Section: **QAPI**	Policy Name: **Incident Event Reporting & Monitoring**	Policy Number: **03.05**
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Required By: ☐ **BBA** ☒ **MDHHS** ☐ **Other (please specify):** _____	Final Approval By: Alena Lacey	Date Approved: Jun 9, 2023
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☐ **Other (please specify):** _____	Effective Date: **9/29/2014**

Policy: All critical incidents, as defined by the State of Michigan, must be reported to Southwest Michigan Behavioral Health (SWMBH), who will report the incident 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 Medicaid beneficiaries. All incidents not related to members (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 and risk events to SWMBH by the timelines outlined in this policy.

Definitions:

A. Immediate Event: An event (likely considered sentinel) that 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.

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. Unexpected deaths include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect. 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/physical management is considered a sentinel event. MDHHS also requires PIHPs to report, review, investigate, and act upon sentinel events for members receiving Substance Use Disorder (SUD) services that are living in substance abuse residential treatment programs.

C. Unexpected Occurrence: A behavior or event that is not covered within the consumer's treatment/behavior plan, a planned procedure (surgery, etc.), or a natural result of the consumer's chronic or underlying condition or old age.

D. Serious Physical Harm: "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])

E. 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 or a lifestyle change.

F. 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 his/her hand.

G. Root-Cause Analysis (RCA): A class of problem-solving methods aimed at identifying the root causes of problems or events. The practice of an 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. The RCA is focused on identifying systematic areas for improvement, not issues with individual performance. By directing corrective measures at the root causes, it is more probable that reoccurrence will be prevented, or at least reduced.

H. 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. The action plan must be specific, identify who is responsible for implementing the corrective action(s), and a timeline for implementation. Justification must be included if no action plan is deemed necessary.

I. 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.

J. Critical Incident**:** An incident that meets the state reporting definitions of: 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.

1. Suicides must be reported for:

a. Individuals who were actively receiving services at the time of death, and/or

b. Individuals who received emergency services within 30 days prior to their death.

2. Non-Suicide Deaths must be reported for:
   a. Individuals who were actively receiving services at the time of death and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution, or
   b. Individuals who were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver, or Children's Waiver services.
3. Other Critical Incidents must be reported for:
   a. Individuals who were actively receiving services at the time of the incident and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution, or
   b. Individuals who are receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

K. Emergency Medical Treatment (EMT): Emergency medical treatment due to a medication error or an injury that is that is accidental or self-inflicted (i.e., due to harm to self, such as pica, head banging, biting, and including suicide attempts). If the individual is admitted to the hospital the incident should be reported as a hospitalization.

L. 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).

M. Medication Errors: Any medication errors that result in emergency medical treatment or hospitalization, 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

N. Risk Event: A risk event is an occurrence that does not meet the classification of 'critical' or 'sentinel' but may put a consumer at risk of such harm. Risk events minimally include actions taken by members that cause harm to themselves, actions taken by members that cause harm to others, or two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period. Each CMHSP must have 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.

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

P. Elopement: When a person leaves the premises or a safe area without authorization and/or necessary supervision, placing the individual at risk of harm. If a person is late for curfew and there is no expectation of a risk to their safety, it is not considered elopement.

Q. 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.

PIHP's 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 and incidents across Region 4.
2. SWMBH is responsible for reviewing 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 and other required information to the State as per MDHHS 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.
5. The SWMBH QAPI Department will ensure that the required information and reports are provided to the Quality Management Committee (QMC) at least quarterly for review, or at their discretion.
6. The QMC will review reports to:
    a. Assess the consistency in reporting across the region.
    b. Assist in the analysis of all aggregate reports on incidents and risk events to identify any trends and/or 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 conducting investigations and action plans implemented in connection with the events identified above, and the maintenance of all incident reports. A sample of incidents involving investigations and/or a root cause analysis will be reviewed during CMHSP annual delegated function site reviews and may be requested by SWMBH at any time for review.
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 reports to the State of Michigan.

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 as needed.

Reporting Standards and Guidelines:

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.

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. All of the MDHHS required information must be submitted to SWMBH within the appropriate timeframes.

A. Processing of Immediate Event Notifications

1. Each CMHSP must report immediate events as soon as they become aware of them to the SWMBH Quality Assurance and Performance Improvement (QAPI) Department (this includes suspected abuse, neglect, or exploitation). 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) 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. 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 report the information to MDHHS. The following information must be included in the report:
    a. Legal name of beneficiary
    b. Beneficiary Medicaid ID number
    c. Date and place of incident
    d. Preliminary cause of death
    e. CMHSP contact person's name and email address
    f. Provider name

Following an immediate notification, SWMBH will submit to MDHHS within 60 days a written report of its review/analysis of the death of every Medicaid member whose death occurred within one year of the member's discharge from a state-operated service when the PIHP/CMHSP is made aware of the incident (e.g. through the media, a contracted provider, family member, etc.).

B. Processing of Sentinel Events

1. Within three business days of a critical incident a determination must be made by the CMHSP to determine if it meets the criteria of a sentinel event. If it does meet the criteria, the CMHSP has two subsequent business days to start the root cause analysis (RCA) of the incident. Collection of information to determine if it is a sentinel event, including a medical determination for the cause of death, is not equivalent to starting the root cause analysis. While there is no outlined timeframe limit to the RCA, it should be completed timely and thoughtfully.
2. All Sentinel Events must be reported to the PIHP (eventreporting@swmbh.org) within 72 hours of the event, or when the CMHSP becomes aware of the event, due to the severe nature of these incidents.
3. All unexpected deaths of Medicaid members, who at the time of their deaths were receiving specialty supports and services, must be reviewed by the CMHSP and include:
    a. Screens of individual deaths with standard information (e.g., coroner's report, death certificate, etc.)
    b. 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.
    c. Documentation of the mortality review process, findings, and recommendations.
    d. Use of mortality information to address quality of care.

C. Processing of Critical Incidents

1. Residential treatment providers prepare and submit critical incident reports to the respective CMHSP. Each CMHSP must forward a summary report of critical incidents to be reviewed by SWMBH no later than 30 days after the end of the month in which the event occurred. For example, an incident that occurred on October 15th must be submitted to SWMBH by November 30th.
    a. Once it has been determined that a death was suicide, the suicide must be reported within 30 days following the end of the month in which the cause of 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.
2. Critical Incidents are reported to MDHHS by a designated SWMBH staff member via the MDHHS Customer Relationship Management (CRM) system.
3. Remediations that are assigned within the CRM system by MDHHS, or questions asked, are followed up on and responded to by SWMBH within the designated timeframe.
4. Critical incident data is reviewed in the regional Quality Management Committee (QMC) meeting at least quarterly for the purpose of analysis and risk prevention.

D. Processing of Risk Events

1. Each CMHSP must forward a summary report of risk events to be reviewed by SWMBH no later than 30 days after the end of the month in which the event occurred. For example, an event that occurred on October 15th must be submitted to SWMBH by November 30th.
2. SWMBH maintains the risk event data and makes it available to MDHHS upon request.

3. Risk event data is reviewed in the regional Quality Management Committee (QMC) meeting at least quarterly for the purpose of analysis and risk prevention.

E. Education and Monitoring
   1. CMHSPs and Contract Provider agencies within the SWMBH network will have access to this policy and educational resources through the SWMBH website. 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 also includes the PIHP conducting a review of at least 5% of randomly selected incidents for each CMHSP during the annual delegated site audits. The PIHP monitors that CMHSPs are conducting a root cause analysis when needed during that review.
   3. Technical assistance for incident reporting and conducting root cause analyses is available to all providers requesting support from SWMBH.

References:

A. MDHHS/PIHP Medicaid Specialty Supports and Services Contract.
B. MDHHS Quality Assessment and Performance Improvement Program for Specialty Prepaid Inpatient Health Plans Technical Requirement
C. MDHHS Critical Incident Reporting and Event Notification Requirements

Attachments: None

Revision History

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1	3/21/22	Throughout	Annual Review	E. DeLeon
2	6/6/23	Throughout	Annual Review	M. Miller

03.05 Incident Event Reporting Monitoring

Final Audit Report 2023-06-09

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