COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN /PIHP	***Policy*** *Critical Incident, Sentinel Event, and Risk Event Policy*
Department: Compliance **Author:**	**Local Policy Number (if used)**
Regional Operations Committee Approval Date 6/10/20	**Implementation Date** 8/10/20

I. PURPOSE

This policy establishes the standards by which Community Mental Health Partnership of Southeast Michigan (CMHPSM) reviews, investigates, reports, and acts upon, critical incidents, sentinel events, and risk events related to practice of care for its consumers.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
5/5/2014	1	Revised to reflect the new entity. Replaces the Sentinel Event policy.
8/29/2017	2	Due for regional review.
2//12/2020	3	Corrections from HSAG EQR Review on timeframes

III. APPLICATION

This policy shall apply to staff of the CMHPSM as the PIHP, the CMHSPs within the CMHPSM, and administrative/management staff, individual direct service contractors, and directly-operated and contracted network providers of the CMHPSM. Contractual providers are affected to the extent which they would be expected to participate in the reporting and reviews of such events.

IV. POLICY

It is the policy of the CMHPSM that CMHSPs shall have and implemented processes to:

A. Review, investigate, analyze, act upon, internally report and track critical incidents, sentinel events, and risk events, in an accurate and timely manner.
B. Review, investigate, analyze, act upon and report critical incidents and sentinel events to MDHHS in an accurate timely manner.
C. Identify system factors associated with critical corrective action plans to prevent recurrence of critical incidents, sentinel events, and risk events.
D. Develop and implement effective corrective action plans to prevent recurrence of critical incidents, sentinel events, and risk events.

V. DEFINITIONS – All "events" or "incidents" as defined below, shall apply only to individuals actively receiving services.

A. **Critical Incidents:** Any of the following events which should be reported to MDHHS (within the timeframe indicated in below and reviewed by the contracted CMHSP within three (3) business days after occurrence to determine whether it meets the criteria for a sentinel event. If the critical incident is determined to be sentinel event, the PIHP or its delegate has two (2) subsequent business days to commence a root cause analysis of the event. (as defined in section IV.B.)

1. **Suicide**: A death of a consumer when either of the following two conditions exists:
   a. The regional CMHSP or the CMHPSM determines through its death review process, that the consumer's death was a suicide, or
   b. The official death report (i.e. coroner's report) indicates that the consumer's death was a suicide.

2. **Non-suicide death**: any death of a consumer that was not otherwise reported as a suicide. Within this category are expected and unexpected deaths.

3. **Emergency medical treatment due to injury or medication error**: Where an injury to a consumer or medication error results in face-to-face emergency treatment being provided by medical staff at any treatment facility, including personal physicians, medi-centers, urgent care clinics/centers and emergency rooms.

   a. **Injury**: Bodily damage that occurs to an individual due to a specific event such as an accident, assault, or misuse of the body, that results in treatment by medical staff at any treatment facility including personal physicians, medi-centers, urgent care clinics/centers and emergency rooms or admission to a general medical facility. Examples of injuries include cuts, bruises (except those due to illness), contusions, muscle sprains, and broken bones.

   b. **Medication Error**: Where a mistake is made when a consumer takes prescribed medication (i.e. wrong medication, wrong dosage, staff failed to administer). It does <u>not</u> include instances in which consumers have refused medication.

4. **Hospitalization due to injury or medication error**: See above definitions of injury and medication error. Where an injury or medication error results in admission of a consumer to a general medical facility. Hospitalizations due to the natural course of an illness or underlying condition do not fall within this definition.

5. **Arrest**: situation 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.

B. **Sentinel Event**: a critical incident that is an unexpected occurrence involving death or serious physical or psychological injury (emotional harm) or the risk thereof. Serious injury specifically includes the loss of limb or function. The phrase, "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome (i.e. if the event had continued, death or serious physical or psychological injury would have occurred as determined by a physician or

registered nurse.) A sentinel event does not include a death due to natural causes. Additional sentinel events will be described in 1 – 8 below. 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 client death, or other serious medical conditions, must involve a physician or nurse.
Per Michigan Department of Health and Human Services (MDHHS), the sentinel event must be identified and defined as meeting criteria, having occurred for someone within the reportable population. With the exception of arrests/ convictions and serious challenging behaviors, all incidents involving the reportable population should be reviewed within three (3) business days to determine if the incidents meet the criteria and definitions for sentinel events and are related to the practice of care. The outcome of this review is a classification of incidents as either a) sentinel events or b) non-sentinel events.

1. **Unexpected Death***:* The death of a consumer that does not result from natural causes. Unexpected deaths include those that result from suicide, homicide, an undiagnosed condition, accident, or were suspicious due to possible abuse or neglect.

