NORTHCARE NETWORK

POLICY TITLE: Incident, Event, & Death Reporting, Monitoring & Oversight	**CATEGORY:** Quality Improvement	
EFFECTIVE DATE: 10/1/10 (Retro.)	**BOARD APPROVAL DATE:** 8/13/14	
REVIEW DATE: 3/4/22	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☒ **Yes** ☐ **No**
RESPONSIBLE PARTY: Clinical Practices Coordinator	**CEO APPROVAL DATE:** 4/5/22 Dr. Tim Kangas, CEO	

APPLIES TO

NorthCare Network Personnel
Network Providers

POLICY

All applicable parties, or their designee, shall report sentinel events, critical events, risk events and immediately reportable events (event notification) to NorthCare Network as required by MDHHS and outlined in the procedures below. NorthCare Network reviews the range of incidents reported: critical incidents, sentinel events, and risk events for the severity of impact on specific individuals and monitors trending of incidents in certain categories or other trends such as location. NorthCare Network provides oversight when further information and review is determined to be clinically appropriate.

PURPOSE

To define monitoring and oversight responsibilities of the reporting requirements related to unusual events and/or incidents involving persons served**.**

DEFINITIONS

1. ***Critical Incident***. An incident that meets the state reporting definitions defined by the MDHHS/PIHP contract, which include:
   - 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 are living in a Specialized Residential facility (per Administrative Rule R330.1801-09) including Substance Use Disorder residential programs or
   - Individuals who are living in a Child-Caring institution; or
   - Individuals who are receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services
   - 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.

- 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 described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.

2. ***Elopement***. When a person is gone for a period of time that the worker fears for the safety of the individual and/or calls the police because the worker could not find the individual. If a person is late for curfew and there is no expectation of a risk to their safety it is not considered elopement.

3. ***Emergency Medical Treatment (EMT) due to Injury or Medication Error*.** Situation where an injury to a consumer or medication error results in face-to-face emergency medical treatment being provided by medical staff or at an emergency room 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).

4. ***Hospitalization due to Injury or Medication Error*.** Admission to a general medical facility due to Injury or Medication Error. Hospitalizations due to the natural course of an illness or underlying condition do not fall within this definition.

5. ***Major Permanent Loss of Function.*** Sensory motor, physiologic or intellectual impairment not present upon initiation of community mental health or substance use services and occurring as a result of an incident/accident which requires continued treatment of lifestyle change

6. ***MDHHS Critical Incident Reporting.*** The MDHHS Event Reporting Systems require the submission of specific information about five specified critical 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

   Incident Reports regarding individuals receiving CMHSP services are to be entered into the regional electronic Incident Report Module. SUD residential providers are required to submit incident reports per MDHHS guidelines to NorthCare clinical staff for review and follow-up if indicated. All other providers are required to report incidents as outlined in their contract.

7. ***MDHHS Event Notification--Immediately Reportable Events.*** MDHHS requires immediate reporting of an "unexpected occurrence" involving a person receiving services involving unexpected death, homicide, or action by the person receiving services that requires immediate notification of the state to allow the state to address any required immediate follow-up actions including statements to the media, or removal of others from a group setting. This report shall be submitted to MDHHS, by the PIHP,

electronically to QMPMeasures@michigan.gov within 48 hours in the following instances.

i. Any death that occurs because of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation. This report shall be to NorthCare Network immediately or no later than 24 hours of learning of the event.
ii. Relocation of a consumer's placement due to licensing suspension or revocation.
iii. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours
iv. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement.

Except for bullet i above, notification of the remaining events shall be made telephonically or other forms of communication within five (5) business days to contract management staff members in MDHHS's Behavioral Health and Developmental Disabilities Administration.

9. Medication Errors.

1. Wrong medication
2. Double dosage
3. Wrong dosage; and/or
4. Missed dosage that results in injury, death or the risk thereof

Note: This does not include instances in which individuals have refused medications.

10. 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 or gently redirecting his/her hand.

11. ***Risk Events.*** Risk Events are defined in the MDHHS QAPIP as additional incidents that put individuals (in the same population categories as the critical incidents above) 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. MDHHS will request documentation of this process when performing site visits. These events minimally include:

- Actions taken by individuals who receive services that cause harm to themselves
- Actions taken by individuals who receive services that cause harm to others
- Two or more unscheduled admissions to a medical hospital (not due to a planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period

12. 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.

