DBHDS

Virginia Department of Behavioral Health and Developmental Services

DBHDS Mortality Review Office Process Document

February 2024

A Life of Possibilities for All Virginians

Mortality Review Office/Mortality Review Committee
Process and Procedure Document

I. Introduction

A. Documents involved: MRC Charter, electronic Mortality Review Form *(eMRF, see Appendices I & II)*

B. Processes involved:

- The MRC is a select standing quality management and clinical oversight QIC subcommittee with a majority of activities dedicated to clinical functionality regarding provision of care, and another portion responsible for quality improvement.
  - As the MRC's purpose and scope is not defined only as a quality improvement program, meetings are 'closed' pursuant to Virginia Code § 37.2-314.1.
  - Determinations are based on a retrospective review of documents (RCR) where interventions, actions and outcomes of interest have already occurred across the Commonwealth or out of state. Data for the eMRF is compiled from multiple source documents and records prior to any data analysis.
  - The Mortality Review Office (MRO) utilizes an electronic database for the eMRF in order to track and validate data, while maintaining consistency of case information

C. MRC Data

- Obtained from a retrospective review of documents with pre-recorded already existing descriptive information, which are submitted for case composition and review purposes only, not for data analysis. Information for the electronic mortality review form (eMRF) is compiled from these numerous source records and documents.
- Used to identify and describe actions, interventions, or outcomes of interest, in order to alter exposure to them. Since these actions, interventions, or outcomes have already occurred, determining the cause-and-effect *(causation)* relationship is the focus, not the identification of a statistically associated linear relationship *(correlation)*.
- Analyzed to determine recommendations and/or actions that may alter the individual's exposure to the action, intervention, or other variable, with the goal of changing or preventing the outcome for IDD individuals exposed to it in future. Because they measure events in chronological order cohort data are used to distinguish between cause and effect.
- Focused on identification of the exposure and outcome variables to distinguish causation *(did exposure bring about the outcome & is it reproducible?)*. Depending on data type and circumstances, correlation may be discovered or inferred *(is there association between exposure & outcome and if so, was it coincidental and/or effected by other variables?)*.
- Largely text/language based *(either written in documents or spoken through interviews)*, this discrete *(cannot be made more precise)*, intensional *(defined, cannot be added to or changed)* and subjective *(qualitative)* implicit data cannot be measured on a continuous scale.
- Used for conceptual content analysis to: Derive a pattern, Develop a hypothesis, Discover a parameter, or Draw a conclusion *(*PC's 4 Ds of conceptual analysis)*. Through further relational analysis, the area of focus can be determined (which or if all, of the '4 Ds' should be pursued). Case control analysis can compare individual specific case data retrospectively and identify possible predictors of outcome useful for QII identification, rare occurrences or causation, and to generate hypotheses.
- Conceptual vs numerical data. Qualitative data analysis (QDA) software can be used to analyze mortality case review data by measuring or expressing text into numerical values for statistical cohort analysis. This analysis may determine incidence, causes, and prognosis. Only then can text data be categorized based on identified variables *(e.g., attributes, characteristics, labels, properties, trait, trends)* with use of a specific QDA tool *(MAXQDA, Quirkos, ATLAS, e.g.).* The majority of MRC case review data cannot be measured or expressed into numerical values for statistical analysis as it is narrative in form.
- Quantitative numbered data can only be obtained from a limited number of eMRF sections: Mortality case review summaries *(case determinations)*, Cause of death, Date fields, Demographics, Documents reviewed, and End of life care. These are the only concise structured numerical data fields that are measurable and can be analyzed for statistical significance.
- Also used to: Generate quarterly quantitative reports of MRC determinations, Case specific demographics when applicable, and for analysis in compiling the MRC SFY Report annually.

*PC = Patricia Cafaro, DNP, FNP and MRC Clinical Manager

II. Notification of Deaths

A. Documents involved: Master Document Posting Schedule (MDPS) and Office of Licensing process document titled - *"Investigations: Appendix C: DD Death Investigations"*

B. Processes involved:

- A DBHDS Provider submits an incident report when an IDD death occurs. DBHDS requires all DBHDS-licensed providers to report deaths through the incident reporting system within 24 hours of discovery.
- The DBHDS Special Investigations Unit (SIU) reviews all deaths of individuals with an IDD diagnosis reported to DBHDS through its incident reporting system.
  - Each case is assigned to an investigator in the SIU who conducts an initial review of available information within 24 hours after the death is reported to DBHDS or the next business day.
  - Any deaths that appear to be related to abuse or neglect or that pose an imminent and substantial threat to the health, safety, or welfare of other individuals served by that provider have an investigation initiated by the DBHDS Licensing Investigations Team immediately, with actions taken, as appropriate, in accordance with licensing protocols.
- DBHDS provides the identifying information of individuals in the Waiver Management System (WaMS) who receive DBHDS licensed services on a monthly basis to the Virginia Department of Health (VDH), who will identify the names for which a death certificate is on file. The results are provided to DBHDS and used by DBHDS to attempt to identify deaths that were not reported through the incident management system. The DBHDS Office of Licensing (OL) will investigate all unreported deaths of DBHDS licensed providers identified by this process and take appropriate action in accordance with DBHDS licensing regulations and protocols.
  - SIU will investigate unreported deaths where it was identified that the individual was admitted to a DBHDS licensed service when the death occurred.
  - SIU will track death investigations initiated by this process, on the MDPS
  - SIU will collaborate with Human Rights if there are any suspected abuse/neglect allegations surrounding the death investigation. The investigator will immediately initiate an investigation by opening an investigation in OLIS, with actions taken as appropriate, in accordance with licensing protocols for any deaths that appear to be related to abuse or neglect; or that pose an imminent and substantial threat to the health, safety, or welfare of other individuals served by that provider. If the death is considered an imminent and substantial threat to other individuals served by the provider, the investigator will complete an on-site inspection within 24 hours.
- The SIU provides available records and information it obtains and the completed investigation report to the MRO within 45 business days *(9 weeks*) of the date the death was reported on 86% or greater of deaths required to be reviewed by the MRC.
  - Providers are required to submit MRC documents within 10 days of discovery of death to the OL mortality email address (MRC_Documents@dbhds.virginia.gov)
  - SIU reviews all deaths of individuals with IDD reported to DBHDS through its incident reporting system. Available records and information are obtained for individuals with IDD who were receiving a licensed service within 30 days of date of death, and the OL Investigation (OLI) is submitted to the MRO within 45 business days (9 weeks) of the date the death was reported.
  - The MRO then has 13 days after receipt of the OLI to compile a case review. Within 90 calendar days of a death, *(and for any unreported deaths)*, the Mortality Review Team (MRT) composes a review summary of the death *(see section IV below)*.
  - Investigators will ensure that investigations are completed within 45 business days of the date of death was reported *(9 weeks*). SIU Manager (SIUM) completes the MDPS to indicate date the completed investigation was placed in MRC shared and restricted access folder. MRC must report on meeting this indicator per DOJ settlement agreement.
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III. Validation and Tracking of Deaths

A. Documents involved: DW-0080a, MDPS, eMRF, eMRF Death Data Load Process, and document titled *"Investigations: Appendix C: DD Death Investigations"*

B. Processes involved:

- For licensed DD providers, the SIUM runs report DW-0080a weekly and forwards results to the Mortality Review Office Program Coordinator (MROPC).
- The MROPC adds the decedent information from SIU and report DW0080a to the MDPS and verifies any discrepancies *(e.g. multiple dates of death for same individual).* Folders are then created for these decedents on the MRC shared drive, for documents to be uploaded as they are received in OL. *(Document sources may include but are not limited to; OL, CSB, Providers, OCME, Police, Media, Clinics, Healthcare providers, Family, Attorneys, Internal DBHDS Offices, and External state agencies)*.
- On a monthly basis, the SIUM and MROPC finalize the list of deaths based on DW-0080a *(Appendix I)*
- The MROPC verifies that list of deaths with the query run by the Data Warehouse team and collaborates with the Incident Management Unit (IMU) to correct any discrepancies related to demographics data (Appendix I).
- Deaths are loaded to the eMRF via an automated process overseen by the Data Warehouse team (Appendix I).
- For those IDD deaths that are not required to be reported in the automated electronic OL system, but have been discovered through other systems or means - the MROPC validates and manually adds these deaths to the MDPS for the usual mortality review process to occur (Appendix I).
- The MROPC also adds any IDD state facility deaths to the MDPS obtained from state facility 45-Day reports submitted to the MRO.
- The date by which each case needs to be reviewed is calculated by the MROPC based on the date of death (DoD). This is also tracked on the MDPS
  - If for any reason a death is not reviewed within the 90-day timeframe, the MRT will identify barriers and make every effort to ensure cases are reviewed within the 90-day timeframe.
  - To monitor 90-day requirement compliance, data is extracted from the eMRF on at least a quarterly basis, if not more frequently. Data is reviewed in Excel *(N = Number of deaths reviewed within 90 days. D = Total number of deaths reviewed).*
  - The calculation for the cases due to be reviewed within 90 days is last day of the month, plus three months. The schedule for case review is outlined below;

