behavioral health facilities by 25 percent compared to the baseline measurement year, among foster care members receiving behavioral health treatment (403 for 1st quarter 2019).

The Plan will use the formula for "Calculating the 95th Confidence Interval" as referenced in Volume 2 of the *HEDIS® Technical Specifications for Health Plans* for the specified performance indicator. This is to ensure target rates/goals are at a minimum statistically different from the baseline period, and indicate substantial improvements at the Plan population level. Goal was set based upon CMS recommendations for attainable comparison rates that reflect meaningful improvement. Per CMS recommendations, goals should be "bold," yet attainable. The goal is focused and realistic based upon what the data suggests.

The data collected by the Plan will be reviewed, analyzed and reported for the performance indicator and for the quarterly Intervention Tracking Measures (ITMs). Any identified plateaued or decreasing trends will be further analyzed to identify the root cause and any addition barriers with interventions revised and/or added as needed. Any changes will be included in subsequent PIP reports.

Procedures to ensure member confidentiality:

The Plan has in place all HIPAA confidentiality processes and procedures, which are utilized to protect member confidentiality.

3. Timeline

Report the baseline, interim and final measurement data collections periods below.

Baseline Measurement Period:
Start date: 1/1/2020
End date: 12/31/2020

Submission of Proposal/Baseline Report Due: 9/1/2021

Interim Measurement Period:
Start date: 1/1/2021
End date: 12/31/2021

Submission of Interim Report Due: 9/1/2022

Final Measurement Period:
Start date: 1/1/2022
End date: 12/31/2022

Submission of Final Report Due: 9/1/2023

Barriers, Interventions, and Monitoring

This section describes the barriers identified and the related interventions planned to overcome those barriers in order to achieve improvement.

1. Populate the table below with relevant information, based upon instructions in the footnotes.

Table 3: Alignment of Barriers, Interventions and Intervention Tracking Measures

Description of Barrier[1]	Method and Source of Barrier Identification[2]	Description of Intervention Designed to Overcome Barrier[3]	Enter Target Group: "E" for Enrollee "P" for Provider "C" for Community "M" for MCO	Intervention Timeframe[4]
Reluctance of facility leadership within the facility to change (i.e., to make violence prevention a high priority; to reduce/eliminate organizational barriers; to provide or re-allocate the necessary resources)	*Literature Review and Internal Focus Group*	*Conduct face-to-face meetings with behavioral health facility leadership to partner and collaborate on ways to develop/train staff, identify violence prevention as a priority, develop a violence and seclusion and restraint prevention plan, and improve oversight of untoward events.*	*P, M*	Start: 1/1/2020 End: 12/31/2022
Unwillingness of facility to use data/ information to drive practice change.	*Literature Review and Internal Focus Group*	*Collaborate with behavioral health facility partners to establish consistent definitions of violent events; guidelines for the use of seclusion and restraint; recognition of imminent danger; identify reportable injuries and appropriateness of stat medication administration; compile historical data by events/hours; and to mandate ongoing compiling of data for analysis to effect positive change.*	*P, M*	Start: 1/1/2020 End: 12/31/2022
Varying facility staff knowledge, education, and training, and experience levels in regards to alternatives to seclusion and restraint.	*Literature Review and Internal Focus Group*	*Collaborate with behavioral health facilities to develop and implement staff training in: matching interventions with behaviors; use of prevention tools to de-escalate a potentially violent situations; introduction of trauma-informed services; and the importance of debriefing after the use of seclusion and restraint.*	*P. M*	Start: 1/1/2020 End: 12/31/2022
Lack of violence prevention tools.	*Literature Review and Internal Focus Group*	*Collaborate with behavioral health facilities to develop and implement violence, seclusion and restraint prevention tools to include: assessing the risk factors for violence and the use of seclusion or restraint; assessing risk factors for potential injury or death; implementation of a universal trauma assessment form;*	*P, M*	Start: 1/1/2020 End: 12/31/2022

Description of Barrier[1]	Method and Source of Barrier Identification[2]	Description of Intervention Designed to Overcome Barrier[3]	Enter Target Group: "E" for Enrollee "P" for Provider "C" for Community "M" for MCO	Intervention Timeframe[4]
		development of safety and crisis plans; and directives to identify triggers and preferences.		
Unwillingness of facility to include rigorous debriefing as a part of their overall strategies to reduce the usage of seclusion and restraint.	*Literature Review and Internal Focus Group*	*Collaborate with behavioral health facilities to include a debriefing phase as a part of their process whenever seclusion or restraint are used. This debriefing process should include: an analysis of each critical event; examination of what occurred before during and after the event; and determine what could have been done to prevent the event from occurring again and what could have been done better during the event.*	*P, M*	Start: 1/1/2020 End: 12/31/2022

[1]Barrier analysis should include analyses of both quantitative and qualitative data (such as surveys, access and availability data or focus groups and interviews) and review of published literature where appropriate. In addition, ongoing barrier analysis can be conducted by care managers who obtain direct member and provider feedback through telephonic and face-to-face outreach. Newly identified barriers should be added to a new row, with corresponding new or modified interventions designed to address the newly identified barrier. **Barriers,** such as lack of member or provider knowledge, insufficient number of providers in rural areas, lack of transportation, lack of standardized tools, and lack of adequate discharge planning should be distinguished from challenges the MCO confronted conducting the study and collecting data; these challenges should be described in the **Limitations** section (page 21); e.g., lack of resources / insufficient nurses for chart abstraction.

[2]How the barrier was identified: Barriers should be based on data collected from sources that are both internal (e.g., QI committee brainstorming) and external (discussion with providers); e.g., focus group, interview, survey, provider or member interviews, observation, literature review, etc.

[3]Interventions should be developed to improve health plan and provider performance, as well as health outcomes among membership. Interventions should be likely to induce a permanent change rather than a short-term effect. They should be aligned with the study aims, objectives and indicators. Modifications to interventions are sometimes necessary; these modifications should be indicated in the table, with corresponding dates and the findings from the intervention tracking/process measure(s) that informed that modification.

[4]Intervention Timeframe: Interventions should be timed for optimal impact, ideally at the end of or after baseline measurement period and early enough to allow time to impact the re-measurement results (i.e., interim and final measurement); an interval of at least 6 to 9 months is generally necessary to detect measurable impact of your interventions.

Table 4: Interim Year Quarterly Reporting of Rates for Intervention Tracking Measures

Summary of Intervention	Description of Intervention Tracking Measures[1]	Q1 Enter year	Q2 Enter year	Q3 Enter year	Q4 Enter year
1. *Face-to-face meetings with behavioral health facility leadership to partner and collaborate on ways to develop/train staff, identify violence prevention as a priority, develop a violence and seclusion and restraint prevention plan, and improve oversight of untoward events.*	*Percentage of behavioral health facilities who developed and implemented violence and seclusion and restraint prevention trainings for staff* *Num: # of behavioral health facilities who developed and implemented violence and seclusion and restraint prevention trainings for staff* *Denom: # of behavioral health facilities reporting incidents of seclusion and restraint events*	*Numerator:* *Denominator:* *Rate: %*	*Numerator:* *Denominator:* *Rate: %*	*Numerator:* *Denominator:* *Rate: %*	*Numerator:* *Denominator:* *Rate: %*
2. *With behavioral health facilities, establish consistent definitions of violent events; guidelines for the use of seclusion and restraint; recognition of imminent danger; identify reportable injuries and appropriateness of stat medication administration; compile historical data by events/hours; and to mandate ongoing compiling of data for analysis to effect positive change.*	*Percentage of behavioral health facilities who developed recommended guidelines and ongoing data compiling and analysis of violent events and incidents of seclusion and restraint* *Num: # of behavioral health facilities who developed recommended guidelines and ongoing data compiling and analysis of violent events and incidents of seclusion and restraint* *Denom: # of behavioral health facilities reporting incidents of seclusion and restraint events*	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom

Summary of Intervention	Description of Intervention Tracking Measures[1]	Q1 Enter year	Q2 Enter year	Q3 Enter year	Q4 Enter year
3. *With behavioral health facilities, develop and implement staff training in: matching interventions with behaviors; use of prevention tools to de-escalate a potentially violent situations; introduction of trauma-informed services; and the importance of debriefing after the use of seclusion and restraint.*	*Percentage of behavioral health facilities who developed and implemented staff training in: matching interventions with behaviors; use of prevention tools to de-escalate a potentially violent situations; introduction of trauma-informed services; and the importance of debriefing after the use of seclusion and restraint* *Num: # of behavioral health facilities who developed and implemented recommended staff training* *Denom: # of behavioral health facilities reporting incidents of seclusion and restraint events*	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate:Enter results of num÷denom
4. *With behavioral health facilities, develop and implement violence, seclusion and restraint prevention tools to include: assessing the risk factors for violence and the use of seclusion or restraint; assessing risk factors for potential injury or death; implementation of a universal trauma assessment form; development of*	*Percentage of behavioral health facilities who developed and implemented violence, seclusion and restraint prevention tools to include: assessing the risk factors for violence and the use of seclusion or restraint; assessing risk factors for potential injury or death; implementation of a universal trauma assessment form; development of safety and crisis plans; and directives to identify triggers and preferences* *Num: # of behavioral health facilities who developed and implemented recommended prevention tools* *Denom: # of behavioral health facilities reporting incidents of seclusion and restraint events*	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate:Enter results of num÷denom

Summary of Intervention	Description of Intervention Tracking Measures[1]	Q1 Enter year	Q2 Enter year	Q3 Enter year	Q4 Enter year
safety and crisis plans; and directives to identify triggers and preferences.					
5. *With behavioral health facilities, develop a debriefing phase as a part of their process whenever seclusion or restraint are used. This debriefing process should include: an analysis of each critical event; examination of what occurred before during and after the event; and determine what could have been done to prevent the event from occurring again and what could have been done better during the event.*	*Percentage of behavioral health facilities who developed a debriefing phase as a part of their process whenever seclusion or restraint are used. This debriefing process should include: an analysis of each critical event; examination of what occurred before during and after the event; and determine what could have been done to prevent the event from occurring again and what could have been done better during the event* *Num: # of behavioral health facilities who developed and implemented recommended debriefing phase as a part of their process whenever seclusion or restraint are used.* *Denom: # of behavioral health facilities reporting incidents of seclusion and restraint events*	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom

[1] Intervention tracking measures are also known as process measures. These measures answer the questions: Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system?