2. **Serious Physical Injury***:* Physical damage suffered by a consumer that a physician or registered nurse determines caused or could have caused the death of a consumer, the impairment of his or her bodily functions, loss of limb, or permanent disfigurement. Injuries that require emergency room visits or admission to hospitals include those resulting from abuse or accidents. Required visits to emergency rooms, medi-centers and urgent care clinics/centers and/or admissions to hospitals should be included in the injury reporting. In many communities where hospitals do not exist, medi-centers and urgent care clinics or centers are used in place of hospital emergency rooms.

3. **Emotional Harm***:* Impaired psychological functioning, growth, or development that is significant in nature as evidenced by observable physical symptomatology, as determined by a mental health professional/ psychiatrist.

4. **Death by Natural Causes***:* Deaths occurring as a result of a disease process in which death is an anticipated outcome. Examples of deaths by natural causes are as follows: death of a consumer due to an acute or long-standing disease process; increased susceptibility to death as a result of diabetes, cancer, advanced heart disease, AIDS, serious infection, etc.; or death of consumer who has been receiving hospice care or treatment for end stage disease. Deaths by natural causes are not considered sentinel events.

5. **Physical Illness requiring admissions to hospitals*:*** Planned surgeries, whether outpatient or inpatient, are not considered unexpected occurrences and therefore are not included in the reporting of illnesses requiring admissions to hospitals. 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.

6. **Serious Challenging Behaviors*:*** Serious challenging behaviors include significant (in excess of $100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leave of absence. They include behaviors not already addressed in a treatment plan.

7. **Medication Errors*:*** mean a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage that resulted in death or serious injury or the risk thereof. It does not include instances where consumers have refused medication.

8. **Arrests/Convictions:** are any arrest or conviction that occurs with an individual who is in the reportable population at the time the arrest or conviction takes place. These events must be reported as Sentinel Events, but do not require a Root Cause Analysis. These must be reported as separate categories through the MDHHS Performance Indicator process.

C. **Risk Event**: An event that puts an individual at risk of harm. Such an event is reported internally and analyzed to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. Risk events minimally include:

1. **Harm to Self**: Actions taken by consumers that cause physical harm requiring emergency medical treatment or hospitalization due to an injury that is self-inflicted (e.g. pica, head banging, self-mutilation, biting, suicide attempts.)

2. **Harm to Others**: Actions taken by consumers that cause physical harm to others (family, friends, staff, peers, public, etc.) that result in injuries requiring emergency medical treatment or hospitalization of the other person(s).

3. **Police Calls:** Police calls by staff of specialized residential settings, or general (AFC) residential homes or other provider agency staff for assistance with a consumer during a behavioral crisis situation regardless of whether contacting police is addressed in a behavioral treatment plan. (See the Behavior Treatment Committee Policy.)

4. **Emergency Use of Physical Management**: Emergency use of physical management by trained staff in response to a behavioral crisis.

5. **Physical Management***:* A technique used as an emergency intervention to restrict the movement of an individual by continued direct physical contact in spite of the individual's resistance in order to prevent him or her from physically harming him/herself or others. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection or holding his/her hand. *(See also definition in the "Behavior Treatment Committee Policy for additional information.)*

D. **Unscheduled Hospitalizations**: Two or more unscheduled admissions to a medical hospital not due to planned surgery or the natural course of a chronic illness (such as a terminal illness) within a 12-month period. Admission to a medical hospital does not include use of an emergency room or emergency department.

E. **Actively Receiving Services**: For reporting purposes, a consumer is actively receiving services" when any of the following occur:

1. A face-to-face intake has occurred, and the individual was deemed eligible for ongoing service, or

2. A Regional Provider has authorized the individual for ongoing service, either through a face-to-face assessment or a telephone screening, or the individual has received a non-crisis, non-screening encounter; and

The occurrence (defined above) takes place between the date when the decision is made to start providing ongoing non-emergent services and the date when the consumer is formally discharged from services.

F. **Actively Receiving a Specific Service**: For reporting purposes, a consumer is considered a recipient of a specific service when service delivery for that specific service takes place between:

1. The date when the consumer has been determined to be eligible, and
2. The date then the consumer is formally terminated from that type of service.
3. Examples of formal termination (end of service) include:

    a) Transfer to another Program,
    b) Discharge from the Program providing the service,
    c) Discharge from the CMHSP service system, or
    d) Removal of the service from the consumer's individual plan of service.

The consumer must have received the specific service at least once.

G. **Clinical Risk Review**: All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:

1. Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
2. Involvement of medical personnel in the mortality reviews
3. Documentation of the mortality review process, findings, and recommendations.
4. Use of mortality information to address quality of care
5. Aggregation of mortality data over time to identify possible trends.