90-Day IDD MRC Schedule

Month IDD death occurred	Date of MRC meeting that case MUST be reviewed by *(within 90 days)*	Case DoD SFY/Quarter
October	January – 4th Thursday of the month	Q2/previous SFY
November	February – 4th Thursday of the month	Q2/previous SFY
December	March – 4th Thursday of the month	Q2/previous SFY
January	April – 4th Thursday of the month	Q3/previous SFY
February	May – 4th Thursday of the month	Q3/previous SFY
March	June – 4th Thursday of the month	Q3/previous SFY
April	July – 4th Thursday of the month	Q4/previous SFY
May	August – 4th Thursday of the month	Q4/previous SFY
June	September – 4th Thursday of the month	Q4/previous SFY
July	October – 4th Thursday of the month	Q1/current SFY
August	November – schedule TBD based on Holiday date	Q1/current SFY
September	December – schedule TBD based on Holiday date	Q1/current SFY
October	January – 4th Thursday of the month	Q2/current SFY
November	February – 4th Thursday of the month	Q2/current SFY
December	March – 4th Thursday of the month	Q2/current SFY

- SIU provides available documents and records it obtains from sources listed above, including the completed investigation report (OLI), to the MRO within 45 business days *(9 weeks*) of the date the death was reported. This is achieved for at least 86% of deaths required to be reviewed by the MRC
  - To monitor compliance, data is extracted from the MDPS on a monthly and quarterly basis and reviewed *(N = Number of deaths for which documents were provided within 45 days, D = Total number of deaths reported).* Data is also monitored more frequently as circumstances warrant.

- For continuous monitoring, formulas in the MDPS *(Excel spreadsheet)* calculate the 45-day timeframe. If documents are submitted after that date, the MDPS provides an alert by highlighting the cell in red font.

- For the MRC meetings - the Mortality Review Team (MRT) then has 13 calendar days from SIU investigation submissions, to compile all clinical reviews due within the 90-day timeframe, for that next MRC meeting.

IV. Clinical Summary, Tier Categories and Case Status

A. Documents involved: *MDPS, eMRF (Appendix I)*

B. Processes involved:

- Based on the deaths requiring review at the next scheduled MRC meeting identified on the MDPS list - the MRT Clinical Nurse Reviewers (CNRs) complete a succinct clinical summary of the events leadings up to each decedent's death *(case-by-case basis)*.
- The development of Comprehensive Clinical Case Summaries *(CCS - see Definitions)* occurs within two weeks of receiving the documents from SIU and includes the review of the availability/unavailability of:
  - Medical records, including physician, nurse practitioner and physician assistant progress notes and nurse's notes, and all incident reports - for the three months preceding the individual's death
  - Incident reports for three months preceding death
  - The most recent individualized service program plan
  - Medical and physical examination records
  - The death certificate from VDH and autopsy or external examination report *(from OCME, when/if performed)*
  - Any evidence of maltreatment related to the death
  - Interviews *(as warranted)* of any persons having information regarding the individual's care
- When the MRT CNRs determine additional medical records or documents are needed, the MRO will request these documents and records from appropriate entities *(see Section V).*
- The CNRs then compose a succinct clinical case summary from reviews of all documents submitted by OL, and any additional documents as needed when requested and received. This relevant information is recorded into the eMRF, reviewed by the Lead Clinical Nurse Reviewer for chronology and timeline event sequence. The eMRF case is then placed into the Appraisal Workflow queue in the electronic application/database for MD/NP appraisal and Tier status, by close of business on the Monday prior to MRC meeting.
  - The Deputy Commissioner for Clinical and Quality Management MD or Clinical Manager/MRO Director NP reviews all clinical case summaries and assigns a Tier category based on the sequential information and related events surrounding that individual's death. Additional information is requested if needed, to clarify or expand the sequence of events leading to an individual's death. The criteria for each Tier category are utilized to make tier status determinations.
- The MD/NP makes Tier status determinations using the following Tier classification criteria:
  - A case is categorized as TIER 1 when <u>any</u> of the following exists:
    - Cause of death cannot clearly be determined or established, or is unknown
    - Any unexpected death *(such as suicide, homicide or accident).* This includes any death that was: not anticipated or related to a known terminal illness or medical condition, related to injury, accident, inadequate care or associated with suspicions of abuse or neglect. A death due to 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
    - Abuse or neglect is specifically documented
    - Documentation of investigation by or involvement of law enforcement or similar agency *(including forensic)*
    - Specific or well-defined risks to safety and well-being are documented

- A case is categorized as TIER 2 when <u>all the first 4</u> criteria exist:
  - Cause of death can clearly be determined or established
  - No documentation of abuse or neglect is noted
  - No documentation of investigation by, or involvement of, law enforcement or similar agency *(including forensic)* is cited.
  - No documentation of specific or well-defined risks to safety and well-being are noted
  - An expected 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
  - An unexpected (unexplained) death that occurred as a result of a condition that was previously undiagnosed, occurred suddenly, or was not anticipated. This includes any death that was: not anticipated or related to a known terminal illness or medical condition, related to injury, accident, inadequate care or associated with suspicions of abuse or neglect. A death due to 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.

- These cases are then considered final clinical summary status and moved to the Committee Review workflow of the electronic database or the MRC meeting dated case folder in the MRC shared drive if the electronic database is unavailable/down.
- A facilitated discussion is conducted during MRC meetings for all Tier 1 cases and for those cases where the Tier category could not be determined without MRC discussion and decision-making.
- To ensure confidentiality and adhere to mandated privacy regulations and guidelines, case reviews are provided to MRC members during the meeting only. At that time, a facilitated narration with discussion occurs

V. Medical Records Request

A. Documents involved: *DBHDS medical records request forms, Virginia Code §§2.2-3705.5, 2.2-3711, 2.2-4002 amendment of the Virginia Code, and online Sfax application*

B. Processes involved:

- DBHDS utilizes the secure online fax application 'Sfax' which adheres to HIPAA mandates related to PHI
- This replaces a nonsecure physical shared fax machine where document access is not restricted and PHI may be visible to anyone
- The limit for repeat requests of medical records and additional documents is three
- A log of medical records is kept to track: Facility names, contact phone numbers, dates of records requested and received, number of attempts, MRO staff member making the request(s), and other comments as needed related to documents and records requested
- Some facilities utilize external medical records vendors who will email the MRO at mortalityreview@dbhds.virginia.gov when medical records have been uploaded to their external secure password access only site
- Medical records received via Sfax are then uploaded by MRO staff to the shared secured and limited access MRC drive
- The MRT CNRs are then notified via email or MS Teams chat that medical records have been received and are ready for review
- In the event medical records are mailed to DBHDS by vendors, they are hand delivered to the OL Offices for scanning to the SIUM, who will then upload them to the shared secured and limited access MRC drive
- MRO Medical Records Process is as follows:

Mortality Review Office Medical Records Request Process

1. Utilizing the email requests from the OL and MRO Clinical Reviewers;
   a) Ensure the email request includes the decedent & facility names and dates of service
   b) From MS Teams;

Select the appropriate Memo request template

download it to your desktop and change the following;

i. Date of request
ii. Facility Name
iii. Facility Office and Fax numbers
iv. Decedent's name, DoB & DoD
v. Dates of Service

