Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 2005-056

December 1, 2005

MORTALITY ASSESSMENT

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy regarding the assessment of mortality at Department of Veterans Affairs (VA) medical centers.

2. BACKGROUND

a. In response to a 1999 Office of Inspector General (OIG) report on VHA Quality Management, the Chief Network Officer issued guidance to the field on the importance of mortality analyses and the implementation of Veterans Integrated Service Network (VISN) statistical consultant services to support statistical analyses related to trending mortality and morbidity. The field has attempted varied measurement approaches without success. The measurement obstacles include difficulty detecting true difference or unusual patterns, no valid method for risk adjustment in a clinically complex patient population, and small number of outcomes. These measurement complications challenge assessment of mortality in any health care system. Standardized trending is one mechanism to identify and review any unexplained increases in mortality.

(1) In response to a series of recent OIG reports on VHA quality management, VHA reiterates its support to review all deaths at all VA medical centers, to conduct further review of all mortality events that meet established criteria or appear suspicious (e.g., clinical review, peer review, administrative investigation), and to continue to track population mortality among VA system users.

(2) The intent of this Directive is to reduce confusion in the field about standardized mechanisms to trend mortality data to identify suspicious events and trends. Although VHA recognizes there are many methodological challenges to mortality measurement and implementation of mortality assessment in the field, it continues to explore approaches to systematic identification of suspicious deaths at all its facilities.

b. **National Mortality Database.** VHA continues to examine mortality through the ongoing maintenance of a national database, jointly managed by the VISN Service Support Center and the Management Science Group, that tracks deaths in the veteran user population by clinical condition. This system tracks deaths for all VA patients that occur in and outside VA facilities; it employs the Clinical Classification System for Health Policy Research (CCHPR) and a risk adjustment system (Charlson Index). However, the limited risk-adjusted capability and the absence of actual cause of deaths prevent wide-spread use of the database to profile hospitals. The database can be used to address questions about how the specific disease profile of deceased veterans fits into the background risk of deaths for each facility and clinical classifications. Techniques are not currently available for implementation of a comprehensive population risk-adjusted assessment of mortality.

THIS VHA DIRECTIVE EXPIRES DECEMBER 31, 2010

c. **Education.** Educational and training opportunities for VHA staff that collect, analyze, or use quality data in their decision making process is available through the Employee Education System Learning Catalog at http://vaww.sites.lrn.va.gov/vacatalog/. Search on the key words Quality Improvement, Performance Improvement, or Data Management for a listing of current offerings.

3. POLICY: It is VHA policy that standardized trending of deaths that occur in VA inpatient or procedure units is to be implemented at each medical facility.

4. ACTION: Each facility Director is responsible for ensuring that:

a. Trending of mortality data to identify suspicious events and trends is implemented. Deaths are to be trended by facility, ward, service line, shift time, and provider when a specific provider can be linked to the care of specific patients, i.e., attending physician.

b. Results are plotted and/or graphed and discussed in a regular forum (e.g., Executive Counsel, quality management (QM) meetings, Mortality and Morbidity (M&M) Committee) to identify unusual patterns and trends. Unusual patterns or trends in mortality data are to be identified using reasonable interpretation of trend lines or curves plotted from the data.

NOTE: *See Attachment A for graph examples that can be used to display results. Facilities may use a variety of graphical formats to display and understand data including histograms, bar or line graphs, trend charts, etc.*

c. All deaths associated with unusual patterns undergo a formal peer review process within each facility. Clinical staff must perform this qualitative analysis of each death to identify any suspicious events and report findings to the facility leadership. Additionally, all deaths must be screened against death review criteria and exceptions to the death review criteria (see Att. B). Cases that meet criteria must be referred for protected peer review for quality improvement.

d. All mortalities and all major morbidities associated with any surgical procedure (whether elective or not) and/or any mortality later during the same hospitalization (or related to readmission for the same condition) are peer reviewed within 30 days of the original procedure, in accordance with national surgical guidance. ***NOTE:*** *Formal tests of statistical significance or methods of risk adjustment are not required since there is not a good model currently in use to confidently detect true differences or trends with a small number of outcomes and a clinically complex patient population.*

NOTE: *Morbidity review and analysis are required, e.g., M & M Surgical Review; however, the type and complexity of morbidity analysis conducted is at the discretion of each facility's medical center Director, with the awareness of the inherent limitations with morbidity measurement (e.g., casemix adjustment, small numbers, etc.).*

5. REFERENCES: None.

6. FOLLOW-UP RESPONSIBILITY: The Chief Quality and Performance Officer (10Q) is responsible for the contents of this Directive. Questions may be addressed to 202-273-8936.

