DBHDS

Virginia Department of Behavioral Health and Developmental Services

DBHDS Mortality Review Office Process Document

January 2025

A Life of Possibilities for All Virginians

Mortality Review Office/Mortality Review Committee
Process and Procedure Document

I. Introduction

A. Documents: MRC Charter, electronic Mortality Review Form *([eMRF] in Appendix A–eMRF Death Data Load Process and Appendix B-eMRF Data Source Process)*

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, MRC Clinical Manager

II. Notification of Deaths

A. Documents: Excel spreadsheet titled-Master Document Posting Schedule (MDPS) and Office Licensing Process Document *(see Appendix C-Investigations: Appendix C: DD Death)*

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.

III. Validation and Tracking of Deaths

A. Documents: DW-0080a, MDPS, eMRF *(Appendices A & B)*, and OL document (*Appendix C)*

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
- 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
- Deaths are loaded to the eMRF via an automated process overseen by the Data Warehouse team
- 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.
- 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 the 90-day requirement indicator, 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 monthly and quarterly *(more frequently as warranted)* and reviewed *(N = #of deaths for which documents were provided within 45 days, D = Total # of deaths reported).*

- For continuous monitoring, formulas in the MDPS 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, Case Composition, Tier Categories and Case Status

A. Documents: MDPS, eMRF, and CNR Case Composition Guidance Document *(Appendix D)*

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 (See Appendix D).
  - The Deputy Commissioner for Clinical and Quality Management (MD) or Mortality Review 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 in 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: 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: 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 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: 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: 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: 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: MMM, MNS, ATL, eMRF, MRC & Commissioner's 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: 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: 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: 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: 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: 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: 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: 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:

- Two data formats are 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
- Comprehensive clinical case summaries (CCS) 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

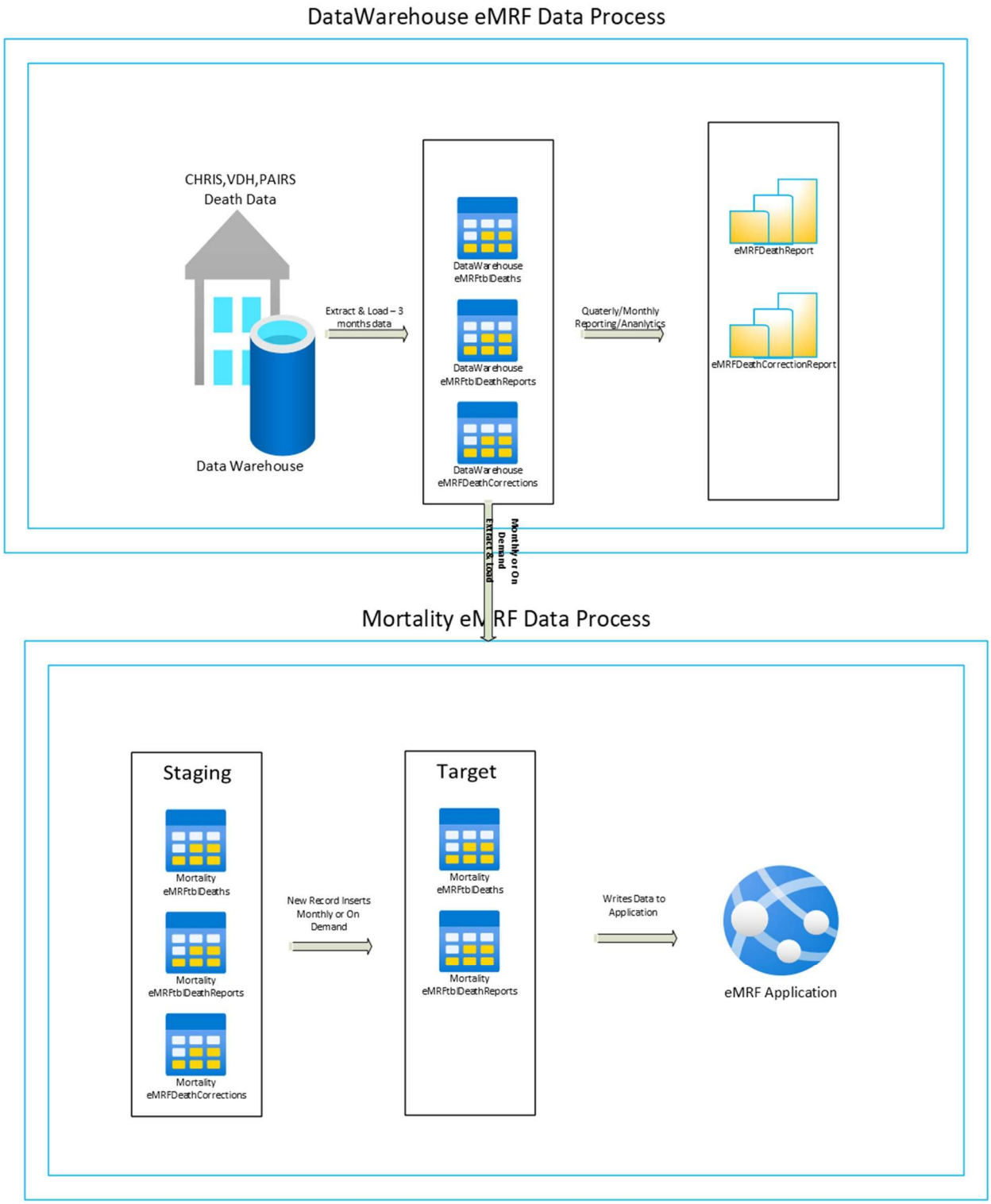
Appendix A – eMRF Death Data Load Process

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 the next two pages (Pages 21 and 22) is the technical representation of how data flows in the process described above.

Appendix A – eMRF Death Data Load Process (continued)



Appendix A – eMRF Death Data Load Process (continued)

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

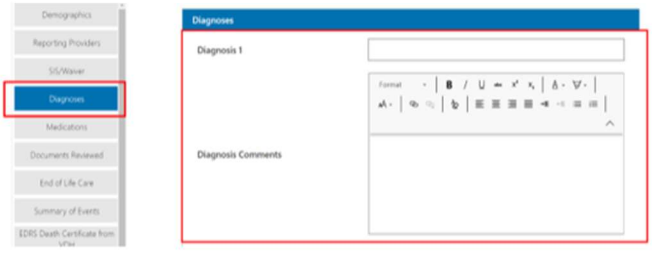
Appendix A – eMRF Death Data Load Process (continued)

	• 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		

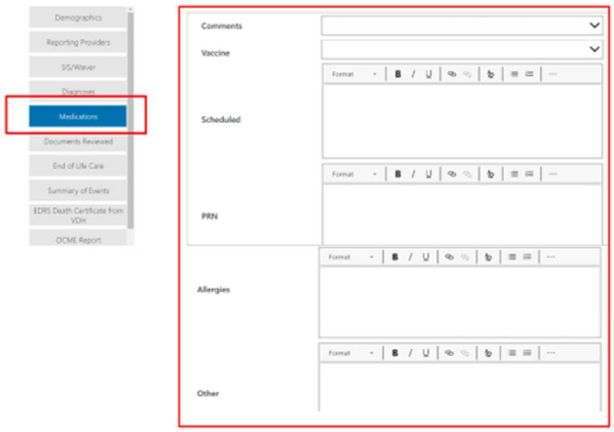
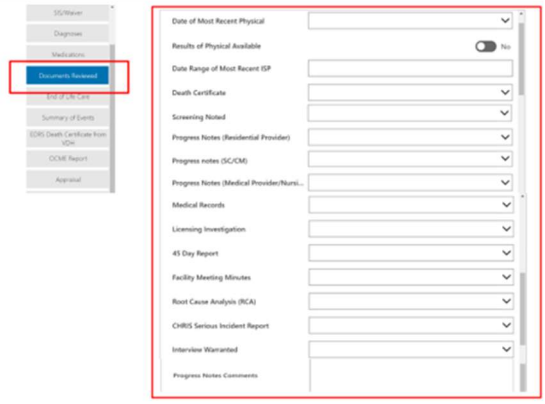
2	**Trigger**: CHRIS Corrections Needed spreadsheet posted in MS Teams
	
	Actions:
	• IMU will contact provider(s) to make necessary corrections
	  ○ Within 7 business days, IMU will review the document and ensure corrections were made, or document in Comments column the reason why discrepancies cannot 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

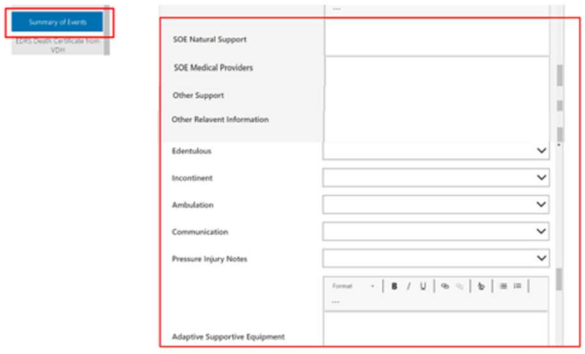
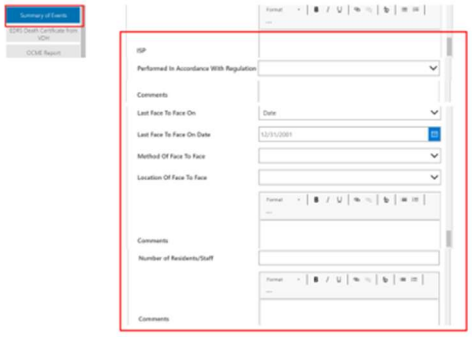
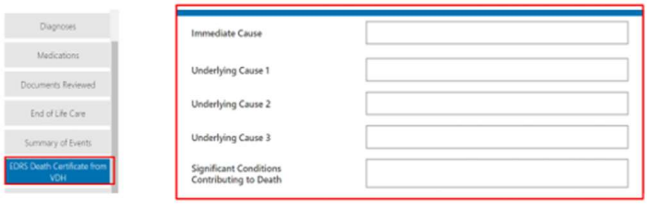
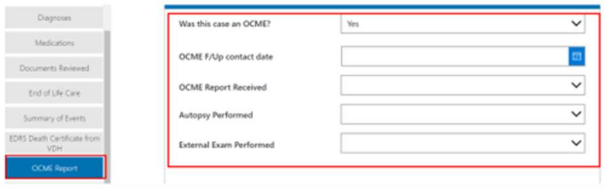
Appendix B – eMRF Data Source Process

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.

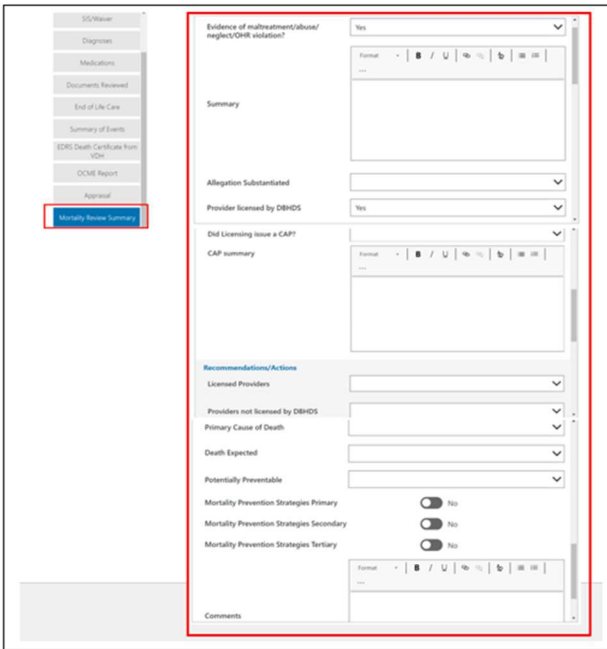
Appendix B – eMRF Data Source Process (continued)

	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.

Appendix B – eMRF Data Source Process (continued)

	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.

Appendix B – eMRF Data Source Process (continued)

	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).

DD DEATH INVESTIGATIONS

Per Mortality Review Committee (MRC) Definitions Updated July 2021:

Unexpected 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.

Expected Death: 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.

Potentially Preventable Death: 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, and educational). Deaths determined to be PP have identifiable actions or care measures that should have occurred or been utilized. 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. 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:

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

Tier 1 Case Criteria:

A case is categorized as Tier 1 when any of the following criteria 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 (including forensic) or similar agency
- Specific or well defined risks to safety and well-being are documented

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Tier 2 Case Criteria:
A case is categorized as Tier 2 when all the first 4 criteria exists:

- Cause of death can clearly be determined or established
- No documentation of abuse or neglect
- No documentation of investigation by or involvement of law enforcement or similar agency (including forensic)
- 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.

Procedures for DD Death Investigations:

1. Every reported DD death will be investigated by an Investigator.
2. **Unreported death:**
    - DBHDS provides the identifying information of individuals in the Waiver Management System (WaMS) who receive DBHDS licensed services to the Virginia Department of Health on a monthly basis, which 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 will investigate allunreported 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. Currently the SIU internal DD spreadsheet will track if death investigations are initiated via this process.
    - A provider is not required to report a death in CHRIS if the individual was discharged prior to death. If it is discovered that an individual was discharged greater than 30days from the date of death from a DBHDS licensed provider, then SIU is not required to complete an investigation. However, MRC documents are required from that provider if that individual received services within the last 90days. SIU will make contact with the provider to ensure that the provider submits all applicable MRC docs for MRC review. If MRC determines in their review of the case that the provider had potential OL concerns, SIU manager will then communicate to SIU investigator that an investigation is required.
3. **Reported deaths:**
    1. The investigator will conduct an initial review of death incident via the SIU shared queue within 24 hours of receipt of the incident being triaged and initiate a formal investigation within 3 business days upon receipt from IMU of the death. This will occur by opening an investigation in Connect;

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include actions taken as appropriate; are 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.

