Chapter: **QUALITY IMPROVEMENT**
Title: **REPORTING AND RESPONDING TO CRITICAL INCIDENTS, SENTINEL EVENTS, AND RISK EVENTS**

Prior Approval Date: 07/02/13
Current Approval Date: 01/05/23

Proposed by: _____ 01/05/2023
Chief Executive Officer Date

Approved by: Al Lorenzo 01/05/2023
County Executive Office Date

I. ABSTRACT

This policy establishes the standards of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, regarding MCCMH's adherence to and compliance with the legal requirements for the public behavioral health Prepaid Inpatient Health Plan (PIHP).

II. APPLICATION

This policy shall apply to the administrative offices and directly operated and contract network providers of MCCMH.

III. POLICY

It is the policy of MCCMH to:

A. Review, investigate, act upon, and report critical incidents to MDHHS in an accurate and timely manner;

B. Review, investigate, act upon, and internally report and track critical incidents, sentinel events, and risk events in an accurate and timely manner;

C. Identify system factors associated with critical incidents, sentinel events, and risk events; and

D. Develop and implement effective corrective action plans to reduce the likelihood of recurrence of critical incidents, sentinel events, and risk events.

IV. DEFINITIONS

A. Actively Receiving Services:
For reporting purposes, a person served is "actively receiving services" when any of the following have occurred within the last six (6) months:

1. A face-to-face intake occurred, and the individual was deemed eligible for ongoing

service;

2. A provider authorized the individual for ongoing service, either through a face-to-face assessment or a telephone screening, or the individual has received a non-crisis, non-screening encounter; or

3. A service takes place between the date when the decision is made to start providing ongoing non-emergent services and the date when the person served is formally discharged from services. Examples of formal discharge/termination include:

    a. Transfer to another program;

    b. Discharge from the program providing the service;

    c. Discharge from MCCMH service system; or

    d. Removal of the service from the person's plan of service.

B. Clinical Risk Review:
A formal process conducted by the members of the Clinical Risk Management Committee (CRMC) which includes a review of clinical risk areas. The process must include individuals with the appropriate credentials to review the scope of care and include individuals not involved in the treatment or care of the person served, as well as individuals or professionals who may contribute to a thorough review process. The process shall result in an understanding of causes of the event and if necessary, a root cause analysis with a subsequent corrective action plan shall be implemented in hopes of avoiding similar events from occurring in the future.

C. Critical Incident:
Any of the following events are reported to MDHHS and reviewed by MCCMH within (3) business days after occurrence to determine whether it meets the criteria for a sentinel event.

1. Suicide death:
A death of a person served when MCCMH determines through its death review process that the person's death was a suicide; or the official death report (i.e., coroner's report) indicates that the person's death was a suicide.

2. Non-suicide death:
A death of a person served that was not otherwise reported as a suicide. Within this category are expected and unexpected deaths.

3. Emergency medical treatment due to injury or medication error:
Where an injury to a person served or medication error results in face-to-face emergency treatment being provided by medical staff at any treatment facility, including personal physicians, medical centers, urgent care clinics/centers, and emergency rooms.

    a. Injury:
    Bodily damage that occurs to an individual due to a specific event such as an accident, assault, or misuse of the body and results in treatment by medical staff at any treatment facility including personal physicians, medical centers, urgent care clinics/centers, and emergency rooms or admission to a general medical facility. Examples of injuries include cuts, bruises (except those due to illness), contusions, muscle sprains, and broken bones.

b. Medication Error:
A mistake is made and a person served takes prescribed medication that is the wrong medication, wrong dosage, or staff failed to administer the medication. It does not include instances in which persons served have refused medication.

4. Hospitalization due to injury or medication error:
Where an injury or medication error results in admission of a person served to a general medical facility. Hospitalizations due to the natural course of an illness or underlying condition do not fall within this definition.

5. Arrest:
A situation where a person served is held or taken by a law enforcement officer based on the belief that a crime may have been committed. Situations where a person served is transported for the purpose of receiving emergency mental health services or where a person served is held in protective custody are not considered to be an arrest.

