Virginia Department of Behavioral Health & Developmental Services

Mortality Review Committee Member Orientation

July 28, 2022

DBHDS Vision: A life of possibilities for all Virginians

Topics Covered

- Policies, Processes, and Procedures review
- Role and Responsibilities of the Members
- Definitions
- Review of cause of death (CoD) on Death Certificates (DCs)

Mortality Review Committee Purpose

The purpose of the DBHDS Mortality Review Committee (MRC) is to focus on system-wide quality improvement by;

- Conducting mortality reviews of individuals with an intellectual disability and/or developmental disability (ID/DD)
- Reviewing all deaths of ID/DD individuals who received services in a state-operated facility or in the community through a DBHDS-licensed provider
- Providing ongoing monitoring and data analysis to identify trends/patterns
- Making recommendations to promote the health, safety and well-being of these individuals in order to reduce the incidence of potentially preventable deaths.

DBHDS and MRC Mission

DBHDS MISSION & VISION

Vision Statement: A life of possibilities for all Virginians

Mission Statement: Supporting individuals by promoting recovery, self-determination, and wellness in all aspects of life

As a commitment to the Commonwealth of Virginia, DBHDS and the MRC contribute to the system of care improvements through;

- *integration of clinical evidence*
- *data driven determinations*
- *evidenced based quality improvement recommendations*

DBHDS DD Mortality Review Committee

- The Mortality Review Committee (MRC) was formed in 2012, to understand and identify potentially preventable deaths in the I/DD population.
- The underlying concern as individuals moved into integrated community settings from highly structured and supervised institutional settings, is that they may experience increased risks of preventable mortality.

DOJ SA Provision for Mortality Review

- The Commonwealth shall **conduct monthly mortality reviews for unexplained or unexpected deaths** reported through its incident reporting system. The Commissioner shall establish the monthly mortality review team, to include the **DBHDS Medical Director, the Assistant Commissioner for Quality Improvement, MRO staff, and others as determined by DBHDS, who possess appropriate experience, knowledge, and skills**. The team **shall also have at least one member with the clinical experience to conduct mortality reviews who is otherwise independent of the State. Within ninety days of a death**, the mortality review team shall:

  (a) review, or document the unavailability of:

  (i) medical records, including physician case notes and nurse's notes, and all incident reports, for the three months preceding the individual's death;

  (ii) the most recent individualized program plan and physical examination records;

  (iii) the death certificate and autopsy report; and

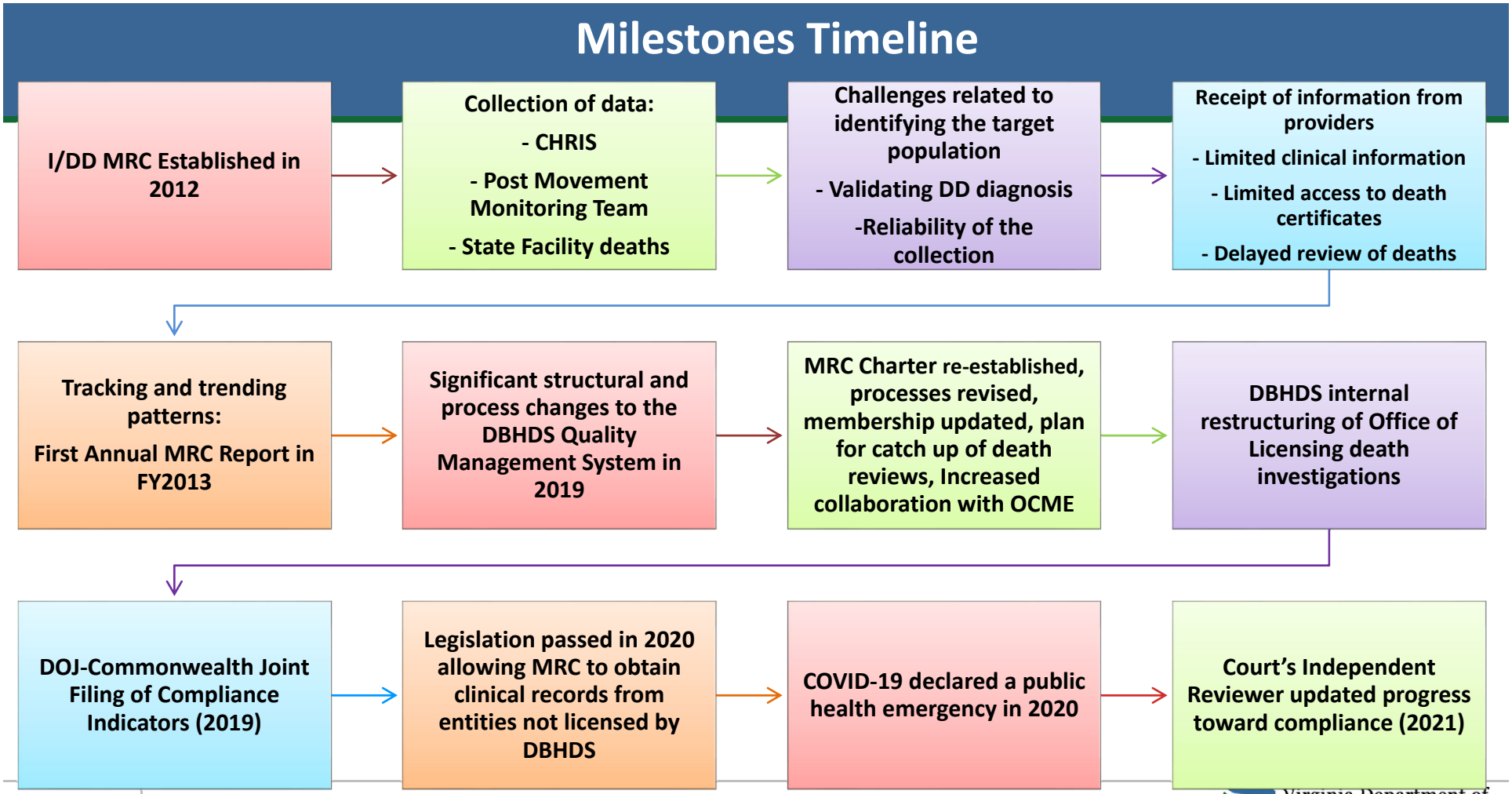
  (iv) any evidence of maltreatment related to the death;