2. 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 Investigator will collaborate with Human Rights if there are any suspected abuse/neglect allegations surrounding the death investigation
3. Incident Management System (IMU) triages all DD Death Serious Incident (DSI) reports within 1 business day via the Connect system.
    - **DD Deaths (Not Day Support):** IMU staff will follow applicable steps in CONNECT to update the status of the DSI to "Referred to Investigations". When IMU updates the DSI to this status, the Connect system automatically creates the Investigation Folder. IMU should ensure that the assigned investigator is updated to "blank" to ensure that the DD DSI populates in the SIU Shared Work Queue.
    - **DD Deaths (Reported by Day Support Providers):** IMU follows applicable steps in CONNECT to leave the status of the DSI as "Pending" and ensure the assigned investigator is updated to "blank" to ensure that the DD DSI populates in the SIU Shared Work Queue. Investigators then review the CHRIS report for day support provider and follow applicable steps to either initiate investigation if death occurred during provision of day support services or to close out the DSI/Case if death did not occur during provision of day support services. SIU will ensure that an IMU action is entered if an investigation at day support is not required, before updating the DSI to no action.
4. DD Death investigations triaged in the Connect system will display in the SIU Shared Work Queue. SIU investigators will review the SIU Shared Work Queue daily and consult with their peer in their assigned region to make determinations as to who will be assigned to initiate the investigation.
5. Investigations must be initiated within Connect within **3 business days** of notification.
    - DD Death investigations must be **initiated within 3 business days** of notification. Initiating an investigation refers to opening the case/investigation in Connect. At a minimum the Investigator shall include an investigation action of initiating the investigation and may include other items such as making an entry detailing the course of action for the investigation, scheduling the onsite visit if applicable, requesting documents, and/or completion of onsite investigation. When initiating the investigation the Investigator shall update the Investigation Begin Date to the Date of Death.
    - The investigator should review the service authorizations in WaMS to ensure all licensed providers supporting this individual have reported the death as appropriate.
    - **Helpful Tip**: Investigators should use the Wavier Management System (WAMs) as a resource to review documents in preparation for conducting DD death investigations. Documents such as Part 1-5 of the Individual Support Plans can be accessed and reviewed prior to conducting onsite inspections.
    - **Helpful Tip**: The investigator should pull previous Level II and Level III SIRs via CHRIS or Connect (Query/Case by type and status) to determine previous incidents to look for trends and to ensure previously identified risks were appropriately addressed.

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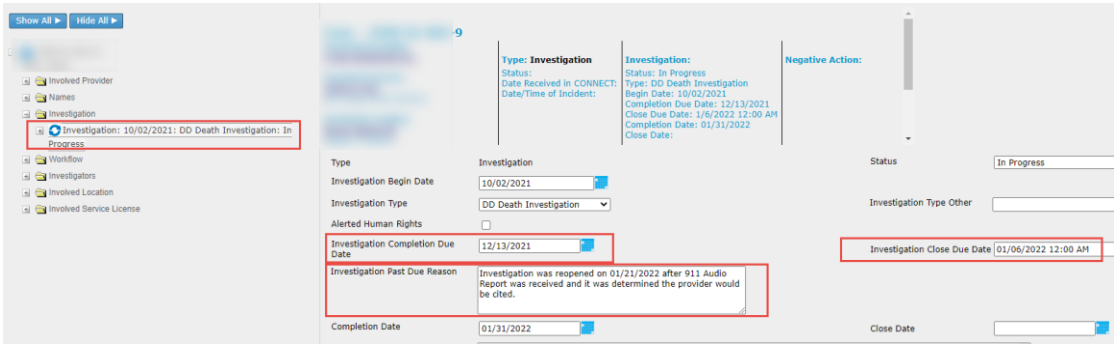
6. Investigations are required to be **completed within 45 business days** of the date of the death. Completed means the findings report is complete and any licensing report has been issued to the provider, if applicable.
    - If there are extenuating circumstances as to why the investigation could not be completed, it must discussed with the SIU manager and documented in Connect via the Investigation Screen in the text box "Investigation Past Due Reason". See screenshot below.
    - If a CAP is issued that is designated as "**Health & Safety CAP"** then the investigation must remain open until the Investigator completes their required 30 business day follow-up to confirm that the provider is implementing their CAP as agreed upon. This follow up should be documented as a second Investigation Inspection in CONNECT with a purpose of re-inspection. (See Investigation Inspection Process Guide Step 110)
    - Investigators should reference the Health & Safety CAP internal memo for more details regarding the Health & Safety CAP process. The Health and Safety CAP internal memo can be found in Licensing All TEAMs.
7. Investigator should issue Licensing Reports by the 45th business completion date but no later than **within 3 business days** of completion of the death investigation. Any CAPs issued should focus on the death investigation. A general review ofregulations will occur at renewal inspections and annual inspections.
8. Investigations are required to be **closed within 60 business days** of the notification of the death. Closed means that any licensing report issued is returned, accepted and findings report is finalized and entered in CONNECT.
    - If there are extenuating circumstances as to why an investigation must remain open past 60 business days, the investigator will note this in Connect via the Investigation Screen in the text box "Investigation Past Due Reason". See screenshot below.
    - For example, if a corrective action plan cannot be fully accepted at 1st review, the investigator will note in the text box information regarding the CAP process being the reason why investigation could not be closed by 60th business due date.
    - Past due reason should also be entered as an investigation action, as investigation actions will populate in the findings report.



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9. **Imminent/Substantial Threat: Expansion of Records Reviewed to Ensure Safety:** If during an investigation the investigator discovers possible health and safety violations that could affect the remaining individuals receiving service at the location, the investigator will review a larger sample of individual and/or employee records and incorporate those findings into the investigation ~~and~~ along with any applicable licensing report issued.
    - ***Individual Example:*** *If reviewing the Individual's MAR there are several medication errors noted, the investigator will pull at least two or more other Individual records to review those MARs to determine if there is a systemic issue regarding MARs. Citations for all records reviewed will be incorporated into the findings report and licensing report as applicable. The findings report and inspection summary should note that because of potential health and safety concerns, the investigator reviewed a larger sample of individual records to ensure the health and safety of the remaining individuals receiving service at that location.*
    - ***Employee Example****: If it is discovered that both staff did not have updated CPR records when reviewing the employee records of staff involved inadministering CPR during death incident, then the investigator should review a larger sample of employees scheduled to work at that location to determine if there is a systemic issue regarding current CPR training records. The findings report and inspection summary description should note that because of potential health and safety concerns, the investigator reviewed a larger sample of employee records to ensure the health and safety of the remaining individuals receiving service at that location.*
    - The investigator should make a determination as to whether a CAP should be labeled as "Health and Safety CAP" based on the results of the investigation, in consultation with their manager and in accordance with the Health and Safety CAP internal memo.

10. DD Death Investigations: Day Support: Effective 9/1/2020

1. SIU will review all notifications of a developmental disability death reported by a day support service via SIU Shared Work Queue in Connect.
2. The investigator will review the information reported by the day support provider via CHRIS in Connect. If the death did not occur during the provision of day support services, then the investigator will NOT be required to initiate an investigation for the day support service.
3. The day support provider will still be required to submit all MRC docs as outlined in the MRC Memo dated July 2019 to the MRC email address at mrc_documents@dbhds.virginia.gov. The provider shall submit all documents per the Mortality Review Submission Checklist.
4. The investigator will add in Connect an IMU Action of "No Investigation Conducted" and include in the text box that due to death not occurring during the provision of day support services, no investigation is required at this time. Investigator will then update the DSI status to "No Action", hit save, so the DSI and case will be closed.
    - For example, "After review of CHRIS information #20220451, the death did not occur during the provision of day support service. No further investigation will be conducted at this time, however if during completion of the case management or residential investigation, there are any noted concerns regarding day support services in relation to the death, an investigation will be initiated for the death for day support service".

- If MRC reviewer notes any concerns upon their review of the death regarding day support services, the MRC reviewer will notify the SIU manager who will then inform the assigned investigator that an investigation into the day support services is now required. If the investigator notices any concerns upon review of the other licensed services, the investigator shall open an investigation into the day support.
- SIU investigator will immediately update the day support case in Connect to refer to investigations and initiate the investigation in Connect, following investigation protocols.

Mortality Review Committee Documents:

All DD death documents must be collected and submitted to MRC email directly by the licensed providers as outlined in the MRC Document Submission Memo found on the DBHDS OL website. Investigators should ensure that the provider is reminded about this requirement when conducting the death investigation if the provider failed to submit required documentation.

- **The Licensing Investigations Team provides available records and information it obtains and the completed investigation report to the MRC within 45 business days of the date the death. Per DOJ indicator, this shall occur for at least 86% of deaths required to be reviewed by the MRC.**
- Providers are required to submit MRC documents within 10 business days of discovery of death to the MRC email address.
- Investigators will ensure that investigations are completed within 45 business days of the datethe death occurred and the SIU manager completes the Master Document Posting Schedule (MDPS) to indicate date completed investigation was placed in MRC folder. MRC will report onmeeting this indicator.
- **OL/SIU Representation on MRC:** The SIU manager is a standing member of the Mortality Review Committee.
- **SIU Manager (or Designee) Duties Regarding MRC Documents Includes:**
    - The SIU manager checks the MRC email address daily;
    - Ensures that MRC documents submitted by providers are moved into the appropriate drives for the MRC;
    - Ensures that Investigators are notified via e-mail when providers submit MRC documents;
    - Completes applicable steps in Connect to document that MRC documents have been submitted by the provider.
    - Updates the MRC spreadsheet-Master Posting Document Spreadsheet (MPDS) when documents are placed in the MRC file and if Licensing Reports (CAPS) are issued to provider.
- If needed, Investigator can request copies of any documents required to complete their investigation, regardless of the provider's requirement to submit documents directly to MRC email as outlined in the MRC Document Submission Memo.
- If an Investigator collects documents that are not part of the MRC documents that are submitted by providers and are pertinent to the conclusions of the death investigation, the Investigator must ensure those documents are scanned into the OL shared drive under folder labeled **"For Mortality Review-Specialists**." See screenshots on next page:

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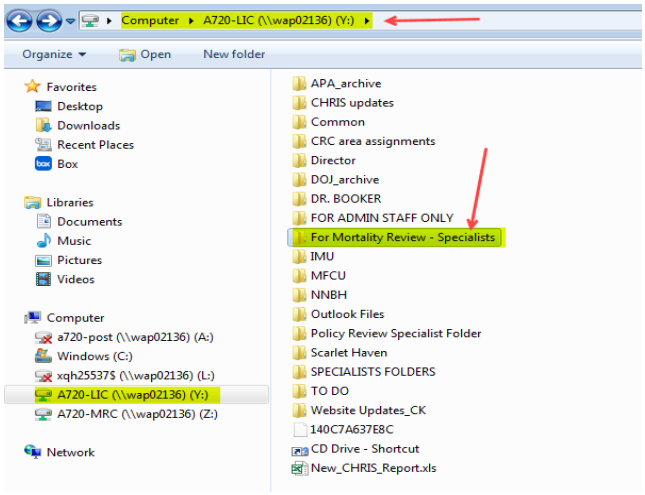
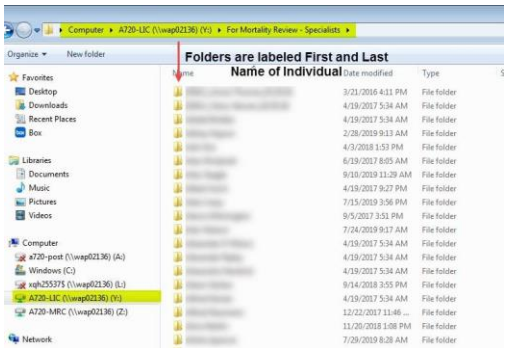


- The investigator should then notify the SIU Manager or designee that additional documents are placed in the respective individual folder. SIU manager will then move those additional documents into the MRC folder. This can occur as documentation is received or when the investigation is completed ensuring the documentation is moved by the 45th business day so the MRC has access to the files. Examples of types of additional documents can include the following:
    - Copies of letters sent to request 911 records
    - 911 reports
    - 911 audio files
    - Providers policies and procedures
    - Other records as requested including missing required documents
- Once an Investigator closes out an investigation and the CAP associated with a DD investigation, they should submit a PDF copy of the FINAL Investigation Findings Report and a PDF copy of the FINAL Accepted CAP to the applicable MRC findings folder for the identified individual and notify SIU manager or designee. All OL findings reports and CAPS if applicable must be electronically saved to OL shared drive under folder labeled “For Mortality Review-Specialist” subfolder of individual nameand then subfolder “Findings”.
- The SIU manager (or designee) is responsible for ensuring that the final closed findings report and CAP (if applicable) are submitted to the MRC folder for review by the MRC.



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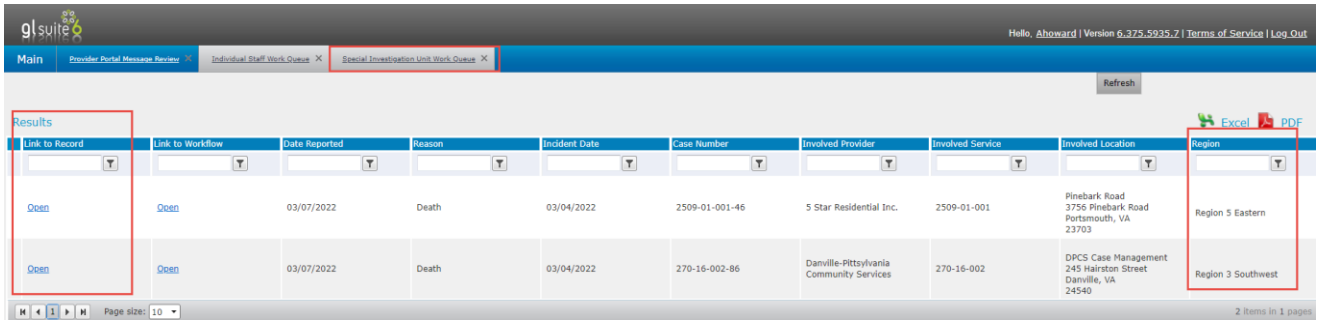
IMPORTANT DD DEATH PROCEDURES FOR DOCUMENTATION IN CONNECT

1. The SIU Shared Work Queue must be reviewed daily to determine DD deaths reported per assigned region. Investigators will consult with their peers regarding who is up next to take the investigations.