D. Mortality Review:
A process for identifying the basic or causal factors that underlie variations in performance when the occurrence of a death of a person served is determined not to be a sentinel event.

E. Risk Event:
An event that puts an individual at risk of harm. Such an event is reported and analyzed to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. Risk events include:

1. Harm to Self:
Actions taken by persons served that cause physical harm requiring emergency medical treatment or hospitalization due to an injury that is self-inflicted (e.g., pica, head banging, self-mutilation, biting, suicide attempts.)

2. Harm to Others:
Actions taken by persons served that cause physical harm to others that result in injuries requiring emergency medical treatment or hospitalization of the other person(s).

3. Police Calls:
Police calls for assistance with a person served during a behavioral crisis regardless of whether contacting police is addressed in a behavioral treatment plan. (See MCO Policy 8-008 "Behavior Treatment Plans" for additional information.)

4. Emergency Use of Physical Management:
Emergency use of physical management by staff in response to a behavioral crisis. Physical management is a technique used as an emergency intervention to restrict the movement of an individual by continued direct physical contact despite the individual's resistance to prevent him or her from physically harming him/herself or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. The term "physical management" does not include briefly holding an individual to comfort him or her or to demonstrate affection or holding his/her hand. (See MCO Policy 8-008 "Behavior Treatment Plans" for additional information.)

5. Unscheduled Hospitalizations:
   Two or more unscheduled admissions to a medical hospital not due to planned surgery or the natural course of a chronic illness (such as a terminal illness) within a 12-month period. Admission to a medical hospital does not include use of an emergency room or emergency department.

F. Root Cause Analysis:
   A process for identifying the basic or causal factors that underlie variations in performance, including the occurrence or possible occurrence of a sentinel event or other serious event. A root cause analysis focuses on systems and processes, not individual performance, and gives the potential for redesign to reduce risk.

G. Sentinel Event:
   A critical incident that is an unexpected occurrence involving death or a serious physical or psychological injury (emotional harm) or the risk thereof. Serious injury specifically includes the loss of limb or function. The phrase, "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome (i.e., if the event had continued, death or serious physical or psychological injury would have occurred as determined by a physician or registered nurse.) A sentinel event does not include a death due to natural causes. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve a person's death, or other serious medical conditions, must involve a physician or nurse.

   Per Michigan Department of Health and Human Services (MDHHS), sentinel events must be identified and defined as meeting criteria and having occurred for someone within the reportable population. Apart from arrests/ convictions and serious challenging behaviors, all incidents involving the reportable population should be reviewed to determine if the incidents meet the criteria and definitions for sentinel events and are related to the practice of care. The outcome of such a review is the classification of incidents as either sentinel events or non-sentinel events.

   1. Unexpected Death:
      The death of a person served that does not result from natural causes. Unexpected deaths include those that result from suicide, homicide, an undiagnosed condition, accident, or were suspicious due to possible abuse or neglect.

   2. Serious Physical Injury:
      Physical damage suffered by a person served that a physician or registered nurse determines caused or could have caused the death of a person served, the impairment of his or her bodily functions, loss of limb, or permanent disfigurement. Injuries that require emergency room visits or admission to hospitals include those resulting from abuse or accidents. Required visits to emergency rooms, medical centers, and urgent care clinics/centers and/or admissions to hospitals should be included in the injury reporting. In many communities where hospitals do not exist, medical centers and urgent care clinics or centers are used in place of hospital emergency rooms.

   3. Emotional Harm:
      Impaired psychological functioning, growth, or development that is significant in nature

as evidenced by observable physical symptomatology, as determined by a mental health professional / psychiatrist.

4. Death by Natural Causes:
   Death occurring as a result of a disease process in which death is an anticipated outcome. Examples of deaths by natural causes are as follows: death of a person served due to an acute or long-standing disease process; increased susceptibility to death as a result of diabetes, cancer, advanced heart disease, AIDS, serious infection, etc.; or death of a person who has been receiving hospice care or treatment for end stage disease. Deaths by natural causes are not considered sentinel events.

