

Missouri Division of Behavioral Health

Bulletin Number: FY 14—Clinical #25	COMMUNITY TREATMENT BULLETIN	Effective Date: July 1, 2014
New	Subject: Death Review Processes for Community Behavioral Health Providers and DBH Oversight	Number of Pages: 4

1. Programs Affected

- 1.1 Community substance abuse and mental health treatment providers contracted with the Department of Mental Health (DMH).

2. Background and Purpose

- 2.1 To further consolidate processes within the Division of Behavioral Health (DBH), a uniform death review process has been developed that will apply to agencies providing both substance abuse treatment services and mental health treatment services.

3. Definitions

- 3.1. Discharge Date – In the context of death review processes, this is the last date services were provided by the contracted agency.
- 3.2 Department Client – Such is defined as any person receiving DMH services from a contracted provider that is licensed, certified and/or funded by the DMH.
- 3.3 Child – In the context of death review processes, a child is anyone under the age of 18 years, or including anyone 18-21 years if in alternate care.

4. Provider Policies and Procedures

- 4.1 The contracted treatment provider must have established internal policies and procedures to guide its death review processes.
 - 4.1.1. The procedures must ensure a thorough and timely review is completed by agency staff for all DMH client deaths.
 - 4.1.2. The agency reviews must meet DMH criteria and/or criteria established by a national accreditation organization, whichever is more stringent.
- 4.2 The contracted provider shall notify the DMH of all client deaths that occur during an open episode of care (EOC) or within 15 days of being discharged from services. This is done by completing the Event Management Tracking (EMT) notification process.
- 4.3. Following EMT reporting, the provider shall conduct a review of the client's death based on a determination by a Medical Examiner or Coroner indicating

the circumstances surrounding the cause and manner of death which includes, but is not limited to, the following:

- 4.3.1. Any death of a child;
- 4.3.2. Crime;
- 4.3.3. Suicide;
- 4.3.4. Accidental overdose not attributed to suicide;
- 4.3.5. Suspicion of, or attributed to, inadequate standard of care.

5. DBH Death Review Oversight Process

5.1. For Non-accredited Contracted Providers

- 5.1.1. The DBH Death Review Oversight Process may be conducted by a Regional Executive Officer (REO) or his/her designee, a Chief of Adult Community Operations (CACO), a Chief of Children's Community Operations (C3O), District Administrators, or an Area Treatment Coordinator.
 - 5.1.1.1. The initial DBH review of contracted providers' death review processes will be completed within six months of the scheduled Death Review Processes training. This will ensure death review policies and procedures are developed and implemented within each agency. DBH staff may conduct this follow-up on agency policies and procedures on-site or via desk audit.
 - 5.1.1.2. Thereafter, DBH will conduct death review oversight activities at contracted providers every two years.
 - 5.1.1.3. The DBH reserves the right to review a death event at the request of the contracted provider, DMH administration, the Mental Health Fatality Review Panel, or due to other compelling reasons.
- 5.1.2. DBH will conduct a review of the provider's completed death review(s). Components included in this review shall include, but not be limited to, the following:
 - 5.1.2.1. The provider's analysis of the circumstances surrounding the cause and manner of death;
 - 5.1.2.2. The agency's performance improvement activities resulting from death review findings;
 - 5.1.2.3. The rigor of the agency's procedures;

- 5.1.2.4. The appropriateness of the agency's corrective actions;
- 5.1.2.5. The agency's submission of required data to the DMH.
- 5.1.3. As a result of the DBH's review of the agency's client death review process and actual death reviews, the DBH may require the provider to initiate performance improvement activities.
- 5.1.4. The DBH will document findings of the death review oversight process, including recommendations and/or required corrective action, using a standardized report format.
 - 5.1.4.1. The report will be sent to the provider's CEO/designee and to appropriate DBH staff within 30 days of the conclusion of the review.
 - 5.1.4.2. If a corrective action plan is required, it must be submitted to the DBH within 30 days of receipt of the report.

5.2. For **Nationally Accredited** Contracted Providers

- 5.2.1. The DBH accepts as sufficient the national accreditation body's oversight of the contracted death review process; thus, DBH oversight activities will not be routinely scheduled.
- 5.2.2. The DBH reserves the right to review any death event at the request of the contracted provider, DMH administration, the Mental Health Fatality Review Panel, or due to other compelling reasons.
 - 5.2.2.1. Corrective action and/or performance improvement activities may be required as a result of such DBH reviews.
- 5.3. Periodic training and technical assistance will be made available by the DBH for contracted providers and designated DBH staff regarding death review processes and DBH expectations.
- 5.4. For deaths selected for review by the Mental Health Fatality Review Panel, designated DMH staff will ensure a thorough review is conducted.