Moving Forward Together:

Using Mortality Review for Quality Improvement

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UNM SCHOOL of MEDICINE | *Continuum of Care Project*

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Neither developer/presenter has conflicts of interest to disclose.

Session Outline:

- An Introduction to Mortality Review for persons living with I/DD
- The Process of Mortality Review
- Findings from I/DD Mortality Review in New Mexico
- The 4 Big Questions to Ask
- Case Study - Learning Together
- Opportunities to use Mortality Review

Learning Objectives:

By the end of this session, learners will be able to:

- Describe how mortality review is used to improve quality at the individual, provider and system levels.
- Describe the leading causes of mortality among persons with intellectual/developmental disabilities in New Mexico.
- Apply the Four Big Questions to a mortality review case in order to identify opportunities for quality improvement.

The New Mexico Department of Health's DD Mortality Review Process

- Purpose is to identify statewide, system-level opportunities for improvement.
- Nurse review of all deaths of persons who receive DD services from NMDOH.
- Additional independent physician review for all Jackson class members

Mortality Review…

- Is ***NOT*** an investigation to find blame…

- It ***IS*** a way to find better ways to serve persons with Intellectual and/or Developmental Disabilities

Quality Assurance and Quality Improvement

Quality Assurance:

- Did providers meet expected standards of care?
- If yes, move to QI
- If no, what needs to change to facilitate in the future? Go to QI

Quality Improvement:

- Are there ways to improve the quality of care?
- If yes, ***who*** needs to do ***what*** to accomplish this?

Mortality Review is also:

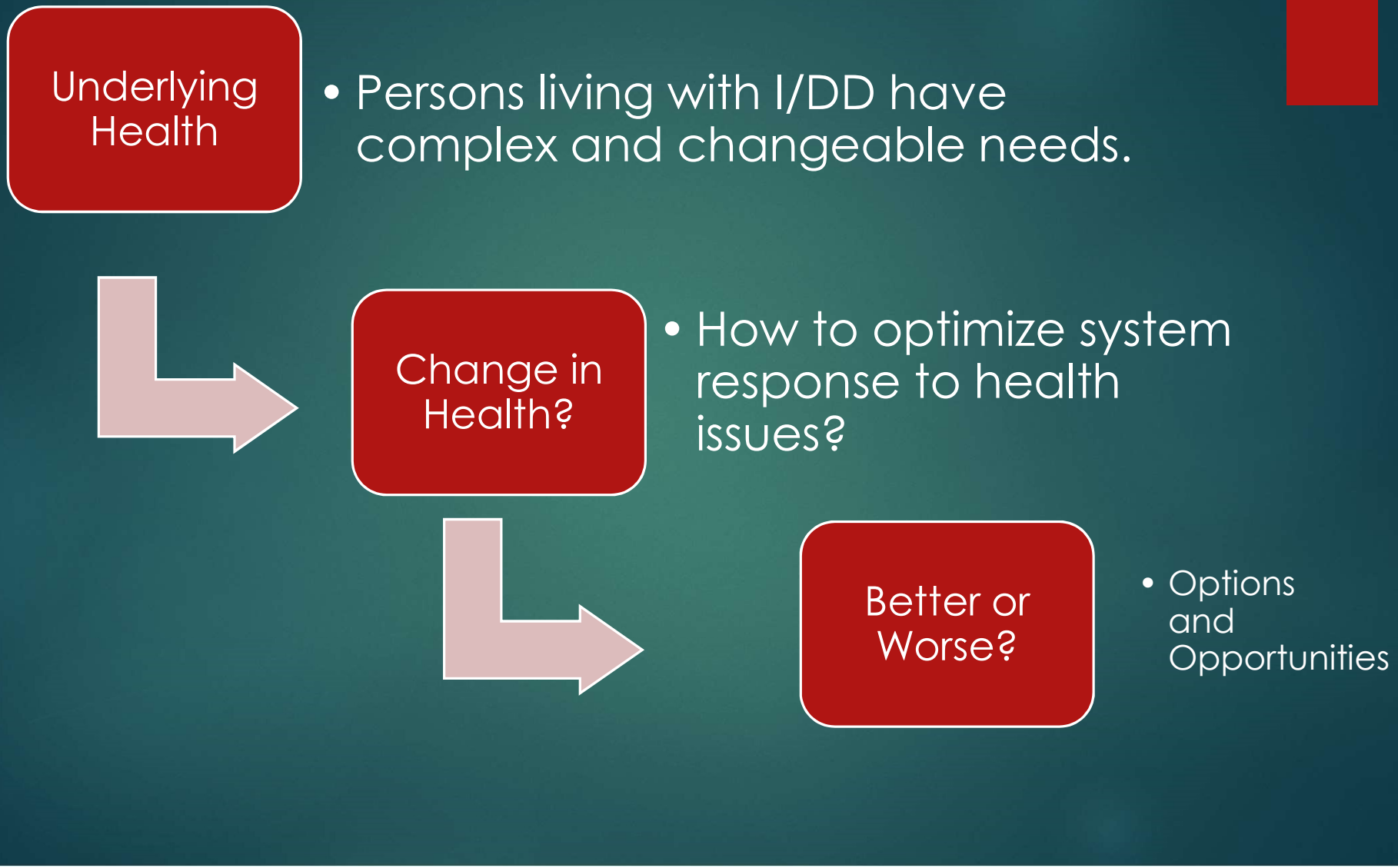
- An opportunity to reflect and honor the individual who has died
- A learning opportunity for those who provided services and supports for the person in order to improve supports and services for others

Multiple levels of Quality Improvement:

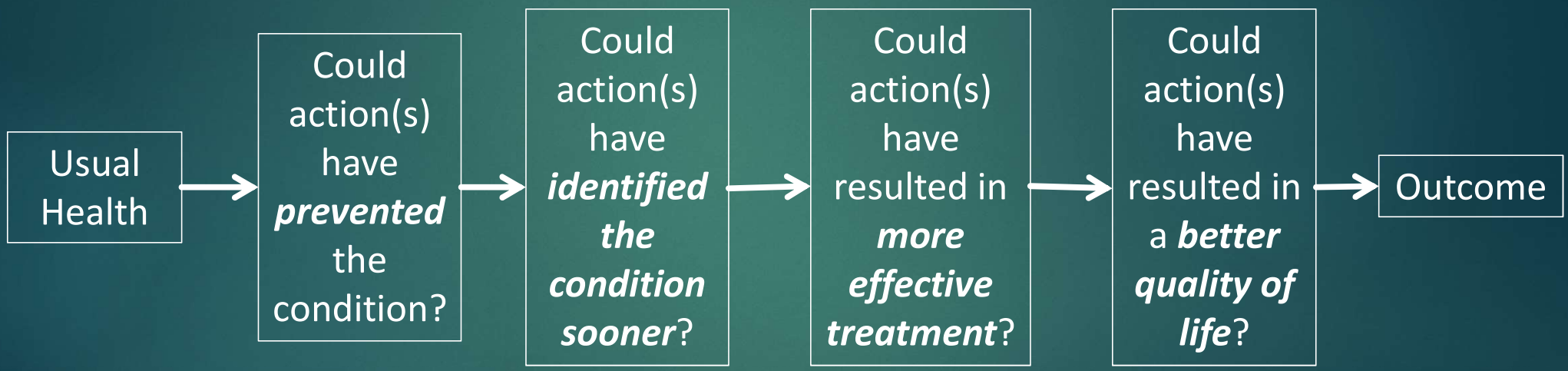
- *Individual* – how might services have been improved for this person?
- *Program/Provider* – What can be learned from this experience in order to improve policies and practices for others?
- *System* - How can we use this process to improve the whole system of supports for persons with I/DD?

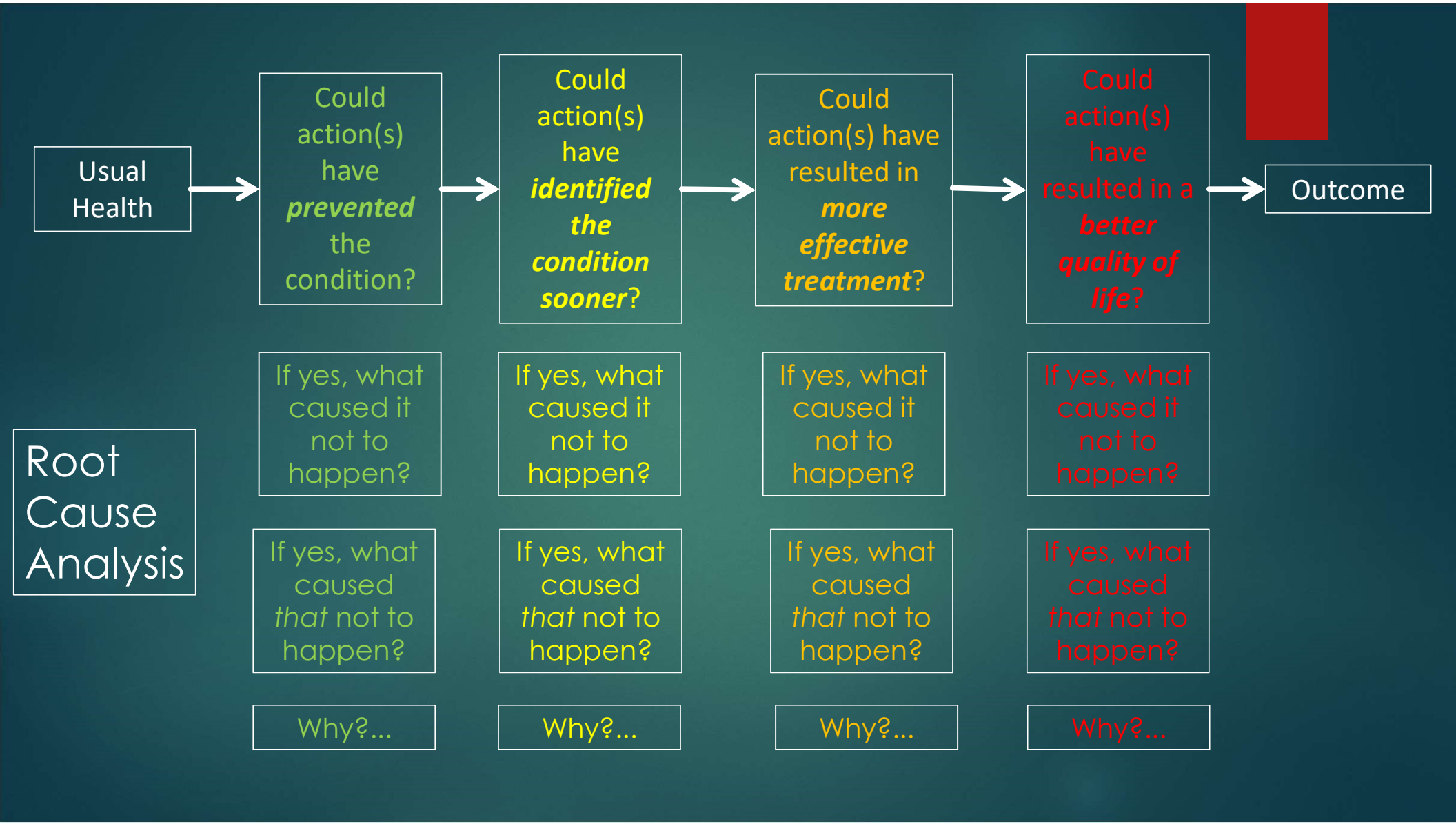
Reflecting to Improve:

- What went well?
- What opportunities do we have for improvement?
- What resources will we need to make changes work?
- What barriers will we face to improve? How will we overcome them?


