Transforming Lives

DDA Mortality Review Overview

December 2020

Washington State Department of Social & Health Services
Transforming lives

PO Box 45310, Olympia, WA 98504 | www.dshs.wa.gov

Background

In 2018, DDA completed a self-assessment improvement project following recommendations from federal oversight agencies related to state incident management and mortality review systems.

In January 2019, DDA changed the mortality review process based on the project's workgroup recommendations. The goal is to streamline the process and review all deaths within scope in a timely manner in order to make system changes and improve quality of the services we provide to individuals.

Scope

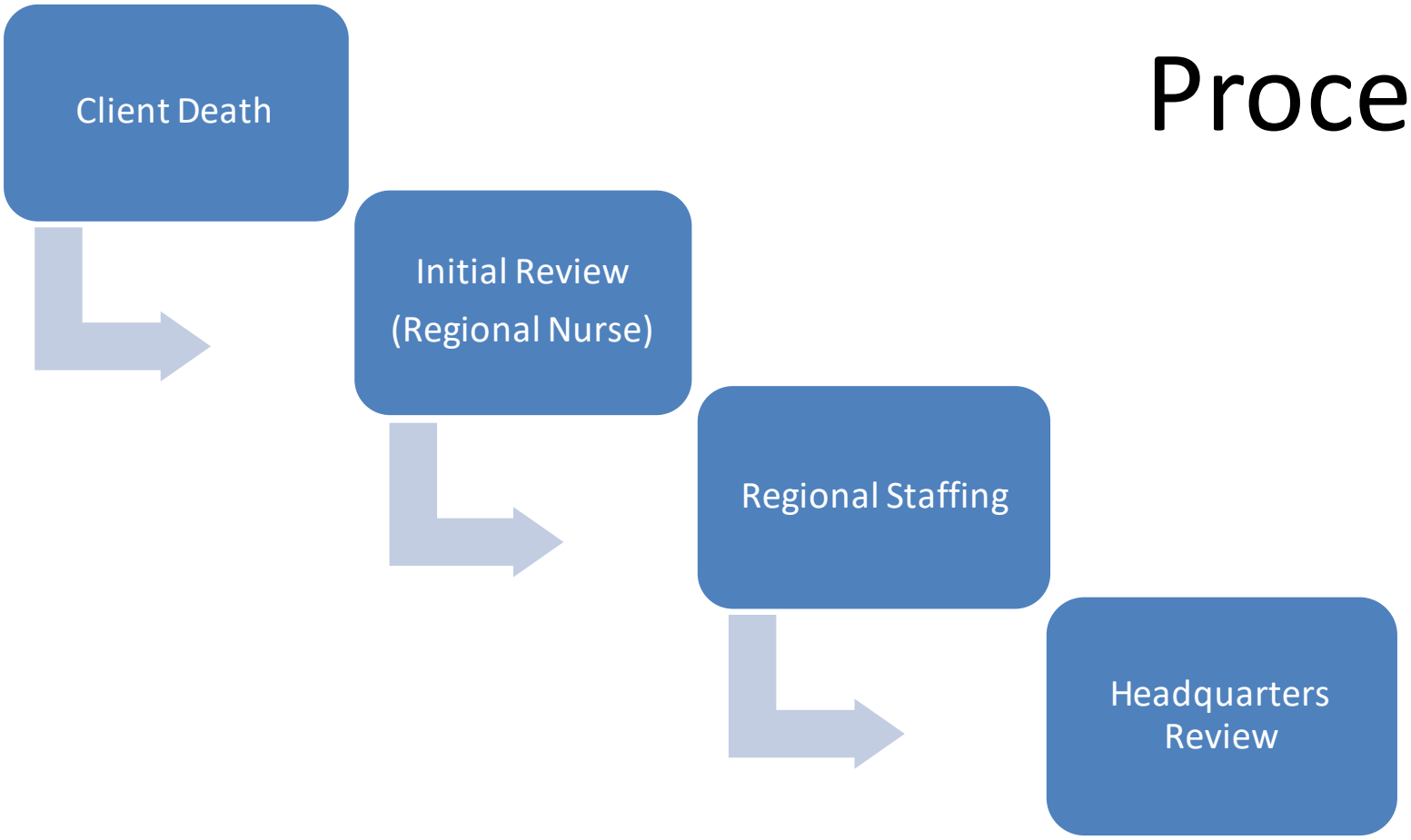
DDA must conduct a mortality review for a client who received the following services and died **while in those services or within 30 days of transfer or admittance to** a long-term care or medical facility from those services:

Adult family home services	Medically intensive children's program services
Children's intensive in-home behavior services	Private duty nursing services
Community Intermediate Care Facilities for Individuals with Intellectual Disabilities	Residential Habilitation Centers
Companion home services	Supported living services, including state-operated living alternative (SOLA) services
Group home services	Voluntary placement services
Group training home services	

Scope

DDA must conduct a **mortality review** if a client dies while receiving:	
Community crisis stabilization services	Enhanced respite services
County services funded by DDA	Overnight planned respite services
Diversion bed program services	Pre-Admission Screening and Resident Review specialized services
The Case Resource Manager must **consult** their regional administrator/designee, and the quality assurance manager **to determine if a mortality review is required** when a client dies while:	
Receiving alternative living services	
Receiving personal care services in a child foster home	
In the care of an Individual or Agency provider, such as a personal care or respite care provider	

Process


Client Death
Initial Review (Regional Nurse)
Regional Staffing
Headquarters Review

Regional Staffing

- Initial review - regional Nursing Care Consultant
  - No concerns/issues identified
    - Sent to Regional Administrator for review/approval
    - Headquarters Quality Assurance Review
  - Concerns/issues/questions
    - Regional staffing held
    - Determine if there are recommendations
    - Communicate recommendations/findings to provider

Headquarters Review

- Headquarters Mortality Review Team reviews deaths that:
  - Were unexpected;
  - Occurred under suspicious circumstances;
  - May have involved provider misconduct, abuse, or neglect; or
  - Resulted in findings during the regional staffing
- All other deaths under scope:
  - Receive a quality assurance review
  - DDA Medical Director & Residential Quality Assurance Unit Manager
  - Information added for data collection purposes
- Headquarters Mortality Review Team:
  - Reviews Mortality Review Log and all attachments, Comprehensive Assessment Reporting and Evaluation (CARE) system information, incident reports, investigative findings, etc.
  - Identifies trends or patterns in order to recommend necessary system changes, policy changes, training, etc.

Headquarters Review

- Headquarters Mortality Review Team recommendations examples
  - Care Provider Bulletins
    - Advance Care Planning
    - Aspiration
    - Choking
    - Dehydration
    - Diabetes
    - Flu and Pneumonia
    - Life Sustaining Equipment
    - Water Safety
  - New Trainings
    - Beyond First Aid
  - CARE enhancements
    - Clients on ventilators and other life sustaining equipment: mandatory safety questions
  - Provider Resources
    - Actions to Take Before and After Someone Passes Away