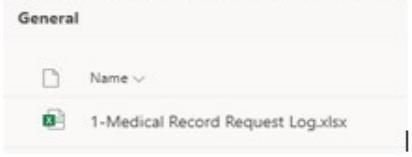
   c) Log into the Sfax application and fax the medical records request to that facility
      i. If the Facility is NOT already in Sfax, look up the Office and Fax #'s online *(may need to call the facility's Office to obtain the fax # if not available online)*. Ensure this information is the same as on the Memo and add it to the Sfax address book

      ii. Attach the required VA legislation *("Add from library")*

      iii. Drag & drop the memo from your desktop into Sfax *("Upload documents")*

      iv. Click "Send" (not Save) to have Sfax send the request

   d) Add the information onto the Master Medical Record Request Log Excel spreadsheet located in MSTeams *(Columns A to J & Initials in Q)*



2. Every week, open the Master Medical Record Request Log in Teams and call the facilities that have had faxed requests
   a) Check the dates for non-highlighted facilities
   b) If a non-highlighted facility had a faxed request 10 business days ago, call the Office number and
      i. Have the decedent's name & DoB available as the facility will ask for this information
      ii. State your name, purpose of call and that you are following up on the faxed request for medical records sent on "xx date", that we have not received any records back as of today and that you are following up to ensure the request was received. *("Hello, my name is _____ and I'm calling on behalf of Dr. Cafaro in the Mortality Review Office of DBHDS. I am following up on the status of a medical records request we faxed to your facility on ____date")*
         - If they say that they did not receive it, or ask for it again, verify the fax number it was originally sent to, and obtain a new one if incorrect
         - Refax the request again immediately after this call to the new #, or again to the original # if verified
         - Use the same memo w/o changing any information, and add "Second Request as per our phone discussion today" to the Remarks section for this new faxed request in Sfax *(last line displayed on the Sfax screen)*

      iii. If they say the request is in process, notify them that; this is a US Department of Justice mandate to review deaths of individuals receiving a service from our Agency, and permitted by Virginia legislation
         - Stress that we are aware of the short notice but need these records ASAP in order to comply with the DOJ mandate
         - We appreciate anything they can do to expedite the request
      iv. Document the date of the call in the appropriate columns of the Master Medical Record Request Log Excel spreadsheet located in teams

         - Note that only two follow-up calls are required
      v. Document a summary of the conversation in the last "Comments" column on the Master Medical Record Request Log Excel spreadsheet located in teams

         - Include your initials before the text you type in so that other users know who made the follow up calls (e.g. *PC-Spoke with "Victor" who said they never rec'd the fax. Refaxed again on 02/14.*)

VI. Death Certificates

A. Documents involved: *Decedent List*

B. Processes involved:

- Secure and encrypted email communications are sent to and from the VDH Office of Vital Records from the mortalityreview@dbhds.virgiinia.gov DBHDS email address to maintain HIPAA PHI mandates.
- The Decedent List (DL) is completed by the MROPC with the previous month's decedent information and emailed to VDH by the 12th of the month, or the nearest business day
- Death certificates (DCs) are encrypted and emailed from the VDH Office of Vital Records to the MRO, on or before the 20th of the same month
- The MROPC verifies and matches the receipt of each DC to the DL and then downloads this document into the shared secured and limited access MRC drive. From here each DC is separated out and uploaded to that one specific decedent's file in order to maintain and protect PHI. The DC is then reviewed by the MRO CNRs and information is added to the appropriate section of the eMRF.
- If a DC is not received for an individual on the DL, it is requested again the following month. If it is still not available after the second request, that indicates it was never entered into the Electronic Death Reporting System (EDRS) of VDH by the provider who completed it/pronounced death and will not be available for review in time for the MRC meeting where that death is due to be reviewed. That notation is made on the eMRF.

VII. MRC Meeting

A. Documents involved: *MRC Charter, MRC Agenda, MRC Meeting Minutes (MMM), MRC Notes Summary (MNS), eMRF, Action Tracking Log (ATL)*

B. Processes involved:

- The MRC meets monthly or more often as needed
- Quorum requirements are met as set forth by the MRC Charter and ensured at the start of each Meeting, before each required deliberation *(see Section VIII. B)* and after the break
- Every attempt is made to ensure that cases are reviewed within 90 days of the individual's DoD
- MRC meetings are scheduled by the MROPC at least six months in advance
- MRC Agenda is emailed by the MROPC to MRC members no later than Wednesday before the MRC meeting
- To ensure confidentiality and adhere to mandated privacy regulations and guidelines, case reviews are provided to MRC members virtually/online during the virtual MRC meeting only and the download functionality is disabled
- The MROPC converts each decedent's case from the 'Committee review' workflow (*see Section IV above*) eMRF into one pdf document which is uploaded into the secured MRC member limited access only MS Teams folder on the morning of the virtual MRC meeting. This process meets HIPAA mandates r/t PHI
- Other MRC documents (*in A above)* are also uploaded into the virtual meeting folder on the morning of the MRC meeting by the MROPC as needed
- The MRC reviews the previous meeting's minutes or entertains revision suggestions, then accepts motions to approve
- The MRC then reviews new and pending *(if any)* cases through a facilitated narration and discussion
- The MRC:
  - Performs comprehensive clinical mortality reviews utilizing a multidisciplinary approach that addresses relevant factors *(e.g., medical, genetic, social, environmental, risk, susceptibility, and others as specific to the individual)* and quality of service.
  - Evaluates the quality of the decedent's licensed services related to disease, disability, health status, service use, and access to care, to ensure provision of a reliable, person-centered approach.
  - Identifies risk factors and gaps in service and recommends quality improvement strategies to promote safety, freedom from harm, and physical, mental, and behavioral health and wellbeing.
  - Reviews OL Corrective Action Plans (CAPs) related to required recommendations, to ensure no further action is required and for inclusion in meeting minutes.

- ♦ Makes additional recommendations for further investigation and/or actions by other DBHDS Offices represented by MRC members, as appropriate
- ♦ Assigns these recommendations and/or actions to specific MRC member(s) as appropriate.
- ♦ Reviews and track the status of previously assigned recommended actions to ensure completion.
- ♦ The committee may also interview any persons having information regarding the individual's case.

- For each case reviewed, the MRC seeks to identify:
  - ♦ The cause of death (CoD)
  - ♦ If the death was expected (XP)
  - ♦ Whether the death was potentially preventable (PP)
  - ♦ Deficits in the timeliness or absence of at least one of the four factors listed in the PP definition (see Definitions) if the death is identified as PP
  - ♦ Primary, Secondary and/or Tertiary prevention strategies[1]
  - ♦ Any relevant factors impacting the individual's death
  - ♦ Whether there are other actions that may reduce these risks, to include provider training and communication regarding risks, alerts and opportunities for education
  - ♦ Other findings that could affect the health, safety, and welfare of these individuals
- If any actions are identified based on the case review, the MRC will then make and document relevant recommendations and/or interventions
- The MRC makes recommendations *(including but not limited to QIIs)* in order to reduce mortality rates to the fullest extent practicable
  - ♦ The case may be closed or pended. If all determinations are made, the case is closed by the committee. If additional information is needed in order to make a determination, the case is pended until the next meeting
  - ♦ Cases that are pended are considered reviewed within 90 days of the individual's death based on the beginning review date
  - ♦ A pended case remains open until the following meeting, when the assigned committee member provides an update, or specific information was received as requested. If all determinations can be made, the pended case is closed by the committee.
- During the MRC meetings - documentation of determinations, recommendations, actions, activities, motions and discussions are made by the MROPC on the MMM, MNS and ATL. One CNR also makes relevant notations on the eMRF
- The ATL is reviewed during each MRC meeting
  - ♦ The member assigned to the action provides a status update to the MRC
  - ♦ Members may ask for more information, clarification or discussion
  - ♦ If more information or activities need to occur or are pending, the action will remain open until the next meeting
  - ♦ If no additional action or activity is needed, motions to complete the action are accepted
- Additional meetings and/or meeting time changes *(early or extended)* for case reviews are scheduled and held as needed depending on the number and complexity of decedent cases
- Within 60 minutes of the MRC meeting adjournment, the MROPC deletes all the above mentioned documents from the MS Teams secured member only access folder. This process meets HIPAA mandates r/t PHI & confidential information

VIII. Attendance, Membership, Quorum Monitoring

A. Documents involved: *MRC Meeting Minutes (MMM), MRC Charter*

B. Processes involved:

- The MRC meets at least monthly and more often as needed to conduct required reviews of deaths. Meetings meet quorum requirements as set forth by the MRC Charter.
- Attendance is tracked on the MRC meeting minutes to ensure that members or their designees attend at least 75% of meetings per fiscal year and a quorum is met for voting purposes.