Underlying Health
• Persons living with I/DD have complex and changeable needs.
Change in Health?
• How to optimize system response to health issues?
Better or Worse?
• Options and Opportunities

Timeline Analysis




Usual Health
Could action(s) have *prevented* the condition?
Could action(s) have ***identified the condition sooner***?
Could action(s) have resulted in ***more effective treatment***?
Could action(s) have resulted in a ***better quality of life***?
Outcome
Root Cause Analysis
If yes, what caused it not to happen?
If yes, what caused it not to happen?
If yes, what caused it not to happen?
If yes, what caused it not to happen?
If yes, what caused *that* not to happen?
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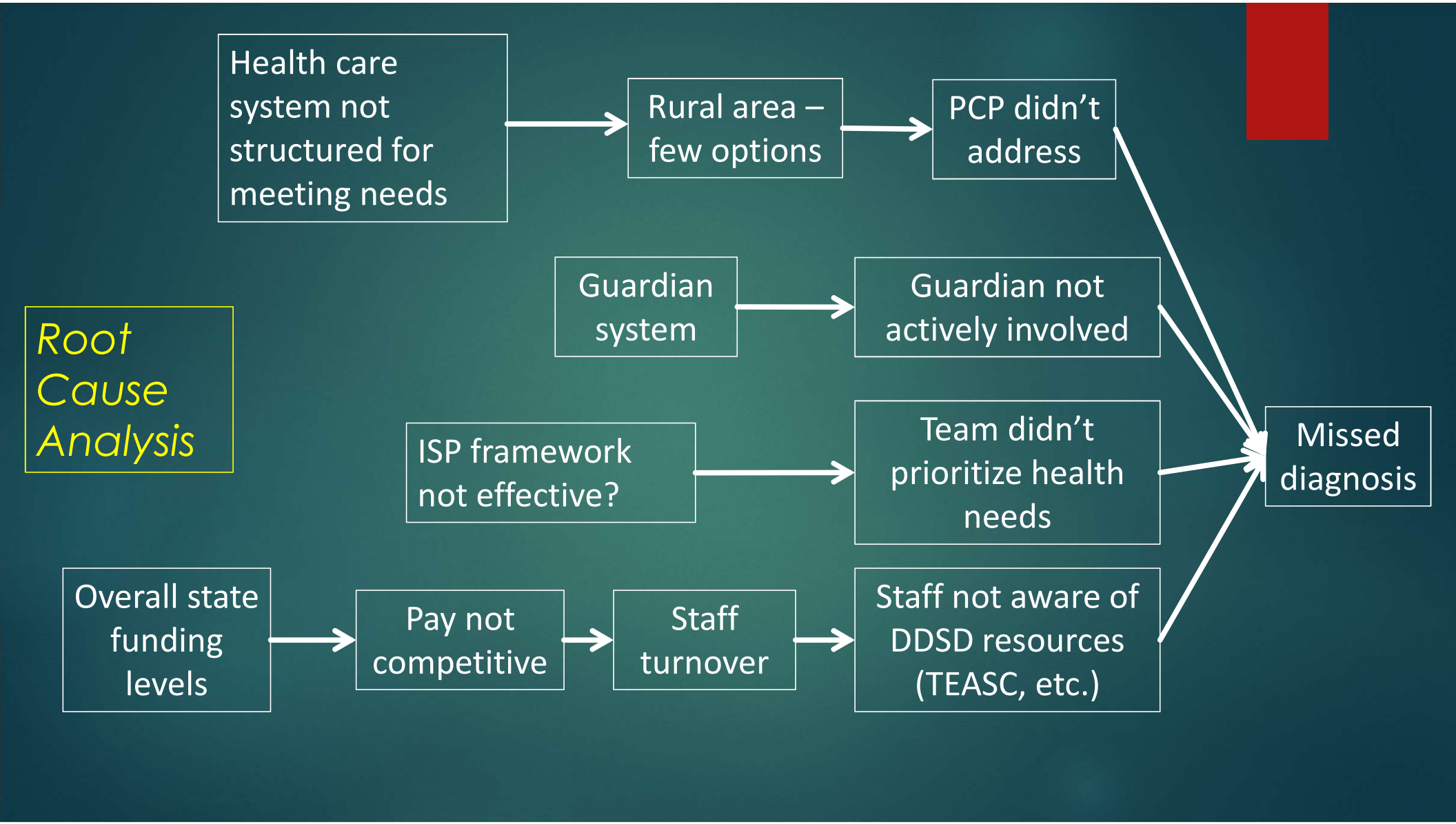
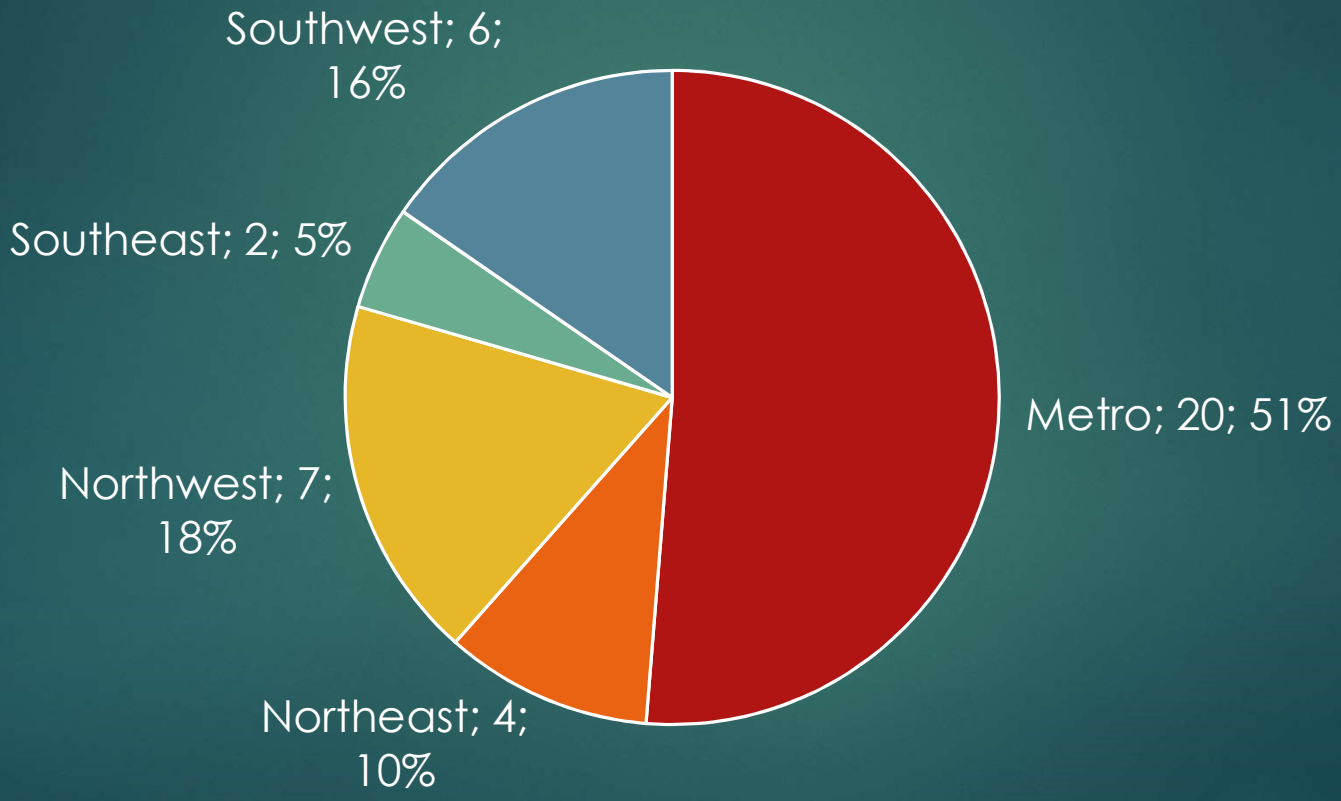
If yes, what caused *that* not to happen?
Why?...
Why?...
Why?...
Why?...


