Developmental Disabilities Program Policy and Procedures Manual

Control #0103407
Volume 1: Program Administration
Section 3: Developmental Disabilities Program Policies
Subject: DDP Mortality Review Work Group Policy

1. PURPOSE:

1.1 The Mortality Review Work Group (MRWG) was formed in 2006 to review the deaths of persons receiving services through the Developmental Disabilities Program (DDP). This work group is an integral part of the Quality Improvement Process for the Developmental Disabilities Program of the Department of Public Health and Human Services (DPHHS). The MRWG helps to safeguard the health and well being of persons receiving services.

2. SCOPE:

2.1 This policy applies to all DDP staff and Providers of services to developmentally disabled persons funded by the Developmental Disabilities Program.

3. POLICY:

3.1 The Developmental Disabilities Program has established a consistent process for review of all deaths of developmentally disabled persons supported by the Program, as defined in the Procedures section of this policy in an effort to identify factors that may have contributed to those deaths.

3.2 The MRWG reviews the information relative to the death of persons receiving services to identify trends, help direct training and education needs, and provide information to service providers regarding prevention and best practices.

3.3 The MRWG does not investigate criminal activity, abuse, neglect, or medical malpractice. However, the MRWG may write reports or make referrals/recommendations and forward them to the appropriate entity (ies), including Adult Protective Services, DPHHS Bureau of Licensure, Medicaid Fraud Unit, Disability Rights Montana, and Law Enforcement.

3.4 The MRWG will send all recommendations regarding systemic issues, trends, and training needs to the Director of the Developmental Disabilities Program.

4. PROCEDURE:

4.1 Criteria for review by the MRWG

The MRWG reviews each death of an individual that occurs in one of the following situations:

4.1.1 In the Montana Developmental Center;

4.1.2 In a community-based setting funded by a Medicaid Home and Community Based Waiver Program with an ICF/MR level of care;

4.1.3 During a hospitalization from one of the above settings; or

4.1.4 In a community based setting funded by the Developmental Disabilities Program if an employee is present (on the premises); and

4.1.5 Other persons with a developmental disability whose deaths are referred to the MRWG.

4.1.6 In general, deaths of individuals living with family members are not reviewed unless an employee of a provider with Developmental Disabilities Program funding is present at the time of death.

4.2 Reporting of deaths

The Developmental Disabilities Program Incident Management Procedures Manual describes the procedure for investigating deaths.

4.2.1 After a death, the Provider or Case Manager notifies the Quality Improvement Specialist (QIS).

4.2.2 If a death occurs during the provision of services, both the Provider and QIS initiate critical incident investigations.

4.2.3 Based on the circumstances of the death, the QIS will conduct the investigation using the Triage Review Form or the Full Investigation Report Form.

4.2.4 A QIS Death Investigation Report and Checklist will be completed and forwarded with either the Triage Review Form or the Full Investigation Report Form to the Medical Director. Any Quality Assurance Observation Sheets issued during the investigation will be forwarded to the Medical Director also. Information should be sent within 30 days of the death.

4.2.5 For deaths that did not occur during the provision of services, the QIS will send the QIS Death Investigation Report and Checklist with as much information as can be easily obtained to the Medical Director.

4.3 The Mortality Review Work Group includes representatives from:

4.3.1 Developmental Disabilities Program Medical Director (chairperson);

4.3.2 Adult Protective Services,

4.3.3 Disability Rights Montana, the Protection and Advocacy System for Montana;

4.3.4 A representative from DPHHS Bureau of Licensure;

4.3.5 A Provider representative; and

4.3.6 A family member of a developmentally disabled person.

4.3.7 MRWG will partner, as appropriate, with relevant local Developmental Disabilities Program staff, consumers, advocates or any appropriate professional.

4.4 Review of cases

4.4.1 The Developmental Disabilities Program Medical Director receives, reviews, and organizes all mortality files.

4.4.2 After a preliminary review of a file, the Medical Director may:

4.4.2.1 Ask for additional information or investigation by the Quality Improvement Specialist;

4.4.2.2 Report the death at the next MRWG meeting; or

4.4.2.3 Assign it for full MRWG review.

4.4.3 Deaths not assigned for review by the entire group include those that would not require a full investigation, such as:

4.4.3.1 A person living alone that is found to have a terminal illness and had Hospice Services; and

4.4.3.2 A person that resided with family and a full investigation was not possible.

4.4.4 Files are copied and either sent to MRWG members or handed out at meetings.

4.4.5 A copy of each file is kept at Developmental Disabilities Program central office and all other copies are shredded after review.

4.5 Meetings

The MRWG will meet as needed to review deaths. Meetings are generally conducted quarterly but may be as frequent as monthly.

4.5.1 Meetings are organized by the MRWG chairperson (Developmental Disabilities Program Medical Director).

4.5.1.1 Meeting agendas are sent out prior to each meeting.

4.5.1.2 Meeting minutes are kept and reviewed at each subsequent meeting.

4.5.1.3 All deaths are listed on a Pending Cases document.

4.5.1.4 Data and recommendations are organized on a data spreadsheet.

4.5.2 At least three members of the MRWG must be present to conduct a meeting.

4.5.3 After reviewing a death, the work group will either close the file with or without recommendations/actions or may leave the file open, especially if requesting additional information or research regarding the death.

4.5.4 Because the information reviewed by the MRWG is protected by the right to privacy guaranteed by the Montana Constitution or is protected health information as defined by Federal health privacy law and regulations and these rights exceed the merits of public disclosure, the meetings are closed to the public.

4.6 Recommendations

Recommendations may be made by the MRWG. These can be provider-specific or systemic.

4.6.1 Provider-specific recommendations:

4.6.1.1 Should relate to current rules and policies (Administrative Rules of Montana, Montana Code Annotated, Developmental Disability Services Polices, or Provider Policies) and generally accepted standards of care.

4.6.1.2 Will be reviewed by a State Quality Improvement Specialist.

4.6.1.3 A State Quality Improvement Specialist will provide follow up with Providers regarding the recommendations.

4.6.2 Systemic recommendations:

4.6.2.1 Will be forwarded to the Developmental Disabilities Program Director for review and, when appropriate, implementation.

4.6.2.2 Based on recommendations, policy and procedure changes as well as training may occur.

Director, Developmental Disabilities Program — Date 4/18/13

Web Manager, DDP — Date Apr 18, 2013