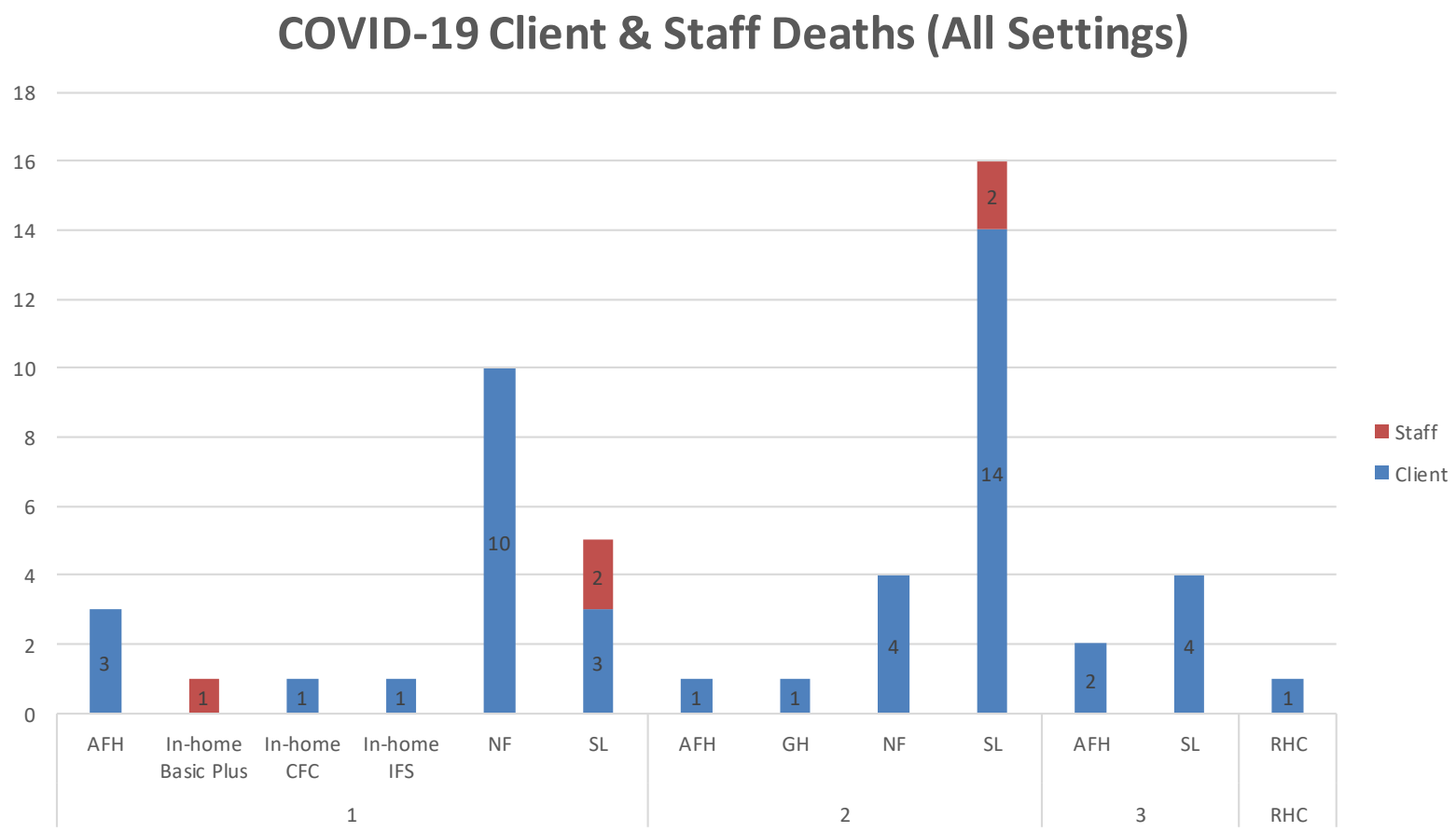
HCBS QA Committee

- Deaths related to medication errors
  - Recommendations implemented, lessons learned?
    - Category to identify “complications of therapy”
    - No trends identified, cases are low related to medication errors

- Deaths related to COVID-19
  - Recommendations implemented, lessons learned?
    - As of 12/14/2020, **15** cases reviewed by Mortality Review Team
    - 5 cases had no significant underlying causes of death
    - 1 case also had dysphagia, progressive neurodevelopmental decline
    - 1 case also had dysphagia, progressive organ failure, reoccurring infection
    - 3 cases also had multi organ systems failure
    - 1 case also had multi organ system failure, progressive neurodevelopmental decline, reoccurring infection
    - 2 case also had progressive neurodevelopmental decline
    - 2 cases also had progressive organ failure

