NORTHCARE NETWORK

POLICY TITLE: SUD Incident, Event, & Death Reporting, Monitoring & Oversight	**CATEGORY:** Quality Improvement	
EFFECTIVE DATE: 2/11/26	**BOARD APPROVAL DATE:** 2/11/26	
REVIEW DATE: N/A -New Policy	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☐ **No**	**OTHER REVISION(S):** ☐ **Yes** ☐ **No**
RESPONSIBLE PARTY: SUD Services Director, SUD Clinical Director, and QI/UM Director	**CEO APPROVAL DATE:** 2/3/26 Megan Rooney, CEO	

APPLIES TO:
NorthCare Network Personnel
SUD Residential Providers

POLICY:
All applicable parties, or their designee, shall report incident/risk events, immediately reportable events (event notification), and sentinel events to NorthCare Network as required by Michigan Department of Health and Human Services (MDHHS) and outlined below. NorthCare Network reviews the range of incidents/events reported for the severity of impact on individuals receiving SUD services and monitors trends of incidents by category of incident, location, staff involved, etc. based on incidents received. NorthCare Network provides oversight when further information and review is determined to be clinically appropriate. Reporting by SUD Residential Providers is based on the licensed provider site not the individual client being served.

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

DEFINITIONS;
Immediately Reportable Event Notification: 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 to MDHHS to allow MDHHS 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 NorthCare within 24 hours of learning of the event.** NorthCare will then submit a report of the event to MDHHS, via the CRM, within 48 hours. This includes:

1. 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 reported within 48 hours of either the death, the PIHPs receipt of notification of the death, or the PIHPs receipt of notification that a recipient rights, licensing, and/or police investigation has commenced to the CRM system and include the following information:
    a. Name of beneficiary
    b. Beneficiary Medicaid ID number
    c. Consumer ID if there is no beneficiary ID number.

    d. Date, time, and place of death.
    e. Preliminary cause of death
    f. Contact person's name and email address.
2. Relocation of a consumer's placement due to licensing suspension or revocation.
3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours. Must be
4. 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.
5. Any changes to the composition of the provider network organizations that negatively affect access to care. The PIHPs shall have procedures to address changes in their network that negatively affect access to care (e.g., agency site closure) Changes in provider network composition that the MDHHS determines to negatively affect recipient access to covered services may be grounds for sanctions..
6. Executive personnel changes.
7. Incidents which may be newsworthy or represent a community crisis

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.

Risk Events: Additional incidents 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. MDHHS will request documentation of this process when performing site visits. These events minimally include:

1. Actions taken by individuals who receive services that cause harm to themselves
2. Actions taken by individuals who receive services that cause harm to others
3. Multiple (2+) unplanned hospitalizations not related to the natural course of a chronic illness other than the individual's substance use disorder.

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.

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.

1. RCAs should:
    a. Identify the factors that lead to the event
    b. Identify an 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.
    c. Complete Analysis: Documentation that the action plan has been implemented and reviewed for effectiveness.
2. NorthCare provides the RCA form and is available for clinical consultation throughout the review process. Only Sentinel Events and Remediations (steps taken to prevent re-occurrence) will be entered within the Customer Relationship Management (CRM) system by NorthCare staff upon notification from the SUD Residential Provider that an event has occurred.
3. An RCA may be conducted on any unusual event as warranted regardless of its event categorization.
4. 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.

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. An event can also be considered sentinel event even if the outcome was not death, permanent harm, severe temporary harm and intervention required to sustain life. A sentinel event is considered a Patient Safety Event that reaches a patient and results in any of the following:

1. Death
2. Permanent harm
3. Severe temporary harm and intervention required to sustain life.

SUD Residential Incident: Any incident which falls under any of the categories listed below, must be reviewed and reported to NorthCare by the SUD Residential Provider and a determination must be made if the incident/event is sentinel or non-sentinel.

1. Death of a recipient - that which is not by natural cause or does not occur as a natural outcome to a chronic condition (e.g. terminal illness) or old age.
2. Illness requiring admission to a hospital - Physical illness resulting in admission to a hospital does not include planned surgeries, whether inpatient or outpatient. It also does not include admissions directly related to the natural course of the person's chronic illness, or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.
3. Alleged cause of abuse or neglect

4. Accident - an injury to recipient requiring emergency room visit or hospital admission - resulting in injuries that result in death or loss of limb or function, and which required visits to emergency rooms, medical centers and urgent care clinics/centers and/or admissions to hospital should be included in the reporting. In many communities where hospitals do not exist, medical centers and urgent care clinics/centers are used in place of hospital emergency rooms.
5. Arrest and/or conviction – 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.
6. Serious challenging behaviors – behaviors not already addressed in a treatment plan that include significant (in excess of $100.00) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence that result in death or loss of limb or function to the individual or risk thereof.
7. Serious physical harm: The State of Michigan Administrative Code for Health and Human Services (330.7001 Rights of Recipients) further defines serious physical harm 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."
8. Medication error - wrong medication; wrong dosage; double dosage; any difference from prescription; and/or missed dosage which resulted in death or loss of limb or function or the risk thereof. It does not include instances in which consumers have refused medication.

