

Mortality Review as a Tool for Quality Improvement

Cathy Stevenson, Deputy Director
Developmental Disabilities Supports Division
New Mexico Department of Health



Mortality Review in New Mexico

- The Department of Health mortality review process is an interdivisional and cross-agency activity that seeks to use information related to mortality among individuals receiving Developmental Disabilities Services to guide systemic improvement and promote the health, safety and welfare of persons served.



Consistent with GAO

- There are 6 basic components for state mortality review recommended by Governmental Accountability Office in May 2008:
 - Standard information is collected and screened by DOH staff to determine if further review is needed. (72 hour review)
 - If quality of care concerns present, a more in-depth review is conducted (Specialty Surveyor)



GAO continued

- Mortality review includes medical professionals (MD and RN)
- The mortality review process is documented
- The process may result in recommendations that address any quality of care concerns identified
- Data is aggregated to identify trends over time



Mortality Review in NM

- In New Mexico the death of any person served in the Developmental Disabilities System (both state only and federal/state funded programs) is reviewed by the Mortality Review Committee.
- Deaths among Jackson Class members receive an external review as well.



The DOH Infrastructure

- Division of Health Improvement (DHI)
 - Death investigation unit – Nurse Reviewer and Specialty Surveyor
 - Incident Management and Quality Management Bureaus
- Developmental Disabilities Supports Division (DDSD)
 - Regional Offices
 - Clinical Services Bureau
- Department of Health Medical Director and Department Secretary
- Public Health and Epidemiology Divisions (resource support as needed)



The DOH Infrastructure

- ❑ Mortality Review Committee (MRC)
- ❑ Internal Review Committee (IRC)
- ❑ DDSD Management Team
- ❑ DDSD/DHI Joint Bureau Chiefs
- ❑ Developmental Disabilities Quality Improvement Steering Committee (DDSQI)



Who Participates on the MRC

- Mortality Review Committee
 - DOH Medical Director/DDSD Medical Director
 - DDSD and DHI Division Directors
 - Medicaid designee (QM Bureau Chief)
 - DHI Nurse Reviewer
 - DDSD Clinical Services Bureau Chief (nurse)
 - Others as indicated



The Process

- Death reported through Incident Management System
- 72 hour death investigation occurs
 - Possible referral to DDSD Regional Office
 - Possible referral to Quality Management Bureau for Focused review
 - Possible referral to IRC for consideration of sanctions
- Report to Mortality Review Committee



The Process

- ❑ For Jackson class members an external review is conducted and the resulting report goes to the MRC.
- ❑ MRC convenes and reviews all available information.
- ❑ MRC determines what, if any, follow-up action is needed
- ❑ MRC makes appropriate referrals to DOH Divisions and closes the review.



The Process

- DDSD receives MRC recommendations and follows up, as appropriate, with
 - Systemic/statewide action
 - Regional action
 - Interdisciplinary Team level action
 - Provider specific action
 - Or a combination
- DDSD tracks action taken



The Process

□ DDSQI –

- Receives information from the divisions
- Reviews trends and underlying issues
- Develop systemic/regional action plans to address significant issues.
- Monitors implementation of the plans
- Reports back to DOH Senior Management and MRC



Challenges

- The process can be resource intensive
- Provider concerns
 - Feel MRC review could lead to litigation
 - May view intervention as a sanction
 - May not want to dedicate time and resources
- Change efforts involving external/generic systems (e.g. physicians) are difficult.