2. Click on the link to open the record.

3. Use the following applicable process guides in Connect when completing investigations:
   a. Death and Serious Incident Reporting Process Guide
   b. Investigation Process Guide
   c. Investigation Inspection Process Guide
   d. Website-Provider Corrective Action Process Guide
   e. Conclude with Investigation Process Guide

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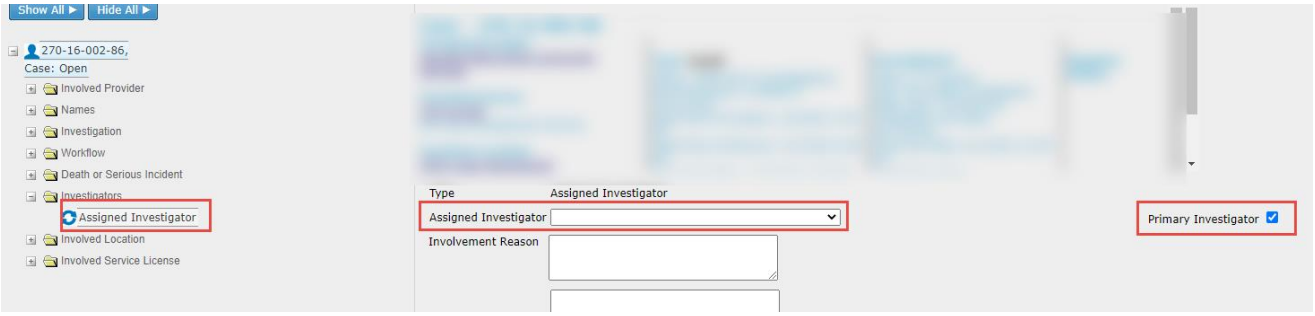
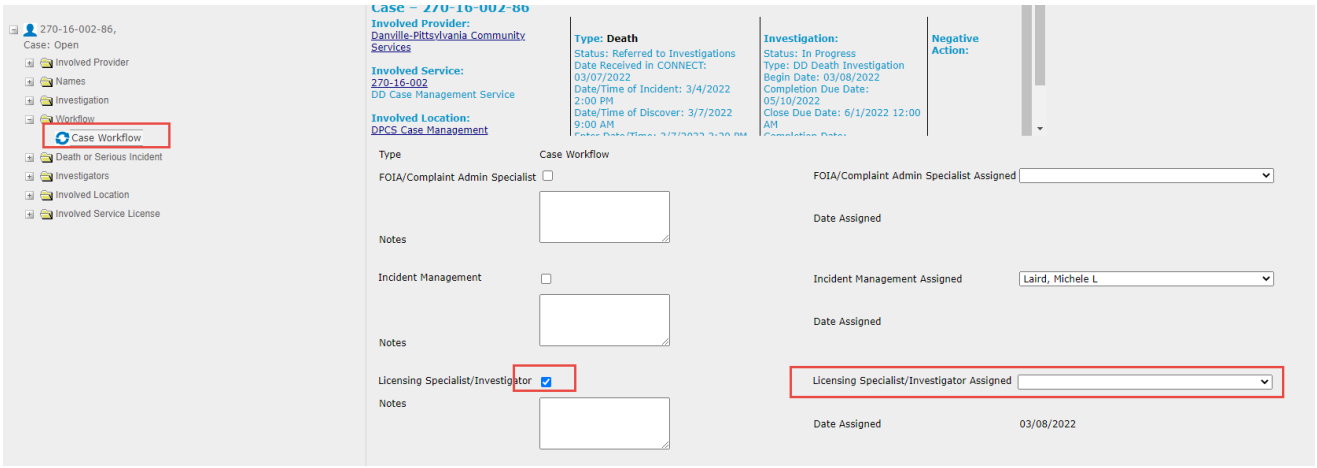
4. The following are key steps to follow when initiating a DD death investigation in Connect:

a. **Click on the Investigators Folder and ensure your name is selected and check box for primary investigator. This ensures that the case is taken out of the SIU shared queue.**



b. **Click on the Workflow folder in the tree and ensure the workflow box is checked for LS/Investigator and that you update this to your name. This ensures that the case will show in your individual work queue.**



c. **Click on the DSI in the tree of the case.**

d. **Run the DSI Death Report to review information regarding what the provider reported in CHRIS. Click on Death or Serious Incident Folder in the Tree, click on the DSI, go to New>Report>Death Report. See screenshots on next page.**

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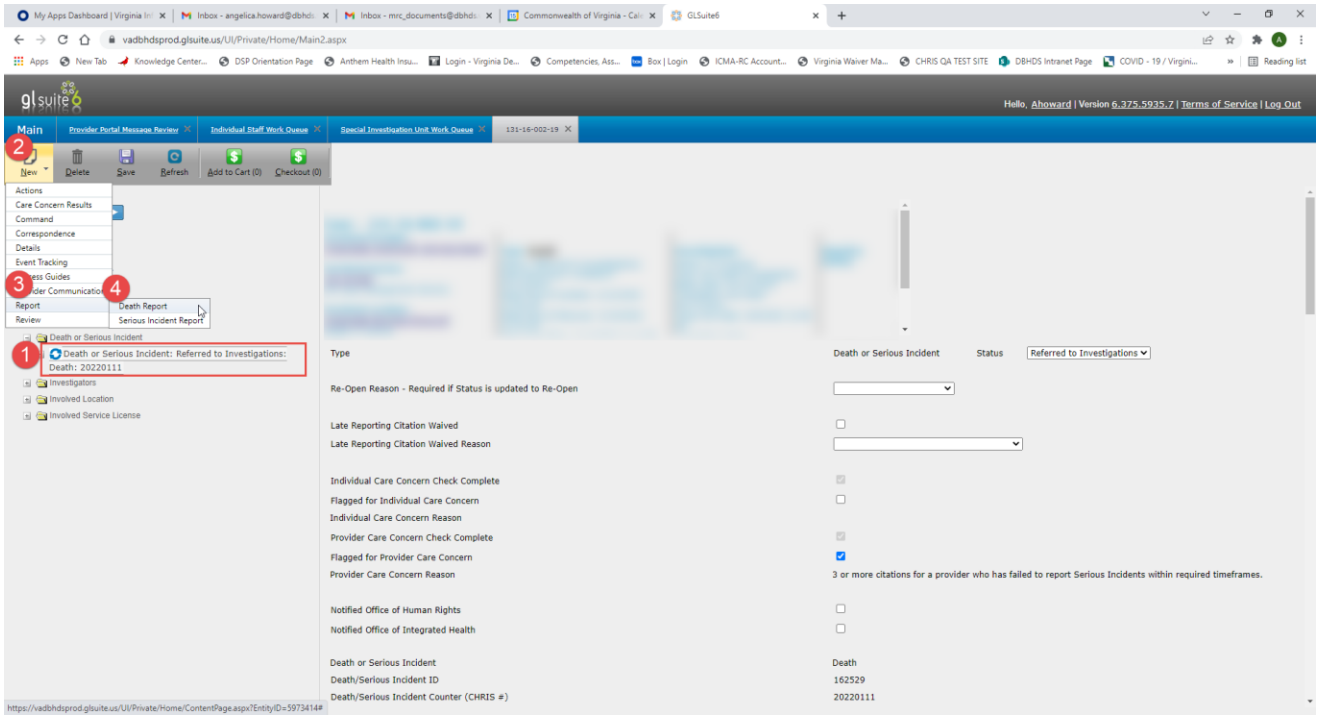

Summary of Death Report received from CHRIS for

Death ID: 162529
Date Received in CONNECT: 03/14/2022

CHRIS Number: 20220111
Enter Date/Time: 3/14/2022 3:14 PM

Involved Individual:
Consumer ID: 131202231415154
DOB:
Ethnicity/Race: White / Caucasian
Gender: Male

Involved Service: 131-16-002
Service Type: DD Case Management Service

Involved Location:

Specific Site of Death:
Clients Bedroom

Waiver Service Recipient: Yes
Medicaid Number: 161024550013
Waiver Type: Community Living waiver (CL)
Case Management Provider:
Board

Date/Time of Death: 3/12/2022 12:00 AM
Discovery Date/Time: 3/14/2022 12:54 PM

Originator/Witness:

Relationship with the consumer:

*For cases of DD death, providers are responsible for submitting the required documentation listed on the Mortality Review Record Sumbission Checklist, within 10 business days following a death. By checking here, I acknowledge responsibility for providing these documents per the Process instituted by DBHDS for all DD Deaths. I further acknowledge that any documentation containing the Protected Health Information of the deceased individual will be submitted in a secure fashion to ensure compliance with federal and state privacy laws.

☒ By checking here, I acknowledge responsibility for providing these documents.
☐ This was not a DD death and therefore the regulation does not apply.

Suspected Type of Death: Undetermined
Expected/Unexpected: Unexpected
Suspected Event: Unknown
Description if other:

Referred to Medical Examiner: No
Autopsy: No
Status if yes:
Case Involved:
If other, please specify:

Known Facts Regarding Death:

e. Run the case summary template report to copy and paste DSI info into Investigation Details section in the Investigation.

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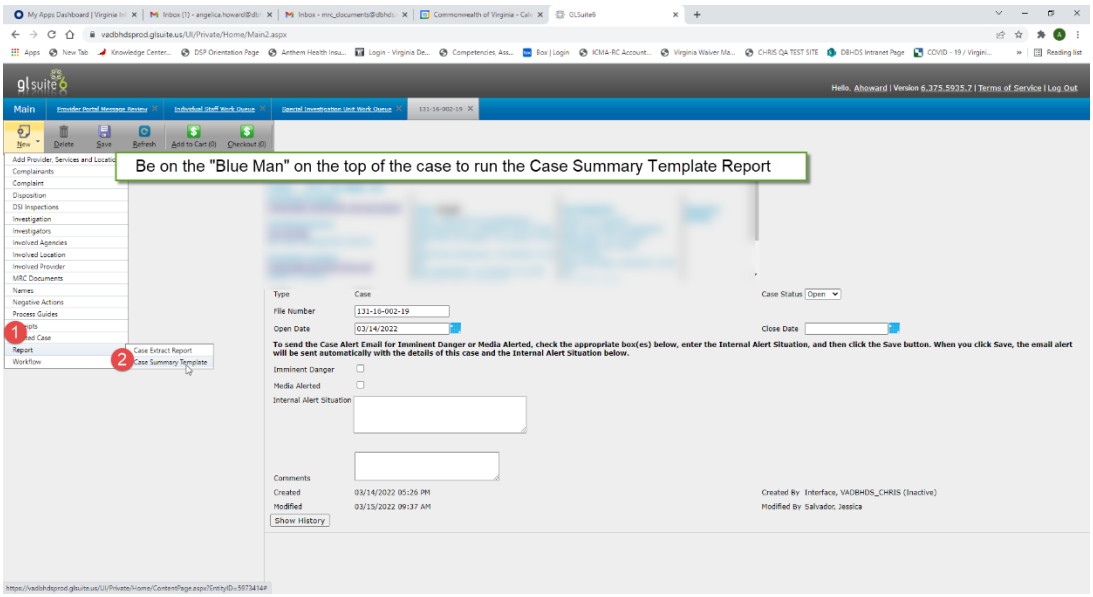

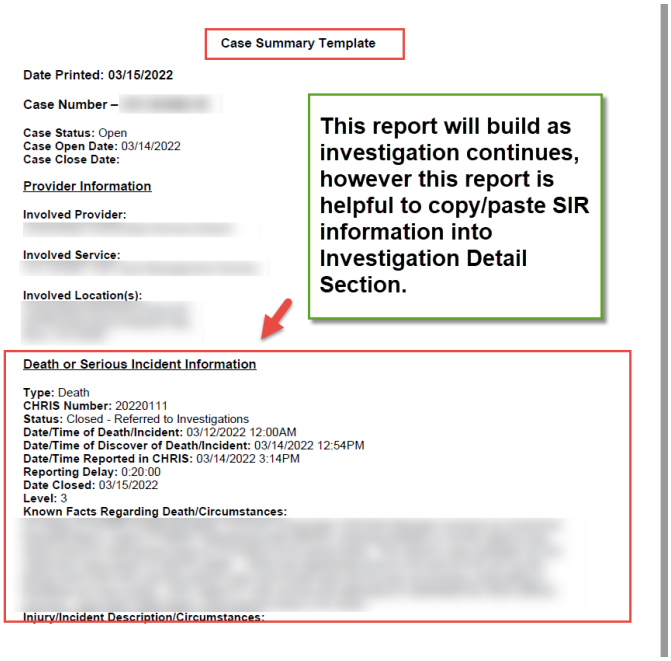

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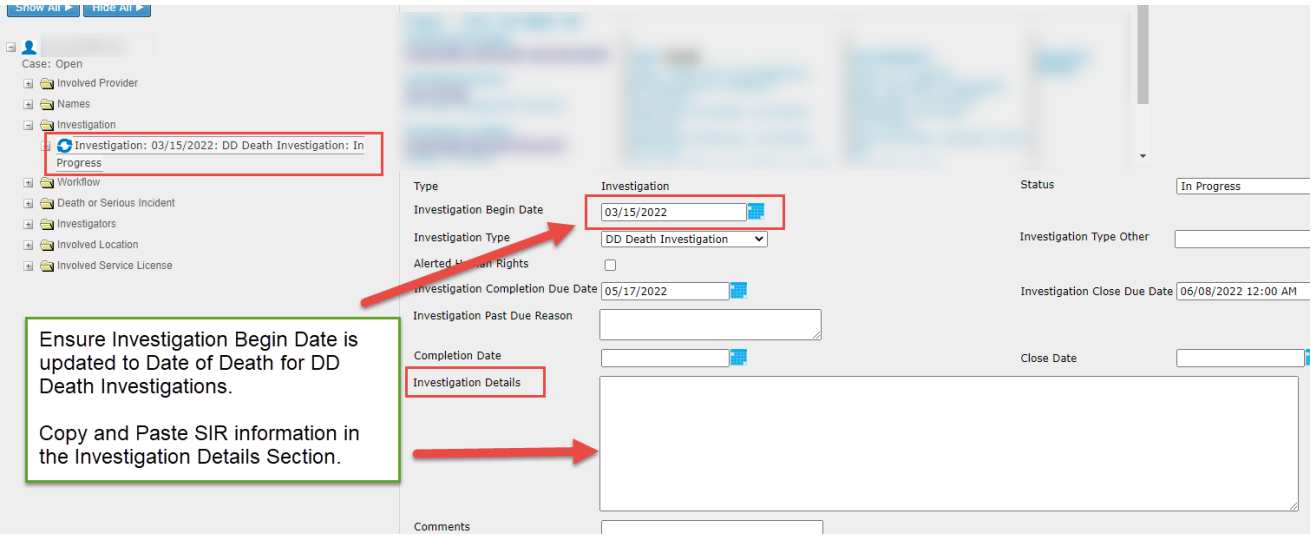
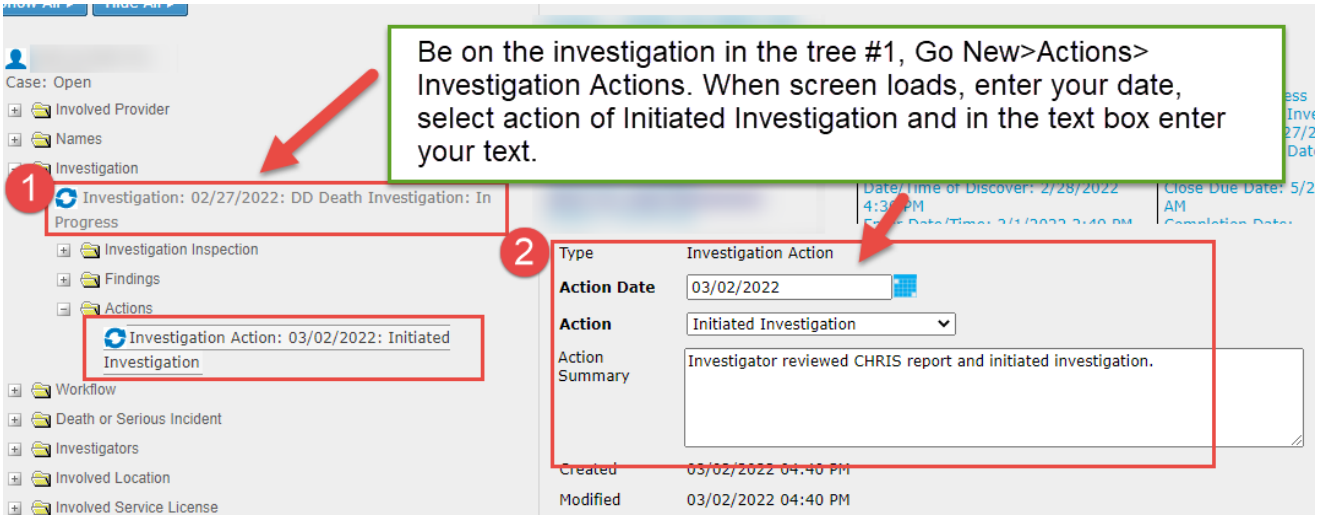
f. Ensure the investigation begin date is updated to date of death for all DD death investigations. This ensures that the completion due date is updated to match MRC MPDS due dates. Copy and paste SIR information from Case Summary Template Report into Investigation Details section.



g. Add 1st Investigation Action of Initiated Investigation into Connect.