  (b) interview, as warranted, any persons having information regarding the individual's care; and

  (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any.

- The team also shall **collect and analyze mortality data to identify trends, patterns, and problems at the individual service delivery and systemic levels and develop and implement quality improvement initiatives** to reduce mortality rates to the fullest extent practicable.

Milestones Timeline



Virginia Department of Behavioral Health & Developmental Services

Significant Enhancements (2020)

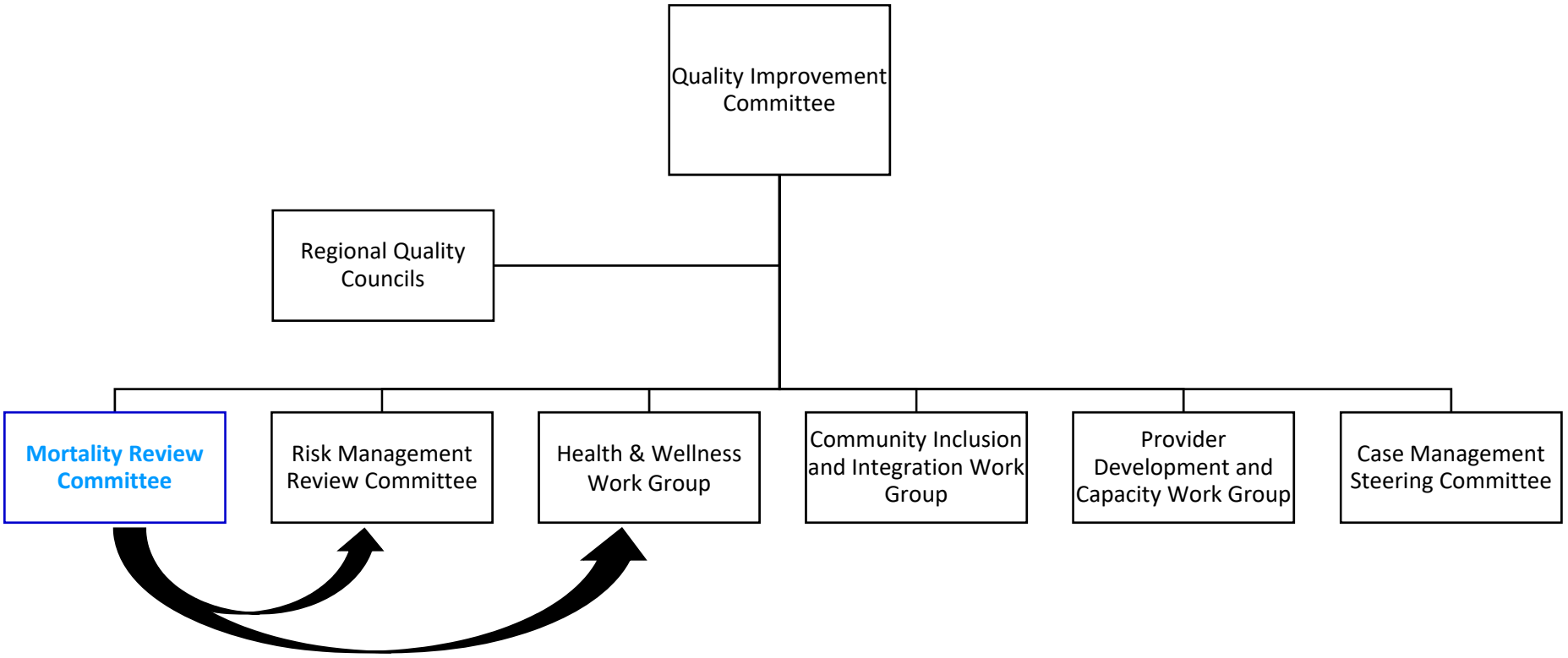
- SB 482 was passed by the 2020 General Assembly and became effective on July 1, 2020. This legislatively established the DBHDS I/DD MRC and provided greater access to information and records regarding individuals whose deaths are being reviewed by the Committee.

