POLICY AND PROCEDURE MANUAL

SUBJECT: Critical Incident, Risk Event, Sentinel Event, and Death Reporting	ACCOUNTABILITY: NMRE, NMRE Network providers.	Effective Date: March 27, 2019	Pages: 6
REQUIRED BY	BBA Section: NMRE Specialty Services Contract with the state of Michigan, "Behavior Treatment Plan Review Committee" Other: (listed under "References")	Last Review Date: 03/13/2023	Past Review Date: June 3, 2020
Policy: ☒ Procedure: ☐	Review Cycle: Annual Author: Compliance Director	Responsible Department: Compliance & Quality	Reviewers: NMRE Operations Committee

Definitions

Action Plan: The product of a root cause analysis is an "action plan" that identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future.

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or his/her representative.

Critical Event: Any event that actually or allegedly creates a significant risk of substantial or serious harm to the physical or mental health, safety, or wellbeing of a beneficiary.

Critical Incident: An MDHHS reportable event which must be reviewed by the Network Provider to determine whether it meets the criteria for a sentinel event.

(1) Suicide: The death of a beneficiary when either of the following two conditions exist:

(a) The Network Provider determines, through its death review process, that the death was a suicide; or

(b) The official death report indicates that the death was a suicide.

(2) Non-suicide Death: Any death of a beneficiary that was not otherwise reported as a suicide. Within this category are expected and unexpected deaths.

(3) Emergency Medical Treatment Due to Injury or Medication Error: An injury to a beneficiary or a medication error that results in face-to-face emergency treatment by medical staff in any treatment facility including personal physicians, medical centers, urgent care clinics, and/or emergency rooms.

   (a) Injury: Bodily damage to a beneficiary due to a specific event such as an accident, assault, or misuse of the body that necessitates treatment by medical staff at any treatment facility including personal physicians, medical centers, urgent care clinics, and/or emergency rooms, or an admission to a general medical facility.

   (b) Medication Error: A mistake made in giving a beneficiary prescribed medication (wrong medication, wrong dosage, or missed dose). Refusal of medication by a beneficiary is **not** considered a medication error.

(4) Hospitalization Due to Injury or Medication Error: Using the definitions provided in (3)(a) and (b), instances when the injury or medication error resulted in the admission of a beneficiary to a general medical facility. Hospitalization due to the natural course of a chronic illness or underlying condition does **not** fall within this definition.

(5) Arrest: A situation in which a beneficiary is taken by law enforcement based on the belief that a crime may have been committed. Situations in which a beneficiary is transported by law enforcement to receive emergency treatment, or situations in which a beneficiary is held in protective custody, are **not** considered an arrest.

Sentinel Event: A critical incident that is an "unexpected occurrence" involving death or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). A sentinel event does not include a death attributed to natural causes. Investigation of a sentinel event must be conducted by a staff with the appropriate credentials to review the event; for example, a sentinel event involving a death or serious medical condition must involve a physician or nurse.

To be a sentinel event, the incident must have occurred to a beneficiary in a reportable population and determined, through investigation, to be a sentinel event. Except for arrests/conviction and serious challenging behavior, each incident should be reviewed to determine if it meets sentinel event criteria.

(1) Unexpected Death: The death of a beneficiary that is not the result of natural causes. An unexpected death includes any death that results from suicide, homicide, an undiagnosed condition, accident, or where it appears suspicious for possible abuse and/or neglect.

(2) Serious Physical Injury: Serious damage suffered by a beneficiary that a physician or nurse determines caused, or could have caused, the death of the beneficiary, the impairment of his/her bodily functions, loss of limb, or permanent disfigurement. An injury caused by actual or suspected abuse or accident must be treated at a medical facility. The treating medical facility must be noted on the incident report.

(3) Emotional Harm: Impaired psychological functioning, growth, or development that is significant in nature as evidenced by observable physical symptomatology, as determined by a mental health professional or psychiatrist.

