HEALTHWEST

Policy

No. 04-021

Prepared by: | Effective: November 1, 1989
Reviewed: April 6, 2018

Risk Management Committee

Approved by: | Subject: Reporting a Review of Recipient Death

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Julia Rupp, Executive Director

I. POLICY

The policy of HealthWest is that all deaths of persons receiving HealthWest services at the time of death be internally reviewed by appropriate clinical, supervisory, and Recipient Rights staff and reported to designated MDHHS representatives.

II. PURPOSE

To ensure that appropriate services were provided to the recipient and that correct reporting procedures were followed by CMH and contracted provider staff.

III. APPLICATION

All HealthWest employees and contracted providers.

IV. DEFINITIONS

Death: Expired.

V. PROCEDURE – ALL DEATHS

A. Primary Therapist/Worker:

1. Notifies their immediate supervisor and Recipient Rights Officer/Advisor of recipient death and completes/obtains an Incident Report (C260) within twenty-four (24) hours.

2. Request/obtains a copy of the Certificate of Death from the County Clerk's office and completes a HealthWest Report of Death form (C272). A Certificate of Death can be requested from the County Clerk's office through interagency mail. This information is forwarded to the immediate supervisor who will then forward all documents to the Recipient Rights Officer within thirty (30) days.

3. Primary worker will request an Autopsy Report from the Muskegon County Health Department/Coroner's Office if one is completed. It may take up to three (3) months for it to be ready for distribution.

4. Complete and finalize a Discharge Summary in the Electronic Record.

5. Complete SS/DHS Status Change Form (DSH 3471) to stop benefits and payments.

B. Designated Supervisor:

1. Follows the Agency hierarchy to notify the Executive Director/Designee, Executive Team, and Recipient Rights Officer of the recipient death within twenty-four (24) hours from the time of notification of death.

2. Reviews the Incident Report (C260) and Report of Death form (C272), comments/investigates as needed, and forwards the completed forms to the Recipient Rights Officer/Advisor within time frames as specified in Policy & Procedure No. 04-019 – Reporting Unusual Incidents, Section IV.

3. The supervisor will determine the need for a critical incident review with their staff member(s) of each recipient death as part of the quality improvement process.

4. The supervisor will assure the autopsy report is requested from the County Medical Examiner when an autopsy has been completed. (Note: The Medical Examiner will determine if an autopsy is necessary.)

C. Recipient Rights Officer/Advisor:

1. Reviews Incident Report, Report of Death, Certificate of Death, and autopsy report when available. Investigates any apparent recipient rights violations.

2. Forwards reports as indicated to Executive Director/Designee, Deputy Director, responsible Program Manager, and PIHP Regulatory Manager.

3. The Recipient Rights Officer/Advisor shall inform the Recipient Rights/Personnel Committee monthly of the total number of recipient deaths.

4. On a biannual basis, the Recipient Rights Officer/Advisor shall complete an aggregated report of death, which shall be forwarded to Contract Management staff members at the Michigan Department of Health and Human Services (MDHHS) Mental Health and Substance Abuse Administration.

5. In addition, the PIHP shall immediately notify MDHHS of any consumer death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation. This report shall be submitted electronically within forty-eight (48) hours of

either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification that a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:

a. Name of beneficiary;

b. Beneficiary ID number (Medicaid, ABW, MIChild);

c. Consumer ID (CONID) if there is no beneficiary ID number;

d. Date, time, and place of death (if a licensed foster care facility, include the license number);

e. Preliminary cause of death; and

f. Contact person's name and e-mail address.

6. The RRO/Advisor initiates protocol for a Sentinel Event if criteria are met or if a Critical Incident.

D. Recipient Death at a HealthWest Service Site:

1. For a HealthWest directly-operated residential facility or contracted HealthWest program location: If recipient death occurs while the recipient is under the direct care of a HealthWest employee, the on-site provider, volunteer, or responsible HealthWest staff must notify Central Dispatch.

2. For Contract Services sites: HealthWest staff that is made aware of a recipient death at a contract service site must assure appropriate notification to Central Dispatch.

3. Supervisory Notification: Responsible HealthWest staff must immediately notify their direct supervisor that Central Dispatch has been called. The supervisory hierarchy will be followed to notify the HealthWest Executive Director/Designee. Staff must complete paperwork as required in Policy 04-019.

