LAKESHORE REGIONAL ENTITY

POLICY TITLE:	CRITICAL INCIDENT, SENTINEL EVENT, AND RISK EVENT REPORTING	POLICY #7.3	REVIEW DATES	
Topic Area:	QUALITY	ISSUED BY: Chief Executive Officer APPROVED BY: Board of Directors	2/1/2015	
Applies to:	LRE, All Member CMHSPs, LRE Provider Network		3/31/2017	
Review Cycle:	Annually		10/14/2020	
Developed and Maintained by:	LRE Chief Executive Officer or Designee		2/25/2022	
Supersedes:	N/A	Effective Date: January 1, 2014	Revised Date: September 15, 2022	

I. POLICY

Through regular data monitoring and oversight, Lakeshore Regional Entity (LRE) will ensure that all Critical Incidents, Sentinel Events, and Risk Events (CIRE) are reported to the Michigan Department of Health and Human Services (MDHHS) as required by the Prepaid Inpatient Health Plan (PIHP) Medicaid Managed Support and Services Contract.

LRE delegates responsibility for initial identification, investigation, and follow up of Critical Incidents, Sentinel Events, and Risk Events to its Member Community Mental Health Service Programs (CMHSPs), with oversight and monitoring by the LRE. Each Member CMHSP will have established policies and related procedures to ensure compliance with MDHHS regulations regarding reporting Critical Incidents, Sentinel Events, and Risk Events. Member CMHSPs are responsible for reporting data to the LRE within the established time frames.

The LRE CIRE Workgroup and LRE Quality Improvement Regional Operations Advisory Team meet regularly to review data, identify trends, and determine actions needed and required follow-up to Sentinel Events.

The LRE Quality Improvement Regional Operations Advisory Team meets regularly to review data, identify trends, and determine actions needed and required follow-up to Critical Incidents and Risk Events.

Sentinel Events

A. At a minimum, Sentinel Events as defined in the MDHHS contract must be reviewed and acted upon as appropriate. The PIHP or its delegate has three (3) business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two (2) subsequent business days to commence a root cause analysis of the event.
B. Individuals 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.

C. Based on the outcome of the analysis or investigation, the provider must ensure that a plan of action is developed and implemented to prevent further occurrence of the sentinel event. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the provider may prepare a rationale for not pursuing a preventive plan. See Risk Events Management.
D. All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty support and services, must be reviewed and 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.
E. Following immediate event notification to the MDHHS, the PIHP will submit information on relevant events through the Critical Incident Reporting System.

Critical Incidents
The Critical Incident Reporting System captures information on five specific reportable events.

Critical incidents are defined as:
1. Suicides: by any consumer actively receiving services or who received an emergent service within the last 30 calendar days.
2. Non-Suicide Deaths: by consumers who were actively receiving services at the time of their death and met any one of the 2 following conditions:
    a. Living in a Specialized Residential or a Child-Caring Institution or
    b. Receiving any of the following:
        i. Community Living Supports,
        ii. Supports Coordination,
        iii. Targeted Case management
        iv. ACT
        v. Home-Based
        vi. Wrap-Around
        vii. Habilitation Supports Waiver (HSW)
        viii. Serious Emotional Disturbance (SED) Waiver Services or Child Waiver Program Services (CWPS)
3. Emergency Medical Treatment due to Injury or Medication Errors: report consumers who, at the time of event were actively receiving services and met any one of the following two conditions:
    a. Living in a 24-hour Specialized Residential setting (per the Administrative Rule R330.1801- 09) or in a Child-Caring Institution, or

   b. Receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.
4. Hospitalization due to Injury or Medication Errors: by consumers who at the time of the event were actively receiving services and met any one of the following two conditions:
   a. Living in a 24-hour Specialized Residential setting (per the Administrative Rule R330.1801- 09) or in a Child-Caring Institution, or
   b. Receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.
5. Arrests: of consumers who, at the time of their arrest, were actively receiving services and met either of the following two conditions:
   a. Living in a 24-hour Specialized Residential setting (per the Administrative Rule R330.1801- 09) or in a Child-Caring Institution, or
   b. Receiving Habilitation Supports Waiver Services, SED Waiver Services or Child Waiver Services.
6. Unexpected deaths who at the time of their deaths were receiving specialty support and services, are subject to additional review and 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 reviews
   c. Documentation of the mortality review process, findings, and recommendations
   d. Use of mortality information to address quality of care
   e. Aggregation of mortality data over time to identify possible trends

Critical Incidents – PIHP Reporting Timelines: Following notification to the MDHHS, the PIHP will report Critical Incidents, except Suicide, within 60 days after the end of the month in which the event occurred for individuals actively receiving services. 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.

Risk Events Management

The LRE QAPIP has a process for analyzing additional critical incidents that put individuals (in the same population categories as the critical incidents above) at risk of harm. This analysis is 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.

These events minimally include:

1. Actions taken by individuals who receive services that cause harm to themselves.
2. Actions taken by individuals who receive services that cause harm to others.

3. 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.

II. PURPOSE

To ensure the LRE complies with MDHHS contractual requirements for identification, investigation and reporting of all Critical Incidents, Sentinel Events, and Risk Events for individuals served.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the LRE and LRE member CMHSPs.

IV. MONITORING AND REVIEW

This policy will be reviewed by the LRE CEO or Designee on an annual basis.

V. DEFINITIONS

Child Caring Institution: A childcare facility which is organized for the purpose of receiving minor children for care, maintenance, and supervision, usually on a 24-hour basis, in buildings maintained by the institution for that purpose, and operates throughout the year.

Root Cause Analysis: A process for identifying the basic or causal factors that underlies variation in performance, including the occurrence, or possible occurrence, of a Sentinel Event.

Sentinel Event: An “unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes 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." (JCAHO, 1998)

Specialized Residential Setting: Homes/Facilities that are staffed 24 hours a day and are licensed as Adult Foster Care Homes with a specialized residential certification from the Department of Licensing and Regulatory Affairs. Qualified to provide both Community Living Support and Personal Care services under the requirements detailed in the Mental Health and Substance Abuse Section of the Medicaid Provider Manual.

Unexpected Deaths: Include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

Medication Errors: a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage which resulted in death or serious injury or the risk thereof. It does not include instances in which recipients have refused medication.

VI. RELATED POLICIES AND PROCEDURES

A. LRE Quality Policies and Procedures
B. LRE Compliance Policy and Procedures
C. LRE QAPIP
D. LRE Corporate Comp

VII. REFERENCES /LEGAL AUTHORITY

A. MI Administrative Code R330.1801
B. MI Mental Health Code
C. MDHHS Medicaid Specialty Supports and Services Contract
D. MDHHS Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans Policy
E. MDHHS Critical Incident Reporting and Event Notification Requirements

VIII. CHANGE LOG

Date of Change	**Description of Change**	**Responsible Party**
9/9/2022	Added CIRE Workgroup and QI ROAT review responsibilities.	CQO
9/9/2022	Added Sentinel Event definition.	CQO
9/9/2022	Corrected and Added Critical Incidents – PIHP Reporting Timelines	CQO
9/9/2022	Under Reference/Legal Authority Added MDHHS Critical Incident Reporting and Event Notification Requirements	CQO