



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

DDS
Mortality Review Committee
Fiscal Year 2018
Report

March 10, 2020



I. Introduction

This Mortality Review Committee 2018 Fiscal Year Report is a summary of the work performed by the District of Columbia Department on Disability Services (DDS) Mortality Review Committee, which conducts DDS internal mortality case reviews. The MRC is charged with examining the events surrounding the deaths of individuals who were receiving services from DDS at the time of their death. The DDS MRC is a multi-disciplinary, multi-agency effort established for the purpose of conducting retrospective reviews of relevant service delivery systems and the events surrounding the deaths of persons who receive services and or supports from DDS. One goal of the DDS MRC is to identify trends and make recommendations to improve the supports and services received by the eligible residents of the District of Columbia.

The committee membership is a representation of a range of disciplines including public and private agencies. Membership includes representation from DDS Health and Wellness Division, Service Planning and Coordination Division, DC Coalition of Disability Service providers, Georgetown University initiative, Quality Trust for Individuals with Disabilities, Department of Health Care Finance, DDS provider community and persons receiving services from DDS. The primary function of the DDS MRC involves the collection, review, and analysis of individual's death-related data in order to identify consistent patterns and trends, which assist in increasing knowledge related to risk factors and guiding system change/enhancements. The mortality review process includes the examination of an independent investigative report of each individual death that includes a summary of the forensic autopsy reports or death certificate, the individual's social history, living conditions prior to death; medical diagnoses, and medical history; and services provided by DDS and its contractors. It also includes the assessment of agency policies and practices and compliance with District laws and regulations and national standards of care. Some case reviews result in the identification of systemic problems and gaps in services that may impact the individual's quality of life. Another important result of this process is the recognition of best practices and recommendations to create and implement these practices as a critical component of systemic change.

The analysis of the data is based on the **38** mortality investigation cases reviewed between October 1, 2017 and September 30, 2018. The mortality investigation case summaries were conducted and provided by *The Columbus Organization*. DDS provides life-long services to eligible residents of the District of Columbia; therefore, mortality cases will inevitably be reported on aging persons receiving our services. The purpose of this report is to provide a brief overview, of the DDS Mortality Review Committees process and the tracking of repeated committee recommendations.



II. The Number of DC DDS Reviewed Mortality Cases:

Case Reviewed

There were a total of 38 mortality cases reviewed by the Mortality Review Committee between October 1, 2017 and September 30, 2018. Twenty-two (22) of the 38 decedents were male. There was a significantly higher number of deaths among African-American (27) compared to Caucasians (9). Though females lived longer than males (avg. age at death (61.3 and 56.8 respectively). Caucasians lived longer than African Americans (avg. age 68 and 56 respectively). This pattern closely resembles that among the US population as a whole according to the CDC (2017). The average life expectancy for Americans is 78.7 years according to Organization for Economic Cooperation and Development (OECD). The average age of death for persons receiving services from DDS for FY 18 was 57 years.

III. Findings

A. Trends/Patterns

The following trends/patterns were found after reviewing the 38 mortality investigation reports for the above noted people.

Ethnicity:

- 27 people were African-American
- 9 people were Caucasian
- 1 person was Latino
- 1 person was Asian

During FY18, DDS supported 2,450 people. Of this number, 1,891 people were African-American, 136 people were Caucasian, 54 people were Latino, and 369 people were other races (Asian, Native American, unknown, or other). DDS recorded forty death in the FY 18.

Sex:

- 22 people were male
- 16 were female

Age Range:

- 3 person died who was between the ages of 21-30 years old
- 2 people died who were between the ages of 31-40 years old
- 5 people died who were between the ages of 41-50 years old



- 7 people died who were between the ages of 51-60 years old
- 13 people died who were between the ages of 61-70 years old
- 3 people died who were between the ages of 71-80 years old
- 4 people died who were between the ages of 81-90 years old
- 1 person died who were between the ages of 91-93 years old

According to the National Center for the Health Statistics, people with intellectual and developmental disabilities of all ages have a life expectancy of 50.4 to 58.7 years compared to the general US population of 78.5 years (CDC 2011).

