Delaware Health
And Social Services

Office of the Secretary

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DHSS Policy Memorandum 65 **REVISED: January 25, 2018**
Subject: DHSS Mortality Review Committee **Previous: August 12, 2014**

I. Mission/Purpose

The Delaware Health and Social Services (DHSS) Mortality Review Committee will conduct reviews of all deaths of individuals 18 years of age and older who received services in a residential setting/facility (licensed or unlicensed) operated by or for any DHSS Division, excluding any facilities/settings/programs in which the only contact with DHSS is through the Medicaid program. See the chart below for the facilities covered by this policy. Notwithstanding the above, other cases can be referred to the committee at the discretion of the applicable Division Director.

DSAAPD	DDDS	DSAMH
DHCI	Stockley Center	DPC
GBHC	Group Homes	Group Homes
	Shared Living	
	Neighborhood Homes	
	CLA's	

The review will be undertaken in order to gather and analyze evidence about deaths in this population; to safeguard and improve health; to ensure the safety and welfare of service recipients; to reduce the number of preventable deaths and to promote quality improvement efforts. The Committee is a quality performance improvement initiative and work products of the Committee are peer protected and shall not be disclosed.

**The review includes residents of the (4) DHSS Long Term Care facilities, DDDS and DSAMH group/residential homes.*

II. Membership

The Mortality Review Committee shall be comprised of members appointed by the DHSS Cabinet Secretary and shall include:

- DPH Medical Director (Committee Chair)
- DHSS Chief Policy Advisor
- Office of the Secretary Representative
- Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)
- Division of Developmental Disabilities Services Representative (DDDS)
- Division of Substance Abuse and Mental Health Representative (DSAMH)
- Division of Long Term Care Residents Protection Representative (DLTCRP)

The committee shall also include representatives from:

- Department of Justice
- Department of Safety and Homeland Security/Division of Forensic Science
- Two (2) members from the community

Ad hoc participants may be invited, as needed.

III. Quorum Requirement

51% (6) of all members must be present in order to constitute a quorum. The presence of the Committee Chair or designated alternate and at least one of the community members shall be required to establish a quorum.

IV. Committee Duties

A. Expeditiously review deaths, as defined in Section 1.

B. Analyze the causes and circumstances contributing to these deaths.

C. Review and evaluate services provided by public and private systems that are responsible for protecting or providing services to this population and assess whether said entities have properly carried out their respective duties and responsibilities.

D. Based on the results of the reviews (both individual and in the aggregate), identify strengths and weaknesses in the governmental and private agencies and/or programs and make recommendations to the applicable Division Director(s) to implement systemic and/or individual-specific changes to improve services or to rectify deficiencies. The recommendations may address, but are not limited to, proposing legislation or regulations, policies or procedures (both new or amendments to existing ones); creating or modifying training for persons who provide services, enhancing coordination and communication among entities providing or monitoring services.

E. Meet every other month (and more frequently as needed) to conduct reviews, document comments and recommendations, and discuss general Quality Assurance issues and concerns.

F. Produce a report by June 30 of each year for the preceding calendar year, to include the review of all deaths, analysis of data (age, gender, manner of death), identification of trends and patterns, systemic recommendations and information regarding the outcome of all committee recommendations. This report shall be disseminated to the DHSS Secretary and all committee members.

V. Case Review Procedures

A. Case review meetings shall be convened on a bi-monthly basis and Death Report Form shall be reviewed within 60 days of the receipt of the report. The review may be preliminary pending the receipt of outstanding information.

B. The case review process may also include presentations of relevant information by any agencies or persons involved with the decedent or investigator of the death.

C. Following presentation of the facts, the Committee will discuss the case and any issues highlighted, guided by the following principles and questions:

1. What factors or circumstances caused or contributed to the death?
2. What responses and investigations resulted from the death and were all necessary agencies notified, responsive and proactive in instituting corrective actions?
3. Were the services and intervention concerning the decedent appropriate and adequate for his/her needs?
4. Were staff involved with the decedent adequately prepared, trained and supported to perform their duties correctly?
5. Was there adequate communication and coordination among the various entities involved with the decedent?
6. Are the applicable statutes, regulations, policies and procedures adequate to serve the needs of the target population? If not, what changes are needed?

