Quality Assessment Performance Improvement Program
Quality Improvement Council – Critical Incidents

Overview

Mid-State Health Network values the safety of the individuals served within the MSHN Provider Network. The Quality Assessment and Performance Improvement Program(QAPIP) outlines a process for monitoring and reviewing adverse events that put individuals served at risk. The review and monitoring of adverse events will assist in identifying the underlying causes and implementing changes to prevent recurrence and increase the safety of the individual served.

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrant additional review. A subset of the adverse events will qualify as "reportable events" in accordance with the Michigan Department of Health and Human Services (MDHHS) Critical Incident and Event Notification Technical Requirement. MDHHS defined events include sentinel events, critical incidents, and risk events.

MSHN ensures that the MSHN Provider Network has a system in place to monitor these events and utilize staff with appropriate credentials for the scope of care, for review and/or follow up within the required timeframes. The following bullets outline the responsibilities of both the MSHN region and the MSHN Provider Network.

- MSHN submits and/or reports required events to MDHHS including events requiring immediate notification as specified in the MDHHS PIHP FY23 contract and the Critical Incident Reporting and Event Notification Policy. Beginning in FY23 the reporting system transitioned to the Behavioral Health (BH) Customer Relationship Management System (CRM) from the MPHI PIHP Warehouse.
- MSHN delegates the responsibility of the review and follow-up of sentinel events, critical incidents, and other risk events that put people at risk of harm to the MSHN Provider Network.
- The MSHN Provider Network is responsible for reviewing critical incidents to determine if the incident is sentinel. Once appropriately qualified and credentialed staff identify an incident as sentinel, a root cause analysis/investigation is to commence within 2 business days of the identification of the sentinel event.
    - The Community Mental Health Service Program (CMHSP) Participants report suicide deaths, non-suicide deaths, arrests, emergency medical treatment and/or hospitalization for injuries and medication errors for required populations as defined by MDHHS.[1] Additionally, subcategories reported for deaths include accidental/unexpected and homicide. Subcategories for emergency medical treatment and hospitalizations include those injuries from the use of physical management.
- The MSHN Provider Network, based on the root cause analysis/ investigation, will develop and implement either a plan of action to address immediate safety issues, an intervention to prevent further occurrence or recurrence of the adverse event, or documentation of the rationale for not pursuing an intervention. The plan shall address the staff and/or

[1] Quality-Critical Incidents

program/committee responsible for implementation and oversight, timelines, and strategies for measuring the effectiveness of the action. [2]

- The MSHN Provider Network is responsible to report any death that occurs as a result of staff action or inaction, subject to recipient rights, licensing, or police investigation within 48 hours of the death or receipt of the notification of the death and/or investigation.
- The CMHSP Participants monitor risk events and include actions taken by individuals receiving services as defined by MDHHS, that may cause harm to self or others, and have had two or more unscheduled admissions to a medical hospital within 12 months.
- MSHN provides oversight and monitoring of the MSHN Provider Network processes for reporting sentinel events, critical events, events requiring immediate notification to MDHHS, and monitoring of risk events. In addition, a quarterly analysis of the events, identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction is reviewed with the relevant committees and councils.

The MDHHS BH CRM currently does not have reporting functions. The source of the information in this report is from MSHN REMI Critical Incident Standard Report. Changes in the events that are reported through the critical incident reporting system are indicated below in red font for additions and strike through font for deletions.

The following events are reported by the CMHSP Participants for population subsets based on event.

- Deaths-Suicide (All)
- Non-Suicide- Subsets of deaths include natural cause, accidental, homicidal.
- Unknown Cause of Death (New FY23)-Any death that cannot be determined as suicide or natural cause without additional information. This event type can be updated when cause of death is confirmed.
- Emergency Medical Treatment-Subsets include medication error and injury.
- Hospitalization- Subsets include medication error and injury.
- Arrest