Root Cause Analysis
Health care system not structured for meeting needs
Rural area – few options
PCP didn't address
Guardian system
Guardian not actively involved
ISP framework not effective?
Team didn't prioritize health needs
Overall state funding levels
Pay not competitive
Staff turnover
Staff not aware of DDSD resources (TEASC, etc.)
Missed diagnosis

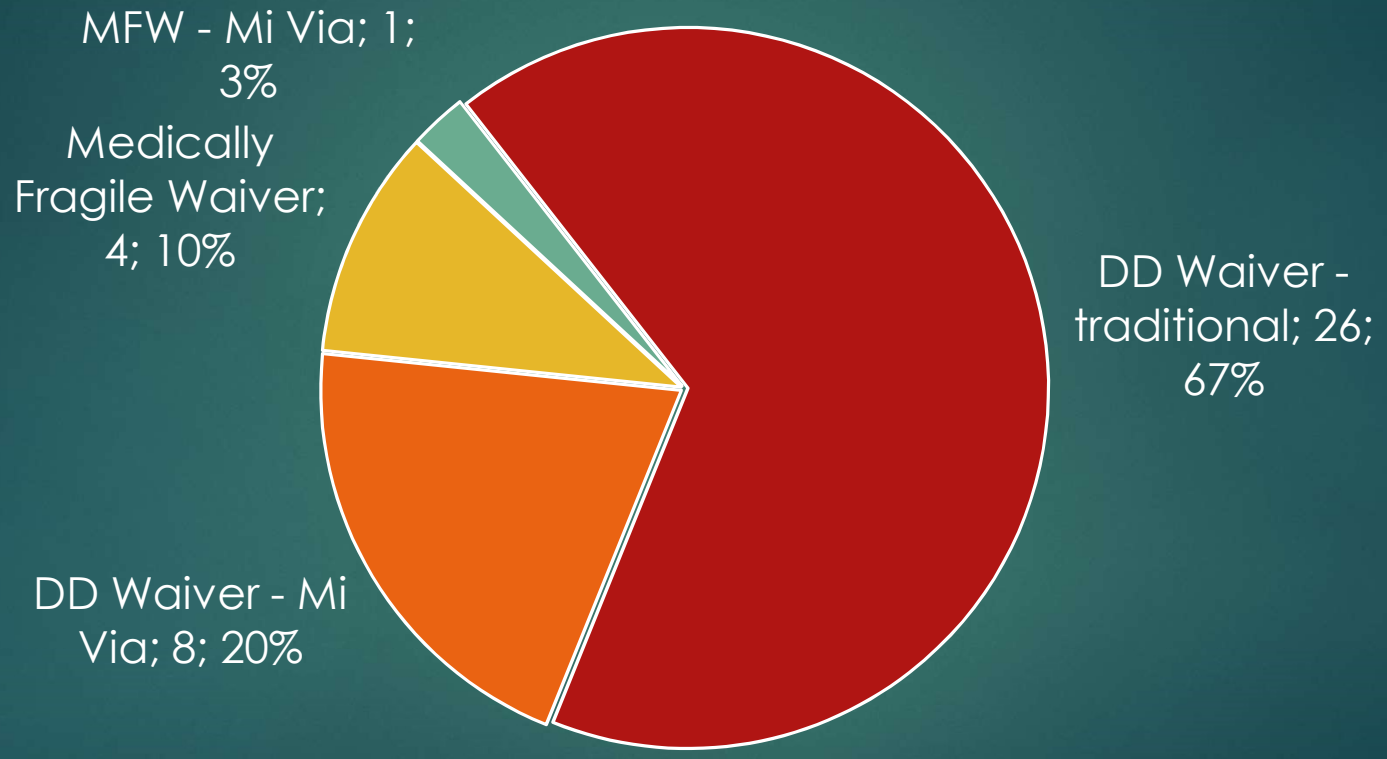
Findings from Mortality Review in New Mexico:

Fiscal Year 2019

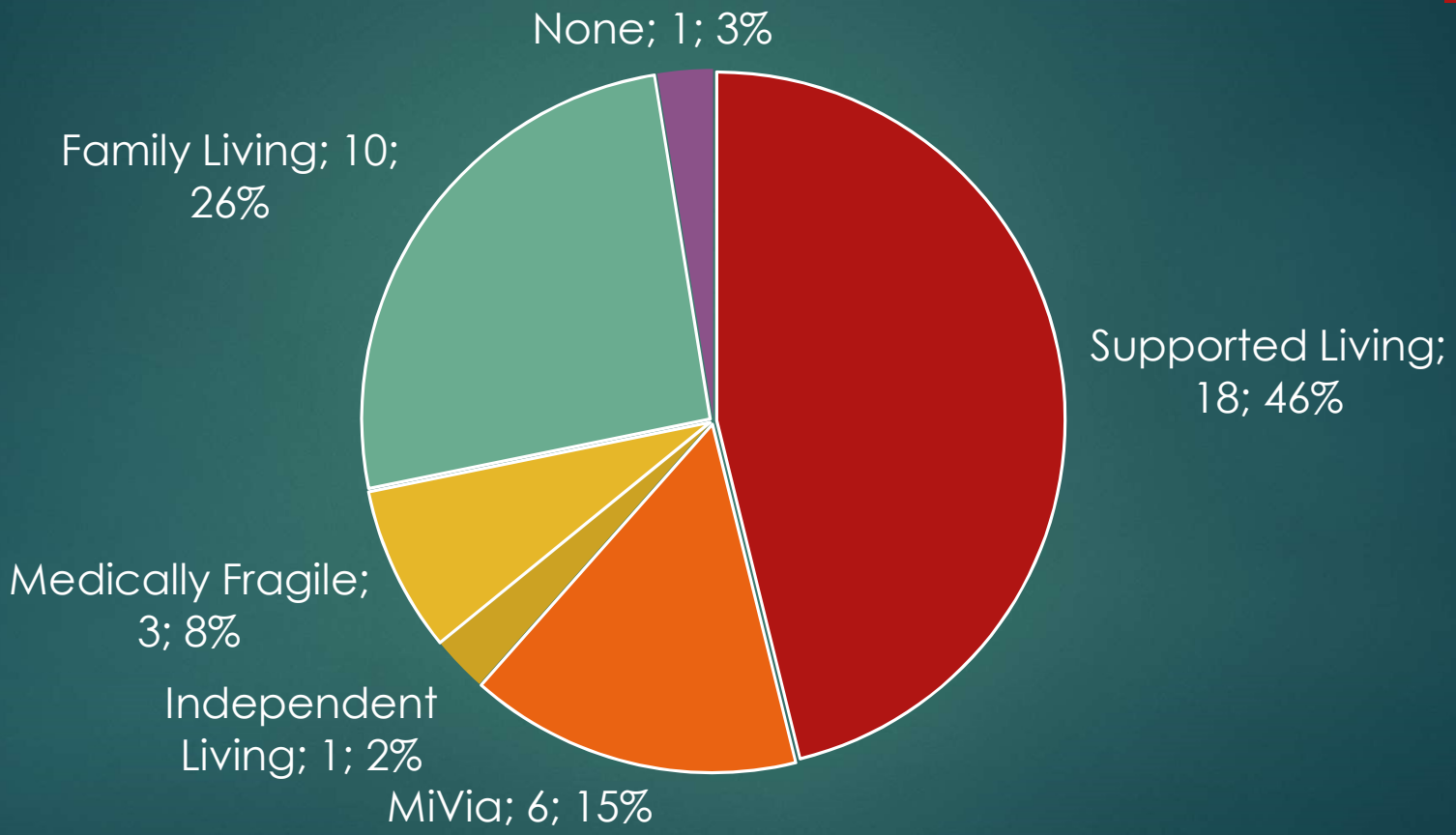
Number of MRC Reviews in FY2019, by DDSD Region in which Person Received Services



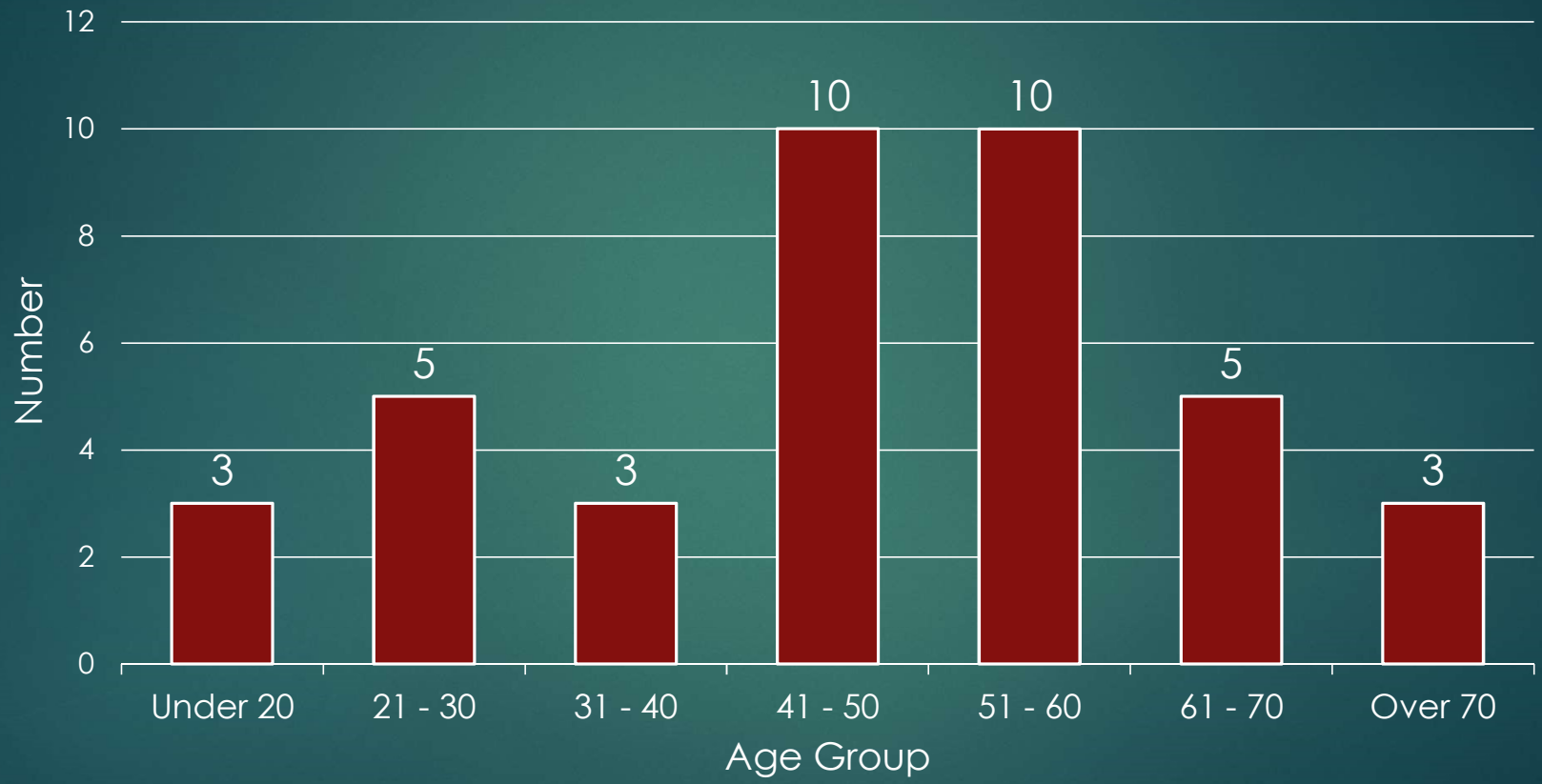
Number of deaths reviewed, by waiver type, FY2019