The review must be a formal process which includes a review of areas of clinical risk. The process must include individuals with the appropriate credentials to review the scope of care and include individuals who were not involved in the treatment/ care of the consumer as well as individuals / professionals who may contribute to a thorough review process.

The process shall result in an understanding of causes of the event and if necessary, a root cause analysis with a subsequent action plan implemented in hopes of avoiding similar events from occurring.

H. **Root Cause Analysis**: A process for identifying the basic or causal factors that underlie variations in performance, including the occurrence or possible occurrence of a sentinel event or other serious event. A root cause analysis focuses on systems and processes, not individual performance, and gives the potential for redesign to reduce risk. *(See Exhibit A, Provider Root Cause Analysis Report.)*

I. **Mortality Review**: A process for identifying the basic or causal factors that underlie variations in performance, when the occurrence of a death of a consumer is determined not to be a sentinel event. (For a Sample of Review format, see Exhibit C, Mortality Review Report.)

J. **Program / Setting Definitions**

1. **Child-Caring Institution**: A facility providing residential care for children that is licensed under MCL 722.111, et seq.

2. **Substance Abuse Residential Treatment Program**: Planned individual and group therapeutic and rehabilitative counseling and didactic service that is provided as an intense, organized, daily treatment regimen in a residential setting which includes 24-hour services.

VI. STANDARDS

A. The CMHPSM and the CMHSPs shall collect and require internal reporting on all critical incidents (including sentinel events) and risk events related to practice of care according to MDHHS standards.

B. The CMHPSM electronic health record shall be the means by which critical incidents and risk events are reported by all entities in the CMHPSM system.

C. Incident reports shall be written for all critical incidents and risk events according to CMHPSM incident reporting requirements.

D. The CMHPSM and the Regional CMHSPs shall report to the Michigan Department of Community Health (MDHHS) critical incidents occurring within the populations specified, and in the time frames provided, for each critical incident, in accordance with the provisions of the MDHHS contract.

E. The following parameters shall be met in reporting **critical incidents**:

1. Suicide

a. A consumer's death that has been determined to be a suicide shall be reported on any consumer who was actively receiving services, and all consumers who had received an emergency service within the last 30 calendar days.

b. The suicide shall be reported within 30 days after the end of the month in which the cause of death was determined to be a suicide. If 90 calendar days have elapsed without a determination of cause of death, the responsible Service Providing Agency shall submit a "best judgment" determination of whether the death was a suicide. In this case, the submission is due within 30 days after the end of the month in which this "best judgment" determination was made.

2. Non-Suicide Death

a. Deaths that have not otherwise been reported as a suicide shall be reported on all consumers who, at the time of their deaths were:

1) Living in a 24-hour Specialized Residential setting (per), or a Child- Caring Institution, or living in a substance abuse residential treatment program or

2) Actively receiving Community Living Supports, Supports Coordination, Targeted Case Management, Assertive Community Treatment (ACT), Home Based, Wraparound, Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.

b. The non-suicide death shall be reported within 60 days after the end of the month in which the death occurred, unless reporting is delayed while the responsible Service Providing Agency attempts to determine whether the death was due to suicide. In this case, the submission is due within 30 days after the end of the month in which the responsible Service Providing Agency determined the death was not due to suicide. Natural cause deaths shall be reported, indicating the specific natural cause (e.g. heart disease, pneumonia/influenza, lung disease, vascular disease, etc.)

3. Emergency Medical Treatment Due to Injury or Medication Error

a. Situations where an injury to a consumer or a medication error results in face-to-face emergency treatment shall be reported on all consumers who, at the time of the event were:

1) Living in a 24-hour Specialized Residential setting, or a Child-Caring Institution, or living in a substance abuse residential treatment program, or

2) Actively receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.

b. The incident shall be reported within 60 days after the end of the month in which the emergency medical treatment began.

4. Hospitalization Due to Injury or Medication Error

a. Situations where injury to a consumer or a medication error results in inpatient admission shall be reported on all consumers who, at the time of the event were:

1) Living in a 24-hour Specialized Residential setting), or a Child-Caring Institution, or living in a substance abuse residential treatment program, or

2) Actively receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.

b. The incident shall be reported within 60 days after the end of the month in which the hospitalization began.

5. Arrest of Consumer

a. Arrests shall be reported on all consumers who, at the time of the arrest, were:

1) Living in a 24-hour Specialized Residential setting (), or a Child-Caring Institution, or living in a substance abuse residential treatment program, or

2) Actively receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.

b. The incident shall be reported within 60 days after the end of the month in which the arrest took place.

