Quality Assessment Performance Improvement Program
Critical Incidents -Performance Summary

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 FY24 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 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.

[1] Quality-Critical Incidents

[2] Quality-Sentinel Events

- 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

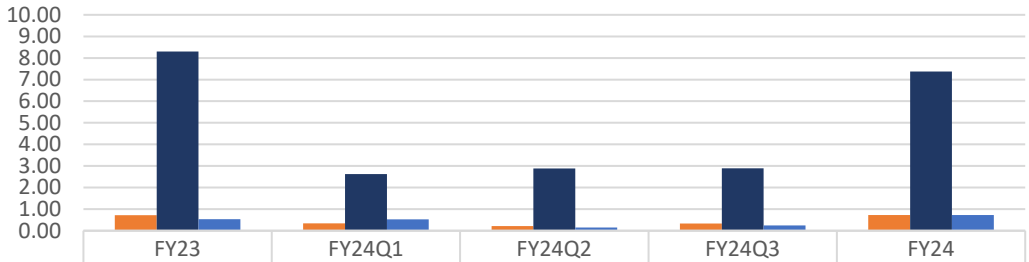
- Review performance
- Identify areas of improvement

Performance Summary

MSHN Balanced Scorecard Measure:

1. The rate of critical incidents, per 1000 persons served, will demonstrate a decrease from the previous measurement period. (CMHSP) (excluding deaths) Cumulative YTD.
   (FY23 8.56, updated 7/17/2024 to FY23 9.55) MSHN's current cumulative rate through FY24Q3 is 8.85.
   Numerator: The cumulative number of critical incidents (excluding death) that occurred during the YTD FY quarter. (REMI Report Catalog>Critical Incidents>Export to CSV File)
   Denominator: The number of cumulative distinct individuals served during the fiscal year YTD quarter. (PowerBI Unique Medicaid Consumers by CMHSP)

Figure 1: CIRS-Critical Events excluding Deaths. Quarterly rate with cumulative YTD FY rate per 1000 unique consumers served.



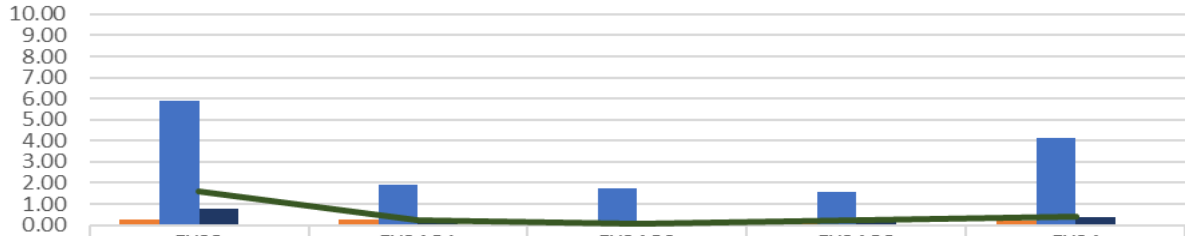
	FY23	FY24Q1	FY24Q2	FY24Q3	FY24
Arrest	0.719	0.339	0.212	0.335	0.727
EMT due to Injury/Medication Error	8.297	2.622	2.883	2.889	7.373
Hospitalization due to Injury/Medication Error	0.534	0.524	0.152	0.243	0.727

2. The rate, per 1000 persons served, of Unexpected Deaths will demonstrate a decrease from previous measurement period. (CMHSP) Cumulative YTD. (FY23 1.047, updated 7/17/2024 1.623) MSHN's current cumulative rate through FY24Q3 is .395.

   Numerator: The cumulative number of unexpected deaths which include suicide death, accidental death, homicide death that occurred during the YTD FY quarter. (REMI Report Catalog>Critical Incidents>Export to CSV File)

   Denominator: The number of cumulative distinct individuals served during the fiscal year YTD quarter. (PowerBI Unique Medicaid Consumers by CMHSP)

Figure 2: CIRS-Unexpected Deaths. Quarterly rate with cumulative FY YTD rate per 1000 unique consumers served.



