

Department of Behavioral Health  
**TRANSMITTAL LETTER**

<b>SUBJECT</b> Mortality Review		
<b>POLICY NUMBER</b> DBH Policy 115.1	<b>DATE</b> JAN 13 2016	<b>TL#</b> 296

**Purpose.** This policy establishes the procedures for reviewing deaths of individuals receiving services from the Department of Behavioral Health (DBH) and its providers (mental health and substance use disorder services providers). The mortality reviews described in this policy are in addition to any other investigations conducted by DBH or other official entities.

This revision adapts the policy from the former Department of Mental Health, now merged into the new Department of Behavioral Health, in accordance with the DBH Establishment Act of 2013.

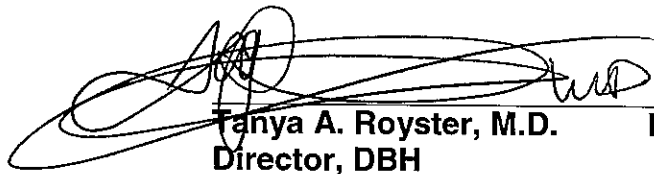
**Applicability.** Applies to the following: Core Services Agencies (CSAs), Substance Use Disorder (SUD) Treatment Providers with a Human Care Agreement, Saint Elizabeths Hospital (SEH), Comprehensive Psychiatric Emergency Program (CPEP), Psychiatric Residential Treatment Facilities (PRTFs), and contracted hospitals.

**Policy Clearance.** Reviewed by affected responsible staff and cleared through appropriate Behavioral Health Authority (BHA) offices.

**Effective Date.** This policy is effective immediately.

**Superseded Policy.** This policy replaces DMH Policy 115.1A, same title, dated February 04, 2013.

**Distribution.** This policy will be posted on the DBH web site at [www.dbh.dc.gov](http://www.dbh.dc.gov) under Policies and Rules. Applicable entities are required to ensure that affected staff is familiar with the contents of this policy.

  
Tanya A. Royster, M.D.      Date 1/13/2016  
Director, DBH

<p>GOVERNMENT OF THE DISTRICT OF COLUMBIA</p> <p>***</p> <p>DEPARTMENT OF BEHAVIORAL HEALTH</p>	<p><b>Policy No.</b> <b>115.1</b></p>	<p><b>Date</b> <b>JAN 13 2016</b></p>	<p><b>Page 1</b></p>
<p><b>Subject: Mortality Review</b></p>			

Supersedes  
DMH Policy 115.1A, Mortality Review, dated  
February 4, 2013

1. **Purpose.** This policy establishes the procedures for reviewing deaths of individuals receiving services from the Department of Behavioral Health (DBH) and its providers (mental health and substance use disorder services providers). The mortality reviews described in this policy are in addition to any other investigations conducted by DBH or other official entities.
2. **Applicability.** Applies to the following: Core Services Agencies (CSAs), Substance Use Disorder (SUD) Treatment Providers with a Human Care Agreement, Saint Elizabeths Hospital (SEH), Comprehensive Psychiatric Emergency Program (CPEP), Psychiatric Residential Treatment Facilities (PRTFs), and contracted hospitals.
3. **Authority.** D.C. Law 2-139, the Department of Behavioral Health Establishment Act of 2013 § 7-1131.01 and 22 DCMR Chapter A34, Mental Health Rehabilitation Services (MHRS) Provider Certification Standards, 22 DCMR Chapter 63, Certification Standards for Substance Use Disorder Treatment and Recovery Providers, and 42 CFR Part II.
4. **Policy.** Mortality reviews shall be conducted to: (1) review the cause of consumer/client deaths; (2) assess the quality of services and treatment provided prior to their deaths; and (3) to identify trends and develop recommendations for improvements for the providers and system-wide service delivery.
5. **Procedures.**
  - 5a. Each provider shall:
    - (1) Assign responsibility for the mortality review and completion of a mortality review report to an individual or committee.
    - (2) Conduct a mortality review of all consumer/client deaths regardless of the circumstances of death (Exhibit 1- flowchart of the mortality review process).
    - (3) Ensure that the medical director or other designated physician evaluates the consumer/client's treatment history prior to death and identifies any medical care issues at the provider level.
    - (4) Include the cause of death on the Mortality Review Report (Exhibit 2) and whether the finding was based upon clinical judgment, autopsy, or death certificate.
    - (5) Conduct an initial expedited review (see section 11(3) below) for all suicides, homicides, unexpected deaths at SEH or CPEP, deaths of children/youth consumer/clients