[1]Steven Staugaitis & Emily Lauer, "Risk Management Mortality Review and Reporting in Developmental Disabilities: How to Use Mortality Review and Reporting as a Quality Enhancement Tool in Development Disability Service Organizations", *University of Massachusetts Medical School*, (2015):69.

- The Commissioner shall establish the monthly mortality review membership, to include the DBHDS Deputy Commissioner of Clinical and Quality Management (*DCCQM)*, the Senior Director of Clinical Quality Management, and others as determined by the Agency who possess appropriate experience, knowledge, and skills.
- The team shall have at least one member with the clinical experience to conduct mortality reviews who is otherwise independent of the State
- Required MRC members currently include:
  - Deputy Commissioner of Clinical and Quality Management (*MD staff member with QI and programmatic/operational [P/O] expertise*)
  - Assistant Commissioner of Developmental Services, or designee *(staff member with QI and P/O expertise*)
  - Senior Director, Office of Clinical Quality Management (*staff member with QI and P/O expertise*)
  - Director, Office of Human Rights, or designee (*staff member with regulatory, QI and P/O expertise*)
  - Director, Office of Integrated Health, or designee (*staff member with QI and PO expertise*)
  - MRO Clinical Director/MRC Clinical Manager, MRC Co-Chair (*NP and staff member with QI and P/O expertise*)
  - OL Manager, SIU (*staff member with regulatory and P/O expertise*)
  - Office of Pharmacy Services Manager (*PharmD and staff member with regulatory, QI and P/O expertise*)
  - MRO Clinical Nurse Reviewers (NP/*RNs and staff member with QI and P/O expertise*)
  - MRO Program Coordinator (*Staff member with QI and P/O expertise*)
  - A member with clinical experience to conduct mortality reviews who is otherwise independent of the State (*medical doctor, nurse practitioner, or physician assistant, who is an external member with P/O expertise*)
- Quorum status is monitored throughout the meeting with verification of quorum status before voting on these deliberations that require quorum: Approval of minutes, recommendations to the QIC, approval/denial of quality improvement initiatives (QIIs), PMIs and charter revisions
- A quorum is 50% of voting membership plus one, with attendance of at least: *(one member may satisfy two roles):*
  - A medical clinician *(medical doctor, nurse practitioner, or physician assistant)*
  - A member with clinical experience to conduct mortality reviews
  - A professional with quality improvement expertise
  - A professional with programmatic/operational expertise
- Current Advisory *(nonvoting members)* nominated by DBHDS Commissioner or MRC Chair:
  - DBHDS Deputy Commissioner, Policy & Public Affairs, or designee
  - DBHDS Settlement Agreement Advisor, or designee
  - Representative, DBHDS Office of Licensing Investigative Management Unit (IMU)
  - Representative, Department of Medical Assistance Services
  - Representative, Department of Health
  - Representative. Department of Social Services
- Representative, Office of Chief Medical Examiner (OCME)
  - Representative, Community Services Board
  - Other subject matter experts such as representatives from a DD Provider or Advocacy Organizations
- Voting members:
  - Have decision making capability and voting status.
  - Attend 75% of meetings per year and may send a designee that is approved by the MRC chair (*or Co-Chair*) prior to the meeting
  - Review data and reports for meeting discussion
  - May send a designee to MRC meetings but should attend at least one meeting per quarter. The designee shall have decision-making capability and voting status, and should come prepared for the meeting
  - 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 are unable to attend

- Recognize that an excused absence does not contribute to the 75% attendance requirement

- Advisory members:
  - Are non-voting stakeholder members selected and approved by the QIC and DBHDS Commissioner whose various perspectives provide insight on MRC reviews, clinical insight, medical expertise, and MRC performance goals, outcomes, required and recommended actions.
  - Inform the committee by identifying and prioritizing MRC decision making and recommendations.
  - May be appointed for a term of two years, and may be reappointed as ex-officio member
  - Are expected to attend one meeting every quarter (4/year) and may send a designee who 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, that the advisory member and/or designee are unable to attend
  - Recognize that an excused absence does not contribute to the attendance requirement

IX. MRC Member Recusal

A. Documents involved: *MRC Meeting Minutes (MMM), MRC Charter*

B. Processes involved:

- 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 as listed below)*
  - 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 *(including determinations and recommendations)* of the decedent, to include employment, property interests, research, funding or support, industry partnerships and consulting relationships
- Should a COI arise during the review process, the MRC member will:
  - Immediately disclose the potential COI and cease participation in the case review related to the existing or potential COI
  - Disclose the COI privately to the Chair/Co-Chair, or publicly to the members in attendance
- 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

X. Recommendations & Quality Improvement Initiatives

A. Documents involved: *MMM, MNS, ATL, eMRF, MRC Quarterly report, Commissioner Quarterly Report, MRC Annual Report*

B. Processes involved:

- The MRC 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
- Two data formats are utilized
  - Reviewed – denotes actual cases reviewed by the MRC in a specified timeframe, which may include a death that happened at any point in time
  - Occurred – denotes only deaths that transpired during a specified timeframe
- From this analysis, the MRC makes one recommendation per quarter or four recommendations per year for systemic quality improvement initiatives, and reports these recommendations to the QIC and the DBHDS Commissioner on a quarterly basis
- Also on a quarterly basis, the MRC prepares and delivers to the QIC a report specific to the committee's findings
- Additionally, the MRC:
  - Establishes performance measure indicators (PMIs) that align with the eight domains when applicable

- Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance
- Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised, or retired in keeping with continuous quality improvement practices.
- Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures
- Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns
- Share data or findings with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee
- Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed
- Implements approved QIIs within 90 days of the date of approval
- Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed
- Evaluates the effectiveness of the approved QII for its intended purpose
- Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training
- Completes a committee performance evaluation annually that includes accomplishments and barriers

XI. Member Orientation & Confidentiality Forms

A. Documents involved: *MRC & QM Orientation PowerPoint, Confidentiality Agreements*

B. Processes involved:

- All new members must attend orientation within 30 business days of joining the committee.
- 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.
  - Member confidentiality forms are valid for the entire term of MRC membership
- MRC Member Orientation training 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 sign the MRC Member Orientation Acknowledgement Form

XII. Potential Unreported Deaths

A. Documents involved: *DW-0096, Potential Unreported Death Log (PUDL), MDPS*

B. Processes involved:

- DBHDS provides the identifying information of individuals in the Waiver Management System (WaMS) who receive DBHDS-licensed services on a monthly basis to VDH, who identifies the names for which a death certificate is on file in the state's VDH Electronic Death Reporting System (EDRS).The results are provided to DBHDS and used by MRO in attempt to identify deaths that were not reported through the DBHDS incident reporting system *(see Section VI).*
- The MROPC runs DW-0096 on the closest business day of the 27th of each month, for the previous month, and adds information from DW-0096 report to the PUDL.
- The MROPC compares the DW report to the MDPS to validate deaths on the DW report are on the MDPS *(ensuring no discrepancy)*.
- The PUDL is updated monthly on the MRC limited access secure shared drive and the SIUM is notified that the log has been updated, by the MROPC.
- The SIUM reviews the DL to determine if the SIU needs to investigate the unreported deaths based on OL protocols.
- The SIUM reviews information in WaMS to determine if the individual was admitted to a DBHDS licensed service at the time of death.
- Within 10 business days, the SIUM updates the PUDL and MDPS related to appropriate OL actions. The SIU team investigates all unreported deaths identified by this process and takes appropriate action in accordance with DBHDS licensing regulations and protocols.
- Upon completion of the OL investigation, if a death is determined to require MRC review, the MRT will initiate the usual review process for the case as per current standard operating procedure.
- The MROPC will add the date the case was reviewed by the MRC to the PUDL