(4) Death by Natural Causes: The death of a beneficiary that occurred as the result of a disease process from which death is an anticipated outcome. A death by natural causes is **not** a sentinel event.

(5) Physical Illness Requiring Hospital Admission: The unexpected hospitalization of a beneficiary for a previously unknown or undiagnosed illness. A planned surgery, whether outpatient or inpatient, is **not** considered and unexpected occurrence and, therefore, not included in reporting under this definition. A hospital admission for an illness directly related to a beneficiary's chronic or underlying illness is also **not** reported as sentinel event.

(6) Serious Challenging Behavior: A behavior that results in significant (over $100) property damage, an attempt at self-inflicted harm or harm to others, or an unauthorized leave of absence. A serious challenging behavior includes behaviors not previously addressed in a Behavior Treatment Plan.

(7) Medication Error: The delivery of medication to a beneficiary that is the wrong medication, wrong dosage, or double dosage, or failure to deliver medication that resulted in death or serious injury or the risk thereof. An instance where a beneficiary refused medication is **not** a medication error.

(8) Arrest/Conviction: Any arrest or conviction of a beneficiary who is in a reportable population at the time of the arrest or conviction. An arrest or conviction must be reported as a sentinel event (through the MDHHS Michigan Crisis and Access Line (MiCAL) but does not require a root cause analysis.

Substance Use Disorder (SUD) Sentinel Event Reporting: Required semi-annual reporting to MDHHS of specific sentinel events that occurred to beneficiaries who were living in a 24-hour specialized residential substance abuse treatment settings at the time of the event. The specific categories are:

(1) Death

(2) Accident that requires an emergency room visit and/or hospital admission

(3) Physical illness that required a hospital admission

(4) Arrest or conviction

(5) Serious Challenging Behavior

(6) Medication error

Risk Event: An event that puts a beneficiary who is in a reportable population at risk of harm. A risk event is reported for internal analysis to determine what actions are needed to remediate the problem or situation and to prevent reoccurrence.

(1) Harm to Self: An action taken by a beneficiary that causes them physical harm that requires emergency medical treatment or hospitalization (e.g., pica, head banging, self-mutilation, biting,

suicide attempt).

(2) Harm to Others: An action taken by a beneficiary that cause physical harm to an individual(s) (family, friend, staff, peer, public, etc.) that requires emergency medical treatment or hospitalization of the injured person(s).

(3) Police Call: A call to police by a staff of a specialized residential setting, or general (AFC) residential home, or other provider agency requesting assistance with a beneficiary during a behavioral crisis, regardless of whether contacting law enforcement is addressed in a Behavior Treatment Plan.

(4) Emergency Use of Physical Management: The of physical management by a trained staff in response to a behavioral crisis.

(5) Physical Management: A technique used as an emergency intervention to restrict the movement of a beneficiary by continued direct physical contact despite their resistance, to prevent them from physically harming themselves or someone else. "Physical management" does not include briefly holding a beneficiary to comfort them or demonstrate affection or holding their hand.

(6) Unscheduled Hospitalizations: Two or more unscheduled admissions of a beneficiary to a medical hospital within a 12-month period not due to planned surgery or the natural course of a chronic illness. The use of an emergency room or emergency department is **not** considered a hospital admission.

Critical Risk Review: The review of an unexpected death of a beneficiary who at the time of death was receiving specialty supports and services. The review must include:

(1) Confirmation of beneficiary's death (e.g., coroner's reports and/or death certificate)

(2) Involvement of medical personnel in the mortality review

(3) Documentation of the mortality review process, findings, and recommendations

(4) Use of mortality information to review quality of care

(5) Aggregate mortality data to identify possible trends over time

The review must be a "formal process" and include areas of clinical risk. The review team must include individuals with appropriate credentials to review the scope of care, individuals who were not involved in the treatment of the beneficiary, and any additional individuals who may contribute to a thorough review process.