or other deaths reported as a major unusual incident (see DBH Policy 480.1). Complete and submit the expedited review and report within ten (10) working days from the date of, or notification of death.

(6) Forward the Mortality Review Report to the organization's CEO (or equivalent) following approval by the responsible medical director/clinical director, prior to submission to DBH as required in Section 6b below.

5b. In addition to the above, providers shall.

(1) Submit Mortality Review Reports to the DBH Division of Incident Management and Investigations (DIMI) within forty five (45) calendar days of a death or notification of death, or sooner if an expedited review is warranted as indicated in Section 11 (3).

(2) Note outstanding information in the Mortality Review Report, if information from autopsy reports, death certificate, or other external sources is pending. Forward the additional information once received to the DBH DIMI as an addendum to the original Mortality Review Report, within fifteen (15) days of receipt.

(3) Initiate and maintain a quarterly tracking log (see Exhibit 3) of all performance improvement and corrective action plans or recommendations generated from Mortality Review Reports. The tracking log will include the date a recommendation was completed or fully implemented. Items must be carried over to the next quarter until completed or fully implemented. Forward a copy of the log to DBH DIMI by the fifth day following the end of each quarter (January 5, April 5, July 5, and October 5).

5c. In addition to the above, SEH shall submit the following reports to DBH:

- (1) SEH Unusual Incident Report and Investigation Findings;
- (2) SEH Serious Event Review Committee Report (if applicable);
- (3) SEH Death Summary Nursing Review;
- (4) SEH Mortality Review Risk Management Incident Summary;
- (5) SEH Recommendation Tracking Report; and
- (6) SEH Discharge Summary.

5d. Mortality Review Reports from hospital units designated for mental health or SUD treatment that are not under the direct authority of DBH or under contract with DBH, will be addressed as follows:

(1) The DBH Office of Accountability (OA) will collaborate with the DC Department of Health (DOH), the hospitals' licensing agency, regarding the death of patients in hospital units designated for mental health or SUD treatment that are not under the direct authority of DBH or under contract with DBH.

(2) Information gathered from the hospital units shall be included in the DBH Critical Incident and Mortality Review Committee (CIMRC) review process and inform the committee's analysis and response. Unresolved issues and questions about deaths in these

hospitals will be relayed to the DOH in order for DOH to address these concerns with the hospitals.

**6. Specific Responsibilities for Mortality Reviews**

6a. The CSA shall complete the mortality review for consumers/clients who are enrolled with the provider and not at SEH at the time of death. The referring provider shall submit to DBH a mortality review for consumers/clients who have been transferred to a new provider for less than thirty (30) calendar days, and for consumer /clients who have been transferred, but never seen by the receiving provider.

In situations where a consumer is enrolled in a CSA, but receives services from an ACT or CBI Provider, the ACT or CBI team must notify the CSA of the consumer's or client's death; conduct the mortality review in collaboration with the CSA; and submit the Mortality Review Report to DBH.

6b. SEH shall complete the mortality review for all consumer hospitalized at SEH at the time of death, including instances where consumers were temporarily transferred from SEH to another medical facility for care and were expected to return to SEH, and notify the respective CSA of the consumer's death.