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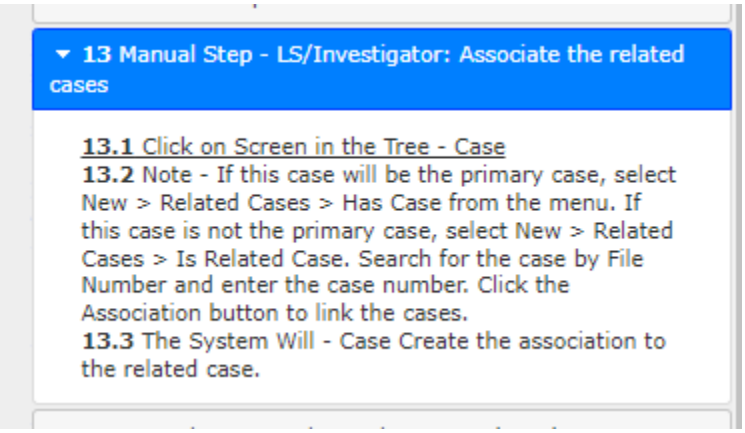
Relating Cases in Connect

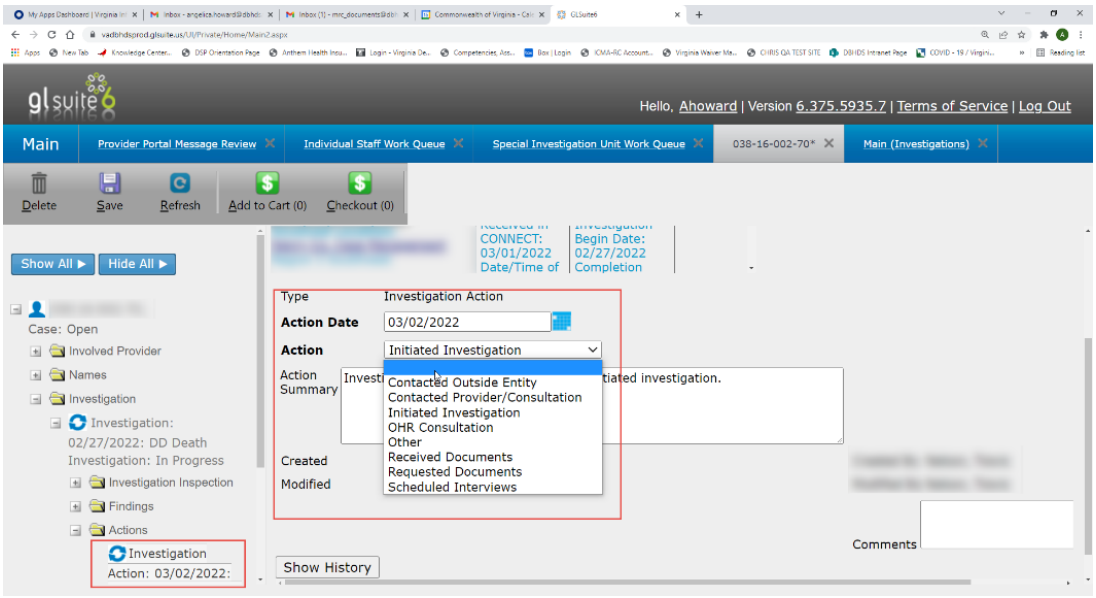
- In the **Investigation Process Guide** Step 13 speaks to relating cases in Connect. Relating cases in Connect, helps users to know if cases are related to one another. This is applicable to do for the following situations/scenarios for DD death investigations:
    - **CSB (Residential & DDCM):** If for example, a CSB reported a DD death via their group home service in CHRIS and the individual was also receiving DDCM service from the CSB, the primary case will be the DDGH case and you will have to create an investigation for the DDCM service in Connect. Remember you must know the DDCM location before creating the investigation in Connect for the DDCM service if the CSB has more than 1 location for DDCM service. When you relate the cases, the DDGH case will be the primary case, because that case has the DSI, and the DDCM case will be the secondary case. Note the investigation findings will still be entered under both investigations in Connect. This also applies when a provider provides multiple licensed services to the same individual such as group home and day support.
    - **Death and Complaint:** If you have an active DD death investigation, and you also receive a DD complaint while the DD death investigation is active, you could decide to relate the DD complaint to the DD death investigation, close out the DD complaint case, and add the complaint information to the DD death investigation. In this scenario, the DD death investigation would be the primary case, the DD complaint would be the secondary. For the DD complaint case, you would enter a comment indicating that there is a current open-active DD death investigation for this individual and the complaint information will be added to the death investigation, include the case number of the death investigation, then update the complaint to no action.



Distributed 12/9/20
SIU Trained 12/3/19
Formal OL Training 1/7/20 & 1/8/20
Revisions: 4/1/20; 9/1/20; 2/4/21; For Connect August 2022

Investigation Actions Vs Investigation Inspection

- **Investigation Actions:** These are all the actions taken as part of the investigation process **(Investigation Process Guide Step 24)**. It is essentially a timeline (high level) of the actions you took as part of your investigation. The investigation actions will populate in your findings report, so ensuring information is factual and accurate is important. The investigation actions should not simply include copying and pasting of email correspondence with the provider. Also ensuring that no HIPAA information is included and instead record review identifiers such as Employee #1, #2, Entity #1, Individual #1 is also important. Some examples of actions might include the following:
    - Documenting Initiating the Investigation
    - Scheduling of Interviews
    - Logging requesting additional documents
    - Logging conducting interviews.
    - Consulting outside entity or provider
    - OHR Consultation
    - Other-Any other actions to show the timeline of your major actions during course of the investigation.



Distributed 12/9/20
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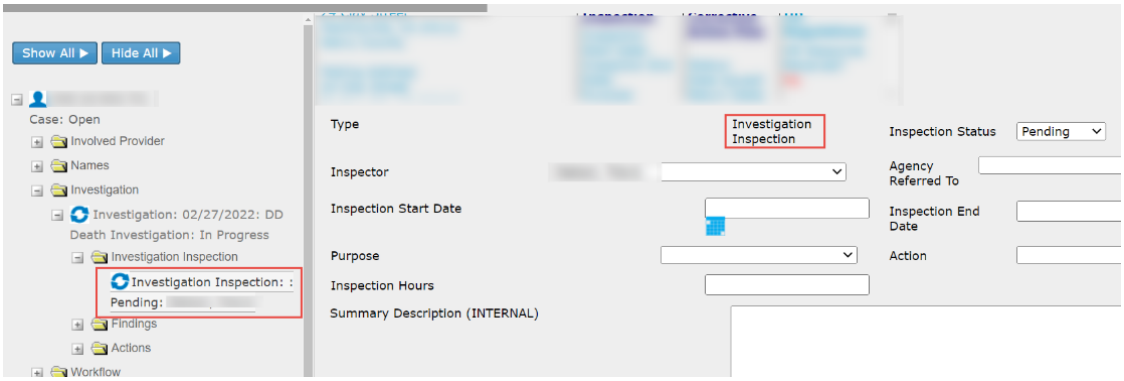
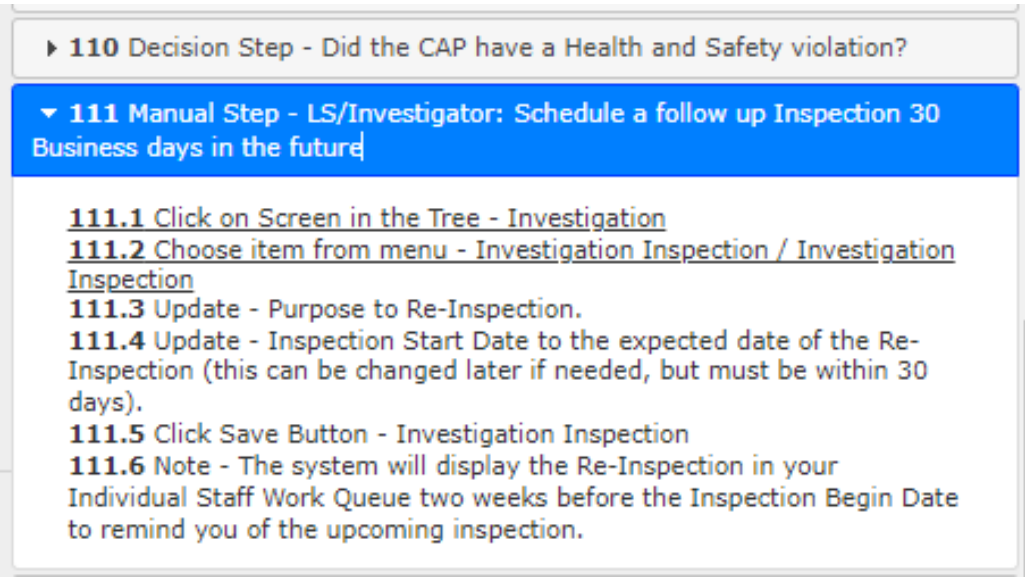
Formal OL Training 1/7/20 & 1/8/20
Revisions: 4/1/20; 9/1/20; 2/4/21; For Connect August 2022

- **Investigation Inspection:** The majority of Investigations will have only 1 Investigation Inspection. The Investigation Inspection is the date in which you are making your final review to determine if the provider is in violation of regulations. There are two scenarios in which there is an exception.
    1. **The first scenario in which an investigation would have more than 1 Investigation Inspection, is if your 1st Investigation Inspection resulted in the issuance of a Health & Safety CAP.** If your 1st Investigation Inspection resulted in the issuance of a Health & Safety CAP, then the Investigation Inspection PG has steps to follow to schedule your 2nd Investigation Inspection (Step 110).
    2. **A second scenario in which there may be more than one investigation inspection on a case may be when imminent risk is identified.** In this scenario an immediate investigation inspection is required to issue an immediate CAP, and then later a 2nd investigation inspection would be entered for review of the death itself.





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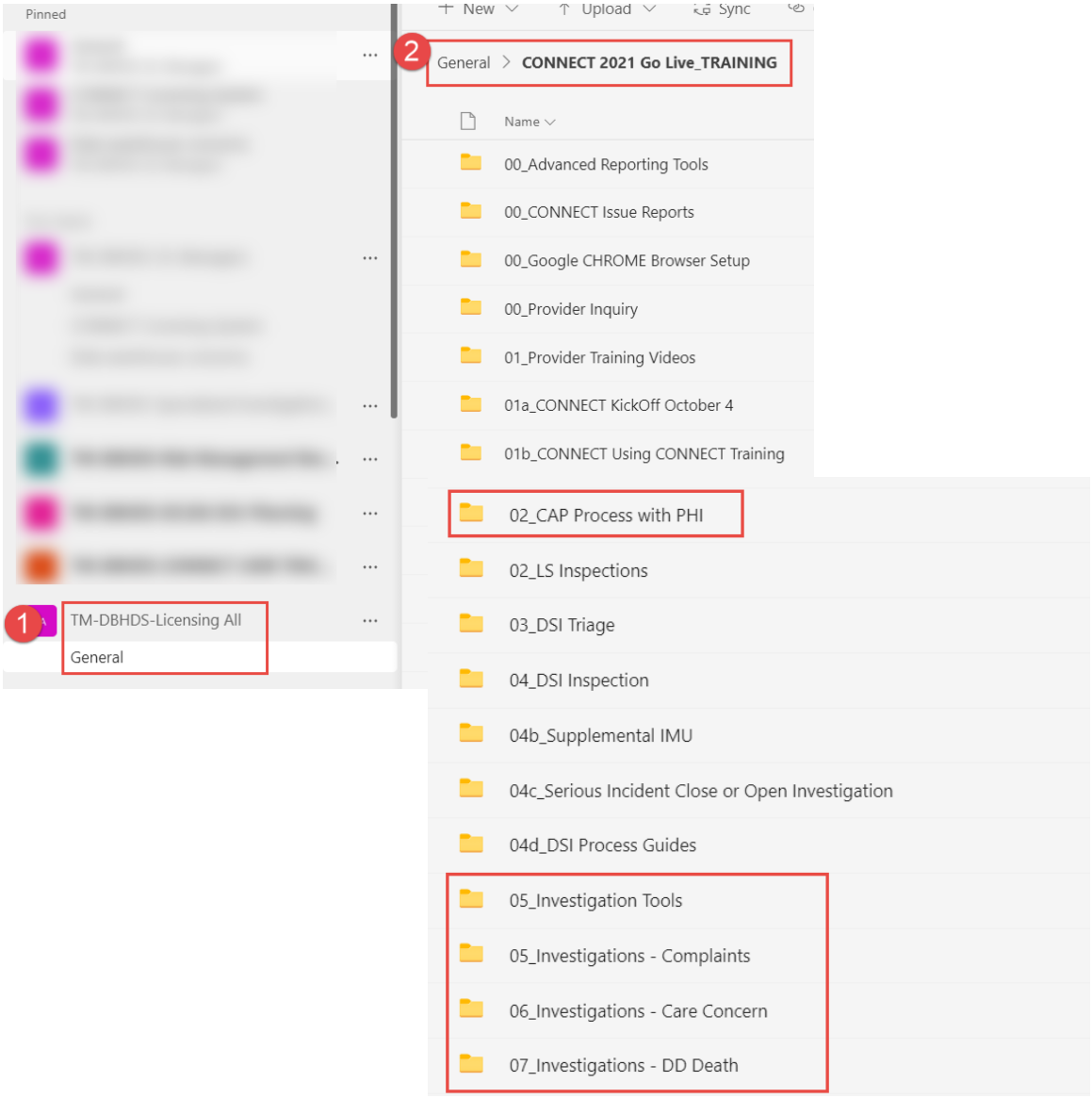
Revisions: 4/1/20; 9/1/20; 2/4/21; For Connect August 2022

RESOURCES: CONNECT GO LIVE TRAININGS/VIDEOS

- There are several Connect Go Live Trainings in the Licensing All Staff TEAMS for access to review regarding investigations.