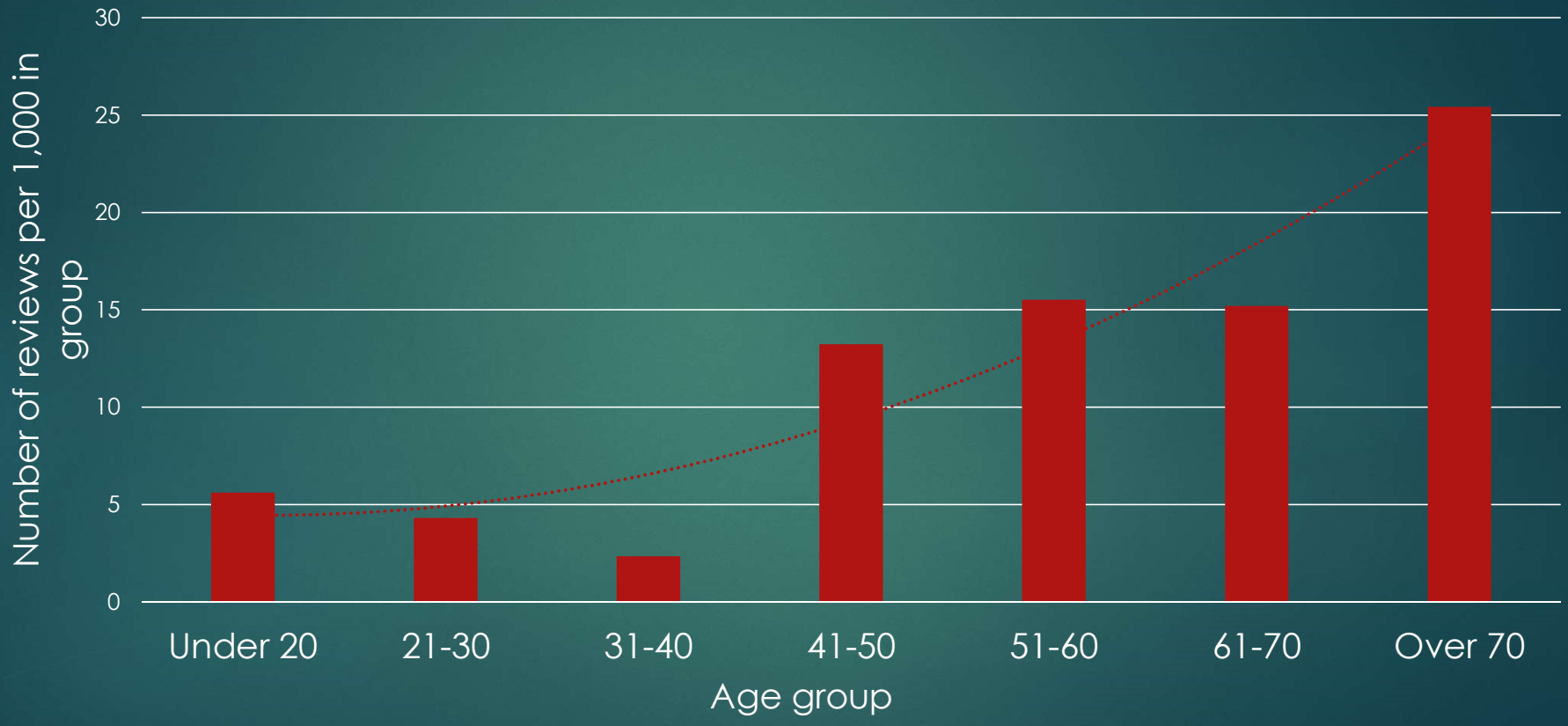
Number of deaths reviewed, by type of services received



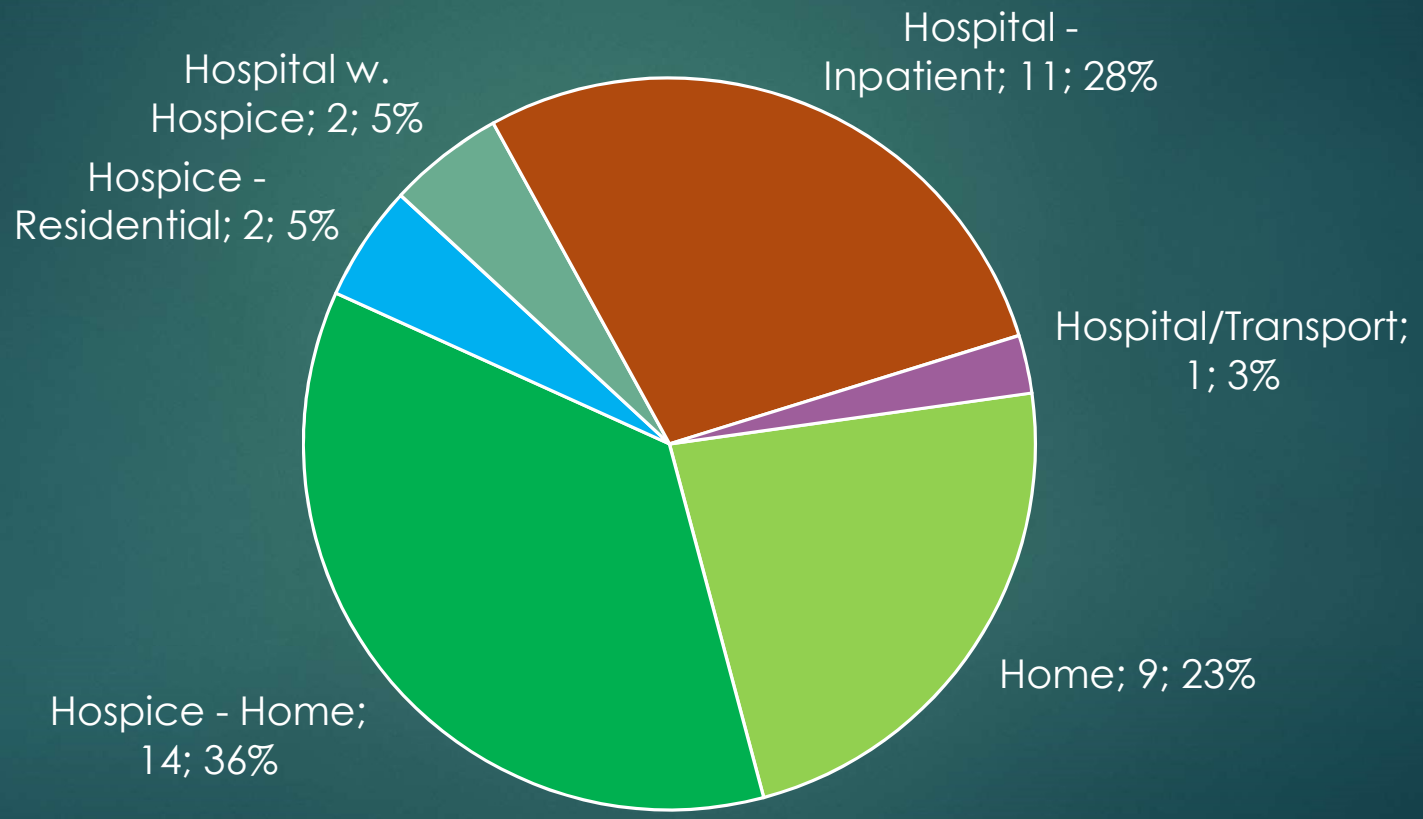
Number of MRC reviews by age at death, FY2019



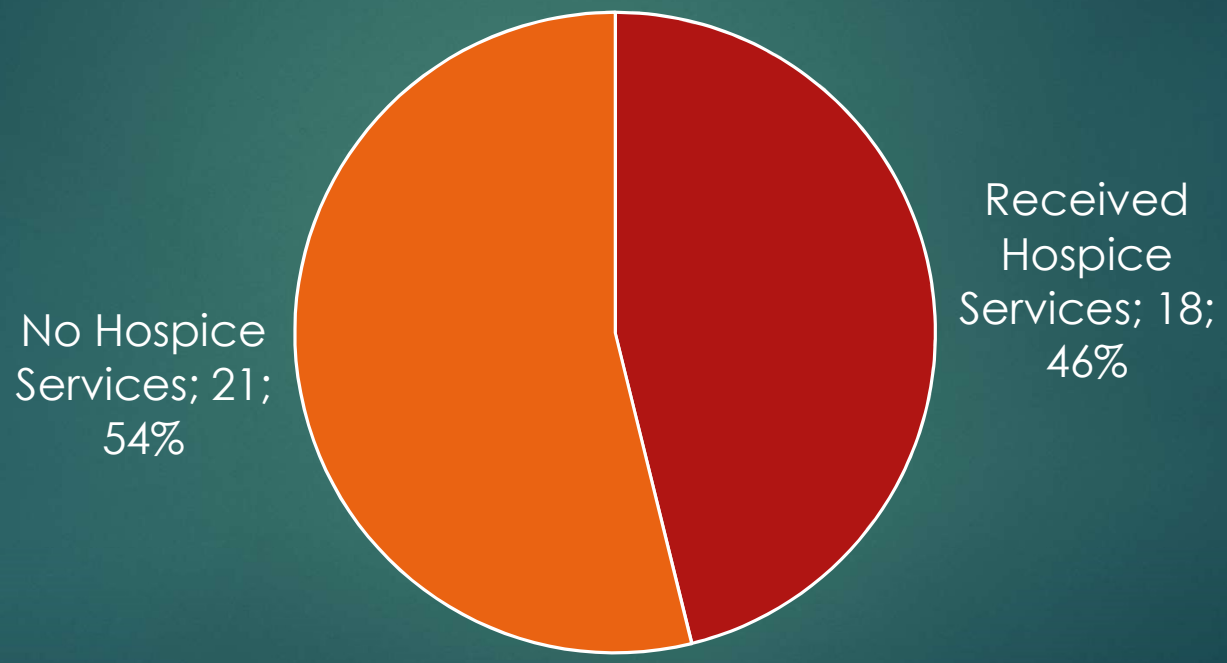
Ratio of MRC reviews to number in age group, FY2019