Root-Cause Analysis (RCA): 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 should result in an action plan designed to reduce or attempt to reduce future incidents. Within three (3) days of a critical incident, network provider staff must determine whether it meets the sentinel event standard; if it does meet that standard network provider staff must initiate a root cause analysis within two (2) days of the determination. A request for additional information, such as a coroner's report or death certificate, constitutes the start of a root cause analysis.

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

Treatment Setting Definitions:

(1) Child-Caring Institution: A facility that provides residential care for children that is licensed under MCL 722.111, *et seq*.

(2) Substance Abuse Residential Treatment Program: A 24-hour residential setting that provides planned individual and group therapeutic and rehabilitative counseling and didactic services to treat a substance use disorder.

MDHHS Michigan Crisis and Access Line (MiCAL)**:** A file-based system for timely and regular submission by the NMRE on specific beneficiary information:

(1) Suicide

(2) Non-suicide death

(3) Emergency medical treatment due to injury or medication error

(4) Hospitalization due to injury or medication error

(5) Arrest of person receivingservices

Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services pursuant to the NMRE's Specialty Supports and Services Contract with the State, including its five member CMHSPs and the Substance Use Disorder Provider Panel.

Personnel: Anyone working for the Northern Michigan Regional Entity (NMRE) and whose salary is paid by the NMRE and members of the NMRE Board of Directors and NMRE Substance Use Disorder Oversight Policy Board.

Risk Event Management: A process for analyzing events that puts beneficiaries at risk of harm. The analysis should be used to determine what action is needed to remediate the problem or situation and prevent reoccurrence.

Unexpected Occurrence: A behavior or event not covered within a beneficiary's treatment plan, and is not a planned procedure (surgery, etc.) or the natural result of the beneficiary's chronic or underlying condition or aging process.

Purpose

The purpose of this policy is to ensure that the NMRE complies with its Specialty Supports and Services Contract with the State, the Critical Incident Reporting System, and to provide clear guidance for the reporting and reviewing of critical incidents, sentinel events, risk events, and/or deaths of beneficiaries.

Policy

The NMRE and its network providers will have established policies to ensure compliance with regulations regarding reporting critical incidents, sentinel events, risk events, and deaths of beneficiaries. The NMRE will monitor its network providers for compliance annually, or as needed. All incidents not related to beneficiaries (i.e., staff, volunteers, interns, and visitors) will be reported per appropriate NMRE or network provider policy.

It is the policy of the NMRE that its network providers will have and implemented a process to:

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

B. Review, investigate, analyze, act upon, and report critical incidents, risk events and sentinel events to the NMRE in an accurate and timely manner.

C. Identify system factors associated with critical corrective action plans to prevent recurrence of critical incidents, sentinel events, and risk events.

D. Develop and implement effective corrective action plans to prevent recurrence of critical incidents, sentinel events, and risk events. The NMRE will review, analyze, act upon when necessary, and report critical incidents and sentinel events to MDHHS in an accurate timely manner.

References

1) NMRE Quality Assessment and Performance Improvement Program (QAPIP) workplan.
2) NMRE Managed Specialty Supports and Services Contract with the state.
3) MDHHS-PIHP Contract; Schedule E Contractor Reporting Requirements.
4) MDHHS-PIHP Contract; K.2. Quality Assessment and Performance Improvement Programs Standards.
5) MDHHS Critical Incidents Reporting and Events Notification Requirements.
6) Michigan Mental Health Code MCL 330.1748(9); MCL 330.1100c(5) MDHHS Administrative Rules R 330.1274; R 330.7046
7) *Methodology and instructions for reporting are posted on the MDHHS website at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html*

APPROVAL SIGNATURE

Eric Kurtz, CEO

3/22/23

Date

SUBJECT: Critical Incident, Risk Event, Sentinel Event, and Death Reporting	ACCOUNTABILITY: NMRE and NMRE Network providers.	Effective Date: March 27, 2019	Pages: 7
REQUIRED BY	BBA Section: NMRE Specialty Services Contract with the state of Michigan, "Behavior Treatment Plan Review Committee" Other: (listed under "References")	Last Review Date: 03/13/2023	Past Review Date: June 3, 2020
Policy ☐ Procedure ☒	Review Cycle: Annual Author: Compliance Director	Responsible Department: Compliance & Quality	Reviewers: NMRE Operations Committee

Procedure

A. The NMRE requires that all network providers report critical incidents to the NMRE monthly, as defined by NMRE policy and Michigan Department of Health and Human Services (MDHHS).

