

6002-M MORTALITY REVIEW PROCESS

REVISION DATE: 11/29/2017, 3/2/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 11-597

The purpose of this policy section is to improve quality of care for members by a systematic examination of deaths.

Notification Procedure

When a death is reported to a Support Coordinator, the Support Coordinator will complete the *Incident Call Report (DDD-1746A FORFF)* and submit to the District Quality Unit's Incident Report mailbox for entry into the Incident Management System (IMS) database within 48 hours of notification of a death.

Once the Support Coordinator is alerted to an incident, he/she must notify the responsible person or next of kin, if they have not already been notified. The Quality Assurance Manager or designee must immediately notify the appropriate District Manager or designee within 24 hours of the Division's notification of a member's death. All service authorizations must be closed in Focus with the date of death as the effective date by the Support Coordinator. Support Coordination (Department of Child Safety) and Bereavement Counseling offered to the family may remain authorized after the Division was notified of the death. If staff becomes aware of any service utilization after the date of the member's death, staff should report the service utilization into the IMS.

If Health Care Services (HCS) staff is notified of a death, HCS staff must notify the Central Office on-call person within 24 hours.

The District Manager or designee must notify:

- The Assistant Director/designee or the Division's on-call line within 24 hours of being notified of a death
- The Adult Protective Services or Department of Child Safety agency as required by statute.
- The Human Rights Committee District liaison.

Central Office designees will notify the Department of Administration (DOA) Risk Management, if the death may give rise to a liability claim against the state.

Review Procedure

A. District Review

1. The Support Coordinator and his/her supervisor must jointly review all deaths within 30 days, to identify apparent issues relating to care or cause of death.

2. The Support Coordinator or designee must enter the following information and answer the following questions, as applicable relating to the death, into the IMS database:
 - a. Member's underlying primary medical conditions
 - b. Detailed circumstances of the death: Date of Death. What happened? Where did it happen? Was a provider present? Did providers follow policy such as calling 911 and performing CPR? Had the member been ill? Was the member recently seen by PCP? What symptoms of illness did the member have? What is the suspected cause of death (if known)?
 - c. Was hospice involved?
 - d. Did the member have an Advance Directive in place?
 - e. Had Department of Child Safety/Adult Protective Services (DCS/APS) been involved within the last year?
 - f. Is there litigation pending?
 - g. Is there further fact-finding pending?
 - h. Was the family/guardian notified?
 - i. Did the Division offer support/grief counseling for the family?
 3. The District must send the primary case file to Central Office Health care Services within 60 days after being notified of the death.
- B. Health Care Services Quality Assurance Investigative Nurse (HCS QA Nurse) Review
1. The Health Care Services Quality Assurance (QA) Nurse reviews the mortality information documented in the IMS database and requests further information, as necessary.
 2. The Chief Medical Officer assigns the death into one of the following categories:
 - Level A These include deaths that are expected and/or anticipated, due to natural causes, such as terminal illness or congenital anomalies. Level A deaths typically would also include members who lived with family or independently and were not receiving any services from the Division at the time of death.
 - Level B These include deaths that are not expected and/or are sudden, such as trauma or pneumonia that progresses to respiratory failure. These deaths require a closer inspection into the circumstances surrounding the death and assessment of any systemic issues which should be addressed. Other situations where Level B is indicated include: aspiration, coroner cases, law enforcement/9-1-1 calls, decubitis, methicillin-resistant staphylococcus aureus (MRSA), unexpected circumstances, unusual or suspicious circumstances, and

problems with emergency or other medical care.

- C. The HCS QA Nurse must:
 - 1. Request death certificates and when indicated, autopsy reports.
 - 2. Gather additional medical records for review when indicated.
 - 3. Track mortality information in a database specifically designed to collect information related to member deaths.
- D. The Chief Medical Officer must:
 - 1. Communicate via IMS the status of the mortality review and when the case is considered closed.
 - 2. Share any recommendations in the summary.
- E. Based on the information reviewed by the Chief Medical Officer, cases will be selected from the Level B deaths to present to the Mortality Review Committee at their next quarterly meeting; the selected cases warrant additional review by the Committee and demonstrate situations where systemic improvement may be made.

Mortality Committee Review

- A. The Mortality Review Committee must:
 - 1. Discuss each case selected and identify changes to practice, training, or processes that may positively affect care and treatment.
 - 2. Report in writing their recommendations to the Management Team.
- B. The Management Team must, within 30 days of receiving a recommendation from the Mortality Review Committee, report their disposition and intended steps to respond to recommendation(s).
- C. Following the Mortality Review Committee review, the case must be closed unless it is referred for Level C review.

Review Level C – Root Cause Analysis Review

- A. The Chief Medical Officer must arrange the Root Cause Analysis, which must follow the general protocols recommended by the Joint Commission on Accreditation of Health Care Organizations, and must be conducted on cases recommended to the Assistant Director by the Mortality Review Committee or as requested by the Assistant Director.
- B. No more than three Root Cause Analyses must be conducted in a fiscal year.
- C. The HCS QA Nurse must monitor the implementation of recommendations from a Root Cause Analysis.

Process

- A. The Mortality Review Committee must meet at least quarterly.
- B. The Chief Medical Officer must issue annually a Mortality Review and Analysis that will aggregate, analyze, and summarize mortality data and actions taken for system improvements.
- C. The HCS QA Nurse is responsible for monitoring the mortality review process and conducting integrity checks, including protecting any privacy rights of the deceased.
- D. Autopsies must always be requested for children in foster care. For all other deaths, requests must be made whenever it is possible that something can be learned about the death. Consent for an autopsy rests with the responsible person or next of kin, unless the county attorney or coroner is involved.

The HCS QA Nurse requests:

- 1. An autopsy from the county medical examiner

Arizona Revised Statute 11-597 provides for county medical examiners to complete an autopsy and outlines when this is required.
 - 2. Authorization for an autopsy from the family (when the medical examiner does not identify a need for an autopsy)

The Division can request the family to authorize an autopsy, at the expense of the Division, when the Division's Chief Medical Officer believes there are unanswered questions surrounding the death.
- E. Death Certificates will be requested by the HCS QA Nurse.
 - F. Reviewers and all others involved with these processes must in all cases exhibit compassion and sensitivity to next of kin, caregivers, and others who cared about the member.