MCCMH MCO Policy 8-003

*(was MCCMH MCO Policies 8-003, 8-004 and 8-005)*

Category: **QUALITY IMPROVEMENT**
Title: **REPORTING AND RESPONDING TO CRITICAL INCIDENTS, SENTINEL EVENTS AND RISK EVENTS**
**(see also MCCMH MCO Policy 8-004, "Reporting and Responding to Medication Errors/Discrepancies and Adverse Drug Events;" 8-008, "Behavior Treatment Plan Review Committee;" and 9-321, "Consumer Incident, Accident, Illness, Death, or Arrest Report Monitoring.")**

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Executive Director Date

## I. Abstract

This policy establishes the standards and procedures by which Macomb County Community Mental Health (MCCMH) shall:

A. Review, investigate, act upon, and report to the Michigan Department of Community Health (MDCH) critical incidents, sentinel events and risk events for its consumers who meet the criteria established by MDCH, and

B. Conduct accurate root cause analyses in response to critical incidents, sentinel events, and risk events, and review and investigate deaths of consumers which occur within the MCCMH provider network, for the purpose of improving:

- Risk management
- Overall quality of care, and
- Accuracy of statistical reporting

## II. Application

This policy shall apply to MCCMH administrative/management staff, individual direct service contractors, and directly-operated and contracted network providers of the MCCMH Board.

## III. Policy

It is the policy of the MCCMH Board to have a process to:

A. Review, investigate, analyze, act upon and report critical incidents and sentinel events to MDCH in an accurate, timely manner;

B. Review, investigate, analyze, 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 prevent recurrence of critical incidents, sentinel events and risk events.

## IV. Definitions

A. Critical Incidents
Any of the following events which should be reported to MDCH (within the time frames indicated in V.A) and reviewed by MCCMH within three (3) business days after occurrence to determine whether it meets the criteria for a sentinel event (as defined at IV.B):

1. Suicide
A death of a consumer when either of the following two conditions exists:

a. MCCMH determines, through its death review process, that the consumer's death was a suicide, or

b. The official death report (i.e. coroner's report) indicates that the consumer's death was a suicide.

2. Non-suicide death
Any death of a consumer that was not otherwise reported as a suicide.

3. Emergency Medical Treatment Due to Injury or Medication Error
Where an injury to a consumer or a medication error results in face-to-face emergency treatment being provided by medical staff at any treatment facility, including personal physicians, medi-centers, urgent care clinics/centers and emergency rooms.

*Injury*
Bodily damage that occurs to an individual due to a specific event such as an accident, assault, or misuse of the body, that results in treatment by medical staff at any treatment facility, including personal physicians, medi-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.

*Medication Error*
Where a mistake is made when a consumer takes prescribed medication (i.e. wrong medication, wrong dosage, staff failed to administer.) It does not include instances in which consumers have refused medication.

4. Hospitalization Due to Injury or Medication Error (see above definitions for *injury* and *medication error*)
   Where an injury or medication error results in admission of a consumer 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
   Situation where a consumer is held or taken by a law enforcement officer based on the belief that a crime may have been committed. Situations where a consumer is transported for the purpose of receiving emergency mental health services, or situations where a consumer is held in protective custody, are not considered to be an arrest.

B. Sentinel Event
A critical incident that is an unexpected occurrence involving death or serious physical or psychological injury (emotional harm), or the risk thereof. 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. The process for review of sentinel events shall begin within five (5) business days of the occurrence.

*Unexpected Death*
The death of a consumer 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.

*Serious Physical Injury*
Physical damage suffered by a consumer that a physician or registered nurse determines caused or could have caused the death of a consumer, the impairment of his or her bodily functions, loss of limb, or permanent disfigurement.

*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.

*Death by Natural Causes*
Deaths 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 consumer 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 consumer who has been receiving hospice care or treatment for end stage disease. Deaths by natural causes are not considered sentinel events.

C. Risk Event

An event that puts an individual at risk of harm. Such an event is reported internally 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 minimally include:

1. Harm to Self
   Actions taken by consumers 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 consumers that cause physical harm to others (family, friends, staff, peers, public, etc.) that result in injuries requiring emergency medical treatment or hospitalization of the other person(s).

3. Police Calls
   Police calls by staff of specialized residential settings, or general (AFC) residential homes or other provider agency staff for assistance with a consumer during a behavioral crisis situation regardless of whether contacting police is addressed in a behavioral treatment plan. (See MCCMH MCO Policy 8-008 for requirements for the Behavior Treatment Plan Review Committee.)

4. Emergency Use of Physical Management
   Emergency use of physical management by trained staff in response to a behavioral crisis.

   *Physical Management*
   A technique used as an emergency intervention to restrict the movement of an individual by continued direct physical contact in spite of the individual's resistance in order to prevent him or her from physically harming him/herself or others. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. (See also definition in MCCMH MCO Policy 8-008, "Behavior Treatment Plan Review Committee," 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.

D. Actively Receiving Services
For reporting purposes, a consumer is "actively receiving services" when:

1. Any of the following occur:

   a. A face-to-face intake has occurred and the individual was deemed eligible for ongoing service, or

b. MCCMH has authorized the individual for ongoing service, either through a face-to-face assessment or a telephone screening, or

c. The individual has received a non-crisis, non-screening encounter; and

2. The occurrence (above, IV.D.1.a.-c.) takes place between the date when the decision is made to start providing ongoing non-emergent services and the date when the consumer is formally discharged from services.

E. Actively Receiving a Specific Service
For reporting purposes, a consumer is considered a recipient of a specific service when service delivery for that specific service takes place between:

1. The date when the consumer has been determined to be eligible, and

2. The date when the consumer is formally terminated from that type of service. Examples of formal termination (end of service) include:

a. Transfer to another unit,
b. Discharge from the unit providing the service,
c. Discharge from the MCCMH service system, or
d. Removal of the service from the consumer's individual plan of service.

