MCCMH MCO Policy 8-003

Chapter: **QUALITY IMPROVEMENT**

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

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Chief Executive Officer Date

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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), as well as for the directly operated and contract network providers of MCCMH.

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 the Michigan Department of Health and Human Services (MDHHS) in an accurate and timely manner;

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

C. Identify systemic factors contributing to critical incidents, sentinel events, and risk events; and

D. Review corrective action plans submitted by providers 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, in accordance with MCCMH Policy 9-321:

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

2. A provider authorized the individual for ongoing service, either through a face-to- face assessment or a tele-health 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 the MCCMH service system; or
    D. Removal of the service from the person's plan of service.

B. Critical Risk Management Committee Review:
A formal process conducted by the members of the Critical Risk Management Committee (CRMC) to review clinical risk areas and recommend strategies to mitigate the probability of recurrence and/or the impact of future adverse events. This process may include a Root-Cause Analysis. The CRMC meets monthly unless a review is not necessary. CRMC members shall include individuals with appropriate credentials to review the scope of care who were not involved in the treatment or care of the person served, as well as individuals or professionals who may contribute to a thorough review. The outcome of the review should lead to an understanding of the event's causes and a corrective action plan.

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

1. Suicide death:
The 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:
The death of a person served that was not otherwise reported as a suicide. Within this category, unexpected deaths are expected.

3. Emergency medical treatment due to injury or medication error:
Where an injury to a person served, or a 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, fall, emergency use of physical management, 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 receives the wrong medication, the wrong dosage, or the staff fails 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 resulting from the natural course of an illness or an underlying condition are not covered by 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 in which a person served is transported to receive emergency mental health services or is held in protective custody are not considered arrests.

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 require an RCA.

E. Risk Event:
An event that puts an individual at risk of harm. Such an event is reported and analyzed to determine the necessary action to remediate the problem or situation and to prevent 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, etc.)

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.)

a. Situations where police are contacted to help a consumer be transported for the purpose of receiving care for medical concerns would not fall under this type of event.

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, to demonstrate affection, or to hold 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 are 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.

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

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 provides opportunities for redesign to reduce risk.

G. Sentinel Event:
A critical incident 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 limbs or functions. 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 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 whether they 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. The following are considered Sentinel Events:

1. Unexpected Death:
   The death of a person who 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 without hospitals, medical centers and urgent care clinics serve as alternatives to hospital emergency rooms.

3. Serious 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. This may include psychological trauma, anxiety, chronic depression, or PTSD, among other psychological problems, if significant in nature.

4. 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.

V. STANDARDS

H. Incident reports shall be written for all incidents and submitted to MCCMH in accordance with MCO Policy 9-321.

   1. Incident Reports, along with necessary additional forms, shall be completed for any critical incident by the end of the individual's work shift or within eight (8) hours of the occurrence, whichever comes first.

I. Providers shall submit incident reports to the PIHP through the MCCMH incident report module in FOCUS or the ORR fax line

J. MCCMH shall internally track critical incidents (including sentinel events), risk events, and immediately reportable events in accordance with the provisions of this policy and MDHHS requirements.

K. MCCMH, through the PIHP, shall report to MDHHS the following incidents for beneficiaries actively receiving services with individual-level data on consumer ID, event date, and event type:

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 prior to death.

    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 the 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 who were receiving community living supports, supports coordination, targeted case management, Assertive Community Treatment (ACT), Home-based, Wraparound, Habilitation Supports Waiver, SED Waiver, Children's Waiver services, or 1915 iSPA 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 PIHP 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 "best judgment" determination occurred.

    b. Natural cause deaths shall be reported, indicating the specific natural cause (e.g., heart disease, pneumonia/influenza, lung disease, vascular disease, etc.) The PIHP will notify MDHHS of the cause of death upon receiving the individual's death certificate, using the MDHHS CRM System.