7. RESCISSIONS: None. This VHA Directive expires December 31, 2010.

S/Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health

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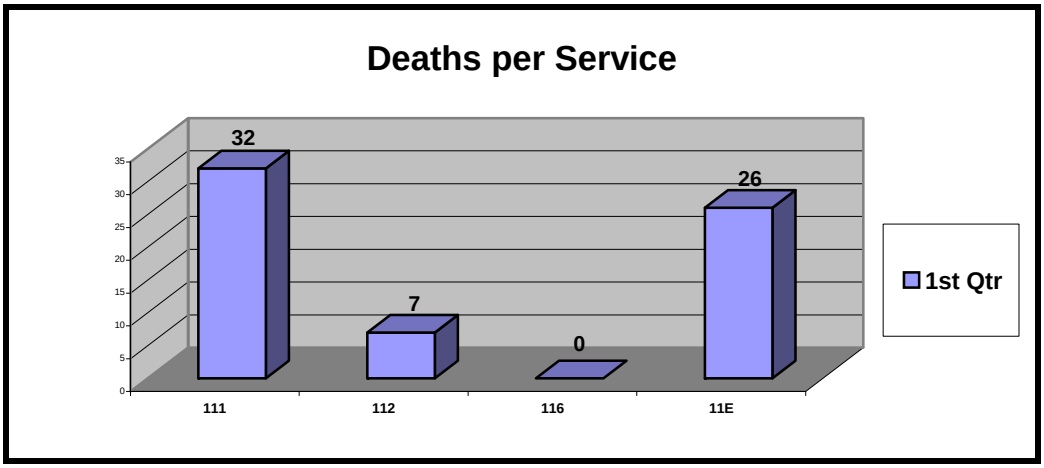
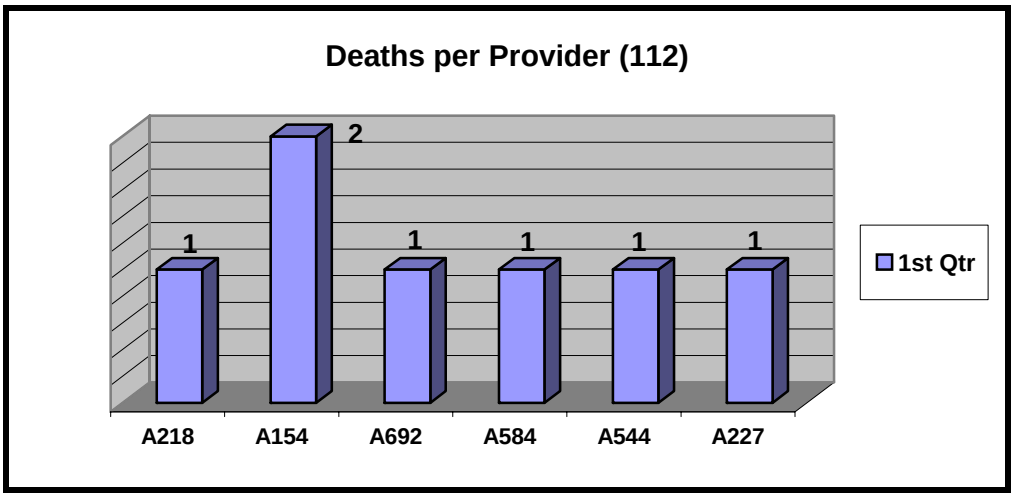
ATTACHMENT A

