Quality Improvement Committee (QIC) Meeting Minutes
Tuesday, June 4, 2013

In Attendance:
Cathy Yadamec, Manager, Quality Improvement Division
Cathy Anderson, DDS, Deputy Director for DDA
Winslow Woodland, Director of Service Planning Coordination Division
Emma Hambright, Rights and Advocacy Specialist
Lisa Alexander, George Washington Univ.
Joyce Maring, George Washington Univ.
Brenda Sheingold, George Washington Univ.
Alison Whyte, Program Analyst
Shirley Quarles-Owens, Supervisor Community Health Nurse
June Walden-Yeager, DHCF
Dianne Jackson, DDS
Cheryl Smith, DDS
Brandi Crawley, DDS
Erin Leveton, DDS
Marc Clarke, DDS
Alyce Fergusson, Staff Assistant QMD

Dianne Jackson
Presented on the Unmet Needs –"The presentation of the Unmet Needs Report raised questions about the integrity of the data and the accuracy of the information in the report. DDA management asked that an update be given at a later date after a more thorough revision of the Unmet Needs Report."

Marc Clarke
Presented on Mortality Review- Handouts were given to the committee to follow the presentation. The report showed the Second Quarter FY 2013 MRC Report, Focused on the final 12 reports from Columbus Organization that a large number of people who died during the reported time framed lived in Supported Living; the age range; as well as the cause of deaths. The report also listed the number of death of people by range of according to the Wechsler Adult Intelligence Scale (WAIS). The committee recommended that portion of the report but removed. Marc also talked about the new Mayor Order, the subject Autopsies of Deceased Consumers of the Department on Disability Services. The attached language was the focus

4. *If the decedent is not a member of the class in Evans v. Gray (D.D.C. Civil Action No. 76- 0293), the OCME shall not be required to perform a physical examination (external examination or autopsy) of the remains of persons described in Paragraph 1 of this Order if a certifying physician signs the death certificate and there are otherwise no questionable circumstances concerning the cause or manner of death.*

a. If the death certificate has not been signed by a certifying physician, or there are any questionable circumstances concerning the cause or manner of death as determined in the discretion of the Chief

Medical Examiner exercising his or her authority under D.C. Official Code § 5-1405, then the OCME shall perform an autopsy of the remains of the person except in the following circumstances (in which case an external examination may be performed):

i. *Where the Chief Medical Examiner determines, in writing, that an autopsy is not required to establish the cause and contributing causes -of death with a reasonable degree of medical certainty; provided, that the said determination is based upon a review of medical records, information from a treating physician, or such other documentation, evidence, or information upon which the Chief Medical Examiner may properly rely on in establishing that the cause of death was a result of the natural progression of a disease or medical condition for which the decedent was receiving medical care; or*

ii. *Where, prior to death, a person whose remains otherwise would be subject to this order expresses a religious or other objection to the performance of an autopsy, or where, prior to or after death of the said person, such an objection is expressed by the said person's next of kin or authorized legal representative; provided, that the OCME shall proceed to conduct an autopsy, notwithstanding the wishes to the contrary voiced by the person or his or her representative, where the Chief Medical Examiner determines, in writing, that there is a compelling medical reason to perform an autopsy in order to determine or rule out questionable circumstances concerning the cause or manner of death of the decedent and that no less invasive procedure is available to ascertain the cause or manner of death to a reasonable degree of medicolegal certainty.*

5. The OCME shall promptly forward the reports of autopsies conducted in accordance with this Order to the Developmental Disabilities Fatality Review Committee, or any successor entity.

6. ***LEGAL APPLICATION***
Nothing in this Mayor's Order shall be deemed to create legal rights or entitlements on the part of persons who are the subject of this Order, their families, estates, or legal representatives or to give rise to causes of action prosecutable by any of said persons.

Alison Whyte

Presented on Incident Management – she presented a power point presentation that defined the purpose of the report such as provides point-in-time demographics; Summarizes data of serious reportable incidents (SRIs) and reportable incidents (RIs) and any differences between groups; tracks substantiated allegations of abuse, neglect, serious physical injury and hospitalizations; reviews timely reporting by providers; reviews timely closure of investigations; reviews provider recommendation outcomes and makes recommendations for improvement in incident management.

The incident Management report also recommendation updates and On-Going:

a) Create a culture within DDA and providers to prioritize timely reporting of incidents
   Timely reporting discussed at May Provider Leadership meetings
   4 Provider Report Cards have been distributed

b) Continue the work with the Quality Improvement Committee (QIC) to determine systemic issues and trends regarding incident management
Incident report changes to ER visits and hospitalizations have not yet been made
Next report will examine people who experience a high number of both ER visits and hospitalizations

c) The QI/QE Unit will monitor the increase in substantiated allegations of abuse, neglect and serious physical injury. This issue should also be presented to the February IRC Core Group for discussion and action steps.

There was not an increase in the percentage of substantiated incidents in the second quarter. The IRC Core Group scans incident trends, including incident substantiation at the beginning of each month. Any recommendations are made to the Director of QMD.

d) The QI/QE Program Specialist will research national data regarding abuse and neglect in order to compare the data from DC. These results will be included in the next quarterly report.

e) The QI/QE Program Specialist will further examine incidents that happen on transportation and include that information in the next quarterly report