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Appendix D – CNR Case Composition Guidance Document

This guide is not intended to replace formal orientation and mentoring with SMEs in the Mortality Review Office (MRO). However, due to the complex process of composing case reviews, this guide serves as a helpful starting point in producing a comprehensive mortality review. Information in this guide is intended to demonstrate the process for composing mortality case reviews rather than a detailed summary of the electronic mortality review form (eMRF). While the electronic application may change, the process of composing cases should not change.

This icon is found throughout the document. It alerts the reader to additional information that may be useful.

Glossary of Terms

Corrective Action Plan (CAP): The written document by SIU to a DBHDS licensed provider when they are found in violation of licensing regulations

Case Review Template (CRT): The Word document that a clinical reviewer uses to compose a case review. This document is used to transfer information to the eMRF when completed. (See Appendix IV)

Clinical Nurse Reviewer (CNR): The Mortality Review Team (MRT) staff member *(see Appendix I)* responsible for composing succinct mortality clinical case summaries and submitting them for review by the Clinical Manager or Chief Clinical Officer. The Lead CNR is responsible for coordinating all activities of the CNRs.

Death Certificate (DC): Legal document completed by a physician, nurse practitioner, or physician assistant, henceforth considered HCP (Health Care Provider), that indicates decedent information including date, time, location and reason of death. It is received from the Virginia Department of Health's (VDH) Electronic Death Registration System (EDRS).

Department of Justice (DOJ): The federal entity regulating the compliance indicators of the DBHDS Settlement Agreement. The goal is to successfully exit this Agreement.

Electronic Mortality Review Form (eMRF): The final form that is a digital application used for review during MRC meetings and for the storing of mortality case reviews. Data is queried from this application, pdf forms are generated for MRC members to review during MRC meetings, it is updated in real time during every MRC meeting, and is utilized by the DOJ to ensure compliance with the Settlement Agreement mandates.

Individual Service Plan (ISP): Person-centered document that outlines supports for an individual's health and safety. Updated annually for all Waiver services by Support Coordinators and others in the individual's care team. Utilized as an individualized plan of care for the IDD individual.

Intellectually and Developmentally Disabled (IDD): Individuals that the Agency serves in the Commonwealth with the goal of promoting their Health, Safety and Welfare (HSW).

Investigation Findings Report (IFR): A document compiled by the Office of Licensing's (OL) Specialized Investigative Unit (SIU) staff for every reported IDD death.

Master Documents Posted Spreadsheet (MDPS): An Excel database containing Office of Licensing (OL) document dates and status in addition to MRT information used for quality improvement initiatives in addition to quarterly & annual reports *(such as potential trends, patterns, statistics, data, and/or internal CNR information - see Step 9 on Page 16).*

Appendix D – CNR Case Composition Guidance Document (continued)

Important note when composing reviews - the purpose of the review is to present objective facts and information of care provided in a succinct and direct way. It is not to determine whether the decedent received adequate healthcare, or second-guess the actions taken of licensed healthcare professionals.

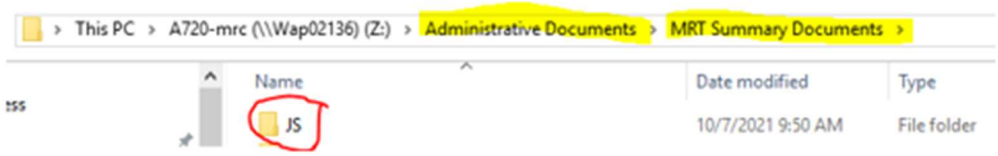
Step 1:

Locate Client records within the shared drive (*Z: in example below but may be another letter*). Files are stored according to the fiscal year and month an individual died. The example below is a case where the individual died on May 11th of state fiscal year 2021

Permission to access this shared drive (SD) must be granted by DBHDS Production Services (DBHDS PS). This process takes time and must be requested by the Clinical Manager. Items found on the MRC shared drive should never be printed or shared with others who do not have the same confidentiality clearance. NOTE: logging onto the VPN is required to view files on the shared drive.

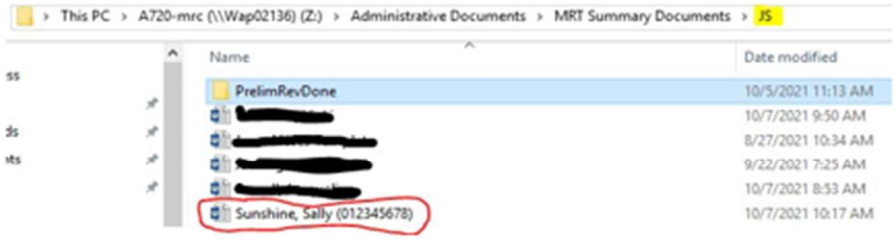
Step 2:

A folder on the SD has been created for you. Your folder should be identified with your initials. Below example is for employee Jane Smith or JS. The location of this folder is seen below:



Step 3:

A. You use this folder to save all your case reviews (*completed and in progress*). Open a new case review template (CRT) and save it in your work folder in the SD (*see Appendix III*). Case reviews are saved with the individual's "last name, first name" and includes the individual's DBHDSID. See example below:

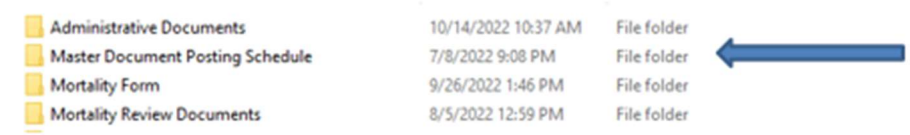


DBHDS ID is found on the eMRF. Permission to access the eMRF must be granted by DBHDS PS. If you lack access, save the file with the individual's name and omit the DBHDS ID. The DBHDS ID is a non-identifiable number for HIPPA purposes, and used

Appendix D – CNR Case Composition Guidance Document (continued)

when the record is sent to outside agencies (e.g., for the Department of Justice), to maintain confidentiality.

B. Open the MDPS spreadsheet in the shared drive and enter your initials in the appropriate column. This lets MRT staff know who is working on the case in the event they need to contact you.



Date of Death	Last Name	First Name	Reporting Provider(s)	Final Due Date 45 Business Days from Date of Report	Office of Licensing			Other	MRO	MRO
					Provider Documents Posted Prior to Final Due	OL Notes (i.e. Different dates of provider documentation posted)	DATE OF OL Investigation Posted	Facility Documents Posted Prior to Final Due	DATE OF Clinical Reviewer Completion	Clinical Reviewer Ack. Column R (Initials)

Step 4:

Open your newly saved CRT to begin entering information onto it. The next few sections of this guide are focused on how to compose a review efficiently and effectively. Once you are more comfortable composing case reviews, feel free to individualize your process.

Initially, using the format below ensures full, concise, and consistent reviews. This will help your overall efficiency and also promote concise use of language. Remember to maintain objectivity.

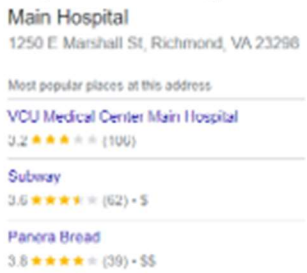
1. **Death Certificate (DC)**
   A. Start with the DC, as it contains important information that needs to be filled in on the CRT. Key areas that need to be completed are:
      i. Date of Death (DoD)
      ii. Time of Death
      iii. Location of Death
      iv. HCP completing DC
      v. Cause of Death
         a) Immediate
         b) Other contributing conditions

The DC is a standardized template consisting of several numbered boxes from 1-52. This guide will refer the reader to specific boxes to obtain the required information.

a). Date of death is found in box #3.
b). Time of death is found in box #34
c). Location of death is found in box #25-28b
   i. Death location can be the name of a hospital or other facility (#25-25a)
   ii. Or it may be a home address (#26-28b)
d). Person completing DC is found in box #48-51a
   i. #48 & 49 typically lists the same name of the HCP completing the DC
   ii. #48a identifies the role of the healthcare professional (MD, NP, PA)

Appendix D – CNR Case Composition Guidance Document (continued)

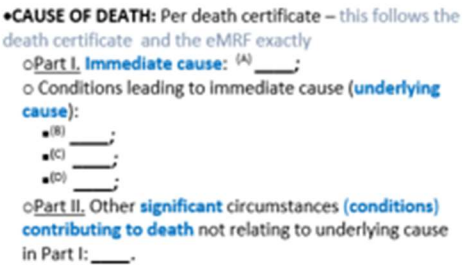
iii. #49a lists the physical address of the person completing the DC
- ✓ Often this location will need to be 'Googled' to determine who this person is and their role *(hospice HCP, PCP or an inpatient HCP, etc)*. The address will give you clues as to where this person works so you can identify them. (*In the example below, the address in #49a was a Hospice office and the HCP was listed as a staff NP in the facility).*
- ✓ Example: Per Google search type in:*"What is located at 1250 East Marshall street, 23298?"* to get this result:



- It is obvious for the purpose of mortality reviews, that food locations/restaurants are not documented as relevant locations. So in this example, the NP who completed the DC at this address, appears to be a VCUHS hospital HCP.

e). Cause of death is found in box #35

i. There is a section on the CRT for DC information, where the information from the DC should be entered on the appropriate lines:



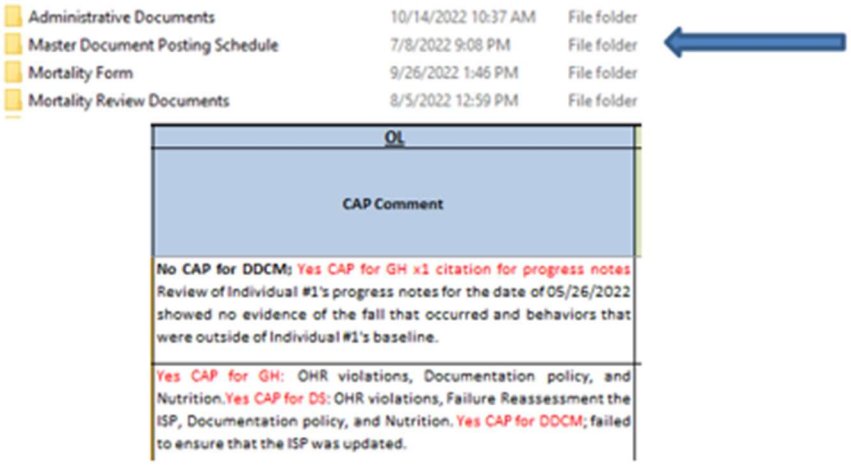
ii. The information is also added to the SOE narrative as this:

f). If the DC is NOT available - Check with the MRO Program Coordinator via MS Teams to determine if it has been requested two or more times. If it has NOT been received after the second request, it usually means that it is not on file in the VDH EDRS and will need to be followed up on. This follow-up is done by the Lead CNR or an MRT member.

Appendix D – CNR Case Composition Guidance Document (continued)

i. Follow-up involves reading through the documents to locate which HCP may have completed the DC (*PCP, Hospital, SNF/Rehab, etc.*)
ii. Once that HCP has been identified, the CNR will need to contact the Office of that HCP to determine if they completed the DC, have a copy or any information on who may have completed it.
iii. If no HCP can be identified, then that information (*including outcome of contacting HCP*) must be documented on the CRT/eMRF

2. **Summary or Sequence of Events (SoE)**
   A. Once a facility name has been used once, refer to the facility using initials rather than the whole name (*i.e. Once Sun Valley Nursing Home (SVNH) has been written once, refer to it as SVNH going forward, and document it this way on the CRT*).
   B. IFR - A summary of CAP and citation information is found on the MDPS (see below) and information for the eMRF & MRC can be found here. It may be more accurate as it is summarized here by the SIU manager, after her review of OLI findings report. Documentation of any Violations/CAP is the same as noted in B.i. & B.ii. below.



   C. CAP information is also available in the IFR and is usually submitted as a separate document. Reviewing this information after obtaining it from the MDPS is good practice, as it validates the information in the MDPS summary. Open the SIU's IFR in the individual's folder on SD. See below:

i. Scroll to the section "Investigation Findings". If the provider "*was found to be in compliance with regulations…"* enter that information on the CRT as follows:

- *Violations/CAP* – None noted

ii. If the provider was NOT found to be in compliance with regulations, and a CAP was issued, indicate that as:

- *Violations/CAP* – SP cited for regulatory violations and CAP issued

Appendix D – CNR Case Composition Guidance Document (continued)

D. Read through the document (*usually in the middle of the 1st page)*, to find the dates of the ISP, and enter those dates onto the CRT

E. Continuing reading through the document to find the, 'Staff: Individual ratio' and enter that ratio as one of these statements on the CRT:

- *Ratio of staff/individuals in the residence at the time of incident-* 4:8
- *Ratio of staff/individuals in the residence at the time of incident-* [NA] Private residence

F. See Appendix I *(Page 18)* for text statements to be used in cases where medical records were requested and not received before the MRC meeting, or cases that were PENDED for medical records *(when Medical records have finally been received after a case was pended)*. These statements go at the top of the SOE section, above the SUMMARY OF EVENTS header.

Investigation Findings Reports (IFRs) are insightful documents that can be of substantial help in composing the mortality case review. These MUST be read in detail during the course of composing cases as it is a mandatory document required for review and is listed in the Documents reviewed section (see Section X below).