B. NMRE and its network providers will collect and require internal reporting on all critical incidents (including sentinel events) and risk events according to MDHHS standards.

C. The NMRE requires that its Network providers review, investigate, and act upon the sentinel events, critical incidents, and risk events of beneficiaries.

D. The NMRE will submit a summary report to MDHHS for each critical incident in accordance with its Specialty Supports and Services Contract with the State.

1. Suicide

    a. A death that is determined to be a suicide will be reported for any beneficiary who was actively receiving services and any beneficiary or who had an emergency service within the 30 days preceding their death.

    b. The suicide will be reported within 30 days after the end of the month in which the cause of death was determined to be suicide. If 90 calendar days elapse without a cause of death determination, the responsible network provider will submit a "best judgment" determination regarding whether the death was a suicide. In this case, reporting is due within 30 days after the end of the month in which the "best judgment" determination was made.

2. Non-Suicide Death

    a. A death that has not otherwise been reported as a suicide will be reported for any beneficiary who, at the time of their death was:

        i. Living in a 24-hour Specialized Residential setting, or a Child-Caring institution, or living in a substance abuse residential treatment program; or

ii. Actively receiving Community Living Supports, Supports Coordination, Targeted Case Management, Assertive Community Treatment (ACT), Home-based, Wraparound, Habilitation Supports Waiver (HSW), SED Waiver, or Child Waiver services.

b. A non-suicide death will be reported within 60 days after the end of the month in which the death occurred unless reporting is delayed while the responsible network provider attempts to determine whether the death was a suicide. In this case, the submission is due within 30 days after the end of the month in which the responsible network provider determined the death was not a suicide. A death due to natural causes will be reported indicating the specific natural cause.

3. Emergency Medical Treatment Due to Injury or Medication Error

a. A situation involving an injury to a beneficiary or a medication error that resulted in face-to-face emergency treatment will be reported on any beneficiary who, at the time of the event, was:

i. Living in a 24-hour Specialized Residential setting, or a Child-Caring Institution, or living in a substance abuse residential treatment program; or

ii. Actively receiving Habilitation Supports Waiver (HSW), SED Waiver, or Child Waiver services.

b. The incident will 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. A Situation involving an injury to a beneficiary or a medication error that resulted in an inpatient admission will be reported on any beneficiary who, at the time of the event, was:

i. Living in a 24-hour Specialized Residential setting, or a Child-Caring Institution, or living in a substance abuse residential treatment program; or

ii. Actively receiving Habilitation Supports Waiver (HSW), SED Waiver, or Child Waiver services.

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

5. Arrest

a. An arrest will be reported on any beneficiary who, at the time of the arrest, was:

i. Living in a 24-hoour Specialized Residential Setting, or a Child-Caring Institution, or living in a substance abuse residential treatment program; or

ii. Actively receiving Habilitation Supports Waiver (HSW), SED Waiver, or Child Waiver services.

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

E. The responsible network provider will internally track risk events occurring within the populations specified as expeditiously as possible, and in accordance with NMRE policy and MDHHS requirements.

The population group for risk event reporting will include any beneficiary who, at the time of the risk event, was actively receiving services including at least one of the following:

1. Supports Coordination
2. Targeted Case Management
3. Assertive Community Treatment (ACT), and
4. Home-based Service

F. The NMRE will ensure that each network provider has a mechanism in place for the following:

1. Classifying and identifying incidents as either sentinel events, critical incidents, or risk events;
2. Performing root cause analyses on sentinel events;
3. Performing a review of risk events; and
4. Performing mortality reviews of deaths that are not sentinel events (deaths from natural causes).

