Mortality Review Committee Charter
QIC Approved September 21, 2020
Revised
QIC Approved November 16, 2020

Committee	Mortality Review
Statement of Purpose	The purpose of the DBHDS Developmental Disabilities (DD) Mortality Review Committee (MRC) is to 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 and diagnosed with an intellectual disability and/or developmental disability (I/DD), 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 Chief Clinical Officer (CCO) to establish and supervise the Mortality Review Office (MRO). Through the DBHDS incident reporting system, and in collaboration with the Office of Licensing, the MRC reviews deaths of individuals with I/DD who received a service licensed by DBHDS at the time of death. The MRC is 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 ability, the MRC will determine the cause of an individual's death, whether the death was expected, and if the death was potentially preventable.
Charter Review	The MRC charter is reviewed and/or revised on an annual basis, or as deemed necessary by the committee.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement projects as indicated DBHDS demonstrates on an on-going basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. DBHDS develops and implements quality improvement initiatives, either regionally or statewide, as recommended

	by the MRC and approved by the DBHDS Commissioner, to reduce mortality rates to the fullest extent practicable.
Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement quality improvement initiatives will report data related to the quality improvement initiatives to the MRC to enable the committee to track implementation. Through mortality reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the MRC identifies areas for development of quality improvement initiatives. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. 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. • Implements approved Quality Improvement Initiatives (QII) 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

	• 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
Structure of Committee:	
Membership	The MRC is composed of members with clinical training and experience in the areas of intellectual and developmental disabilities, medical and pharmacy services, quality improvement, compliance, incident management, behavior analysis and data analytics. Required Mortality Review Committee DBHDS members include: • Chief Clinical Officer *(MD, and 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)* • Assistant Commissioner for Compliance, Risk Management, and Audit or designee *(staff member with QI, P/O, and regulatory expertise)* • Senior Director of Quality Improvement *(staff member with QI and P/O expertise)* • Director, Community Quality Improvement, or designee *(RN and 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)* • Mortality Review Office (MRO) Clinical Manager, Co-Chair (*NP and staff member with QI and P/O expertise*) • Office of Licensing Manager, Incident Team *(staff member with regulatory and P/O expertise)* • Office of Licensing Manager, Investigation Team *(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 Reviewer *(RN 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)* Advisory *(non-voting members*) nominated by the Commissioner or Chair of the MRC, which may include;

	• Representative, Department of Medical Assistance Services • Representative, Department of Health • Representative, Department of Social Services • Representative, Office of Chief Medical Examiner • Representative, Community Services Board • Other Subject matter experts such as representatives from a DD Provider or Advocacy Organizations
Meeting Frequency	The MRC meets, at minimum, on a monthly basis or more frequently as necessary to conduct mortality reviews with 90 days of death.
Quorum	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
Leadership and Responsibilities	The DBHDS Commissioner shall serve as the executive sponsor of the MRC and the Chief Clinical Officer, or Mortality Review Clinical Manager, shall serve as committee chair. The committee chair shall be responsible for ensuring the committee performs its functions; consideration and, as appropriate, approval of quality improvement activities, and MRC core processes. <u>Standard operating procedures</u>: • The Licensing Investigations Team reviews all deaths of individuals with a developmental disability reported to DBHDS through its incident reporting system and provides available records and information it obtains and the completed Licensing Investigation Report to the MRC within 45 business days of the date the death was reported. • Within 90 calendar days of a death, (and for any unreported deaths, as defined on page 6), the Mortality Review Team (MRT) compiles a review summary of the death. This includes development of a succinct, clinical case summary 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 (if applicable)
- Any evidence of maltreatment related to the death
- Interviewing, as warranted, any persons having information regarding the individual's care

- The Clinical Reviewer(s) documents all relevant information onto the electronic Mortality Review Form, and the Chief Clinical Officer/Clinical Manager completes a preliminary review of all case summaries prior to an MRC meeting. During the preliminary review, a case is identified as Tier 1 or Tier 2 (*see definitions*).
  - A Tier 1 case requires a detailed, comprehensive review of multiple factors and areas of focus by the MRC.
  - A Tier 2 case does not require a detailed, comprehensive review as the preliminary review was sufficient.