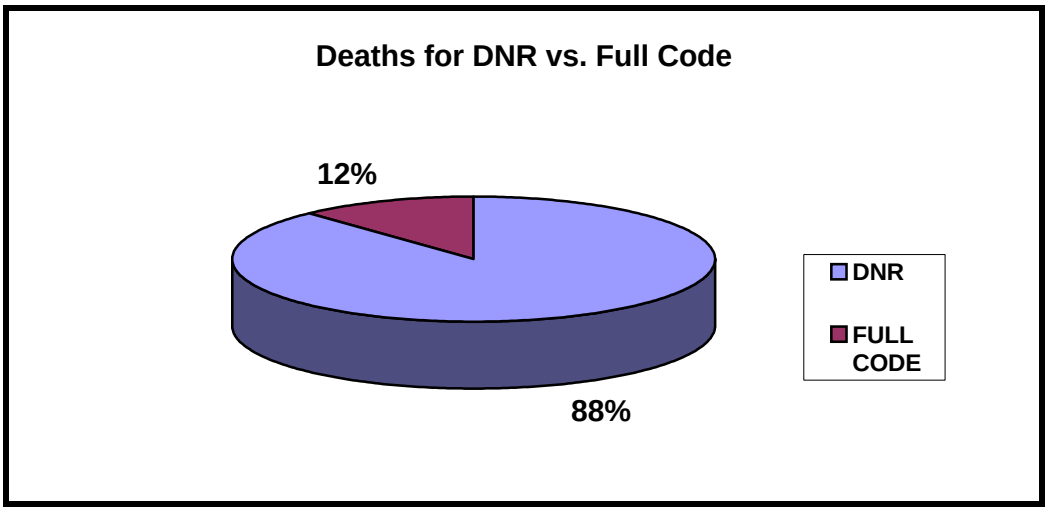
Sample # 1. Mortality Report 1st Quarter Fiscal Year (FY) 2003



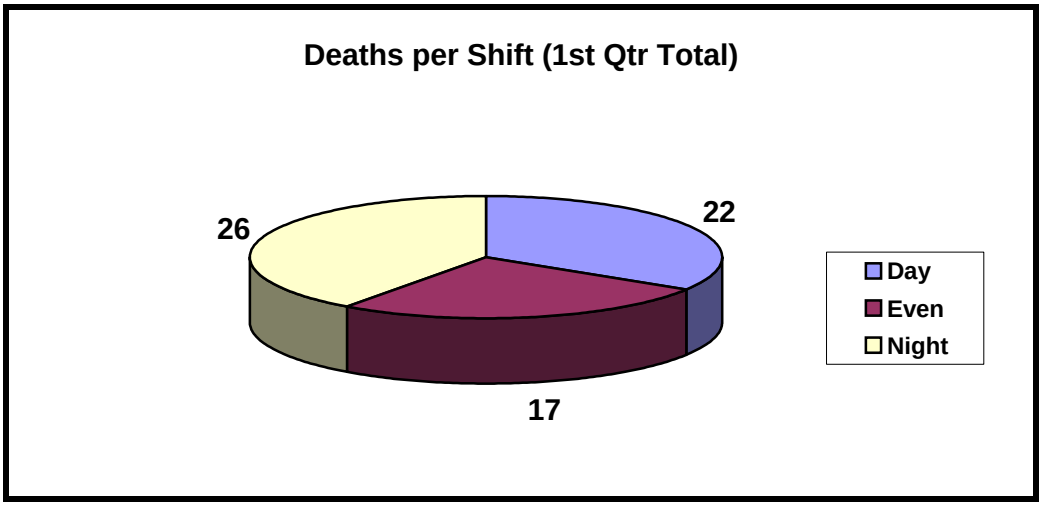
Sample # 2. Mortality Report 1st Quarter FY 2003



