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: 10/4/24	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☒ **Yes** ☐ **No**
RESPONSIBLE PARTY: Clinical Practices Coordinator/SUD Clinical Director	**CEO APPROVAL DATE:** 11/5/24 Megan Rooney, 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. ***Arrest*** situations 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.
2.
3. ***CMH 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, Children's Waiver services, or iSPA 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, Children's Waiver services, or iSPA services.
- For Suicide related deaths: for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death.

SUD Sentinel Event: SUD providers report sentinel events rather than critical incidents. They are events that result in death, harm, temporary harm, or risk thereof.

Reporting by SUD Residential Providers is based on the licensed provider site not the individual client being served. They are reported via email within 24 hours AND the CRM. The following are SUD incidents that are to be reviewed to determine if they are sentinel: :

- Death of a recipient
- Serious illness requiring admission to a hospital
- Alleged cause of abuse or neglect (reported per licensing requirements)
- Accident resulting in an injury to a recipient requiring emergency room visit or hospital admission
- Unanticipated Behavioral episode
- Arrest and/or conviction
- Medication error

Reporting Critical Incidents:

Reporting Timeline to PIHP:

- All events should initially be reported within 3 business days. Determination as to cause of death and root cause analysis may be ongoing and therefore the report may be modified before reporting to MDHHS.

Reporting Timeline to MDHHS:

- For Suicide: Once it has been determined whether or not a death was suicide, the suicide must be reported to MDHHS 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 above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.
- For Non-Suicide related death: if reporting is delayed to determine if the death was caused by suicide, the submission is due within 30 days after the end of the month in which it was determined the death was not due to suicide.
- For 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 reporting is due to MDHHS within 60 days after the end of the month the event occurred in.

4. ***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.

5. ***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 at an emergency room or any treatment facility including urgent care and at a PCP office or by EMTs. *If* emergency treatment is sought due to a possible or suspected injury, the event shall be considered a reportable injury unless medical staff indicate that no injury occurred (i.e., not diagnosed as an injury and no treatment provided for an injury).

    1. If EMT's are unable to assess due to consumer refusal, this will be considered emergency medical treatment as the assessment couldn't occur to indicate that no injury occurred.

6. ***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.

7. ***Injury:*** *bodily damage that occurs to an individual due to a specific event (e.g. accident, assault). Includes bruises, contusions, sprains, breaks. If* emergency treatment is sought due to a possible or suspected injury, the event shall be considered a reportable injury unless medical staff indicate that no injury occurred (i.e., not diagnosed as an injury and no treatment provided for an injury).

    1. Falls will be specially denoted.

8. "Injury during physical management" means any injury to the consumer that occurred while physical management techniques were being used with the injured consumer by staff or others (e.g., police, parents, hospital staff). "Injury during physical management" can only occur during the time period that physical management is being used (e.g., during the time the consumer is being held). The fact that an injury occurred during physical management does not imply that the physical management caused the injury. The physical intervention may have caused the injury, or it may in fact have reduced the severity and/or number of injuries.

    1. If a consumer punches the window, breaking the glass and cutting self and then is held in a physical management hold; the cut was NOT due to physical management as it occurred outside the timeframe of the physical management.

9. ***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

10. ***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:

- Suicide
- Non-suicide death
- Emergency medical treatment due to injury or medication error
- Hospitalization due to injury or medication error
- 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. CMH events are loaded to the CRM via IT process from PCE.

11. ***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. A phone call to notify NorthCare is recommended followed by written report. This report shall be submitted to NorthCare within 24 hours of learning of the event. NorthCare will submit to MDHHS, electronically via manual entry into the CRM within 48 hours.
    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.

    Notification of the following events shall be made to NorthCare within 2 business days. NorthCare will communicate with MDHHS within 5 business days.
    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.

    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.

12. ***Medication Errors.*** *A situation where a mistake is made when a consumer takes a prescribed medication or when a non-prescription medication is taken improperly.*
    - Wrong prescription medication
    - Double dosage
    - Wrong dosage; and/or
    - Wrong time of dosage
    - Missed dosage
    - Misuse of medication / improper use
      that results in injury, death or the risk thereof

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

13. ***Physical Management.*** A technique used by staff to restrict movement of an individual by direct physical contact 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 to comfort him/her or to demonstrate affection or holding or gently redirecting his/her hand. It is used as an emergency intervention only.

10. ***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

11. ***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.