	FY23	FY24Q1	FY24Q2	FY24Q3	FY24
Suicide	0.288	0.247	0.061	0.152	0.208
Natural Cause	5.915	1.912	1.730	1.582	4.112
Accidental	0.760	0.185	0.121	0.213	0.374
Homicidal	0.062	0.031	0.030	0.000	0.042
Unexpected Deaths	1.623	0.216	0.091	0.243	0.395

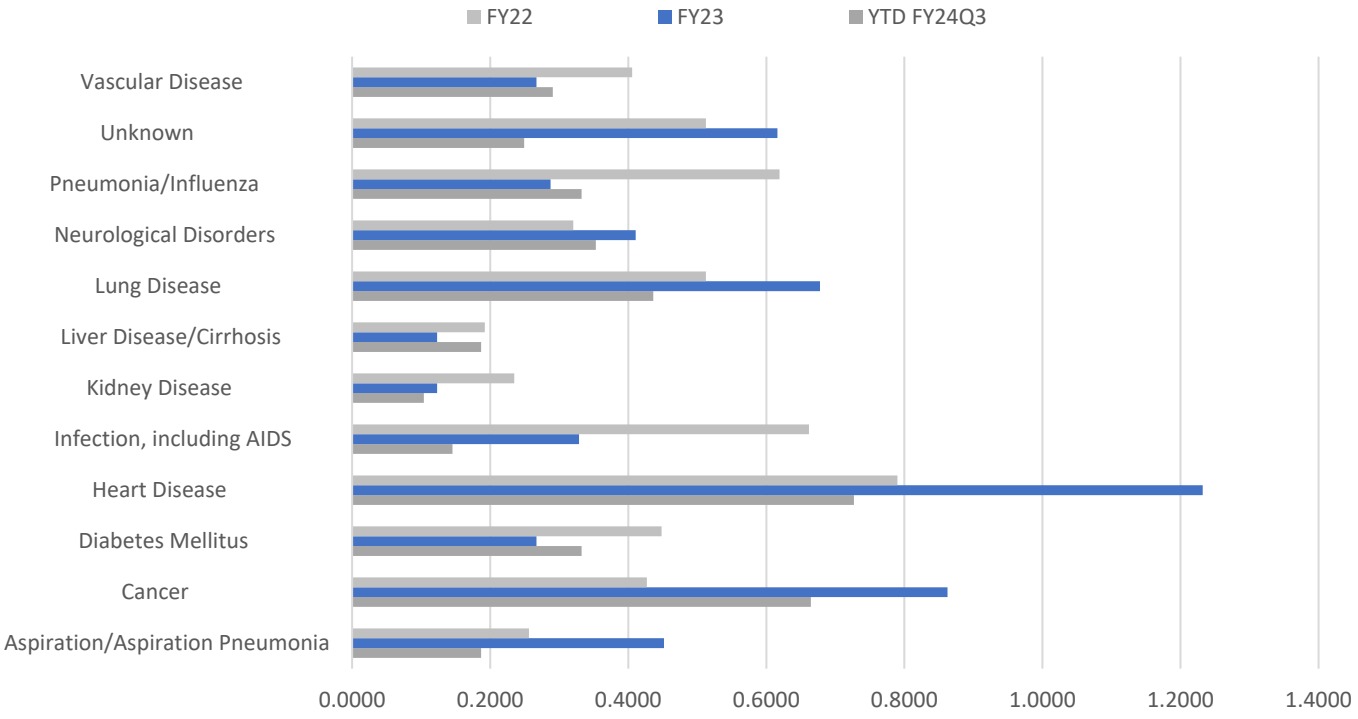
Quality-Track and Trend Data Review:

3. The rate of natural cause deaths, including the leading causes of death. (Track and Trend Data) Natural cause deaths are those that have been diagnosed and treatment has been received.
   The leading cause of death for FY24Q3 was Heart Disease followed by Cancer then Lung Disease.

Recommendations:

- The CMHSPs should develop a process to update unknown deaths.
- Monitor related performance measures to ensure barriers and interventions are being identified and coordination with primary care physicians is occurring.

Figure 3: CIRS-Natural Cause Death. Rate per 1000 unique consumers served FY21 through FY24Q3



Quality Improvement

QAPIP Workplan Goal Statement:

1. MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract and the MDHHS Critical Incident and Event Notification Policy.