Place of Death:

- 27 people died in the hospital or in a Long Term Acute Care Facility
- 11 people died at home

Residential Providers:

- 5 people died while living in their natural homes
- 1 person died while supported by Anna Healthcare, Inc.
- 1 person died while supported by Blossom Services, Inc.
- 6 people died while supported by Capital Care, Inc.
- 2 people died while supported by Community Multi-Services, Inc.
- 1 person died while supported by DC Healthcare, Inc.
- 1 person died while supported by Eckington House, Inc.
- 1 person died while supported by Innovative Life Solutions, Inc. (ILS)
- 1 person died while supported by Jewish Foundation for Group Homes, Inc.
- 1 person died while supported by L'Arche Inc.
- 3 person died while supported by Marjul Homes, Inc.
- 3 people died while supported by Metro Homes, Inc.
- 3 people died while supported by the My Own Place, Inc. (MOP)
- 1 person died while supported by the Multi Therapeutic Services, Inc.
- 1 person died while supported by Project Redirect, Inc.
- 3 people died while supported by RCM of Washington, Inc.
- 2 people died while supported by St. Johns Community Services, Inc.
- 1 person died while supported by Total Care, Inc.
- 1 person died while supported by Volunteers of America, Inc.

Residential Setting Type:

- 13 people lived in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)





- 13 people lived in a Supported Living home
- 6 people lived in their natural home
- 4 people lived in a Residential Habilitation home
- 2 people lived in a Host Home





Cause of Death Source:

- 21 people did not have an autopsy or external examination performed; however, death certificates were submitted for these deaths
- 17 people had an autopsy performed or an external examination performed.

Expected/Unexpected Deaths:

- 22 people's deaths were unexpected
- 16 people's deaths were expected

An unexpected death is defined as a death that was not expected or anticipated as a result of any previously known medical diagnosis/condition or was a death that resulted from an accident.

Manner of Death:

- 36 people had their manner of death listed as natural
- 2 people had their manner of death listed as an accident

Preventable/Unpreventable Death:

- 32 of the deaths appeared not to be preventable
- 3 of the deaths were listed as undetermined
- 3 of the deaths appeared to be preventable

The Determination of whether a death is preventable is often a complex question. After consultation with Columbus Organization physician reviewers, the following is being provided in answer to this question.

Each case is distinctive, and circumstances of each death are typically very specific and unique to that person. Columbus Organization physician reviewers determine whether a death is preventable or not preventable after a careful and thoughtful review of all the records they receive. Two criteria are usually needed for a death to be considered preventable:

- There was a clear deficiency in providing appropriate care or treatment to a person.
- There would have been a reasonable expectation that the person could have recovered/survived if appropriate care or treatment had been provided.
- The death was accidental in nature; if the accident had not occurred the person's death would have been preventable.



If these criteria are determined to be relevant in an individual case, then the determination that the person's death may have been preventable would be made. Outside of these parameters a death most likely would be considered not preventable.

Cause of Death:

- 13 people died from cardiac related causes
- 4 people died from aspiration pneumonia/pneumonia
- 5 people died from cancer
- 5 people died from respiratory related causes
- 4 people died from sepsis
- 1 person died from Alzheimer's disease
- 1 person died from choking
- 1 person died from multiple injuries
- 2 person died from complication of cholangiocarcinoma
- 2 person died from diabetic ketoacidosis

B. Summary of Patterns/Trends

In summary, more people died:

- who were African-American 27 people than were Caucasian 9 people
- who were male 22 were male to 16 who were female
- 13 people between the ages of 60-71 than any other age range
- 27 people in the hospital compared to 11 in their home
- while living in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDD) (13 people)
- whose deaths were not preventable (32 people)
- who had an autopsy performed (17 people)
- from cardiac related causes (13 people)

C. Other Findings

1. Most of the current published literature suggests that a person with Down syndrome has a life expectancy of 50 to 60 years according to Global Down Syndrome Organization. Two person's diagnoses with Down syndrome cases were reviewed in FY 18. One of the person's age was 45 the other 69.