- Collaboration with the Virginia Department of Health's Office of Vital Records to obtain death certificates. This process was initiated in May 2020, and for SFY 2021, death certificates were obtained for 98 percent of deaths reviewed by the DBHDS DD MRC. In SFY21, this process became fully electronic, and no longer required in person pick up of hard copy (paper) documents.

GENERALASSEMBLY.GOV

Virginia Department of Behavioral Health & Developmental Services

DBHDS I/DD Quality Committee Structure



MRC Charter (2021)

- Purpose:
  - ☑ Focus on system-wide quality improvement by conducting mortality reviews of individuals who were receiving a service licensed by DBHDS at the time of death
  - ☑ Utilize an information management system to track the referral and review of these individual deaths.
- Scope & Authority:
  - ☑ The DBHDS Commissioner is the executive sponsor of the MRC and designates the Chief Clinical Officer (CCO) to establish and supervise the Mortality Review Office (MRO).
  - ☑ MRC reviews deaths of individuals with I/DD who received a service licensed by DBHDS at the time of death.
  - ☑ A sub-committee of the Quality Improvement Committee (QIC).
  - ☑ The MRC provides ongoing monitoring and data analysis to identify trends and/or patterns and then makes recommendations to promote the health, safety and well-being of said individuals.
  - ☑ To the best of its ability, the MRC will determine the cause of an individual's death, whether the death was expected, and if the death was potentially preventable.

MRC Required Members

- Chief Clinical Officer
- Assistant Commissioner of Developmental Services, or designee
- Assistant Commissioner for Compliance, Risk Management, and Audit or designee
- Senior Director of Clinical Quality Management
- Director, Community Quality Management, or designee
- Director, Office of Human Rights, or designee
- Director, Office of Integrated Health, or designee
- MRO Clinical Manager, MRC Co-Chair
- OL Manager, Incident Team

- OL Manager, Investigation Team
- Office of Pharmacy Services Manager
- MRO Clinical Reviewer
- MRO Program Coordinator
- A member with clinical experience to conduct mortality reviews who is otherwise independent of the State

Member Status

Voting Members:

- Have decision-making capability and voting status.
- Attend 75% of meetings per year and may send a designee, but must attend at least one meeting per quarter. The designee shall have decision-making capability and voting status
- Absence is considered excused if the member has notified the MRC Co-Chair or MRO Program Coordinator prior to the meeting, that the member and/or designee is unable to attend.
- Review data and reports for meeting discussion.

Advisory Members:

- Are non-voting stakeholder members whose various perspectives provide insight on: MRC reviews, clinical information, medical expertise, and MRC performance goals (including outcomes, required and recommended actions).
- Inform the committee by identifying and prioritizing MRC decision making and recommendations.
- Are expected to attend one meeting every quarter (4/year), and may send a designee whom is approved by the MRC chair prior to the meeting. An absence is considered excused if the advisory member has notified the MRC Co-Chair or MRO Program Coordinator prior to the meeting

Membership responsibilities

- Pursuant to Virginia Code § 37.2-314.1, all MRC members and other persons who attend closed meetings of the MRC are required to sign a confidentiality agreement form.
- New members will receive training within 30 business days of joining the committee, that includes:
  - Orientation to the MRC charter to educate the member on the scope, mission, vision, charge, and function of the MRC
  - Review of the policies, processes, and procedures of the MRC
  - Education on the role/responsibility of the member(s)
  - Training on continuous quality improvement principles.
- Members must recuse themselves from MRC proceedings if a conflict of interest arises, in order to maintain neutrality (prevent bias) and credibility of the MRC mortality review process.

Recusal

- Members must recuse themselves from MRC proceedings if a conflict of interest (COI) arises, in order to maintain neutrality *(prevent bias)* and credibility of the MRC mortality review process. COI exists when an MRC member has a financial, professional or personal interest that could directly influence MRC determinations, findings or recommendations, such as:
  - The MRC member, or an individual from the member's family, was actively involved in the care of the decedent *(direct care r/t employment or financial*)
  - The MRC member may have participated in a facility or institutional mortality review of the decedent
  - The MRC member, or an individual from the member's family, has a financial interest or investment that could be directly affected by the mortality review

- Should a COI arise during the review process, the MRC member will:
  - Immediately disclose (privately to Chairs or publicly to members) the potential COI and cease participation in the case review related to the existing or potential COI.
  - The MRC will then halt discussion of the COI case, move on to the next case and place the COI case at the end. This allows the MRC member with a COI to remain for the review of other cases, and then leave the proceedings prior to the discussion of the COI case.