3. Emergency Medical Treatment Due to Injury or Medication Error shall be reported for persons actively receiving services and living in a Specialized Residential facility, or who were receiving either Habilitation Supports Waiver services, SED Waiver services, Children's Waiver services, or 1915 iSPA services.

    a. These events shall be reported within sixty (60) days after the end of the month in which the emergency medical treatment began. This includes specifying whether the injury was due to a fall or to physical management.

4. Hospitalization due to Injury or Medication Error shall be reported for persons served actively receiving services who were living in a Specialized Residential facility or in a Child-Caring institute or were receiving Habilitation Supports Waiver services, SED Waiver services, Children's Waiver services, or 1915 iSPA services.

a. These events shall be reported within sixty (60) days after the end of the month in which the hospitalization began. This includes specifying whether the injury was due to a fall or to physical management.

5. Arrests of Persons Served shall be reported for individuals living in a Specialized Residential facility or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services within sixty (60) days after the end of the month in which the event occurred.

L. MDHHS requires CCBHC Demonstration sites to report, review, investigate, and act upon sentinel events for persons receiving CCBHC services. MCCMH will ensure the timely reporting of all events involving CCBHC beneficiaries who receive additional services funded through the PIHP.

M. The PIHP shall ensure all incidents are reviewed within three (3) business days of notification of the occurrence. These events will be reviewed to determine whether each is a Sentinel event. MCCMH shall ensure appropriate guidelines are used in determining if an incident is a critical incident, risk event, immediately reportable event, and/or sentinel event.

N. Provider Expectations

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

a. Identifying incidents via timely completion and submission of the Consumer Incident, Accident, Illness, Death, or Arrest Report form (See MCO Policy-9-321 Exhibit A);

b. Commencing root cause analyses, as requested by the PIHP, within two (2) business days after an event is identified as sentinel;

c. Performing a review of risk events and conducting root cause analyses when systemic trends are identified; and

d. Performing mortality reviews on unexpected, natural deaths, as requested by the PIHP.

2. Provider staff identified as responsible for classifying, reviewing, and analyzing 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 involve a person's death or other serious medical conditions must involve a physician or nurse.

3. MCCMH shall ensure that providers:

a. Initiate Root Cause Analyses when requested by the Quality Division or CRMC within two (2) business days of the event being determined to be sentinel. (See Exhibit A, "Root Cause Analysis and Action Plan")

b. Initiate reviews of risk events when requested by the Quality Division or CRMC, within ten (10) business days of the date that the request was made. Alternatively, providers must use an approved review process.

c. Initiate mortality reviews of certain sentinel deaths, when requested by the Quality Division, within ten (10) business days of the date that the request was made. The review must include the involvement of medical personnel, documentation of the review process and findings, and, as applicable, recommendations for improvement and a corrective action plan. Clinically responsible providers are encouraged to Use Exhibit B, "Mortality Review Report," as the review model.

4. The provider shall send the completed Root Cause Analysis/Risk Event Review or Mortality Review, with its corrective action plan, to Quality.Remediation@MCCMH.net within 45 calendar days of the request for remediation. An extension of up to 90 days may be granted while awaiting receipt of additional documentation or direction from the CRMC.

O. 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).

P. MDHHS Event Notification

1. MCCMH, through the PIHP, shall immediately notify MDHHS through the Customer Relationship Management (CRM) system of any death that occurs because of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation. A report shall be filed within 48 hours of either the death, MCCMH's receipt of notification of the death, or MCCMH's receipt of notification that a recipient's rights, licensing, and/or police investigation has commenced to the CRM via the PCE system. 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

2. MCCMH will report to MDHHS within five (5) business days:

   a. The relocation of an individual's placement due to licensing suspension or revocation.
   b. An occurrence that requires the relocation of any MCCMH or provider panel

service site, governance, or administrative operation for more than 24 hours.

c. The conviction of an MCCMH or provider panel staff member for any offense related to the performance of their job duties or responsibilities, which results in exclusion from participation in federal reimbursement

3. MCCMH will report to MDHHS within seven (7) days of any changes to the composition of the provider network organizations that negatively affect access to care.

