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REGION 10 PIHP

SUBJECT	CHAPTER	SECTION	SUBJECT
Sentinel Events, Critical Incident and Risk Events	07	01	03

CHAPTER	SECTION
Rights of Persons Served	Individual Rights

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I. APPLICATION:

☐ PIHP Board ☒ CMHSP Providers ☒ SUD Providers
☒ PIHP Staff ☒ CMHSP Subcontractors

II. POLICY STATEMENT:

It shall be the policy of Region 10 PIHP to identify and review critical incidents, to reduce the occurrence and to improve systems of care.

III. DEFINITIONS:

Critical Incident (CI): A CI pertains to five specific consumer-related events, or incidents as follows: suicide, non-suicide death, hospitalization due to injury or medication error, emergency medical treatment due to injury or medication error, and arrest of individual.

Sentinel Event (SE): 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 for which recurrence would carry a significant chance of a serious adverse outcome. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

Risk Event (RE): Additional critical events that put individuals (in the same population categories as the critical incidents) at risk of harm. Analysis by the Community Mental Health Service Provider (CMHSP)/Substance Use Disorder (SUD) provider should be used to determine what pro/active measures may need to be taken to remediate the problem or situation and prevent the occurrence of additional events or incidents.

Root Cause Analysis (RCA): The process for identifying or uncovering causes of a problem including variance or nonconformance to process. A Root Cause Analysis focuses primarily on systems and processes, not individual performance.

IV. **STANDARDS:**

A. Critical Incident Reporting System

The MDHHS critical incident reporting system collects information on *critical events*, as linked to specific service recipients. Within this system, CMHSP/SUD treatment providers obtain and report information on the five specific events:

1. Suicide: Any individual actively receiving services at the time of death and any who received emergency services within 30 days prior to death. If 90 calendar days have elapsed without a determination of cause of death, the CMHSP/SUD treatment provider must submit a "best judgment" determination of whether the death was a suicide.
2. Non-Suicide: Death 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, Assertive Community Treatment (ACT), Home-based, Wraparound, Habilitation Supports Waiver, Serious Emotional Disturbances (SED) Waiver, Children's Waiver services or 1915 iSPA services. If reporting is delayed because the CMHSP/SUD treatment provider is determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the CMHSP/SUD treatment provider determined the death was not due to suicide.
3. Emergency Medical Treatment Due to Injury or Medication Error: For people who at the time of the event were actively receiving services and were living in Specialized Residential facility (per Administration Rule R330.1801-09) or in a Child-Caring institution; or were receiving either Habilitation Supports Waiver services, SED Waiver services, Children's Waiver services or 1915 iSPA services and an incident resulting in emergency medical treatment due to injury or medication error occurred. This includes specifying whether the injury was due to a fall or a result of physical management.
4. Hospitalization Due to Injury or Medication Error: For individuals living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, Children's Waiver services or 1915 iSPA services and an incident occurred resulting in hospitalization due to injury or medication error. This includes specifying whether the injury was due to a fall or a result of physical management.
5. Arrest of Consumer: For individuals living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver.

B. Sentinel Events

The CMHSP/SUD treatment provider ensures that all incidents are reviewed to determine if the incident meets the criteria for Sentinel Event. This review process determines what action needs to

be taken to remediate the problem or situation and / or to prevent the recurrence. The individuals involved in the review of Sentinel Events must have the appropriate credentials to review the scope of care. SE reviews are monitored and assessed within the Region 10 Quality Assessment and Performance Improvement Program (QAPIP) through Sentinel Event Review Committee (SERC) monitoring and tracking activities. Refer to the Region 10 PIHP home page tab – Forms (Chapter 7: Rights of Persons Served Policy Forms): Sentinel Events Critical Incidents and Risk Events forms (CMHSP, SUD), and the Region 10 Monthly SUD Critical Incident Report form.

C. Risk Event Management

The CMHSP/SUD treatment provider has a process for reviewing and analyzing *additional critical events* that put individuals (in the same population categories as the critical incidents) at risk of harm. Analysis should be used to determine what pro/active measures need to be taken to remediate the problem or situation and prevent the occurrence of additional events or incidents. Risk Events (RE) minimally include actions taken by individuals who receive services that cause a) harm to themselves or b) to others, and/or c) 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. RE reports are monitored within the Region 10 QAPIP through SERC monitoring and tracking activities. PIHP oversight ensures that adequate processes are in place to determine compliance with the requirements related to RE reviews.