13. Root-Cause Analysis (RCA). A method of review 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 subsequent to start the root cause analysis.

- An RCA may be initiated, and it may be evident that an action plan and follow up is not necessary due to the clear nature of the sentinel event. In this instance, the rationale needs to be documented on the RCA form.
- Action Plan: The product of the root cause analysis is an action plan that identifies the strategies, individual(s)/department(s) responsible for the action, and target dates for completion that the organization intends to implement to reduce the risk of similar events occurring in the future.
- Follow-Up to Root Cause Analysis: Documentation that action has been taken to correct the causes identified in the root cause analysis and that the action plan has been implemented.
- The RCA is not included in the electronic clinical record.
- The RCA is reviewed by NorthCare and may be discoverable. Internal deliberations and/or HR functions should not be included.

14. 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.

15. Serious Challenging Behavior. Behaviors which include significant property damage, attempts at self-inflicted harm or harm to others.

16. 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”.

17. 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.

REFERENCES

- MDHHS/PIHP Contract.
  - Critical Incidents
    MDHHS/PIHP Quality Assessment and Performance Improvement Programs
    MDHHS/PIHP Reporting Requirements
    MDHHS/PIHP TR for BTPRC
  - Michigan Performance Indicator Codebook – Section on Critical Incident Reporting
- MDHHS/PIHP Event Reporting - https://mipihpwarehouse.org/MVC/Documentation
- MI Mental Health Code (Act 258 of the Public Acts of 1974 as amended) Section 330.1748 (9)
- M.C.L. 330.723(2)(3) and 330.755f(I)(ii)
- Child Abuse and Neglect Prevention Act, PA 250 of 1982
- Child Protection Law, PA 238 of 1975
- M.C.L. 712A – 712 A.32
- Social Welfare Act, PA 280 of 1939
- Michigan Penal Code, PA 328 of 1931
- Adult Protective Services, PA 519, 1982
- R.330.1801-330.1809
- R.400.51-400.15411
- NorthCare Incident Reporting Codes and descriptions
- NorthCare SUD Provider Manual
- NorthCare SUD Data & Incident Reporting Manual
- NorthCare SUD Residential Treatment Providers Critical Incident Sentinel Event Reporting Procedure
- NorthCare Incident Reporting PowerPoint training

HISTORY

Previous Titles: Event/Death Reporting Notification & Monitoring; Event Reporting & Notification; Sentinel Event Reporting Policy 2009
REVISION DATE: 7/3/08, 9/22/09, 12/15/10, 3/2/11; 12/18/13, 7/14/14, 5/22/15, 3/23/16, 3/1/17, 9/27/17, 4/19/19, 1/7/20, 10/15/20, 5/28/21, 3/4/22
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PROCEDURES

MEMBER CMHSP RESPONSIBILITIES

A. NorthCare Network delegates to the Member CMHSPs the responsibility to review, investigate, and take appropriate action regarding sentinel events, critical events, risk events, immediately reportable events and additional review of other incidents that warrant further clinical review and conduct root cause analyzes as needed. Member CMHSPs report events via the electronic Incident Report Module that is part of the PCE (ELMER) system. Specific mandated reporting is done according to timeliness standards set by MDHHS.
    1. CMHSP staff will denote an incident as critical, sentinel, or risk in the ELMER system within 3 business days of an incident; in accordance with the MDHHS

QAPIP which states, "*The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of the event."*

2. CMHSP's will be responsible for reviewing all unexpected deaths of Medicaid beneficiaries that were receiving specialty supports and services at the time of their deaths and information reviewed will include:
    i. Screens of individual deaths with standard information (e.g. coroner's report, death certificate)
    ii. Involvement of Medical personnel
    iii. Documentation of the morality review process and recommendations
    iv. Use of mortality information to address quality of care
    v. Aggregation of mortality data over time for possible trend identification

B. Systemic reviews by the Member CMHSPs will:
    1. Evaluate the systemic factors involved in any occurrence of critical incidents and at-risk health conditions, and behavioral and medical crisis;
    2. Identify any individual precursors to potential behavioral or medical crises that can serve as a warning to staff;
    3. Identify and implement actions to eliminate or lessen the risk that critical incidents, sentinel events, and behavioral crises will occur.

    Member CMHSPs have the authority to establish more stringent procedures to expand the focus of their reviews and require other reporting and prevention methods than stated in this policy.