V. REFERENCES

Public Mental Health Manual III-001-00110, VI-002-0002T.
HealthWest Policy and Procedure No. 04-005.
HealthWest Policy and Procedure No. 04-019.
MDHHS Master Contract
Attachment: Report of Death (C272) and Instructions
Attachment: Incident Report (C260)

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HEALTHWEST

REPORT OF DEATH

Report Date: ______ **Name:** ______ **Case No.:** ______

HealthWest Program: ______ **Birthdate:** ______

Admission Date: ______ **Date & Time of Death:** ______

Place of Death: ______ **Autopsy Done:** **Yes** ☐ **No** ☐

Discharged from State Facility Within Last 6 Months: **Scheduled:** **Yes** ☐ **No** ☐

Yes ☐ **No** ☐ **Requested:** **Yes** ☐ **No** ☐

Discharged from a Psychiatric Unit in Last 30 Days: **Autopsy Attached:** **Yes** ☐ **No** ☐

Yes ☐ **No** ☐

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1. Death Expected: ☐ Unexpected, Unexplained, Unusual: ☐ Under Hospice Care: ☐

2. Diagnoses (Medical & Psychiatric):
   Axis I ______
   Axis II ______
   Axis III ______

3. Suspected/Stated Cause of Death: ______

4. Relevant Past Medical History: ______

5. Recent Changes in Medical Status: ______

6. Date Condition Changed: ______

7. Summary of Medical Condition and Treatment Preceding Death: ______

8. Medications (Dose and Time Administered):
   A. Last 24 Hours: ______
   B. Last 30 Days: ______
   C. Or attach complete/current med sheets.

9. Circumstances Surrounding Death, Including Treatment: ______

Attach additional sheets as needed.
Attach a copy of the Incident Report.

(Required for Death in 24-hour Residential Care)

______
Signature of Health Professional

______
Supervisor's Signature

C272 (Rev. 04/21/15)
(Closed Files)

AUTHORITY: Title 45 CFR - Social Security Act.
COMPLETION: Required.
PENALTY: Non-issuance of public assistance.

DHS/SSA REFERRAL

Michigan
Department of Human Services

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

1. **TO:**	3. **FROM:**		
2. Address	4. Address:		5. Phone Number
	6. Date	7. Load Number	8. Worker Signature

8. Name of Person				9. Date of Birth
10. Address (Number & street)	City	State	Zip Code	11. Phone Number
12. DHS Case Number	13. Social Security Account Number		14. Social Security Claim Number	
15. Name of Spouse				16. Date of Birth
17. Current Status with Referring Department				

18. CHECK AND COMPLETE APPROPRIATE SECTION(S) BELOW

☐ **Part A. ACTION REQUESTED: DETERMINATION OF LEVEL OF CARE**

Name of Facility	Date of Placement
Address	Phone Number

Children Only: ☐ State Ward ☐ Court Ward ☐ Other Supervising (Placement) Agency

AUTHORIZATION OF LEVEL OF CARE

Level of care has been determined, client qualified for: ☐ Domiciliary Care ☐ Personal Care ☐ Home for Aged Care

Authorizing Worker Signature	Phone Number	Date

☐ **Part B. OTHER ACTION REQUESTED (Describe)**

ACTION TAKEN BY RECEIVING DEPARTMENT

Receiving Department Worker Signature	Phone Number	Date

☐ **Part C. INFORMATION FOR USE BY RECEIVING DEPARTMENT**

Effective Date: Source:

19. ADDITIONAL REMARKS:

DHS/SSA REFERRAL
INSTRUCTIONS FOR USE

General: This form is used only to exchange information regarding SSI applicants and recipients. To obtain information about regular Social Security and Medicare see PAM item 800.

The purpose of this form is to exchange information with the Social Security offices. The Department of Community Health, Community Health Services, or their agents also use this form for “determination of level of care” purposes.

The Department initiating the form is called the “originating department.” The department to whom the form is sent is called the “receiving department.”

Items 1 through 17 are to be completed by the originating department.

- 1 - 2. Enter name and address of department to whom the form is being sent.
- 3 - 5. Enter the name, address, and telephone number of department sending the form.
- 6 - 7. Enter the date and signature of person sending the form.
- 8 - 12. These items identify the person about whom information is being requested or reported.
- 13. Enter the person’s Social Security Account Number.
- 14. Enter the number under which the person is receiving RSDI or Medicare.
- 15 - 16. Enter name and birth date of spouse.
- 17. Enter current program status with originating department of person about whom information is being requested or reported. Enter program information on this line and give eligibility, closure, or denial date.
- 18. Originating department checks the appropriate block or blocks (Part A - Part B - Part C).
- 19. To be used by either department to add additional information.