3. The consumer must have received the specific service at least once.

F. Clinical Risk Management Committee (CRMC)
A formal standing committee of the Quality Assessment and Performance Improvement Program (QAPIP) that reviews areas of clinical risk. The committee is comprised of the MCCMH Medical Director, the MCCMH Clinical Director / Clinical Strategies & Improvement Division Director, the MCCMH Recipient Rights Director, the Macomb County Office of Substance Abuse (MCOSA) Director or designee, and the Business Management Director. Additional MCCMH staff representatives of professional disciplines (e.g., pharmacy, psychology, social work, or nursing) may be invited by the Chair or Vice-Chair of the Committee as needed for a specific issue or review. The Committee is chaired by the Medical Director. The MCCMH Clinical Director / Clinical Strategies & Improvement Division Director is the Vice-Chair.

The CRMC meets on a monthly basis (or more frequently if necessary) in order to review clinical risk areas, including but not limited to consumer morbidity and mortality, critical incidents, sentinel events, risk events, grievances and appeals, and violations of recipients' rights. CRMC requires clinical teams from the clinically-responsible provider to perform a Root Cause Analysis (RCA) on incidents determined to be sentinel events, and to perform either a RCA or a Mortality Review on specific consumer deaths. Results and action plans developed through the reviews of the clinical teams are reviewed and monitored by the CRMC.

Members of the CRMC may meet or consult as needed to review critical incidents, to ensure they are reported to the MDCH in a timely fashion and managed in accordance with the standards and procedures of this policy.

G. Clinically-Responsible Provider
A service provider with over-all responsibility for the management of the care of a consumer in MCCMH services.

1. The clinically-responsible provider is the consumer's casemanager or supports coordinator, if one has been assigned. If no casemanager or supports coordinator has been assigned, the clinically-responsible provider is the consumer's psychiatrist. If the consumer does not have a psychiatrist, the clinically-responsible provider is the consumer's therapist.

2. ACT providers are the clinically-responsible provider for consumers enrolled in the ACT program.

3. For purposes of this policy, the clinically-responsible provider for consumers who are members of Clubhouse programs, only, shall be the administrative entity operating the Clubhouse.

4. For purposes of this policy, the Access Center shall be the clinically-responsible provider for consumers whose services have been authorized, but who have not yet received services within the MCCMH provider network.

H. Incident Review Team
A team of appropriately credentialed individuals established for the purposes of classifying and identifying incidents as either "sentinel events" or "risk events;" performing root cause analyses on sentinel events; performing a review of risk events, at a minimum, based on specified protocol; and performing mortality reviews on deaths that are determined not to be sentinel events (e.g. death by natural causes). The composition of the Incident Review Team shall include, at 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 may include other staff as necessary, but at all times the staff involved in reviewing and analyzing the events must have the appropriate credentials to review the scope of care.

I. Corrective Action Plan
A written corrective plan developed following the completion of a sentinel event review, or a root cause analysis; or a written plan developed in response to the completion of a mortality review, when a death of a consumer has been determined not to be a sentinel event; or a written plan developed in response to a risk events review investigation. The corrective action plan designates the actions to be implemented to resolve and / or prevent the recurrence of the event. The plan must designate time frames for completion and strategies for measuring the effectiveness of actions taken.

J. 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. (See Exhibit A, Provider Root Cause Analysis Report.)

K. Mortality Review
A process for identifying the basic or causal factors that underlie variations in performance, when the occurrence of a death of a consumer is determined not to be a sentinel event. A mortality review focuses on systems and processes, not individual performance, and gives the potential for redesign to reduce risk. (See Exhibit C, Mortality Review Report.)

L. Program / Setting Definitions

1. Child-Caring Institution
A facility providing residential care for children that is licensed under MCL 722.111, et seq.

2. Substance Abuse Residential Treatment Program
Planned individual and group therapeutic and rehabilitative counseling and didactic service that is provided as an intense, organized, daily treatment regimen in a residential setting which includes 24 hour services.

For definitions and descriptions of additional programs and settings referred to in this policy, please see MCCMH MCO Policy 2-000, "Plan for Behavioral Health Services."

## V. Standards

A. MCCMH shall collect and require internal reporting on all critical incidents (including sentinel events) and risk events according to the standards and procedures contained in MCCMH MCO Policy 9-321, "Consumer Incident, Accident, Illness, Death, or Arrest Report Monitoring," this policy, and those of the current MDCH/MCCMH Medicaid Managed Specialty Supports and Services Contract, and the Managed Mental Health Supports and Services Contract.

B. MCCMH shall report to the Michigan Department of Community Health (MDCH) critical incidents occurring within the populations specified, and in the time frames provided, for each critical incident, in accordance with the provisions of the current year MDCH/MCCMH Medicaid Managed Specialty Supports and Services Contract, and Managed Mental Health Supports and Services Contract. Reporting to MDCH shall take place through data entry into the MCCMH FOCUS EMR Critical Incident Module.

1. Suicide

a. A consumer's death that has been determined to be a suicide shall be reported on any consumer who was actively receiving services, and all

consumers who had received an emergency service within the last 30 calendar days.

b. The suicide shall be reported within 30 days after the end of the month in which the cause of death was determined to be a suicide. If 90 calendar days have elapsed without a determination of cause of death, MCCMH shall submit a "best judgment" determination of whether the death was a suicide. In this case, the submission is due within 30 days after the end of the month in which this "best judgment" determination was made.