Place of death for reviewed deaths, FY2019

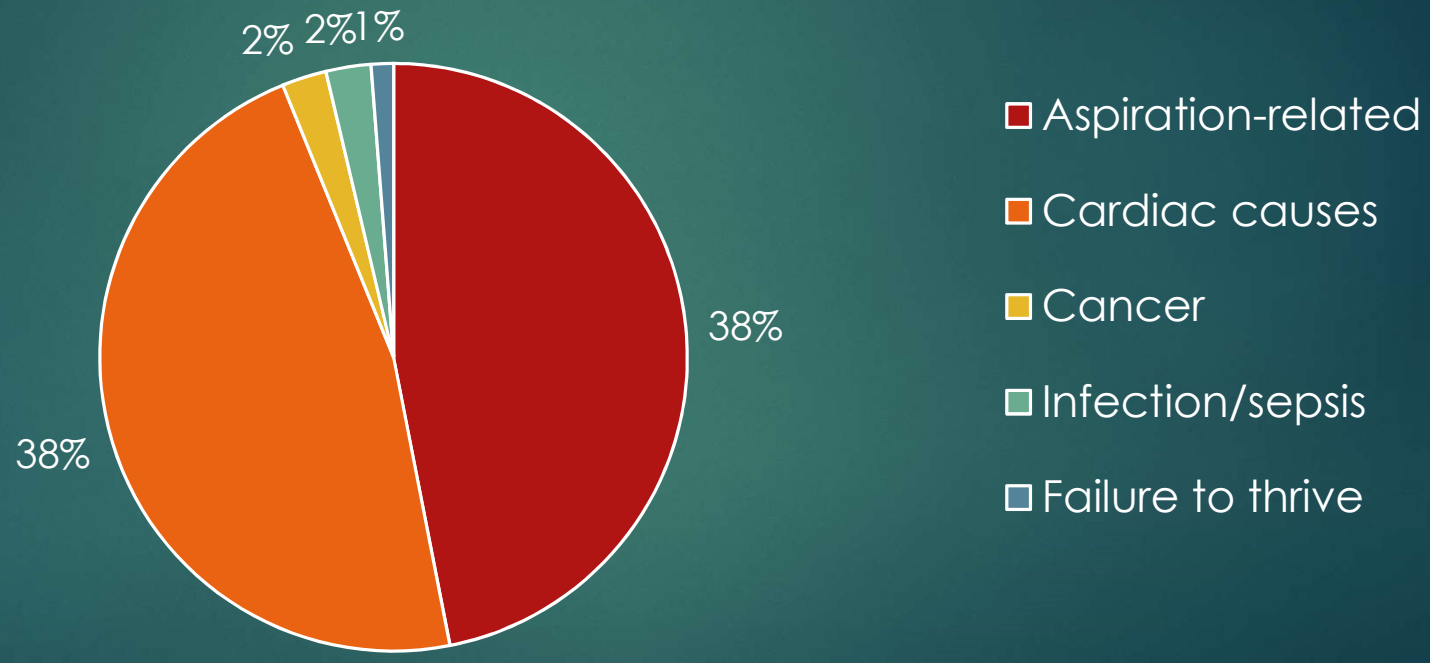


Proportion who received hospice services, FY2019

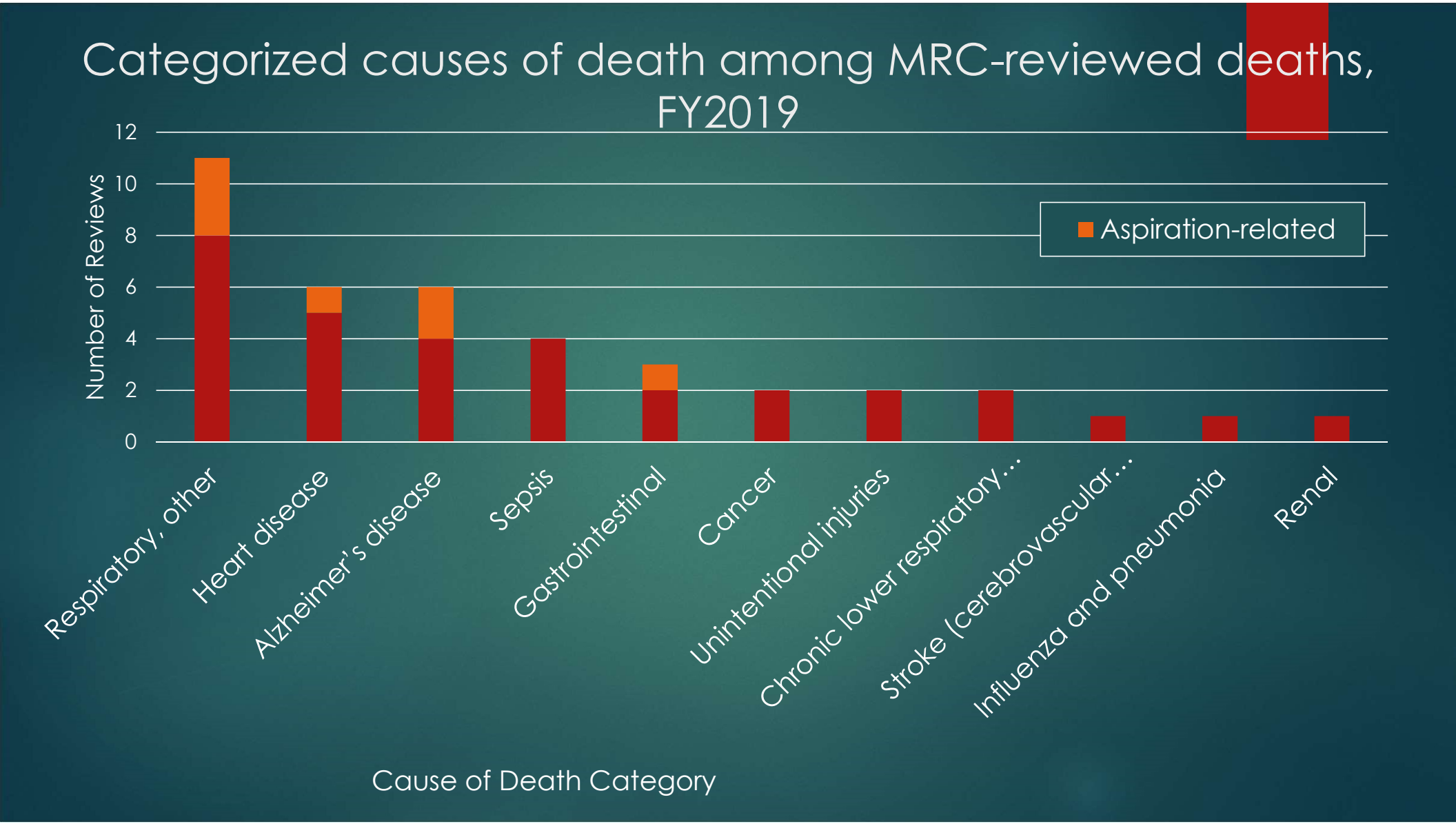


Duration of hospice services, FY2019

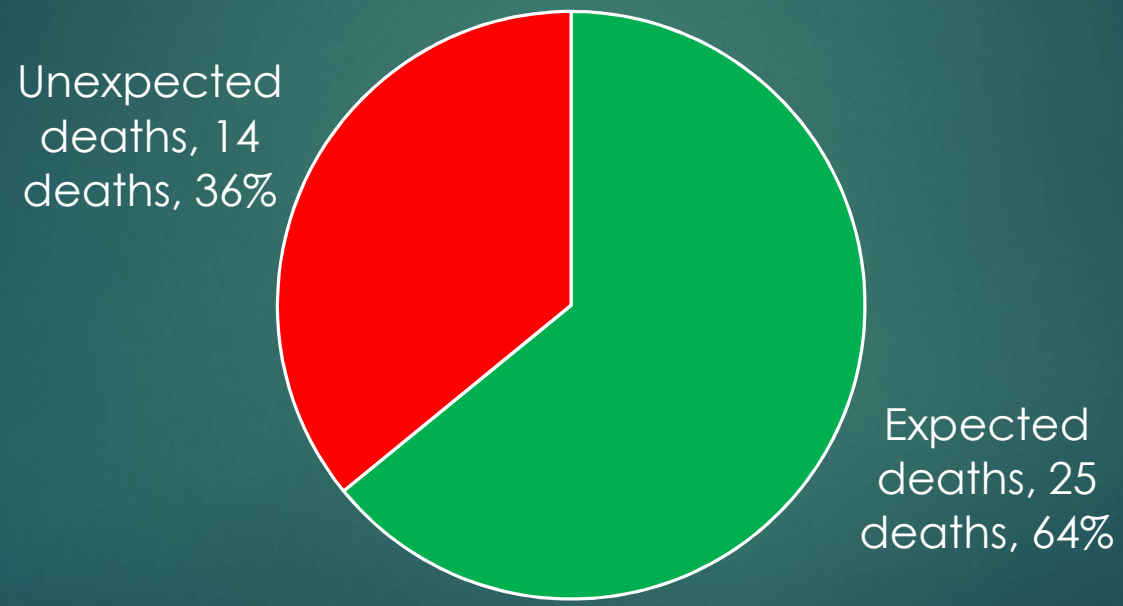
What were the causes of death?



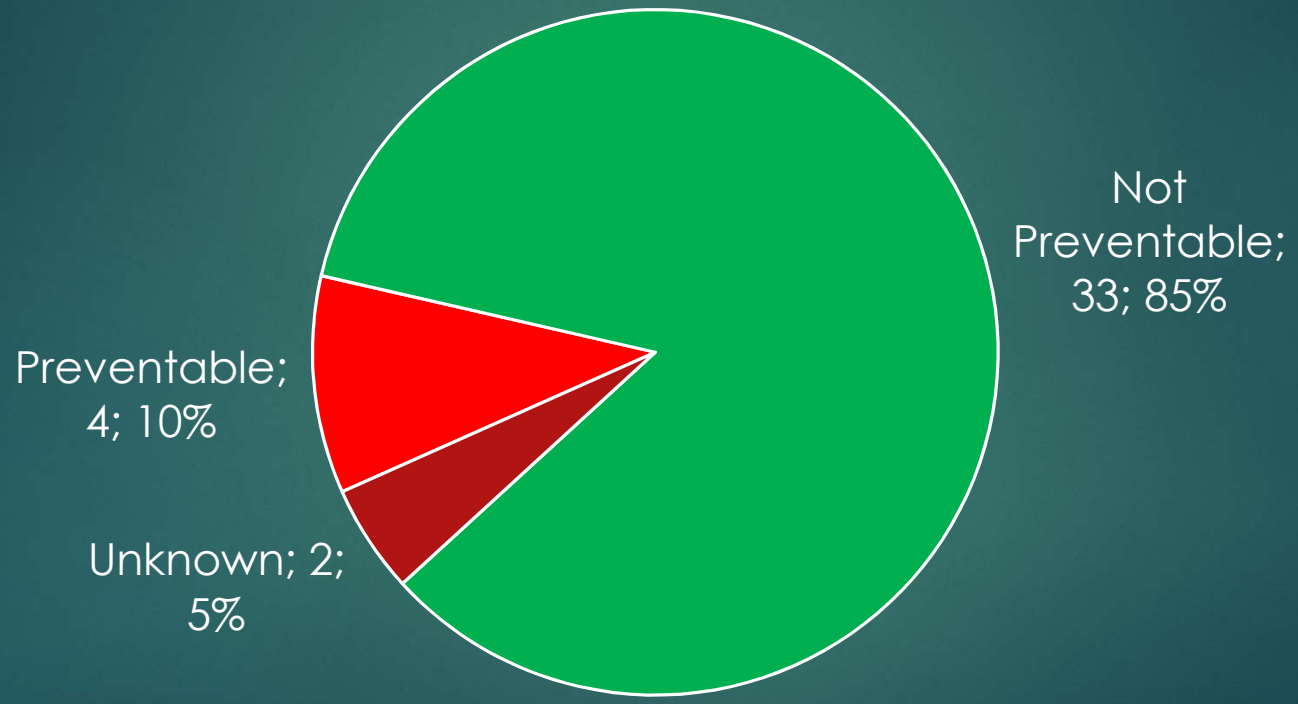
Categorized causes of death among MRC-reviewed deaths, FY2019