F. The responsible CMHSP shall internally track **risk events**, occurring within the populations specified below, as expeditiously as possible, and in accordance with the provisions of this policy, and MDHHS requirements.

The population group for risk event reporting includes all consumers who, at the time of the **risk event** (see definition) were actively receiving services and were receiving at least one of the following:

a. Supports Coordination
b. Targeted Case Management
c. ACT
d. Home-based Services

G. The CMHPSM shall ensure that each CMHSP has a mechanism for performance of the following tasks:

1. Classifying and identifying incidents as either sentinel events "critical incidents, or "risk events;"
2. Performing root cause analyses on sentinel events;
3. Performing a review of risk events, and;
4. Performing mortality reviews on deaths that are not sentinel events (e.g. death by natural causes).

All critical incidents would be either a sentinel event or a risk event, and as such would be reviewed/analyzed.

H. Staff identified as responsible to classify, review and analyze the events must not have been directly involved in the incident that is the subject of the review and shall have the appropriate credentials to review the scope of care. For example, events that involved consumer death, or other serious medical conditions, must involve a physician or nurse.

I. The CMHPSM and each CMHSP shall ensure that, within three business days after occurrence an incident is classified as a sentinel event, risk event, critical incident, or non-sentinel deaths.

J. CMHSPs shall ensure guidelines are used in determining if an incident is a critical incident, a risk event, and/or a sentinel event. Once the determination is made, the CMHSP shall ensure that risk events and critical incidents are reviewed and analyzed, and a root cause analysis is completed for sentinel events within the required timeframes.

K. Guidelines for determining if a critical incident is a sentinel event include the following (also see Exhibit E, "Sentinel Event Determination Chart"):

1. The qualifying event involves consumers actively receiving services who meet the population specification for that event; and

2. The incident was unexpected; and

3. The incident resulted in death or serious physical or psychological injury, or (as determined by a physician or nurse) there is a significant change that had the events continued, death or serious physical or psychological injury would have occurred.

4. If the incident is a death, the following deaths shall be considered "unexpected" for purposes of defining the death as sentinel:

a. Consumer deaths that result in a Recipient Rights investigation (e.g. possible abuse or neglect from a care provider);
b. Consumer deaths that result in a police investigation (e.g. possible or actual suicide or homicide);
c. Consumer deaths during elopement, or wandering, from a 24-hour care setting;
d. Consumer deaths that were accidental;
e. Consumer deaths that resulted from an undiagnosed condition.

A critical event will be reviewed within three (3) business days after occurrence to determine whether it meets the criteria for a sentinel event. If the critical incident is determined to be sentinel event, the PIHP or its delegate has two (2) subsequent business days to commence a root cause analysis of the event

L. The CMHPSM shall ensure that CMHSP providers:

1. Initiate root cause analyses of perceived sentinel events immediately upon the incident classification as sentinel, utilizing an approved review process, such as Exhibit A, "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event" based upon The Joint Commission (TJC) configuration. The root cause analysis must be initiated within five days of the date of the occurrence.

2. Initiate reviews of risk events not determined to be sentinel events within ten (10) business days of the date that the incidents are classified as a risk event, utilizing at a minimum, the classification of causal factors, below. Alternately, providers may utilize an approved review process, such as Exhibit A, "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event." Minimally, reports of risk event reviews shall include:

a) Personal Identifying Information
b) Method/Procedure
c) communication
d) Staff-Related
e) Environment
f) Equipment/Materials

3. Initiate mortality reviews of non-sentinel deaths within ten (10) business days of the date that the deaths were classified as non-sentinel. The review must include standard death information, such coroner's report, death certificate (as available); involvement of medical personnel in the review; documentation of the review process and findings; and, as applicable, recommendations for improvement and a corrective action plan. CMHSPs are encouraged to utilize Exhibit C, "Provider Mortality Review," as the review model.

M. When an incident under review is the subject of an active recipient rights investigation, the clinically-responsible provider shall be careful that it not impede, interfere or otherwise compromise the investigation of the ORR pursuant to the standards and procedures under the Policy Office of Recipient Rights (e.g. clinically-responsible provider may not investigate the details of the event but shall instead focus on systemic issues, etc.).

N. For consumer deaths, if, upon receipt of additional documentation, it is determined that an event originally perceived as meeting the definition of a sentinel event is not sentinel (e.g. autopsy report indicates death is due to natural causes) the review team shall perform a mortality review of the death.

O. For consumer deaths, if, upon receipt of additional documentation, it is determined that an event originally perceived as not meeting the definition of a sentinel event is actually determined to be a sentinel event (e.g. autopsy report indicates death is not due to natural causes) the CMHSP shall implement their procedures for a root cause analysis of the death.

