| Section:<br>**QAPI** | Policy Name:<br>**Incident Event Reporting & Monitoring** | | Policy Number:<br>**03.05** |
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| Application:<br>☒ **SWMBH Staff/Ops**<br>☒ **Participant CMHSPs**<br>☒ **SUD Providers**<br>☒ **MH/IDD Providers**<br>☐ **Other (please specify):**<br>_____________________ | Line of Business:<br>☒ **Medicaid**<br>☒ **Healthy Michigan**<br>☒ **SUD Block Grant**<br>☒ **SUD Medicaid**<br>☒ **MI Health Link** | ☐ **Other (please specify):**<br>_____________________ | Effective Date:<br>**9/29/2014** |

**Policy:** All critical incidents as defined by the State of Michigan must be reported to Southwest Michigan Behavioral Health (SWMBH), which will submit a summary report to the State of Michigan as defined in the Prepaid Inpatient Health Plan (PIHP) contract.

**Purpose:** To provide clear guidance for the reporting and review of all deaths and unusual events and/or incidents 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.

**Scope:** The PIHP requires that each participant Community Mental Health Services Program (CMHSP) review, investigate, and act upon sentinel events, critical incidents, and risk events for Medicaid beneficiaries. SWMBH requires that each participant CMHSP report critical incidents as defined by the state of Michigan monthly to SWMBH.
SWMBH staff, volunteers and interns will report suspected abuse, neglect, and exploitation according to the standards set forth in this policy.

**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
   2. Populations that qualify:
      a. Individuals who living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or
      b. Individuals who are living in a Child-Caring institution; or

c. Individuals who are receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services

3. 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.
4. 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 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 previously determined above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.

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: 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.

1. The five specific reportable events are:
    a. Suicide
    b. Non-suicide death
    c. Emergency medical treatment due to injury or medication error
    d. Hospitalization due to injury or medication error
    e. Arrest of person receiving services
2. And includes population and service clarifications on when to report incidents for each event type (Immediate, Sentinel, Critical, and Risk).

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. Immediate Notification: 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.

G. Emergency Medical Treatment (EMT): Medical treatment (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).

H. 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.

I. Medication Errors

1. Any medication errors that result in injury, death, or the risk thereof including:
    a. Missed Medication
    b. Wrong Medication
    c. Wrong Dosage
    d. Wrong Time
    e. Pharmacy Error
    f. Medication Refusal
    g. Medication found/cheeking
    h. Medication Protocol Not Followed
    i. Disposed Medications
    j. Other

J. Injury: A bodily damage that occurs to an individual due to a specific event such as an accident, assault, or misuse of the body. Examples of injuries include bruises (except those due to illness), contusions, muscle sprains, and broken bones. 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).

K. 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.

1. The term "Physical Management" does not include briefly holding an individual to comfort him/her or to demonstrate affection or holding his/her hand.

L. 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.

M. 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.

N. 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.

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

P. 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])

Q. 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.

R. 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.

**Responsibilities:**

A. PIHP Role and Responsibilities:

1. The SWMBH Quality Assurance and Performance Improvement (QAPI) Department is responsible to ensure consistent reporting, recording, tracking and the analysis of all events including critical incidents across Region 4.
2. SWMBH 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. SWMBH will facilitate the reporting of all critical incidents, deaths, and other required data to the State as per MDHHS-Integrated Care Organization (ICO) contract requirements, and other organizations as defined by law and SWMBH contract(s).
4. As per section 6.1.1. of the Michigan Department of Health and Human Services (MDHHS) Managed Specialty Supports contract with the PIHPs; the SWMBH designee will notify MDHHS of 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 SWMBH's receipt of notification of the death, or the SWMBH's receipt of notification that a recipient rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:
   a. Beneficiary ID number (Medicaid, ABW, MIChild)
   b. Consumer ID (CONID) if there is no beneficiary ID number
   c. Date, time, and place of death (if a licensed foster care facility, include the license #)
   d. Preliminary cause of death
   e. Contact person's name and E-mail address
5. The SWMBH Quality Management Department will ensure that the required information and reports are provided to the Quality Management Committee (QMC) for quarterly review or at their discretion.
6. The QMC will review reports on at least a quarterly basis to:
   a. Assess the consistency in reporting across the 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 CMHSPs 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. SWMBH holds no responsibility for determining whether any SWMBH staff member, provider or other SWMBH third party has committed any action or inaction or is otherwise responsible for any

of the events listed above, including a death. SWMBH will be involved as appropriate to meet contractual obligations. The participant CMHSPs and other organizations shall be solely responsible for notifying SWMBH of any of the events noted above, investigating the events, and providing sufficient information to SWMBH to enable it to make all required monthly reports to the State of Michigan and the ICOs.

9. SWMBH will abide by the findings of the participant CMHSP responsible for investigating the event, report the findings to the State based solely on the investigation results and staff leadership determination made by the CMHSP. SWMBH will be involved in and discuss with the appropriate organization about individual events.