- 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.

<u>At each meeting the MRC members:</u>

- Perform comprehensive clinical mortality reviews utilizing a multidisciplinary approach that addresses relevant factors *(medical, genetic, social, environmental, risk, susceptibility, and others as specific to the individual)* and quality of service.
- Evaluate 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.
- Identify risk factors and gaps in service and recommend quality improvement strategies to promote safety, freedom from harm, and physical, mental and behavioral health and wellbeing.
- Review Office of Licensing Corrective Action Plans (CAPs) related to required recommendations, to ensure no further action is required and for inclusion in meeting minutes.
- Refer any required recommendations not included in the initial CAP to the Office of Licensing for further investigation, and/or other divisions represented by members, when appropriate.
- Assign recommendations and/or actions to MRC member(s) as appropriate.
- Review 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 care.

After the case review, the MRC seeks to identify:

- The cause of death
- If the death was expected
- Whether the death was potentially preventable
- 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 which may reduce these risks, to include provider training and communication regarding risks, alerts, and opportunities for education *(see Definitions under "Leadership and Responsibilities" section).*
- If any actions are identified based on the case review, the MRC will then make and document relevant recommendations and/or interventions
- Documentation of all the above is then made in the meeting minutes and on the electronic Mortality Review Form

The MRC will make recommendations *(including but not limited to, quality improvement initiatives)* 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 have been 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 designated committee member provides an update or specific information as requested. If all determinations are made, the pended case is closed by the committee.

- Monthly, for quality assurance purposes and to attempt to identify deaths that were not reported through DBHDS' incident reporting system, the Mortality Review Office (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.
- The MRO forwards the information to the DBHDS Office of Licensing, who 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 usual standard operating procedure (*see page 4*).

- The MRC documents recommendations for systemic quality improvement initiatives coming from patterns of individual reviews on an ongoing basis, and analyzes patterns that emerge from any aggregate examination of mortality data.

  - From this analysis, the MRC makes one recommendation per quarter *(four recommendations/year)* for systemic quality improvement initiatives, and reports these recommendations to the QIC (*quarterly*) and the DBHDS Commissioner *(annually*).
  - On a quarterly basis, the MRC also prepares and delivers to the QIC a report specific to the committee's findings.
  - Within ninety days of a death, the MRC will prepare and deliver to the Commissioner of DBHDS, a report specific to the committee's deliberations, findings, and recommendations. If the MRC elected not to make any recommendations, documentation will affirmatively state that no recommendations were warranted.
  - The MRC prepares an annual report of aggregate mortality trends and patterns for all individuals reviewed by the MRC, within six months of the end of the year. A summary of the findings is released publicly.

<u>Membership responsibilities:</u>

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. Members shall notify the MRC Co-Chair and/or MRO Program Coordinator prior to having a guest attend a meeting so that arrangements may be made for the guest to sign the confidentiality agreement form before (s)he is permitted to attend. Member confidentiality

	forms are valid for the entire term of MRC membership, and guest confidentiality forms are valid for repeat attendance at MRC meetings. • All MRC members must receive training 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 New members will receive training within 30 business days of joining the committee. • **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. The designee 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 (2) years, and may be reappointed for up to two additional terms.

	♦ Are expected to attend 75% of meetings per year, and may send a designee that 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 75% attendance requirement.
Recusal	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. Conflict of interest 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 conflict of interest arise during the review process, the MRC member will: • Immediately disclose the potential conflict of interest and cease participation in the case review related to the existing or potential conflict of interest. • Disclose the conflict of interest privately to the Chair/Co-Chair, or publicly to the members in attendance. The MRC will then halt discussion of the conflict of interest case, move on to the next case and place the conflict of interest case at the end. This allows the MRC member with a conflict of interest to remain for the review of other cases, and then leave the proceedings prior to the discussion of the conflict of interest case.
Definitions	• <u>Tier 1</u> case criteria: ♦ Cause of death cannot clearly be determined or established, or is unknown; ♦ Any unexpected death *(such as suicide, homicide or accident*); ♦ Abuse or neglect is specifically documented;

- Documentation of investigation by or involvement of law enforcement *(including forensic*) or similar agency; and
- Specific or well defined risks to safety and well-being are documented.

- Tier 2 case criteria:
  - Cause of death can clearly be determined or established;
  - An expected death, if no abuse or neglect, involvement of law enforcement or well defined safety and well-being risks are documented;
  - An unexpected (*unexplained*) 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, as long as no abuse or neglect, involvement of law enforcement or well defined safety and well-being risks are documented;
  - No documentation of abuse or neglect;
  - No documentation of investigation by or involvement of law enforcement (*including forensic*) or similar agency; and
  - No documentation of specific or well defined risks to safety and well-being noted.
- Expected Death denotes a death that was consistent with, and as a result of, an individual's previously diagnosed terminal condition. A death can be expected if the person had a known terminal condition *(e.g., end stage renal disease)* or if the person was elderly and had a period of deterioration and increasing medical frailty. In both cases, the person, family, and caregivers were aware that the condition was terminal, end of the life decisions were in place, and primary health care and palliative care teams, if applicable, were involved. The individual, legally authorized representative, power of attorney or legal guardian *(if the individual lacked capacity to make advance directive decisions)*, and family, were all aware that the illness or condition would result in death and had an opportunity to discuss, if not decide, end of life matters and clinical measures to be taken or not taken.

- Unexpected Death denotes a death that occurred as a result of an acute medical event that was not expected in advance nor based on a person's known medical conditions. Examples might include suicide, homicide, accident, acute medical event, a new medical condition, or sudden and unexpected consequences of a known medical condition. An unexplained death also 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 (Cause of Death) 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 Deaths are deaths that are considered to be premature and may have been avoided, based on a combination of known medical, genetic, social, environmental, or other factors *(such as pre-morbid conditions)*. When the MRC determines a death is potentially preventable, the committee categorizes factors that might have prevented the death. For a death to be determined potentially preventable, 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:
    1. Coordination of care
    2. Access to care, including delay in seeking treatment
    3. Execution of established protocols
    4. Assessment of the individual's needs or changes in status

- The following standard definitions as referenced in Part I of the Quality Improvement Plan (*Program Description)* are established for all quality committees:

    - Committee - Subject areas with expertise and accountability
    - Sub-committee - QIC is the overseeing quality committee and all other quality committees report into the QIC as sub-committees.
    - Steering Committee - An advisory committee that provides direction, decides on priorities or order of business, and manages the general course of operations and reports to the QIC.
    - Workgroup – Appointed by a quality committee or agency senior leader for a specific purpose or to achieve an outcome for a focused scope of work. Reports progress to and makes recommendations for a specific quality committee who is responsible for oversight
    - Council – Members are nominated by other council members and DBHDS
    - Committee Chair - Responsible for ensuring the committee performs its functions, the quality plan activities and core monitoring metrics

	♦ Key Performance Area (KPA) – DBHDS' three defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity. ♦ Performance Measure Indicators (PMIs) – Include both outcome and output measures established by DBHDS and reviewed by the DBHDS QIC. Outcome measures focus on what individuals receive as a result of the services and supports they receive. Output measures focus on what the system provides or the products it uses. The PMIs allow for tracking the efficacy of preventative, corrective, and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies, recommends and prioritizes quality improvement initiatives to address identified issues for QIC review and approval. ♦ Quality Management (QM) Plan - Ongoing organizational strategic quality management and improvement plan and serves as a monitoring and evaluation tool for the agency and stakeholders as well focuses on improving efficiency, effectiveness and output. ♦ Quality Improvement Initiative (QII)- Focuses on a specific area within a QM plan with identified actions.