2. Non-Suicide Death

a. Deaths that have not otherwise been reported as a suicide shall be reported on all consumers who, at the time of their deaths were:

1) Living in a 24-hour Specialized Residential setting (per MDCH Administrative Rule 330.1801-09, Subpart 8. Certification of Specialized Programs Offered in Adult Foster Care Home to Clients with Mental Illness or Developmental Disability), or a Child-Caring Institution, or living in a substance abuse residential treatment program or

2) Actively receiving Community Living Supports, Supports Coordination, Targeted Case Management, ACT, Home-based, Wraparound, Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.

b. The non-suicide death shall be reported within 60 days after the end of the month in which the death occurred, unless reporting is delayed while MCCMH attempts to determine whether the death was due to suicide. In this case, the submission is due within 30 days after the end of the month in which MCCMH determined the death was not due to suicide. 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

a. Situations where an injury to a consumer or a medication error results in face-to-face emergency treatment shall be reported on all consumers who, at the time of the event were:

1) Living in a 24-hour Specialized Residential setting (per MDCH Administrative Rule 330.1801-09, Subpart 8. Certification of Specialized Programs Offered in Adult Foster Care Home to Clients with Mental Illness or Developmental Disability), or a Child-Caring Institution, or living in a substance abuse residential treatment program, or

2) Actively receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.

b. The incident shall be reported within 60 days after the end of the month in which the emergency medical treatment began.

4. Hospitalization Due to Injury or Medication Error

a. Situations where injury to a consumer or a medication error results in inpatient admission shall be reported on all consumers who, at the time of the event were:

1) Living in a 24-hour Specialized Residential setting (per MDCH Administrative Rule 330.1801-09, Subpart 8. Certification of Specialized Programs Offered in Adult Foster Care Home to Clients with Mental Illness or Developmental Disability), or a Child-Caring Institution, or living in a substance abuse residential treatment program, or

2) Actively receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.

b. The incident shall be reported within 60 days after the end of the month in which the hospitalization began.

5. Arrest of Consumer

a. Situations where a consumer is held or taken by a law enforcement officer based on the belief that a crime may have been committed shall be reported on all consumers who, at the time of the arrest, were:

1) Living in a 24-hour Specialized Residential setting (per MDCH Administrative Rule 330.1801-09, Subpart 8. Certification of Specialized Programs Offered in Adult Foster Care Home to Clients with Mental Illness or Developmental Disability), or a Child-Caring Institution, or living in a substance abuse residential treatment program, or

2) Actively receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.

b. The incident shall be reported within 60 days after the end of the month in which the arrest took place.

C. MCCMH shall internally track risk events, occurring within the populations specified below, as expeditiously as possible, and in accordance with the provisions of this policy, and the current year MDCH/MCCMH Medicaid Managed Specialty Supports and Services Contract, and the

Managed Mental Health Supports and Services Contract. Risk events will be tracked in the MCCMH information system database until functionality is present in the FOCUS EMR system.

1. The population group for risk event reporting includes all consumers who, at the time of the risk event, were actively receiving services and were receiving at least one of the following:

    a. Supports Coordination

    b. Targeted Case Management

    c. ACT

    d. Home-based Services.

2. At a minimum, the following risk events shall be reported:

    a. Harm to Self

    b. Harm to Others

    c. Police Calls

    d. Emergency Use of Physical Management

    e. Unscheduled Hospitalizations

D. MCCMH shall ensure that each clinically-responsible provider has a mechanism for performance of the following tasks:

1. Classifying and identifying incidents as either “sentinel events” or “risk events;”

2. Performing root cause analyses on sentinel events;

3. Performing a review of risk events, at a minimum, based on specified protocol contained herein; and

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

E. Staff identified as being 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 consumer death, or other serious medical conditions, must involve a physician or nurse. (If the clinically-responsible 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 CRMC.)

F. MCCMH shall ensure that, within three business days after occurrences, clinically-responsible providers classify incidents as sentinel events, risk events, or non-sentinel deaths. (Exhibits E., "Sentinel Event Determination Chart," and F., "Risk Event Determination Chart," are included in this policy to provide assistance in the classification process.)

G. Guidelines for determining if a critical incident is a sentinel event include the following (also see Exhibit E, "Sentinel Event Determination Chart"):

1. The qualifying event involves consumers actively receiving services who meet the population specification for that event; and

2. The incident was unexpected; and

3. The incident resulted in death or serious physical or psychological injury, or (as determined by a physician or nurse) there is a significant change that had the events continued, death or serious physical or psychological injury would have occurred.

4. If the incident is a death, the following deaths shall be considered "unexpected" for purposes of defining the death as sentinel:

a. Consumer death which occurs on the premises of a MCCMH directly-operated provider, contract provider or a MCCMH funded program (i.e., community inpatient, outpatient, partial day, skill building or residential service);

b Consumer death as a result of a transportation accident involving a MCCMH funded vehicle;

c. Death of a consumer with an unresolved MCCMH Office of Recipient Rights investigation;

d. Consumer deaths that result in a police investigation (e.g. possible or actual suicide or homicide);

e. Consumer deaths during elopement, or wandering, from a MCCMH 24-hour care setting.

f. Consumer deaths that were accidental.

g. Consumer deaths that resulted from an undiagnosed condition.

H. MCCMH shall ensure that clinically-responsible providers:

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, "A Framework for a Root Cause Analysis and Action Plan

in Response to a Sentinel Event" based upon the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) configuration.

2. Initiate reviews of risk events within ten (10) business days of the date that the incidents are classified as a risk event, utilizing at a minimum, the classification of causal factors, below. Alternately, providers may utilize an approved review process, such as Exhibit A, "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event." Minimally, reports of risk event reviews shall include:

   a. Personal Identifying Information
   (Name, Medicaid ID, disability designation, residential living arrangement type, name of TCM/SC/HB/ACT provider agency, note if consumer self-directs services with name of provider. If event occurred at home, name of CLS or personal care, including Home Help. If event occurred in a licensed AFC facility, license number, licensee name and name of home.)

   b. Method/Procedure
   (Adequacy of clinical assessment, completeness of plan(s), implementation of plans/procedures, consistency of plan(s) with technical requirements and/or best practices)

   c. Communication
   (Awareness of consumer's plan; awareness of organizational policies/protocols; contradictory, confusing or missing information /instructions)

   d. Staff-Related
   (Staffing levels, staff skill set or competency in applying the methods or procedures, staff training)

   e. Environment
   (Noise levels, physical proximity, amount of space for consumer or staff, lighting, physical hazards or condition of the environment)

   f. Equipment/Materials
   (Necessary equipment or materials not in proper condition, improperly used, in disrepair, missing)

3. Initiate mortality reviews of non-sentinel deaths within ten (10) business days of the date that the deaths were classified as non-sentinel. The review must include screens of individual deaths with standard information (e.g., coroner's report, death certificate); involvement of medical personnel in the review; documentation of the review process and findings; recommendations for improvement and a corrective action plan. Clinically-responsible providers are encouraged to utilize Exhibit C, "Provider Mortality Review," as the review model.

I. When an incident under review is the subject of an active recipient rights investigation, the clinically-responsible provider shall be careful that it not impede, interfere or otherwise

compromise the investigation of the MCCMH ORR pursuant to the standards and procedures under MCCMH MCO Policy 9-510, "Recipient Rights Investigation" (e.g. clinically-responsible provider may not investigate the details of the event but shall instead focus on systemic issues, etc.)

J. MCCMH, through the Clinical Risk Management Committee (CRMC), shall ensure that related documents (police report, death certificate, autopsy report if performed, etc.) shall be compiled and ordered (as applicable) as soon as possible after the occurrence of an event necessitating such documentation, but no later than within five (5) business days after the occurrence. MCCMH shall additionally ensure that the necessary documentation is forwarded to the clinically-responsible provider that is responsible for completion of the review of the event, upon receipt or review by the CRMC.

K. Time frames indicated for initiation of reviews of incidents shall be adhered to; when additional documentation is forthcoming from MCCMH CRMC (police reports, death certificates, autopsy reports, etc.) clinically-responsible providers shall not wait until receipt of documentation to begin the review, but shall begin the root cause analyses of sentinel events, reviews of risk events, or mortality reviews within the stated time frames indicated within this policy.

L. The clinically-responsible provider shall send the completed Root Cause Analysis, the completed Risk Event Review, or Mortality Review, with corrective action plans, to the Chair of the MCCMH CRMC (the MCCMH Medical Director) within 90 calendar days of initiation of the review, or within 45 calendar days of receipt of additional documentation or direction from MCCMH.

M. For consumer deaths, if, upon receipt of additional documentation from MCCMH, 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 of the death.

N. For consumer deaths, if, upon receipt of additional documentation from MCCMH, it is determined that an event originally perceived as not meeting the definition of a sentinel event is actually determined to be a sentinel event (e.g. autopsy report indicates death is not due to natural causes) the review team shall perform a root cause analysis of the death.

O. Death Reporting

1. MCCMH, through the ORR, shall immediately report to MDCH:

   a. Any death that occurs as a result of suspected staff member action or inaction, or

   b. Any death that is the subject of a recipient rights, licensing, or police investigation.

2. This report shall be submitted electronically within 48 hours of either the death, or MCCMH's receipt of notification of the death, or MCCMH's receipt of notification that a rights, licensing, and/or police investigation has commenced to: QMPMeasures@michigan.gov and include the following information:

    a. Name of beneficiary
    b. Beneficiary ID number (Medicaid, ABW, MiChild)
    c. Consumer I (CONID) if there is no beneficiary 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

3. Following immediate notification to MDCH, MCCMH shall submit information on relevant events through the Critical Incident Reporting System in the manner described here.

P. MCCMH, through the CRMC, shall be responsible for reviewing the completed Root Cause Analyses, Mortality Reviews, Risk Event reviews, and submitted corrective action plans, and shall ensure the development, monitoring and implementation of either (1) a corrective action plan or intervention to prevent further occurrence of the sentinel event or risk event; or (2) 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.

Q. Clinically-responsible 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.

R. Pursuant to the Quality Assessment and Performance Improvement Program, MCCMH, through the CRMC, shall analyze at least quarterly the critical incidents, sentinel events, non-sentinel deaths and risk events to determine what actions need to be taken to remediate the problems or situations and to prevent the occurrence of additional events and incidents. Additionally:

1. The review of sentinel and non-sentinel deaths shall include a quarterly internal report that examines mortality information to address quality of care, and aggregation of mortality data over time to identify possible causes and trends.

2. The review of risk events shall include the development of a quarterly internal report that classifies the reasons for the events identified above, at V.H.2.a.-f., and shall:

    a. For all risk events except unscheduled hospitalizations, include an analysis of the total number of incidents per calendar month, and the rate of incidents per 100 people served in the identified population, with cumulative year to date from the beginning of the current fiscal year;

b. For risk events that are unscheduled hospitalizations, include:

1) An aggregate of the total number of hospitalizations by reason/condition per calendar month, and the rate of number of total hospitalizations per 100 people served in the identified population, with cumulative year to date from the beginning of the current fiscal year; and

2) An analysis of the data to identify trends and to identify individuals with multiple hospital admissions shall be included.

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

T. MCCMH shall cooperate in the MDCH annual review of MCCMH's process for the review, investigation, and monitoring of the critical incident, sentinel event, and risk event management processes, including making associated data and reports available to MDCH upon request.

U. Documentation generated during the peer review of sentinel events or deaths of consumers are confidential Quality Improvement/Quality Assurance documents, 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, as quality assurance documents, do not constitute summary reports and no copy of such documents shall be maintained in the clinical records of consumers. Quality Assurance documents include, but are not limited to:

1. The Provider Report of Death (Exhibit B)

2. The Provider Root Cause Analysis Report (Exhibit A)

3. The Mortality Review Report (Exhibit C)

4. Provider Risk Event Reviews

5. The MCCMH Clinical Risk Management Committee Review of Provider-Level RCA / Consumer Death Report / Risk Event Review (Exhibit H)

6. Minutes of CRMC meetings

7. Reports by the MCCMH ORR to MDCH

8. Consumer Incident, Accident, Illness, Death or Arrest Report (Exhibit A to MCO Policy 9-321, “Consumer Incident, Accident, Illness, Death, or Arrest Report Monitoring,” and

9. Peer Review reports

10. Corrective Action Plans and other quality improvement plans

## VI. Procedures

A. Within 24 hours, MCCMH service provider staff members (direct and contracted) who observe or become aware of incidents shall complete Consumer Incident, Accident, Illness, Death or Arrest Reports and any associated forms according to the provisions of MCCMH MCO Policy 9-321, "Consumer Incident, Accident, Illness, Death, or Arrest Report Monitoring," and forward them to the MCCMH Office of Recipient Rights (ORR). No incident report shall be completed for consumers who have received an OBRA assessment. Reviews of these incidents are considered the responsibility of the 24/7 treatment centers. Allegations of, apparent or suspected abuse or neglect must be reported immediately to ORR according to the provisions of MCCMH MCO Policy 9-321.

B. In addition to the completion of the Consumer Incident, Accident, Illness, Death or Arrest Report, if the incident involved the death of a consumer (excluding the death of a consumer who had received an OBRA assessment) within five (5) business days of the date of the death (or of the date the provider staff became aware of the death) the MCCMH service provider staff member shall complete the Provider Report of Death, Exhibit B, and forward to the MCCMH ORR. The provider shall verify the following documents are complete, and that they are accessible for review in the MCCMH FOCUS EHR. If not accessible for review in the MCCMH FOCUS EHR, attach copies of the following to the Report of Death:

- Comprehensive Assessment;
- Health Assessment;
- Psychiatric Evaluation;
- Medication Review;
- Person-Centered Plan;
- Person-Centered Plan Review;
- Medication list by prescribing person(s);
- Care Coordination documentation;
- Other documentation, deemed relevant, e.g. Progress Notes, Closing Summary, etc.

C. Immediately upon receipt of the incident reports and death reports submitted by the clinically-responsible providers, the MCCMH Office of Recipient Rights (ORR) shall:

1. Review for circumstances that indicate the possibility of recipient rights violations, and, if warranted, begin a Recipient Rights Investigation immediately for allegations, of abuse and neglect, and in a timely and efficient manner for all other suspected rights violations.

2. Forward to the MCCMH Medical Director and the MCCMH Clinical Director / Clinical Strategies & Improvement Division Director via the FOCUS EMR Incident Report Module, copies of incident reports for CRMC oversight and monitoring of critical incident reporting, sentinel event reviews, and risk event reviews.

3. Forward to the MCCMH Business Management Division Director (or designee) incident reports that present as potential critical incidents for reporting to MDCH, and risk events for internal tracking.

4. If the event involves the death of a consumer:

   a. Immediately, but no later than five (5) business days after the death occurred, order all related documents (medical records, police report, death certificate, autopsy report if performed, etc., as applicable).

   b. Inform the MCCMH Executive Director, Medical Director and the MCCMH Clinical Director / Clinical Strategies & Improvement Division Director of the death of the consumer;

   c. Log the Report of Death within the mortality review database, and generate a mortality report number.

   d. Report to MDCH deaths of Medicaid consumers in the manner and within the time frames indicated (see V.O.1.-3.).

   e. Upon receipt of documentation (medical records, police report, death certificate, autopsy report if performed, etc.):

      1) Enter appropriate fields of information within the mortality review database for that consumer based on the documentation received;

      2) Forward Provider Report of Death with said documents as attachments, to the MCCMH CRMC Chair, the MCCMH Medical Director.

D. Each clinically-responsible 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).

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 at all times 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 is a sentinel event or a risk event, or a non-sentinel death (e.g. death by natural causes), as those terms are defined in this policy. The team may utilize Exhibits E., "Sentinel Event Determination Chart," and F., "Risk Event Determination Chart," to assist in the classification process.

F. 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, "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event" based upon the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) configuration.

2. Initiate reviews of risk events within ten (10) business days of the date that the incidents are classified as risk events, utilizing at a minimum, the classification of causal factors, outlined in V.H.2.a.-f.. Alternately, providers may utilize an approved review process, such as Exhibit A, "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event."

3. Initiate a review 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 V.H.3. (See Exhibit C, "Provider 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 Medical Director) within 90 calendar days of initiation of the review, or within 45 calendar days of receipt of additional documentation or direction from MCCMH.

G. Upon receipt from the MCCMH ORR, the MCCMH Business Management Director (or designee) shall immediately review all incident reports to determine if the events meet the definition of critical incident for purposes of reporting to MDCH (see Exhibit D), and the definition of risk events for purposes of internal tracking, reporting (see Exhibit F).

1. The Business Management Director (or designee) shall report the classification of events as "critical incidents" within the Critical Incident Module of the MCCMH FOCUS EMR system, for the population and within the time frames according to the provisions of this policy. Events identified as critical incidents within the FOCUS EMR system are automatically reported to MDCH upon entry.

2. The Business Management Director (or designee) shall track the classification of events as "risk events" within the Critical Incident Module of the MCCMH FOCUS EMR system, on the population and within the time frames according to the provisions

of this policy. Risk events will be tracked in the MCCMH information system database until functionality is present in the FOCUS EMR system.

3. The Business Management Director (or designee) shall review the Critical Incident Module of the MCCMH FOCUS EMR system on a periodic basis, when additional information is received on events, to ensure proper reporting of critical incidents and tracking of risk events.

H. Upon receipt, the MCCMH Medical Director, as Chair of the CRMC, shall forward documentation and reports to the CRMC members for review, including but not limited to the following:

- Incident Reports and associated documentation (e.g., Death Reports, etc.)
- Police Reports
- Autopsy Reports
- Root Cause Analyses
- Mortality Reviews
- Identified Risk Events Reports
- Corrective Action Plans

I. At the next monthly scheduled CRMC meeting, the members shall review the incident reports and associated documentation regarding critical incidents, sentinel events and risk events, as well as the results and recommendations of the clinically-responsible providers' 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 shall record recommendations for additional actions or interventions utilizing Exhibit H, Review of Provider-Level Root Cause Analysis / Mortality Review / Risk Event Investigation. CRMC shall:

   a. Forward the completed Exhibit H with recommendations for additional action to the clinically-responsible provider, with a copy to the Executive Director, within 10 business days of review of the clinically-responsible provider's root cause analysis, mortality review, or risk event report.

   b. Monitor corrective actions or interventions taken and the results of those actions or interventions. This monitoring may occur through the submission of a provider-generated report to the CRMC and/or an audit conducted by MCCMH.

3. Based upon its review of the documentation, CRMC may request that a provider-level Root Cause Analysis, Mortality Review, or Risk Event Investigation be initiated, where the clinically-responsible provider has failed to take action, or has taken insufficient

action, utilizing Exhibit G, Request for Provider-Level Root Cause Analysis / Mortality Review / Risk Event Investigation.

4. CMRC shall assist in the provider-level Root Cause Analyses and Mortality Reviews when requested by the clinically-responsible provider for inability to meet composition requirements, or because of a conflict of interest.

5. CRMC 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.

6. Quarterly summary reports shall be provided to the Quality Council.

7. The MCCMH Medical Director may call for a CRMC meeting more often than monthly, if circumstances are warranted.

J. MCCMH staff shall:

1. Cooperatively participate in the MDCH annual review of MCCMH's process for the (a) review of critical incidents; (b) investigation (or analysis) of sentinel events; (c) review of risk events; (d) intervention (or corrective action plan) conducted in response to all events; and (e) the rationale for not pursuing an intervention.

2. Provide to MDCH, upon request, evidence of the critical incident /sentinel event / risk event review processes, identify the service providers and administrative staff involved in the processes, and present examples of how the processes were implemented.

3. Monitor the implementation of remedial action plans that will be reviewed by MDCH contract managers during the annual MDCH site visit.

## VII. References / Legal Authority

A. MDCH-MCCMH Medicaid Managed Specialty Supports and Services Contract, FY2013, Part II, 6.1.1 Event Notification; Contract Attachment P6.5.1.1. (Amendment 1, rev. 3/26/12), "PIHP Reporting Requirements for Medicaid Specialty Supports and Services Beneficiaries;" Contract Attachment P6.7.1.1. (FY 12), "QAPIP for Specialty PIHPs"; Technical Guidance on Implementation of Contract Attachment P6.7.1.1. (August 2011); Data Exchange Workgroup – CIO Forum on MDCH/PIHP Event Reporting (May 11, 2011)

B. Application for Participation, January 3, 2002, MDCH Specialty Pre-paid Health Plan, §2.7.1, p 51

C. Commission on Accreditation of Rehabilitation Facilities (CARF) 2013 Standards Manual, §1., H., "Health & Safety," 8., 9.

D. Michigan Mental Health Code

1. MCL 330.1748(9)
2. MCL 330.1100c(5)

E. Michigan Department of Community Health, Administrative Rules R 330.1274; R 330.7046

F. MDCH Medicaid Provider Manual, Mental Health / Substance Abuse

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

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

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

## VIII. Exhibits

A. Provider Root Cause Analysis Report, using *A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event* (based upon the JCAHO configuration)

B. Provider Report of Death

C. Mortality Review Report

D. Critical Incident Reporting Chart

E. Sentinel Event Determination Chart

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

G. MCCMH Clinical Risk Management Committee Request for Provider-Level Root Cause Analysis / Mortality Review / Risk Event Investigation

H. MCCMH Clinical Risk Management Committee Review of Provider-Level RCA / Mortality Review Report / Risk Event Investigation

# ROOT CAUSE ANALYSIS AND ACTION PLAN
## Cover Sheet

Date:

Program:

Consumer Name:

Case #:

Date Root Cause Analysis completed:

Meeting Attendees:

| Name, Credentials | Position |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Send form with completed Root Cause Analysis and Action Plan (Exhibit A to MCCMH MCO Policy 8-003) to:

MCCMH Office of the Medical Director
22550 Hall Road
Clinton Township, MI 48036

## A Framework for a Root Cause Analysis and Action Plan
## In Response to a Sentinel Event

| Level of Analysis | | Questions | Findings | Root Cause? | Ask "Why?" | Take Action? |
|---|---|---|---|---|---|---|
| What happened? | Sentinel event | What are the details of the event? (Brief description) | | | | |
| ↓ | | When did the event occur? (Date, day of week, time) | | | | |
| | | What area/service was impacted? | | | | |
| Why did it happen?<br>----<br>What were the most proximate factors?<br><br>*(Typically "special cause" variations)*<br>↓ | The process or activity in which the event occurred | What are the steps in the process, as designed? (A flow diagram may be helpful here) | | | | |
| | | What steps were involved in (contributed to) the event? | | | | |
| | Human factors | What human factors were relevant to the outcome? | | | | |
| ↓ | Equipment factors | How did the equipment performance affect the outcome? | | | | |
| ↓ | Controllable environmental factors | What factors directly affected the outcome? | | | | |
| ↓ | Uncontrollable external factors | Are they truly beyond the organization's control? | | | | |
| | Other | Are there any other factors that have directly influenced this outcome? | | | | |
| | | What other areas or services are impacted? | | | | |

This template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case, and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for "root causes" and risk reduction.

As an aid to avoiding "loose ends," the three columns on the right are provided to be checked off for later reference:

- "Root cause?" should be answered "yes" or "no" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding that is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a "Why?" question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- "Ask "Why?" should be checked off whenever it is reasonable to ask why the particular finding occurred (or didn't occur when it should have) - in other words, to drill down further. Each item checked in this column should be addressed later in the analysis with a "Why?" question. It is expected that any significant findings that are not identified as root causes will have check marks in this column. Also, items that are identified as root causes will often be checked in this column, since many root causes themselves have "roots."
- "Take action?" should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write the number of the associated Action item on page 3 in the "Take Action?" column for each of the Findings that requires an action.

# Framework for a Root Cause Analysis (continued)

| Level of Analysis | | Questions | Findings | Root Cause? | Ask "Why?" | Take Action? |
|---|---|---|---|---|---|---|
| Why did that happen? What systems and processes underlie those proximate factors?<br><br>*(Common cause variation here may lead to special cause variation in dependent processes).*<br><br>⬇<br><br>⬇<br><br>⬇ | Human resources issues | To what degree are staff properly qualified and currently competent for their responsibilities? | | | | |
| | | How did actual staffing compare with ideal levels? | | | | |
| | | What are the plans for dealing with contingencies that would tend to reduce effective staffing levels? | | | | |
| | | To what degree is staff performance in the operant process(es) addressed? | | | | |
| | | How can orientation & in-service training be improved? | | | | |
| | Information management issues | To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous? | | | | |
| | | To what degree is communication among participants adequate? | | | | |
| | Environmental management issues | To what degree was the physical environment appropriate for the processes being carried out? | | | | |
| | | What systems are in place to identify environmental risks? | | | | |
| | | What emergency and failure-mode responses have been planned and tested? | | | | |
| | Leadership issues: corporate culture | To what degree is the culture conducive to risk identification and reduction? | | | | |
| | Encouragement of communication | What are the barriers to communication of potential risk factors? | | | | |
| | Clear communication of priorities | To what degree is the prevention of adverse outcomes communicated as a high priority? How? | | | | |
| | Uncontrollable factors | What can be done to protect against the effects of these uncontrollable factors? | | | | |

# Framework for an Action Plan in Response to a Sentinel Event

| | Risk Reduction Strategies | Measures of Effectiveness |
|---|---|---|
| For each of the findings identified in the analysis as needing an action, indicate the planned action, expected implementation date, and associated measure of effectiveness, OR...<br><br>If, after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time.<br><br>Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.<br><br>Consider whether pilot testing of a planned improvement should be conducted.<br><br>Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented. | Action Item #1: | Measure: |
| | Action Item #2: | Measure: |
| | Action Item #3: | Measure: |
| | Action Item #4: | Measure: |
| | Action Item #5: | Measure: |
| | Action Item #6: | Measure: |
| | Action Item #7: | Measure: |
| | Action Item #8: | Measure: |
| Cite any books or journal articles that were considered in developing this analysis and action plan: | | |

# MACOMB COUNTY COMMUNITY MENTAL HEALTH
# PROVIDER MORTALITY REVIEW

**(To be completed by clinically responsible provider Mortality Review Team)**

**VENDOR ORGANIZATION NAME:** _____

Vendor #_____

Provider #_____

**PROVIDER NAME:** _____

**Consumer Information**:

Consumer: _____ Clinical Record # _____

**Documents Reviewed:** [List all documents reviewed, i.e.: clinical record, autopsy report]

_____

_____

_____

**Summary of Findings:** _____

_____

_____

**Identified Areas for Improvement:** _____

_____

_____

**Plan of Action / Recommendations:** _____

_____

_____

**Review Team Members:** _____

_____

_____

_____

_____

**Send to:** MCCMH Office of the Medical Director
22550 Hall Road
Clinton Township, MI 48036

# Critical Incidents
# (Reported to MDCH)

| Service (Actively Receiving) or Living Situation | Suicide | Non-Suicide Death | Emergency Medical Treatment (EMT) due to Injury or Medication Error | Hospitalization due to Injury or Medication Error | Arrest of Consumer |
|---|---|---|---|---|---|
| Emergency Service within the last 30 calendar days | X | | | | |
| 24-hour Specialized Residential Setting / Child-Caring Institution / Substance Abuse Residential Treatment Program | X | X | X | X | X |
| Community Living Supports | X | X | | | |
| Supports Coordination / Targeted Case Management | X | X | | | |
| ACT | X | X | | | |
| Home-Based | X | X | | | |
| Wraparound | X | X | | | |
| Habilitation Supports Waiver | X | X | X | X | X |
| SED Waiver | X | X | X | X | X |
| Child Waiver | X | X | X | X | X |
| Any Other Service | X | | | | |
| ***Reporting Time Frame** | • Within 30 days after end of month death determined a suicide, or<br>• Within 30 days after end of month "best judgment" determination made that death was a suicide | • Within 60 days after end of month death occurred, or<br>• Within 30 days after end of month death determined not due to suicide | Within 60 days after end of month in which the EMT began | Within 60 days after end of month in which the hospitalization began | Within 60 days after end of month in which the arrest took place |

***Report the incident if the indicated services have been provided, or if the consumer resides in any of the living situations. Only one checked situation is necessary for the incident to require reporting.**

# Determining a Sentinel Event

| Service (Actively Receiving) or Living Situation | Suicide | Non-Suicide Death | Emergency Medical Treatment (EMT) due to Injury or Medication Error | Hospitalization due to Injury or Medication Error | Arrest of Consumer |
|---|---|---|---|---|---|
| Emergency Service within the last 30 calendar days | X | | | | |
| 24-hour Specialized Residential Setting / Child-Caring Institution / Substance Abuse Residential Treatment Program | X | X | X | X | X |
| Community Living Supports | X | X | | | |
| Supports Coordination / Targeted Case Management | X | X | | | |
| ACT | X | X | | | |
| Home-Based | X | X | | | |
| Wraparound | X | X | | | |
| Habilitation Supports Waiver | X | X | X | X | X |
| SED Waiver | X | X | X | X | X |
| Child Waiver | X | X | X | X | X |
| Any Other Service | X | | | | |
| **The event is a "critical incident" if the indicated services have been provided, or if the consumer resides in any of the living situations. Only one checked situation is necessary for the incident to be a reportable "critical incident."** | | | | | |

**Step 1: Is Event a "Critical Incident?" (See above chart)**
If no, Stop.
If yes, go to Step 2.

**Step 2: Was the incident an unexpected occurrence (not from natural causes)?**
If no, Stop.
If yes, go to Step 3.

**Step 3: Did the incident result in death or serious physical or psychological injury? (Serious injury is major permanent loss of limb or function as determined by a physician or registered nurse; psychological injury is impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology, as determined by a mental health professional.)**
If no, go to Step 4.
If yes, CLASSIFY AS SENTINEL EVENT

**Step 4: Was there risk of loss? (If the event had continued, loss, i.e., death or serious physical or psychological injury, would have occurred as determined by a physician or registered nurse.)**
If no, Stop.
If yes, CLASSIFY AS SENTINEL EVENT AND PERFORM ROOT CAUSE ANALYSIS

# Determining a Risk Event

| Service | Physical Harm to self (requiring EMT or hospitalization) | Physical Harm to others (requiring EMT or hospitalization) | Police Calls (by staff) | Emergency Use of Physical Management | Unscheduled Hospitalizations (2 in a 12-month period) |
|---|---|---|---|---|---|
| Targeted case management/ supports coordination | X | X | X | X | X |
| Home-Based | X | X | X | X | X |
| ACT services | X | X | X | X | X |

**The event is a "risk event" if the indicated services have been provided. Only one checked situation is necessary for the incident to be a "risk event" that requires a root cause analysis be performed.**

Clinically Responsible Providers shall provide a written review each Risk Event, addressing, at a minimum, the following:

a. Personal Identifying Information – name, Medicaid ID, disability designation, residential living arrangement type, name of TCM/SC/HB/ACT provider agency, note if consumer self-directs services with name of provider. If event occurred at home, collect name of CLS or personal care, including Home Help. If occurred in a licensed AFC facility, include license number, licensee name and name of home.

b. Method/Procedure – adequacy of clinical assessment, completeness of plan(s), implementation of plans/procedures, consistency of plan(s) with technical requirements and/or best practices.

c. Communication – awareness of consumer's plan; awareness of organizational policies/protocols; contradictory, confusing or missing information /instructions.

d. Staff-Related – staffing levels, staff skill set or competency in applying the methods or procedures, staff training.

e. Environment – noise levels, physical proximity, amount of space for consumer or staff, lighting, physical hazards or condition of the environment.

f. Equipment/Materials – necessary equipment or materials not in proper condition, improperly used, in disrepair, missing.

Please forward written review, with corrective action plan, to:

MCCMH Office of the Medical Director
22550 Hall Road
Clinton Township, MI 48036

DATE: _____

TO: _____

FROM: Norma Josef, M.D.
MCCMH Medical Director, Chair of MCCMH CRMC

RE: Consumer No.:

☐ The Clinical Risk Management Committee (CRMC) has reviewed the incident report dated: _____ concerning the above referenced consumer who received services from your program at the time the incident occurred. Because of the circumstances surrounding this incident, it has been determined to be a:

☐ Sentinel Event ☐ Non-Sentinel Event ☐ Risk Event

Therefore, you are being directed to complete a:

☐ Root Cause Analysis ☐ Mortality Review ☐ Risk Event Investigation

Into the circumstances of this incident in accordance with MCCMH MCO Policy 8-003.

Please submit your completed report to the MCCMH Office of the Medical Director within 90 calendar days of receipt of this notification. If you have questions, you may call the MCCMH Clinical Director / Clinical Strategies & Improvement Division Director, at (586) 469-7039.

**OR:**

☐ The Clinical Risk Management Committee (CRMC) has reviewed the incident report dated: _____ concerning the above referenced consumer who received services from your program at the time the incident occurred. CRMC has determined that no further action is needed to be taken at this time.

## MCCMH Clinical Risk Management Committee
## Review of Action Plan Based on Root Cause Analysis / Mortality Review Report / Risk Event Investigation

**Program Name:** **Consumer:** **Case #:**

| Risk Reduction Strategies | Measures of Effectiveness | Reporting Period<br>☐ 1st Qtr ☐ 2nd Qtr ☐ 3rd Qtr ☐ 4th Qtr |
|---|---|---|
| Action Item #1: | Measure: | Actions Taken: |
| Action Item #2: | Measure: | Actions Taken: |
| Action Item #3: | Measure: | Actions Taken: |
| Action Item #4: | Measure: | Actions Taken: |
| Action Item #5: | Measure: | Actions Taken: |
| Action Item #6: | Measure: | Actions Taken: |
| Action Item #7: | Measure: | Actions Taken: |

*Signature:* _____ *Date:* _____

Exhibit H, CRMC Review of Provider-Level RCA, Mortality Review or Risk Event Investigation, MCCMH MCO Policy 8-003, 'REPORTING AND RESPONDING TO CRITICAL INCIDENTS, SENTINEL EVENTS AND RISK EVENTS" (Rev. 6/12)