Table 5: Final Measurement Year Quarterly Reporting of Rates for Intervention Tracking Measures

Summary of Intervention	Description of Intervention Tracking Measures[1]	Q1 Enter year	Q2 Enter year	Q3 Enter year	Q4 Enter year
Summarize intervention #1 here	Describe intervention tracking measure that corresponds to intervention #1 Num: Enter description Denom: Enter description	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom
Summarize intervention #2 here	Describe intervention tracking measure that corresponds to intervention #2 Num: Enter description Denom: Enter description	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate:Enter results of num÷denom
Summarize intervention #3 here	Describe intervention tracking measure that corresponds to intervention #3 Num: Enter description Denom: Enter description	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate: Enter results of num÷denom	Numerator: Enter # Denominator: Enter # Rate:Enter results of num÷denom

[1] Intervention tracking measures are also known as process measures. These measures answer the questions: Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system?

2. Optional PDSA (Plan-Do-Study-Act) Worksheet

Although the PDSA method is recommended by the Agency for Healthcare Research and Quality (AHRQ), it is not a requirement.

If the PDSA method was performed, use the AHRQ worksheet below to provide information regarding each PDSA component. Discuss any changes made to interventions and rationale for doing so. Intervention tracking measures that led to changes in your interventions should be presented here.

Plan

- We plan to test (intervention) from (start date) to (end date):
- We hope this produces/leads to: (indicate measurable goal here)
- Steps to execute: (what, by whom, when and where?)

Do

- What did you observe when your intervention(s) was implemented? What worked? What did not work? Problems? Unexpected observations?

Study

- What did you learn? Did you meet your measurement goal?

Act

- What did you conclude from this PDSA cycle (i.e., from the stated start and end date indicated above under **Plan**)? What interventions need modification? What is going to be adopted going forward?

Results

The results section should present project findings related to performance indicators. ***Do not*** *interpret the results in this section.*

Please address the following items, and provide results in ***Table 7****.*

Indicator #1:

- **Entire eligible population size:** # of foster care members receiving treatment in a behavioral health facility during the measurement year
- **Sample size (if sampling is conducted):** N/A
- **Number of members excluded due to failure to meet eligible population criteria, reason(s) for exclusions, and the number associated with each. If there are no exclusions, state "no exclusions":** No exclusions

Table 6: Results

Performance Indicator	Baseline Period Jan 1, 2020 to Dec 31, 2020	Interim Period Jan 1, 2021 to Dec 31, 2021	Final Period Jan 1, 2022 to Dec 31, 2022	Final Goal/Target Rate
Indicator #1: The percentage of reported incidents of the use of seclusion and restraint by behavioral health facilities among foster care members receiving behavioral health treatment	Numerator = Enter # Denominator = Enter # Rate = Enter %	Numerator = Enter # Denominator = Enter # Rate = Enter %	Numerator = Enter # Denominator = Enter # Rate = Enter %	Numerator = Enter # Denominator = Enter # Rate = Enter %

OPTIONAL: Additional tables, graphs, and bar charts can be an effective means of displaying data that are unique to your PIP in a concise way for the reader. If you choose to present additional data, include only data that you used to inform barrier analysis, development and refinement of interventions, and/or analysis of PIP performance.

In the results section, the narrative to accompany each table and/or chart should be descriptive in nature. Describe the most important results, simplify the results, and highlight patterns or relationships that are meaningful from a population health perspective. ***Do not*** interpret the results in terms of performance improvement in this section.

Table 7a: Reported Incidents of Seclusion or Restraint Use during 2019

FACILITY	QTR 1	QTR 2	QTR 3	QTR 4
1. ABS LINCS KY, LLC				
2. Central State Hospital				
3. Eastern State Hospital				
4. Western State Hospital				
5. Harlan ARH Hospital				
6. Lincoln Trail Behavioral Health System				
7. Mercy Health – Lourdes Hospital				
8. UHS Bowling Green, LLC				
9. UHS Ridge, LLC				
10. University of Kentucky Hospital				
11. The Brook				
12. The Brook KMI				
13. Our Lady of Peace				
TOTALS				

Table 7b: Reported Incidents of Seclusion or Restraint Use during 2020

FACILITY	QTR 1	QTR 2	QTR 3	QTR 4
1. ABS LINCS KY, LLC				
2. Central State Hospital				
3. Eastern State Hospital				
4. Western State Hospital				
5. Harlan ARH Hospital				
6. Lincoln Trail Behavioral Health System				
7. Mercy Health – Lourdes Hospital				
8. UHS Bowling Green, LLC				
9. UHS Ridge, LLC				
10. University of Kentucky Hospital				
11. The Brook				
12. The Brook KMI				
13. Our Lady of Peace				
TOTALS				

Table 7c: Reported Incidents of Seclusion or Restraint Use during 2021

FACILITY	QTR 1	QTR 2	QTR 3	QTR 4
1. ABS LINCS KY, LLC				
2. Central State Hospital				
3. Eastern State Hospital				
4. Western State Hospital				
5. Harlan ARH Hospital				
6. Lincoln Trail Behavioral Health System				

7.	Mercy Health – Lourdes Hospital
8.	UHS Bowling Green, LLC
9.	UHS Ridge, LLC
10.	University of Kentucky Hospital
11.	The Brook
12.	The Brook KMI
13.	Our Lady of Peace
TOTALS	

Table 8a: Face-to-Face Visits during 2020

FACILITY	QTR 1	QTR 2	QTR 3	QTR 4
1. ABS LINCS KY, LLC				
2. Central State Hospital				
3. Eastern State Hospital				
4. Western State Hospital				
5. Harlan ARH Hospital				
6. Lincoln Trail Behavioral Health System				
7. Mercy Health – Lourdes Hospital				
8. UHS Bowling Green, LLC				
9. UHS Ridge, LLC				
10. University of Kentucky Hospital				
11. The Brook				
12. The Brook KMI				
13. Our Lady of Peace				
TOTALS				

Table 8b: Face-to-Face Visits during 2021

FACILITY	QTR 1	QTR 2	QTR 3	QTR 4
1. ABS LINCS KY, LLC				
2. Central State Hospital				
3. Eastern State Hospital				
4. Western State Hospital				
5. Harlan ARH Hospital				
6. Lincoln Trail Behavioral Health System				
7. Mercy Health – Lourdes Hospital				
8. UHS Bowling Green, LLC				
9. UHS Ridge, LLC				
10. University of Kentucky Hospital				
11. The Brook				
12. The Brook KMI				
13. Our Lady of Peace				
TOTALS				

Table 8c: Face-to-Face Visits during 2022

FACILITY	QTR 1	QTR 2	QTR 3	QTR 4
1. ABS LINCS KY, LLC				
2. Central State Hospital				
3. Eastern State Hospital				
4. Western State Hospital				
5. Harlan ARH Hospital				
6. Lincoln Trail Behavioral Health System				
7. Mercy Health – Lourdes Hospital				
8. UHS Bowling Green, LLC				
9. UHS Ridge, LLC				
10. University of Kentucky Hospital				
11. The Brook				
12. The Brook KMI				
13. Our Lady of Peace				
TOTALS				

Discussion

The discussion section is for explanation and interpretation of the results.

1. Discussion of Results

Interpret the performance indicator rates for each measurement period, i.e., describe whether rates improved or declined between baseline and interim, between interim and final and between baseline and final measurement periods: Click here to enter text.

Explain and interpret the results by reviewing the degree to which objectives and goals were achieved: Click here to enter text.

What factors were associated with success or failure? Click here to enter text.

2. Limitations

As in any population health study, there are study design limitations for a PIP. Address the limitations of your project design, below.

- **Were there any factors that may pose a threat to the internal validity of the findings?** Click here to enter text.
  Definition and examples: internal validity means that the data measure what they were intended to measure, e.g., if the PIP data source did not capture all children 5-11 with an asthma diagnosis due to inaccurate ICD-10 coding for certain subsets of children with asthma, there is an internal validity problem.
- **Were there any threats to the external validity of the findings?** Click here to enter text.
  Definition and examples: external validity describes the extent that findings can be applied or generalized to the larger/entire member population, e.g., a sample that was not randomly selected from the eligible population or that includes too many/too few members from a certain subpopulation (e.g., under-representation from a certain region).
- **Describe any data collection challenges.** Click here to enter text.
  Definition and examples: data collection challenges include low survey response rates, low medical record retrieval rates, difficulty in retrieving claims data, or difficulty tracking case management interventions.

3. Member Participation

Click here to describe the extent of member participation in the project, including topic selection, measurements, focus groups, interventions, etc.

Describe methods utilized to solicit or encourage membership participation: Click here to enter text.

4. Financial Impact (For Final PIP Phase Only)

Describe any long or short-term financial impacts of the project including cost/benefit analysis or other consideration of financial impact. Address the bottom line, project beneficiaries (i.e., member subpopulations and their providers) as well as the extent of cost savings, and whether cost savings will be redirected towards ongoing implementation of interventions. In addition, conduct and interpret an analysis of how financial impact (e.g., financial drivers such as care management staffing, data entry staffing, information systems resources, member financial incentives, provider financial incentives) might determine sustainability of improvement achieved beyond the PIP timeframe.

Next Steps

In this final section, discuss ideas for taking your project experience and findings to the next step.

1. Lessons Learned

- **Summarize what worked, and what did not work, and plans to improve quality of care for members going forward:** Click here to enter text.
- **Indicate if an intervention was planned but was not implemented, or if an intervention was modified, and why:** Click here to enter text.
- **Topics/areas for further study:** Click here to enter text.
- **Can the findings from this PIP be extrapolated/applied to other members or systems?** Click here to enter text.

2. Dissemination of Findings

- **Describe the methods used to make the findings available to members, providers, or other interested parties:** Click here to enter text. Examples include member/provider newsletters, meetings/presentations and website postings.
- **Identify future goals for disseminating the project's key findings and the lessons learned:** Click here to enter text.