12. ***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. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the provider may prepare a rationale for not pursuing a preventive plan.
    - 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.

- For CMH: The RCA is reviewed by NorthCare and may be discoverable. Internal deliberations and/or HR functions should not be included.
- For SUD: NorthCare provides the RCA form and is available for clinical consultation throughout the review process. SUD Sentinel Events and Remediations (steps taken to prevent re-occurrence) will be entered **only** within the Customer Relationship Management (CRM) system by NorthCare staff upon notification from the SUD provider that an event has occurred.

13. ***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.
    a. Reporting Sentinel Events - CMH
        i. 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.
        ii. 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.
        iii. RCA may be conducted on any unusual event as warranted regardless of its event categorization.
    b. Reporting sentinel events – SUD
        i. SUD sentinel events will be manually entered into the CRM by NorthCare staff.
        ii. SUD sentinel events must be reported via email as well within 24 hours.

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

15. ***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".

16. ***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, as amended https://www.michigan.gov/mdhhs/doing-business/contractor
- 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
- Social Welfare Act, PA 280 of 1939
- Michigan Penal Code, PA 328 of 1931
- Adult Protective Services, PA 519, 1982
- Certification of specialized programs offered in AFC homes. Michigan Admin Code R.330.1801-330.1809
- Search Requests and reports. Michigan Admin Code R.400.51-400.15411
- NorthCare Incident Reporting Codes and descriptions
- NorthCare SUD Provider Manual
- MDHHS Policies & Practices Guidelines
  https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines
    - Quality Assessment and Performance Improvement Programs
    - Critical Incident Reporting and Event Notification Requirements
- NorthCare SUD Critical Incident Report form

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, 2/21/23,2/5/24, 10/4/24
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CEO APPROVAL DATE: 3/13/13, 12/18/13, 7/14/14, 6/2/15,4/4/16, 7/29/16, 4/4/17, 10/3/17, 7/3/18, 5/6/19, 2/26/20, 11/3/20, 6/1/21, 4/5/22, 3/7/23, 2/6/24, 11/5/24
BOARD APPROVAL DATE: 3/2/11, 8/13/14

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 enter and 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

3. Systemic reviews by the Member CMHSPs will:
   i. Evaluate the systemic factors involved in any occurrence of critical incidents and at-risk health conditions, and behavioral and medical crisis;
   ii. Identify any individual precursors to potential behavioral or medical crises that can serve as a warning to staff;
   iii. 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.

Substance Use Disorder Provider (Residential) Responsibilities

A. NorthCare Network SUD Residential 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 to NorthCare using the NorthCare Network SUD Residential Critical Incident Report Form. Specific mandated reporting is done according to timeliness standards set by MDHHS:

1. Residential SUD providers have the reporting requirements outlined in definitions 6, 7 and 13 above.

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.

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 appropriate Committees and further action taken as appropriate.

F. 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 Provider Responsibilities

1. Sentinel/Critical/and Immediately Reportable 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 Quality Improvement and to the responsible CMHSP Recipient Rights Officer (RRO) within 24 hours.
   a. The CMHSP RRO will add an incident report to the ELMER IR module
   b. Minimum data to be reported by the hospital:
      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

Incident Reporting - per QAPIP, BTC, and Event Reporting Tech							
Event Type	All Services	Homebased / ACT	Case Management	CLS / Wraparound	Waiver (HAB, SED, Child, iSPA)	Living Arrangement: CCI / Specialized Residential	SUD Residential
Immediate Event							
Death - Staff Action / Investigation							
Relocation of placement - licensing							
Relocation of provider							
Conviction of staff							
Changes to network composition							
Newsworthy Critical Incidents							
Sentinel Event							
Homicide							
Suicide							
Unexpected Death							
Serious Injury / Loss of Functioning							
Injuries / Death due to Staff Abuse/ Neglect							
Injury or death due to behavior management							
Critical Incident							
Suicide							
Death							
EMT							
Hospitalization							
Arrest							
Risk Event							
Risk of Harm to Self							
Risk of Harm to Others							
Medical Hospitalizations							
Physical Management							
Law Enforcement Involvement - BTPRC							
Death - if discharged from state hospital in past year							
Other							
SUD Incidents /Sentinel Event (SE denotes sentinel)							
Death							SE
Hospitalization for Illness							SE
Abuse / Neglect							
EMT / Hospitalization Injury							SE
Arrest							
Serious Challenging Behaviors							
Medication Error							SE?