3. **Individual Support Plan (ISP) and SoE Information**

A. Within the decedent's file, locate the ISP. There are key elements located in the ISP that need to be transcribed into the CRT. These areas include:

i. Date of last physical exam (PE)

a) This is located under the WaMS ISP heading, '*Last Exam Date'*. Transcribe this to the following location on the template:

Last Physical Exam – Date here

b) The date of the most recent PE may not be accurate as listed in the ISP, so use this date, but try to verify accuracy by viewing the actual PE document if available or, go to that date in the progress notes *(see appropriate section)*.

ii. Date range for ISP

a) An ISP must be renewed annually. You will find the dates of the individual's ISP in the SIU IFR as mentioned above, or on the very first page of the WaMS ISP. See below on how to enter this information:

- *ISP* – 10/12/2021-10/11/2022

iii. Residence type:

a) Refer to the Glossary of DBHDS License Numbers (*see Appendix II*)
b) The ISP should outline the type of service an individual received through the Waiver. This can be difficult to determine if an agency provided multiple services and/or provided more than one service for that decedent.
c) Under the 'Providers' section of the ISP is the name of the agencies that provided services for the individual. List only those that are current.
d) Section IV of the ISP may have this information also. Further review of documents is needed if neither the IFR nor the ISP specifically identify what type(s) of service a decedent received. For example, there are numerous types of residential services, and often the documentation doesn't differentiate between group home (GH) and sponsored residential (SR).

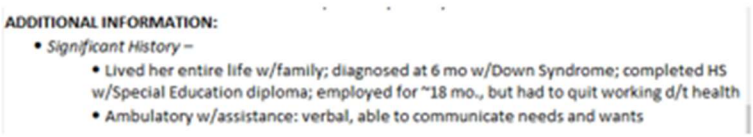
Appendix D – CNR Case Composition Guidance Document (continued)

If after a thorough review of the documentation, this information isn't clear or identified, then the SIU Investigator whose name is on the IFR, needs to be contacted via MS Teams or DBHDS email.

iv. Significant history

a) This section of the CRT is where a brief social and family history is summarized by the CNR to provide additional information on the decedent's past history that may help with MRC determinations. It should include the following if deemed relevant; birth and development, family history, living arrangements/previous residences, and abuse/neglect. Other optional information only when relevant (*may have been a factor in the decedent's death, waiver status or provision of licensed services*) can be included such as educational background and employment. Remember to be brief and concise here!

- This information in on the ISP under the '*Social, Developmental, Behavioral and Family History*' section. However, as you review documents you can add more information from other sources as it is located/discovered.
- This is also where information r/t deficits are noted, specifically: ambulation, communication, hearing, visual and dentition. See example below for complete documentation of the above:


ADDITIONAL INFORMATION:
- *Significant History –*
  - Lived her entire life w/family; diagnosed at 6 mo w/Down Syndrome; completed HS w/Special Education diploma; employed for ~18 mo., but had to quit working d/t health
  - Ambulatory w/assistance: verbal, able to communicate needs and wants

v. Support Systems (*see the example at the bottom of this section*)

a) This section of the case review identifies people in the decedent's life. Often these are individuals and groups who provided social support, and services to the individual prior to death. They may be siblings, spouses, legal guardians, home health care, hospice, etc.

- Natural Support - This information is obtained in the ISP, IFR, or Support Coordinator (SC)/Case Management (CM) progress notes and may be Legal Guardian (LG) and/or Power of Attorney (POA)
- Other Support - This section of the case review is to identify services that the individual may have in place such as Day Support, Nursing Services, Hospice and/or Home Health care.
- Followed Medically – This is where the list of all HCPs that have been identified throughout all the documentation reviewed is noted
- Identifying natural supports and surrogate decision makers - Depending on the Waiver services an individual had, there may not be residential progress notes that clearly document all the supports they had prior to death. Sometimes the ISP & IFR summarizes this information for the quarter.

Appendix D– CNR Case Composition Guidance Document (continued)

Support Systems –

- Natural Support – Parents (LGs)
- Other Support – DS (Visions Community Services) until closed 3/18 due to COVID-19 restrictions, then Our Summer Place in-home
- Followed medically by PCP, Psychiatrist, Cardiologist, Neurologist

vi. Adaptive/Supportive equipment

a) This portion of the case review is for information on adaptive and other supportive equipment such as wheelchairs, walkers, communication boards, hospital beds etc.

b) This information is typically found in the `Communication, Assistive Technology and Modifications' portion of the ISP.

- *Adaptive/Supportive Equipment* – Motorized WC, mechanical lift, shower chair, WC scale, compression stockings

vii. ISP summary of supports

a) This section is an overview of the support a person needed as outlined in the ISP. It is found throughout the plan, and a good starting point is to check the `Part III. Shared Planning' portion of the plan for a general outline of supports provided. Here is what the final eMRF version should look like:

- *ISP* –SUPPORT FOR: Socialization and community engagement, Engaging in desired activities, Medication management, Repositioning, Maintaining personal care, ADL/IADL, Toileting, Transfers, Avoiding hazards, Dietary and transportation needs, and Providing wound care management; PRECAUTIONS: Aspiration, Falls, Skin, UTI, and Dehydration; MONITORING: Weight weekly, BM and voids, Dietary intake, and Changes in needs and services; LOGS: BM, VS (Q week) and Meals/Food intake

b) This is also where the PE information can be found and remember to verify that the date and information listed here is actual PE information as verified by the other sources mentioned previously on Page 5. Section A.i.

- *Last Physical Exam* – Good general WNL exam; Cerumen flush bilaterally, w/normal and intact TMs; ; Scalp areas treated w/Nitrogen, no special wound care needed; Recommended FUV Q3mos; Labs previously drawn (6/08) reviewed (no results submitted for review).

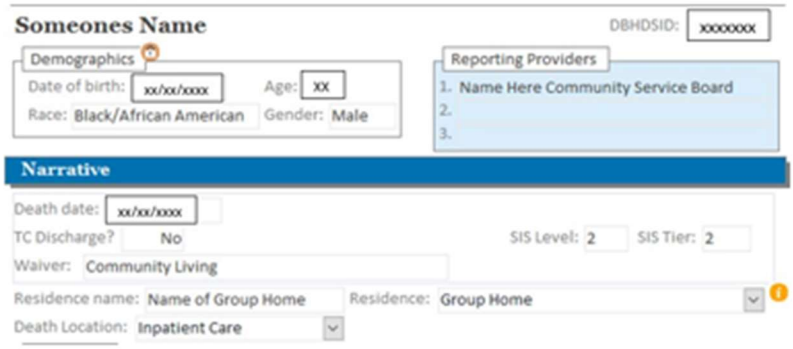
viii. Evidence of Maltreatment

a) If there is any mention of abuse, neglect, APS (Adult Protective Services) then this sentence needs to reflect that finding (below), and the OHR must be notified via MS Teams. If there is no mention of any of these three allegations nor any HSW issue (Health, Safety & Welfare), then the second statement below needs to be documented on the CRT.

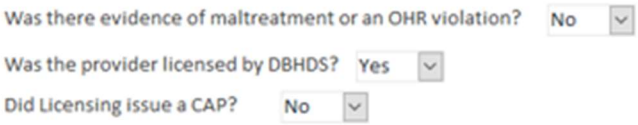
- *Evidence of Maltreatment* – Yes, and OHR notified. See CHRIS report below
- *Evidence of Maltreatment* – None noted in documents submitted for review.

Appendix D – CNR Case Composition Guidance Document (continued)

b) Copy/paste via Snipping Tool or write the following information out on the OHR MS Teams folder/thread for OHR staff to locate the case:



c) Then ensure these sections are correctly completed on the eMRF



4. Diagnoses

A. The ISP has the decedent's medical diagnoses and is especially true for their IDD and mental health diagnosis. Typically, the ISP will specify a person's ID as mild, moderate, severe or profound.

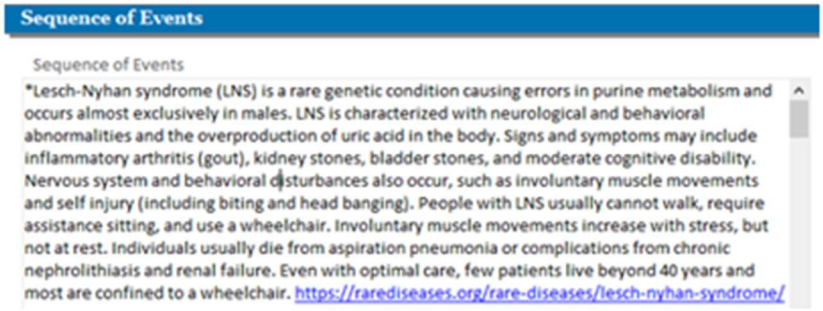
B. Other diagnoses (*e.g., Epilepsy, HTN, COPD, etc.*) are found in medical records, and these are the most valid and reliable source documents. When obtained for review, they should be used to validate and complete any section of the CRT/eMRF, as they are considered more accurate than other sources. The ISP and IFR may also list medical diagnoses and conditions but are usually not accurate because they are completed by nonmedical staff and are often 'second or third hand' information. Try and organize all diseases/diagnoses by body system from head to toe *(all neuro grouped together, then cardiac, pulmonary next, see example below)*

C. Use history of (H/O) at the end of this section for recent hospitalizations and relevant information in chronological/most recent first order, such as in this example:

Diagnoses: Intellectual Disability: ID - Moderate ; Seizure DO (last over 2 yrs ago); Kyphosis; Anxiety; Depression; OCD; HTN; Hyperlipidemia; Afib; Iron deficiency Anemia; Pre-diabetes; Osteoporosis/OA; Soft tissue mass (NOS, 04/23/2024).
H/O: Falls, Hospitalizations x3 (2024 x2 & 2021) - RUE hematoma (04/2024), Fall/UTI (06/2024), and Hip fx s/p total anterior arthroplasty hospitalization (2021), Wrist fx 2/2 fall (2019), and Blood transfusions

D. If there is an uncommon disease as a diagnosis for the decedent, put an asterisk in front of it, then define and briefly summarize it in the SoE. The summary needs to be succinct, uncomplicated and include; genetic vs congenital, prevalence, s/s, prognosis and a source citation. There is an MRC Definitions list in the SD of the ones that have been utilized to date. If the uncommon disease is NOT on that list, an internet search must be done, and that information summarized on the CRT/eMRF as a citation, and then added to the MRC Definitions list. See the example here:

Appendix D – CNR Case Composition Guidance Document (continued)



5. **Support Coordinator (SC) or Case Manager (CM)/CSB Progress Notes**
   A. SC/CM progress notes for the last 90-days before death must be provided. This is information about how the decedent was doing physically, emotionally and mentally prior to death. It is in the form of a summary of services provided. Additionally, notes on additional services and events may be found here.
      i. Take your time reviewing this information. These documents help you begin to create a timeline and outline for the SOE section of the CRT/eMRF
      ii. While reviewing any Person-Centered Reviews (PCRs) and progress notes submitted by the SC/CM, take note of significant events and dates and transcribe those into the SOE narrative. The narrative can always be modified later as more information is gathered, as it is helpful to have a timeline for the individual, and a sequential progression of events prior to death (*activities, symptoms, actions taken, etc.,*)
      iii. SC/CM Visits - used to provide a short overview of the SC services frequency by documenting when the last "face to face" (f2f or F2F) visit occurred. These visits are mandatory and must occur at least monthly, with a f2f visit every 30 days for ECM (Enhanced Case Management), and every 90 days for all others.
      iv. Use this section to identify the date of the last f2f visit and highlight any specific areas of concern that were addressed in the notes. Indicate if this was an actual 'in person' visit, virtual visit or telephone/conference call by including the location information in italics. Also, if the note indicates who was present with the individual, include their role (*use initials only*).

- *SC/CM Visits -*
  - Performed in accordance with regulation
  - Last *face to face* on 10/06/2021 *at nursing home* and no acute issues were noted in documentation provided

Do not identify people by names in case reviews. Instead, identify them by the role they play. For example, if the Support Coordinator's name is Jane Johnson rather than saying Jane Johnson, say "SC" or "CM". If you must use reference a person, then use initials only, (J).

Appendix D – CNR Case Composition Guidance Document (continued)

6. Shift Notes/Other Progress Notes

A. As mentioned above, depending on the type of Waiver services an individual received, the type of documentation available for review also varies. If an individual lived independently (*Private residence*) and received minimal services by DBHDS licensed providers, the availability of progress notes or documentation submitted for review will be minimal. However, if an individual received more intensive support from DBHDS licensed services, such as GH or DS (Day Support), there is usually quite a bit of documentation available.

B. After a timeline of events has been identified from the IFR and corroborated from Medical records and SC/CM progress notes, then other documents should be reviewed. These include GH Progress notes and other documents, linked to the dates, actions and events identified previously. For example, if the PCR indicates an individual was hospitalized on September 12th and resided in a GH, you should review the residential progress notes for a few days prior to, and after, that hospitalization on the 12th.

C. Reviewing these notes will also provide a depiction of an individual's overall wellbeing and baseline status prior to their death. This also allows the CNR to identify any subtle significant deviations that may need to be expanded on or pursued.

7. Medical Records

A. Reviewing hospital medical records is of paramount importance to complete the CRT/eMRF. The amount of information that needs to be reviewed varies and may be significant.

There are occasions where hospital records are not available but are necessary to complete a thorough review. Try to identify if you need these documents as early in the review process as possible, so you can request them as you start, and before you complete, the review. Requesting and receiving these documents takes a significant amount of time, so the sooner you request them, the sooner the information becomes available for review and inclusion in the CRT.

i. Ensure the dates of the hospitalization are within 90 days of Date of Death (DoD) and are mentioned in other source documents such as IFR, SC/CM and/or residential progress notes. CNRs may determine if medical records are needed >90 days from DoD

ii. Review the hospital records for: RFA (Reason For Admission), Home meds, Diagnoses, Relevant radiological and lab results, Hospital course (*including significant events and condition changes*), DNR status, POC (Plan Of Care), and Discharge (D/C) Summary.

iii. Summarize these in the narrative as you would for an inpatient note or shift report. Always use medical terminology since this is a clinical summary review.

iv. The intent is to provide an objective (unbiased) summary of hospital events, not a subjective (opinion) of care provided. Any relevant information you feel that may have impacted the course of the hospitalization should be included.