XIII. Discrepancy Log

A. Documents involved: *eMRF, Discrepancy Log (DL), MDPS*

B. Processes involved:

- When a DBHDS licensed provider reports the death of an individual who was not receiving a licensed service, or not receiving any licensed services 30 days prior to their death, the OL confirms that the decedent was not receiving any licensed service(s) through DBHDS. The SIUM adds a notation with details into the MDPS and notifies the MROPC. This decedent's record is then deleted from the eMRF and added to the DL by the MROPC for tracking purposes. The rationale for the discrepancy is noted on the DL by the MROPC.
- Deaths of IDD individuals that did NOT receive any DBHDS licensed service, are not reviewed by the MRC and are therefore not entered into the usual mortality case review process.
- The MRO is notified by the OL and/or DBHDS state facilities, of IDD state facility deaths. If the decedent is not listed on the monthly queries run by the SIUM and Data Warehouse team *(see Section III.B)*, the MROPC manually adds that decedent to the eMRF and MDPS

XIV. MRC Charter

A. Documents involved: *MRC Charter*

B. Processes involved:

- The MRC Charter includes:
  - Statement of Purpose
    - The purpose of the DBHDS Developmental Disabilities (IDD) Mortality Review Committee (MRC) is to focus on system-wide quality improvement by conducting mortality reviews of individuals who receiving a service licensed by DBHDS at the time of death *(or within 90 days of death)* and diagnosed with IDD, utilizing an information management system to track the referral and review of these individual deaths.
  - Authorization/Scope of Authority
    - The DBHDS Commissioner is the executive sponsor of the MRC and designates the Deputy Commissioner of Clinical and Quality Management to establish and supervise the MRO. Through the DBHDS incident reporting system, and in collaboration with OL, the MRC reviews deaths of individuals with IDD who received a service licensed by DBHDS at the time of death *(or within 90 days of death)*. The MRC is a sub-committee of the Quality Improvement Committee (QIC)
  - Charter Review timeframe
    - The MRC charter is reviewed and/or revised on an annual basis, or as deemed necessary by the committee
  - DBHDS Model for Quality Improvement
    - On a quarterly basis, DBHDS staff assigned to implement QIIs will report data related to the QIIs to the MRC to enable the committee to track implementation
    - The MRO collects data from case specific mortality reviews and then performs analysis of case noted data, including trends, patterns, and problems at individual service delivery and systemic levels. From this data analysis, the MRC identifies areas for development of QIIs.
    - To that end, the MRC determines the Aim, Measure and Change in order to implement the Plan/Do/Study/Act Cycle
    - Additionally, the MRC establishes, implements, monitors progress, assesses and evaluates, preventive corrective performance measure indicators (PMIs) that align with eight domains (*see Quality Management section XVII*).
- Charter Approval Process
  - When any revisions are made by the MRC, the MRC Charter is then presented to the QIC for approval.
  - The QIC approved MRC Charter is effective from the beginning of the fiscal year (*July 1*) or immediately (*if approved after the start of the fiscal year*)

XV. Report to the Commissioner

A. Documents involved: *MRC Quarterly Report to Commissioner*

B. Processes involved:
- Within ninety days of the last death review *(see 90-Day IDD MRC Schedule on page 4)*, the MRT shall prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations (if any)
- For 86% of deaths requiring review within 90 days of the death, the MRC prepares and delivers to the DBHDS Commissioner a report of deliberations, findings, and recommendations (if any)
  - If the MRC elected not to make any recommendations, documentation will affirmatively state that no recommendations were warranted. Proposed QII's are also documented in the report
- Data is collected via the eMRF, MDPS, PUDL, ATL, QII spreadsheets and PowerPoint presentations
- Data is extracted from data sources to Excel, then analyzed and communicated via tables, charts, and graphs

XVI. MRC Annual Report

A. Documents involved: *MRC Annual Report*

B. Processes involved:
- The MRC prepares an annual report of aggregate mortality trends and patterns for all cases reviewed by the MRC, and for those deaths that occurred in that SFY, within six months of the end of the year. The annual report will at a minimum, include:
  - The total number of deaths and cause of death in DBHDS-licensed residential settings.
  - Crude mortality rate of individuals on a DD HCBS waiver and receiving aDBHDS licensed service.
  - Crude mortality rate of individuals by residential setting in aggregate known to DBHDS.
  - Crude mortality rate of individuals by age, gender, and race
  - Analyses of patterns of mortality by age, gender, and race residential settings and DBHDS facilities; service program; and cause of death.
- The MRO notifies the responsible DBHDS data staff individual once all deaths for the SFY have been reviewed by the MRC *(usually September of each year).*
- This assigned data staff individual runs queries, then compiles and develops data diagrams for the MRC Annual Report
- Once a clean dataset is prepared for analysis, there is relatively little variation in the structure and format of the Mortality Report between fiscal years. At a high level, the Mortality Report is organized as follows:
  1. Cover page
  2. Executive Summary
     a. Includes date parameters for analysis
     b. Provides context for report
     c. Presents overall number of deaths organized by various groupings
  3. Key Findings
     a. Between three and five important findings from the current fiscal year
     b. Findings should note trends related to causes of death, potentially preventable deaths, and crude mortality rates
  4. Recommendations
     a. Four or more recommendations formally proposed and adopted by the MRC related to the findings of the report
     b. These recommendations are monitored closely by DOJ and the Independent Reviewer, so it is expected that these recommendations set realistic public goals to which DBHDS can reasonably commit
  5. Purpose/Approach/Definitions
     a. Includes main definitions related to whether a death is expected, the cause of death, and whether a death is potentially preventable
     b. May include background information describing how the MRC operates or recent changes to processes and organization
  6. Virginia Deaths
     a. Causes of Death
        i. Summarizes the leading causes of death for the current SFY
        ii. Includes trend data for previous SFYs
     b. Do Not Resuscitate (DNR) *(added in SFY 2021 report)*
        i. Presents the number and percentage of documented DNR statuses
        ii. Includes a table of DNR status by residential setting

c. Hospice Service (*added in SFY 2021 report*)
    i. Presents the number and percentage deaths receiving hospice services
    ii. Includes tables showing hospice service deaths by residential setting and by age group
d. Expected and Unexpected Deaths
    i. Presents number and percentage of expected, unexpected, and unknown deaths for the current SFY
    ii. Includes trend data from previous SFYs
e. Potentially Preventable Deaths
    i. Presents number and percentage of potentially preventable deaths
    ii. Includes trend data from previous SFYs

7. Population Demographics
    a. Age
        i. Presents crude mortality rates by age range on the HCBS waivers
        ii. May include historical trend data and other findings
    b. Gender
        i. Presents crude mortality rates by gender on the HCBS waivers
        ii. May include historical trend data and other findings
    c. Race
        i. Presents crude mortality rates by race on the HCBS waivers
        ii. May include historical trend data and other findings
    d. SIS Level
        i. Presents crude mortality rates by SIS level on the HCBS waivers
        ii. May include historical trend data and other findings
    e. Residential Setting
        i. Presents crude mortality rates by residential grouping and residential setting on the HCBS waivers
        ii. May include historical trend data and other findings
    f. Individuals Discharged from Training Centers
        i. Presents number of deaths among training center discharge population
        ii. Presents average age at death and average community tenure among training center discharge population
8. Summary

- The MRO develops narrative sections (*Executive Summary, Key Findings, Recommendations, Conclusion*), after data analysis and diagram development is completed
- In the event that the MRT identifies discrepancies between the data presented in the draft of the Annual Report and its internal data, the DCCQM will be notified immediately and provided with relevant evidence to support alternative findings. All other changes to the report draft, such as language changes to the key findings, can appropriately be made with tracked changes in the main Word document.
- Once the MRC Annual Report is finalized, a ticket is submitted before or immediately after December 25th for IT to publish the document to the DBHDS website before December 31st of each year

XVII. DBHDS Quality Management System

A. Documents involved: *Developmental Disabilities Quality Management Plan, MRC Charter*
B. Processes involved:

- Every organization should implement a quality management system that is cross lifespan, appropriate to its size, scope and populations served. The DBHDS Quality Management System is based on the DBHDS Vision, Mission and Strategic Plan and incorporates these nationally recognized quality principles. DBHDS developed a multi-faceted approach using these quality frameworks and principles to develop a culture of quality. The system's infrastructure is:
    - Supported through the organization's leadership who is:
        - Committed to the success of the QM plan
        - Supportive of the organizational culture of quality improvement
        - Prepared to designate resources for critical support mechanisms
        - Willing to give authority to staff to make changes
        - Person and family-centered