D. Based on the case discussion, the Committee shall formulate recommendations for consideration by the applicable Division Director (with copy to the DHSS Secretary).

E. The Committee shall review all reports submitted by Division Directors that respond to the Mortality Review Committee recommendations.

VI. Case Notification Procedures

A. The Divisions shall provide a completed DHSS Death Notification Form (See Appendix A), via secure email, to the DHSS Death Notification Mailbox (DHSS_DeathNotification_Report) of any deaths that occur as defined in Section I. This notification shall occur no later than the next business day following the death.

B. The Divisions shall also provide a completed DHSS Death Report Form (See Appendix B), via secure email, to the DHSS Death Notification Mailbox (DHSS_DeathNotification_Report) within ten (10) business days from the date of death.

C. The Administrative Support staff person (assigned to the DHSS Mortality Review Committee) shall be responsible for managing and tracking the Notifications and Reports submitted by the Divisions. The Administrative Support staff person will also forward them to the Committee Chair for review to determine those that would need further review by the Committee members. In addition, the Administrative Support staff person will enter specified data from the Notification and Report onto a spreadsheet that will be distributed to the Committee members prior to the next meeting. All disseminated materials shall be marked as "Confidential".

VII. Division Responsibilities

A. Submits the completed DHSS Death Notification and DHSS Death Report Forms (See Appendix A and Appendix B) within the time specified to the DHSS Death Notification Mailbox (DHSS_DeathNotification_Report).

B. Ensures the availability of a Division representative at the date/time of the scheduled Committee review meeting for consultation with the Committee members.

C. Considers and acts upon Committee recommendations and completes any follow-up reporting required by the Committee.

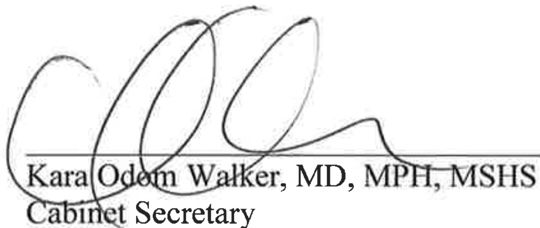
VIII Confidentiality

A. The work products obtained by, presented to, considered by and recommended by the Committee are confidential and shall not be released under any circumstances.

B. All Mortality Review Committee members shall sign a confidentiality agreement (See Appendix C), on an annual basis.

IX Retention of Records

All records shall be maintained in a secure manner for a period of three (3) years and will thereafter be destroyed.



Kara Odom Walker, MD, MPH, MSHS
Cabinet Secretary

1/25/18
Date

APPENDIX A

State of Delaware
Department of Health and Social Services

DHSS DEATH NOTIFICATION FORM

THIS NOTIFICATION SHALL OCCUR NO LATER THAN THE NEXT BUSINESS DAY FOLLOWING THE DATE OF DEATH

*** SEND COMPLETED FORM, VIA SECURE EMAIL, TO: DHSS_DeathNotification_Report**

If any information requested on this form is unavailable or unknown at the time that this form is completed, please mark the area with the notation of To Be Determined (TBD).

Date:______________________________ **Time:** ______________________________

Name/Title/Email of Person Completing Form:______________________________

____

Name of Facility and Funding Division: ______________________________

Name of Deceased: ______________________________

MCI# of Deceased. Medicaid# *(if applicable)*: ______________________________

Gender: Male ☐ Female ☐

Race/Ethnicity *(check all that apply)*:

White/Anglo ☐ Black/African American ☐ Asian/Pacific Islander ☐

Hispanic/Latino ☐ Native American ☐ Other (Specify)______________________________

Date of Birth:______________________________**Admission Date:** ______________________________

Date of Death: ______________________________**Time of Death:** ______________________________

Place of Death:______________________________

Tentative Cause (s) of Death (If Known):______________________________

____

Name of Physician and/or Psychiatrist:______________________________

Name of Facility/Contract Provider Director: ______________________________

Name of Facility/Contract Provider Director of Nursing:______________________________