The Pay Off - Outcomes

- ❑ System and local level improvements that benefit individuals
- ❑ A better understanding of our system and what's working / what's not
- ❑ Skill development for staff and providers regarding critical thinking and strategic action
- ❑ Process changes that can promote wellness, health and safety



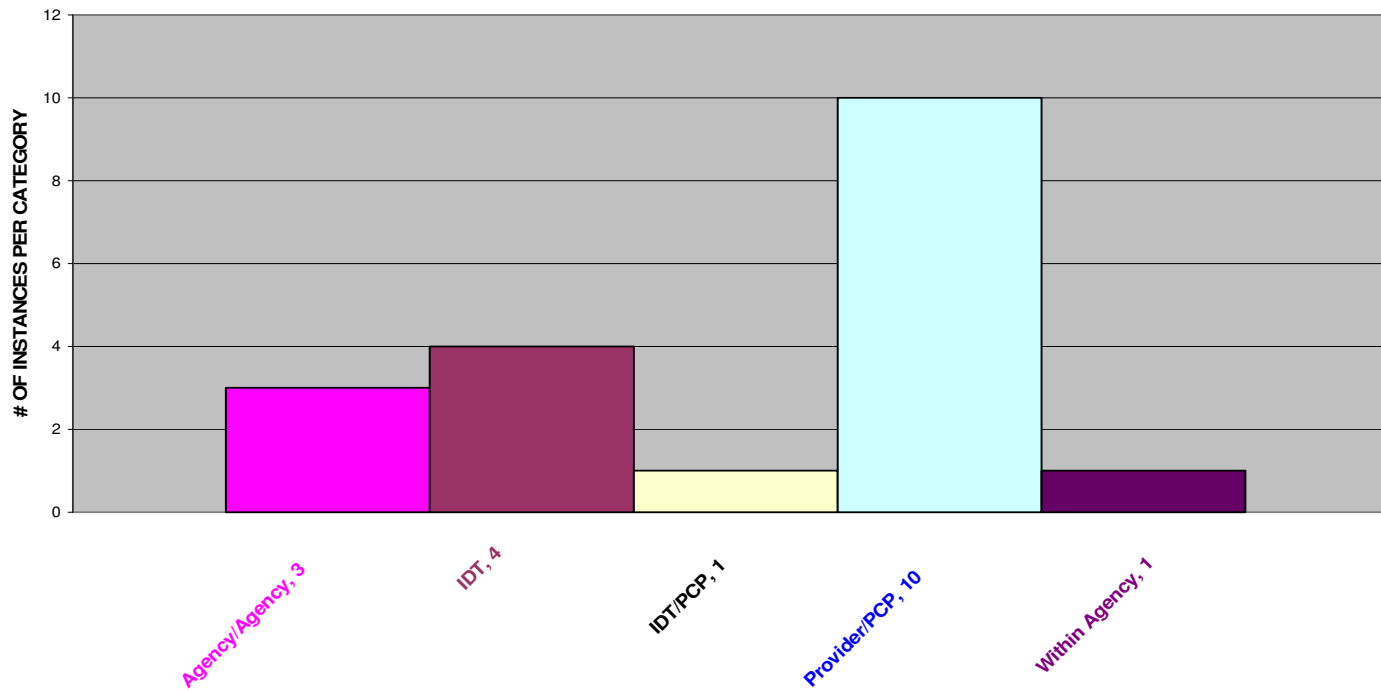
Two Examples

- Health Care Coordination
- Aspiration related mortality

Health Care Coordination

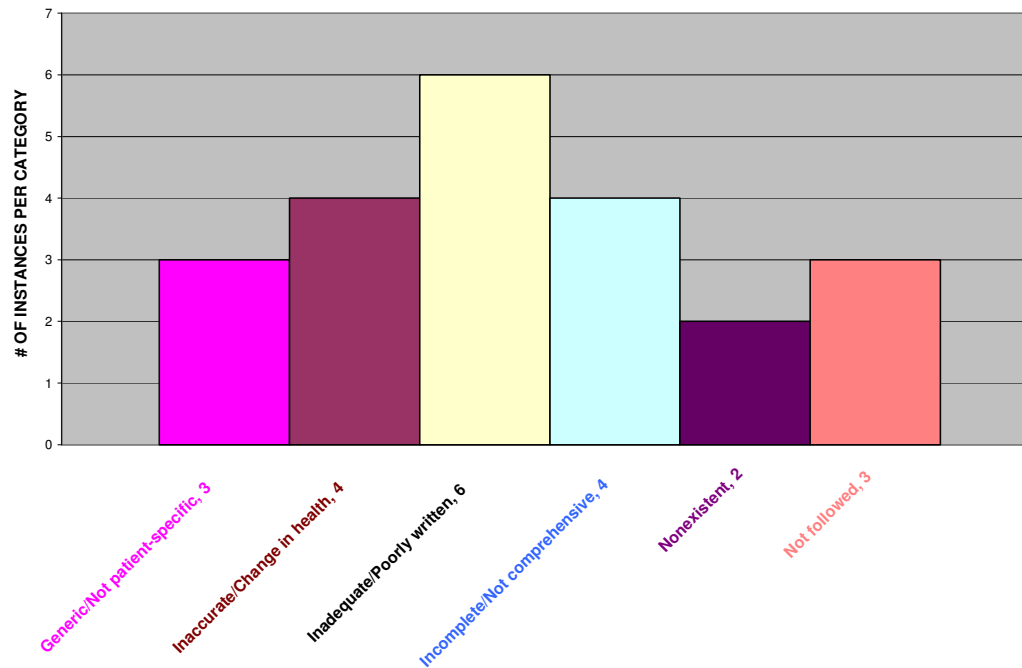
DRAFT - FOURTH MOST FREQUENT CATEGORY IN JCM CASES: COMMUNICATION