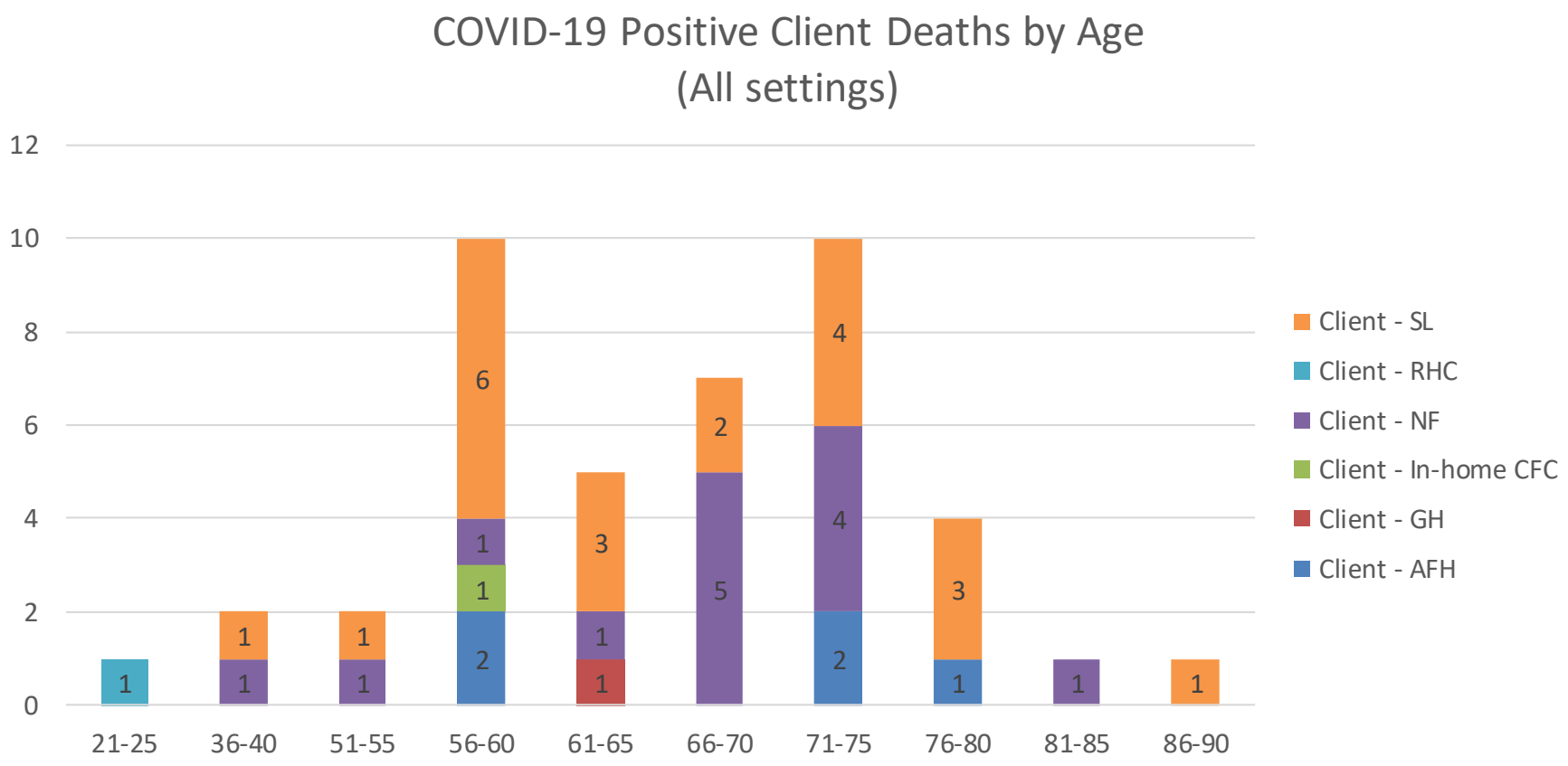
HCBS QA Committee

- Deaths related to COVID-19 (as of 12/14/2020)



HCBS QA Committee

- Deaths related to COVID-19 by age (as of 12/14/2020)



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Thank you!

Lori Gianetto Bare

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