GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

POLICY	
Department on Disability Services	Subject: Mortality Review
Responsible Program or Office: Developmental Disabilities Administration and DDS Quality Management Division	Policy Number: 2013-DDS-QMD-POL005
Date of Approval by the Director: May 29, 2013	Number of Pages: 3
Effective Date: June 1, 2013	Expiration Date, if Any: N/A
Supersedes Policy Dated: August 1, 2011	
Cross References and Related Policies and Procedures: Mortality Review Committee Procedure	

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 service delivery for people who received services and support through the DDA service delivery system until their death. The mortality review process is designed to look at a person's life to identify any areas of concern that may have kept a person from having optimal medical or behavioral health, well-being and quality of life; learn from the person's experience; and make recommendations to improve the quality of services and supports overall.

2. APPLICABILITY

This applies to all DDA employees, subcontractors, providers, vendors, consultants, volunteers, and governmental agencies that provide services and supports to people with intellectual and developmental disabilities who receive services as part of the DDA Service Delivery System, funded by DDA and/or the Department of Health Care Finance ("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 "Citizens with Intellectual Disabilities 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 that all people receiving services through the DDA service system have access to and receive quality supports, services, and health care. The death of people served by DDA shall be subject to mortality review, which provides a mechanism for monitoring and evaluating the service delivery system. Through this review, committee members identify and make recommendations on 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 the people who receive services through DDA.

5. RESPONSIBILITY

The responsibility for this policy is vested in the Director, DDS. Implementation of this policy is the responsibility of the Program Manager, DDS Quality Management Division ("QMD"), and the DDS Deputy Director for DDA.

6. STANDARDS

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

A. DDS shall maintain a Mortality Review Committee ("MRC"), comprised of DDS employees, including representation by the DDS QMD, and public members appointed by the DDS Deputy Director for DDA.

B. The MRC shall meet at least ten (10) times per year, and shall review all death investigations within 45 days of QMD's receipt of the final Death Investigation Report.

C. The MRC shall review the Death Investigation Report recommendations, and for each shall accept, modify, defer for lack of sufficient information, or reject the recommendation. The MRC may also make its own recommendations to providers and DDA on individual and systemic issues and areas of needed improvement that impact overall care and supports provided to the people served by DDA. The MRC recommendations shall identify improvements necessary to ensure health, safety, wellbeing and quality of life for people supported by the DDA service delivery system; and may include a recommendation for development and/or modification of DDA or provider policies, procedures, or systems.

D. The MRC shall also:

1. Refer cases of suspicious deaths to the DDA Deputy Director for referral to the appropriate authorities.

2. Refer individual licensed clinicians, employees of DDA, or employees of provider agencies, to Professional Licensing Boards and/or other outside investigation and oversight organizations or agencies when evidence is presented that may indicate

negligence, sub-standard clinical practice, fraud or abuse. Non-licensed providers or employees may be referred to the Office of the Inspector General for fraud or abuse.

3. Share relevant final Death Investigation Reports with licensing agencies, such as the Health Regulation and Licensing Administration, for review and action, as appropriate.

E. DDS shall ensure all MRC recommendations are completed via follow-up by QMD, documented in MCIS, DDA's database, and reported as part of the provider performance metrics.

F. The QMD shall submit all MRC final reports to the District of Columbia Developmental Disabilities Fatality Review Committee within ten (10) business days following the MRC review.

Laura L Nuss

Laura L. Nuss, Director

5/25/2013

Approval Date