6c. CPEP shall complete the mortality review for every individual who dies while under the care of CPEP and those who died within seventy two (72) hours of discharge from CPEP. The Chief Clinical Director may also direct mortality review by CPEP outside of these mentioned circumstances.

6d. PRTFs shall complete the mortality review for DBH consumer/client while under the care of a PRTF.

6e. SUD treatment providers shall complete the Mortality Review for DBH clients who are only enrolled with a SUD treatment provider. If the client is also enrolled with a CSA, the CSA will be responsible for the mortality review.

6f. Providers, PRTFs, Mental Health Community Residence Facilities (MHCRFs), group homes, and any other provider or entity that DBH licenses, certifies or has a contractual relationship with, are required to provide all necessary documentation and information, and to cooperate fully with the CSA or DBH staff in completing the Mortality Review Report.

6g. DBH reserves the right to:

- (1) Initiate a review and investigation by staff at the Department level at any time, including through the major unusual incident reporting process.
- (2) Make final determination on responsibility for conducting mortality review, where necessary, in unusual situations where the responsibility is unclear.
- (3) Facilitate and ensure expedited reviews for any situation, at any time, when warranted.

6h. Any person directly involved in the primary care and/or management of a consumer/client who dies may not conduct the mortality review for that consumer/client; however, the person is expected to provide information to the individual or committee conducting the mortality review.

7. **The DBH DIMI, Office of Accountability Specific Responsibilities.** The DIMI shall:

7a. Conduct initial review of all provider Mortality Review Reports under the direction of the Deputy Director, Office of Accountability, and provide the Mortality Review Reports with comments/recommendations to the DBH Chief Clinical Officer (CCO). The DIMI Director and the CCO will refer reports that need additional review and analysis to the DBH CIMRC.

7b. Track the completion of mortality reviews for all deaths.

7c. Report the completion status of all mortality reviews including any findings and recommendations to the DBH Director through the OA Director on a quarterly basis.

7d. Analyze mortality review findings to identify trends in deaths and problems or gaps in consumer/client care and service delivery, and provide results to the DBH CIMRC quarterly.

8. **DBH Critical Incident and Mortality Review Committee (CIMRC).**

8a. CIMRC Chairperson and Co-Chair. The DBH DIMI Director serves as the Chairperson and the Risk Manager serves as co-chair.

8b. Committee Membership. The CIMRC consists of the following DBH staff:

- (1) Chief Clinical Officer;
- (1) General Counsel;
- (2) OA Deputy Director;
- (3) General Medical Officer;
- (4) Director, Provider Relations;
- (5) OA Investigator; and
- (6) other DBH Behavioral Health Authority representatives, as designated by the DBH Director.

At the request of the Chairperson, the SEH Director of Medical Affairs, Director of Adult Services, Director of Child and Youth Services, and Director of CPEP shall serve on the Committee on an ad hoc basis when mortality reviews are related to their area of responsibility.

8c. Committee Functions. The CIMRC shall:

- (1) Review all Mortality Review Reports involving suicide, unexpected deaths at SEH and CPEP, death of a child/youth (a person under eighteen (18) years of age; or a person under twenty two (22) years of age who receives special education youth or child welfare services with certain conditions) and other deaths referred by the DBH CCO.

- (2) Review and analyze mortality review reports and determine whether the report warrants further investigation for thoroughness and completeness;
- (3) Report in writing mortality review findings, trends, and recommendations to the DBH Director, quarterly, or upon request;
- (4) Convey significant findings, trends, and recommendations to the provider; and
- (5) Make other recommendations relevant to policies, programs or corrective or improvement measures.

8d. Timeline. The CIMRC will complete written findings within thirty (30) calendar days after the CIMRC has reviewed and analyzed the death.

9. **Confidentiality**. Information pertaining to mortality reviews is privileged and will be treated as confidential pursuant to the D.C. Mental Health Information Act, the Confidentiality of Drug and Alcohol Abuse Record Regulations, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). See also DBH Privacy Manual.