3. System-level Changes Made and/or Planned

- **Describe actions that will be taken to sustain improvement:** Click here to enter text. Ensure that any improvements reported, and interventions that led to improvements, will be continued beyond the PIP timeframe.
- **Describe enhancements planned for next steps of interventions:** Click here to enter text.
- **Describe plans to spread successful interventions to other member populations and organizational processes, as applicable:** Click here to enter text.

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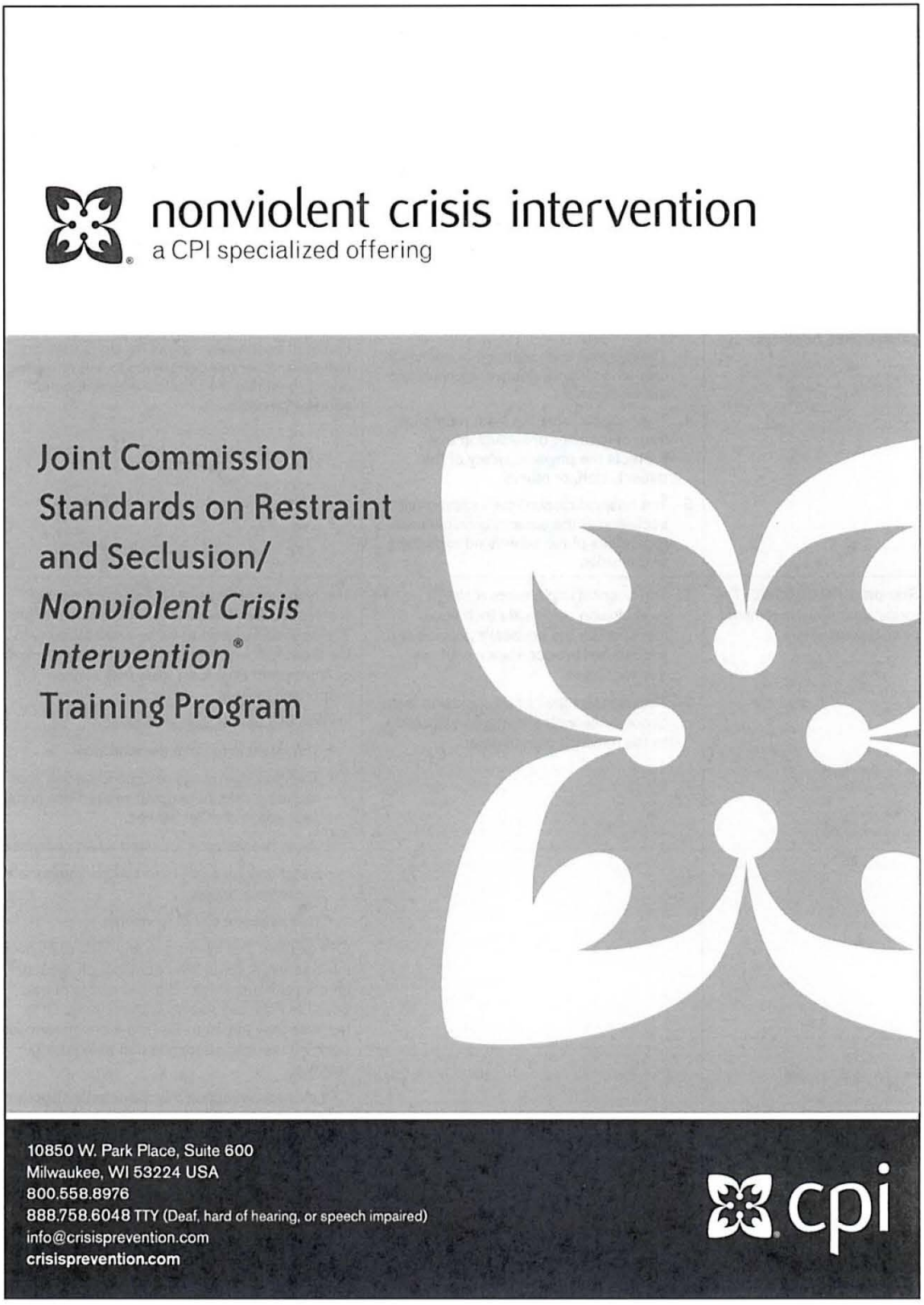
APPENDIX A


nonviolent crisis intervention
a CPI specialized offering
Joint Commission Standards on Restraint and Seclusion/ *Nonviolent Crisis Intervention*® Training Program
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10-CPI-LEG-032 12/10

Joint Commission Standards on Restraint and Seclusion/*Nonviolent Crisis Intervention*® Training Program

Alignment

Joint Commission Standard	Joint Commission Element of Performance	How CPI Works With the Element of Performance
Standard PC.03.05.01: The [organization] uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.	1. The hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others. 2. The hospital does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation. 3. The hospital uses restraint or seclusion only when less restrictive interventions are ineffective. 4. The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others. 5. The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order.	CPI recommends that physical intervention be used only as a last resort when a patient has become a danger to self or others, and that the least restrictive intervention be used at all possible times. CPI does not recommend or endorse time limits on physical interventions. Instead, CPI advises that staff continually assess for signs that the patient is no longer dangerous to self or others and discontinue the physical intervention as soon as possible.
Standard PC.03.05.03: The [organization] uses restraint or seclusion safely.	1. The hospital implements restraint or seclusion using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation. 2. The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care.	The *Nonviolent Physical Crisis Intervention*℠ techniques are designed for safety and allow a Therapeutic Rapport to be re-established with the individual who has lost control. Key elements of *Nonviolent Physical Crisis Intervention*℠ responses include: • No element of pain is involved. • The intent is to calm the individual. • The individual is not restrained on the floor, reducing risks of restraint-related positional asphyxia and other injuries. • Team interventions are used when necessary. • Used only as a last resort when someone presents a danger. • Use to protect—not to punish. CPI teaches that inherent in any form of physical intervention is some level of risk of physical or emotional harm. When staff are aware of the possible risks associated with restraint, CPI believes they are more likely to more strenuously seek intervention strategies that avoid using restraint. CPI also recommends that Certified Instructors incorporate into training population-specific examples. In this way, staff are educated regarding the care plan(s) of those in care. Further, CPI suggests that an organization evaluate each individual patient for any medical or psychological conditions that may contraindicate the use of restraint. If possible, CPI recommends that this information be included directly in an individual's care plan to ensure the best possible care for that person.

Joint Commission Standard	Joint Commission Element of Performance	How CPI Works With the Element of Performance
Standard PC.03.05.05: The [organization] initiates restraint or seclusion based on an individual order.	1. A physician or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation. 2. The hospital does not use standing orders or PRN (also known as "as needed") orders for restraint or seclusion. 3. The attending physician is consulted as soon as possible, in accordance with hospital policy, if he or she did not order the restraint or seclusion. 4. Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed within the following limits: – 4 hours for adults 18 years of age or older – 2 hours for children and adolescents 9 to 17 years of age – 1 hour for children under 9 years of age Orders may be renewed according to the time limits for a maximum of 24 consecutive hours. 5. Unless state law is more restrictive, every 24 hours, a physician or other authorized licensed independent practitioner primarily responsible for the patient's ongoing care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with hospital policy and law and regulation. 6. Orders for restraint used to protect the physical safety of the nonviolent or non–self-destructive patient are renewed in accordance with hospital policy.	All interventions are designed to protect the *Care, Welfare, Safety, and Security*℠ of the service users and providers. CPI strongly suggests that organizations review information regarding any pertinent local, state, or federal policy. With that in mind, CPI will always suggest that staff consult and work with a patient's direct care provider to ensure that all interventions used are medically appropriate. CPI does not advocate use of timed physical interventions, but rather continual assessment for opportunities to discontinue a physical intervention or—at the very least—an opportunity to utilize a less restrictive intervention.
Standard PC.03.05.07: The [organization] monitors patients who are restrained or secluded.	1. Physicians or other licensed independent practitioners or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion. (See also PC.03.05.17, EP 3.)	The *Nonviolent Crisis Intervention*® training program teaches participants to monitor the physical and psychological needs of the person being restrained. CPI recommends that an additional staff member who is trained in proper restraint use—but not directly involved in the restraint—continuously monitor the person's physical and psychological status, including but not limited to vital signs, circulation, and comfort.

Joint Commission Standard	Joint Commission Element of Performance	How CPI Works With the Element of Performance
Standard PC.03.05.09: The [organization] has written policies and procedures that guide the use of restraint or seclusion.	1. The hospital's policies and procedures regarding restraint or seclusion include the following: – Physician and other authorized licensed independent practitioner training requirements – Staff training requirements – The determination of who has authority to order restraint and seclusion – The determination of who has authority to discontinue the use of restraint or seclusion – The determination of who can initiate the use of restraint or seclusion – The circumstances under which restraint or seclusion is discontinued – The requirement that restraint or seclusion is discontinued as soon as is safely possible – A definition of restraint in accordance with 42 CFR 482.13(e)(1)(i)(A–C) – A definition of seclusion in accordance with 42 CFR 482.13(e)(1)(ii) – A definition or description of what constitutes the use of medications as a restraint in accordance with 42 CFR 482.13(e)(1)(i)(B) – A determination of who can assess and monitor patients in restraint or seclusion – Time frames for assessing and monitoring patients in restraint or seclusion 2. Physicians and other licensed independent practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint and seclusion.	The *Nonviolent Crisis Intervention®* training program is built upon the information taught in the CPI *Crisis Development Model℠*. This model establishes a framework for assessing crisis situations and it is discussed here when staff shall utilize physical intervention(s). CPI supports that only trained staff members be allowed to intervene in a crisis, specifically when an intervention has moved to a physical level. Further, CPI strongly suggests that an organization have written policies and procedures regarding who has authority to physically intervene, how that decision is made, and when the physical intervention will be discontinued, as well as which techniques staff are authorized to utilize. CPI recommends that an organization review its policies on a regular and ongoing basis to ensure that policies are in accordance with not only best practice standards and guidelines but also legislative regulations. CPI also recommends that its Certified Instructors incorporate this information directly within their training of the *Nonviolent Crisis Intervention®* program so as to keep all staff informed of these rules/regulations.