- Characterized by employees and providers who are continuously learning and empowered as innovative change agents
- Effective in utilizing data for ongoing quality improvement
- Sustainable and continuous

- While compliance is what we must achieve, the ultimate goal is a system of quality services that allows individuals to direct their own lives and recovery, to access and fully participate in their community and balances risk, health, safety, and well-being. An effective quality/risk management structure includes quality assurance, risk management and quality improvement (QI) processes.
- The foundation of the framework is compliance with federal and state laws and regulations that focus on individual protections, rights, and liberties and standards to ensure safe consistent quality of care.
- DBHDS strives towards a culture of quality, which recognizes that quality is a shared responsibility of all individuals within an organization. While this may require a fundamental shift in perspective, all employees should be empowered to be change agents.
- Quality improvement is the systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care.
- Performance Outcomes and Improvement Initiatives
  - Quality remains a continuous process, rather than a one-time activity, and connects with the agency's mission, vision, and strategic plan. This process involves:
    - Development of quality outputs and outcomes
    - Data collection
    - Data analysis
    - Evaluating the effectiveness of the overall system
    - Determining findings and conclusions
    - Identifying trends that need to be addressed
    - Identifying corrective actions, remedies, or quality improvement initiatives as needed
    - Implementing quality improvement initiatives, corrective actions, or remedies
    - Evaluating the effectiveness of implemented corrective actions, remedies, and or quality improvement initiatives
- Regardless of an organization's chosen quality model, leadership commitment, engagement of employees, defined structures and processes, defined performance measures, data driven quality initiatives, and customer focus are all essential elements of any quality management framework.
- The QI Subcommittee Work Plans provide a means for all quality subcommittees, workgroups, and councils to document areas of focus, including quality improvement efforts, and ensures consistent reporting to the QIC. This work plan is used to consistently identify patterns and trends and track the subsequent development and implementation of quality improvement initiatives (QIIs) related to their regular review of data within their focus areas. The work plan template is used by the DBHDS Quality Improvement Specialists, Quality Improvement Coordinator, and the Quality Management Coordinator to document achievement of committee requirements to monitor performance measure indicators and QII implementation

XVII. DEFINITIONS:

- <u>Two data formats</u> utilized by the MRO & DQV:
  - Reviewed – denotes actual cases reviewed by the MRC in a specified timeframe, which may include a death that happened at any point in time
  - Occurred – denotes only deaths that transpired during a specified timeframe
- <u>Comprehensive clinical case summaries (CCS)</u> denote an in-depth inclusive review of clinical and sequential information related to the events surrounding the individual's death. After review by the CCO or CM, CCS's are assigned a Tier category and considered final clinical summaries. These may be reassigned at the recommendation of the MRC.

- 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. An expected death is also considered an anticipated death.
- 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 or 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.
- Other denotes a cause of death that is not attributable to one of the major causes of death used by the MRC for data trending.
- 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).* If the individual was provided with known effective medical treatment or public health intervention and died despite this provision of evidenced based care, the death is not considered potentially preventable. A death may be determined to be PP regardless of whether the death is actionable by DBHDS or within the control of DBHDS. Deaths that occur in settings that are not licensed by DBHDS may be PP deaths. Deaths that do not indicate a violation of a licensing standard may be PP. Deaths determined to be PP have identifiable actions or care measures that should have occurred or been utilized. When the MRC determines a death is PP, the committee categorizes factors that might have prevented the death. 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 changes in status

- For actions recommended by the MRC, the MRC shall consider which of the following Three Prevention Strategies[1] may be utilized:
    - Primary Prevention Strategies – Education and service changes designed to help prevent a condition or event from taking place, when identified as contributing to that individual's morbidity or mortality (*e.g., reducing falls through education, or supporting healthy lifestyles though education and practice programs such as weight management*).
    - Secondary Prevention Strategies – Minimizing harmful effects and preventing further morbidity and mortality by focusing on early detection and timely treatment of conditions or injuries (*e.g., training direct support staff and providers to realize signs and symptoms of serious medication effects and illness, or implementing programs that support and advocate for preventive cancer screenings*)
    - Tertiary Prevention Strategies – Utilizing evidence-based practice standards, this strategy focuses on the management and treatment of conditions and injuries in order to reduce mortality rates (*e.g., diabetes management education to direct support staff and providers, or establishment of aspiration prevention and management protocols through intensive education and staff training to prevent aspiration and/or aspiration pneumonia.*

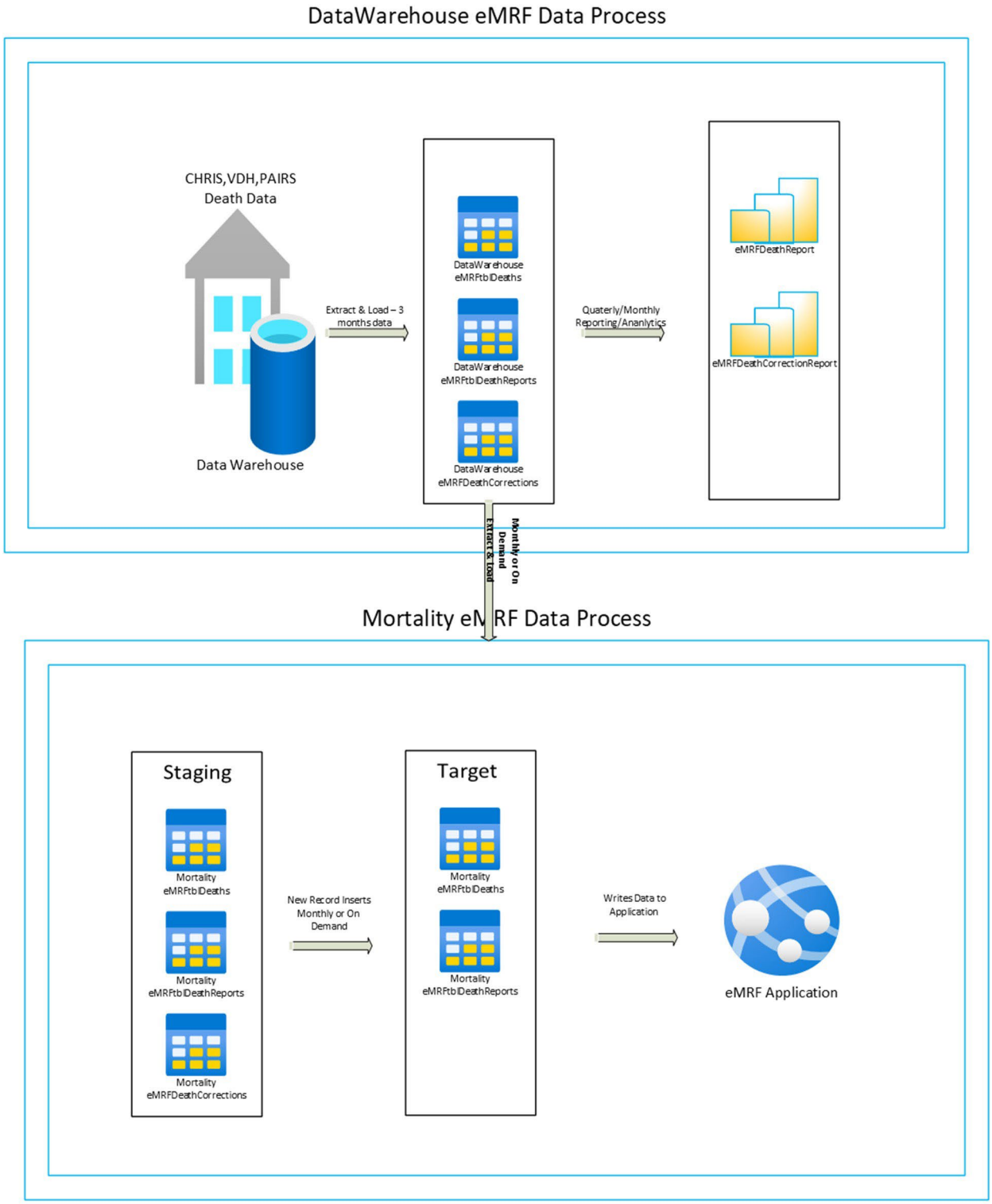
[1] Steven Staugaitis & Emily Lauer, "Risk Management Mortality Review and Reporting in Developmental Disabilities: How to Use Mortality Review and Reporting as a Quality Enhancement Tool in Development Disability Service Organizations", *University of Massachusetts Medical School*, (2015):69

Appendix I – eMRF Death Data Load Process

The data required for the Mortality Review Committee (MRC) to review deaths in the Electronic Mortality Review Form (eMRF) application is loaded with the following mechanism, using SQL queries from the DW80a report with additional business logic which aligns with the business rules prescribed.