P. Death Reporting

1. The PIHP and/ or the CMHSP shall immediately report to MDHHS:

    a. Any death of a consumer who was discharged from a State Facility within 12 months of the date of their death;
    b. Any death that occurs as a result of suspected staff member action or inaction, OR
    c. Any death that is the subject of a recipient rights, licensing, or police investigation.

2. This report shall be submitted electronically within 48 hours of either the death, or the responsible service provider's receipt of notification of the death, or the responsible service provider's receipt of notification that a rights, licensing, and/or police investigation has commenced to: QMPMeasures@michigan.gov and a designated individual of the PIHP and include the following information:

    a. Name of beneficiary
    b. Beneficiary ID number (Medicaid, ABW, MiChild)
    c. Consumer I (CONID) if there is no beneficiary ID number
    d. Date, time and place of death (if a licensed foster care facility, include the license #)
    e. Preliminary cause of death
    f. Contact person's name and E-mail address

    Following notification to MDHHS, the PIHP/ Service Provider shall submit information on relevant events through the MDCH Critical Incident Reporting System.

3. For all deaths, the CMHSP shall submit a written report of its review/analysis of the death to the PIHP, within 45 days of the after the month in which the death occurred. The PIHP will submit the analysis to MDHHS within 60 days after the month in which the death occurred,

Q. Clinically responsible providers shall cooperate with and respond to requests by the PIHP to perform Root Cause Analyses, Mortality Reviews, or Risk Event Investigations, and to follow the PIHP's recommendations for additional action on corrective action plans.

R. The PIHP requires that each CMHSP shall analyze at least quarterly the critical incidents, sentinel events, non- sentinel deaths and risk events to determine what actions need to be taken to remediate the problems or situations and to prevent the occurrence of additional events and incidents.

S. Quarterly reviews of sentinel and non-sentinel deaths shall serve as the basis for an internal report that examines mortality information to address quality of care, and aggregation of mortality data over time to identify possible causes and trends.

T. Quarterly reviews of risk events shall serve as the basis for a report that classifies the reasons for the events

1) For all risk events, **except** unscheduled hospitalizations, the report shall include an analysis of the total number of incidents per calendar month, and the rate of incidents per 100 people served in the identified population, with cumulative year to date from the beginning of the current fiscal year;

2) For risk events that are unscheduled hospitalizations, the report shall include:

a. An aggregate of the total number of hospitalizations by reason/condition per calendar month, and the rate of number of total hospitalizations per 100 people served in the identified population, with cumulative year to date from the beginning of the current fiscal year; and

b. An analysis of the data to identify trends and to identify individuals with multiple hospital admissions.

U. Each CMHSP shall ensure appropriate remediation at the individual and system level, when applicable, and shall maintain records as appropriate to document evidence of remediation efforts.

V. Upon the request of MDHHS or the PIHP, CMHSPs shall cooperate with any MDHHS/PIHP review in providing information/documentation related to the CMHSP's process for the review, investigation, and monitoring of critical incidents, sentinel events, and risk events.

W. Documentation generated during the peer review of sentinel events or deaths of consumers are considered confidential peer review/quality assurance documents. Therefore, all written reports, findings, and recommendations for remedial actions created during the root cause analysis or mortality review shall be kept in a confidential peer review administrative file. No copy of such documents shall be maintained in consumers clinical records Peer review/quality assurance documents include, but are not limited to:

1. The Provider Report of Death
2. The Provider Root Cause Analysis Report
3. The Mortality Review Report
4. Risk Event Reviews
5. Minutes of meetings where event incidents were reviewed and/ or discussed
6. Reports by the WCHO ORR to MDHHS
7. Incident Reports
8. Peer Review reports
9. Corrective Action Plans and other quality improvement plans

VII. EXHIBITS

A. Example of a Template for a Provider Root Cause Analysis Report, using *A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event* (based upon the JCAHO configuration)
B. Example of a Provider Report of Death
C. Example of a Mortality Review Report
D. Critical Incident Reporting Chart
E. Sentinel Event Determination Chart

F. Risk Event Determination Chart (Internal Reporting and Maintaining)
G. Review of Action Plan Based on Root Cause Analysis / Mortality Review Report / Risk Event Investigation