Sample # 3. Mortality Report 1st Quarter FY 2003

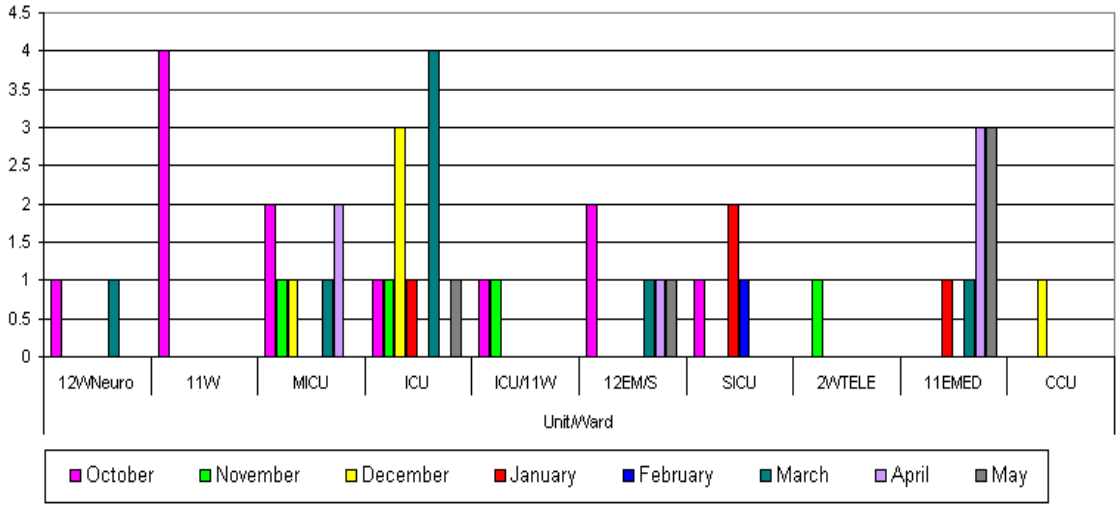


Sample # 4. Mortality Report 1st Quarter FY 2003



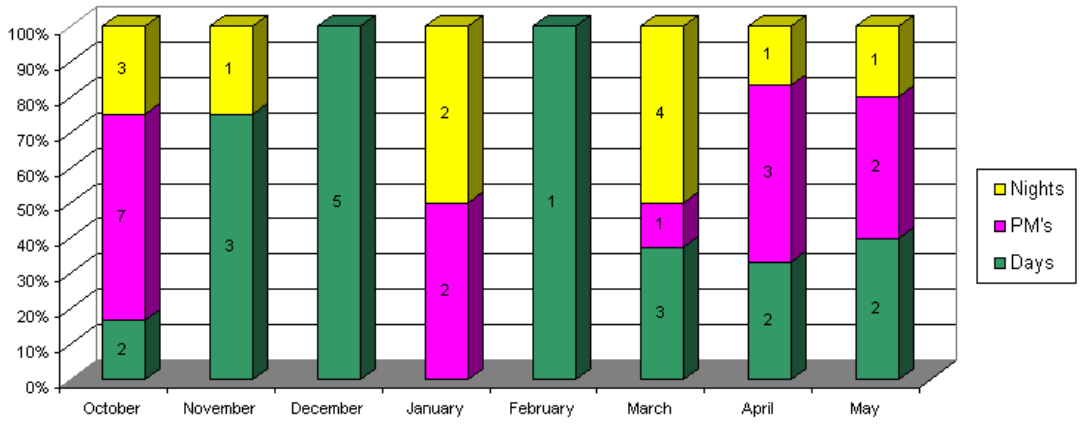
Sample # 5. Mortality Report 1st Quarter FY 2003

Deaths within Wards in Hospital B – FY 03
Data Source: Data Submitted by each Facility



Sample # 6. Mortality Report 1st Quarter FY 2003

Deaths within Shifts at Hospital B – FY 03



Data Source: Data Submitted by each Facility

ATTACHMENT B

DEATH REVIEW SCREENING CRITERIA

If any of the following criteria is present, peer review is required.

1. If there is lack of documentation of patient's deterioration during 48 hours preceding death.

2. If there was a change in patient's condition with no action taken during 48 hours preceding death.

3. If there was a cardiac or pulmonary arrest, could it have been avoided?

4. If there was a lack of concordance between patient's pre-mortem and post-mortem diagnoses.

5. If it appears there were signs of patient's deteriorating condition that should have been noted and/or communicated to the physician, but were not.

6. If death appears to be related to a failure to carry out orders.

7. If there is a lack of documentation indicating explanation for the death.

8. If there is a lack of documentation indicating that the patient's death was expected.

9. If death appears to be related to a hospital-incurred incident or a complication of treatment.

10. If death occurs within 24 hours of admission (except in cases in which death is anticipated and clearly documented, such as transfer from hospice care).

11. If death occurs within 72 hours of transfer out of a special care unit (unless the transfer was made because death was expected).

12. If death occurs during or within 30 days of a surgical procedure or (if after 30 days) death is suspected to be related to the original procedure.

13. If death appears to be related to a medication error or a choice of medication.

14. If there is any reason to think death may have been preventable.