- The following source databases are queried - CHRIS (Community deaths) and PAIRS (Facility Deaths), death data for individuals identified as IDD are cross checked with WAMS data to verify if the individual has a waiver, waitlist, SIS, and Training Center flag information. This cross check is performed for consistency across reporting.
- For the community deaths (CHRIS), if one individual's death is reported by multiple providers, that death information is processed as one record only.
- This mechanism outputs a full list of community and facility IDD deaths that comprises those deaths that the MRC is tasked to review.
- This compiled list of community and facility deaths is then matched against death certificate data from the VDH to validate the death date.
- If all the information matches VDH death data, these records are considered valid and are loaded into the eMRF application for review.
- If there is information that does not match due to missing/incorrect data from CHRIS or PAIRS, an exception report is generated, and the MRC works with the Incident Management Unit (IMU) in the DBHDS Office of Licensing. Providers or facilities are notified to correct those records in the source system with the accurate information.
- Once the information is corrected those records are described as 'clean records' and are loaded into the eMRF application for review.
- When a death occurs out of state, it is reported in the Exceptions Report. Once the Mortality Review Office has validated it as an out of state death, it is designated as such and the record is loaded into the eMRF application for review.

The diagram on Pages 21 and 22 is the technical representation of how data flows in the process described above.


DataWarehouse eMRF Data Process
CHRIS,VDH,PAIRS
Death Data
Data Warehouse
Extract & Load – 3
months data
DataWarehouse
eMRFtblDeaths
DataWarehouse
eMRFtblDeathReports
DataWarehouse
eMRFDeathCorrections
Quaterly/Monthly
Reporting/Ananlytics
eMRFDeathReport
eMRFDeathCorrectionReport
Extract & Load
Monthly or On
Demand
Mortality eMRF Data Process
Staging
Mortality
eMRFtblDeaths
Mortality
eMRFtblDeathReports
Mortality
eMRFDeathCorrections
New Record Inserts
Monthly or On
Demand
Target
Mortality
eMRFtblDeaths
Mortality
eMRFtblDeathReports
Writes Data to
Application
eMRF Application

Mortality Review Office/Mortality Review Committee
Process and Procedure Document

Resources required to complete this process: (List all resources external to this process document that will be necessary to complete the process)	
Resource name	**Location (file directory, box, etc.)**
MRC DD Death Documentation	https://covgov.sharepoint.com/:f:/r/sites/tm-dbhds-imuworkgroup/Shared%20Documents/MRC%20DD%20Death%20Documentation?csf=1&web=1&e=pxZdhu
MS PA eMRF Database Microsoft PowerApps	https://apps.gov.powerapps.us/play/e/adfab656-ca5c-42c7-9403-8c7f6bcd02da/a/9a4e05b1-0f23-4d72-b230-5fed99864362?tenantId=620ae5a9-4ec1-4fa0-8641-5d9f386c7309&source=portal

Acronyms:	
Acronym:	**Definition:**
DW	Data Warehouse
I/DD	Intellectual & Developmental Disabilities
IMU	Incident Management Unit
MRC	Mortality Review Committee
MRO	Mortality Review Office
MS PA database	Electronic database where eMRF is located

Process Scope/Purpose: Perform quality control and load new deaths into MS PA database, on a monthly basis
Process Outcome: I/DD deaths loaded into electronic mortality review database, monthly
Process Trigger: Monthly I/DD Death DW Query is run by DW team and emailed to the MRO Program Coordinator

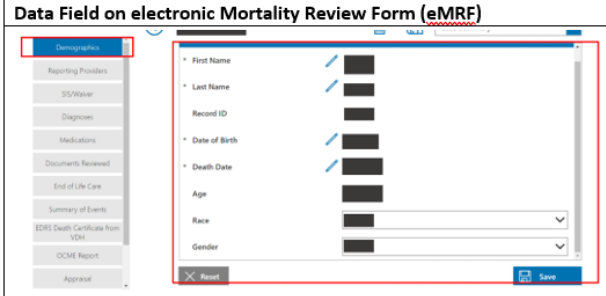
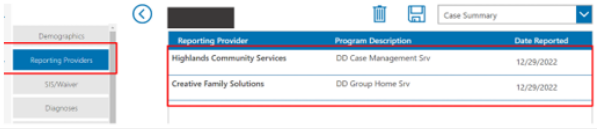
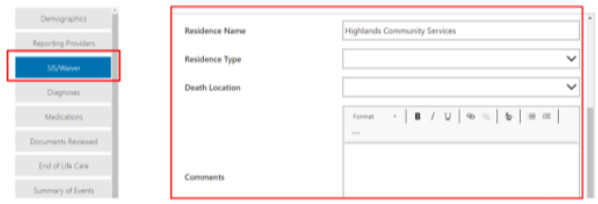
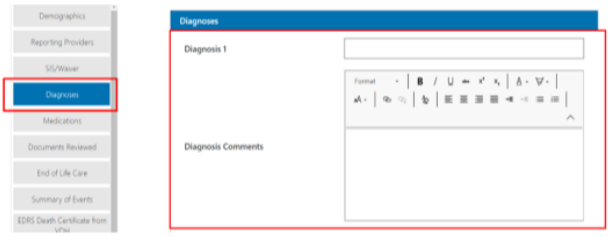
STEP#	PROCESS STEPS	Inputs/Outputs	PERFORMED BY
1	**Trigger:** DW query report emailed to MRO Program Coordinator by the 10th of each month. **Actions:** • Open attachment containing new I/DD deaths	**Input:** Monthly I/DD Death DW Query **Output:** CHRIS Corrections Needed Spreadsheet	DW and MRO Program Coordinator

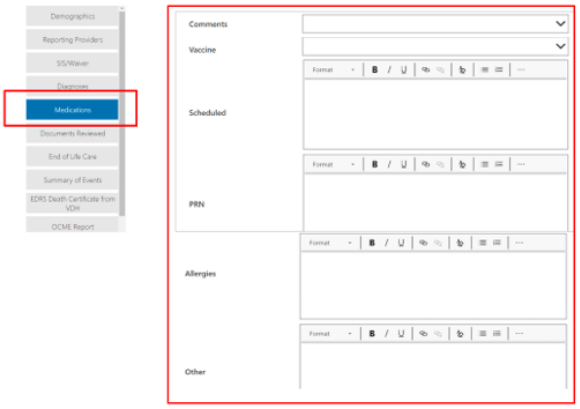
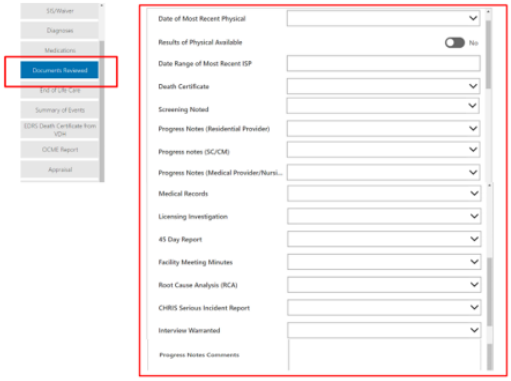
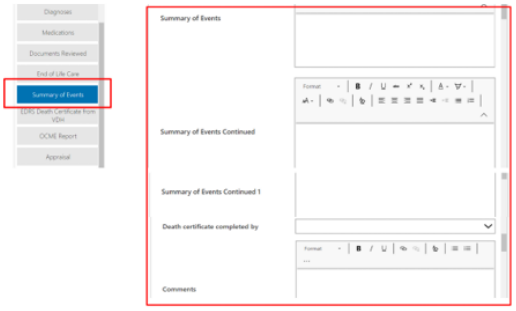
	• Reconcile death information by comparing DW query and DW80a with VDH data
	  ○ Compare first name, last name, date of birth, date of death, SSN, and reporting provider(s)
	  ○ Post CHRIS Corrections Needed spreadsheet in MS teams for IMU to correct any discrepancies		