VIII. REFERENCES

A. MDHHS-PIHP Medicaid Managed Specialty Supports and Services Contract, FY
B. 2013, Part II, 6.1.1 Event Notification; Contract Attachment P6.5.1.1. (10/1/11), "PIHP Reporting Requirements for Medicaid Specialty Supports and Services Beneficiaries;" Contract Attachment P6.7.1.1. (FY 12), "QAPIP for Specialty PIHPs"; Technical Guidance on Implementation of Contract Attachment P6.7.1.1. (August 2011)
C. Michigan Mental Health Code, MCL 330.1748(9) 2.MCL 330.1100c(5)
D. Michigan Department of Community Health, Administrative Rules R 330.1274; R330.7046
E. MDHHS Medicaid Provider Manual, Mental Health / Substance Abuse
F. A Framework for a Root Cause Analysis and Action Plan in Response to a
G. Sentinel Event (The Joint Commission)
H. CMHPSM Incident Reporting Policy
I. CMHPSM Office of Recipient Rights Policy
J. CMHPSM Report and Review of Death Policy

Reference:	**Check if applies:**	**Standard Numbers:**
42 CFR Parts 400 et al. (Balanced Budget Act)	X	
45 CFR Parts 160 & 164 (HIPAA)	X	
42 CFR Part 2 (Substance Abuse)	X	
Michigan Mental Health Code Act 258 of 1974	X	
The Joint Commission - Behavioral Health Standards	X	
Michigan Department of Community Health (MDHHS) Medicaid Contract	X	
MDHHS Substance Abuse Contract	X	
Michigan Medicaid Provider Manual	X	
MDHHS Administrative Rule 330.1801-09, Subpart 8. Certification of Specialized Programs Offered in Adult Foster Care Home to Clients with Mental Illness or	X	
CMHPSM Peer Review Policy	X	

Exhibit A, Sample A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event (based on Joint Commission configuration),

SAMPLE

ROOT CAUSE ANALYSIS AND ACTION PLAN
Cover Sheet

Date: Program:

Consumer Name:

Case #:

Date Root Cause Analysis completed:

Meeting Attendees:

Name, Credentials	Position

Exhibit A

Sample - A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action?
What happened?	Sentinel event	What are the details of the event? (Brief description)				
		When did the event occur? (Date, day of week, time)				
		What area/service was impacted?				
Why did it happen? ---- What were the most proximate factors? *(Typically "special cause" variations)*	The process or activity in which the event occurred	What are the steps in the process, as designed? (A flow diagram may be helpful here)				
		What steps were involved in (contributed to) the event?				
	Human factors	What human factors were relevant to the outcome?				
	Equipment factors	How did the equipment performance affect the outcome?				
	Controllable environmental factors	What factors directly affected the outcome?				
	Uncontrollable external factors	Are they truly beyond the organization's control?				
	Other	Are there any other factors that have directly influenced this outcome?				
		What other areas or services are impacted?				

This template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case, and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for "root causes" and risk reduction.

As an aid to avoiding "loose ends," the three columns on the right are provided to be checked off for later reference:

- "Root cause?" should be answered "yes" or "no" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding that is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a "Why?" question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- "Ask "Why?" should be checked off whenever it is reasonable to ask why the particular finding occurred (or didn't occur when it should have) - in other words, to drill down further. Each item checked in this column should be addressed later in the analysis with a "Why?" question. It is expected that any significant findings that are not identified as root causes will have check marks in this column. Also, items that are identified as root causes will often be checked in this column, since many root causes themselves have "roots."
- "Take action?" should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write the number of the associated Action item on page 3 in the "Take Action?" column for each of the Findings that requires an action.

Framework for a Root Cause Analysis (continued)

Level of Analysis		Questions	Findings	
Why did that happen? What systems and processes underlie those proximate factors? *(Common cause variation here may lead to special cause variation in dependent processes).*	Human resources issues	To what degree are staff properly qualified and currently competent for their responsibilities?		
		How did actual staffing compare with ideal levels?		
		What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?		
		To what degree is staff performance in the operant process(es) addressed?		
		How can orientation & in-service training be improved?		
	Information management issues	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?		
		To what degree is communication among participants adequate?		
	Environmental management issues	To what degree was the physical environment appropriate for the processes being carried out?		
		What systems are in place to identify environmental risks?		
		What emergency and failure-mode responses have been planned and tested?		

	Leadership issues: corporate culture	To what degree is the culture conducive to risk identification and reduction?		
	Encouragement of communication	What are the barriers to communication of potential risk factors?		
	Clear communication of priorities	To what degree is the prevention of adverse outcomes communicated as a high priority? How?		
	Uncontrollable factors	What can be done to protect against the effects of these uncontrollable factors?		