IV. Areas of Concern

The one major concern during this review period was the two accidental deaths. One person died of multiple injuries sustained in a car accident on her way to her day program. According to the driver of the van it swerved to avoid hitting something in the road, to the other accidental death, the person choked. The OCME Autopsy Report determined the decedent's cause of death was asphyxia due to choking and his death was accidental. It is unknown how, when, or under what circumstances the decedent obtained the food he choked on. It is also of grave concern that according to the documentation reviewed, the decedent was not observed by staff from 9:00 pm, 11:00 pm, or 11:30 pm (all these times were documented as the last time he was seen) on March 29, 2017 until 7:40 am on March 30. It should be noted that the decedent lived in a group home in Maryland and received services from Maryland not the District. DDS was only provided payment of his cost of care, all services were being rendered by Maryland.

The concerns found in the 38 mortality investigation report reviews, included, but are not limited to:

- Health Care Management Plans (HCMPs), Health Passports, and/or nursing assessments that were incomplete, inaccurate, or not up-to-date (15 people)
- Lack of recognition when a person has a change in condition, a life-threatening situation, and/or when to seek prompt medical attention (8 people)
- Lack of end-of-life planning (7 people)
- Medication indications not listed on the Medication Administration Records (MARs) or the physician orders and/or medication dosages not accurately listed on the MARs, Health Passport, and/or other pertinent records (15 people)
- Nursing assessments were not completed when the person had a significant change in condition and/or the assessment was not timely (5 people)
- Inaccurate date of birth documented (2 people)

Recommendations

The Mortality Review Committee reviewed a total of 38 cases in FY 18 and developed or adopted one hundred ninety seven recommendation (197) as a result of the committee's review. Thirty-three of these recommendations were to the Department on Disability Services with only one of these recommendations being rejected. The rejected recommendation is for DDS to revise its Health and Wellness Standards to include provider nurses to contact the PCP for all hospital visits. This recommendation was rejected by DDS, because it is the responsibility of the hospital to provide a detail discharge summary which explains the service received and any on-going





treatment. Currently it is the practice of the provider nurse to assess all person's being discharged from a hospital within 24 hours and read and sign the discharge orders.

All of the following recommendations were specifically made in the individual mortality investigation reports completed.

DDS should ensure that the DDS SCs assure that end-of-life planning is completed for all people supported or the rationale for not completing this planning is clearly documented.

DDS providers should ensure all staff are assessed and trained to appropriately respond to life-threatening emergency events, including when to call 911 and initiate CPR. This should include the incorporation of quarterly CPR drills into their staff training.

DDS should continue to follow up with reviewing the guardianship training process to ensure that enhanced training is provided to guardians regarding quality of life issues, and timeliness of DNR implementation.

DDS community provider agencies should put in place, if not already in place, processes to ensure that:

- HCMPs and Health Passports are complete, accurate, and up-to-date;
- All support staff are adequately trained to recognize a change in a person's condition, a life-threatening situation, and when to seek prompt medical attention;
- End-of-life planning is completed for all people supported or the rationale for not completing this planning is clearly documented;
- All medication indications are listed on the MARS and the physician orders; and all medication dosages are accurately listed on the MARS, Health Passport, and/or other pertinent records;
- Nursing assessments are promptly completed when a person has a significant change in condition;
- That the person's date of birth is accurately listed on all of his/her records; and
- All of a person's immunizations and healthcare screenings are documented in the person's record.

IV Conclusion

By reviewing the information from each death, the MRC hopes to continue the initiation of the necessary changes to institute safer services for all individuals being served by DDS. An important outgrowth of this process is the recognition of best practices, and recommendations to implement those practices as systemic changes. The MRC understands that the information submitted for review cannot change the circumstances that led to the individual's death, however, this body





strives to use the information that results from cases reviewed to identify trends, direct training needs, recommend development and/or modification of public agency and provider policies in order to address systemic issues and to improve the quality of life for these citizens of the District.

Acknowledgement

DDS would like to acknowledge the dedication and unwavering support of the public servants, private agency/program representatives, and community volunteers who serve as members on the Department on Disability Services Mortality Review Committee. The willingness of Committee members to step outside of their traditional professional roles to examine the circumstances that may have contributed to these deaths and to seriously consider ways to improve the quality of life and prevent future fatalities is an admirable and difficult challenge. This challenge speaks to the commitment of members to our goal of improving services and making life better for the individuals we serve. Without this level of dedication, the work of the Committee would not be possible.

We would like to thank the members of the Committee for volunteering your time, giving of your resources, support and dedication to achieving our common goal.

