Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy* **SUD Sentinel Event Policy**
Committee/Department: **Substance Use Services**	**Regional Operations Committee Review Date** **09/11/2024**
Implementation Date **09/26/2024**	**Oversight Policy Board Approval Date** **09/26/2024**

I. PURPOSE

This policy establishes the standards by which Community Mental Health Partnership of Southeast Michigan (CMHPSM) reports on sentinel events, related to practice of care for individuals receiving SUD residential treatment services, including withdrawal management.

II. REVISION HISTORY

DATE	MODIFICATION
09/26/2024	New policy

III. APPLICATION

This policy applies to:

☐ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☐ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☐ Mental Health / Intellectual or Developmental Disability Service Providers
☒ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Customer Relations Management (CRM) System: For the purposes of this policy, CRM refers to the MDHHS secure electronic database by which the state requires the reporting of sentinel events by the PIHPs.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

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.

Sentinel Event: An incident that is an unexpected occurrence involving death or serious physical or psychological injury (emotional harm) or the risk thereof, shall apply only to individuals actively receiving SUD residential treatment services. Defined further below.

Substance Use Residential Treatment Program: Planned individual and group therapeutic and rehabilitative counseling and didactic service provided in a 24-hour residential setting. This includes ASAM level 3.2 and 3.7 withdrawal management services.

V. POLICY

This policy establishes the standards by which SUD residential treatment providers within the Community Mental Health Partnership of Southeast Michigan (CMHPSM) system of care report on sentinel events to the CMHPSM, and how the CMHPSM will ensure these events are reported to MDHHS through the state the CRM system.

SUD providers covered by this policy shall ensure sentinel events that occur at their agency are reported internally and to CMHSPM accurately and within the required timeframes. Providers will use the CMHPSM Sentinel Event Reporting Form (Exhibit A) when reporting sentinel events to the CMHPSM. In addition, they will complete an internal root cause analysis including any system factors or corrective action plans related to preventing the recurrence of a sentinel event. Providers shall ensure they follow standards related to their accrediting body where applicable.

A sentinel event must be identified and defined as meeting criteria and have occurred for someone within the reportable population. See timeframes in Standards Section A.

Only the incidents outlined below are classified as sentinel events and are to be reported to the CMHPSM:

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 or Psychological 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 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, 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, urgent care clinics or centers are used in place of hospital emergency rooms. Psychological injury or emotional harm may also be included.

3. Unexpected Physical Illness: This is considered a sentinel event if it requires admission to a hospital. It is not considered a sentinel event for admissions directly related to the

natural course of a chronic illness, or underlying condition. Planned surgeries, whether outpatient or inpatient, are also not included in the reporting of sentinel events. 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.

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

5. Serious Challenging Behaviors: These 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.

6. Arrests/Convictions: Any arrest or conviction that occurs with an individual in SUD residential treatment services 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.

Deaths by natural causes are not considered sentinel events. 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 related illnesses, serious infection, etc.; or death of consumer who has been receiving hospice care or treatment for end stage disease.

Root Cause Analysis Process

A root cause analysis must be completed within two (2) subsequent business days after the incident is determined to be a sentinel event. Specifically, providers have three (3) business days to determine if the incident meets the criteria and definition for a sentinel event and is related to the practice of care. Then two (2) business days thereafter to commence a root cause analysis of the event if it had been identified as a sentinel event. This is not required for submission but should be available to CMHPSM upon request. Please see below for more detailed instructions.

PIHP Sentinel Events Tracking and Compliance

CMHPSM tracks information internally on timeliness of reporting and compliance with standards by SUD provider.

VI. STANDARDS

A. SUD Provider Reporting and Documentation

1. SUD Providers covered under this policy will ensure sentinel events are reported to the CMHSPM within the required timeframe of 24 hours using the CMHPSM SUD Sentinel Event Report Form.
2. SUD Providers covered under this policy will ensure all timeframes in identifying, reporting, and conducting a root cause analysis of a sentinel event are met and reported to the CMHPSM
3. Sentinel events involving the reportable population shall be reviewed within three (3) business days of discovery to determine if the incident meets the criteria and definitions for a sentinel event and is related to the practice of care.
4. If not immediately determined as a sentinel event, the SUD provider must report final determination to CMHPSM within 24 hours of this decision.
5. The SUD provider will ensure a root cause analysis is completed for sentinel events within two (2) subsequent business days after the determination was made.

