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Quality of Care Program Mortality Review

March Update

April 3, 2018

Agenda

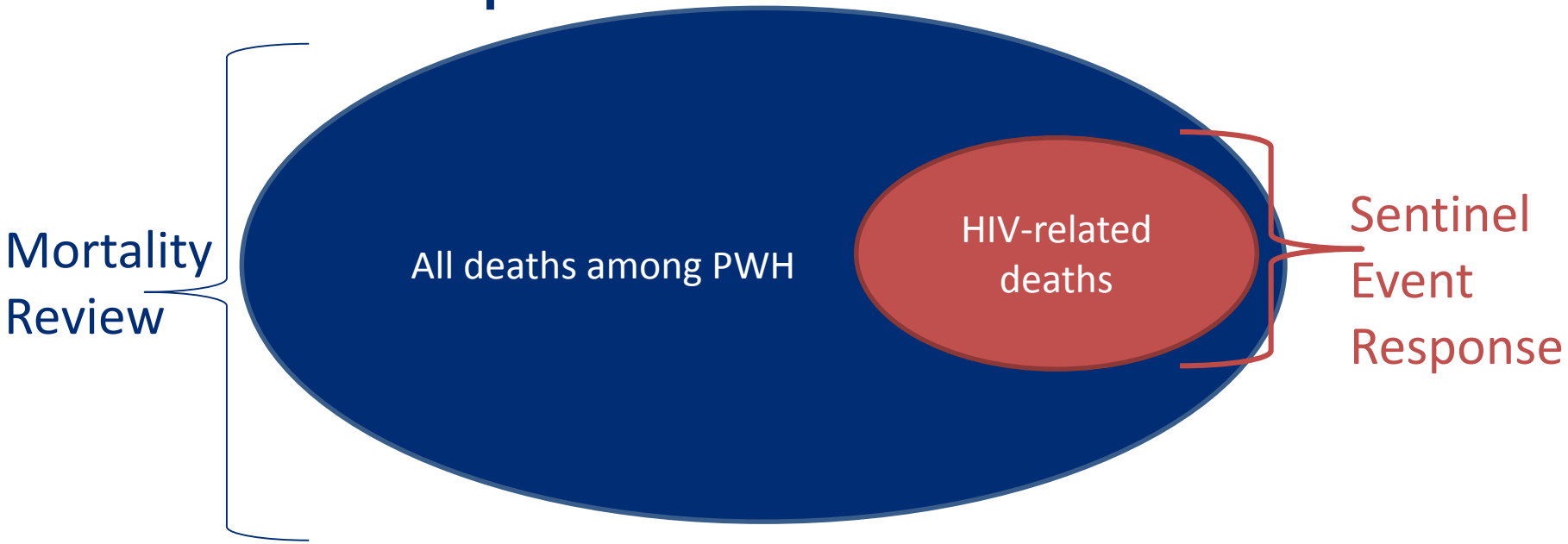
1. QOC Program Mortality Review vs. AIDS Mortality Sentinel Event Response

2. Changes in the tool since September 2017

3. Preliminary guidance on review methodology

4. Remaining topics for discussion

Quality of Care Program Mortality Review V.S. AIDS Mortality Sentinel Event Response



- The actions taken at the organization-level as a result of the mortality review will contribute to the sentinel event response efforts

New York State Mortality Data Collection Form:

Updates since September

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Introduction Section

Can help identify location of relevant medical information for patients who were not active at your site

1. Active Patient: ☐ Yes ☐ No

If no, name of organization where patient is active_ _____ ☐ Unknown

Date of last known outpatient visit: ____/___/_____ ☐ Unknown
MM/ DD/ YYYY

From the beginning, can stratify based on whether access to HIV care/treatment might have been a concern

2. Died at Institution: ☐ Yes ☐ No

If no, facility/location where death occurred: _____

3. a. Patient's zip code_____ b. Zip code of facility where patient
c. Zip code of facility where patient died (if different) _____

4. On ART at time of death: ☐ Yes ☐ No 5. Virally suppressed at time of death: ☐ Yes ☐ No

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Section Order

1. **Data Sources***
2. Background Demographics
3. Risk Factors
4. Co-Morbidities
5. ART and Laboratory Values prior to Death
6. Hospitalizations
7. **Post-Mortem/ Autopsy***
8. Cause of Death
9. Medical Treatment
10. **Access to Care***

Understand completeness of review from the beginning

Information is relevant to assessing cause of death

New section!