REFERENCES

- MDHHS Policies & Practices Guidelines: Critical Incident, Event Notification and SUD Sentinel Event Reporting Requirements
  https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines
  MDHHS Policies & Practices Guidelines: QAPIP
- NorthCare SUD Services Operations Manual
- NorthCare Network SUD Residential Incident Reporting Form

HISTORY

Previously part of Incident, Event,& Death Reporting, Monitoring & Oversight Policy
NEW POLICY: 2/11/26
REVIEW DATE: N/A
REVISION DATE: N/A
CEO APPROVAL DATE: 2/3/26
BOARD APPROVAL DATE: 2/11/26

PROCEDURES:

A. All occurrences described under the DEFINITIONS section above must be reviewed and reported to NorthCare by the SUD Residential Provider using the *NorthCare Network SUD Residential Notification for Incident Reporting/Sentinel Event/Immediately Reportable Event Form (also known as the NorthCare Network SUD Residential Incident Reporting Form)*. This form is available from NorthCare SUD Access staff.

B. Any of the occurrences described under the DEFINITIONS section above that are immediately reportable events or sentinel events are required to be reported to MDHHS by the PIHP. SUD sentinel events are occurrences that result in death, permanent harm, or temporary harm with intervention to sustain life or psychological injury or risk thereof. SUD sentinel events and immediately reportable events **must be submitted within 24 hours to NorthCare** who will further report them to MDHHS.

C. The response to a SUD sentinel event must include the actions outlined below and must be included in Root Cause Analysis (RCA):
   1. A formalized team response that stabilizes the individual served, discloses the event to the individual served and family, and provides support for the family as well as staff involved in the event.
   2. Notification to organization leadership
   3. Immediate investigation
   4. Completion of a comprehensive systematic analysis for identifying the causal and contributory factors
   5. Strong corrective actions derived from the identified causal and contributing factors that eliminate or control system hazards or vulnerabilities and result in sustainable improvement over time
   6. Timeline for implementation of corrective actions
   7. Systemic improvement with measurable outcomes.

SUD RESIDENTIAL PROVIDER RESPONSIBILITIES

A. NorthCare Network SUD Residential Providers are contractually responsible to review, investigate, report to NorthCare timely, and take timely appropriate action for all sentinel events, immediately reportable events, and any risk concerns.

B. Regardless if an incident/event is determined to be sentinel or not sentinel, it still MUST be reported to NorthCare via the mechanisms outlined in this policy for NorthCare consumers. NorthCare only reports those incidents/events meeting criteria for reporting to MDHHS.

C. SUD Residential Providers report events to NorthCare using the NorthCare Network SUD Residential Notification Report Form.

D. SUD Residential Providers should submit this reporting form, via NorthCare's secure ELMER messaging system to the NorthCare SUD Clinical Director.

E. SUD Residential Providers are responsible for reporting events within the timeliness standards set by MDHHS.

For reporting purposes, the number of individuals receiving services in the SUD residential facility, regardless of funding, must be reported for the day of the incident.

PIHP ROLE AND RESPONSIBILITIES

A. NorthCare monitors SUD Residential Providers incident reporting for proper coding and review of individual and aggregate incidents and events. NorthCare reserves the right to determine if an incident/event is Sentinel and request an RCA be initiated by the SUD Residential Provider.

B. NorthCare Network's CEO or designee facilitates the reporting of incidents/events, deaths and other required data to MDHHS via the CRM as per MDHHS reporting requirements.

C. NorthCare Network's CEO or designee will notify MDHHS of any death that is immediately reportable. This report shall be submitted in accordance with contract requirements.

D. 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 incidents/events, 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. Report findings/activities to the NorthCare Network SUD Services Director, the Medical Director via the Health and Safety Committee, others on the Leadership Team 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.
   5. Create, update, and provide training as necessary.

E. Education and Training
   1. Providers will have access to this policy through NorthCare Network's website: www.northcarenetwork.org
   2. Technical assistance from NorthCare Network for event reporting and conducting root cause analyses is available to all providers.