BREAKDOWN OF 19 SYSTEMIC CLINICAL ISSUES OCCURING IN 13 MORTALITY CASES
OUT OF 20 FROM 10/4/2002 THROUGH 6/9/2006
MORTALITY REVIEWS AUG 2006 AND FEB 2007
"ALL NOTED CONCERNS CAUSITIVE & NON-CAUSITIVE REGARDING DEATH"



Health Care Coordination

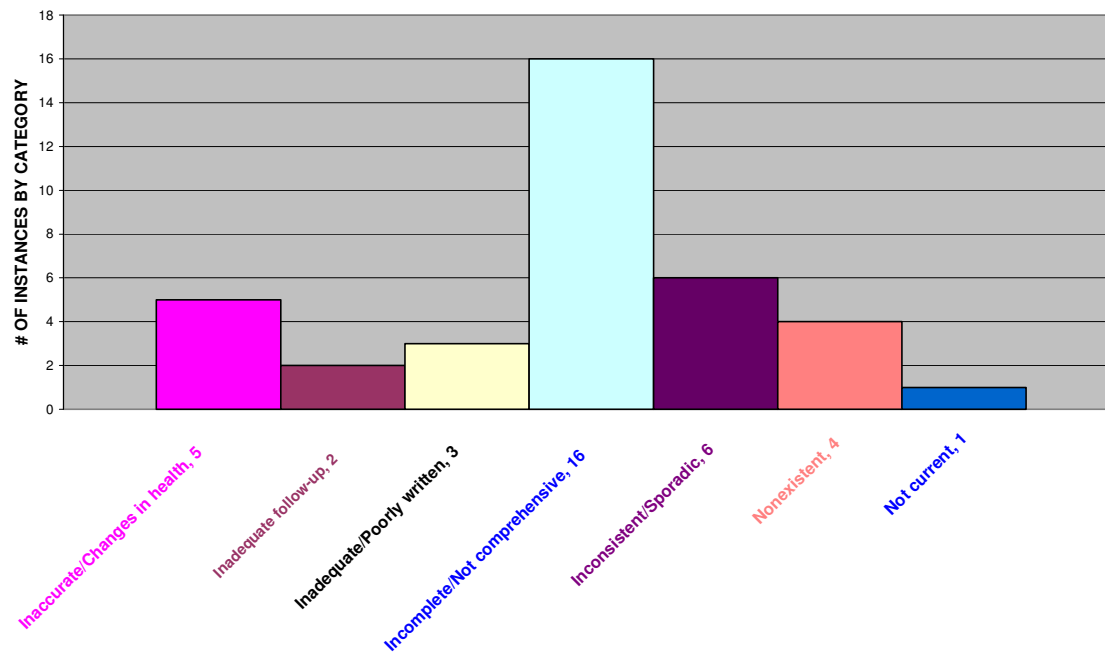
DRAFT - THIRD MOST FREQUENT CATEGORY IN JCM CASES: HEALTH CARE PLAN
BREAKDOWN OF 22 SYSTEMIC CLINICAL ISSUES OCCURING IN 12 MORTALITY CASES
OUT OF 20 FROM 10/4/2002 THROUGH 6/9/2006
MORTALITY REVIEWS AUG 2006 AND FEB 2007
"ALL NOTED CONCERNS CAUSITIVE & NON-CAUSITIVE REGARDING DEATH"