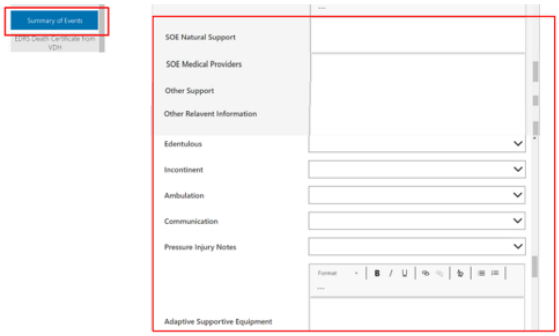
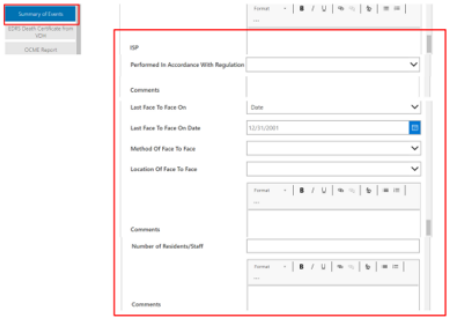
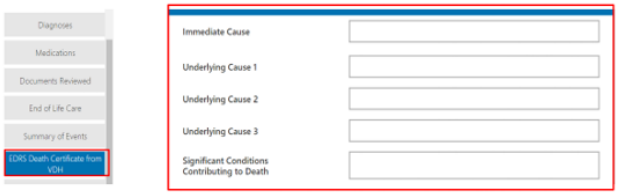
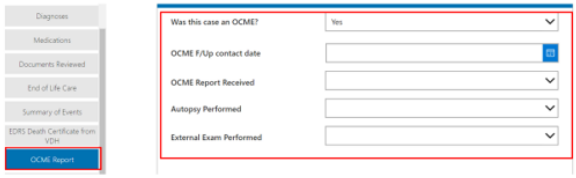
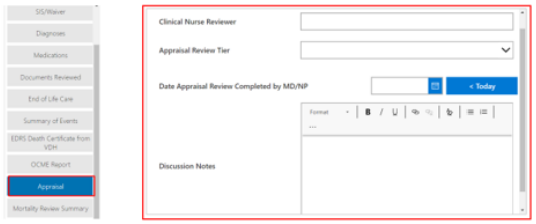
2	**Trigger**: CHRIS Corrections Needed spreadsheet posted in MS Teams
	
	Actions:
	• IMU will contact provider(s) to make necessary corrections
	  ○ Within 7 business days, IMU will review the document and ensure corrections were made, or document in Comments column the reason why discrepancies cannot be resolved.
	  ○ Corrections needed to CHRIS data are resolved and marked as such, or the reason why the discrepancy cannot be resolved.
		Input: CHRIS Corrections Needed Spreadsheet
		
		Output: CHRIS Corrections Needed Spreadsheet With corrections made
			MRO Program Coordinator and IMU Manager (or designee)

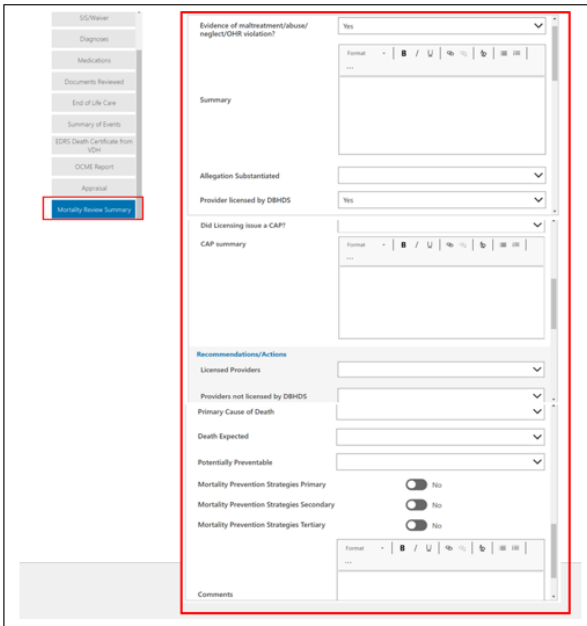
3	**Trigger**: CHRIS Corrections Needed Spreadsheet updated by the IMU with follow-up **Actions**: • On the 8th business day, reconciled CHRIS Corrections Needed spreadsheet will be obtained from MS Teams folder • Note any IMU comments and take action to validate using death certificate or other documents required to be submitted • Communicate with the DW about whether corrections have been made and deaths can be loaded to the eMRF, or whether specific deaths will need to be loaded manually per the Exceptions process.	**Input**: CHRIS Corrections Needed Spreadsheet with corrections made **Output**: Quality control completed and data ready to load	MRO Program Coordinator and DW
4	**Trigger:** Post communication with DW r/t corrections Made r/t deaths load (via system or manual) **Actions:** • Deaths are loaded into MS PA by system if corrections made • Deaths are manually loaded in MS PA per Exceptions process	**Input:** Validated CHRIS Corrections Needed Spreadsheet **Output:** All deaths loaded into MS PA	MRO Program Coordinator and DW

Appendix II – eMRF Data Source Process

Data Field on electronic Mortality Review Form (eMRF)	Data Source
	Data in all 8 fields auto populated from CHRIS and/or PAIRS database, then validated against VDH data via the data warehouse.
	'Reporting Providers' required to report death auto populated from CHRIS and/or PAIRS database.
	Training center discharge auto populated from CHRIS and verified by CNR during case composition from the Mortality Review Office (MRO) Training Center Master Discharge List.
	Data in all 4 fields auto populated from WaMS and verified by CNR manually through WaMS. When "Not a Waiver Recipient" is selected under 'Waiver', 'SISLevel' and 'SISTier' fields are not visible.
	Data in all 4 fields entered by CNR from documents submitted for review. Comments field is for additional relevant information when needed.
	Diagnoses data fields (x20) entered by CNR from documents submitted for review. Comments field is for definition of uncommon diagnoses with the appropriate reference citation (such as Coffin-Lowry Syndrome) in addition to other relevant information when needed.

	Data in all 6 fields entered by CNR from documents submitted for review. Other field for additional relevant information when needed.
	Data in all 15 fields entered by CNR from documents submitted for review. 'Progress Notes Comments' field used for CHRIS report summaries and other relevant information.
	Data in all 7 fields entered by CNR from documents submitted for review. Note: When "No" selected for 'End of Life Care Documented', only "DNR/DDNR in place" field is visible.
	Data in all 5 fields entered by CNR from documents submitted for review. Comments field for additional relevant information when needed. Note: Sequence of Events fields limited to 3000 characters, thus fields will be blank depending on SOE length.

	Data in all 10 fields entered by CNR from documents submitted for review.
	Data in all 7 fields entered by CNR from documents submitted for review. Comments fields for additional relevant information when needed.
	Data entered by CNR exactly as displayed on death certificate, thus blank fields are also blank on the death certificate.
	Data entered by CNR from documents submitted for review. When "No" selected for 'Was this case an OCME?', no other fields are visible.
	Name and credentials entered in first field by CNR and remaining 3 fields completed by NP during Appraisal Review. 'Appraisal Review Tier' selection is based on Tier criteria as defined in MRC Charter.

	Data entered by CNR as determinations are made in real time during MRC meetings. Comments field for additional relevant information as discussed during MRC meeting when needed. Note: When "No" selected for 'Evidence of maltreatment/abuse/neglect/OHR violation?', 'Summary and Allegation Substantiated' fields are not visible. When "No" selected for 'Provider licensed by DBHDS', 'Did Licensing issue a CAP' and 'CAP summary' fields are not visible.
	Data entered by MRO within 6 hours after the MRC meeting in which the case was reviewed. Each case is closed within 12 hours after the MRC meeting (barring unforeseen circumstances).