Joint Commission Standard	Joint Commission Element of Performance	How CPI Works With the Element of Performance
Standard PC.03.05.11: The [organization] evaluates and reevaluates the patient who is restrained or secluded.	1. A physician or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3. 2. When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse or trained physician assistant, he or she consults with the attending physician or other licensed independent practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy. 3. The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others, includes the following: – An evaluation of the patient's immediate situation – The patient's reaction to the intervention – The patient's medical and behavioral condition – The need to continue or terminate the restraint or seclusion	CPI recommends that everyone who was involved in the crisis be involved in a debriefing process. The *Nonviolent Crisis Intervention*® training program's unit on Postvention provides a structure for reviewing incidents with the person who was in crisis, staff members, and any witnesses. The CPI *COPING Model*℠ assists in identifying events leading up to the incident and/or patterns of behaviors and provides the individual with the opportunity to assist the staff in identifying alternative behaviors and/or interventions that could be utilized to prevent recurrence.
Standard PC.03.05.13: The [organization] continually monitors patients who are simultaneously restrained and secluded.	1. The patient who is simultaneously restrained and secluded is continually monitored by trained staff either in-person or through the use of both video and audio equipment that is in close proximity to the patient.	CPI supports this principle: CPI strongly advocates not for time limits but rather for continuous—"ongoing, without interruption"—assessment for opportunities to discontinue the physical intervention, or, at the very least, to look for an opportunity to engage in a less restrictive intervention.

Joint Commission Standard	Joint Commission Element of Performance	How CPI Works With the Element of Performance
Standard PC.03.05.15: The [organization] documents the use of restraint or seclusion.	1. Documentation of restraint and seclusion in the medical record includes the following: – Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior – A description of the patient's behavior and the intervention used – Any alternatives or other less restrictive interventions attempted – The patient's condition or symptom(s) that warranted the use of the restraint or seclusion – The patient's response to the intervention(s) used, including the rationale for continued use of the intervention – Individual patient assessments and reassessments – The intervals for monitoring – Revisions to the plan of care – The patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion – Injuries to the patient – Death associated with the use of restraint or seclusion – The identity of the physician or other licensed independent practitioner who ordered the restraint or seclusion – Orders for restraint or seclusion – Notification of the use of restraint or seclusion to the attending physician – Consultations	The CPI *COPING Model*℠ provides a framework for staff to debrief with an individual after a crisis. Within this framework, staff are taught to review and document observed behaviors of the individual prior to and during a crisis, alternatives and other less restrictive interventions attempted, the individual's condition which warranted the use of restraint and/or other interventions, the individual's responses to those interventions, review and alteration to the individual's plan, and notification of other interested parties. Further, CPI is willing to assist organizations in collecting and organizing data through our Research and Development department.

Joint Commission Standard	Joint Commission Element of Performance	How CPI Works With the Element of Performance
Standard PC.03.05.17: The [organization] trains staff to safely implement the use of restraint or seclusion.	1. The hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals: – At orientation – Before participating in the use of restraint and seclusion – On a periodic basis thereafter 2. Based on the population served, staff education, training, and demonstrated knowledge focus on the following: – Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion – Use of nonphysical intervention skills – Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition – Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia) – Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary – Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion – Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification (See also PC.03.05.07, EP 1) 3. Individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion. 4. The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed.	CPI recognizes and supports that training is an ongoing process, not a one-time event. CPI recommends that staff either be retrained in the *Nonviolent Crisis Intervention®* training program—or that staff attend a formal refresher training—every 6–12 months. Further, CPI supports the implementation of regular drills, rehearsals, and practice sessions for staff; these are to include additional practice, and they are to apply both verbal and physical intervention skills to unique situations that may arise. CPI suggests that these sessions be recorded to help Certified Instructors keep track and assess which staff need additional training, as well as to assess staffs' competency in applying the skills learned in the *Nonviolent Crisis Intervention®* program.

Joint Commission Standard	Joint Commission Element of Performance	How CPI Works With the Element of Performance
Standard PC.03.05.19: The [organization] reports deaths associated with the use of restraint and seclusion.	1. The hospital reports the following information to the Centers for Medicare & Medicaid Services (CMS): – Each death that occurs while a patient is in restraint or seclusion – Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion – Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death 2. The deaths addressed in PC.03.05.19, EP 1 are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.	In the *Nonviolent Crisis Intervention*® training program as well as in the Instructor Manual is an addendum, "Understanding the Risks of Restraints." This information can assist in educating staff regarding the dangers associated with using restraints, and it reinforces the reasoning behind discontinuing a restraint as soon as a patient is no longer a danger to self or others. CPI strongly recommends that, in the event of a death, proper authorities be notified immediately and that the death be thoroughly investigated in accordance with any federal, state, and local legislation/ regulation.

APPENDIX B

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Six Core Strategies for Reducing Seclusion and Restraint Use©

Note: This document contains the following items: (1) a **Snapshot** of the Six Core Strategies©; (2) a **Planning Tool**; and (3) an **Example of Debriefing Policies and Procedures.**

A Snapshot of Six Core Strategies for the Reduction of S/R ©

(Revised 11/20/06 by Kevin Ann Huckshorn)

These strategies were developed through extensive literature reviews (available upon request from joan.gillece@nasmhpd.org) and dialogues with experts who have successfully reduced the use of S/R in a variety of mental health settings for children and adults across the United States and internationally.

1. Leadership toward Organizational Change

This first strategy is considered core to reducing the use of seclusion and restraint (S/R) through the consistent and continuous involvement of senior facility leadership (most specifically the CEO, CNO, and COO). Leadership strategies to be implemented include defining and articulating a vision, values and philosophy that expects S/R reduction; developing and implementing a targeted facility or unit based performance improvement action plan (similar to a facility "treatment plan"); and holding people accountable to that plan. This intervention includes the elevation of oversight of every S/R event by senior management that includes the daily involvement of the CEO or COO in all S/R events (24/7) in order to investigate causality (antecedents), review and revise facility policy and procedures that may instigate conflicts, monitor and improve workforce development issues and involve administration with direct care staff in this important work. The action plan developed needs to be based on a public health prevention approach and follow the principles of continuous quality improvement. The use of a multi-disciplinary performance improvement team or taskforce is recommended.

This is a mandatory core intervention.

2. Use of Data To Inform Practice

This core strategy suggests that successfully reducing the use of S/R requires the collection and use of data by facilities at the individual unit level. This strategy includes the collection of data to identify the facility/units' S/R use baseline; the continuous

gathering of data on facility usage by unit, shift, day; individual staff member's involved in events; involved consumer demographic characteristics; the concurrent use of stat involuntary medications; the tracking of injuries related to S/R events in both consumers and staff and other variables. The facility/unit is encouraged to set improvement goals and comparatively monitor use and changes over time.

3. Workforce Development

This strategy suggests the creation of a treatment environment whose policy, procedures, and practices are based on the knowledge and principles of recovery and the characteristics of trauma informed systems of care. The purpose of this strategy is to create a treatment environment that is less likely to be coercive or trigger conflicts and in this sense is a core primary prevention intervention. This strategy is implemented through intensive and ongoing staff training and education and HRD activities. It includes S/R application training and vendor choice, the adequate provision of treatment activities that offer choices to the people we serve and that are designed to teach illness and emotional self-management of symptoms and individual triggers that lead to loss of control. This strategy requires individualized person centered treatment planning activities that include persons served in all planning. This strategy also includes consistent communication, mentoring, supervision and follow-up to assure that staff are provided the required knowledge, skills and abilities, with regards to S/R reduction through training about the prevalence of violence in the population of people that are served in mental health settings; the effects of traumatic life experiences on developmental learning and subsequent emotional development; and the concept of recovery, resiliency and health in general. This work is done through staff development training, new hire applicants interview questions, job descriptions, performance evaluations, new employee orientation, and other similar activities.

4. Use of S/R Prevention Tools

This strategy reduces the use of S/R through the use of a variety of tools and assessments that are integrated into facility policy and procedures and each individual consumer's recovery plan. This strategy relies heavily on the concept of individualized treatment It includes the use of assessment tools to identify risk for violence and S/R history; the use of an universal trauma assessment; tools to identify persons with high risk factors for death and injury; the use of de-escalation surveys or safety plans; the use of person-first, non-discriminatory language in speech and written documents; environmental changes to include comfort and sensory rooms; sensory modulation interventions; and other meaningful treatment activities designed to teach people emotional self management skills.

5. Consumer Roles in Inpatient Settings

This strategy involves the full and formal inclusion of consumers, children, families and external advocates in various roles and at all levels in the organization to assist in the reduction of seclusion and restraint. It includes consumers of services and advocates in

event oversight, monitoring, debriefing interviews, and peer support services as well as mandates significant roles in key facility committees. It also involves the elevation of supervision of these staff members and volunteers to executive staff who recognize the difficulty inherent in these roles and who are poised to support, protect, mediate and advocate for the assimilation of these special staff members and volunteers. ADA issues are paramount here in terms of job descriptions, expectations, work hours, and an ability to communicate to staff the legitimacy of the purpose and function of these important roles.

6. Debriefing Techniques

This core strategy recognizes the usefulness of a thorough analysis of every S/R event. It values the fact that reducing the use of S/R occurs through knowledge gained from a rigorous analysis of S/R events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future. A secondary goal of this intervention is to attempt to mitigate, to the extent possible, the adverse and potentially traumatizing effects of a S/R event for involved staff and consumers and for all witnesses to the event. Recommended debriefing activities include two - an immediate post-event acute analysis and the more formal problem analysis with the treatment team. Using the steps in root cause analysis (RCA) is recommended. (Please see the attached Debriefing Policy and Procedure template.) For facilities that treat kids and who use holds frequently, the use of full debriefing procedures for each event may not be manageable. These facilities need to discriminate their use of holds and target multiple holds on same children, identify same staff member involvement in these events so as to note training needs and explore holds that last longer than usual.

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Six Core Strategies for Reducing Seclusion & Restraint Use©
Planning Tool
(Kevin Ann Huckshorn, revised 2008)

Purpose: The Planning Tool is designed for use as a template or checklist that guides the design of a seclusion and restraint (S/R) reduction plan that incorporates the use of a prevention approach, includes the six core strategies to reduce the use of S/R© described in the NASMHPD curriculum, and ascribes to the principles of continuous quality improvement. Also may be used as a monitoring tool to supervise implementation of a reduction plan and identify problems, issues, barriers and successes. Best used as a working guide by an assigned Performance Improvement/Seclusion and Restraint Reduction Team or Task Force.