Standard Operating Procedures

- The Specialized Investigation Unit (SIU) reviews all deaths of individuals with I/DD reported to DBHDS through its incident reporting system, and **has 45 business days** to provide information to the MRO (through review and investigation).
- **Within 90 calendar days of a death,** the Mortality Review Team (MRT) compiles a review summary of the death. This includes development of succinct clinical case summaries (*within 13 days*) by reviewing and documenting the availability or unavailability, of:
  - Medical records: Including healthcare provider and nursing notes for three months preceding death
  - Incident reports for three months preceding death
  - Most recent individualized service program plan
  - Medical and physical examination records
  - Death certificate and autopsy report (when performed)
  - Any evidence of maltreatment related to the death
  - Interviewing, as warranted, any persons having information regarding the individual's care
  - When additional documents are needed, the MRT will request these records from appropriate entities per Virginia Code §§2.2-3705.5, 2.2-3711, and 2.2-4002 amendment of the Virginia Code

Standard Operating Procedures (continued)

- The composed clinical case summary from a review of all documents submitted by OL, is recorded into the electronic Mortality Review Form, and submitted for MD/NP appraisal. A Tier category is then assigned based on sequential information r/t events surrounding that individual's death, and Tier criteria (see definitions).
- Additional information is requested if needed, to clarify or expand the sequence of events leading to an individual's death.
- A facilitated discussion is conducted during MRC meetings for all Tier 1 cases and those cases where the Tier category could not be determined without MRC discussion and decision-making.

MRC Confidentiality Procedures

- To ensure confidentiality and adherence to mandated privacy regulations and guidelines, case reviews are provided to MRC members during the meeting only. All meeting material with identifying information is removed from the Teams folder after the meeting. It should never be printed or distributed.

- Mortality reviews are conducted in accordance with Virginia Code § 37.2-314.1. Portions of meetings in which individual death cases are reviewed by the MRC are closed pursuant to Virginia Code § 2.2-3711(A)(21). In addition; information, records, discussion, and opinions disclosed during meetings at which the MRC reviews a specific death are confidential. Pursuant to Virginia Code § 37.2-314.1, members of the MRC and any person presenting information or records on specific deaths, shall sign an agreement to maintain this confidentiality.

MRC RESPONSIBILITIES

- Conduct 2 meetings each month, (each meeting is now 3.5 to 4 hours in length).
- Review trends quarterly.
- Follow-up on actions taken at each meeting.
- Develop a QII each quarter (4X/year)

MRC Determinations

The MRC seeks to identify:

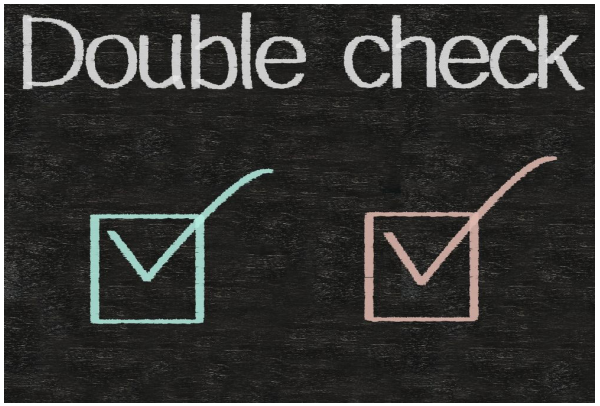
- The cause of death (CoD)
- If the death was expected (XP)
- Whether the death was potentially preventable (PP)
- Any relevant factors impacting the individual's death
- Any other findings that could affect the health, safety, and welfare of these individuals
- Whether there are other actions that may reduce these risks, to include provider training and communication regarding risks, alerts, and opportunities for education
- If any actions are identified based on the case review, the MRC will then make and document relevant recommendations and/or interventions

➡ These recommendations are made in order to reduce mortality rates to the fullest extent practicable.

Quality Assurance

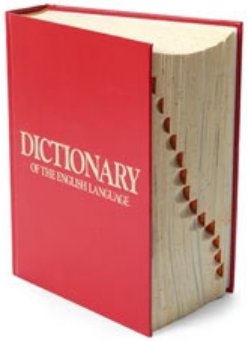
Monthly, for quality assurance purposes and to attempt to identify deaths that were not reported through DBHDS' incident reporting system:

- ✓ The MRO provides a list of identifying information for I/DD individuals in the Waiver Management System who received DBHDS-licensed services to the Virginia Department of Health (VDH)
- ✓ VDH identifies names from that list for which a death certificate is on file and provides results back to the MRO.
- ✓ DBHDS reviews the information against the incident reporting systems to determine if the individual was receiving a DBHDS licensed service at the time of death and therefore was not reported by a DBHDS licensed provider



Definitions

ALL deaths reported into the DBHDS incident management system are investigated, systematically and clinically reviewed and a case summary is prepared. The following standardized definitions are applied for each case:



- **Expected Death** denotes a death that occurred as a result of a known medical condition, anticipated by health care providers to occur as a result of that condition and for which there is no indication that the individual was not receiving appropriate care. Clear evidence that the individual received appropriate and timely care for the medical condition exists.
- **Unexpected Death** denotes a death that occurred as a result of a condition that was previously undiagnosed, occurred suddenly, or was not anticipated. Deaths are considered unexpected when they: are not anticipated nor related to a known terminal illness or medical condition; are related to injury, accidents, inadequate care; or are associated with suspicions of abuse or neglect. An acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death. An unexplained death is considered an unexpected death.
- **Unknown** indicates there is insufficient information to classify a death as either expected or unexpected or there is insufficient information to make a determination as to the cause of death.

