POLICY TITLE	CRITICAL INCIDENT, EVENT NOTIFICATION, AND SENTINEL EVENT REPORTING	POLICY # 7.3	REVIEW DATES	
Topic Area	**QUALITY IMPROVEMENT**	**ISSUED BY:** Chief Executive Officer	2/1/15	3/31/17
Applies to:	LRE, All Member CMHSPs, LRE Provider Network		10/14/20	2/25/22
			7/1/25	7/1/26
Developed and Maintained by:	LRE Chief Executive Officer or Designee	**APPROVED BY:** Chief Executive Officer		
Supersedes:	N/A	**Effective Date:** January 1, 2014	**Revised Date:** 9/15/22	

I. PURPOSE

To ensure the Lakeshore Regional Entity (LRE) complies with Michigan Department of Health and Human Services (MDHHS) contractual requirements for identification, investigation and reporting of all Critical Incident, Event Notification, and Sentinel Events for individuals served.

II. POLICY

A. Through regular data monitoring and oversight, Lakeshore Regional Entity (LRE) will ensure that all Critical Incident, Event Notification, and Sentinel Events are reported to the Michigan Department of Health and Human Services (MDHHS) as required by the MDHHS/PIHP Master Contract.

B. LRE delegates responsibility for initial identification, investigation and follow up of Critical Incident, Event Notification, and Sentinel Events to its Member Community Mental Health Service Programs (CMHSPs), with oversight and monitoring by the LRE.

1. Member CMHSPs are responsible for reporting data to the LRE within the established time frames.
2. Member CMHSPs will have established policies and procedures to ensure compliance with MDHHS regulations and consistent with LRE Policy 7.3: Critical Incident, Event Notification, and Sentinel Event Reporting.

C. The LRE Quality Improvement Regional Operations Advisory Team (QI ROAT) will regularly review data, identifies trends, and determines required follow-up actions as necessary to Critical Incident, Event Notification, and Sentinel Events.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the LRE and 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.

Critical Incident: Suicide; Non-suicide death; Emergency Medical Treatment due to injury or Medication Error; Hospitalization due to Injury or Medication Error; Arrest of Consumer

Event Notification: Events **i**mmediately reportable to MDHHS as identified in the Critical Incident, Event Notification, And Substance Use Disorder (SUD) Sentinel Event Reporting Requirements.

Master Contract: The agreement between the Michigan Department of Health and Human Services and the Lakeshore Regional entity for the provision of Medicaid Covered Behavioral Health Services.

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. REFERENCES AND SUPPORTING DOCUMENTS

- MI Mental Health Code
- MDHHS/PIHP Master Contract
- MDHHS Critical Incident, Event Notification, and Substance Use Disorder (SUD) Sentinel Event Reporting Requirements
- LRE Corporate Compliance Plan
- LRE Quality Assurance and Performance Improvement Plan (QAPIP)

VII. RELATED POLICIES AND PROCEDURES

- LRE Quality Policies and Procedures

- LRE Compliance Policy and Procedures

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
9/9/2022	Updated Workgroup and ROAT review responsibilities; Updated definitions, reporting Timelines, and references	CQO
7/1/2025	Revised title, updated language, removed procedures (new 7.3b)	COO