Note: The word *consumer* is used in this document to include adults, children, and families.

Seclusion/Restraint Plan Template or Monitoring Tool Draft Instrument

(Each item needs to be demonstrated through documentation, leadership activities, staff interviews, review of policies, or other relevant ways.)

Strategy One: Leadership Towards Organizational Change

GOAL ONE: To reduce the use of seclusion and restraint by defining and articulating a mission, philosophy of care, guiding values, and assuring for the development of a S/R reduction plan and plan implementation. The guidance, direction, participation and ongoing review by executive leadership is clearly demonstrated throughout the S/R reduction project.

1. Has the facility reviewed/revised facility mission statement, philosophy and core values to assure congruence with S/R reduction initiative? For example, referencing S/R reduction as congruent with principles of recovery; building a trauma informed system of care; creating violence free and coercion free environments; assuring safe environments for staff and consumers; and facilitating a return to the community. This step must include an organizational values exercise where values statements are cross-walked with actual clinical and administrative practices to assure for congruence.

2. Has the facility developed a facility S/R policy statement that includes beliefs to guide use and is congruent with mission, vision, values and recovery principles? As above, this statement would include statements such as S/R is not treatment but a safety measure of last resort; that S/R indicates treatment failure; and facility's commitment to reduction/elimination etc. There are examples of policy statements available to review.

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3. Has the facility leadership developed a individualized facility-based S/R reduction action plan based on a performance improvement and prevention approach as the overall umbrella including the assignment of a S/R reduction or PI team; the creation of goals, objectives and action steps assigned to responsible individuals and noted due dates; and are there consistent reviews and revisions with senior executive oversight and review? (See policy statement, policy and procedures, actual plan.)

4. Has leadership reviewed and analyzed their S/R related data in an effort to discover critical details of events such as time of day, location, points of conflicts? Has leadership determined data driven hospital goals to reduce S/R? (See data component for specifics.) This objective is leaderships' commitment and intention to use and monitor real time data in the reduction efforts.

5. Has the leadership committed to create a collaborative, non-punitive environment, to identify and work through problems by communicating expectations to staff, and to be consistent in maintenance of effort? This step may include a statement to staff that while individual staff members may act with best intent, it may be determined later that there were other avenues or interventions that could have been taken. It is only through staff's trust in leadership that they will be able to speak freely of the circumstances leading up to a S/R event so that the event can be carefully analyzed and learning can occur. However, the rules defining abuse and neglect are clear and the previous statement does not lift accountability for those kind of performance issues.

6. Are all staff aware of the role of the CEO/Administrator to direct the S/R reduction initiative? This will include senior level involvement in motivating staff including and understanding and commitment from the facility medical director. A "kickoff" event for the rollout of this initiative is recommended or a celebration if facility is already involved in a reduction effort. This steps calls for active, routine and observable CEO/Administrator activities including the inclusion of status report at all management meetings.

7. Has leadership evaluated the impact of reducing S/R on the whole environment? This includes issues such as increased destruction of property; extended time involved in de-escalation attempt, additional admission assessment questions, debriefing activities and processes to document event, etc.

8. Has the leadership set up a staff recognition project to reward individual staff, unit staff and S/R champions for their work on an ongoing basis?

9. Does the leadership approved, S/R reduction plan delegate tasks and hold people accountable through routine reports and reviews?

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10. Has leadership addressed staff culture issues, training needs and attitudes? (See Workforce Development.) Leadership will assure for staff training and development in knowledge, skills and abilities, including choice of training program for S/R application techniques and will include Human Resources (HR).

11. Has leadership reviewed the facility's plan for clinical treatment activities in an effort to assure that active, daily, person-centered, effective treatment activities are offered to all persons receiving services; that these services are offered off living units preferably; and that persons attending have some personal choice in what activities they attend. (The minimal criteria to meet under this objective are to assure that service recipients are not spending their days in enclosed areas with no active effective psycho-social or psychiatric rehabilitation occurring that is effective in teaching living, learning, recreational and working skills.)

12. Has facility leadership ensured oversight accountability by watching and elevating the visibility of every event 24 hours a day/7days per week by assigning specific duties and responsibilities to multiple levels of staff including on-call executives, on-site nursing supervisor, direct care staff, advocates/consumers?

Note "*Creating responsibilities for oversight for events*" includes the following functions:

A. On-call Executive Role (member of executive team)

1. 24/7 on call supervision for event analysis
2. Use knowledge gained by event analysis to identify organizational problems, potential resolutions and ensure timely follow-up
3. Make S/R a standing agenda item for all meetings at all levels
4. Ensure that data is collected, used and shared
5. Ensure staff accountability and performance recognition

B. On-site Supervisor Role

1. 24 hr on site response, supervision and attendance at all events and near misses when possible (to observe what worked and why)
2. Take lead post a S/R event by debriefing all staff involved, the service recipient, all event witnesses, gathering event timelines, reviewing documentation, and providing a report (verbally and written) to oncoming supervisor or administrator

C. Line Staff (Direct Care)

1. Understand and be able to describe the organizational approach in reducing S/R
2. Be introduced to project and philosophy, through:

- New hire application and interview
- New staff orientation
- Job description
- Competency review
- Meet performance criteria in evaluations
- Demonstrate positive attitude about the project

D. Consumer Role

1. Use employed internal consumer staff or external consumer consultants to act as interviewers, gather data, investigate and to provide a critical perspective
2. Representation on all S/R related committees and task forces

Strategy Two: Using Data to Inform Practice

GOAL TWO: To reduce the use of S/R by using data in an empirical, non-punitive, manner. Includes using data to analyze characteristics of facility usage by unit, shift day, and staff member; identifying facility baseline; setting improvement goals and comparatively monitoring use over time in all care areas, units and/or state system's like facilities.

1. Has the facility collected and graphed baseline data on S/R events to include at a minimum, incidents, hours, use of involuntary medication, and injuries?

2. Has the facility set goals and communicated these to staff, setting realistic data improvement thresholds? Has the facility created non-punitive, healthy competition among units or sister facilities by posting data in general treatment areas and through letters of agreement with external facilities?

3. Has the facility chosen standard core and supplemental measures including seclusion and restraint incidents and hours by shift, day, unit, time; use of involuntary IM medications; consumer and staff related injury rates; type of restraint, consumer involvement in event debriefing activities; grievances, consumer demographics including gender, race; diagnosis insurance type; and other measures as desired?

4. Does leadership have access to data that represents individual staff member involvement in S/R events and is this information kept confidential and used to identify training needs for individual staff members? (For supervisors only.)

5. Is the facility able to observe and record "near misses" and the processes involved in those successful events to assist in leadership and staff learning of best practices to reduce S/R use?

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Strategy Three: Workforce Development

GOAL THREE: To create a treatment environment whose policy, procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services and the experiences of our staff. This includes an understanding of the characteristics and principles of trauma informed care systems. It also includes the principles of recovery-oriented systems of care such as person-centered care, choice, respect, dignity, partnerships, self-management, and full inclusion. This intervention is designed to create an environment that is less likely to be coercive or conflictual. It is implemented primarily through staff training and education and HR department activities and includes safe S/R application training, choice of vendors and the inclusion of technical and attitudinal competencies in job descriptions and performance evaluations. This also includes the provision of effective and person centered psychosocial or psychiatric rehabilitation like treatment activities on a daily basis that are designed to teach life skills (See Goal One).

1. Has the staff development department introduced recovery/resiliency, prevention, and performance improvement theory and rational to staff?

2. Has the facility revised the organizational mission, philosophy, and policies and procedures to address the above theory and principles?

3. Has the facility appointed a committee and chair to address workforce development agenda and lead this organizational change? (Includes HR.)

4. Has the facility assured for education/training for staff at all levels in theory and approaches including:

    a. Experiences of consumers and staff
    b. Common assumptions and myths
    c. Trauma Informed Care
    d. Neurobiological Effects of Trauma
    e. Public Health Prevention Model
    f. Performance Improvement Principles
    g. S/R Reduction Core Strategies as appropriate
    h. Risk for Violence
    i. Medical/Physical Risk Factor for Injury or Death
    j. Use of Safety Planning Tools or Advance Directives
    k. Core Skills in Building Therapeutic and Person Based Relationships
    l. Safe Restraint application procedures including continuous face-to-face monitoring while a person is in restraint
    m. Non-confrontational limit setting

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5. Has the facility encourage staff to explore unit "rules" with an eye to analyzing these for logic and necessity? Most inpatient facilities have historical rules that are habits or patterns of behavior that are not congruent with a non-coercive, recovery facilitating environment, for instance rules such as putting people who self abuse in non lethal ways in restraint, or putting people who are intrusive only in restraint.

6. Has the facility addressed staff empowerment issues? For example do staff have input into rules and regulations? Does the facility allow staff to suspend "rules" within defined limits to avoid incidents?

7. Does the facility empower staff (e.g. self-schedule, flex schedules, and switch assignments)?

8. Does the facility assume that all staff at all levels are responsible, capable adults, albeit perhaps injured by trauma, and communicated this value to all? How?

9. Has the facility included HR in the planning and implementation efforts to include the development and insertion of knowledge, skills and abilities considered mandatory in job descriptions and competencies for all staff at every level of the organization? Does this include both technical competence and attitudinal competence and how these are demonstrated?

Strategy Four: Use of S/R Reduction Tools

GOAL FOUR: To reduce the use of S/R through the use of a variety of tools and assessments that are integrated into each individual consumer's treatment stay. Includes the use of assessment tools to identify risk factors for violence and seclusion and restraint history; use of a trauma assessment; tools to identify persons with risk factors for death and injury; the use of de-escalation or safety surveys and contracts; and environmental changes to include comfort and sensory rooms and other meaningful clinical interventions that assist people in emotional self management.

1. Has the facility implemented assessment tools to identify risk factors for inpatient incidents of aggression and violence? Research shows best predictor is past violent behavior in inpatient settings and past involvement with S/R use. (Examples of tools are available.)