Framework for an Action Plan in Response to a Sentinel Event

	Risk Reduction Strategies	Measures of Effectiveness
For each of the findings identified in the analysis as needing an action, indicate the planned action, expected implementation date, and associated measure of effectiveness, OR... If, after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time. Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action. Consider whether pilot testing of a planned improvement should be conducted. Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.	Action Item #1:	Measure:
	Action Item #2:	Measure:
	Action Item #3:	Measure:
	Action Item #4:	Measure:
	Action Item #5:	Measure:
	Action Item #6:	Measure:
	Action Item #7:	Measure:
	Action Item #8:	Measure:
Cite any books or journal articles that were considered in developing this analysis and action plan:		

PROVIDER REPORT OF DEATH

(to be completed by the clinically-responsible provider and submitted to ORR)

Vendor #_____

Provider #_____

VENDOR ORGANIZATION

NAME: PROVIDER NAME:

Consumer Information:	
Consumer:	Clinical Record #:

Incident Report sent to ORR or entered into EII: [ ] YES [ ] NO

Status of case at time of death: [ ] Open [ ] Closed Date closed:

Was the consumer discharged from a state-operated service within one year of the death?

[ ] No [ ] Yes, name of facility: Date of D/C:

Most Recent Address:

Is this a 24-Hour Supervised Residential Arrangement? [ ] Yes [ ] No

Name of Residence:
Type of supervised residence:

[ ] CLF [ ] SIP / Portable Support [ ] AFC [ ] Child Foster Care [ ] Respite Home

Gender: [ ] M [ ] F **Date of Birth:** **Date of Death:**

(Check all that apply)

[ ] Occurred on Provider Premises [ ] Transportation Accident [ ] Apparent Suicide [ ] Apparent Homicide

[ ] Current ORR, Police, or Licensing Investigation into circumstances surrounding death [ ] Undiagnosed condition

[ ] Elopement from WCHO funded 24-hr. Care [ ] Accident

Other:

Most recent diagnosis (DSM-IV):

DSM-IV DIAGNOSIS:		**CODE**						**AXIS IV:**		
AXIS I					:			**1 Primary Support**		
								2 Social		
AXIS I					:			3 Educational		
								4 Occupational		
AXIS I					:			5 Housing		
								6 Economic		
AXIS II					:			7 Health Care		
								8 Legal		
AXIS II					:			9 Other:		
								AXIS V:		
AXIS II					:			Current		
AXIS III (A)					:			Highest in Last Yr		
AXIS III (B)					:			Expected at Dis		

PROVIDER REPORT OF DEATH (continued, p. 2)

Date of most recent med. review: **Physician assigned:**

Medications

All current meds (prescribed, OTC, physical, psychiatric)	**Dosage**	**Blood levels**	**Date**	**Prescribing physician**	**Prescribed**			**Consumer used**		
		(If applicable, e.g., Lithium, Clozaril			W/N 30 day	W/N 24 hour	U/K	W/N 30 day	W/N 24 hour	U/K

(Use additional sheet(s) as needed)

Other substances used, e.g., alcohol, recreational drugs:

Current CMHSP-Arranged Services (provided/scheduled within 30 days prior to death) - *Computer printout of services is acceptable:*

Services	Scheduled (date)	Delivered Y/N

Most recent face-to-face contact with consumer, if any, within last 30 days prior to death (date and type of service):

All crisis interventions (e.g. emergency medication review, visit to hospital ER) within 30 days prior to death:

How was the consumer doing just prior to death or, if discharged, how was consumer doing at time of discharge?

If case was closed at time of death, condition at discharge:

[ ]	Greatly Improved	[ ]	Unchange
[ ]	Moderately Improved	[ ]	Regresse
[ ]	Slightly Improved	[ ]	Unknown

Please circle consumer's condition at discharge.

- 0 1 2 3 4 5 6 7 8 9 10 +
(Worst) (Best

Other relevant information:

Prepared by:

Signature:

Name / Credential / Date (print)

Exhibit C

PROVIDER MORTALITY REVIEW

(To be completed by clinically responsible provider Mortality Review Team)

Consumer Information:

Consumer:_____ Clinical Record # _____

Documents Reviewed: [List all documents reviewed, i.e.: clinical record, autopsy report]

_____

_____

_____

Summary of Findings: _____

_____

_____

Identified Areas for Improvement: _____

_____

_____

Plan of Action / Recommendations: _____

_____

_____

Review Team Members: _____

_____

_____

Exhibit D

Critical Incidents (Reported to MDHHS)

Service (Actively Receiving) or Living Situation	**Suicide**	**Non-Suicide Death**	**Emergency Medical Treatment (EMT) due to Injury or Medication Error**	**Hospitalization due to Injury or Medication Error**	**Arrest of Consumer**
Emergency Service within the last	X				
24-hour Specialized Residential Setting / Child-Caring Institution / Substance	X	X	X	X	X
Community Living Supports	X	X			
Supports Coordination / Targeted Case	X	X			
ACT	X	X			
Home-Based	X	X			
Wraparound	X	X			
Habilitation Supports Waiver	X	X	X	X	X
SED Waiver	X	X	X	X	X
Child Waiver	X	X	X	X	X
Any Other Service	X				
***Reporting Time Frame**	☐ Within 30 days after end of month death determined a suicide, or ☐ Within 30 days after end of month "best judgment" determination	☐ Within 60 days after end of month death occurred, or ☐ Within 30 days after end of month death	☐ Within 60 days after end of month in which the EMT began	☐ Within 60 days after end of month in which the hospitalization began	☐ Within 60 days after end of month in which the arrest took place

