About the Department

The Ohio Department of Developmental Disabilities (DODD) oversees a statewide system of supports and services for people with developmental disabilities and their families. DODD does this by developing services that ensure an individual’s health and safety, encourage participation in the community, increase opportunities for meaningful employment, and provide residential services and support from early childhood through adulthood.

Mission and Vision

Our mission is continuous improvement of the quality of life of Ohioans with developmental disabilities and their families. Our vision is that Ohio’s citizens with developmental disabilities and their families will experience lifestyles that provide opportunities for personal security, physical and emotional well-being, full community participation, productivity, and equal rights.
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Follow up by e-mail or phone to MUI Office at 614-995-3810.
Today’s Presenters

Connie McLaughlin
Regional Manager Supervisor, MUI

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Manager, Intake and Mortality Process

Dr. Rebecca Strafford
Physician, MUI

Today’s Objectives

• Review purpose of mortality reviews
• Discuss processes
• Learn how to read death certificates
• Address challenges and timelines
• Talk about how we can enhance our system
Why do we do death reviews?

• Tells a story of the person’s health and life
• Use Mortality information to address quality of care
• Provide training (Health and Welfare Alerts) on what is learned from case reviews
• Utilize aggregate data over time to identify patterns and trends
• Help providers and staff find better ways to meet health care challenges

Core components of process

• Standardized process for reporting, investigating and reviewing deaths across the state
• Medical professionals participate in the deaths case reviews
• State-level interdisciplinary Mortality Review Committee to review aggregate data and cases meeting certain criteria
• Direct link between mortality findings and system improvement activities
• Publically report and document mortality information
Who reviews ITS death information?

- DODD Staff
- Mortality Review Committee
- Patterns and Trends Committee
- The Ohio Department of Medicaid
- CMS-Performance Measures
- Disability Rights Ohio
- Legislators (House Bill 483)
- Office of the Ohio Attorney General upon request
- Providers
- County Boards

Physician Reviews

DODD Physicians review:

- All non-accidental deaths of people receiving 20 hours or more of waiver services, those who live in an ICF or Developmental Center
- All accidental/suspicious deaths including alleged abuse or neglect
- Some Hospice and Nursing Home deaths may be reviewed
Causes of death

Scenario: A person reportedly died from a choking incident. The physician certifies the cause of death as “natural” on death certificate.

• Why do we mark it as Accidental/Suspicious?

• When should it be marked that way?

• How do physicians define a “natural” death?

The basics of reading a death certificate
Coroner’s Review

Ohio Revised Code § 313.12. Notice to coroner of violent, suspicious, unusual or sudden death or any death of a developmentally disabled person

(A) When any person dies as a result of criminal or other violent means, by casualty, by suicide, or in any suspicious or unusual manner, when any person, including a child under two years of age, dies suddenly when in apparent good health, or when any mentally retarded person or developmentally disabled person dies regardless of the circumstances, the physician called in attendance, or any member of an ambulance service, emergency squad, or law enforcement agency who obtains knowledge thereof arising from the person's duties, shall immediately notify the office of the coroner of the known facts concerning the time, place, manner, and circumstances of the death, and any other information that is required pursuant to sections 313.01 to 313.22 of the Revised Code. In such cases, if a request is made for cremation, the funeral director called in attendance shall immediately notify the coroner.

(B) As used in this section, "mentally retarded person" and "developmentally disabled person" have the same meanings as in section 5123.01 of the Revised Code.

Remember: A Coroner's review means the death was referred to them/they were notified of the death, as required. It does not mean that the Coroner accepted the case.

What is the cause of death?

- Undetermined Natural Cause
- Cardiac Arrest
- Recurrent Pneumonia
- Seizure

How should you enter info in ITS?