10. **Adherence to DBH Mortality Review Policy**. Providers shall have internal policies and procedures related to reporting and reviewing of deaths that adhere to DBH Mortality Review policy. SEH must meet certain mandates that are outside of the DBH CIMRC, and as such, the SEH Mortality Review policy must remain separate but compatible with the DBH policy on Mortality Reviews.

Non-compliance with the requirements of this policy shall result in corrective actions in accordance with DBH regulations and contractual requirements.

11. **Definitions**.

- (1) Consumer/client. Individuals receiving community behavioral health services from DBH for mental health services (consumers) or substance use disorder treatment services (clients). For purposes of this policy, the term “individuals in care” refer to those receiving in-patient services at SEH.
- (2) Expected/Anticipated Death. A death that is a result of a known and documented terminal illness or other condition(s) with poor prognosis.
- (3) Initial Expedited Review. A mortality review for all suicides, homicides, unexpected deaths at SEH or CPEP; deaths of children/youth consumer/client; and other deaths listed in DBH Policy 480.1, Reporting Major Unusual Incidents (MUIs) and Unusual Incidents (UIs). An expedited review must be completed within ten (10) working days from the date of notification.
- (4) Mortality Review. Refers to the examination or analysis of the quality of services and treatment provided to consumer/clients who have died while enrolled at DBH. This process seeks to identify potential gaps in care, trends, and develop recommendations to facilitate improvements for the providers and system-wide service delivery.

(5) Provider. Any individual or entity, public or private, that is licensed or certified by the District of Columbia to provide behavioral health services or supports; or any individual or entity, public or private, that has entered into an agreement with DBH to provide behavioral health services or supports.

(6) Unexpected/Unanticipated Death. A death that was not a result of a known and documented terminal illness or condition(s).

12. **Inquiries**. Questions regarding the contents of this policy should be addressed to the Deputy Director, DBH Office of Accountability.

13. **Exhibits**.

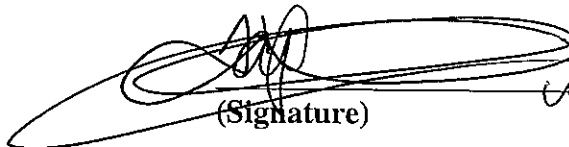
Exhibit 1 – DBH Mortality Review Report (For Use by DBH Providers)