5. Physical Illness Requiring Admissions to Hospitals:
   Planned surgeries, whether outpatient or inpatient, are not considered unexpected occurrences and therefore are not included in the reporting of illnesses requiring admissions to hospitals. It also does not include admissions directly related to the natural course of the person's chronic illness or underlying condition. For example, hospitalization of an individual who has a known terminal illness to treat the conditions associated with the terminal illness is not a sentinel event.

6. Serious Challenging Behaviors:
   Serious challenging behaviors include significant (in excess of $100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leave of absence. They include behaviors not already addressed in a treatment plan.

7. Medication Errors:
   The receipt of wrong medication, wrong dosage, double dosage, or missed dosage that resulted in death or serious injury or the risk thereof. It does not include instances where persons served have refused medication.

8. Arrests/ Convictions:
   Any arrest or conviction that occurs with an individual who is in the reportable population at the time the arrest or conviction takes place. These events must be reported as Sentinel Events, but do not require a Root Cause Analysis. These must be reported as separate categories through the MDHHS Performance Indicator process.

V. STANDARDS

A. Incident reports shall be written for all critical incidents and risk events according to MCCMH incident reporting requirements.

B. MCCMH providers shall report critical incidents and risk events through the MCCMH incident report module in FOCUS. If a provider does not have access to FOCUS, they shall send all necessary information directly to MCCMH.

C. MCCMH shall internally track critical incidents (including sentinel events) and risk events

in accordance with the provisions of this policy and MDHHS requirements.

D. MCCMH shall report to MDHHS the following incidents for beneficiaries enrolled in the Children's Waiver Program (CWP), Serious Emotional Disturbances Waiver (SEDW), Habilitation Supports Waiver (HSW), and the 1115/1915(i) State Plan: Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Errors.

1. A person's death determined to be a suicide shall be reported for persons actively receiving services and all who received an emergency service within the last thirty (30) calendar days.

    a. The suicide shall be reported within thirty (30) days after the end of the month in which the cause of death was determined to be a suicide.

    b. If ninety (90) calendar days have elapsed without a determination of cause of death, the responsible service providing agency shall submit a "best judgment" determination of whether the death was a suicide. In this case, the submission is due within thirty (30) days after the end of the month in which this "best judgment" determination was made.

2. Non-suicide deaths will be reported for persons actively receiving services and living in a Specialized Residential facility or in a Child-Caring institution or were receiving community living supports, supports coordination, targeted case management, Assertive Community Treatment (ACT), Home-based, Wraparound, Habilitation Supports Waiver, SED Waiver, or Children's Waiver services.

    a. A non-suicide death shall be reported within sixty (60) days after the end of the month in which the death occurred unless reporting is delayed while the responsible provider attempts to determine whether the death was due to suicide. In this case, the submission is due within thirty (30) days after the end of the month in which the responsible provider determined the death was not due to suicide.

    b. Natural cause deaths shall be reported, indicating the specific natural cause (e.g., heart disease, pneumonia/influenza, lung disease, vascular disease, etc.)

3. Emergency Medical Treatment Due to Injury or Medication Error shall be reported within sixty (60) days after the end of the month in which the emergency medical treatment began for individuals who at the time of the event were actively receiving services and were living in a Specialized Residential facility or a Child-Caring institution or were receiving either Habilitation Supports Waiver services, SED waiver services or Children's Waiver services.

4. Arrests of Persons Served and Hospitalization Due to Injury or Medication Error shall be reported within sixty (60) days after the end of the month in which the event occurred for persons living in a Specialized Residential facility or in a Child-Caring institution or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

E. MCCMH shall ensure an incident is classified as a sentinel event, risk event, critical incident, or non-sentinel death within three (3) business days of occurrence. MCCMH shall ensure appropriate guidelines are used in determining if an incident is a critical incident, risk event, and/or sentinel event.