Name of Provider Agency (if applicable):______________________________

Was Hospice involved in Deceased care? Yes ☐ No ☐

Was a "Do Not Resuscitate" (DNR) in effect? Yes ☐ No☐

Police Involved? Yes ☐ No ☐ **Medical Examiner Involved?** Yes ☐ No ☐

DHSS PM 46 Investigation? Yes ☐ No ☐ **Was Death Expected?** Yes ☐ No ☐

State of Delaware
Department of Health and Social Services

CONFIDENTIAL **DHSS DEATH REPORT FORM** **CONFIDENTIAL**

This form is used to report deaths involving any/all persons 18 years of age and older who received services in a residential setting/facility (licensed or unlicensed) operated by or for any DHSS Division. Pursuant to 42 CFR 482.13(f)(7); 29 Del. C., § 4706; and DHSS PM 46, all deaths related to the use of seclusion or restraint, accidents, homicides, suicides or violence (including those suspected as consumer abuse, neglect, and mistreatment) must be reported. This is a confidential quality assurance document and is peer protected pursuant to 24 Del. C., § 1768. Confidentiality of consumer information is protected under Federal Regulations (42 U.S.C. 4582 and 21 U.S.C. 1175) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 C.F.R. Pts. 160 and 164). Please provide an explanation for any requested information that is unavailable. If additional space is needed, attach separate sheets, referencing the part of the form to which the information pertains. Additional information that is considered relevant, such as client assessments and discharge summaries may be included. Do not file this review report in the consumer's service record. Please keep a copy of the report for your records.

THIS FORM NEEDS TO BE COMPLETED AND SUBMITTED WITHIN TEN (10) BUSINESS DAYS OF THE DEATH. * SEND COMPLETED FORM BY SECURE EMAIL TO: DHSS_DeathNotification_Report

DHSS DIVISION: ☐ **DDDS** ☐ **DSAAPD** ☐ **DSAMH**

CONSUMER INFORMATION:	
NAME OF DECEASED	**MCI # OF DECEASED/MEDICAID # (if applicable)**
GENDER: ☐ **MALE** ☐ **FEMALE** **DATE OF BIRTH:** ______/______/________ **DATE OF DEATH:** ______/______/________ **ADMISSION DATE:**______/______/________ **Decision Maker (check one):** Own Decision Maker ____________________ Guardian____________________ DPOA____________________ Surrogate Decision Maker ____________________	**PLACE OF DEATH:** ☐ **RESIDENCE** ☐ **HOSPITAL** ________________ **(Name of Hospital)** ☐ **HOSPICE FACILITY/HOME** **DHSS Facility:** ☐**DHCI** ☐**GBHC** ☐**DPC** ☐**Stockley** ☐ **OTHER (specify)**____________________
REPORTING INFORMATION:	
NAME OF REPORTING AGENCY/FACILITY	**ADDRESS OF AGENCY/FACILITY**
NAME OF THERAPIST/CASE MANAGER/PHYSICIAN	**NAME OF IMMEDIATE SUPERVISOR**
NAME OF PERSON PREPARING REPORT (*Must be a RN)*	**DATE/TIME REPORT PREPARED**
MOST RECENT DECEASED CONTACT BY DIVISION OR DIVISION CONTRACTOR: **DATE:** ______/______/________	**RACE/ETHNICITY** (*check all that apply*) ☐**1 WHITE/ANGLO** ☐**2 BLACK/AFRICAN AMERICAN** ☐**3 ASIA/PACIFIC ISLANDER** ☐**4 NATIVE AMERICAN** ☐**5 HISPANIC/LATINO** ☐**6 OTHER (specify)**____________________
POST MORTEM INVESTIGATIONS: **POLICE INVOLVED :** ☐**YES** ☐**NO** **DETAILS:**____________________ ____________________ **MEDICAL EXAMINER INVOLVED:** ☐**YES** ☐**NO** **AUTOPSY COMPLETED:** ☐**YES** ☐**NO** **TOXICOLOGY REPORT:** ☐**YES** ☐**NO**	**DHSS PM 46 INVESTIGATION:** ☐**YES** ☐**NO** **IF YES, TYPE:** ☐ **ABUSE** ☐**ASSAULT** ☐**INJURY** ☐ **MISTREATMENT** ☐ **NEGLECT** **SUBSTANTIATED:** ☐**YES** ☐**NO** ☐**RESULTS PENDING** **FACILITY REPORT SUBMITTED ON:**____________________