Exhibit 2 – Mortality Review Process

Exhibit 3 – Quarterly Program Tracking Log for Death Reviews

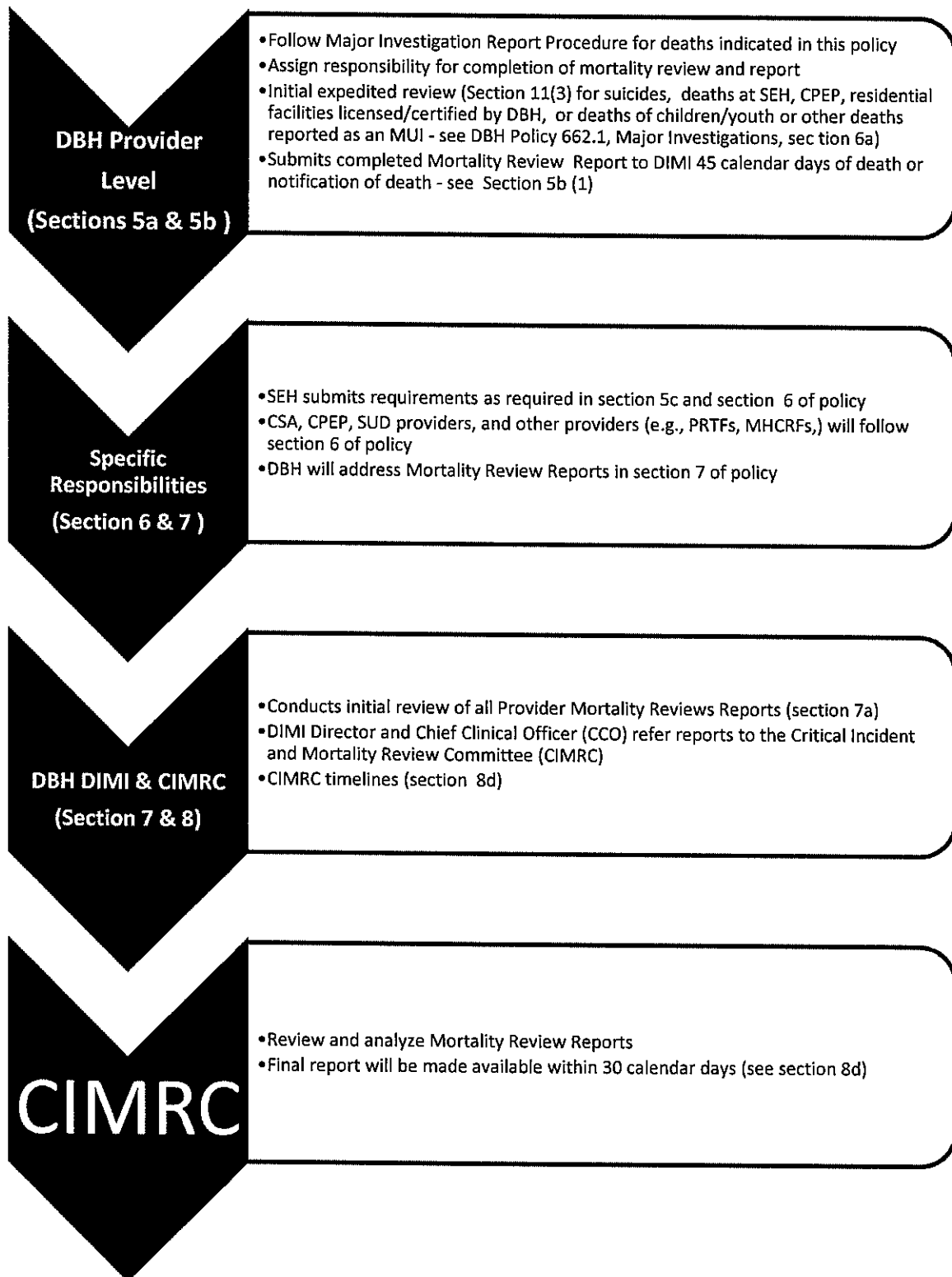
Approved By:

Tanya A. Royster, M.D.  
Director, DBH

  
(Signature)

 1/13/2016  
(Date)

## DBH MORTALITY REVIEW FLOW CHART





**CONFIDENTIAL**

Department of Behavioral Health  
Office of Accountability  
DBH Form # 22

DBH Policy 115.1  
Exhibit 2 Sec. 5a (4)



**DBH Mortality Review Report**  
**For use by Behavioral Health Providers**

Fax the form to the Office of Accountability, Division of Incident Management and Investigations (DIMI) at: **(202) 673 – 2191** or email to **MUI.OA@dc.gov**, within 45 calendar days of a death or notification of death.

**SECTION 1. Background Information**

**1A. Consumer Background Information**

Name – Consumer/Client (Last, First, MI) _____		iCAMS Number _____	Birthdate: __/__/__
Address: _____			Gender: <input type="checkbox"/> M <input type="checkbox"/> F
			<u>DATE OF DEATH</u> __/__/__
Ethnicity (Check One below) <input type="checkbox"/> Black (not Hispanic) <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> American Indian/Alaska native <input type="checkbox"/> White (not Hispanic ) <input type="checkbox"/> Hispanic (Mexican, Puerto Rican, Cuban )		Has this death been reported to the Medical Examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**1B. Mental Health (MH)/Substance Use Disorder (SUD) Provider (if applicable)**