Definitions (continued)

- **Potentially Preventable (PP) Deaths** denotes deaths in the opinion of the MRC that might have been prevented with reasonable valid intervention (*e.g., medical, social, psychological, legal, educational*). Deaths determined to be PP have identifiable actions or care measures that should have occurred or been utilized. For a death to be determined PP, the actions and events immediately surrounding the individual's death must be related to deficits in the timeliness or absence of, at least one of the following factors:
  - Coordination and optimization of care
  - Access to care, including delay in seeking treatment
  - Execution of established protocols
  - Assessment of, and response to, the individual's needs or change in status
- For actions recommended by the MRC, the MRC shall consider if one of the following mortality prevention strategies may be utilized:
  - Primary Prevention Strategies—Educational and changes to services designed to help prevent a condition or event from taking place, that have been found to contribute to morbidity or mortality, such as education on reducing falls
  - Secondary Prevention Strategies—Focus on early detection and timely treatment of conditions or injuries to minimize harmful effects and prevent further morbidity or mortality, such as interventions that support and promote cancer screening
  - Tertiary Prevention Strategies—Optimization of the treatment and management of conditions or injuries, such as ensuring access to evidence-based treatment

Tier Status Review of All I/DD Deaths

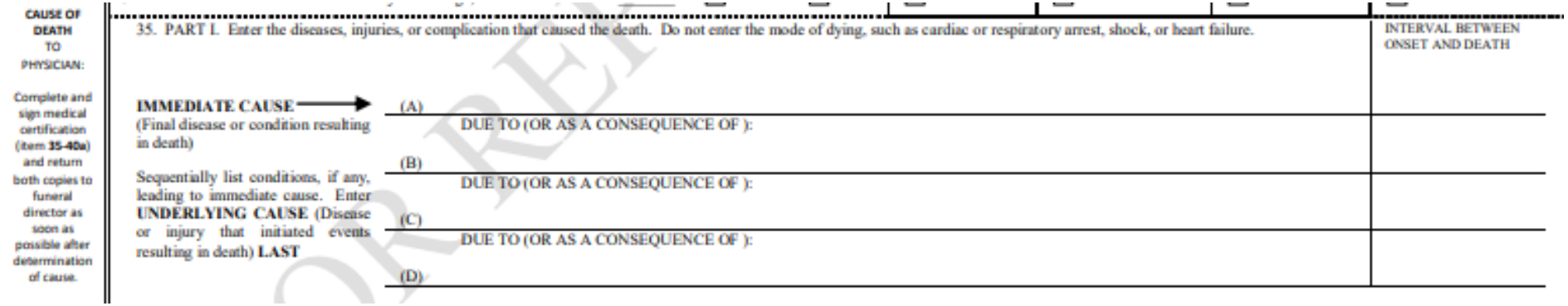
- **Tier 1 Criteria:** *(A Tier 1 case requires a detailed, comprehensive review of multiple factors and areas of focus by the mortality review committee)* When **any** of the following is present:
  - Cause of death cannot clearly be determined or established, or is unknown
  - Any unexpected suicide or homicide
  - Abuse and/or neglect is specifically documented
  - Documentation of investigation or involvement of Police, Forensic, other law enforcement or similar agency; and
  - Specific or well defined risks to safety and well-being are documented

- **Tier 2 Criteria:** *(A Tier 2 case does not require additional review by the full committee)* When **first 4** criteria are present:
  - Cause of death can clearly be determined or established
  - No documentation of abuse and/or neglect
  - No documentation of investigation or involvement of Police, Forensic, other law enforcement or similar agency, and
  - No documentation of specific or well defined risks to safety and well-being noted
  - An Expected death, if no abuse/neglect, involvement of law enforcement or well defined safety and well-being risks are documented
  - An Unexpected Death that occurred as a result of an acute medical event, a new medical condition, or sudden and unexpected consequences of a known medical condition, if no abuse/neglect, involvement of law enforcement or well defined safety and well-being risks are documented

Cause of Death on Death Certificates

Per CAP (College of American Pathologists)(2006) and Center for Disease Control (2020):

"Deaths are classified by the underlying cause of death – the underlying cause of death is the disease or injury (or poisoning) that initiated the chain of morbid events that led directly and inevitably to death" (CAP, p.11), and is the lowest used line in Part I of the death certificate" (CDC, p.1)



CAUSE OF DEATH TO PHYSICIAN:

Complete and sign medical certification (item 35-40a) and return both copies to funeral director as soon as possible after determination of cause.

35. PART I. Enter the diseases, injuries, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.

INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (Final disease or condition resulting in death) → (A)

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter **UNDERLYING CAUSE** (Disease or injury that initiated events resulting in death) **LAST**

(B)

DUE TO (OR AS A CONSEQUENCE OF):

(C)

DUE TO (OR AS A CONSEQUENCE OF):

(D)

Per World Health Organization (2020):

"Cause of death is the causal chain of events that ultimately leads to death and is the underlying or initial event in the causal sequence most remote from the time of death. This information is filled in last, at the bottom line of the death certificate" (p.3).