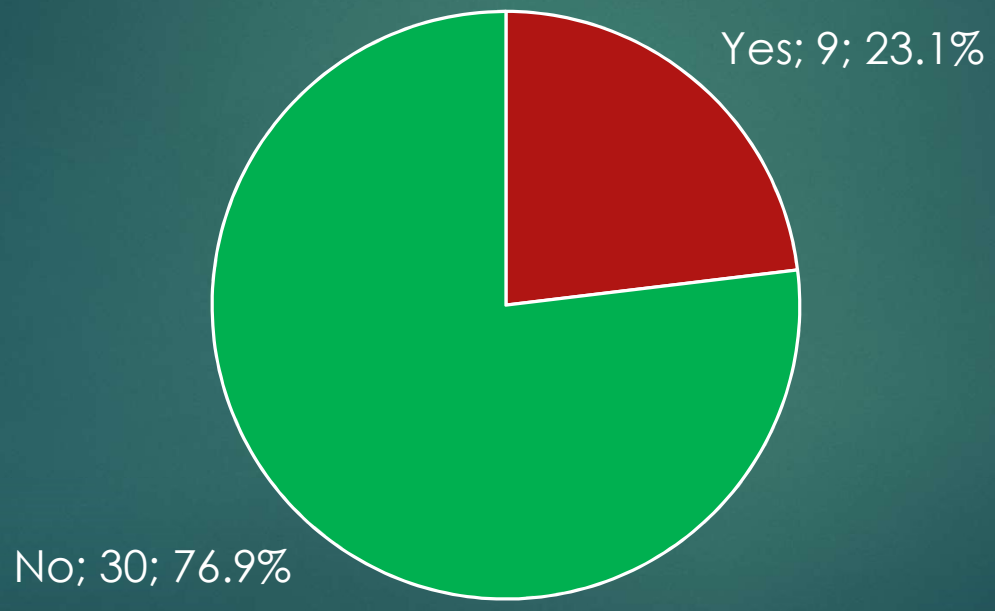
Classification of deaths as expected or unexpected, FY2019



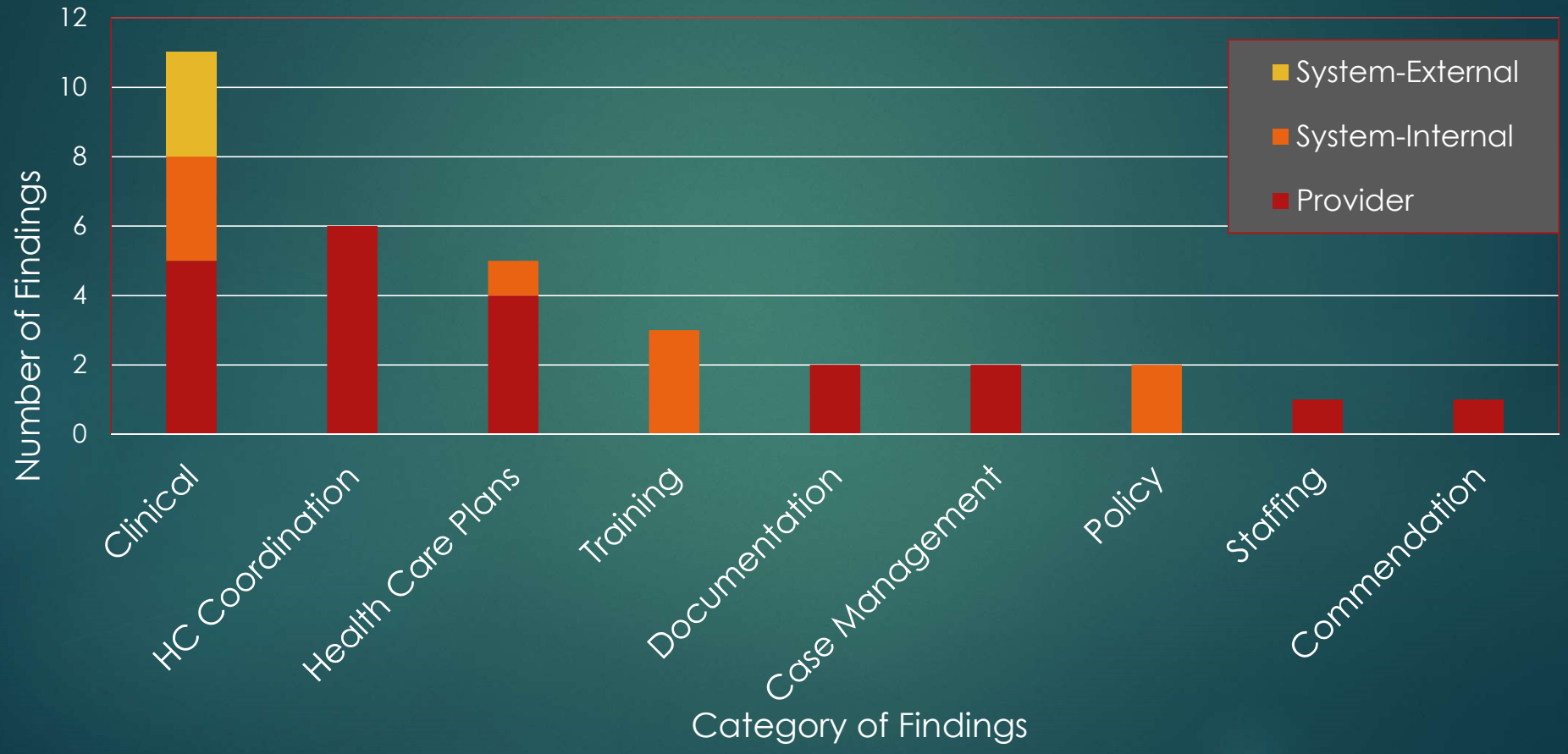
MRC classification of deaths as preventable vs. non-preventable, FY2019

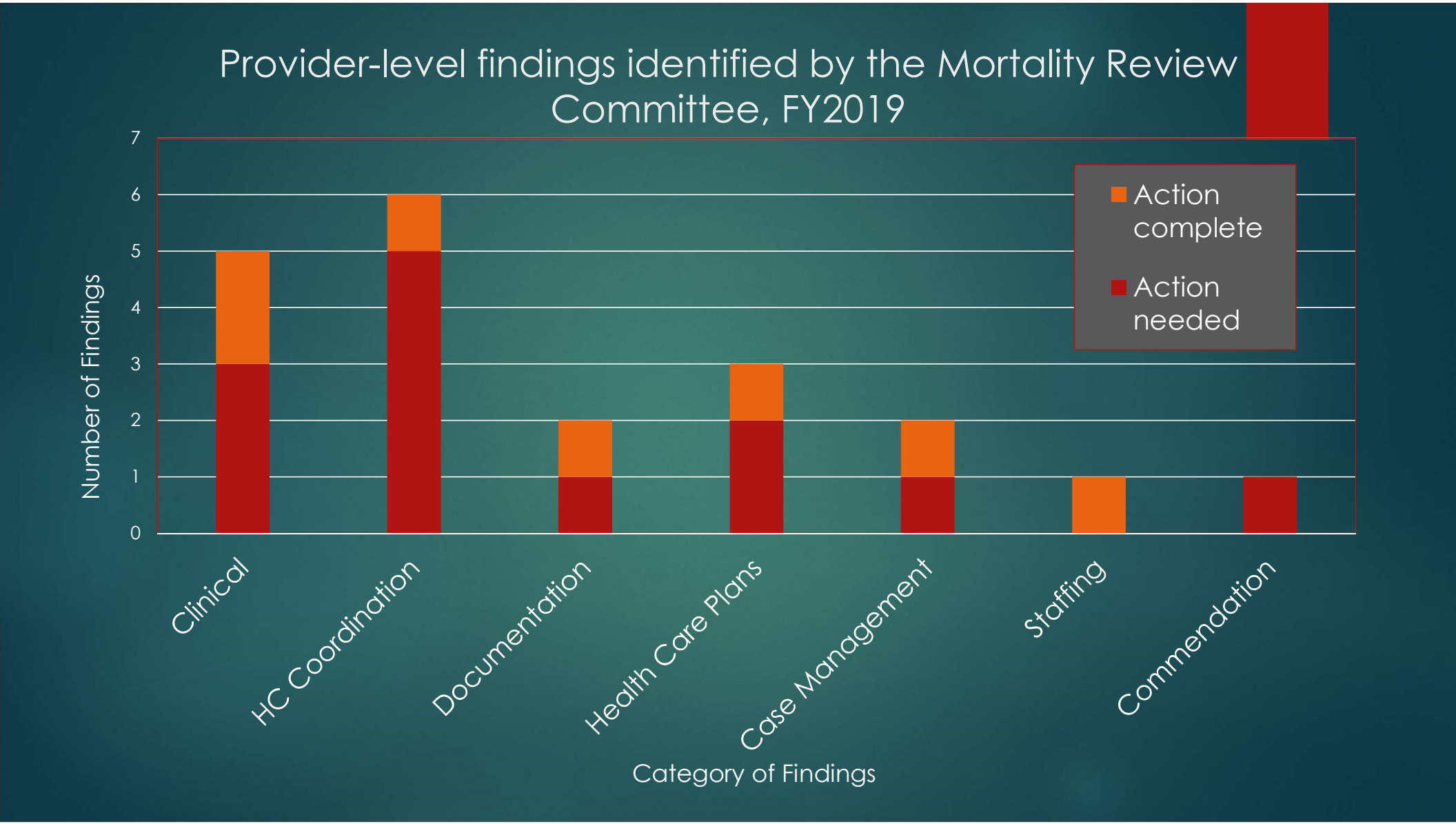


Number of reviews for which MRC identified care issues, FY2019



Overall findings identified by the Mortality Review Committee, FY2019




Provider-level findings identified by the Mortality Review Committee, FY2019
Number of Findings
0
1
2
3
4
5
6
7
Action complete
Action needed
Clinical
HC Coordination
Documentation
Health Care Plans
Case Management
Staffing
Commendation
Category of Findings