2. Has the facility implemented assessment tools on the most common risk factors for death or serious injury caused by restraint use? These include obesity, history of respiratory problems including asthma, recent ingestion of food, certain medications, polypharmacy, history of cardiac problems, history of acute stress disorder or PTSD.

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3. Has the facility implemented the use of a trauma history assessment that identifies persons at risk for re-traumatization and addresses signs and symptoms related to untreated trauma sequelae? (Examples of tools are available.)

4. Has the facility implemented a de-escalation tool or safety planning assessment that includes the identification of individual triggers and personally chosen and effective emotional self management interventions? (Examples of tools are available.)

5. Has the facility:

    a. Implemented communication techniques/conflict mediation procedures?
    b. Reduced environmental signs of overt/covert coercion?
    c. Made environment of care changes (use of comfort rooms & sensory rooms)?

6. Has the facility utilized an aggression control behavior scale that assists staff to discriminate between agitated, disruptive, destructive, dangerous and lethal behaviors and decreases the premature use of restraint/seclusion?

7. Has the facility written policies and procedures for use of the above interventions and disseminated these to all staff?

8. Has the facility created a way that individual safety planning or de-escalation information is readily available in a crisis and is integrated in the treatment plan?

9. Has the facility made available expert and timely consultation with appropriately trained staff or consultants to assist in developing individualized, trauma informed, overall support and behavioral support interventions for service recipients who demonstrate consistently challenging behaviors?

Strategy Five: Consumer Roles in Inpatient Settings

GOAL FIVE: To assure for the full and formal inclusion of consumers or people in recovery in a variety of roles in the organization to assist in the reduction of S/R.

1. Has the facility integrated consumer choices at every opportunity? For children's treatment programs this also focuses on family member choices.

2. Has the facility used vacant FTE's to create full or part-time roles for older adolescent/adult consumers such as:
    a. Director of Advocacy Services
    b. Peer Specialists
    c. Drop-In Center Director
    d. Community Consumers

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3. Has the facility educated staff as to the importance and need to involve consumers at all operational levels, both through respectful inclusion in operations decisions as appropriate and in the consistent attention to the provision of choices?

4. Has the facility included consumer representation in key committees and workgroups throughout organization?

5. Has the facility empowered consumers to do their facility-related jobs and support this work (new roles for consumers) at the highest level by setting up appropriate supervision systems?

6. Has the facility implemented consumer satisfaction surveys, discussed results with staff, and used results to direct revisions in service provision? In children's programs satisfaction surveys would also be geared to families.

7. Has the facility invited external advocates to provide suggestions and be involved in operations?

Strategy Six: Debriefing Techniques

GOAL SIX: To reduce the use of S/R through knowledge gained from a rigorous analysis of S/R events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future. A secondary goal of this intervention is to attempt to mitigate to the extent possible the adverse and potentially traumatizing effects of a S/R event for involved staff and consumers and all witnesses to the event.
It is imperative that senior clinical and medical staff, including the medical director, participate in these events.

1. Has the facility revised policy and procedures to include two debriefing activities for each event as follows:

    a. An immediate "post-event" debriefing that is done onsite after each event, is led by the senior on-site supervisor who immediately responds to that unit or area? The goals of this post-acute event debriefing is to assure that everyone is safe, that documentation is sufficient to be helpful in later analysis, to briefly check in with involved staff, consumers and witnesses to the event to gather information, to try and return the milieu to pre-event status, to identify potential needs for policy and procedure revisions, and to assure that the consumer in restraint is safe and being monitored appropriately. If the facility has implemented "witnessing" (see Goal One) he on-site supervisor calls in the information gathered in this post-acute debriefing event to the off site executive staff person who is on call or report to administration if during weekday hours.

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b. A formal debriefing that includes a rigorous analysis that occurs one to several days following the event and includes attendance by the involved staff, the treatment team including the attending physician, and a representative administration. It is recommended that this formal debriefing follow the steps in a root cause analysis (RCA) or a similar rigorous problem solving procedure to identify what went wrong, what knowledge was unknown or missed, what could have been done differently, and how to avoid in the future. It is also recommended that RCA be used in situations where individuals are injured; where S/R has been used more than twice in a month and at any time where S/R event lasts more than eight hours.

c. Has the facility assured the involvement of the consumer in all debriefing activities either in person or by proxy? is extremely important to include the consumers' experience or voice in this activity and if the consumer cannot or will not participate it is recommended that another consumer or staff person act as that person's advocate at the meeting. It is also recommended that the consumer or staff, in advocacy roles, also be involved and that the person running the meeting is well versed in objective problem solving and was not involved in the triggering event.

2. Do the debriefing policies and procedures specify: (see S/R Debriefing P & P)

   a. Goals of debriefing
   b. Who is present
   c. Responsibilities/roles
   d. Process
   e. Documentation
   f. Follow-up

3. Has the facility implemented debriefing policies and procedure that address staff responses to the event, consumer responses and issues, and "observer" response and issues?

4. Has the facility provided training on how debriefing will revise treatment planning?

5. Has the facility made an attempt to assist staff in their individual responses to S/R events, up to and including the use of EAP (Employee Assistance Program) services or other supportive resources?

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Six Core Strategies for Reducing Seclusion and Restraint Use©

Example: Policy and Procedure on Debriefing for Seclusion and Restraint Reduction Projects

(Kevin Ann Huckshorn, revised 2008)

Policy: The use of seclusion and restraint (S/R) are high risk, problem prone interventions for both consumers and staff and are to be avoided whenever possible. S/R shall only be used in the face of imminent danger and when unavoidable. The use of S/R may cause trauma and re-traumatization in an already vulnerable group of persons and may also cause trauma, stress and injury for staff persons. Preventing the use of S/R is the organizational goal and this includes the mandatory use of debriefing procedures whenever an event of S/R does occur.

Debriefing procedures for the purpose of this policy are defined as three discrete events. The first is titled an "immediate post acute event analysis" and occurs immediately following the S/R episode and with all involved parties including those witnessing the event. The second Debriefing activity is also called "Witnessing or Elevating Oversight" and includes a call from the person in charge of the unit where the event took place to a facility executive staff person to relate what occurred 24 hours/7 days a week. The third Debriefing activity is a formal rigorous event analysis that takes place within 24 to 48 working hours following the S/R event and includes the participation of key professional, administrative and support staff as well as participation by the consumer involved or his or her designee.

It is noted, that with the Centers for Medicare and Medicaid's issuance of the Final Rule on Patient's Rights in January of 2007, that physical holds are now considered restraint. Physical or manual "holds" are most often (but not always) used in child and adolescent units. These holds can be very brief ; often under 5 minutes. For units who now must count these kinds of brief holds as restraint, it is recommended that supervisory staff determine when these holds reach the level of significance that require that activities described in this policy. For some units this may be for kids that require brief holds over 5 minutes, any holds that were disruptive to the unit, more than three holds in one week on the same child, or any holds that resulted in injuries to staff or the patient. Each unit will need to determine their threshold for a thorough review.

IMMEDIATE POST ACUTE EVENT ANALYSIS

Procedure:

1. When the S/R event code is called the onsite clinical supervisor or administrator/designee will immediately respond to the site. The responder will need to be an objective mid-level or senior level clinical staff member with

training in S/R policy and procedures and should not be someone involved in the S/R event occurring at the time.

2. Upon reaching the unit or site of the occurrence, the clinical supervisor will immediately survey the environment and seek to assure that all persons are safe and that processes are orderly. Unless an emergency occurs that requires direct intervention, the clinical supervisor's role is to document what occurred, who was involved, the antecedents to the event, least restrictive alternatives attempted and the results, specific dangerous behaviors necessitating the use of S/R, and the staff's response. In addition the physical and emotional safety of the consumer and other consumer witnesses to the event will be assessed and responded to.

3. The onsite clinical supervisor will document their findings and report these to the executive on-call (or whomever they are supposed to report to). The onsite clinical supervisor shall assist the unit staff in returning the milieu to a pre-crisis level and assure that all necessary documentation has been completely adequately.

4. When possible, the onsite clinical supervisor will attend the formal debriefing. If that is not possibly, the onsite clinical supervisor (whether charge nurse or another person) will need to communicate what occurred through either written documentation, shift report, or phone in participation in the formal debriefing. The point here is that the post acute event information gets passed on up to the formal debriefing activity so that all information is communicated and shared with the entire team.

5. In facilities where there is no onsite supervisor, the charge nurse on the unit will need to take responsibility for these activities. It is always best to have additional staff respond in these kinds of events but when not possible the senior clinical person on the unit will need to do so.

WITNESSING OR ELEVATING OVERSIGHT

Procedure:

1. This procedure expects the senior clinical person responsible for patient care to communicate information regarding a seclusion or restraint event to a designated agency executive staff member 24 hours/7 days a week (in real time). This procedure assumes that agency leadership have already set up an executive staff, on call process, to receive these communications.

2. The senior, onsite, staff person best able to report key information to the executive staff member on call is the one that is expected to make this call and provide the necessary information. Information communicated is critical and can include, but not be limited to the following:

    A. A description of the event (what happened)

B. What was the result (seclusion, restraint, involuntary medication, any injuries to staff or patients
C. Who was involved in events leading up to the seclusion, restraint or involuntary procedure
D. What were the antecedents (patient history, past events, behavior immediately prior to the event)
E. Was there any warning or change in behavior prior to the event and what did staff do?
F. Did we know that this was a high risk for violence person? If so, what had been done to prevent this event?
G. What was the source of the conflict, if any?
H. What did staff do?
I. When the escalating behavior was noted, were other interventions tried, and if so, what and what was the response?
J. Did the person have a relationship with anyone on staff at this time of the event and did that person try to intervene?
K. Was the person offered alternatives and what was the response?
L. Had the person developed a safety plan and was that used?
M. What staff were directly involved and are they ok?
N. Is the person safe and where are they now?
O. What have staff done to prevent another occurrence?
P. What is the person saying at this point, if anything?
Q. Were the event "observers" debriefed and how are they?
R. Were the staff involved debriefed and how are they?
S. Is there anything, right now, that you can add regarding how this event could have been avoided?
T. Can you attend or "call in" for the formal event debriefing and, if not, how can we get your information to the team members who will debrief this event.
U. Is there anything that can be done now to prevent this from happening again?