F. Each provider shall have established mechanisms for the following tasks:

1. Identifying incidents as either sentinel events, critical incidents, or risk events;

2. Performing root cause analyses within two (2) days for events identified as sentinel;

3. Performing a review of risk events; and

4. Performing mortality reviews on deaths that are not sentinel events (e.g., death by natural causes).

*All critical incidents are either a sentinel event or risk event and must be reviewed/analyzed by the MCCMH Quality Division.

G. Provider staff identified as responsible to classify, review, and analyze the events must not have been directly involved in the incident that is the subject of the review and shall have the appropriate credentials to review the scope of care. For example, events that involved a person's death, or other serious medical conditions, must involve a physician or nurse. (If the provider is unable to perform a root cause analysis or mortality review due to an inability to meet composition requirements, or because of a conflict of interest, it shall refer the review to the MCCMH Critical Risk Management Committee.)

H. MCCMH shall ensure that providers:

1. Initiate reviews of risk when requested by the Quality Division or CRMC, within ten (10) business days of the date that the incidents are classified as a risk event. Alternately, providers must utilize an approved review process. Reports of risk event reviews shall, at a minimum, include:

a) Personal Identifying Information

b) Method/Procedure

c) Communication

d) Staff-Related

e) Environment

f) Equipment/Materials

2. Initiate mortality reviews of non-sentinel deaths within ten (10) business days of the date that the death was classified as non-sentinel. The review must include standard death information, such as a coroner's report, death certificate (as available), involvement of medical personnel in the review, documentation of the review process and findings and, as applicable, recommendations for improvement and a corrective action plan. Clinically responsible providers are encouraged to utilize

Exhibit B, "Mortality Review Report," as the review model.

I. When an incident under review is the subject of an active recipient rights investigation, MCCMH and the providers shall ensure that it does not impede, interfere, or otherwise compromise the investigation of the ORR pursuant to the standards and procedures under MCCMH MCO Policy 9-510 "Recipient Rights Investigation." (Providers may not investigate the details of the event but shall instead focus on systemic issues.)

J. Timeframes indicated for initiation of reviews of incidents shall be adhered to when additional documentation is forthcoming from MCCMH CRMC such as police reports, death certificates, and autopsy reports. Providers shall not wait until receipt of documentation to begin the review but shall begin root cause analyses of sentinel events, risk events, or mortality reviews within the stated time frames indicated in this policy.

K. The provider shall send the completed Root Cause Analysis/Risk Event Review or Mortality Review, with its corrective action plan, to the Chair of the MCCMH CRMC (the MCCMH Chief Medical Officer) within 90 calendar days of initiation of the review, or within 45 calendar days of receipt of additional documentation or direction from MCCMH.

L. For person served deaths, if upon receipt of additional documentation, it is determined that an event originally perceived as meeting the definition of a sentinel event is not sentinel (e.g., autopsy report indicates death is due to natural causes) the review team shall perform a mortality review and/or a root cause analysis of the death.

M. Death Reporting

1. MCCMH shall immediately report to MDHHS any death upon receipt of an incident report.

2. Following notification to MDHHS, MCCMH will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid member whose death occurred within one year of the individual's discharge from a State-operated service.

3. A report shall be submitted electronically within 48 hours of either the death, the responsible service provider's receipt of notification of the death, or the responsible service provider's receipt of notification that a rights, licensing, and/or police investigation has commenced to: QMPMeasures@michigan.gov and a designated individual of MCCMH. The following information must be included:

   a. Name of person served

   b. Person's case number or Medicaid ID number

   d. Date, time, and place of death (if a licensed foster care facility, include the license #)

   e. Preliminary cause of death

   f. Contact person's name and e-mail address

4. Following notification to MDHHS, MCCMH shall submit information on relevant events through the MDHHS Critical Incident Reporting System.

N. MCCMH, through the CRMC, will review the completed Root Cause Analyses, Mortality Reviews, Risk Event reviews, and submitted corrective action plans. They shall ensure the development, monitoring, and implementation of either a corrective action plan or intervention to prevent further occurrence of the sentinel event or risk event; or presentation of a rationale for not pursuing an intervention. A corrective action plan or intervention must identify who will implement the provisions of the plan and the time period(s) and method(s) by which implementation will be monitored and/or evaluated.