Name of Provider: \_\_\_\_\_

Consumer/Client Enrollment/Admission Date: \_\_\_\_\_

Name of Lead Staff and Title (e.g., Community Support Worker/Clinical Manager/Social Worker): \_\_\_\_\_

Telephone # : \_\_\_\_\_

**1C. Sub-Providers/Specialty Providers (if applicable)**

Sub-providers: \_\_\_\_\_ Specialty Providers: \_\_\_\_\_

Types of Service (circle): SUD Service (Specify: \_\_\_\_\_)

ACT CBI IDT MST Crisis/Emer Day Svcs Comm/Sup C/S Grp Med/Somatic Counseling

Diagnostic/Assess MH Clubhs Supp Ind Livng Supp Employ FFT

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**SECTION 2. Manner of Death** (Please describe circumstances of death and check the applicable box in the area below. Refer to the last page of form if additional space is needed).

**2A Manner of death: Check ALL that apply (Must be completed by Medical Director/Staff)**

- ☐ Natural      ☐ Homicide      ☐ Suicide      ☐ Accidental      ☐ Unknown  
☐ Unexpected      ☐ Expected

**2B Cause of death (specify):**

Check ALL that apply. If Unknown at this time, indicate Unknown, If Preliminary, Check Preliminary:

- |   |   |
|---|---|
| <input type="checkbox"/> Coronary heart disease                             | <input type="checkbox"/> Complications due to Diabetes mellitus |
| <input type="checkbox"/> Stroke and other cerebrovascular diseases          | <input type="checkbox"/> Complications due to HIV/AIDS          |
| <input type="checkbox"/> Renal Failure                                      | <input type="checkbox"/> Other _____                            |
| <input type="checkbox"/> Lower respiratory infections                       | <input type="checkbox"/> Unknown                                |
| <input type="checkbox"/> Chronic obstructive pulmonary disease              | Preliminary _____   |
| <input type="checkbox"/> Complications due to Alzheimer and other dementias |   |
| <input type="checkbox"/> Cancer (specify type): _____                       |   |

**2C. Description of Circumstances.**

Describe in concise narrative form the circumstances surrounding the death. Focus on the current physical/medical and psychiatric conditions that are believed to have contributed to the death. Please include any physical complaints or any unusual behavior exhibited by the consumer during the past month. Include information if individual in care was suffering from a terminal illness or had a chronic condition and the death involved natural course of an illness or disease. If applicable, also include any outreach service provided and date of last contact with consumer and attach last psychiatric note (Attach additional papers, as needed)

Date of Last Contact:

Type of Contact:

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**SECTION 3. Location of Death**

☐ Home / Apartment    ☐ CRF    ☐ SEH    ☐ Nursing Home    ☐ PRTF

☐ Other Hospital (specify) \_\_\_\_\_ ☐ Other (Specify) \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Tel. #: \_\_\_\_\_ email: \_\_\_\_\_

Name of Point of Contact: \_\_\_\_\_ Position: \_\_\_\_\_

Tel. #: \_\_\_\_\_ email: \_\_\_\_\_

**SECTION 4. Law Enforcement Involvement**

Indicate which law enforcement agency was involved, if any: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Tel. #: \_\_\_\_\_

**SECTION 5. For suspicious death, please complete all of the following:**

Awaiting information from Medical Examiner ☐ YES ☐ NO

**SUICIDE** ☐ YES ☐ NO (If yes continue below)

	<u>YES</u>	<u>NO</u>
1. Was there evidence that the consumer was having suicidal thoughts during the last month?	<input type="checkbox"/>	<input type="checkbox"/>
2. Did the consumer make any suicide threats or statements during the last month?	<input type="checkbox"/>	<input type="checkbox"/>
3. Did the consumer make a suicide attempt in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
4. Did the consumer give away personal possessions within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
5. Was the consumer found in a position or circumstance which might indicate the death was due to suicide?	<input type="checkbox"/>	<input type="checkbox"/>

Specify circumstances:

☐ hanging    ☐ drowning    ☐ drug overdose    ☐ gunshot    ☐ jumping    ☐ other (Specify below) \_\_\_\_\_

☐

**HOMICIDE** ☐ YES ☐ NO (If yes continue below)

1. Where did this happen? \_\_\_\_\_

2. Specify circumstances of homicide:

☐ asphyxiation    ☐ gunshot    ☐ stabbing    ☐ beating    ☐ other (Specify below) \_\_\_\_\_

**PHYSICAL RESTRAINTS AND SECLUSION**

	<u>YES</u>	<u>NO</u>
1. Did the consumer die while in restraint or seclusion? (If yes, continue below)	<input type="checkbox"/>	<input type="checkbox"/>
2. Did the restraint/seclusion have a direct relationship on the consumer's death?	<input type="checkbox"/>	<input type="checkbox"/>
3. Did the consumer sustain any injury while in restraint or seclusion?	<input type="checkbox"/>	<input type="checkbox"/>
4. Was the consumer in a prone (face down) position when a physical restraint was used?	<input type="checkbox"/>	<input type="checkbox"/>

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Please provide additional narrative, if the consumer died while in restraint or seclusion.

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**SECTION 6. Diagnostic/Medical Information**

Please attach a copy of the consumer's most recent IRP/IPC.

**6A. Psychiatric / Medical Diagnostic Information**

Date of Most recent ICD-10-CM Diagnosis


**6B. Give narrative account as needed on above ICD-10-CM diagnosis**

(Specify if co-occurring disorder was active problem at time of death)


**6C. Current Psychiatric Medications**

Medication Name	Dosage	Frequency & Length of time on medication	Date of Doctor's /APRN's most recent order	Describe responses to medications and identify any possible drug reactions

**6D. Other Medications**

Medication Name	Dosage	Frequency & Length of time on medication	Date of Doctor's /APRN's most recent order	Describe responses to medications and identify any possible drug reactions

**6E. Psychiatric History**

1. Provide a brief summary of consumer's psychiatric history, including history of suicidal ideation/gestures/attempts, substance abuse, and other high risk behaviors that may have contributed to the consumer's death:
2. Please indicate name of the consumer's treating psychiatrist and the date and time when consumer was last seen by the psychiatrist:
3. Please indicate the date of hospitalizations or emergency room visits within the last year and visits to the Comprehensive Psychiatric Emergency Program (CPEP) for the six month period prior to the death:

6F. Primary Care Physician's Name and clinic(s) name(s)	Telephone # and Address

Is there a copy of the most recent physical exam in your record? ☐ **YES** ☐ **NO** If yes, please give date of last physical examination and lab findings. Are these findings consistent with ICD-10-CM Diagnosis above? \_\_\_\_\_

**Date and Results of any diagnostic studies within the past 180 days** (lab, x-ray, medical procedures that relate to the last physical exam, current medications, or current medical conditions): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION 7. Sources of Information:**

**7A.** Note all sources of information, including the consumer's clinical record(s), consumer's roommates, family, treatment team, etc.

**7B.** Additional pertinent data and/or circumstances.

**SECTION 8. Notification of Death:**

Details of how the family and the agency were notified of the death:

Provide date/time/details of how consumer's family or significant other was notified of death.

Provide date/details of how this facility/agency was notified of death

Assistance offered to the family? (Specify)

**9. SIGNATURES** (must include at least the following three (3) signatures)

- 1.
- Name and signature of person completing this review

Name	/	Signature	Title	Date
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- 2.
- Name and signature of provider's medical director (or contract medical director) reviewing this report.

Name	/	Signature	Title	Date
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- 3.
- Name and signature of CEO/senior executive.

Name	/	Signature	Title	Date
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**Other signature(s) (if required internally)**

Name	/	Signature	Title	Date
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Name	/	Signature	Title	Date
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**PLEASE ATTACH ANY OTHER RELEVANT INFORMATION**

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