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Section 1: Data Sources

- Assess whether available data provide a complete history of events leading to death as opposed to completeness of each data source

Section 2: Background Demographics

- No longer asks for sex assigned at birth, only current gender identity
- Insurance categories expanded to include all HIV Uninsured Care Programs

Sections 3, 5, 6: *no changes*

Section 4: Co-Morbidities

- History of Depression: now puts 12 month timeframe for evidence of having received clinical care or medication for depression to better distinguish factors related to depression that may be relevant to the cause of death

Section 7: Post-mortem/ Autopsy

- Now specifies formal verbal autopsy, as opposed to informal conversations with friends and family of the decedent

Section 8: Cause of Death

Cause of Death	Illness/ Condition/ Injury (From table C)	CoDe (01-92)	Certainty[a]		
			Definite	Likely	Possible
Condition that directly caused death (			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
Due to or as a consequence of:			☐	☐	☐
Condition that initiated the train of morbid events **(Underlying Cause)**	ICD10 code (optional)__ __ __._ __ __		☐	☐	☐

Reviewers will include cause of death codes from original CoDe protocol

[a]**Certainty of Diagnosis: Definite**=95-100% certainty, **Likely**=80-95% certainty, **Possible**=50-80% certainty

Section 9: Medical Treatment *(formerly adverse effects of medical treatment)*

A1. Was the death considered to be related to an adverse eff

☐ Yes ☐ No ☐ Possibly

A2. The suspected relation was to: ☐ Antiretroviral treatment ☐ Other medical treatment or procedure

B1. Were there difficulties accessing a

dition, or injury that the patient had at the time of death (see tabl

☐ Yes ☐ No ☐ Possibly

B2. The difficulty was in accessing: ☐ Antiretroviral treatment ☐ Other medical treatment or procedure

C1. Was inappropriate treatment given for a

ient had at the time of death (see table 8.C)

☐ Yes ☐ No ☐ Possibly

C2. The inappropriate treatment was related to: ☐ Antiretroviral treatment ☐ Other medical treatment

Please provide a brief narrative for any question to which the response was "yes" or "possibly":

nt

Adverse effects

Difficulty accessing

Inappropriate treatment

Section 10: Access to Care

A. Were there delays in access to general or specialty care identified in this review?

☐ Yes ☐ No ☐ Unknown

Please provide a brief narrative indicating what kind of care was delayed and any identifiable reasons why the patient was delayed in accessing or unable to access the indicated care.

B. Was the patient receiving care coordination services during the 12 months prior to death? ☐ Yes ☐ No ☐ Unknown

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Preliminary Guidance on Review Methodology

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Identifying Decedents for Review

- 2017 deaths to be identified by the reviewing organization as part of 2017 Organizational HIV Treatment Cascade process
- Organizations **ARE** responsible for:
  - Deaths among active patients
  - Deaths among any PLWH who die at the institution
- Organizations are **NOT** responsible for reviewing non-active patients who died elsewhere
- A representative sample can be reviewed for organizations with more than a certain number of decedents—guidance for sampling methodology will be provided

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Completing the Review Form

- 1 or more people (but no more than a small group) can complete each form

- Reviewers should have appropriate knowledge, skills and access to information

Identifying and Addressing Quality Issues

(Ideas under consideration)

- Organization-wide (broken down by site/service locations if relevant) **summary** of quality of care issues identified
  - Quality issues may be evident throughout the review tool, particularly in sections 9 and 10
  - Guidance will be developed for identifying and grouping system-level factors that contribute to death

- **Action plan** focusing on issues that can be addressed through QI

Remaining Discussion Topics

Incomplete information

- Decedent was an active patient who died outside of the institution→ reviewing organization may be missing information on the immediate cause of death
- Decedent was a non-active patient who died at the institution→ reviewing organization may be missing information on past medical history

How do we bring together relevant information from multiple institutions???

- AI Staff and Mortality Review Subcommittee Members will be continuing discussions to determine possible resources for overcoming this barrier

Other topics

1. Threshold for reviewing all decedents vs. a sample

2. Format for distribution of tool (fillable PDF?)

3. Timeline for review

4. Details of review report to be submitted by each organization

Next Steps

1. Meetings of Mortality Subcommittee chairs and AI leadership to discuss resources for bringing together information from multiple institutions

2. Methodology Subgroup meeting to discuss details of review scope and timeline

3. Analysis Subgroup meeting to discuss review reporting requirements