CAUSE OF DEATH: *(check all that apply)*

☐ACCIDENT:
☐FALL ☐HOUSEHOLD ☐MOTOR VEHICLE
☐ASPERATION/CHOKING
☐OTHER:_______________

☐MEDICAL REASON:
☐CANCER ☐DIABETES ☐DEMENTIA
☐ HEART DISEASE ☐ KIDNEY DISEASE
☐ LIVER DISEASE ☐PNEUMONIA
☐ RESPIRATORY DISEASE /COPD
☐ STROKE
☐ OTHER:_______________

☐DRUG OVERDOSE: ☐ACCIDENTIAL ☐SUICIDE
☐ PRESCRIPTION DRUG
☐ NONPRESCRIPTION DRUG

☐SUICIDE: Method_______________

☐HOMICIDE/VIOLENCE

☐EXPECTED or ☐UNEXPECTED:
Explain:_______________

CIRCUMSTANCES 72 HOURS PRIOR TO DEATH:
(Attach documents including medical information, police reports etc., if available)

MEDICAL DIAGNOSES AT TIME OF DEATH:
(check all that apply)

☐ALCOHOL RELATED DISEASE
☐CANCER
☐DEMENTIA
☐DIABETES
☐HEART DISEASE
☐HEPITITIS C
☐HIV
☐INFECTIOUS DISEASE(other)
☐HYPERLIPIDEMIA
☐HYPERTENSION
☐KIDNEY DISEASE
☐LIVER DISEASE
☐OBESITY
☐PERIPHERAL VASCULAR DISEASE
☐PNEUMONIA
☐RESPIRATORY DISEASE
☐STROKE
☐OTHER _______________

PSYCHIATRIC DIAGNOSES AT TIME OF DEATH:

☐ANXIETY DISORDER
☐BIPOLAR DISORDER
☐DEPRESSIVE DISORDER
☐PTSD
☐PERSONALITY DISORDER
☐SCHIZOPHRENIA/PSYCHOTIC DISORDER
☐OTHER _______________

SUBSTANCE ABUSE HISTORY

HISTORY OF ALCOHOL ABUSE:	☐ YES	☐ NO
HISTORY OF DRUG ABUSE:	☐ YES	☐ NO
INTERVENOUS DRUG ABUSE:	☐YES	☐NO

TOBACCO USE

CURRENT SMOKER:	☐ YES	☐NO
HISTORY OF SMOKING:	☐ YES	☐NO
OTHER TOBACCO USE HISTORY:	☐ YES	☐ NO

LIST PSYCHOTROPIC/MEDICAL MEDICATIONS: *(Name and Dosage)*

PSYCHOSOCIAL RISK FACTOR:

☐HISTORY OF ABUSE
☐PAST HOMELESSNESS
☐LEGAL ISSUES
☐OTHER _______________

REVIEWED BY FACILITY/CONTRACT PROVIDER DIRECTOR:
NAME:_______________ DATE:_______

REVIEWED BY DHSS FACILITY MEDICAL DIRECTOR (if applicable):
NAME:_______________ DATE:_______

REVIEWED BY DIVISION DIRECTOR:
NAME:_______________ DATE:_______

APPENDIX C

Mortality Review Committee

Confidentiality Agreement

I, ___________________________________, understand that all information discussed within the context of the Mortality Review Committee (MRC) is confidential in nature. I further understand and agree that it is my personal responsibility to protect and safeguard against the disclosure of the said information outside the boundaries of MRC business.

I understand that information that is disseminated for the purposes of MRC business shall not be duplicated in any form. MRC documents, with the exception of the MRC meeting minutes, shall be returned to MRC Administrative Support staff person upon completion of the associated task.

I agree to immediately contact the MRC Chairperson if there is an attempt to force disclosure of information that is related to documents or discussions related to MRC business.

___________________________________ ____________________

Signature of MRC Member **Date of Signature**

___________________________________ ____________________

Signature of MRC Chairperson **Date of Signature**