O. Providers shall cooperate with and respond to requests by MCCMH CRMC to perform Root Cause Analyses, Mortality Reviews, or Risk Event Investigations and to follow CRMC's recommendations for additional action on submitted corrective action plans.

P. Quarterly reviews of risk events shall serve as the basis for a report that classifies the reasons for the events.

Q. MCCMH shall ensure appropriate remediation at individual and system levels and maintain records as appropriate to document evidence of remediation efforts.

R. At the request of MDHHS or MCCMH, providers shall cooperate with any review by providing information/documentation related to the provider's process for the review, investigation, and monitoring of critical incidents, sentinel events, and risk events.

S. Documentation generated during the peer review of sentinel events or deaths of persons served are confidential, pursuant to the Michigan Mental Health Code. All written reports, findings, and recommendations for remedial actions created during the root cause analysis or mortality review shall be stamped "CONFIDENTIAL" and kept in a MCCMH administrative file. Peer review or incident reports, such as quality assurance documents, do not constitute summary reports and no copy of such documents shall be maintained in the clinical records of persons served. Quality Assurance documents include, but are not limited to:

1. MCCMH Framework for a Root Cause Analysis & Action Plan in Response to a Sentinel Event

2. Mortality Review Reports

3. Provider Risk Event Reviews

4. The MCCMH CRMC Review of Provider-Level Root Cause Analysis (RCA) / Consumer Death Report / Risk Event Review

5. CRMC Meeting Minutes

6. Reports by the MCCMH ORR to MDHHS

7. Incident, Accident, Illness, Death, or Arrest Reports

8. Peer Review Reports

VI. PROCEDURES

A. When an incident involves the death of a person served (excluding the death of a person who received an OBRA assessment) provider staff shall complete and forward a Report of Death to MCCMH (in addition to the completed Incident, Accident, Illness, Death, or Arrest Report) within five (5) business days of the date of the death or the date the provider became aware of the death.

B. The provider shall verify the following documents are complete and accessible for review in the MCCMH EMR. If they are not accessible for review in the MCCMH EMR, copies of the following must be attached to the Report of Death:

1. Comprehensive Assessment
2. Health Assessment
3. Psychiatric Evaluation
4. Medication Review
5. Person-Centered Plan
6. Person-Centered Plan Review
7. Medication list by prescribing person(s)
8. Care Coordination documentation
9. Other documentation, deemed relevant, e.g., progress notes, closing summary, etc.

C. Immediately upon receipt of the incident and death reports from a provider, the MCCMH Office of Recipient Rights (ORR) shall review for circumstances that indicate the possibility of recipient rights violations, and, if warranted, begin a Recipient Rights Investigation for allegations of abuse and neglect and in a timely and efficient manner for all other suspected rights violations.

D. Each provider shall establish an Incident Review Team which shall be responsible for:

1. Classifying and identifying incidents as either sentinel events or risk events;
2. Performing root cause analyses on sentinel events and risk events;
3. Performing a review of risk events, at a minimum, based on specified protocol; and
4. Performing mortality reviews on deaths that are not sentinel. (e.g., death by natural causes)

E. The Incident Review Team shall be composed of, at a minimum, a psychiatrist, a nurse, and a senior-level clinical staff member, none of whom were directly involved in the

incident that is the subject of the review. The membership of the Incident Review Team may include other staff as necessary, but the staff involved in reviewing and analyzing the events must have the appropriate credentials to review the scope of care.

F. The Incident Review Team shall determine within three (3) business days after an incident occurred whether it was a sentinel event, a risk event, or a non-sentinel death (e.g., death by natural causes). The team may utilize Exhibits D and E to assist in the classification process.