Provider-level Findings

- ***Clinical***:
  - Not having or using personal protective equipment for infection control
  - Medication administration, including verifying dosages
  - Identifying changes in health status

- ***Healthcare Coordination***:
  - Need for improved communication between the agency and hospice
  - Coordination of agency and dietitian regarding tube feedings
  - Need for assuring follow-up with specialists and evaluations

- ***Health Care Plans***:
  - Incomplete generation of health care plans to address all and/or new health needs
  - Need for better coordination between provider plans and hospice care plans

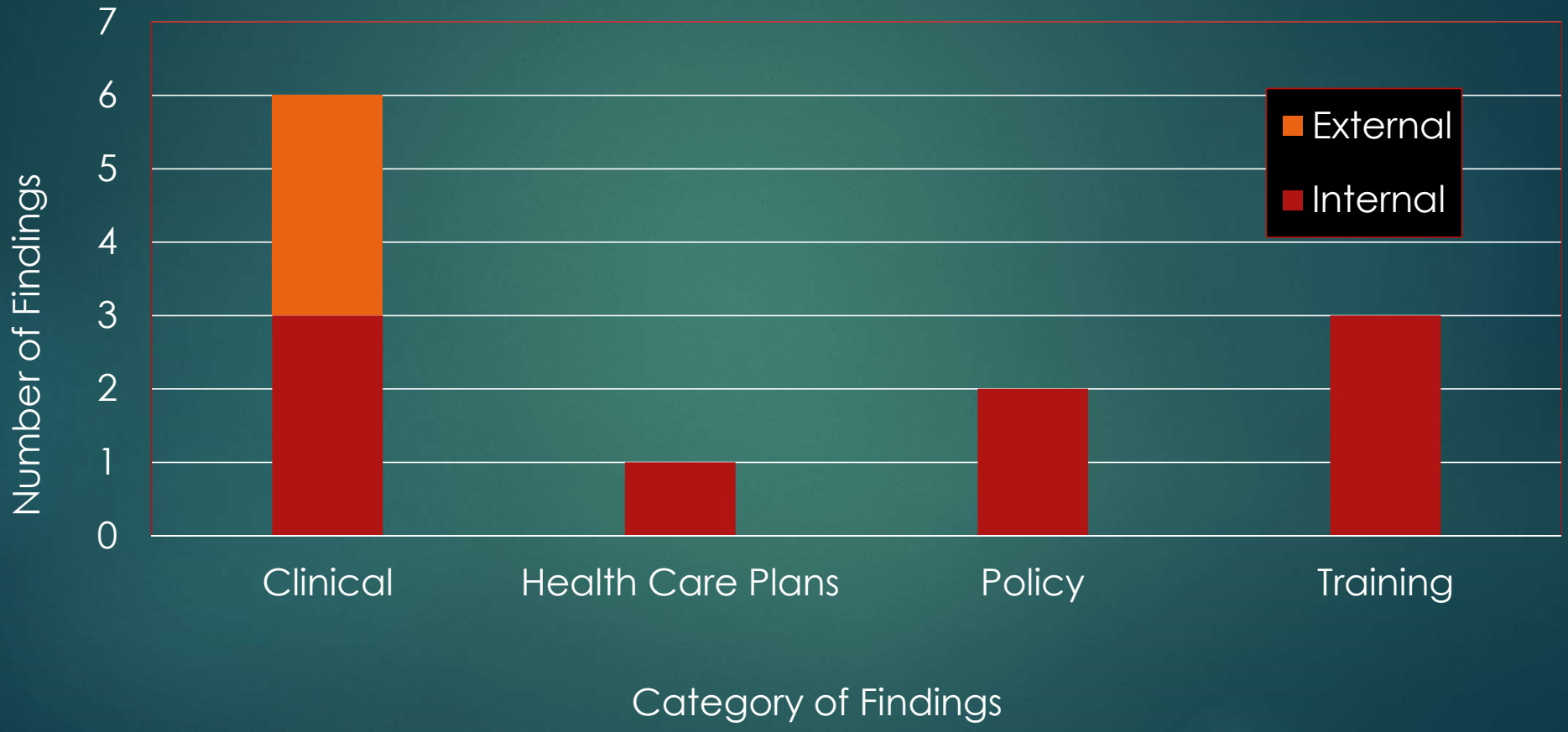
Provider-level Findings, continued

- ***Case Management***:
  - Need for clear documentation of issues (Medically Fragile Waiver)
  - Need for documentation and addressing of changes in condition

- ***Staffing***:
  - There had been nursing and staffing issues at a particular agency

- ***Commendation***:
  - The MRC noted excellent care provided by a person's team, including excellence in responding to challenging factors and frequent care plan changes.

System-level findings identified by the Mortality Review Committee, FY2019



System-level findings

Clinical:

- Need for assuring adequate pain control
- Need to improve identification of risk for pressure ulcers
- Need to increase awareness by MCOs of Waiver resources for hospital sitters.
- Need to address medication continuity at times of staff turnover.
- Need to assure safe use of bed rails
- Concern that the diagnosis of Failure to Thrive may have been used to initiate hospice without adequately assessing underlying diagnosis.

Health Care Plans:

- Need to avoid delays in using 911 system during medical emergencies
- Need to assure development of health care plans for chronic conditions.

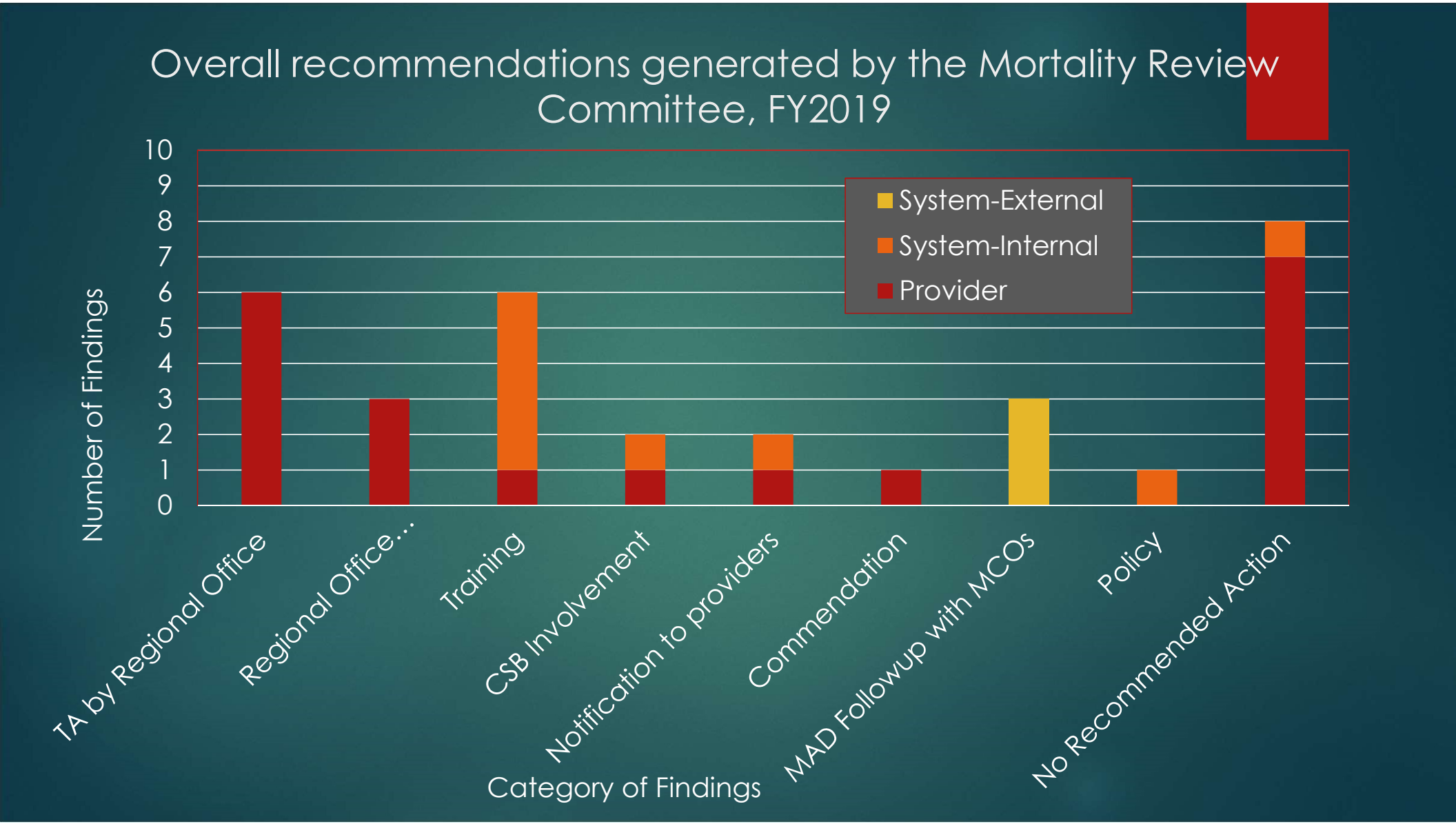
System-level findings, continued

Policy:

- Need to increase appropriate utilization of resources for hospital sitters when needed.
- Need for clarification of Departmental position if a provider is not supporting an individual's DNR order.

Training:

- Broad training regarding OSHA requirement for use of personal protective equipment.
- Providing resources on dementia to both DD Waiver and Mi Via providers
- Assuring that providers are aware of availability of nutrition services.


