MCCMH MCO Policy 9-515

Chapter: **RECIPIENT RIGHTS**
Title: **REPEATED RIGHTS EVENTS REVIEW COMMITTEE**

Prior Approval Date: N/A
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Approved by: BOARD ACTION

Executive Director — Date 04/27/11

I. Abstract

This policy establishes the standards and procedures for the implementation and operation of a Repeated Rights Events Review Committee process for all network providers of Macomb County Community Mental Health (MCCMH) in order to improve care, treatment and services to consumers of the MCCMH Board through the identification and resolution of underlying systemic causes of repeated rights events thereby preventing their recurrence, and reducing the number of rights complaints and substantiated rights violations.

II. Application

This policy shall apply to all directly-operated and contract network providers of the MCCMH Board.

III. Policy

It is the policy of the MCCMH Board that a Repeated Rights Events Review Committee (RRERC) be established and maintained:

A. To improve consumer care, treatment and services through the prevention of repeated rights events;

B. To focus the attention of network providers of the MCCMH Board that have experienced repeated rights events on identifying and resolving underlying causes of such events, and on changing its systems and processes to reduce the probability of such events in the future;

C. To increase general knowledge about repeated rights events, their causes, and strategies for prevention;

D. To maintain and protect the confidence of the public and the integrity of the public mental health recipient rights protection system.

IV. Definitions

A. Clinically-Responsible Provider
For the purposes of this policy, a service provider with direct responsibility for the management of the care of a consumer in MCCMH services at the time of the event which was found to be a substantiated recipient rights event.

B. Rights Event
An incident which, following investigation by the MCCMH Office of Recipient Rights, is found to be a substantiated recipient rights violation; a rights event which involves multiple consumers is to be deemed a single rights event.

C. Repeated Rights Events
Repeated rights events may include:

1. A consumer who has been subject to two substantiated recipient rights violations within the past 12 months, or

2. Identified staff of the Clinically-Responsible Provider who has had two substantiated recipient rights violations within the past 12 months, or

3. A Clinically-Responsible Provider that has had two substantiated recipient rights violations that have occurred in the same location involving identical sections of the Mental Health Code and/or corresponding Administrative Rules within the past 12 months; or

4. Where the MCCMH ORR has identified a trend or pattern in substantiated rights violations.

D. Root Cause Analysis
For purposes of this policy, a process for identifying the basic or causal factors that underlie variation in performance regarding the occurrence of a repeated rights event. A root cause analysis focuses primarily on systems and processes, not on individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and systems and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis that no such improvement opportunities exist. (See Root Cause Analysis and Action Plan, Exhibit A.)

V. Standards

A. There shall be a MCCMH Repeated Rights Events Review Committee (RRERC) whose function shall be to:

1. Request Clinically-Responsible Providers to conduct Root Cause Analyses upon notification by the MCCMH Office of Recipient Rights (ORR) of repeated rights events;

2. Use discretion in whether to request a Root Cause Analysis of Clinically-Responsible Providers when the ORR has notified the RRERC of identified trends or patterns in substantiated rights violations;

3. Review the outcomes of the completed Root Cause Analyses as submitted by Clinically-Responsible Providers;

4. Monitor the development and implementation of a corrective action plan or intervention to prevent further occurrence of the event(s); and

5. Make recommendations and referrals to other MCCMH departmental staff or to the Clinically-Responsible Provider, as appropriate, for further action to be taken where necessary.

B. The RRERC shall be comprised of representatives from MCCMH Clinical Strategy / Improvement (QI), Business Management (Corporate Compliance), Directly-Operated Clinical Management, and Office of Recipient Rights. Additional individuals with expertise in areas cited as potential process/systems improvement may also be included as needed.

C. The Chair of the RRERC shall be appointed by the Committee for a term of two (2) years and may be appointed to consecutive terms.

D. Documentation generated during review of repeated rights events are <u>confidential</u> 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 shall be stamped “CONFIDENTIAL” and kept in a MCCMH administrative file. RRERC review materials and incident reports are quality assurance documents, and do not constitute summary reports. No copy of such documents shall be maintained in the clinical records of consumers.

VI. Procedures

A. Within five (5) business days of completion of investigation and a determination of repeated rights events, or a determination that identified trends or patterns in substantiated rights violations warrant further inquiry, the Office of Recipient Rights (ORR) shall notify the RRERC and the RRERC shall request that a Root Cause Analysis be conducted by the Clinically-Responsible Provider. The determination of a repeated rights event is based on the date of substantiation of the first rights violation.

B. The Clinically-Responsible Provider shall conduct a Root Cause Analysis (Exhibit A) within twenty (20) business days of receipt of request. The Clinically-Responsible Provider shall not re-investigate the rights complaint or attempt to change the findings / conclusions of the ORR.