Health Care Coordination

DRAFT - SECOND MOST FREQUENT CATEGORY IN JCM CASES: DOCUMENTATION

BREAKDOWN OF 37 SYSTEMIC CLINICAL ISSUES OCCURING IN 16 MORTALITY
CASES OUT OF 20 FROM 10/4/2002 THROUGH 6/9/2006
MORTALITY REVIEWS AUG 2006 AND FEB 2007
"ALL NOTED CONCERNS CAUSITIVE & NON-CAUSITIVE REGARDING DEATH"





Health Care Coordination

DDSQI review of mortality data/trends

- Issue identified
- Action plan developed and initiated
- Community Medical Issues workgroups convened
 - Stakeholder participation
 - Address identified issues from DDSQI and other sources



Health Care Coordination

- Outcomes
 - Systemic
 - New Health Assessment system – online
 - Regional Office
 - protocol for “in-hospital” support
 - IDT
 - Health Coordinator guidelines and toolkit
 - Individual
 - Health Passport
 - Emergency Packet
 - Master Diagnoses List
 - Doctor Visit Form

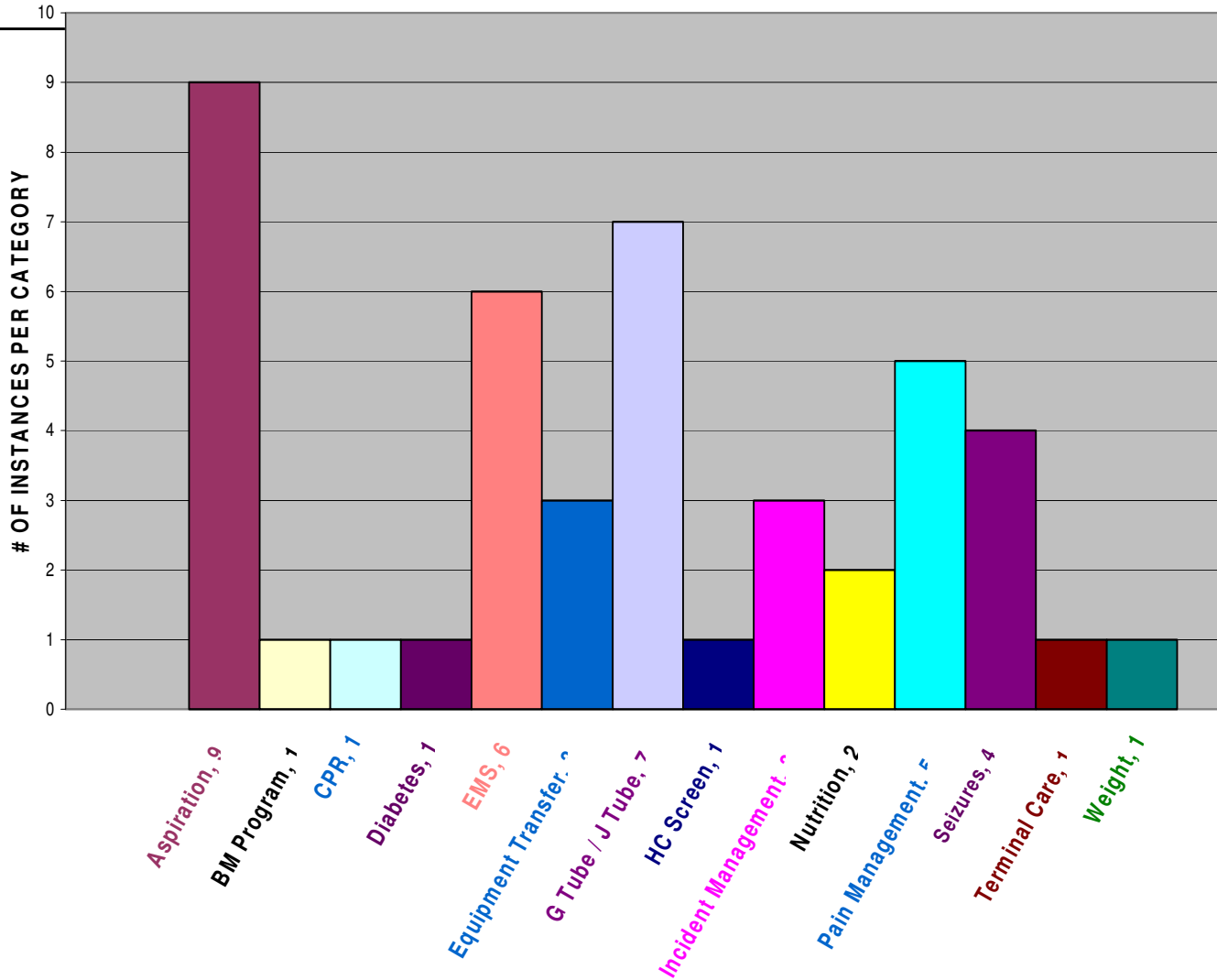


Aspiration Initiative

- Aspiration was identified as the leading cause of death among individuals with developmental disabilities in New Mexico
- The Department of Health responded to this information and other concerns raised in regards to deaths from aspiration pneumonia.
 - Epidemiological study
 - Planned surveillance by DOH to track hospitalization and deaths related to Aspiration
 - Systemic intervention
 - Physical Nutritional Management Demonstration Project
