

**NORTHERN MICHIGAN REGIONAL ENTITY  
ADMINISTRATIVE MANUAL**

**PROCEDURE NAME:** CRITICAL INCIDENTS AND SENTINEL EVENTS REPORTING PROCEDURE  
**CHAPTER:** FOUR – QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT  
**PROCEDURE #:** 04-02-002  
**EFFECTIVE DATE:** May 27, 2014

**PURPOSE**

To provide clear guidance for the reporting and review of all deaths and critical incidents and/or risk events of persons served. All incidents not related to persons served (i.e., staff, volunteers, interns and visitors) must be reported as per appropriate agency policy and/or procedure.

**APPLICATION**

This policy applies to the five Member Community Mental Health Services Programs (CMHSPs), and the NMRE Substance Use Disorder Services provider panel.

**PROCEDURE**

All critical incidents as defined by the Michigan Department of Health and Human Services (MDHHS) must be reported to Northern Michigan Regional Entity (NMRE), which will submit a summary report to the state as defined in the Prepaid Inpatient Health Plan (PIHP) contract.

The NMRE requires that each participant Community Mental Health (CMH), and the NMRE Substance Use Disorder (SUD) Services provider panel, review, investigate, and act upon sentinel events, critical incidents, and risk events for Medicaid beneficiaries. NMRE requires that each participant CMH, and SUD provider, report critical incidents as defined by the state of Michigan monthly to NMRE.

CMH and SUD provider staff, volunteers and interns will report suspected abuse, neglect and exploitation according to the standards set forth in this policy.

**I. Standards and Guidelines**

A. The NMRE minimal standard is to report all critical incidents or events (occurrence or condition which adversely affect the course of treatment or represents actual or potential serious harm or risk to persons served), except Suicide, within 60 days after the end of the month in which the event occurred for individuals actively receiving services, with individual level data on consumer ID, event date, and event type. Critical incidents include any suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, or arrest of a consumer that meets the population standards set by the MDHHS contract.

*(Methodology and instructions for reporting are posted on the MDHHS website at Michigan.gov/mdhhs. Click “Keeping Michigan Healthy”, then “Behavioral Health & Developmental Disability”, and finally “Reporting Requirements”.)*

B. Each CMH, CMH as a provider, and/or their contract provider, and/or NMRE contract providers within NMRE may establish additional procedures needed for expanding the types of incidents to be reported and the process for reporting, tracking, and preventing incidents. CMH procedures may be more stringent but must meet the requirements within this policy.

- C. Each CMH must forward a summary report of incidents that meet sentinel event, critical incident, or risk event definitions to be reviewed by NMRE. Critical Incidents will be reported to MDHHS by a designated NMRE staff member. Each CMH must report critical events as soon as they become aware of them to the Director of Quality and Performance Management (this includes suspected abuse, neglect, or exploitation).
- D. Documentation of Incidents
  - 1. All the MDHHS required information for reporting to law enforcement and/or tracking incident and events must be submitted to NMRE within the appropriate timeframes.
  - 2. All additional data elements that are part of the reporting system, as discussed in the Quality Management Committee (QMC), will be tracked and reported as discussed in the QMC. Information from this additional data will be tracked by NMRE and available to the CMHs.
- E. Processing of Sentinel Events
  - 1. Immediately notify NMRE of sentinel events and other critical incidents and events that put people at risk of harm.
  - 2. Within three days of a critical incident a determination by the reporting-organization must be made if it meets the sentinel event standard. If it does meet that standard the organization has two days from the date of the determination to start the root cause analysis of the incident. Collection of information to determine if it is a sentinel event including a medical determination for the cause of death does consist of starting the root cause analysis.
  - 3. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve an individual's death or other serious medical conditions, must involve a physician or nurse.
- F. PIHP Role and Responsibilities
  - 1. The NMRE Quality Management Department is responsible to ensure consistent reporting, recording, tracking and the analysis of all events including critical incidents across the region.
  - 2. The NMRE will be responsible to review all incident report summaries forwarded to them in a timely manner and take any required follow-up actions as indicated.
  - 3. The NMRE will facilitate the reporting of all critical incidents, deaths and other required data to the Michigan Department of Health and Human Services (MDHHS) as per MDHHS requirements (Attachment 7.7.1.1), and other organizations as defined by law and NMRE contract(s).
  - 4. As per Attachment P.7.7.1.1 "Event Notification" of the MDHHS Managed Specialty Supports contract with the PIHP's, the NMRE will immediately notify MDHHS of any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation. This report shall be submitted electronically within 48 hours of either the death, or NMRE's receipt of notification of the death, or the NMRE's receipt of notification that a rights, licensing, and/or police investigation has commenced to [QMPMeasures@michigan.gov](mailto:QMPMeasures@michigan.gov) and include the following information:
    - a. Name of beneficiary
    - b. Beneficiary ID number (Medicaid, ABW, MiChild)
    - 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 E-mail address