C. Reporting Sentinel Events
    1. Within three days of a critical incident, the reporting organization must determine 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 (RCA) of the incident.
    2. Persons involved in the review of sentinel events or RCA 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.
    3. RCA may be conducted on any unusual event as warranted regardless of its event categorization.

<u>Substance Use Disorder Providers and SUD Residential Programs</u>

A. NorthCare Network SUD Providers are contractually responsible to review, investigate, and take appropriate action regarding sentinel events, critical events, immediately reportable events and additional review of other incidents that warrant further clinical review and conduct root cause analyzes as needed. Providers report events through the procedures outlined in the NorthCare SUD Data and Incident Reporting Manual. Specific mandated reporting is done according to timeliness standards set by MDHHS:

1. All SUD providers have the reporting requirements outlined in definition #8 *MDHHS Immediate Reporting* other than the first requirement for death reporting. For death reporting, SUD providers have a more stringent reporting requirement of reporting to NorthCare within 24 hours.

2. SUD Residential Providers have the critical event reporting requirements outlined in definition #7 *MDHHS Critical Incident Reporting*.
3. See also NorthCare's Standard Operating Procedure for SUD Provider Critical Incident reporting.

PIHP ROLE AND RESPONSIBILITIES

A. NorthCare Network Peer Review Staff monitors Member CMHSP /SUD Providers incident reporting for proper coding and review of individual and aggregate critical incidents and events.

B. All Member CMHSP/SUD Providers requests for single incident or summary reviews by NorthCare Network will be conducted in a timely manner and any required follow up actions will be referred back to the Member CMHSP.

C. NorthCare Network's CEO or designee facilitates the reporting of critical incidents, deaths and other required data to the Michigan Department of Health and Human Services as per MDHHS reporting requirements.

D. NorthCare Network's CEO or designee will notify MDHHS of any death that is the subject of a recipient rights, licensing, or police investigation. This report shall be submitted in accordance with contract requirements listed in the MDHHS/PIHP contract.

E. NorthCare Network's Peer Review Staff and/or Health & Safety Committee will:
   1. Assess the consistency of application of MDHHS reporting guidelines across NorthCare Network region through analysis of aggregate and individual reports on incidents, events, uses of physical management, and deaths to identify trends and areas needing follow-up and/or additional opportunities for improvement. The team will provide feedback to the provider with either an agreement to the findings or a request for further review of itemized clinical concerns identified by the NorthCare Network team.
   2. Analyze, at least quarterly, the critical, sentinel, and risk events to determine if additional action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.
   3. Facilitate improvements beyond those put in place by the Member CMHSPs through the monitoring of individual and trend reports.
   4. Report findings/activities to the NorthCare Network senior clinical leaders, the Medical Director and/or CEO, who may review and make any recommendations for follow up by the appropriate NorthCare Network Committee.
   4. Aggregate de-identified data is reviewed by the NorthCare QI Committee at least quarterly and further action taken as appropriate.

F. Event Notification – Deaths defined under Event Notification will be submitted to NorthCare Network within 24 hours of either the death or the provider learning of the death or provider's receipt of notification that a rights, licensing, and/or police investigation has commenced. This provides NorthCare Network an additional 24 hours to report to MDHHS (48 hours total). Following immediate event notification to MDHHS, NorthCare Network will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the individual's

discharge from a State-operated service. Except for deaths, notification of the remaining events shall be made by the provider to NorthCare Network within two (2) business days of the event or learning of the event and NorthCare Network will notify MDHHS within three (3) additional business days (5 days total from the time the provider learns of the event).

G. Education and Training
   1. Network Providers within NorthCare Network will have access to this policy through the NorthCare Network public website.
   2. Technical assistance from NorthCare Network for event reporting and conducting root cause analyses is available to all providers.

Hospital Incident Reports

1. Sentinel/Critical Events occurring while an individual is on the Inpatient Psychiatric unit, if the individual was placed on the unit via a preadmission screening by the local CMHSP, will be reported by the contracted hospital to NorthCare Clinical Practice Coordinator and to the responsible CMHSP Recipient Rights Officer within 48 hours of incident.
   a. The CMHSP RRO will add an incident report to the ELMER IR module
   b. Minimum data to be reported:
      a. Patient name and date of birth
      b. Date of incident
      c. Approximate time incident happened
      d. Brief description of incident
      e. Steps taken to remediate and ensure immediate safety
      f. Plan to mitigate reoccurrence