3. The Executive staff member on call is expected to take this call or call back in a timely manner. It is recommended that this staff person "on call" make informal notes regarding what happened along with any notes that indicate a need to follow-up the next day. These "called-in" occurrences need to be discussed with other senior clinical staff the next working day and all issues requiring follow-up passed on to the appropriate person.

4. In general, this procedure is meant to provide three outcomes. First, to make the executive team well-acquainted with what occurs on units in a timely manner as well as to orient executive staff to the working conditions that direct care staff are facing. Second, this procedure is done to try and make direct care staff aware that the agency leadership is also affected by these events, is supportive, and is available. Third, this activity is designed to make executive staff, with formal power, aware of policy, procedures, and operational issues that could be creating

conflict on units, as well as to help gather information that could be helpful to cover in staff training activities.

5. It is critically important, that unless egregious behavior occurs during an event, that no blaming occurs and that the overall response is not punitive in nature.

6. Finally, it is recommended that the "on-call" responsibilities of executive staff be shared among several of the executive team members. This on-call responsibility can be disruptive at times and more than one person needs to share this load.

FORMAL RIGOROUS EVENT ANALYSIS

Procedure:

1. A formal rigorous event analysis will follow every incident of seclusion and restraint and will occur within the first 24 to 48 working hours post event.

2. The treatment team leader or designee will schedule the formal debriefing and notify all invited participants to include the treatment team, the consumer and/or proxy, surrogate or advocate representative, all other involved parties and other agency staff as appropriate. All care and attention shall be paid to the comfort and safety of the consumer involved and their informed consent and ability to participate without being overly stressed, coerced, or overwhelmed by this activity.

   In certain situations, where the consumer does not want or cannot participate, all efforts will be made to debrief the consumer ahead of time and to gather their input into what occurred and what could have prevented the event. This additional interview will be documented and brought to the formal debriefing by a formal representative and presented as such. Peer staff, if available, should be used to gather this kind of information.

3. The formal event debriefing will begin the process of PDCA (Plan, Do, Check, Act). PDCA is a continuous quality improvement process that provides a stepwise map with which to rigorously analyze a problem and implement effective solutions. "Plan is focused on defining the problem (the event); analyzing the problem for underlying issues and root causes; brainstorming potential solutions based on underlying issues and root causes; deciding on solutions from the bank of potential solutions and creating a plan to implement the solution. "Do" is focused on implementing efforts based on the plan. "Check" is focused on checking the overall process by evaluating what worked or did not work through measurable indicators, making mid-course adjustments or going back to the idea bank if solution fails in the future and revisiting the planning stages if plans did not work or only partially worked. "Act" is establishing a new system, policies, procedures or programs based on positive outcomes and determining how to

sustain and maintain improvement over time. The formal event debriefing activity supports the PDCA process and provides a feedback loop between Act and Plan.

4. Debriefing includes an analysis of: 1) triggers, 2) antecedent behaviors, 3) alternative behaviors, 4) least restrictive or alternative interventions attempted, 5) de-escalation preferences or safety planning measures identified and 6) treatment plan strategies.

5. The facilitator leading the debriefing needs to be clinically skilled in root cause analysis and not directly involved in the event. Questions formulated by the facilitator are directed by the individual characteristics inherent in the event but also share the common characteristic of drilling down to core activities and processes by asking why to the lowest common denominator. The facilitator needs to be skilled and knowledgeable about the common steps in the process of a behavioral escalation that leads to the use of S/R and opportunities for effective staff interventions to avoid, de-escalate or as last resort if S/R is necessary, to avoid injury and minimize trauma. Debriefing processes lead to recommendations for both senior administrative and clinical staff; staff development and direct care staff. These steps are outlined here and include examples of questions that can stimulate thinking and discussion.

S/R Prevention Tree, Staff Intervention Opportunities and Debriefing Questions

Step 1: *Has a treatment environment been created where conflict is minimized (or not)?*

This intervention opportunity asks staff to consider whether the agency has done everything possible to create a treatment setting that prevents conflict and aggression. Potential preventative interventions include the use of person-first language; adopting a trauma informed, recovery focused philosophy of care; comparing actual operational practice, policy and procedures against recovery and trauma informed values; assuring the staff have the knowledge, skill and ability in building therapeutic relationships immediately on admission; making the treatment environment welcoming and non-stressful; using prevention tools such as admission based trauma assessments, risk assessments, safety planning, comfort and sensory rooms and avoiding overt and covert coercion.

Questions to think about or explore:

1) Was the environment calm and welcoming?
2) Was the environment personalized and normalizing or institutional?
3) Was the milieu calm and mostly quiet?
4) Had any staff developed a relationship with the individual?
5) Were there signs about rules, warnings or other indications that might cause a feeling of oppression?

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6) Did the individual witness a S/R or other upsetting event?
7) What were the trigger(s) to the aggressive or dangerous behavior?
8) Did we know the individual well enough to know their personal triggers?
9) Was the individual a trauma survivor and if so, did something in the environment create a traumatic re-enaction?
10) What set the individual off?
11) Did anyone on shift talk to the individual or "check in" before the event?

12) Was the individual's behavior a change during the shift or earlier?
13) Did the individual want something before the event occurred?

Step 2: *Could the trigger for conflict (disease, personal, environmental) have been avoided (or not)?*

This intervention opportunity addresses the adequacy of the screening and admission process and the skilled gathering of information, specifically risk factors for conflict and violence that can alert staff to the needs for immediate, preventative interventions. For instance, are staff aware that the individual has not been taking his or her medications for some time and has this issue been addressed immediately on admission? Is information gathered in the pre-screening or admission process relating to the individuals past history of aggression or violence on inpatient units and past experiences of being in restraint or seclusion? Do staff know or try and discover, during admission, each person's individual triggers for conflict, anxiety, fear, discomfort, "fight, flight, freeze" and document these so that they can be communicated? Are advance directives/safety plans developed and used? Does the facility understand the importance of minimizing a rule-based culture of care; minimizing wait times, avoiding shaming or humiliation (intentional and unintentional) of people in daily operations and other institutional issues?

Questions to ask?

1) Did the individual participate in the admission process and treatment planning process?
2) Was a trauma assessment done?
3) Was a safety plan done?
4) Did we know if the person had ever been in S/R before?
5) Did the individual receive a phone call or a visit (or lack thereof) that might have caused escalation?
6) Was the individual worried about anything?
7) Did the individual have to wait an inordinate time for something he or she wanted?
8) Did the individual indicate they needed help, attention or assistance beforehand?

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9) Was the individual ignored, treated rudely, shamed, humiliated or consequenced for some behavior?
10) Was the individual taking medication and if so, did they have a therapeutic level? Were they experiencing side effects?
11) Was the individual experiencing signs and symptom of mental illness?
12) Was the individual oriented to the unit and the rules?
13) Is this first admission?

Step 3: *Did staff notice and respond to events timely (or not)?*

This intervention opportunity addresses the staff culture and knowledge base regarding immediate and direct person-to-person responses to changes in individual adult or child behaviors in the milieu. In many facilities staff do not respond immediately due to lack of knowledge regarding types of behavioral escalation that can include both obvious agitation as well as isolative behaviors. In other facilities, staff sometimes have been taught to ignore disruptive or different behavioral changes in the belief that this is attention-seeking behavior and that ignoring it may make it "go away." However, in recovery-oriented facilities, behavioral changes are seen as "attempts at communication" albeit perhaps not clear or direct, that require an immediate and respectful response. Unit staff need to be trained to observe for, detect and respond to changes in the individual behavior or the milieu in general as part of their job and as an important skill in refining the "therapeutic use of self" that is part of being a mental health professional or paraprofessional.

Questions to ask?

1) Who responded and when?
2) Was there any warning that the individual was upset?
3) What were the first signs and who noted them?
4) If no one noticed, why?
5) Should the person have been on precautions?

Step 4: *Did staff choose an effective intervention (or not)?*

This response addresses the knowledge, skills, abilities and personal empowerment of agency staff in identifying an appropriate and least restrictive approach to escalating behavior and then implementing that approach directly and immediately. The ability to formulate an immediate response to an escalating behavioral or emotional problem is not innate and usually requires training and role modeling by clinical supervisors. In addition, the agency culture needs to empower staff to be creative and to, at times, break unit rules to avoid the need for S/R when it is safe to do so. Examples of the latter might include allowing someone to leave group or take personal time in their bedroom during group hours; taking a smoke break to talk to a staff member between smoke break hours; having a snack between meals, being allowed to make a phone call or have a visitor. Unit rules can be interpreted by staff as sacrosanct and this will discourage the use of least

restrictive measures and lead to unnecessary S/R. In addition, fears by staff that "rule breaking will lead to chaos" have not generally been a reality. Individuals who may seem to learn how to get staff to bend rules by acting out will require evaluation by clinical treatment team staff. In general, in our rule based environments, it is fairly easy to label people as manipulative who seek to bend rules but it is important to remember that these rules are institutional in nature and not ones that we apply to ourselves or the client in their natural community.

Staff's ability to be creative and to take the time to try and get to know the individual and his or her needs in crisis is immeasurably helpful and needs to be a part of the expectations for staff knowledge, skills and abilities in the agency job descriptions and performance evaluation process.

Questions to ask?

1) What intervention was tried first and by whom?
2) Why was that technique chosen?
3) Did anything get in the way of the intervention?
4) Did anyone get in the way of the intervention?
5) Was the intervention delayed for any reason?
6) How did the person respond to it?
7) What was the individual's emotional state at the time?
8) What was the staff's emotional state at the time?
9) What else could have been tried but was not?
10) Why not?

Step 5: *If the Intervention was unsuccessful was another chosen (or not)?*

Same as above. Staff need to continue to try alternatives until an intervention works or behavior escalates to the danger level. In the latter situation this is known as "treatment failure" not because the staff person(s) personally failed in their attempt but because the agency did not know enough about the person or had not yet had an opportunity to build a relationship where an intervention could be chosen that was effective.

Questions to ask?