All critical incidents will be either sentinel events or risk events, and as such will be reviewed/analyzed appropriately.

G. The NMRE will ensure network providers have staff able to classify, review, and analyze events. Staff must not have been directly involved in the incident that is the subject of the review and must have the appropriate credentials to review the scope of care. For example, an event that involved a death or serious medical condition will be reviewed by a physician or nurse.

H. The NMRE and its network providers will, within three (3) business days after an incident occurs, classify it as a sentinel event, risk event, critical event, or non-sentinel death.

I. The NMRE will ensure network providers use established guidelines to determine whether an occurrence is a critical incident, risk event, and/or sentinel event. Once the determination is made, the network provider will ensure that risk events and sentinel events are reviewed and analyzed, and sentinel events receive root cause analyses.

J. Guidelines for determining whether a critical incident is a sentinel event will include the following:

1. The qualifying event involves a beneficiary who was actively receiving services that meet the population criteria 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 event continued, death or serious physical or psychological injury would have occurred.

4. If the incident is a death, the following will be considered "unexpected" for the purpose of defining whether the death is a sentinel event:

    a. Beneficiary death that resulted in a Recipient Rights investigation (e.g., possible abuse and/or neglect)

    b. Beneficiary death that resulted in a police investigation (e.g., possible or actual suicide or homicide)

    c. Beneficiary death during elopement or wandering from a 24-hour care setting

    d. Beneficiary death that was accidental

    e. Beneficiary death that resulted from an undiagnosed medical condition.

K. The NMRE will ensure that network providers:

1. Initiate a Root Cause Analysis within five (5) days of any perceived sentinel event: three (3) days to determine that a sentinel event has occurred, and two (2) days to initiate the RCA, utilizing an approved review process.

2. Initiate a review of any risk event within ten (10) business days from the date the incident was classified as a risk event, utilizing at a minimum, the classification of causal factors listed.

    a. Personal identifying information

    b. Any methods/procedures used

    c. Any communication/interviews with staff, witnesses to the incident, or other relevant persons

    d. Staff involved in the incident and the review of the incident

    e. The environment/place of the incident

    f. Any equipment/materials involved

3. Initiate a mortality review of any non-sentinel death within ten (10) business days from the date the death was classified as a non-sentinel event. The review must include standard death information such as coroner's report, death certification (as available), involvement of medical personnel in the review, documentation of the review process and findings and, as applicable, recommendations for improvement and/or a corrective action plan (CAP).

L. A Sentinel event involving a beneficiary who was living in 24-hour specialized residential substance abuse treatment settings at the time of the event will be reported to MDHHS semi-annually on the following schedule:

Six-Month Reporting Period	Due Date for Data Submission
October 1 – March 31	April 30th
April 1 – September 30	October 31st

M. When an incident under review is the subject of an active Recipient Rights investigation, clinically-responsible network provider staff will ensure they do not impede, interfere, or otherwise compromise the Recipient Rights investigation (e.g., clinically responsible network provider staff may not investigate the details of the event but may address systemic issues, etc.).

N. For beneficiary deaths, if, upon receipt of additional documentation, it is determined that an event originally classified as meeting the criteria for a sentinel event, is no longer perceived to be a sentinel event (e.g., autopsy report indicated the death was due to natural causes), the review team will perform a mortality review of the death.

O. For beneficiary deaths, if, upon receipt of additional documentation, it is determined that an event originally classified as not meeting the criteria for a sentinel event, is perceived to be a sentinel event (e.g., autopsy report indicated death is not due to natural causes), appropriate network provider staff will begin a root cause analysis of the death.