Objectives:

1. Develop training documents and complete training outlining the requirements of reporting critical, sentinel, and risk events. Status: In Progress
2. Validate / reconcile reported data through the CRM. Status: In Progress. See Process Improvement Summary.
3. Establish electronic process for submission of sentinel events/immediate notification, remediation documentation, and written analysis for those deaths that occurred within one year of discharge from state operated service. Status: In Progress. See Process Improvement Summary. Updates are being made to the REMI reporting process.

4. Complete CIRS Performance Reports (including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent recurrence) quarterly. Status: Completed-ongoing.

QAPIP Workplan Goal Statement: MSHN will improve the timeliness of remedation response in the CIRS-CRM.

Objectives:

1. Develop dashboard for tracking and monitoring submission timelines and remediation timelines. Status: Planning. See Process Improvement Summary

Provider Network Performance

Figure 4. Number of Critical Event Types per CMHSP (FY23 through FY24YTD pulled 10/17/2024)

Event	FY23Q1	FY23Q2	FY23Q3	FY23Q4	FY23	FY24Q1	FY24Q2	FY24Q3	FY24Q4	FY24YTD
Arrest	12	8	6	9	35	11	7	11	6	35
Death of Unknown Cause	1		2	7	10	5	10	3	12	30
Emergency Medical Treatment due to Injury or Medication Error	80	94	104	126	404	85	95	95	80	355
Injury	79	92	102	122	395	84	94	93	78	349
Injury was not during physical management	79	91	101	120	391	84	94	93	78	349
Injury was during physical management	0	0	0	1	1	0	0	0	0	0
Unknown whether injury was during0 physical management0		1	1	1	3	0	0	0	0	0
Medication Error	1	2	2	3	8	0	1	2	2	5
Overdose	0	0	0	1	1	1	0	0	0	1
Hospitalization due to Injury or Medication Error	4	5	8	9	26	17	5	8	5	35
Injury	4	5	8	9	26	17	5	8	5	35
Non-Suicide Death	92	90	73	80	335	69	63	61	29	222
Accidental	9	8	10	10	37	6	4	7	1	18
Homicide		1		2	3	1	1	0	1	3
Natural Causes	79	79	62	68	288	62	57	52	27	198
Acute bowel disease	1	1	1		3	0	2	0	0	2
Aspiration or Aspiration pneumonia	7	7	4	4	22	4	2	1	2	8
Cancer	7	12	6	17	42	9	8	8	7	32
Diabetes mellitus	3	2	1	7	13	9	5	1	1	16
Endocrine disorders		1			1	0	0	0	0	0
Heart Disease	19	18	14	10	61	14	10	9	2	35
Inanition	1	2	3	3	9	1	1	0	1	3
Infection, including AIDS	7	2	3	4	16	1	5	1	0	7
Kidney disease	3	1	1	1	6	2	1	1	1	5
Liver disease/cirrhosis	1	1	2	2	6	4	2	2	1	9
Lung Disease	10	7	9	7	33	3	8	5	5	21
Neurological disorders	4	3	6	7	20	5	4	7	1	17
Pneumonia/Influenza		10	2	2	14	3	4	8	1	16
Unknown	13	9	6	1	29	1	2	7	2	12
Vascular Disease	3	3	4	3	13	6	3	2	3	14
Overdose Death	4	2	1	0	7	0	1	2	0	3
Serious Challenging Behaviors	1	0	0	3	4	0	1	0	0	1
Suicide	3	1	6	4	14	8	2	6	6	22
Grand Total	193	198	199	238	828	195	183	184	138	700

Data Pull Dates FY24Q1 4/8/2024, FY23 updates and FY24 10/17/2024

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.
- Definitions and causes of deaths are outdated and unclear.

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 causal factors and develop systemic interventions if applicable. *Status: In Progress.*
- Review with regional medical directors for additional insight and recommendations related to death data. Request definitions and updated cause of death listing. *Status: In Progress.*

Prepared by: Sandy Gettel, Quality Manager **Date:** 10/22/2024
Distributed to: MSHN QIC **Date:** 10/24/2024