1) Same as above

Step 6: *Did staff order S/R only in response to imminent danger (or not)?*

This step addresses the premature use of S/R for behavior that is only agitated, disruptive or, at times, destructive but where the individual still has control and can be engaged. This step also addresses S/R patterns of use where individuals are restrained or secluded "every time they hit someone or throw something but then stop" or other usually unwritten but common patterned practices. Patterned staff responses for behavioral "categories" such as throwing something, hitting inanimate objects, refusing to get up off the floor, constant pacing, kicking or hitting in one time only "strikes" need to be

discussed and re-framed. At times these patterns are due to staff not understanding common signs and symptoms of mental illness or trauma response histories, leading to individual being blamed for intentionally "acting out" requiring consequences. However, care must be taken to assure that staff need to be free to respond if they feel they are in danger and that unnecessarily restrictive responses will be addressed through training and supervision first.

Questions to ask?

1) What was the exact behavior that warranted S/R?
2) Did it meet the threshold of imminent danger (what would have happened if S/R was not used)?
3) Who made the decision and why?
4) Did the staff member making the decision have good rationale based on training and experience and knowledge of the individual?

Step 7: *Was S/R is applied safely (or not)?*

For every instance of the use of S/R an objective senior clinical staff needs to assess whether staff followed the agencies policy and procedure for application. In addition, for some agencies, policies may need to be revisited for safety in terms of medical/physical risk factors and the use of prone restraint.

Questions to ask?

1) How was S/R applied and did it follow policy and safety precautions?
2) Were enough staff available to assist?
3) Did a professional nurse provide oversight of the event?

Step 8: *Was the individual monitored safely (or not)?*

One to one, face to face monitoring of individuals in seclusion or restraint is the safest way to monitor use. This does not include the use of cameras or only 10 or 15 minute checks. Constant monitoring of the individual where the individual's face is visible at all times is the expected standard in order to observe distress or problems. One to one, face to face monitoring is fast becoming standard practice. This also includes following CMS and JCAHO guidelines as to bathroom breaks, food and fluids, range of motion and extremity checks.

Questions to ask?

1) How often was the individual monitored?
2) Was the individual restrained in a prone or supine position and why?
3) Was agency policy followed and documented?
4) Was the hospital's policy and procedure followed?

Step 9: *Was the individual released ASAP (or not)?*

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Decisions on when to release a person from seclusion or restraint often requires the judgment of an experienced staff person who is well trained in the physical and emotional risks inherent in S/R use on human beings, has a thorough knowledge of human behavior, and good clinical judgment. In general, individuals (adults or children) who are currently in seclusion or restraint should not have to "jump through hoops to prove" they can be released. Release criteria should mostly be the responsibility of staff and their assessment of regained control. Usually simple questions such as "How are you doing?" "Do you think you can come out yet?", "Are you able to be released and not hurt yourself or anyone?" are sufficient to assess readiness. Again, for individuals who are unknown or who have histories of intentional violence need to be carefully assessed. For persons who fall asleep, best practice calls for restraints to be released or seclusion doors to be opened but with continued face-to-face observation until person awakes and can be assessed. Hospital policy that expects release in 2-4 hours or less can help staff facilitate release in a timely manner.

Questions to ask?

1) When was the individual released?
2) Who made the decision and what was it based on?
3) Was policy followed?
4) Could the individual have been released earlier?
5) Was release too soon and why?
6) What were the documented release criteria were they used and were they appropriate?

Step 10: *Did Post-event activities occur (or not)?*

This step relates to the agencies debriefing processes. The first, described above, is the immediate acute event response by a supervisor or senior clinical staff member. Goals for the post acute (immediate) response include assuring;

- the safety of the individual, the staff and the witnesses to the event;
- that the documentation is accurate and meets the agency standard;
- that information required to inform a formal debriefing is gathered in real time by a person uninvolved in the incident;
- that the milieu is returned to pre-crisis levels

Also included here is the occurrence of a formal debriefing in a timely, rigorous, problem solving, and stepwise process designed to elicit performance improvement ideas and activities. The formal acute and formal debrief activities need to be documented and filed.

Questions to ask?

1) Did the acute response to the event and formal debriefing occur and what were the timelines?
2) Who led the acute response and were they uninvolved in the event?
3) Was this documented and what happened to the findings?
4) Did the findings inform the formal debriefing or practices in general?

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5) Is the formal debriefing documented as to processes and results and where does that go?
6) Were consumer staff or advocates involved in the debriefing process?
7) Did the person attend the formal debriefing or did the person agree to be interviewed by a peer staff person?

Step 11: *Did learning occur and was it integrated into the treatment plan and practice (or not)?*

The integrity of the debriefing process can be measured by the learning that occurs and the changes, revisions, additions, deletions that can be tracked in operational procedures. This debriefing process is a continuous quality improvement process that results in learning from mistakes and crafting new responses including policy and procedure changes, individual treatment plan and de-escalation plan revisions, training and education, individual staff counseling, values clarification, operational rule evaluation and other like events.

Questions to ask?

1) What was learned about the S/R event in the debriefing process?
2) Did this learning inform policy, practices, procedures, rules, the treatment plan, staff training and education, unit rules?
3) Did staff receive training and education or counseling?

Note: This debriefing policy and procedure is to be used as a guide. Toward that end it is probably longer and includes more detail than most policy and procedures. Hospitals and facilities will need to adapt their individual procedure to meet their needs and capabilities. For facilities that are using frequent holds and cannot perform this level of debriefing on every incident, it is recommended that the S/R reduction team determine what frequency or individual characteristics will be put into policy to trigger this level of review. For instance, any child who receives more than three holds a week, any event that results in an injury or a pattern of outlier use by a unit, individual staff member that may indicate additional training needs.

Glossary of PIP Terms

PIP Term	Also known as…	Purpose	Definition
Aim	• Purpose	To state what the MCO is trying to accomplish by implementing their PIP.	An aim clearly articulates the goal or objective of the work being performed for the PIP. It describes the desired outcome. The Aim answers the questions "How much improvement, to what, for whom, and by when?"
Barrier	• Obstacle • Hurdle • Roadblock	To inform meaningful and specific intervention development addressing members, providers, and MCO staff.	Barriers are obstacles that need to be overcome in order for the MCO to be successful in reaching the PIP Aim or target goals. The root cause(s) of barriers should be identified so that interventions can be developed to overcome these barriers and produce improvement for members/providers/MCOs. A barrier analysis should include analyses of both quantitative data (e.g., MCO claims data) and qualitative (such as surveys, access and availability data, focus groups and interviews, and direct member and provider feedback from care management outreach), as well as a review of published literature where appropriate, in order to root out the issues preventing implementation of interventions.
Baseline Rate	• Starting point	To evaluate the MCO's performance in the year prior to implementation of the PIP.	The baseline rate refers to the rate of performance of a given indicator in the year prior to PIP implementation. The baseline rate must be measured for the period before PIP interventions begin.
Benchmark Rate	• Standard • Gauge	To establish a comparison standard against which the MCO can evaluate its own performance.	The benchmark rate refers to a standard that the MCO aims to meet or exceed during the PIP period. For example, this rate can be obtained from the statewide average, or Quality Compass®.
Denominator	• Total Member Count	To provide the bottom number in a fraction used to calculate quality measures that are constructed as proportions or percentages.	The number of, or a sample of, members who meet criteria for a measure because of member characteristics (e.g., enrollment, age, gender) or because of an event, a diagnosis or service.

PIP Term	Also known as…	Purpose	Definition
Eligible Population	• Denominator for administrative measures without additional denominator exclusion criteria	To identify the entire group of members who meet the criteria for a measure.	The entire group of members who meet the denominator criteria for a measure prior to applying denominator exclusion criteria. For administrative measures the denominator and eligible population may be the same group. For hybrid measures, the random sample will be drawn from the eligible population and this subset of measures will become the denominator for the hybrid measure.
Goal	• Target • Aspiration	To establish a desired level of performance.	A goal is a measurable target that is realistic relative to baseline performance, yet ambitious, and that is directly tied to the PIP aim and objectives.
Intervention Tracking Measure	• Process Measure	To gauge the effectiveness of interventions (on a quarterly or monthly basis).	Intervention tracking measures are monthly or quarterly measures of the success of, or barriers to, each intervention, and are used to show where changes in PIP interventions might be necessary to improve success rates on an ongoing basis.
Limitation	• Challenges • Constraints • Problems	To reveal challenges faced by the MCO, and the MCO's ability to conduct a valid PIP.	Limitations are challenges encountered by the MCO when conducting the PIP that might impact the validity of results. Examples include difficulty collecting/ analyzing data, or lack of resources / insufficient nurses for chart abstraction.
MCO	• Managed Care Organization	To stand for Managed Care Organization.	Medicaid Managed Care Organizations are entities that serve Medicaid beneficiaries on a risk basis through a network of affiliated providers.
Measurement	• Baseline measure	To provide a measure of the annual performance indicator prior to implementation of interventions designed to achieve quality improvement.	The assignment of a number to a characteristic of an event that occurs before interventions are implemented, so that it can be compared with subsequent events.
Re-measurement	• Interim measure or Final measure	To provide a measure of the annual performance indicator during the period of implementation of PIP interventions.	The assignment of a number to a characteristic of an event that occurs after the baseline period so that it can be compared with the prior events.
Numerator	• Member count	To provide the top number in a fraction used to calculate quality measures that are constructed as proportions or percentages.	The members of a denominator who meet the criteria for the service or outcome being measured. The numerator is a subset of the denominator.
Objective	• Intention	To state how the MCO intends to accomplish their aim.	Objectives describe the intervention approaches the MCO plans to implement in order to reach its goal(s).

PIP Term	Also known as…	Purpose	Definition
Performance Indicator	• Indicator • Performance Measure (terminology used in HEDIS) • Outcome measure	To measure or gauge health care performance improvement (on a yearly basis).	Performance indicators evaluate the success of a PIP annually (whereas intervention tracking measures monitor interventions on a monthly or quarterly basis). They are a valid and measurable gauge, for example, of improvement in health care status, delivery processes, or access.
Quality Compass®	• NCQA Product • Quality Tool	To inform quality improvement and for benchmarking plan performance.	An NCQA Product that contains individual Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures as well as Plan Specific, Regional, State, Census and National HEDIS and CAHPS rates (the "HEDIS Measures").