Underlying as Cause of Death (CoD)

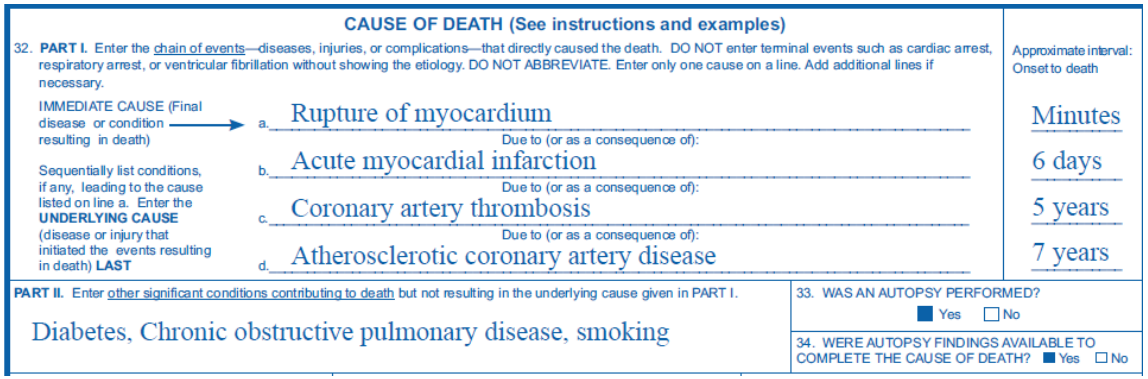
Part I	A. **Most recent condition**
	Due to, or as a consequence of: B. **An older condition**
	Due to, or as a consequence of: C. **An even older condition**
	Due to, or as a consequence of: D. **Oldest condition (what started it all)**
Part II	OTHER SIGNIFICANT CONDITIONS: Conditions contributing to death but not resulting in the underlying cause of death in Part I **Something that contributed to death but did not cause the sequence listed above in Part I**

Underlying CoD (Lines, B, C, D, whichever is last completed line) - are considered *"the cause of death boiled down as the bottom line" (College of American Pathologists).* The underlying CoD should always be present on the lowest line that is used when completing Part I of the CoD statement, as it should be an outline of the sequence of conditions that led to line A. Line B should almost always be used (and perhaps often additional lines C & D).

Line B: Indicates how this person came to have the condition in line A - if *proteus mirabilis sepsis* is on line A, its cause should be on line B (*e.g., infected sacral decubitus ulcer*). **Lines C and D:** Continue backward in time to what led to the preceding line, to the best of the person's completing the DC's knowledge (*e.g., Line C: complications of remote cerebral infarction; Line D: ASHD).* As the mechanism of most deaths is cardiopulmonary arrest, this should NOT be used in Part I as it doesn't not specify the CoD)

Immediate CoD (Line A) - is the final disease, injury, or complication, resulting from the underlying (*that which directly caused death*) CoD. It is the most recent event that occurred prior to death and indicates - what happened right before the patient died, and was the condition that led to cardio/pulmonary/respiratory arrest and death (e.g., p*roteus mirabilis sepsis, CHF, liver failure, LLL pneumonia, GIB).*

CoD Examples



CAUSE OF DEATH (See instructions and examples)

32. **PART I.** Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

Approximate interval: Onset to death

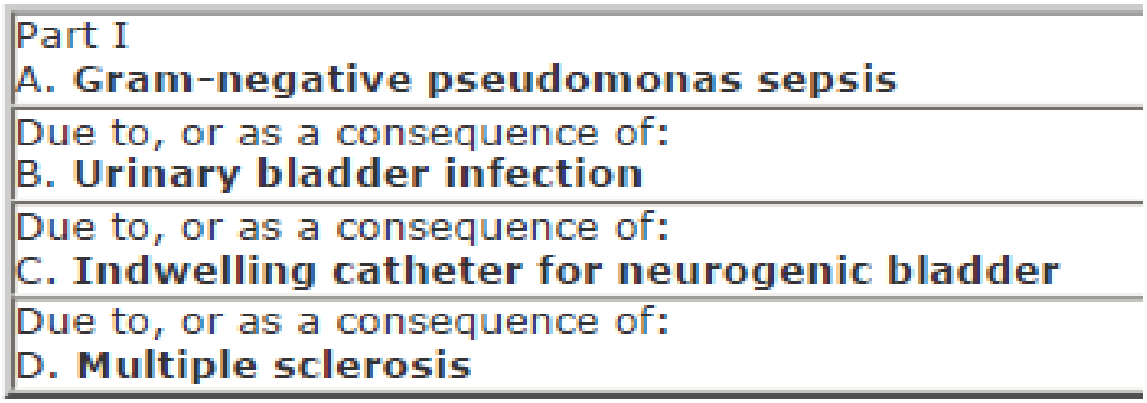
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Rupture of myocardium	Minutes
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the **UNDERLYING CAUSE** (disease or injury that initiated the events resulting in death) **LAST**	b. Acute myocardial infarction	6 days
	Due to (or as a consequence of):	
	c. Coronary artery thrombosis	5 years
	Due to (or as a consequence of):	
	d. Atherosclerotic coronary artery disease	7 years

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.