PART A. ACTION REQUESTED: DETERMINATION OF LEVEL OF CARE

Requests for a level of care determination: SSA (or other department) fills in the name, address, and telephone number of the facility and the date of placement. If the SSI recipient is a child, check legal status and fill in name of supervising (placement) agency. (If any of these items are not known, the receiving department should fill in the missing information.)

Authorization of Level of Care

The Department of Human Services, Department of Community Health, Community Health Services, or their agents complete this section. The worker authorizes the proper level of care by checking one of the boxes, then signs and dates name.

A new level of care determination is required whenever a recipient moves to a different facility.

When the Department of Community Health, Community Health Services, or their agents authorize the level of care, note special instructions for distribution below.

PART B. OTHER ACTION REQUESTED

In this section the originating department can request specific information (other than level of care) or request that any department take specific action. Example: SSA may refer a person to DHS for possible assistance or request that DHS find a representative payee for a SSI recipient.

Action Taken by Receiving Department

This section is to be completed by the receiving department. Give the requested information or describe what action has been taken. The receiving department signs and dates name.

PART C. INFORMATION FOR USE BY RECEIVING DEPARTMENT

This section is to be used by the originating department to inform the receiving department of information which has come to their attention. No reply from the receiving department is expected.

The effective date is the date on which the event or relayed information took place (e.g. date of death).

The source is the person or place from whom the originating department got this information (e.g. relative, other department, etc.).

DISTRIBUTION: The originating department sends the original copy to the receiving department and retains a photo copy for the file. If a reply is needed, the receiving department returns the original copy to the originating department and retains a photo copy for the file.

NOTE: The Department of Community Health, Community Health Services, or their agents must send a photo copy to the local Department of Human Services if the person is an adult. For children, a photo copy is sent to Child and Family Services, Children’s Foster Care Program, Department of Human Services, P.O. Box 30037, Lansing, MI 48909.

INCIDENT REPORT

REPORT DATE	REPORT TIME	REPORTING AGENCY	REPORTING PROGRAM/ HOME	
CONSUMER NAME		CASE NUMBER	GENDER	AGE/DOB

WHEN DID YOU DISCOVER INCIDENT (Date & Time) ☐AM ☐PM	WHEN DID IT HAPPEN (Date & Time) ☐AM ☐PM	WHERE DID INCIDENT HAPPEN (Specific Location)

CONSUMER(S) INVOLVED: _______

EMPLOYEE(S) INVOLVED AND/OR PRESENT: _______

EXPLAIN WHAT HAPPENED: _______

ACTION TAKEN BY STAFF: _______

PHYSICAL INJURY APPARENT? ☐YES ☐NO	REPORTING PERSON'S SIGNATURE & TITLE:	DATE:

REVIEW/COMMENTS FROM SC/CSM/CC: _______

ASSIGNED SC/CSM/CC NAME: (PRINT CLEARLY)	SIGNATURE:	DATE:

IF RELATED TO BEHAVIOR PROGRAM AND/OR P.I., REVIEW AND COMMENTS BY PSYCHOLOGIST: _______

ASSIGNED PSYCHOLOGIST NAME (PRINT CLEARLY):	SIGNATURE:	DATE:

IF INJURY, DESCRIPTION OF INJURY AND CARE/TREATMENT GIVEN BY PHYSICIAN OR R.N.: _______

DATE & TIME CARE GIVEN ☐AM ☐PM	EXTENT OF INJURY AT THIS TIME ☐SERIOUS ☐NONSERIOUS		
IF SERIOUS INJURY: DATE & TIME DIRECTOR OR DESIGNEE NOTIFIED ☐AM ☐PM	IF SERIOUS INJURY: DATE & TIME RIGHTS OFFICER NOTIFIED ☐AM ☐PM	PHYSICIAN'S OR R.N. SIGNATURE	DATE:

DESIGNATED SUPERVISOR (State program or administrative action to remedy and/or prevent reoccurrence of incident, including disciplinary action):
____

NAME OF EMPLOYEE ASSIGNED TO CONSUMER AT TIME OF INCIDENT:	DESIGNATED SUPERVISOR'S SIGNATURE:	DATE:

WITHIN 24 HOURS, DISTRIBUTE: **WHITE COPY to Provider** **YELLOW COPY to Office of Recipient Rights**

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