This performance summary will be used to

- review performance
- identify areas of improvement

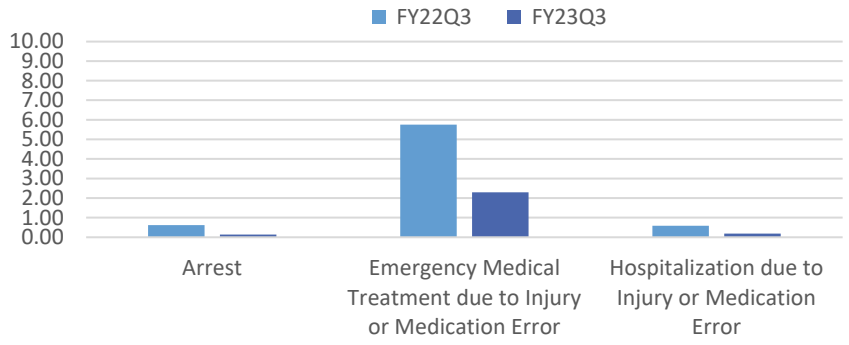
[2] Quality-Sentinel Events

Performance Summary

Outcome Goals:

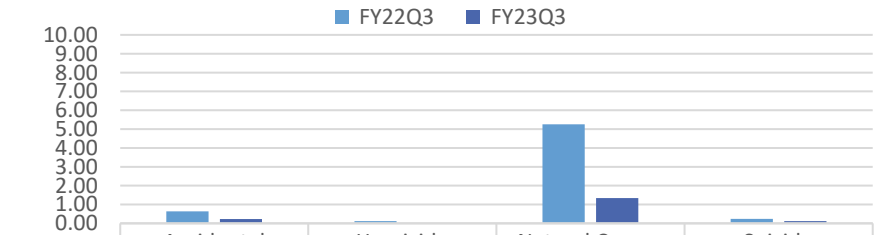
1. MSHN will demonstrate a decrease in the rate of critical incidents, excluding deaths from the previous year. Critical Incidents include an arrest, emergency medical treatment/hospitalization for an injury or medication error for individuals who are receiving a waiver service.

Figure 1: CIRS-Critical Events excluding Deaths.Cumulative rate per 1000 unique consumers served.



2. MSHN will demonstrate a decrease in the rate of Suicide Deaths and Non-Suicide Deaths from the previous year.
   The non-suicide deaths are broken down into three sub types which include: death of unknown cause, accidental, homicidal, natural cause.

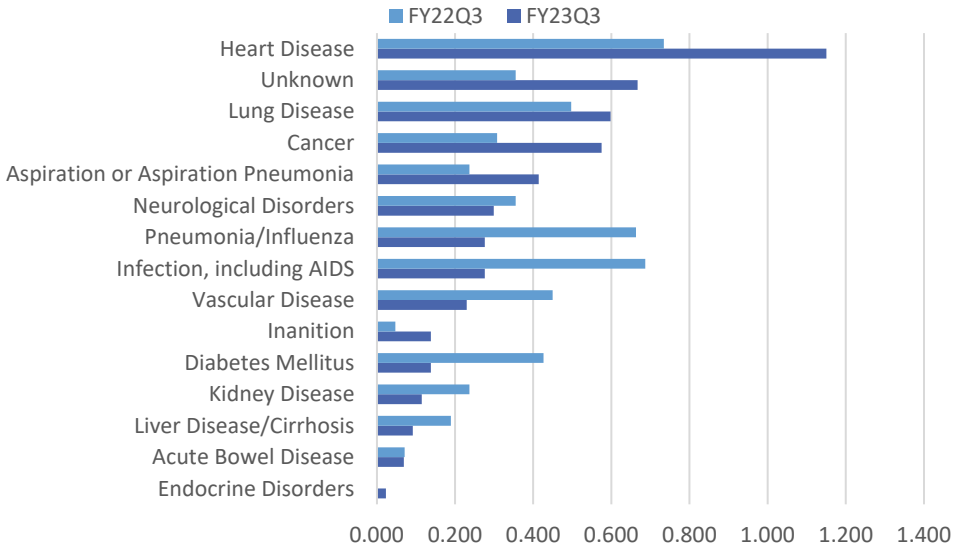
Figure 2: CIRS-Deaths. Cumulative Rate per 1000 unique consumers served.