G. The Incident Review Team shall:

1. Initiate root cause analyses of perceived sentinel events within two (2) business days of the date that the incidents are classified as sentinel, utilizing an approved review process, such as Exhibit A, "MCCMH Framework for a Root Cause Analysis & Action Plan in Response to a Sentinel Event."

2. Initiate reviews of risk events within ten (10) business days of the date that the incidents are classified as risk events, utilizing Exhibit A.

3. Initiate reviews of non-sentinel deaths within ten (10) business days of the date that the team classified the incident as non-sentinel. The review must include information outlined in this policy. See Exhibit B, "Mortality Review," as a model for review of non-sentinel deaths.

4. Forward completed reviews (Root Cause Analyses, Risk Event Reviews, and Mortality Reviews) along with corrective action plans to the Chair of the MCCMH CRMC (the MCCMH Chief Medical Officer) within ninety (90) calendar days of initiation of the review or within forty-five (45) calendar days of receipt of additional documentation or direction from MCCMH.

H. The Chair of the CRMC or designee shall forward received documentation and reports to the CRMC members for review, including but not limited to the following:

1. Incident reports and associated documentation (e.g., death reports, etc.)

2. Police reports

3. Autopsy reports

4. Root cause analyses

5. Mortality reviews

6. Identified risk events reports

7. Corrective action plans

I. At the following CRMC meeting, members shall review critical incidents, sentinel events,

risk events, as well as the results and recommendations of the root cause analyses, mortality reviews, risk event reports, and corrective action plans.

1. CRMC shall recommend acceptance of the corrective action plans or identify additional actions or interventions which must be taken to prevent further occurrences of sentinel events or of other incidents (including risk events).

2. CRMC may request that a provider-level Root Cause Analysis, Mortality Review, or Risk Event Investigation be initiated, where the provider has failed to act or has taken insufficient actions.

3. CRMC shall record recommendations for additional actions or interventions.

4. CRMC shall forward the completed form with recommendations for additional action to the provider within ten (10) business days of review of the provider's root cause analysis, mortality review, or risk event report.

5. CRMC shall monitor corrective actions or interventions taken and their results.

6. CMRC shall assist in provider-level root cause analyses and mortality reviews when requested by the provider due to inability to meet composition requirements or because of a conflict of interest.

7. MCCMH shall ensure the creation of quarterly summary reports on issues or trends pertaining to quality of care based on information received from the mortality review process, sentinel events investigations and action plans, and risk event reports. The MCCMH Quality Division shall provide quarterly summary reports to the CRMC for further review and discussion.

VII. REFERENCES / LEGAL AUTHORITY

A. MDHHS/MCCMH Medicaid Managed Specialty Supports and Services Contract - FY22, Schedule E - PIHP Reporting Requirements

B. MDHHS/CMHSP Managed Mental Health Supports and Services Contract - FY22, C6.5.1.1, Technical Requirement Recipient Rights Data Reporting Requirements

C. Commission on Accreditation of Rehabilitation Facilities (CARF) 2020 Standards Manual, §1. H., "Health & Safety," 8, 9.

D. Michigan Mental Health Code: MCL 330.1748(9); MCL 330.1100c(5)

E. MDHHS Administrative Rules R 330.1274; R330.7046

F. MDHHS Medicaid Provider Manual

G. A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event the Joint Commission (formerly JCAHO)

H. MCCMH MCO Policy 9-321, "Incident, Accident, Illness, Death, or Arrest Report

Monitoring"

I. MCCMH MCO Policy 9-510, "Recipient Rights Investigation"

VIII. EXHIBITS

A. MCCMH Framework for a Root Cause Analysis & Action Plan in Response to a Sentinel Event

B. Mortality Review Report

C. Critical Incident Reporting Chart

D. Sentinel Event Determination Chart

E. Risk Event Determination Chart (Internal Reporting and Maintaining)

F. MCCMH Clinical Risk Management Committee (CRMC) Request for Provider-Level Root Cause Analysis / Mortality Review / Risk Event Investigation

G. Flowchart of Sentinel Events, Root Cause Analysis (RCA), and Mortality Review