Appendix D – CNR Case Composition Guidance Document (continued)

v. For example - frequent blood transfusions due to low H&H levels, s/s, consults, prognosis, infections, treatment plan, individual pulling out lines/tubes, & intubation

vi. When noted, Hospice and Palliative care consults are documented in the CRT SOE section with their own date. Additionally, if an individual's code status changes and there is a specific date of the DNR/DNI discussion and/or status change, document this in the narrative as well. The date of the DNR is also cited in the Hospice & Advanced Directives section of the eMRF, so add that to the CRT template also

vii. As mentioned above, the ISP may not have the most accurate medical diagnosis information. Utilize medical records to obtain accurate information regarding a decedent's medical history and diagnoses when they are available. This is on the CRT:

Diagnosis: [1] Intellectual disability – ; [2] ; [3] ; [4] ; [5] ; [6] ; [7] ; [8] ; [9] ; [10] .

And this is how it looks on the eMRF:

Diagnoses	
Diagnosis 1:	Intellectual disability – Severe
Diagnosis 2:	*Coffin-Lowery Syndrome
Diagnosis 3:	Seizure Disorder
Diagnosis 4:	Anxiety Disorder
Diagnosis 5:	Presbyesophagus; Dysphagia w/Mild Gastritis
Diagnosis 6:	Mixed Hyperlipidemia; Hypokalemia
Diagnosis 7:	Hypothyroidism; HTN
Diagnosis 8:	SOB; OSA
Diagnosis 9:	Pica
Diagnosis 10:	Constipation

Some individuals have a DDNR. This information can be found in several locations within the records. There will not be a copy of the actual DNR/DDNR order for review for the majority of cases. However, often hospital records indicate a copy or a discussion of code status, and that can be used to complete the DNR section of the case review template.

B. Information about the availability of medical records needs to be added on the CRT/eMRF also, as shown here from eMRF: (*see CRT for appropriate section*)

Documents Reviewed

Date of Most Recent Physical: 11/19/2019	Results Available:	No
Date of Most Recent ISP:	05/01/2021-04/30/2022	
Progress Notes (Last 3 Months):	Available	
Death Certificate or Autopsy:	Available	
Medical Records:	Available	
Licensing Investigation:	Available	
CHRIS Serious Injury Report:	Available	
Interview Warranted?	No	

Appendix D – CNR Case Composition Guidance Document (continued)

C. Office Visit Summaries
   i. If an individual visited a healthcare provider (HCP) or Primary Care Provider (PCP) for any reason (*sick visits, hospital follow-up, routine care etc.*), review these documents and include information on the CRT.

8. Miscellaneous Records

A. Occasionally there may be additional records provided for review. How significant these documents are will depend on what is provided and if any information gaps exist at this point in the case composition. Not all documentation available needs to be reviewed by the CNR. Any additional documentation submitted for review is included in the CRT if the CNR deems the information relevant.
B. 911 audio and written logs MUST be reviewed - If neither of these are available for review, the CNR needs to reach out to the SIU Investigator listed on the IFR for contact 911 Dispatcher information in order to request and receive these records. Involve the lead CNR when needed.

9. Medications and Allergies

A. It is best to utilize medical records to gather a comprehensive list of medications (*Scheduled, PRN & Other, see D below*). While the ISP may list them, that information is often not accurate and/or incomplete, as mentioned previously. Other places to look for an accurate list of medications include:
   i. Office visit summaries
   ii. MARS submitted for review
B. While rare, there may be instances where none of these documents are available for review. This usually occurs when the decedent received limited or no DBHDS services, and/or resided in a private residence. Additionally, a person may not have had a visit with a HCP or hospital admission within the last 3-5 months prior to DoD. In those cases, use the best available documentation submitted for review, including the medications listed within the ISP or IFR. Then document the source document in the medications section, using one of the statements below in the Medications Section:

   - *Allergies* – Information not provided in documentation submitted
   - *Medications* – None noted in documents submitted for review
   - *Other* – None noted in documents submitted for review

C. List all scheduled medications and any PRNs identified. Focus only on the ones that were administered within the 90 days prior to death and that are current. Note that Polyethylene Glycol is documented as "PEG".
D. `Other:' is used to designate vaccinations (vax), oxygen (O2) and nutritional supplements *(including tube feeds)*
E. Medications and allergies are in this section of the CRT and look like this:

Appendix D – CNR Case Composition Guidance Document (continued)

MEDICATIONS:

- *Scheduled* – **Phenobarbital** 127.2 mg HS; **Quetiapine** 100 HS; **Risperidone** 1 mg TID; **Pantoprazole** 40 mg QD; **Divalproex** 500 mg q8h; **Zinc oxide Cream** apply to perineum BID
- *PRN* – **Clonazepam** 1-2 mg QD (agitation); **Acetaminophen** 325 mg q4h (HA); **Mylanta** 30 mL after meals &QHS (upset stomach); **Pepto Bismol** 1 tbsp TID (diarrhea); **Robitussin Syrup** 10 mL TID (runny nose/cough); **Guaifenesin DM** 600 mg BID (cough/congestion); **PEG** 17 gm QD (constipation); **Sunscreen SPF 15** (before going out in the sun)
- *Allergies* – **Paroxetine, Chlorpromazine**
- *Other* – None noted in documentation submitted

F. Document all allergies, including medication, food and environmental ones.

Step 5:

At this point, most of the required documents submitted have been reviewed. It is also likely that you have a good portion of the CRT completed. The next important step is to complete the 'Summary of Events' (SOE) portion of the CRT, and be aware that this is the most important aspect of the clinical composition of IDD mortality case reviews. The outline you have created from all the above now requires formatting into a sequential, logical and succinct clinical summary of factors that led to the individual's death.

The SOE should be a chronological timeline of events *(with most recent first)* that occurred within 90-days before DoD. If the CNR deems it relevant, information prior to 90 days may be included only if it provides additional insight into events that may have been a factor in the death. If the individual was admitted and discharged from numerous facilities, make sure those dates, with the appropriate summaries, are clearly documented in the history (HO) 'Diagnoses' section of the CRT as shown again here and mentioned in Section 4.C. *(Page 9)* above.

Diagnoses: Intellectual Disability: ID - Unspecified ; CP w/Spastic Quadriplegia; Central Cord Syndrome @C3 with Cervical Dystonia; Motor Speech DO; COPD; OSA; CHF; HTN; Hyperlipidemia; Anemia; T2DM; PI; Dysphagia; GERD; IBS; Allergic Rhinitis; Atrophic Dermatitis; Bilateral Hearing Loss. H/O: Hospitalization June 2024 for renal calculi s/p stent and 2006 fall w/cervical fx resulting in non-ambulatory status

If the CNR feels additional information outside of the 90-day window is relevant and needs to be included, reference it from the 'H/O' section in the SOE like this:

Diagnoses: Intellectual Disability: ID - Severe ; Encephalopathy; Congenital Hydrocephalus; Epilepsy (Grand Mal & Tonic Clonic, most recent episode summer 2023); ASD; Organic brain syndrome; Psychotic DO w/hallucinations; GAD; ADHD; Mood Do; Bipolar DO (current episode manic severe w/psychotic features); Intestinal volvulus; Constipation; Vit D deficiency. H/O: Falls (Sept and Nov 2023) and Colostomy s/p reversal (2018/2019)

SUMMARY OF EVENTS:

01/10/2024 – Still recovering from falls *(last 2 mos previous)*: Fall risk updated Nov 2023 maintained; Using walker and requesting staff assistance to stand from sitting position and when ambulating on stairs and outdoors

MRC members *(and auditors)* must be able to easily follow the progression of events to make determinations. (*The Why, Where, What, When, and Outcome*) of all information relevant to the individual's death.

Examples: Did they fall before they were taken to the ED?, Was 911 called immediately when they were found unresponsive?, What happened when 911 arrived?, What was the RFA?, What did the Head CT show?, Why were they discharged to a skilled facility and not back to their residence?, Why does the DC say CoD is Cancer with metastasis and there is no mention of cancer?

Appendix D – CNR Case Composition Guidance Document (continued)

Step 6:

You should now have nearly all sections of the CRT completed. If there are areas that are blank, go back to the appropriate source document and attempt to locate the missing information. Or read through other documents submitted to locate the information. Feel free to use the Lead CNR or Clinical Manager as a resource if you have identified a gap in the information and wish to discuss next steps in order to locate that information. Either of these two staff members are usually more effective when contacting other state offices, *(such as the OCME)* in order to obtain or expedite receipt of additional information.

Examples: (a) Hospice may have been initiated before the 90-day review period and hospice rarely provides documentation of services so you may not have those records for review. You will need to determine from SC/CM or in residential services progress notes if hospice was in place.

(b) DNR/DDNR/DNI was in place prior to 90-days, and this information was not included in the ISP, but was noted in other records you reviewed. However, the specific date could not be located or determined. This is when "No" for the 'Date Known' section of the CRT must be selected.

Step 7:

The Documents section is the last section to complete. The purpose of this section is to note if the mandatory documents were received for review (*see Page 12, Section B*). Use the dropdown to indicate the appropriate choice/option as seen here again:

It is the responsibility of each CNR to check the Medical Records Request Log in MS Teams or SharePoint every day to ascertain the status of the medical records you are waiting on. They may not have been received yet, or have arrived via Sfax or Ciox portal, and are now ready for you to review. If medical records have NOT been received after two requests or within 8 business days of the first request, contact the Lead CNR for further follow-up.

Step 8:

The next step is to proofread, spellcheck, and review the CRT as if it is the first time you have read it as an MRC member versus a CNR. You may want to do this the next day, or after some time has passed after it is completed. Do you notice information gaps, confusing SOE, or unanswered questions? If so, go back and try to locate that information, fill in the gap and/or make it understandable.

Once completed, the CRT is now ready to be moved into the 'Appraisal Review' workflow in the eMRF application and/or shared drive folder *(depending on the electronic application in use)*.

Appendix D – CNR Case Composition Guidance Document (continued)

If you do not have access to the electronic database application where the eMRF is located, just upload it to the Case Backup shared folder in the correct MRC meeting dated subfolder. Let the Lead CNR know it's location *(depending on the electronic eMRF application in use)* so (s)he can perform the Preliminary Review and forward it to the Mortality Review Clinical Manager (MRCM) or Chief Clinical Officer (CCO) for final Appraisal Review *(where Tier status is determined)*.

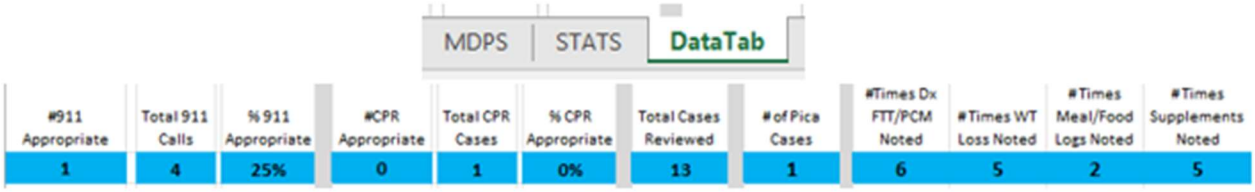
Note that after either the Preliminary Review by the Lead CNR or the Appraisal Review by the MRCM or CCO is done, the Lead CNR may ask you to provide additional information. Please prioritize this request when it occurs so that mandatory timeframes and deadlines are met.

Step 9:

This is the final Step in the mortality case composition process. All you need to do is update the MDPS excel spreadsheet with your initials in the appropriate column (*as seen on Page 3, Section B and again below*).

Date of Death	Last Name	First Name	Reporting Provider(s)	Final Due Date 45 Business Days from Date of Report	Office of Licensing			Other	MRO	MRO
					Provider Documents Posted Prior to Final Due	OL Notes (i.e. Different dates of provider documentation posted)	DATE OF OL Investigation Posted	Facility Documents Posted Prior to Final Due	DATE OF Clinical Reviewer Completion	Clinical Reviewer Ack. Column R (Initials)

There are also tabs at the bottom of the spreadsheet where data is entered for use in quality improvement initiatives and quarterly & annual reports *(such as potential trends, patterns, statistics, data, and/or internal CNR information).* Quality Improvement Initiative (QII) data (*such as pressure injuries, and 911*) are also tracked here. CNRs are responsible for adding this data into the correct columns as you discover them when composing the CRT/eMRF. The tab names and data *(to date)* are:



Step 10:

CNRs attend each MRC meeting in order to answer any questions about that specific case the composed, or to look up information during the MRC meeting as requested by members. It is mandatory that the Lead CNR attend each meeting, to designate or perform any of these actions. One CNR is assigned to enter information, determinations, *(spelling, format and errors that SIU, OHR, OIH, or Pharmacy Offices note)* in real time on the eMRF during the meeting, and this may be the Lead CNR or designee. The Lead CNR will also hold a post MRC meeting immediately after each MRC meeting *(see Appendix I)*.

Appendix D – CNR Case Composition Guidance Document (continued)

Appendix I - CNR Notes

- All CNRs meet for 30 minutes after each MRC meeting to review & discuss revisions and MRC determinations to ensure correct information is entered into each eMRF case.
- The Lead CNR or designee will make all the MRC determinations in the eMRF and close the cases either during or after, the post CNR meeting.
- New CNR staff will orient with the Lead Clinical Nurse Reviewer, and Clinical Nurse Manager.
- CNRs check the CHRIS system for incident reports filed for each case, for inclusion in the CRT.
- The WaMS system is also checked for each case as validation of, or for additional, information.
- They will also check the MS Teams Medical Request Log daily, in addition to the SD before CoB on the Friday before the MRC meeting to: Ensure documents marked "unavailable" have not become available (*med records, progress notes, etc*) and update the case(s) if medical records are now received.
- For cases where additional information is needed to fill information gaps and after the MRC has Pended the case, CNRs will add the additional information directly into the eMRF. Do NOT use your template and then copy/paste from that template to the already completed and existing eMRF. Doing so erases all the information added from the original case review, which the MRC utilized to make the 'Pend' decision. Essentially that would be changing information the MRC used to make the 'pend' decision, which is not ethical, legal nor acceptable per DOJ, chart review and regulating entity guidelines. Nor is it evidenced practice.
- CNRs should communicate with OL and OHR as soon as abuse, neglect, APS or other HSW documentation *(see Page 8, Section viii)* is noted/mentioned. Advance notice of an OHR case is not only a courtesy but allows both Offices to be prepared to discuss the case at the upcoming MRC meeting. They will be able to provide more information and answer questions during that MRC meeting then if they were only made aware during the meeting.
- Cases for the next MRC meeting need to be completed and in the Prelim/Appraisal Review Workflow by CoB on the Friday before the MRC meeting, or by noon on Monday of MRC week at the latest. This allows as much time as possible for the Clinical Manager to review all cases and determine Tier status prior to the MRC meeting that week.
- If additional medical records are needed, CNRs need to either obtain them on their own, or notify the Lead CNR as soon as possible with as much information as they have. The Lead CNR will also follow-up and make calls if the first medical records request was not successful, or for any other additional information that the Mortality Review Team feels is needed. CNRs should keep the Lead CNR apprised of any concerns or issues as (s)he is also available to investigate what other records or documents are needed and to problem solve issues or concerns.

