

**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT ON DISABILITY SERVICES**

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Department on Disability Services	Policy Number: 8.2a
Responsible Program or Office: Deputy Director, Developmental Disabilities Administration	Number of Pages: Ten (3)
Effective Date: August 1, 2011	Number of Attachments: 1
Supersedes Policy: <b>MRDDA Mortality Review Policy dated October 17, 2006</b>	
Subject: Mortality Review Committee	

**1. PURPOSE**

The purpose of this policy is to establish the standards and guidelines by which the Department on Disability Services (DDS), Developmental Disabilities Administration (DDA) will evaluate all issues related to the deaths of individuals served by the Developmental Disabilities Administration (DDA). The purpose of this procedure is to describe the mortality review process utilized by DDA following the death of individuals served by the department. The mortality review process is designed to identify issues and concerns that may have compromised the medical, clinical or overall care provided to individuals served by DDA, and to trigger corrective action **and** strategies to mitigate future risk.

**2. APPLICABILITY**

This policy applies to all DDA employees, subcontractors, providers/vendors, consultants, volunteers, and governmental agencies that provide services and supports on behalf of individuals with disabilities receiving services as part of the DDA Service Delivery System funded by DDA or DHCF.

**3. AUTHORITY**

The authority for this policy is established in the Department on Disability Services as set forth in D.C. Law 16-264, the "Department on Disability Services Establishment Act of 2006," effective March 14, 2007 (D.C. Official Code § 7-761.01 *et seq.*); and D.C. Law 2-137, the "Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978," effective March 3, 1979 (D.C. Official Code § 7-1301.01 *et seq.*).

**4. POLICY**

It is the policy of DDS to ensure all individuals receiving services from the DDA service system, have access to and receive quality supports, services, and health care. The death of individuals served by DDA shall be subject to mortality and fatality review, which provides a mechanism for monitoring and evaluating the service delivery system. Through this review, the Committees identify individual and systemic issues and areas of needed improvement in the health care system, provider

community, DDA, and/or other governmental entities that impact overall care and supports provided to individuals served by DDA.

## 5. RESPONSIBILITY

The responsibility for this policy is vested in the Director, Department on Disability Services. Implementation for this policy is the responsibility of the Deputy Director, Developmental Disabilities Administration.

## 7. STANDARDS

The following are the standards by which DDS will evaluate compliance with this policy:

- A. DDA shall maintain a Mortality Review Committee, co-chaired by the DDS Quality Management Division and an external member of the MRC. The MRC is comprised of DDA and external to DDA members as described in the MRC procedure.
- B. The MRC shall meet at a minimum of 10 times per year or more frequently as needed.
- C. **The MRC shall initiate a review of each Death Investigation Report within 45 days of the QMD's receipt of the report.**
- D. The MRC shall review the investigations and the recommendations in the Death Investigation Report and shall accept the recommendation, **modify the recommendation, or reject the recommendation, in addition** MRC may make its own recommendations to providers and DDA to ensure a safe environment and improve the quality of care for individuals served by DDA. The MRC recommendations shall:
  - 1. Identify process or systemic issues surrounding a death;
  - 2. Identify improvements necessary to ensure safety in all environments; fully evaluate adequate health care and improved health care systems, overall care, and quality of life issues for individuals served by DDA; and
  - 3. Recommend the development and/or modification of DDA policies and/or procedures.
- E. The MRC shall:
  - 1. Review and approve Plans of Correction from providers and DDA.
  - 2. Refer cases of suspicious deaths to the DDA Deputy Director for further action as necessary.
  - 3. Refer individual clinicians, DDA or Provider employees to Professional Licensing Boards and/or other outside investigation and oversight organizations when evidence is presented that may

indicate negligence, sub-standard clinical practice, fraud or abuse.

- F. The QMD shall submit all MRC final reports, POCs and status updates to POCs to the FRC for its consideration and information within 10 business days following the MRC review and approval of same.



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Laura L. Nuss, Director



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Date

Attachments:

Mortality Review Committee Procedure dated August 1, 2011