4. Critical incidents that may be newsworthy or represent a community crisis must be reported to MDHHS immediately.

Q. 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 an intervention to prevent further occurrences of the sentinel event or risk event or present a rationale for not pursuing an intervention. A corrective action plan or intervention must identify who will implement the plan's provisions, the time(s) and method(s) by which implementation will be monitored and/or evaluated, and the time(s) and method(s) by which implementation will be monitored and/or evaluated. The CRMC may require additional action on submitted corrective action plans if deemed necessary.

R. 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.

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

T. 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.

U. 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 kept in an 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:

1. Complete and forward/upload the Incident, Accident, Illness, Death, or Arrest Report to the FOCUS Incident Reporting system or MCCMH ORR Fax Inbox by the end of the shift in which staff became aware of the death.

2. Complete and forward a Provider Report of Death to MCCMH within five (5) business days of the date of the death or the date the provider became aware of the death.

3. Verify that the following documents are complete and accessible for review in the MCCMH EMR (FOCUS). If they are not accessible for review in the MCCMH EMR, copies of the following must be attached to the Incident Report:

    A. Comprehensive Assessment
    B. Health Assessment
    C. Psychiatric Evaluation
    D. Medication Review
    E. Person-Centered Plan
    F. Person-Centered Plan Review
    G. Medication list by prescribing person(s)
    H. Care Coordination documentation
    I. Other documentation, deemed relevant, e.g., progress notes, closing summary, etc.

B. 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.

C. Additionally, upon receipt of the incident and death reports from a provider, the MCCMH Incident Review Team shall review for circumstances that indicate a critical incident, a sentinel event, a risk event, or an immediately reportable event.

D. The Incident Review Team shall be composed of, at a minimum, quality personnel, a licensed prescriber, a senior-level clinical staff member, and other professionals such as a nurse, OT, PT, etc. (when applicable), 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.

E. The Incident Review Team shall determine within three (3) business days after an incident occurred whether it was a sentinel event. The team may use Exhibits D and E to assist in the classification process.

F. The Incident Review Team shall:

1. Request provider completion of root cause analyses (RCA) when applicable (not all sentinel events will require an RCA) for 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 non-sentinel deaths and risk events. The review may lead the Incident Review Team to request that the provider complete a Mortality Review. See Exhibit B, "Mortality Review," as a model for review of unexpected, natural deaths.

3. Upon receipt of Root Cause Analyses, Risk Event Reviews, and Mortality Reviews, along with corrective action plans, the CRMC will review the completed remediation at the following CRMC meeting.

G. The Chair of the CRMC or designee shall present 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. Corrective action plans

H. At the following CRMC meeting, members shall review critical incidents, sentinel events, risk events, and the results and recommendations of the root cause analyses, mortality reviews, and corrective action plans.

1. CRMC shall recommend acceptance of the corrective action plans or identify additional actions or interventions that 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 response 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 review corrective actions or interventions taken and their results. Concerns will be escalated to Network Operations and/or the Quality Department, as applicable.

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 conflict of interest.

7. The PIHP shall ensure the creation of quarterly summary reports on issues or trends pertaining to quality of care based on information received from the 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 - FY26, Schedule E - PIHP Reporting Requirements

B. MDHHS/CMHSP Managed Mental Health Supports and Services Contract - FY26, C6.5.1.1, Technical Requirement Recipient Rights Data Reporting Requirements

C. Commission on Accreditation of Rehabilitation Facilities (CARF) 2025 Standards Manual, §

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"

J. State of Michigan Quality Assessment and Performance Improvement Programs for Specialty Pre-paid Inpatient Health Plans

VIII. EXHIBITS

A. Root Cause Analysis and Action Plan

B. Mortality Review Report

C. Critical Incident Reporting Chart

D. Sentinel Event Determination Chart

E. Risk Event Determination Chart

F. MCCMH Critical Risk Management Committee (CRMC) Review of Root Cause Analysis / Mortality Review