Appendix D – CNR Case Composition Guidance Document (continued)

- **SUMMARY OF EVENTS** (SOE) header statements that go at the top of the SOE section, above the SUMMARY OF EVENTS header:

A. Below are copy/paste text statements for use in eMRF cases where medical records were requested and not received by the Monday before the MRC meeting, or cases were PENDED for medical records and Medical records have finally been received after a case was in pended status. Bolded text are dates the CNR needs to provide.

- For cases still waiting on medical records the Monday before the MRC meeting:
  For 12/12/2024 MRC meeting - Medical records from **facility name** requested on **xx/xx/xxxx**, have not been received as of 12/11/2024 **(date of day before the MRC meeting date goes here)**. However, the MRC may decide there is enough information available to make determinations

- For PENDED cases after medical records were received and information was added to that pended case's eMRF:
  For 12/12/2024 MRC meeting - Case pended 21 November 2024 for medical records requested from **facility name,** which were received on **xx/xx/xxxx**. Additional information from those documents is underlined text in the event summary below.

- For PENDED cases where medical records were still not received:
  For 12/12/2024 MRC meeting – Case pended 11/28/2024 **(date of last MRC meeting date goes here)** for medical records requested from **facility name**, which still have not been received as of 12/11/2024 despite **X (#)** requests.

B. Statements when no documentation was submitted for review/or available

- NOTE - Unable to obtain additional documentation - below is the only available information retrieved from documents submitted for review and no further information can be obtained.

- NOTE - No information provided or available from decedent's family as to who their medical providers were, thus unable to obtain or request additional documentation. Below is the only available information retrieved from documents submitted for review and no further information can be obtained.

- NOS – Not Otherwise Specified is used in the SOE and anywhere on eMRF where applicable to denote that no details or additional information is available. That was the only statement or mention noted in documents submitted for review.

C. Remove any highlighting and/or personal notations from the eMRF before copy/pasting

D. See Pages 5 and 6 for the Tier 1 category criteria as a reference for those cases where additional information may be needed for presentation to the MRC

Appendix D – CNR Case Composition Guidance Document (continued)

Appendix II – Licensing Codes *(also located in Shared Drive)*

SERV ID	PROG ID	Description	License As Statements
01	001	DD Group Home Srv	A developmental disability residential group home service for adults.
01	002	DD Group Home Srv	A developmental disability residential group home service for adults.
01	004	Group Home Srv-REACH	A residential group home with crisis stabilization REACH service for adults with co-occurring diagnosis of developmental disability and behavioral health needs.
01	005	ICF-IID Group Home Service	An intermediate care facility for individuals with a intellectual disability (ICF-IID) residential group home service for adults
01	011	DD Supervised Living Srv	A developmental disability supervised living residential service for adults
01	022	DD Crisis stabilization -Residential	A developmental disability residential crisis stabilization service
01	036	DD Residential Respite Srv	A developmental disability residential respite service for adults
01	037	DD Residential Respite Srv	A developmental disability residential respite service for children and adolescents
01	038	DD Residential Respite Srv	A developmental disability residential respite service for children and adolescents
01	039	DD Center-Based Respite Srv	A developmental disability center-based respite service for adults
01	040	DD Center-Based Respite Srv	A developmental disability center-based respite service for children and adolescents
01	041	DD Group Home Srv - REACH	A residential group home with crisis-stabilization REACH service for children and adolescents with co-occurring diagnosis of developmental disability and behavioral health needs
02	004	DD Center-Based Respite Srv	A developmental disability center-based respite service for adults
02	005	DD Center-Based Respite Srv	A developmental disability center-based respite service for children and adolescents
02	006	DD Day Support Srv	A developmental disability center-based day support service for adults.
02	007	DD Day Support Srv	A developmental disability center-based day support service for children and adolescents
02	008	DD Day Support Srv	A developmental disability non center-based day support service for for adults
02	009	DD Day Support Srv	A developmental disability non center-based day support service for children and adolescents
02	010	DD Day Support Srv	A developmental disability day support service for (population served)
03	011	DD Supportive In-Home Srv	A developmental disability supportive in-home service for children, adolescents, and adults
03	012	DD Supportive In-Home Srv	A developmental disability supportive in-home service for children, adolescents, and adults
07	007	DD Outpatient Srv/Crisis Stabilization - REACH	A non-residential crisis stabilization REACH service for (children, adolescent, and/or adults) with a co-occurring diagnosis of developmental disability and behavioral health needs.
07	008	DD Outpatient Srv/Crisis Stabilization - REACH	A non-residential crisis stabilization REACH service for (children, adolescent, and/or adults) with a co-occurring diagnosis of developmental disability and behavioral health needs.
07	009	DD Crisis Stabilization - Non –Residential	A developmental disability NON-residential crisis stabilization service
08	011	DD Sponsored Residential Homes Srv	A developmental disability sponsored residential home service for adults
08	012	DD Sponsored Residential Homes Srv	A developmental disability sponsored residential home service for adults
08	013	DD Sponsored Residential Homes Srv	A developmental disability sponsored residential home service for children and adolescents
09	001	DD Out-of-Home Respite Srv	An out-of-home respite service for adults
09	002	DD Out-of-Home Respite Srv	An out-of-home respite service for children and adolescents
09	003	DD Out-of-Home Respite	An out-of-home respite service for (population served)
10	001	DD In-Home Respite Srv	An in-home respite service for adults
10	002	DD In-Home Respite Srv	An in-home respite service for children and adolescents
14	035	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	036	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	037	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	038	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	039	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	040	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	041	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	042	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	043	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	044	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	045	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	046	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	047	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	048	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	049	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	050	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	051	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	052	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	053	DD Children Group Home Residential Srv	A developmental disability children's group home residential service
14	059	DD REACH Children Residential Treatment Srv	A residential group home with crisis stabilization REACH service for children and adolescents with a co-occurring diagnosis of developmental disability and behavioral health needs.
16	002	DD Case Management Srv	A developmental disability case management service

Appendix D – CNR Case Composition Guidance Document (continued)

Appendix III – Common Acronyms *(also located in Shared Drive)*

	Abbreviation	Explanation
2	AD	Advance Directives
3	APS	Adult Protective Services
4	AR/AuthRep	Authorized Representative
5	CAP	Corrective Action Plan
6	CD	Consumer Directed
7	CE	Community Engagement
8	CHRIS	Critical Incident Reporting System
9	CNR	Clinical Nurse Reviewer
10	CoD	Cause of Death
11	CRA	Crisis Risk Assessment
12	CRT	Case Review Template
13	CSB	Community Service Board
14	CSH	Central State Hospital
15	CSH	Central State Hospital
16	CVTC	Central Virginia Training Center
17	DC	Death Certificate
18	DDNR	Durable Do Not Resuscitate
19	DMAS	Department of Medical Assistance Services (Virginia Medicaid)
20	DoD	Date of Death
21	DOJ	Department of Justice
22	DoS	Date(s) of Service
23	DS	Day Support
24	DSP	Direct Support Provider
25	ECM	Enhanced Case Management (F2F q30 days)
26	eRMF	Electronic Mortality Review Form
27	ESH	Eastern State Hospital
28	F2F/FTF	Face to Face
29	FTT	Failure to Thrive
30	GH	Group Home
31	HCP	Healthcare Provider
32	HHR	Health & Human Resources
33	HWDMC	Hiram W Davis Medical Center
34	ICF/IID	Intermediate Care Facility for Individuals w/Intellectual Disabilities
35	ID/DD	Intellectual Disability/Developmental Disability

Appendix D – CNR Case Composition Guidance Document (continued)

Appendix III – Common Acronyms (continued)

IHS(P)	In-Home Support (Provider)
IMU	Incident Management Unit (Office of Licensing)
IR	DOJ Independent Reviewer
IFR	Investigative Findings Report
IRA	Individual Residential Alternative
ISP	Individualized Support Plan
LG	Legal Guardian
MDPS	Master Document Posting Schedule
MPS	Mortality Prevention Strategy (Primary, Secondary, Tertiary)
MRO	Mortality Review Office
MRT	Mortality Review Team
NF/SNF/ALF	Nursing Facility/Skilled Nursing Facility/Alternative Living Facility
NVMHI	Northern Virginia Mental Health Institute
OCME	Office of Chief Medical Examiner
OHR	Office of Human Rights
OIH	Office of Integrated Health
OL	Office of Licensing
OLI	Office of Licensing Investigation
OSVT	On-Site Visit Tool
PA/PCA	Personal Assistant/Personal Care Assistant
PGH	Piedmont Geriatric Hospital
POA	Power of Attorney
PP	Potentially Preventable
QIC	Quality Improvement Council
QM	Quality Management
RAT	Risk Assessment Tool
RCA	Root Cause Analysis
RMRC	Risk Management Review Committee
SC/CM	Support Coordinator/Case Manager
SEVTC	Southeastern Virginia Training Center
Sfax	Secure Electronic Fax
SIB	Self Injurious Behavior
SIS	Support Intensity Scale

Appendix D – CNR Case Composition Guidance Document (continued)

Appendix III – Common Acronyms (continued)

SIU	Special Investigation Unit (Office of Licensing)
SP	Sponsored Provider
SROC	Spontaneous Return of Circulation
SVTC	Southside Virginia Training Center
SWVTC	Southwestern Virginia Training Center
TC	Training Center
TDO	Temporary Detention Order
ToD	Time of Death
UXP	Unexpected Death
VDH	Virginia Department of Health
VIDES	Virginia Individual Developmental Disability Eligibility Survey
WaMS	Virginia Waiver Management System
WSH	Western State Hospital
XP	Expected Death

Appendix D – CNR Case Composition Guidance Document (continued)

Appendix IV – Case Review Template *(CRT, also located in Shared Drive)*

DEMOGRAPHICS: NAME **Age:** Race: Choose an item. Gender: Choose an item.
Date of Birth: Click or tap to enter a date. Date of Death: Click or tap to enter a date. Death Location: Choose an item.
Reporting Providers:
Training Center DC: No Waiver: Choose an item. Wait List: No SIS Level Choose an item.
SIS Tier: Choose an item.
Residence Name: Residence Type: Choose an item.
Diagnoses: Intellectual Disability: Choose an item.;
Diagnosis Comments *

MEDICATIONS:

Comments: Choose an item. Vaccine: Choose an item. Vaccine Type: Choose an item.
Scheduled:
PRN:
Allergies:
Other Orders:

DOCUMENTS REVIEWED:

Last Physical Exam Date Click or tap to enter a date.; Physical Exam Available Choose an item.
Last Physical Exam:
Most Recent ISP Date Range:
Screening Noted: Choose an item. Screening Type Miscellaneous Documents Non-contributory
Death Certificate: Available Licensing Investigation: Available Progress notes - (Residential Provider) Choose an item.
Progress notes - (SC/CM): Available Progress notes - (Medical Providers): Choose an item. Medical Records: Choose an item. Root Cause Analysis Choose an item. CHRIS Serious Injury Report: Available Interview Warranted: No

Summary of CHRIS Reports: (#)

-

END OF LIFE CARE:

End of Life Care Documented Choose an item. Comfort Care Choose an item. Hospice Care Choose an item.
Palliative Care Choose an item. End of Life Care Start Date Click or tap to enter a date.
End of Life Care Duration Choose an item. DNR/DDNR Choose an item. DNR/DDNR Date(if known): Click or tap to enter a date.

Appendix D – CNR Case Composition Guidance Document (continued)

Appendix IV – Case Review Template (continued)

SUMMARY OF EVENTS:

[Date]

-

XX/XX/2024

- [ToD] - Deceased @ location (Facility Name) Death Certificate Completed by: Choose an item.

ADDITIONAL INFORMATION:

Support Systems:

- Natural Support –
- Medical Providers – PCP,
- Other support –

Other Significant History:

-

Ambulation: Choose an item. Communication: Choose an item.

Edentulous: Choose an item. Incontinent: Choose an item. Pressure Injury: Choose an item.

Adaptive/Supportive Equipment:

ISP: SUPPORT FOR: ; PRECAUTIONS: ; BEHAVIORAL SUPPORT FOR: ; MONITORING/LOGS:

SC/CM Visits:

Performed IAW Regulations: Yes Comments: Last Face to Face Date: Click or tap to enter a date.

Method of F2F: Choose an item. Location of F2F: Choose an item. **Ratio of Residents/Staff at the time of incident**:

CAUSE OF DEATH:

Part I. **Immediate cause**: (A) _

Conditions leading to immediate cause (**underlying cause**):

(B) _

(C) _

(D) _

Part II. Other **significant** circumstances **(conditions) contributing to death** not relating to underlying cause in Part I:

_.

OCME Case: Choose an item. OCME F/U Contact: Click or tap to enter a date. OCME Report Received: Choose an item. Autopsy Performed: Choose an item. External Exam Performed: Choose an item.

APPRAISAL:

Clinical Nurse Reviewer:

Appraisal Review Tier: Choose an item. Date Appraisal Review Completed by MD/N Click or tap to enter a date.

Discussion Notes:

Appendix D – CNR Case Composition Guidance Document (continued)

Appendix IV – Case Review Template (continued)

Mortality Review Summary:

Provider Licensed by DBHDS: Yes | Violation(s)/CAP(s) Issued: Choose an item. | Comments:

Evidence of Maltreatment: Choose an item. | Allegation Substantiated: Choose an item. | Comments:

CAUSE OF DEATH: _____

Death Expected: Choose an item. | Potentially Preventable? Choose an item.

RECOMMENDATIONS/ACTIONS:

Licensed Providers: Choose an item. | Providers Not Licensed by DBHDS Choose an item.

COMMENT SUMMARY FROM MRC MEETING:

CONTRIBUTING FACTORS:

Access to Care Including Delay in Seeki Choose an item. | Coordination and Optimization of Care Choose an item.

Assessment & Response to Individual's N Choose an item. | Execution of Established Protocol(s) Choose an item.

MORTALITY PREVENTION STRATEGY:

Mortality Prevention Strategy - Primary Choose an item. | Mortality Prevention Strategy - Seconda Choose an item.

Mortality Prevention Strategy - Tertiar Choose an item.

MRC Review:

Beginning Review Date: Click or tap to enter a date. | Case Pended Choose an item. | Review Completed Date: Click or tap to enter a date. | Number of Times Pended Choose an item. | Pended Notes: | Final Review Tier: Choose an item.