**Standards and Guidelines:**

A. The SWMBH minimal standard is to report all unusual 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) as defined in the contract that SWMBH holds with the MDHHS. This includes 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.

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

C. Each CMHSP must forward a summary report of incidents that meet sentinel event, critical incident, or risk event definitions to be reviewed by SWMBH no later than 30 days after the end of the month. Critical Incidents will be reported to MDHHS by a designated SWMBH staff member.

D. Each CMHSP must report immediate events as soon as they become aware of them to the Quality Assurance and Performance Improvement (QAPI) Director

E. Documentation of Incidents

   1. All the MDHHS required information, Integrated Care Organization (ICO) required information, or reporting to law enforcement for reporting and/or tracking incident and events must be submitted to SWMBH within the appropriate timeframes.
   2. All additional data elements that are part of the reporting system, as discussed in the QMC, will be tracked and reported as discussed in the QMC. Information from this additional data will be tracked by SWMBH and available to the CMHSPs.

F. Processing of Immediate Event Notifications

   1. MDHHS requires immediate (within 48 hours) notification if the nature of an event (likely considered sentinel) warrants a police force, licensing, and/or recipient rights investigation (likely a combination). Immediate event notifications can include reports of a death of a recipient, relocation of consumer's placement due to licensing suspension or revocation, an occurrence that requires the relocation of any PIHP/CMHSP/Provider service site or administration, and conviction of PIHP/CMHSP/Provider members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement. These types of events typically garner

interest from the external media and it's important that the PIHP and MDHHS are aware of its implications and can ensure appropriate follow-up.

2. Immediate Event Notification Alerts to the PIHP should be made within 36 hours of learning of the event by email (EventReporting@swmbh.org) and/or telephonically—SWMBH will then forward this information on to MDHHS. When reporting the event notification, please ensure to include the follow pieces of information if applicable:
   a. Legal name of beneficiary
   b. Beneficiary ID number (Medicaid)
   c. Consumer ID (CMHSP)
   d. Date, time, and place of death
   e. Preliminary cause of death
   f. Contact person's name and email address and provider or CMHSP
   g. Condition(s)
   h. Diagnosis(es)
   i. Services received or requested
   j. Quality improvement measures taken to address

G. Processing of Sentinel Events

1. All Sentinel Events must be reported to the PIHP (eventreporting@swmbh.org) within 72 hours of the event or CMHSP become aware of the event due to the severe nature of these incidents. Therefore, 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 must report it to the PIHP (within 72 hours) and 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. While there is no outlined timeframe limit to the RCA, it should be completed timely and thoughtfully.
2. 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.
3. Please see Exhibit B on the PIHP's Event Reporting Submission Process

H. Processing of Critical Incidents

1. Critical incidents must be reported to the PIHP within 30 days following the end of the month in which the event was reported to the CMHSP. For example, an incident that occurred on October 15th should be submitted to SWMBH by November 30th. All events should be compiled into the event reporting excel template provided and sent to EventReporting@swmbh.org. It's important to note the modifiers when reporting these events in the Type, Cause, and Reason columns—for instance, if an injury occurs and staff perform physical management/behavioral intervention to prevent further injury the reason would be "1", whereas if an injury was caused by the physical management, it would be "2" and would be considered a sentinel event as described in the next section.
2. Please see Exhibit B on the PIHP's Event Reporting Submission Process

I. Education and Monitoring

1. ICOs, CMHSPs, and Contract Provider agencies within the SWMBH network will have access to this policy and educational resources through the SWMBH Portal (Resources-Services Policies-Quality

Management). SWMBH will monitor that the policy is being followed by the participating CMHSPs and SWMBH providers, and the CMHSPs are responsible for monitoring their provider network.

2. Monitoring will also include:
    a. The PIHP conducting a Critical Incident and Sentinel Event Audit quarterly on 5% of randomly selected events for each CMHSP.
    b. The PIHP is also to monitor and review that CMHSPs are conducting a root cause analysis when needed. The reviews are completed quarterly (either on-site or by desk audit), or as requested/needed.
3. Technical assistance for event reporting and conducting root cause analysis is available to all providers requesting support from SWMBH.

**References:**

A. MDHHS Medicaid Specialty Supports and Services Contract.
B. Part II, Section 6.1.1 on Event Notification
C. QAPI Programs for Specialty PIHPs (Attachment P.6.7.1.1)
D. Michigan Performance Indicator Codebook – Section on Critical Incident Reporting
E. Technical Requirement for Behavioral Treatment Plan Committee; Revision FY ’12 (Attachment P.1.4.1)
F. MDHHS/PIHP Event Reporting - https://mipihpwarehouse.org/MVC/Documentation
G. M.C.L. 330.723(2) (3) and 330.755f (I) (ii)
H. NCQA – MBHO Standard QI1 - Element B
I. 2020 ICO/SWMBH/MDHHS – 3-way contract, Core Reporting Measures
J. PHIP Contract Section Attachment 6.5.1.1

**Attachments:** None

**Revision History**

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# 03.05 Incident Event Reporting & Monitoring

Final Audit Report 2022-07-25

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