

IV. Clinical Mortality Review: A Guide

Clinical mortality review is the process by which medical and other disciplinary experts review the circumstances of an individual death to explore root causes and identify interventions to prevent future deaths. When done systematically by a standing committee with the authority to direct resources and hold actors accountable, clinical mortality review can improve care and future health outcomes among people experiencing homelessness.

Continuums of care, counties, or cities can conduct clinical homeless mortality review in their communities. Clinical mortality review can be especially effective when conducted in conjunction with homeless mortality surveillance because communities with surveillance systems can have higher confidence that they are capturing cases.

An individual homeless health care provider can also conduct clinical mortality review. While Federally Qualified Health Centers are required to assess the most significant causes of death at least once every three years,ⁱ routine and more frequent clinical mortality review supports a more agile response to shifting trends.

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Benefits of Clinical Mortality Review

As the impacts of the COVID-19 pandemic casts a stark light upon long-standing economic, racial, and ethnic disparities in health care outcomes in the U.S., the need for clinical mortality review of deaths among people experiencing homelessness grows more urgent. Through this process, providers and communities can:

- Understand the circumstances of cases
- Determine if cases could have been prevented
- Improve the quality of care and delivery of services
- Identify and address systemic issues
- Design best practices to reduce preventable deaths
- Evaluate the effectiveness of unedified intervenient

Implementation Guide for Communities and Health Care Providers

1. Identify Cases

- Establish a definition of homelessness informed by the definitions used by different sources of case data in the community
- Review all cases that fit the definition of homelessness, including demographics, acuity, and fatality risk factors that may be informed by the community's mortality surveillance data
- Consider the objectives for conducting clinical mortality review when determining if cases concerning formerly homeless individuals living in permanent housing should be defined as homeless

2. Establish a review committee

- Require representation of medical, behavioral health, and psychiatric expertise
- Consider an interdisciplinary approach, including housing and shelter providers, non-clinical service providers, persons with lived experience of homelessness, and the Office of the Medical Examiner or Coroner

3. Obtain case-level information

- Establish a relationship and/or data sharing agreement with the Office of the Medical Examiner or Coroner
- Establish data sharing agreements with service providers to ensure cases reviews have the necessary context, such as treatment and housing histories, employment, and income status, etc.

4. Choose cases to review

- Use historical data to estimate the likely number of cases on annual basis
- Establish criteria that prioritizes quality improvement opportunities, prevention of death and strategic needs of the community
- Apply criteria during preliminary review to eliminate cases that do not need further review
- Possible factors to include in criteria: quality improvement potential; emerging health or social trends; demographic or geographic groups of interest; community's strategic goals

5. Review cases

- Establish a committee meeting cadence that appropriately fits the review volume
- Ensure a systematic review of each case with a standardized case summary template that guides discussion

- The case summary should include data, cause, manner, location and circumstances of death, as well as diagnostic and treatment history, demographics, fatality risk factors and variables specific to committee priorities, which may evolve over time

6. Follow Up

- Draw on committee members' expertise and resources to identify quality improvement action items and their next steps
- Reserve time in each committee meeting to follow-up on outstanding action items from previous reviews
- Regularly communicate to broader community stakeholders about committee findings and the results of improvement actions
- Quarterly or annual summary reports can reinforce lessons learned, cultivate broader understanding of the purpose of clinical mortality review and increase awareness of emerging trends

Examples of quality improvement actions might include: enhancing documentation workflows to improve cross-disciplinary communication or creating standing orders for vaccinations

References:

ⁱ Health Resources & Services Administration's Health Center Program and Compliance Manual. (2018). <https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/hc-compliance-manual.pdf>