P. Death Reporting:

1. The NMRE and/or the network provider will immediately report to MDHHS:
    a. Any death of a beneficiary who was discharged from a State Facility within 12 months preceding the date of death
    b. Any death that occurs as the result of suspected NMRE or network provider staff action or inaction, or
    c. Any death that is the subject of a Recipient Rights, licensing, or police investigation.
2. The report will be submitted electronically within 24 hours of either the death or the responsible network provider staff's receipt of the death notification, or the responsible Network Provider staff's receipt of notification that a Recipient Rights, licensing, and/or police investigation has commenced to the NMRE Compliance Director. The report will include:
    a. Name of beneficiary
    b. Beneficiary ID Number (Medicaid or Healthy Michigan Plan)
    c. Consumer ID (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 email address
3. For beneficiary deaths, the network provider will submit a written report of its review/analysis of the death to the NMRE within 45 days from the month in which the death occurred. The NMRE will notify MDHHS within 60 days after the month in which the death

occurred.

Q. Clinically responsible network provider staff will cooperate with and respond to requests from the NMRE to perform a root cause analysis, mortality review, or risk event investigation, and to follow the NMRE's recommendations. Following completion of a root cause analysis, the NMRE will develop and implement either a) a plan of action or intervention to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will be responsible for its implementation, when it will be implemented, and how it will be monitored or evaluated.

R. The NMRE will require each network provider to analyze, at least quarterly, critical incidents, sentinel events, non-sentinel deaths, and risk events to determine what actions are needed to remediate problems or situations to prevent reoccurrence.

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

   1. For all risk events **except** unscheduled hospitalizations, reports will include an analysis of the total number of incidents per calendar month, and the rate of incidents per 100 beneficiaries in the identified population, with cumulative year-to-date from the beginning of the current fiscal year.

   2. For risk events that are unscheduled hospitalizations, the report will include:

      a. An aggregate total number of hospitalizations by reason/condition per calendar month, and the rate of total hospitalizations per 100 beneficiaries in the identified population, with cumulative year-to-date from the beginning of the current fiscal year; and

      b. An analysis of the data to monitor trends and identify any beneficiary who has multiple hospital admissions.

T. The NMRE will ensure that each network provider demonstrates appropriate remediation at the staff and system level, when applicable, and will maintain adequate records to document evidence of remedial efforts.

U. At the request of MDHHS or the NMRE, network providers will cooperate with reviews initiated by MDHHS or the NMRE by providing information/documentation related to the network provider's process for the review, investigation, and monitoring of critical incidents, sentinel events, and risk events.

V. Documentation generated during peer reviews of sentinel events or beneficiary deaths are considered confidential peer review/quality assurance documents. All written reports, findings, and recommendations for remedial actions created during the root cause analysis or mortality review, therefore, will be kept in a confidential peer review administrative file. No copies of such documents will be maintained in the beneficiaries' clinical records. Peer review/quality assurance documents will include, but are not limited to:

   1. The network provider's report of death

2. The network provider's root cause analysis report
3. The network provider's mortality review report
4. The network provider's risk event reviews
5. Minutes of meetings where critical incidents, sentinel events, and/or risk events were discussed or reviewed
6. The network provider's recipient rights reports
7. The network provider's incident reports
8. The network provider's peer review reports
9. Corrective action plans (CAP)

W. Education and Monitoring

1. NMRE network providers will have access to the NMRE Critical Incident and Sentinel Event Reporting Policy and Procedure through the nmre.org public website. The NMRE will monitor that the policy and procedure is being followed by its network providers during its annual site reviews.
2. Monitoring will include ensuring that network providers are conducting root cause analyses when needed, and that action has been taken as identified in the RCA summary.
3. Technical assistance for event reporting and conducting root cause analyses will be available to all providers that request support from the NMRE.
4. The NMRE Compliance Director will ensure that required information/reports are presented to the NMRE Quality Oversight Committee (QOC) for review at least quarterly to:
    a. Assess the consistency in reporting across NMRE the region.
    b. Assist in the analysis of all aggregate reports on critical incidents, sentinel events, physical management usage, and deaths to identify trends and areas that need follow-up and/or additional strategies for improvement.
    c. Advocate for and/or facilitate improvements beyond those already made.

APPROVAL SIGNATURE

Eric Kurtz, CEO

3/22/23
Date