***Report the incident if the indicated services have been provided, or if the consumer resides in any of the living situations. Only one checked situation is necessary for the incident to require reporting.**

Exhibit
E

Determining a Sentinel Event

Service (Actively Receiving)	Suicide	Non-Suicide Death	Emergency Medical Treatment (EMT) due to	Hospitalization due to Injury or Medication Error	Arrest of Consumer
Emergency Service within	X				
24-hour Specialized Residential Setting / Child-Caring Institution /	X	X	X	X	X
Community Living Supports	X	X	X	X	X
Supports Coordination / Targeted	X	X	X	X	X
AC	X	X	X	X	X
Home-Based	X	X	X	X	X
Wraparound	X	X	X	X	X
Habilitation Supports	X	X	X	X	X
SED Waiver	X	X	X	X	X
Child Waiver	X	X	X	X	X
Any Other	X				
The event is a "critical incident" if the indicated services have been provided, or if the consumer resides in any of the living situations. Only one checked situation is necessary for the incident to be a reportable "critical incident."					

Step 1: Is Event a "Critical Incident?" (See above chart)
If no, Stop.
If yes, go to Step 2.

Step 2: Was the incident an unexpected occurrence (not from natural causes)?
If no, Stop.
If yes, go to Step 3.

Step 3: Did the incident result in death or serious physical or psychological injury? (Serious injury is major permanent loss of limb or function as determined by a physician or registered nurse; psychological injury is impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology, as determined by a mental health professional.)
If no, go to Step 4.
If yes, CLASSIFY AS SENTINEL EVENT

Step 4: Was there risk of loss? (If the event had continued, loss, i.e., death or serious physical or psychological injury, would have occurred as determined by a physician or registered nurse.)
If no, Stop.
If yes, CLASSIFY AS SENTINEL EVENT AND PERFORM ROOT CAUSE ANALYSIS

Determining a Risk Event

Service	Physical Harm to self (requiring EMT or hospitalization)	Physical Harm to others (requiring EMT or hospitalization)	Police Calls (by staff)	Emergency Use of Physical Management	Unscheduled Hospitalizations (2 in a 12-month period)
Targeted case management/ supports	X	X	X	X	X
Home-Based	X	X	X	X	X
ACT services	X	X	X	X	X
The event is a "risk event" if the indicated services have been provided.					

Clinically Responsible Providers shall have available a written review each Risk Event, addressing, at a minimum, the following:

a. Personal Identifying Information – name, Medicaid ID, disability designation, residential living arrangement type, name of TCM/SC/HB/ACT provider agency, note if consumer self-directs services with name of provider. If event occurred at home, collect name of CLS or personal care, including Home Help. If occurred in a licensed AFC facility, include license number, licensee name and name of home.

b. Method/Procedure – adequacy of clinical assessment, completeness of plan(s), implementation of plans/procedures, consistency of plan(s) with technical requirements and/or best practices.

c. Communication – awareness of consumer's plan; awareness of organizational policies/protocols; contradictory, confusing or missing information /instructions.

d. Staff-Related – staffing levels, staff skill set or competency in applying the methods or procedures, staff training.

e. Environment – noise levels, physical proximity, amount of space for consumer or staff, lighting, physical hazards or condition of the environment.

f. Equipment/Materials – necessary equipment or materials not in proper condition, improperly used, in disrepair, missing.

Exhibit G

(Exhibit G) Clinical Risk Management Committee
Review of Action Plan Based on Root Cause Analysis / Mortality Review Report / Risk Event Investigation

Program Name: **Consumer:** **Case #:** _____

Risk Reduction Strategies	Measures of Effectiveness	Reporting Period ☐ 1st Qtr ☐ 2nd Qtr ☐ 3rd Qtr ☐ 4th Qtr
Action Item #1:	Measure:	Actions Taken:
Action Item #2:	Measure:	Actions Taken:
Action Item #3:	Measure:	Actions Taken:
Action Item #4:	Measure:	Actions Taken:
Action Item #5:	Measure:	Actions Taken:
Action Item #6:	Measure:	Actions Taken:
Action Item #7:	Measure:	Actions Taken:
Signature		Date: