HealthWest

Policy and Procedure

No. 04-024

Prepared by:

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Approved by:

Subject: Peer Review and Root Cause Analysis

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I. POLICY

HealthWest is committed to identifying and correcting processes or variations in care and services that may lead to undesirable or unanticipated events affecting the recipients to whom it provides services. Peer review will be utilized in order to establish evaluation mechanisms for clinical care and service delivery that identify opportunities for improving care.

II. PURPOSE

To define peer review functions of HealthWest and Agency response and processes following a critical incident, risk event, or other significant event so that the risk of any reoccurrence is reduced.

Following a significant event, a group process will occur to review agency procedures, evaluate actions taken, and make recommendations for further training, procedure change, or interventions that will improve care for the recipients served by HealthWest.

III. APPLICATION

All staff within HealthWest including interns, volunteers, and contracted providers.

IV. DEFINITIONS:

A. Clinical Supervision/Case Conferences: Team meetings and/or regular meetings held by clinical service staff where individual care and clinical planning takes place, including peer/supervision suggestions that are given to assist in treatment.

B. Critical Incident: Includes suicide, non-suicide death, hospitalization due to injury or medication error, emergency medical treatment due to injury or medication error, and arrest of a person served.

C. Clinical Chart Review: A process with identified and trained staff that performs case reviews of the Person-Centered Plans and other service documentation of recipients served by HealthWest.

D. Mental Health Professional: An individual who is trained, experienced and licensed in the area of mental illness, substance abuse, and/or intellectual/developmental

disabilities in the State of Michigan.

E. Peer: Any physician, psychiatrist, social worker, psychologist, nurse, nurse practitioner, physician assistant, other clinical professionals and/or designated staff who meet basic qualifications with clinical experience and training to provide an evaluation of a specific significant issue or general case or process review. The peer(s) involved in the review shall have the same license/credentials as the person or persons involved in the event or service process.

F. Peer Review: A process in which mental health professionals evaluate the clinical competence, quality and appropriateness of care/services provided to the recipients served by HealthWest. The review may focus on an individual event or aggregate data and information on clinical practices. These processes are confidential in accordance with section 748 (9) of the Mental Health Code Act 258 of 1974 and are based on criteria established by the facility or community mental health services program itself, the accepted standards of the mental health professions, and the Department of Health and Human Services (MDHHS).

G. Performance Improvement: A systemic way of addressing improvement opportunities that involve the use of soft (facilitation techniques, problem-solving processes) and hard (data analysis, statistical tests) skills to understand, recommend, and implement change.

H. Risk Event: Includes harm to self, harm to others, police calls, use of physical management, and two or more unplanned hospitalizations within a 12-month period.

I. 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 significant event.

J. Significant Event: Includes all critical and risk events, and risk thereof, as well as any other unexpected or unusual occurrences.

K. Unexpected Death: Includes those that result from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

L. Utilization Review: Analysis of patterns of service authorization decisions and service usage in order to determine the means for increasing the value and appropriateness of services provided.

V. STANDARDS REGARDING PEER REVIEW PROCESS

A. HealthWest declares the following business functions and analyses are all defined as PEER REVIEW FUNCTIONS:

1. Significant Event Reports/Root Cause Analysis.

2. Clinical Reviews.

3. Case Conferencing and Clinical Supervision or Team Meetings.

4. Utilization Review.

B. In accordance with the Michigan Mental Health Code 330.1143a, the Administrative Rules R. 330.7046, Public Health Code Act 368 of 1968, Section 333.20175 and 333.21515, all records and information obtained during Peer Review Functions are confidential and shall be used only for the purpose of reviewing the quality and appropriateness of care for improved practices. All documents created during and as a result of Peer Review Functions shall not be public record or available through the Freedom of Information Act (FOIA) and are not subject to Court subpoena.

C. Reports or forms completed as part of a peer review process shall be kept as peer review documents and shall not be kept as part of a recipient's clinical record. A summary of the incident (reported on a form or report) shall be included in the recipient's clinical record for any recipient involved in accordance with the requirements of the Administrative Rules 330.7046.

D. Peer Review Process analysis of events or clinical practices shall be based, as appropriate, on objective evidence drawn from relevant scientific literature, clinical practice guidelines, departmental historical experience and expectations, peer department experience and standards and/or national standards.

E. Risk Management Committee members and Corporate Counsel shall be consulted as needed during any peer review function.

F. Peer Review Functions/Processes shall adhere to all laws and policies including the reporting of any disciplinary action taken by an agency/organization against a health professional licensed or registered in the State of Michigan that adversely affects the licensee's or registrant's clinical privileges for a period of more than one hundred and fifty (150) days. "Adversely affects" means the reduction, restriction, suspension, revocation, denial or failure to review the clinical privileges of a licensee or registrant.

VI. PROCEDURE FOR SIGNIFICANT EVENT AND ROOT CAUSE ANALYSIS

A. All Significant Events will be verbally reported to the Executive Director and the Recipient Rights Officer/Designee utilizing established procedures.

B. All staff with first-hand knowledge of the Significant Event will complete an Incident Report as soon as possible after the event and forward it to the Recipient Rights Officer/Designee by the end of the shift following the incident. The Recipient Rights Officer/Designee will be responsible for notifying the Director of Quality Improvement within twenty-four (24) hours.

C. The Recipient Rights Officer and/or the Director of Quality Improvement has three (3) business days after a critical incident occurred to determine if it is a Significant Event. If the critical incident is classified as a Significant Event, the Director of Quality Improvement has two (2) subsequent business days to commence a Root Cause Analysis of the event.

D. The Director of Quality Improvement will coordinate a root cause analysis to be completed within twenty-five (25) days of becoming aware of the Significant Event. If the critical

incident is determined not to be a reportable Significant Event but involves an unexpected death, a peer review process will be completed as outlined in Section VI, Item F, using the LRE Review of Unexpected Death, A154.

E. The Root Cause Analysis process will involve all persons with first-hand knowledge of the events as well as the Recipient Rights Officer/Designee Quality Improvement staff, and others as determined appropriate. Persons involved in the review of Significant Events must have the appropriate credentials to review the scope of care. If it is determined that a peer review is also needed, the selection process will exclude those responsible for the primary care of the recipient involved and those involved in the systemic review of the Significant Event.

1. Within twenty (20) days of the occurrence, the Director of Quality Improvement will conduct an evaluation and prepare a report containing full documentation of the Root Cause Analysis. The report will not contain any identifying information regarding the recipient except for the case number. The report will contain recommendations for changes in any systems/processes to facilitate improvement. It will also have time frames for these changes to be implemented.

2. The report will be forwarded to the Agency's Executive Director through the Director of Quality Improvement, and the group will then disband.

3. The report shall be maintained in a separate and confidential administrative file labeled "Root Cause Analysis" in coordination with Corporate Counsel.

4. Within ten (10) days of completion of the Root Cause Analysis, the Executive Director will accept or revise the recommendations and assign responsibility for piloting and/or implementing the system and process improvements. The Director of Quality Improvement will forward the completed report to the Risk Management Committee Chairperson, the Lakeshore Regional Entity (LRE) Regulatory Management Supervisor, and the Executive Director.

5. The responsible supervisor, through the risk management process, will monitor the effectiveness of the Root Cause Analysis Work Group recommendations and provide (quarterly, or as often as required) outcome reports to the Risk Management Committee.

6. The Risk Management Committee will ensure an appropriate approach for evaluating the effectiveness of the improvements that have been designed and applied.

F. All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services from the CMHSP, must be reviewed using the LRE Unexpected Death Report Form (# A154), and must include:

1. Screens of recipient 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.

G. If the unexpected death is non-reportable, procedures outlined in Section VI, Item F, Paragraphs 1 through 3, will be followed using the LRE Unexpected Death Report Form (#A154).

H. The Recipient Rights Officer/Designee will assure the Report of Death, autopsy and/or Medical Examiner Reports are received by the CMHSP and will forward a copy to the Director of Quality Improvement.

I. The Director of Quality Improvement will forward the Unexpected Death Report to the Risk Management Committee Chairperson for quality improvement monitoring and trending of mortality information and data.

VII. REFERENCES:

M.C.L. 330.1100b (14); 330.1100c (2); 330.1143a; 330.1723(2) (3); 330.1748(9); 330.1755F (1) (ii); 330.1778
CARF Behavioral Health Standards
MDHHS/CMHSP Managed Specialty Supports and Services Contract Attachment P.6.7.1.1
Review of Unexpected Death, A154

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