6. The SUD provider will maintain documentation of when the event was reported internally and to the CMHPSM, when it was reviewed, whether it was determined to be a sentinel event, and when the root cause analysis commenced.
7. Documentation generated during the peer review of sentinel events is 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 the clinical records of consumers/individuals being served.

B. Root Cause Analysis Process

1. A root cause analysis must be completed for SUD sentinel events within two (2) subsequent business days after the determination was made. Specifically, providers have three (3) business days to determine if an incident meets the criteria and definitions for sentinel events and are related to the practice of care, and two (2) business days thereafter to commence a root cause analysis of the event if it had been identified as a sentinel event.
2. SUD Providers will ensure the Root Cause Analysis (RCA) of a sentinel event meets the following, at minimum:
   - Information reviewed and found regarding the sentinel event
   - Actions taken or changes made, if any
   - Changes that have been implemented and whether they are effective in preventing future occurrences
   - Documentation of trends and findings, and how this information will be tracked.
   - Any improvements made as a result of the RCA and how they will be monitored to ensure the prevention of future occurrences
3. Individuals involved in the RCA 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.
4. Staff identified to classify, conduct the RCA review and analyze the events must not have been directly involved in the incident that is the subject of the review
5. This is not required for submission but should be available to CMHPSM upon request.

C. CMHPSM Reporting and Oversight

1. The CMHPSM shall collect and require reporting on all sentinel events related to practice of care according to MDHHS standards.
   The CMHPSM shall collect data analysis and review trends of SUD sentinel events to identify recommendations or potential performance improvement projects, which will be reported quarterly to the regional Clinical Performance Team as the entity that oversees the CMHPSM Quality Assessment and Performance Improvement Plan (QAPIP).
2. The CMHPSM shall report to MDHHS sentinel events occurring within the populations specified, and in the timeframes provided for each sentinel event in accordance with the provisions of the MDHHS contract. The CMHPSM electronic health record shall be the means by which CMHPSM staff report SUD sentinel events to MDHHS following receipt of a completed report from the SUD provider. This reporting system in the CMHPSM EHR provides a direct feed to the MDHHS CRM event reporting system.
3. At the request of MDHHS or CMHPSM, SUD providers shall cooperate with MDHHS or CMHPSM in providing information or documentation related to the review, investigation, and monitoring of sentinel events.

VII. EXHIBITS

A – C: Sample Frameworks for a Root Cause Analysis and Action Plan in Response to Sentinel Event

VIII. REFERENCES

A. MDHHS-PIHP Medicaid Managed Specialty Supports and Services Contract, FY2024
B. Michigan Mental Health Code, MCL 330.1748(9) 2.MCL 330.1100c(5)
C. MDHHS, Administrative Rules R 330.1274; R330.7046
D. MDHHS Medicaid Provider Manual
E. Sample Framework for a Root Cause Analysis and Action Plan in Response to Sentinel Event (The Joint Commission)
F. CMHPSM Regional Critical Incident, Sentinel Event, and Risk Event Policy

CMHPSM Sentinel Event Policy EXHIBITS

Exhibit A

Sample 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 of Event:

Date Event Determined as Sentinel Event:

Date Root Cause Analysis completed:

Meeting Attendees:

Name, Credentials	Position

Exhibit B

Sample Framework – Sentinel Event Root Cause Analysis and Action Plan

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?				

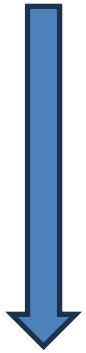
This template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case, and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest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

Sample Framework – Sentinel Event Root Cause Analysis and Action Plan (continued)

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
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?				

Exhibit C

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:		