STATE OF ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES SENIOR AND DISABILITIES SERVICES POLICY & PROCEDURE MANUAL	**Section:** 15 Quality Assurance	**Number:** 15-2	**Page:** 1
	Subject: Mortality Review		
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Purpose

To establish a process for review of deaths of participants.
To delineate responsibilities for oversight and systems improvement.

Policy

Focused reviews of reports of death are an element of the Senior and Disabilities Services (SDS) critical incident reporting and management system. SDS components review and analyze information, submitted by providers in *Critical Incident Reports*, to identify risk factors or unusual circumstances related to reported deaths and to determine whether SDS or provider agency action or inaction contributed to the deaths.

Mortality review findings are presented to oversight groups. Based on the recommendations of these groups, SDS takes action to remediate problems, and to improve its operations to ensure recipient health, safety, and welfare.

Authority

42 CFR 441.302 (a) State assurances of safeguards. SDS Policy and Procedure 15-1: Critical Incident Reporting and Management.

Responsibilities

1. The **Mortality Review Coordinator** is responsible for
   a. reviewing and summarizing reported death information, and
   b. presenting his/her findings to the Mortality Review Task Committee.
2. The **Mortality Review Task Committee** is responsible for
   a. evaluating reported death information, and
   b. developing reports for the Quality Improvement Workgroup.
3. The **Quality Improvement Workgroup** is responsible for
   a. monitoring SDS mortality review activities, and
   b. reporting to the Quality Improvement Steering Committee.

Procedures

A. Reported death information

1. Critical Incident Reports. The Mortality Review Coordinator
   a. reviews all *Critical Incident Reports* of death of a participant, and
      i. analyzes multiple reports of the same incident to clarify circumstances,

ii. completes a *Mortality Review Summary* for each incident,
iii. requests additional information as needed for review, and
iv. enters the date of death in the DS3 database;

b. presents review findings to the Mortality Review Task Committee; and
c. obtains additional information when requested to do so by the Mortality Review Task Committee.

2. Vital Statistics Match Report. The Mortality Review Coordinator
   a. reviews the *Vital Statistics Match Report* prepared quarterly by the Bureau of Vital Statistics
      i. to determine whether deaths reported to the Bureau were reported to SDS in *Critical Incident Reports*, and
      ii. to compare cause of death reported to the Bureau with that reported to SDS; and
   b. reports any discrepancies to the Mortality Review Task Committee.

B. **Focused review of reported deaths**

1. Evaluation. The Mortality Review Task Committee
   a. evaluates the information presented by the Mortality Review Coordinator to determine
      i. on a monthly basis
         (A) whether risk factors or unusual circumstances are associated with the death of a participant, and
         (B) whether SDS or provider agency action (or lack of action) contributed to the death of a participant, and
      ii. on a quarterly basis, whether discrepancies found in the *Vital Statistics Match Report* require SDS action;
   b. requests additional information when necessary to conduct a review; and
   c. if warranted by the additional information, refers the materials to Adult Protective Services for a re-evaluation of the *Critical Incident Report*.

2. Reports. The Mortality Review Task Committee
   a. develops a monthly report, for review by the Quality Improvement Workgroup, including, but not limited to:
      i. findings regarding SDS or provider agency actions (or lack of action) that contributed to a death;
      ii. aggregation and analysis of data; and
      iii. recommendations for
         (A) provider services improvements or remediation,
         (B) development of new, or modification of current, policy and procedures, and

(C) improvements to the critical incident reporting process or the mortality review process; and

b. makes a quarterly report of discrepancies found in the *Vital Statistics Match Report*.

C. Mortality review oversight.

1. Monitoring SDS activities. The Quality Improvement Workgroup
   a. reviews monthly and quarterly reports of findings and recommendations by the Mortality Review Task Committee;
   b. develops a plan to address identified issues;
   c. identifies training and technical assistance needs,
   d. recommends administrative or operational changes, if indicated; and
   e. tracks and evaluates progress on actions items.

2. Reporting. The Quality Improvement Workgroup reports on the performance of SDS mortality review activities to the departmental Quality Improvement Steering Committee on a quarterly basis.

D. Mortality review groups.

1. Mortality Review Task Committee.
   a. Members:
      i. Quality Assurance Unit Manager (Chairperson),
      ii. Mortality Review Coordinator,
      iii. Representative from Adult Protective Services,
      iv. SDS employee who is a Registered Nurse, and
      v. SDS employee who is a Qualified Mental Retardation Professional.
   b. The committee meets monthly, at a minimum.

2. Quality Improvement Workgroup.
   a. Members.
      i. SDS Director (Chairperson),
      ii. SDS Deputy Director,
      iii. SDS Chief of Programs,
      iv. SDS unit managers, and
      v. DHSS Information Technology Project Manager.
   b. The workgroup meets monthly.