Overall recommendations generated by the Mortality Review Committee, FY2019
Number of Findings
10
9
8
7
6
5
4
3
2
1
0
System-External
System-Internal
Provider
TA by Regional Office
Regional Office…
Training
CSB Involvement
Notification to providers
Commendation
MAD Followup with MCOs
Policy
No Recommended Action
Category of Findings

System Recommendations

- Training
  - Clinical care – skin ulcer management, dementia, use of PPE
- Clinical Services Bureau – Health Alert
- Notifications to Providers
  - Need for comprehensive health care plans
  - Availability of nutrition services
- Policy – clarification regarding DNR policy
- Follow-up with MCOs:
  - Pain management
  - Use of Failure to Thrive diagnosis
  - Inform of resources available for in-hospital sitter services

How is a mortality review actually done?

Mortality Review Process

- **Obtain records for 12 months**
  - supported- and family-living staff and administrative records,
  - medical and hospital records,
  - case management records,
  - therapist records,
  - investigations conducted by the Department's Division of Health Improvement
  - Office of the Medical Investigator,
  - Interdisciplinary Team meeting records
  - Other records deemed pertinent.
- **Record-based Review**:
  - A record-based review is conducted by either a DDSD nurse or a contracted registered nurse through the UNM Continuum of Care Project.
  - For deaths that occur among Jackson class members, an external, physician-level review is also conducted
- **Summaries are reviewed, then sent to Mortality Review Committee**
- **Mortality Review Committee reviews each case and identifies findings and recommendations**

Mortality Review Template

DRAFT TEMPLATE - 3

Mortality Reviews Report: Date received:

I. Identifying information:

SSN:	**Gender:**	**Age at death:**	**Jackson class:**
DOB:	**DOD:**	**Site of death:**	**Region:**
Clinical cause of death:			
Cause of death by autopsy:	**Death Certificate#_____**	**Autopsy: N**	**OMI#_____**
Primary Care Provider:			
Consultants/other key providers:			

Mortality Review Template, continued

II. Source Documents: (Specific date ranges)

- Problem list(s)
- Medication list(s)
- Reports from specialists/consultants
- Hospitalization/Emergency Room reports
- List and reports of surgeries and other invasive procedures/interventions
- Primary care provider reports/progress notes
- Residential care staff reports
- Previous medical records from ICF/MR institution (if available)
- Laboratory/radiology reports

Mortality Review Template, continued

III. Case summary: General Health and Life History

- Chronological summary of events leading to time of death (up to one page)

IV. Autopsy Report (etc.):

- Listed cause(s) of death: primary, secondary, associated…
- Findings summarized from OMI report, autopsy, and death certificate.

V. Assessment

- **Biological factors**: contributing medical factors leading to death; genetic predispositions and conditions; natural history of any diseases; epidemiologic information.
- **Preventive health practices**: risks; lifestyle choices; individual and team efforts to achieve specific or general goals.
- **Documentation**: consistency (comprehensive, gaps, major omissions, contradictions in recommendations); completeness (thoroughness); quality (superficial v. in-depth, tangential, generic or non-individualized).
- **Appropriate application of ethical principles**: person-centered; evidence of informed consent; respect for autonomy; non-malfeasance.
- **Standards of medical care adherence**: which standards were identified and followed; reference relevant literature.
- **Communication and healthcare coordination**: addressed overt examples of lapses in communication of essential health information; examples of excellent health communication and HC coordination.

Mortality Review Template, continued

V. Assessment, continued

Category of death: (Select relevant categories)

- Expected or Unexpected?
- Preventable or Not-Preventable
- Abuse or neglect-related?
- Occurred in spite of appropriate care?
  - Or, identify significant issues regarding care

Mortality Review Template, continued

VI. Recommendations:

- Summary points
- Measurable/outcome-changers
- Anticipate training opportunities/applications

The New Mexico Department of Health's DD Mortality Review Process

- Mortality Review Committee
  - Strict Confidentiality
  - Meets at least monthly to review mortality reviews
  - Multidisciplinary –
    - Nursing, Medical, Case Management, DDSD Management
    - Most members are from DDSD and DHI
    - Now also includes a representative from the Governor's Commission on Disability

DD Mortality Review Process, continued

- All members review reports of review and discuss to identify care issues and potential need for QI.
- Timelines and root cause analysis are prepared as needed
- The core function is to make recommendations to the Department regarding opportunities for system-wide quality improvement.

Break

The Four BIG Questions

- Was there a better way to RECOGNIZE the issue?
- Was there a better way to PLAN?
- Was there a better way to ACT?
- Was there a better way to COMMUNICATE?

Adapted from S. Staugaitis and E. Lauer, *Mortality Review and Reporting in DD*, UDiscovering, 2015.

Was there a better way to RECOGNIZE the issue?

- Is there evidence that a medical, health, behavioral, environmental or other physical or social risk that contributed to an avoidable death was not identified in time to take preventive action?

- If so, note what was not recognized as a major risk factor and **WHY**.

Adapted from S. Staugaitis and E. Lauer, *Mortality Review and Reporting in DD*, UDiscovering, 2015.

Was there a better way to PLAN?

- Is there evidence that a medical/health, behavioral or other physical or social risk that contributed to the death was identified but not adequately addressed in the person's plan of care and support?

- If so, note what was not included in the plan and **WHY**.

Adapted from S. Staugaitis and E. Lauer, *Mortality Review and Reporting in DD*, UDiscovering, 2015.

Was there a better way to ACT?

- Is there evidence that an intervention or care, service or support action prior to the death could have prevented the death from taking place?

- Note the type of action and possible reasons **WHY** it did not take place?

Adapted from S. Staugaitis and E. Lauer, *Mortality Review and Reporting in DD*, UDiscovering, 2015.

Was there a better way to COMMUNICATE?

- Is there evidence that inadequate or poor communication may have contributed to the death?
- If so, was it client-to-staff, staff-to-staff, clinician-to-clinician, etc.?
- Or, was it related to inadequate documentation, issues of supervision, problems with management or organizational leadership, etc.?
- Note possible causes **WHY** there were these communication issues.

Adapted from S. Staugaitis and E. Lauer, *Mortality Review and Reporting in DD*, UDiscovering, 2015.

The WHYs are important, but not for finger-pointing.

Understanding WHY something happened (or didn't) helps to:

- Identify issues
- Develop prevention strategies
- Disseminate findings
- Monitor action plans

IN OTHER WORDS, asking WHY helps us continue to find BETTER WAYS to serve our clients.

Mortality Review

Case Study

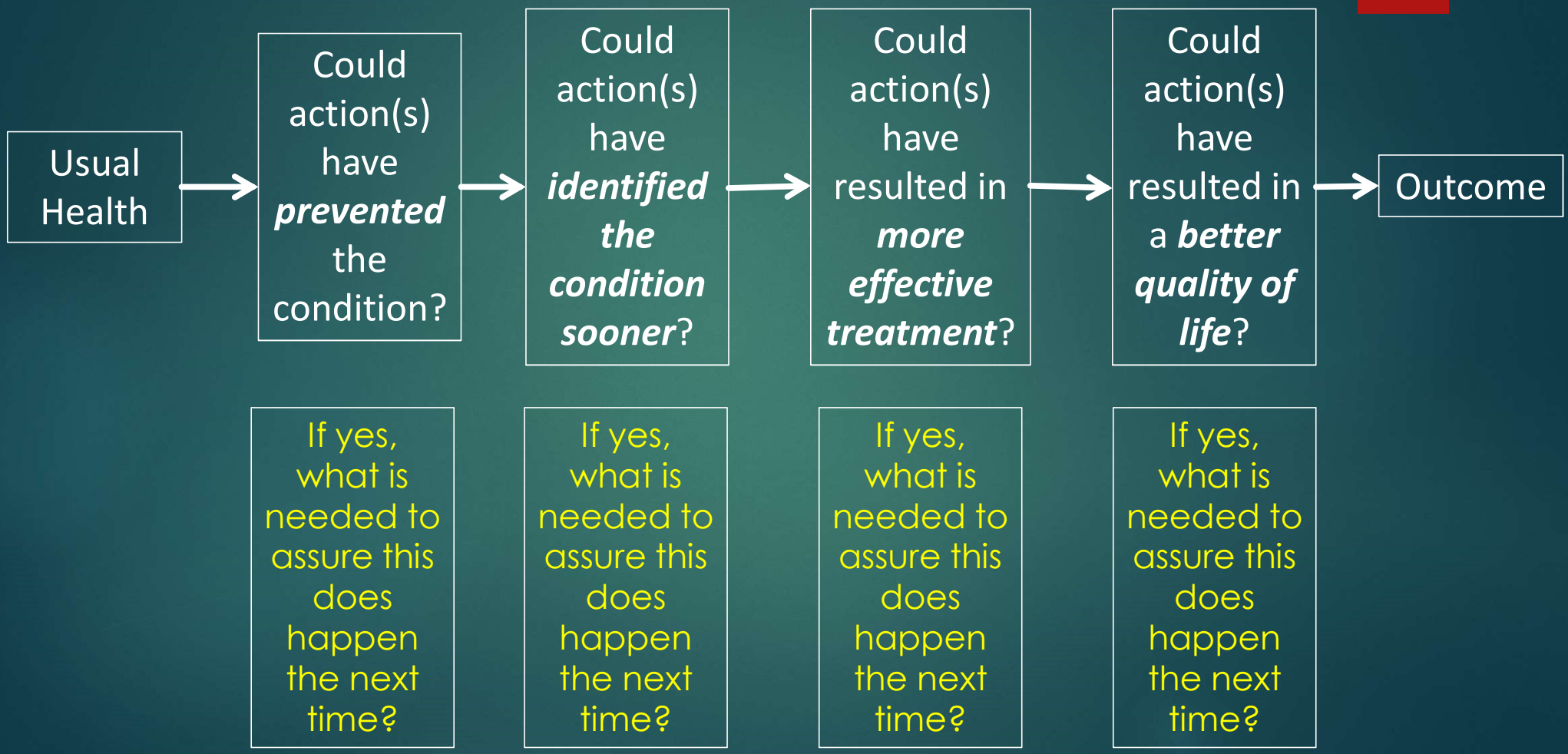
Discussion –

What changes would help in the future?

The Four BIG Questions

- Was there a better way to RECOGNIZE the issue?
- Was there a better way to PLAN?
- Was there a better way to ACT?
- Was there a better way to COMMUNICATE?

Root Cause Analysis for Quality Improvement:



Thank You for All You Do!

Contact Information:

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