D. Unexpected Deaths

The CMHSP/SUD treatment provider has a process for reviewing and analyzing all unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services. Reviews must include a) screens of individual deaths with standard information (e.g., coroner's report, death certificate), b) involvement of medical personnel in the mortality review process, and c) documentation of the mortality review process, findings, and recommendations. Unexpected deaths include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect. Reports are monitored within the Region 10 QAPIP through SERC monitoring and tracking activities. PIHP oversight ensures that adequate processes are in place to determine compliance with the requirements related to unexpected death reviews. The PIHP ensures regional tracking and trending of aggregate mortality data over time and shares this information with CMHSPs and SUD providers. PIHP oversight also maintains a process to ensure that when notified through any sources (e.g., contracted provider, family member, Michigan Department of Health and Human Services (MDHHS)) of the member's death, and after immediate notification to MDHHS, the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid member whose death occurred within one year of the individual's discharge from a state-operated service in the event the PIHP is ever notified of a death in these circumstances.

V. **PROCEDURES:**

A. CRITICAL INCIDENT REPORTING SYSTEM

CMHSP/SUD Provider

1. Reports critical incidents events to the PIHP within fifty (50) days after the end of the month in which the event occurred for individuals actively receiving services. Individual level data on consumer ID, event date, and event type are provided. Reporting is processed through the Region 10 PIHP software system.
2. Reports suicide events within twenty-five (25) days after the end of the month in which the death was determined to be a suicide.

B. SENTINEL EVENTS

CMHSP/SUD Treatment Provider

1. Determines whether a critical incident meets SE criteria within three (3) business days after the event has occurred.
2. Once classified as a SE, commences an initial Root Cause Analysis (RCA) within two (2) subsequent business days.
3. Communicates with the PIHP Chief Clinical Officer or designee within fourteen (14) calendar days the following details regarding the SE:
    a. Name of beneficiary
    b. Beneficiary Medicaid ID
    c. Date, time, and place of death
    d. Preliminary cause of death
    e. Contact person's name and email address.
4. Communicate with the PIHP Chief Clinical Officer or designee at a minimum of every thirty (30) days. Communications pertain to RCA status, including discretionary review of applicable documents, updates or necessary plans of correction, along with final disposition of the SE review process.

Sentinel Event Review Committee (SERC)

1. Meets monthly to provide SE monitoring and follow-up as deemed necessary. Analyzes SE information to a) ensure CMHSP/SUD program compliance in the SE review process, b) assess for regional systems improvement opportunities, and c) report on systems findings and recommendations to the Region 10 PIHP QAPIP.
2. SERC Chair communicates SE findings and disposition to PIHP Contract Manager/Compliance, as such may pertain to issues of contract compliance, systems performance and/or contract amendment.

C. RISK EVENT MANAGEMENT

CMHSP/SUD Treatment Provider

1. Maintains a process for analyzing and addressing additional critical events that put individuals (in the same population categories as the critical incidents) at risk of harm.
2. Submits documentation to SERC on a quarterly basis.

D. UNEXPECTED DEATHS

CMHSP/SUD Provider

1. Maintains a process for conducting reviews of unexpected deaths.
2. Ensures that the review process includes a) screens of individual deaths with standard information (e.g., coroner's report, death certificate), b) involvement of medical personnel in the mortality review process, c) documentation of the mortality review process, findings, and recommendations, d) use of mortality information to address quality of care, and e) aggregation of mortality data over time to identify possible trends.
3. Submits to the Region 10 SERC mid-year and end-of-year reports summarizing review findings and recommendations.

Sentinel Event Review Committee (SERC)

1. Meets as scheduled to provide monitoring and follow-up as deemed necessary. Analyzes semi-annual reports to a) ensure CMHSP/SUD program compliance in the review process, b) assess for regional systems improvement opportunities, and c) report on systems findings and recommendations to the Region 10 PIHP Quality Improvement Committee (QIC).
2. SERC Chair communicates to PIHP Contract Manager/Compliance report findings and disposition, as such may pertain to issues of contract compliance, systems performance and/or contract amendment.

VI. **EXHIBITS:**

None.

VII. **REFERENCES:**

A. MDHHS Mental Health and Substance Abuse Services Guidance on Sentinel Event Reporting
B. MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract
C. MDHHS Mental Health and Substance Abuse Services Guidance on Sentinel Event Reporting

D. MDHHS Critical Incident Event Notification, and Substance Use Disorder (SUD) Sentinel Events Reporting Requirements, Revised on 8/30/2024.