C. The Root Cause Analysis conducted by the Clinically-Responsible Provider shall be credible and must contain the following characteristics:

1. Focus primarily on systems and processes, not on individual performance;

2. Progress from special causes in clinical processes to common causes in organizational processes;

3. Include an analysis of the underlying systems and processes through a series of "Why?" questions to determine where redesign might reduce risk;

4. Inquire into all areas appropriate to the specific type of rights event;

5. Identify risk factors and potential contributions to the specific type of rights event;

6. Determine whether there are potential improvement in processes or systems that would tend to decrease the likelihood of such rights events in the future, or determine, after analysis, that it has concluded that no such improvement opportunities exist;

7. Include participation by the leadership of the organization and by individuals most closely involved in the processes and systems under review;

8. Be internally consistent (that is, does not contradict itself or leave obvious questions unanswered);

9. Provide an explanation for all findings of "not applicable" or "no problem;"

10. Include consideration of any relevant literature it has reviewed.

D. Within ten (10) business days of completion of the root cause analysis, the Clinically-Responsible Provider shall submit in writing the results of the Root Cause Analysis to the Chairperson of the RRERC. The written notice shall include:

1. A description of common causes in the Clinically-Responsible Provider's processes and systems;

2. Potential improvements in processes or systems, if any, that would tend to decrease the likelihood of such rights events in the future;

3. Strategies that the Clinically-Responsible Provider intends to implement in order to reduce the risk of similar rights events occurring in the future;

4. Individual(s) responsible for implementation;

5. Individual(s) responsible for oversight;

6. Time lines;

7. Pilot testing, as applicable; and

8. Strategies for measuring and evaluation the effectiveness of the actions.

E. The Chairperson of the RRERC shall schedule a meeting with the RRERC members within but not later than fifteen (15) business days following receipt of the Root Cause Analysis. At the meeting, the RRERC shall:

1. Review the results and recommendations of the Clinically-Responsible Provider's Root Cause Analysis;

2. Recommend acceptance of the corrective action plan, or identify additional actions or interventions to be taken to prevent further occurrence of the rights event(s);

3. Within ten (10) business days of review of the Root Cause Analysis, forward recommendations for identified additional action to the Clinically- Responsible Provider, with a copy to the Executive Director.

F. The Clinically-Responsible Provider shall incorporate recommendations for additional action into the corrective action plan, if any, and shall provide a copy of the final improvement plan to the members of the RRERC within ten (10) business days of receipt of recommendations for additional action.

G. The Clinically-Responsible Provider shall submit documentation indicating that the implementation of the process/system improvement plan has been completed to the MCCMH Executive Director, Chair of the RRERC, and the Director of the MCCMH ORR.

H. The RRERC shall monitor corrective actions or interventions taken by the Clinically-Responsible Provider and the results of those actions. This monitoring may occur through the submission of periodic Provider-generated reports and/or audits conducted by MCCMH.

VII. References / Legal Authority

A. Michigan Mental Health Code, MCL 330.1137

B. Michigan Mental Health Code, MCL 330.1145(a)

C. Michigan Mental Health Code, MCL 330.1752(1)

D. Michigan Mental Health Code, MCL 330.1780(1)

E. Michigan Mental Health Code, Chapters 7 and 7A, MCL 330.1700, et. seq.; MCL 330.1772, et. seq.

F. MDCH Administrative Rules, Part 7, R 330.7001, et. seq.

G. MDCH/MCCMH Medicaid Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program Contract and Amendments FY 2011; MDCH/MCCMH Managed Mental Health Supports and Services Contract and Amendments FY 2011

H. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Sentinel Event Policy and Procedures, July 29, 2008

I. MCCMH MCO Policy 8-003, "Sentinel Events, Root Cause Analysis, and Mortality Review"

VIII. Exhibits

A. Root Cause Analysis and Action Plan

ROOT CAUSE ANALYSIS AND ACTION PLAN
Cover Sheet

Date:

Program:

Consumer/Staff:

Case #:

Date Root Cause Analysis completed:

Meeting Attendees:

Name, Credentials	Position

Send form with completed Root Cause Analysis and Action Plan

Repeated Rights Event Review Committee
22550 Hall Road
Clinton Township, MI 48036

ATTN: Mark Mishal, Chairperson

A Framework for a Root Cause Analysis and Action Plan
In Response to a Repeated Rights Event

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action?
What happened?	Repeated Rights 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? ---- What were the most proximate factors? *(Typically "special cause" variations)* ↓	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? *(Common cause variation here may lead to special cause variation in dependent processes).* ⬇ ⬇ ⬇	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 Repeated Rights 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... 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. Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action. Consider whether pilot testing of a planned improvement should be conducted. 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:		