Diabetes, Chronic obstructive pulmonary disease, smoking

33. WAS AN AUTOPSY PERFORMED? ■ Yes ☐ No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ■ Yes ☐ No



Part I

A. **Gram-negative pseudomonas sepsis**

Due to, or as a consequence of:

B. **Urinary bladder infection**

Due to, or as a consequence of:

C. **Indwelling catheter for neurogenic bladder**

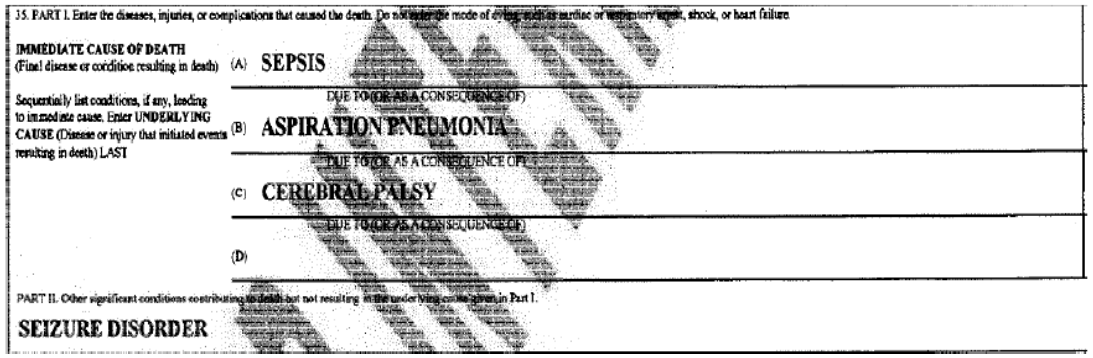
Due to, or as a consequence of:

D. **Multiple sclerosis**

In this scenario, the underlying CoD is the CAD which the decedent had for years, which led to the immediate CoD, or the final complication of Acute MI which then resulted in a ruptured myocardium. Diabetes, COPD and smoking were factors that contributed to ASHD, CAD & MI, but didn't cause the cascade of events resulting in death

Here is an example of MS as CoD for an individual who had MS, a chronic indwelling catheter for a neurogenic bladder, that resulted in a UTI and Sepsis. This DC cites the accurate chain of events that led to the decedent's death

CoD Examples



35. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.

IMMEDIATE CAUSE OF DEATH (Final disease or condition resulting in death) (A) SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF)

(B) ASPIRATION PNEUMONIA

DUE TO (OR AS A CONSEQUENCE OF)

(C) CEREBRAL PALSY

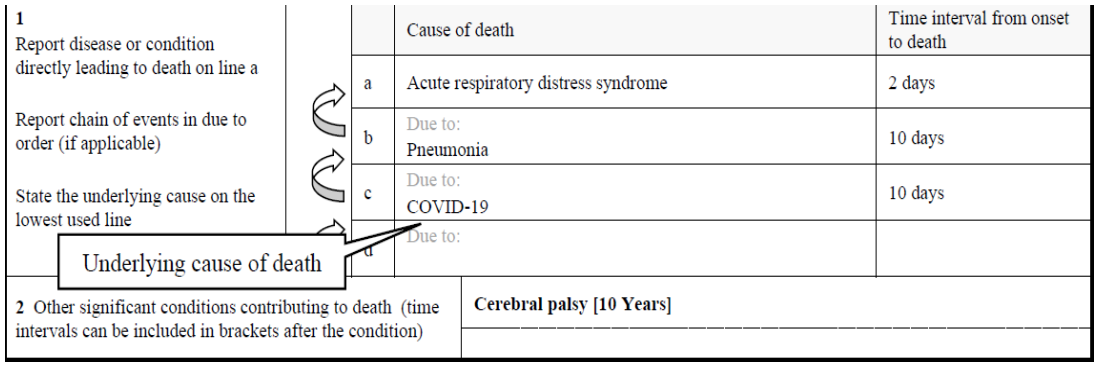
DUE TO (OR AS A CONSEQUENCE OF)

(D)

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

In this example – the underlying CoD is CP (complications of a congenital condition) leading to aspiration pneumonia which ultimately resulted in sepsis. For complete accuracy, the causative organism should have been listed in front of sepsis. A seizure DO was a contributing factor in the chain of events resulting in death, but did not cause the cascade of events resulting in death