5. The NMRE Quality Management Department will ensure that the required information/reports go to the Quality Management Committee (QMC) for their review.
  6. The QMC will review reports on at least a quarterly basis to:
    - a. Assess the consistency in reporting across NMRE region.
    - b. Assist in the analysis of all aggregate reports on all incidents, events, uses of physical management, and deaths to identify any additional trends and areas needing follow-up and/or additional opportunities for improvement.
    - c. Advocate for and/or facilitate improvements beyond those already made.
  7. The Participant CMHs and Providers are responsible for investigations conducted and action plans implemented in connection with the events identified above, and the maintenance of all incident reports.
  8. NMRE has no responsibility for determining whether any CMH staff member, provider or other CMH third party has committed any action or inaction or is otherwise responsible for any of the events listed above, including a death. NMRE will be involved as appropriate to meet contractual obligations. The Participant CMH and other organizations shall be solely responsible for notifying the NMRE of any of the events noted above, investigating the events, and providing sufficient information to the NMRE to enable it to make all required reports to the State of Michigan.
  9. NMRE will abide by the findings of the Participant CMH responsible for investigating the event, and report the findings to the State based solely on the investigation results and staff leadership determination made by the CMH. NMRE will be involved in and discuss with the appropriate organization about individual events.
- G. Education and Monitoring
1. CMH and Contract Provider agencies within NMRE network will have access to this policy through the NMRE public website. NMRE will monitor that the policy is being followed by the participating CMHs and NMRE providers, and the CMHs are responsible for monitoring their provider network.
  2. Monitoring will also include reviewing that CMHs are conducting root cause analysis when needed, and that action has been taken as identified in summary.
  3. Technical assistance for event reporting and conducting root cause analysis is available to all providers requesting support from NMRE.

## II. Definitions

### A. Critical Incident

An incident that meets the state reporting definitions listed:

1. Suicide, Non-Suicide Death, Emergency Medical treatment due to Injury or Medication Error, Hospitalization due to Injury or Medication Error, Arrest of Consumer, or Injury as a result of physical management

Populations that qualify:

- Individuals who live in a Specialized Residential facility (per Administrative Rule R330.1801-09) or
- Individuals who live in a Child-Caring institution; or
- Individuals who receive Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services
- For suicide: for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was

determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a “best judgment” determination of whether the death was a suicide. In this event the time frame for submission will be within 30 days after the end of the month in which this “best judgment” determination occurred.

- For non-suicide related deaths: for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver or Children’s Waiver services.

B. Sentinel Event

An “unexpected occurrence” involving death (not due to the natural course of a health condition) 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). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

C. MDHHS Event Reporting System

The MDHHS Event Reporting System is a file-based system to submit specific information (regarding persons receiving services) about five specified events on a timely and regular basis from the PIHP to MDHHS.

The five specific reportable events are:

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 receiving services

D. Risk Events Management

A process for analyzing risk events that put individuals at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.

E. Unexpected Occurrence

A behavior or event not covered within the consumer’s treatment plan, a planned procedure (surgery, etc.) or a natural result to the consumer’s chronic or underlying condition or old age.

F. Emergency Medical Treatment (EMT)

or hospitalization due to an injury that is self-inflicted (i.e., due to harm to self, such as pica, head banging, biting and including suicide attempts).

G. Medication Errors

Consist of:

1. wrong medication
2. double dosage
3. wrong dosage; and/or
4. missed dosage that result in injury, death or the risk thereof

It does not include instances in which individuals have refused medications.

H. Physical Management

A technique used by staff to restrict movement of an individual by direct physical contact in order to prevent the individual from physically harming himself/herself or others, and shall only

be used on an emergency basis when the situation places the individual or others at imminent risk of serious or non-serious physical harm.

The term “physical management” does not include briefly holding an individual in order to comfort him/her or to demonstrate affection, or holding his/her hand.

I. Root-Cause Analysis (RCA)

A class of problem solving methods aimed at identifying the root causes of problems or events. The practice of RCA is predicated on the belief that problems are best solved by attempting to address, correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. By directing corrective measures at root causes, it is more probable that reoccurrence will be prevented, or at least reduced. Within three days of a critical incident a determination will be made if it meets the sentinel event standard, if it does meet that standard the organization has two days to start the root cause analysis.

J. Action Plan: The product of the 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.

K. Serious Physical Harm

Defined as “physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient”. (source: Administrative Rules for Mental Health [330.70001])

L. Emergency Services

When a person seeks services due to crisis or risk of harm to self and others. If a person refuses services recommended by professional staff and there is no further contact this does not qualify as a reportable event.

## REFERENCE

MDHHS/PIHP Medicaid Specialty Supports and Services Contract

- PIHP Reporting Requirements for Medicaid Specialty Supports and Services Beneficiaries (Attachment P.7.7.1.1 “Event Notification”)
- Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans (Attachment P.7.9.1)
- Technical Requirement for Behavioral Treatment Plan Committees; Revision FY '12 (Attachment P.1.4.1)

MDHHS/PIHP Event Reporting - <https://mipihwarehouse.org/MVC/Documentation>

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Date