	Accidental	Homicide	Natural Causes	Suicide
FY22Q3	0.639	0.118	5.258	0.237
FY23Q3	0.232	0.000	1.343	0.116

Natural cause deaths are those that have been diagnosed and treatment has been received. The leading cause of death was heart disease followed by lung disease and cancer. The largest decreases in rate were pneumonia/influenza, infection including AIDS, and diabetes mellitus.

Figure 3: CIRS-Natural Cause Death. Rate per 1000 unique consumers served FY23Q3 (cumulative).



Barriers:

- CMHSPs are requesting death certificates to verify the cause of death for accurate reporting and interventions. This has resulted in a delay in reporting, and additional cost. County offices are charging different amounts for the request of a death certificate.
- CMHSPs are required to make a Best Judgement determination if a cause of death cannot be determined by a medical examiner within 90 days after the event. A best judgment determination may not be possible due to limited information available to the medical directors.

Recommendations:

Performance

- MSHN to identify shifts in data using control limits, that require additional analysis. *Status: Initiated.*
- MSHN QIC and CMHSPs should review unexpected and accidental deaths to identify specifically the cause of death such as drug related, accidental overdose, or any other cause that may benefit from an intervention. *Status: In Progress. The new reporting system includes a category for overdose deaths for SUDTP. A recommendation has been made to include this category for the CMHSP Participants in addition to the SUDTP.*
- Review with regional medical directors for additional insight and recommendations related to death data. *Status: Initiated*

Prepared by: Sandy Gettel, Quality Manager **Date:** 10/20/2023
Distributed to: MSHN QIC **Date:** 10/26/2023

Attachment 1

MSHN
Mid-State Health Network

Quality Assessment Performance Improvement Program
Quality Improvement Council – Critical Incidents

Table 1. Number of Critical Event Types YTD per CMHSP (FY23Q3)

FY23Q3 YTD	MSHN	BABH	CEI	CMHCM	GIHN	HBH	Right Door	LifeWays	MCN	NCMH	SCCMHA	SHW	TBHS
Arrest	**26**	**1**		**5**			**1**	**3**	**7**		**7**	**2**	
Death of Unknown Cause	**3**		**1**	**1**							**1**		
Emergency Medical Treatment	**277**	**20**	**61**	**44**	**10**	**6**	**2**	**44**	**13**	**8**	**46**	**11**	**12**
Injury	273	19	61	44	10	6	2	44	13	8	43	11	12
Medication Error	4	1									3		
Hospitalization	**16**	**1**	**1**	**9**				**2**	**2**		**1**		
Injury	16	1	1	9				2	2		1		
Non-Suicide Death	**255**	**27**	**47**	**48**	**4**	**9**	**14**	**33**	**10**	**11**	**42**	**9**	**1**
Accidental	34	4	6	3			4	5			10	2	
Homicide	1		1										
Natural Causes	220	23	40	45	4	9	10	28	10	11	32	7	1
• Acute Bowel Disease	3	1	1					1					
• Aspiration/Aspiration Pneumonia	18	2	7	6	2				1				
• Cancer	25	6	1	4			3		2	2	6	1	
• Diabetes Mellitus	6		6										
• Endocrine Disorders	1			1									
• Heart Disease	50	5	5	10	2		1	14	1		9	3	
• Inanition	6			1				3			2		
• Infection, including AIDS	12	3	2	3			1				3		
• Kidney Disease	5			1							4		
• Liver Disease/Cirrhosis	4			1			2				1		
• Lung Disease	26	2	6	5		1		4	2	2	4		
• Neurological Disorders	13	1		6			1	1		1	1	1	1
• Pneumonia/Influenza	12	2	3	2		1			1		2	1	
• Unknown	29		5	4		7	2	4	3	4			
• Vascular Disease	10	1	4	1				1		2		1	
Serious Challenging Behaviors(SUD Only)	**1**		**1**										
Suicide	**9**		**1**	**3**				**1**	**1**		**3**		
Overdose Death	2			1							1		
Suicide	7		1	2				1	1		2		
Grand Total	**587**	**49**	**112**	**110**	**14**	**15**	**17**	**83**	**33**	**19**	**100**	**22**	**13**

Data Pull Dates FY20, FY21 9/15/2022; FY22 11/16/2022; FY23 3/24/2023; FY23Q3 10/19/2023