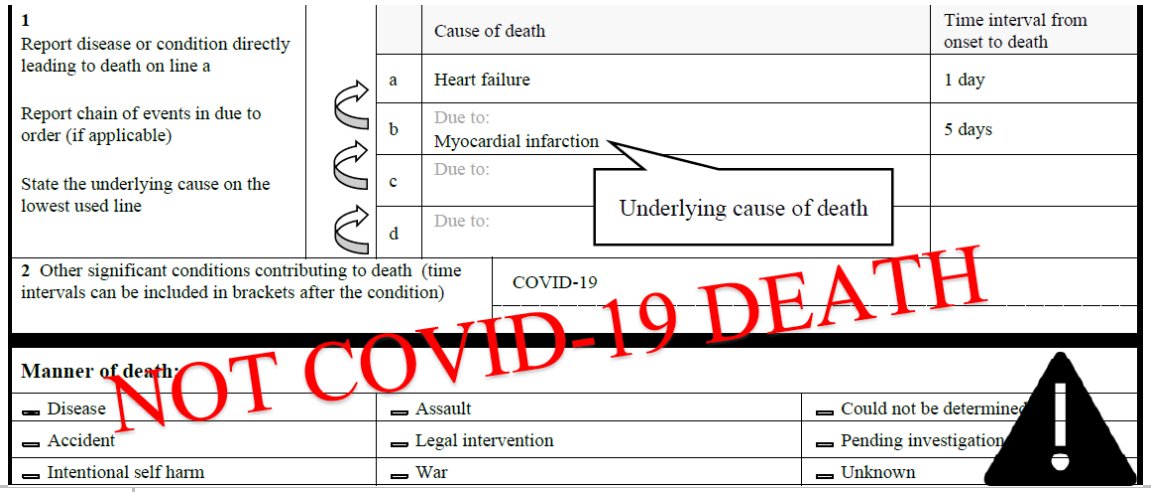
		Cause of death	Time interval from onset to death
1 Report disease or condition directly leading to death on line a Report chain of events in due to order (if applicable) State the underlying cause on the lowest used line	a	Acute respiratory distress syndrome	2 days
	b	Due to: Pneumonia	10 days
	c	Due to: COVID-19	10 days
	d	Due to:	
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)		Cerebral palsy [10 Years]	

Underlying cause of death

Here is an example from the Center for Disease Control (p.5) of a death certificate completed correctly for Covid-19 as CoD, for an individual with the co-morbidity or contributing factor/condition of CP.

CoD Case Scenario

A 68 yo female with I/DD was admitted to the hospital with SOB and moderate chest pain of 3 hours duration. PMH: +Covid-19 x7 days, T2DM and obesity. In ED, CK was elevated, and over the next 24 hours, a fourfold increase of CK *(confirming an acute MI*) with EKG changes occurred. Was transferred to CICU where she developed a Type II second degree AV block and had a temporary pacemaker placed. While in Radiology for a chest CT, she coded and was unable to be revived.



1 Report disease or condition directly leading to death on line a Report chain of events in due to order (if applicable) State the underlying cause on the lowest used line		Cause of death	Time interval from onset to death
	a	Heart failure	1 day
	b	Due to: Myocardial infarction	5 days
	c	Due to:	
	d	Due to:	
2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition)		COVID-19	

Underlying cause of death

NOT COVID-19 DEATH

Manner of death:		
Disease	Assault	Could not be determined
Accident	Legal intervention	Pending investigation
Intentional self harm	War	Unknown

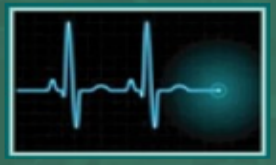
In this example – the underlying CoD is an MI that resulted in heart failure. C-19 was NOT the CoD, but was a contributing factor in the chain of events resulting in death, but did not cause the cascade of events resulting in death (CDC, p.7)

Death Certificate Summary

Improving Cause of Death Reporting

What is meant by “Cause of Death?

The sequence of medical conditions that had the greatest impact on causing death plus the time interval between the onset of each condition and death constitutes the official definition of "Cause of Death."



Conditions of death are not causes

Terms such as cardiac arrest, cardiopulmonary arrest, respiratory arrest, and asystole are used to define death and should not be included in the cause of death section.

Non-specific causes require an etiology

Non-specific conditions such as sepsis, paraplegia, renal failure, or hypotension should not be entered in the Cause of Death section without an explanation of why they occurred.

Nat’l Association of Medical Examiners - https://www.thename.org/death-certification

Resource Documents

- The MRC Charter
  - The MRC Charter is the basis of this orientation (with the exception of the Death Certificate review)
  - Charter revisions reviewed and approved at July 14, 2022 meeting are due for presentation to the QIC for approval September 21, 2022.

- Department of Justice Settlement Agreement (#3:12cv059-JAG, filed 2012)
  - V.C.5 (page 23) – Conducting monthly mortality reviews reported through Commonwealth's incident reporting system

- Commonwealth of Virginia Certificate of Death

Death Certificate Resources

- *Death Certification in the U.S.* - https://www.ncbi.nlm.nih.gov/books/NBK526015/
- Hanzlick, Randy and College of American Pathologists: *Cause of Death and the Death Certificate Handbook*
- CDC - *Instructions for completing CoD Section* - https://www.cdc.gov/nchs/data/dvs/blue_form.pdf
- Nat'l Association of Medical Examiners - https://www.thename.org/death-certification
- NYC Department of Health and Mental Hygiene: *Improving Cause of Death Reporting; mandatory online training for HCPs licensed to complete death certificates* https://www1.nyc.gov/assets/doh/media/icdr/index.html
- WHO: *International Guidelines for Certification and Classification (coding) of Covid-19 as Cause of Death*

Questions or Thoughts