- Desired outcome: Reduce the rate of hospitalization and death related to aspiration among persons with developmental disabilities in NM.

DRAFT - MOST FREQUENT CATEGORY IN JCM CASES: CLINICAL

BREAKDOWN OF 45 SYSTEMIC CLINICAL ISSUES OCCURRING IN 14 MORTALITY CASES
OUT OF 20 FROM 10/4/2002 THROUGH 6/9/2006
MORTALITY REVIEWS AUG 2006 AND FEB 2007
"ALL NOTED CONCERNS CAUSITIVE & NON-CAUSITIVE REGARDING DEATH"





Study

- ❑ Medical Literature Review
- ❑ Systemic tracking and review of these deaths
- ❑ Queries to NASDDDS members
- ❑ Used standardized process comparing states that provided information with data from New Mexico
- ❑ Concluded that there were no unexpected or significant trends when comparing NM to other states.



Intervention – Efforts to Mitigate Risk

- ❑ Piloting revised policy regarding identification and support for person with a high risk of aspiration.
- ❑ Trained Case Managers, Therapists and other team members on support for individuals at risk for health complications related to aspiration
- ❑ Demonstration Project re individual specific training for teams and direct support staff



Resources

- Mikki Rogers - DDSD Director
mikki.rogers@state.nm.us
- David Rodriguez - DHI Director
david.rodriguez@state.nm.us
- Elizabeth Finley, RN – DDSD Clinical Services
Bureau Chief elizabeth.finley@state.nm.us
- Cathy Stevenson or Judy Parks – Co-Chairs DDSQI
cathy.stevenson@state.nm.us or
judith.parks@state.nm.us