<table>
<thead>
<tr>
<th>Allegation Category</th>
<th>Lung Disease</th>
<th>Respiratory Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Accidental/Suspicious Death</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Allegation 4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Allegation 5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Allegation 6</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Decided Category</th>
<th>Heart Disease</th>
<th>Congestive Heart Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Accidental/Suspicious Death</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Decided 4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Decided 5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Decided 6</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Deaths are classified into 4 types

- **Type A** - Individuals whose residence was with entities under the jurisdiction of ODH - Nursing Homes, ODM Waivers
- **Type B** - Cases involving children and adults who live at home and who had access to health care or Live in the Community with no waiver.
- **Type C** - Persons who died of cancer or were in a hospice/palliative care program at the time of death
- **Type D** - All other deaths not covered in the above categories

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**Required Elements – Type D**

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Copy of DC/Autopsy/Coroner Report/Supplementary Medical Certification</td>
<td><em>was coroner notified</em></td>
</tr>
<tr>
<td>2. Location of Death</td>
<td></td>
</tr>
<tr>
<td>3. Death Expected/Unexpected - DNR (order, reason)</td>
<td><em>type: DNR-CC or DNR-CCA</em></td>
</tr>
<tr>
<td>4. What DD services was individual receiving?</td>
<td></td>
</tr>
<tr>
<td>5. Describe in detail 72 hrs prior to death or hospitalization</td>
<td><em>72 hour prior to hospitalization if died in hospital</em></td>
</tr>
<tr>
<td>6. History/Cancer screenings for cancer/hospice death</td>
<td></td>
</tr>
<tr>
<td>7. Law Enforcement Investigation</td>
<td></td>
</tr>
<tr>
<td>8. Med/Psyh Diagnosis prior to death</td>
<td></td>
</tr>
<tr>
<td>9. Medications taking Prior to Death or hospitalization</td>
<td><em>if death occurred during hospitalization</em></td>
</tr>
<tr>
<td>10. Past medical history</td>
<td></td>
</tr>
<tr>
<td>* List previous surgeries or medical treatments</td>
<td></td>
</tr>
<tr>
<td>* List previous illnesses (Pneumonia’s) and chronic medical problems</td>
<td></td>
</tr>
<tr>
<td>* Date of the Most recent pneumonia vaccine and Influenza vaccine</td>
<td></td>
</tr>
<tr>
<td>* Most recent Height and Weight</td>
<td></td>
</tr>
<tr>
<td>11. Name of Primary Physician</td>
<td></td>
</tr>
<tr>
<td>12. Aspiration/Pneumonia/Respiratory Failure cases:</td>
<td></td>
</tr>
<tr>
<td>* what was diet texture</td>
<td><em>was the diet followed</em></td>
</tr>
<tr>
<td>* date of most recent swallowing study</td>
<td><em>how did the individual receive their medications</em></td>
</tr>
</tbody>
</table>
Required Elements – Type C

C.) Hospice/Cancer (If individual lived in ICF or 24/7 Residential setting with a waiver, or did 1 month prior to moving to a hospice setting and passing away = answer questions under "D")

1. Copy of DC/Autopsy/Coroner Report/Supplementary Medical Certification (was coroner notified)
2. Location of Death
3. Death Expected/Unexpected - DNR (order, reason)
   * type: DNR-CC or DNR-CCA
   * what date was it put in place and for what diagnosis or reason
4. What DD services was individual receiving?
5. Describe in detail 72 hrs prior to death or hospitalization (72 hour prior to hospitalization if died in hospital)
6. History/Cancer screenings for cancer/hospice death

Required Elements – Type B

B.) Live at Home or Community (with No Waiver or less than 20 hours of services weekly)

1. Copy of DC/Autopsy/Coroner Report/Supplementary Medical Certification (was coroner notified)
2. Location of Death
3. Death Expected/Unexpected - DNR (order, reason)
   * type: DNR-CC or DNR-CCA
   * what date was it put in place and for what diagnosis or reason
4. What DD services was individual receiving?
5. Describe in detail 72 hrs prior to death or hospitalization (72 hour prior to hospitalization if died in hospital)
Required Elements – Type A

A.) ODH (Nursing Home, ODM Waivers - if individual lived in ICF or 24/7 Residential setting with a waiver or did 1 month prior to moving to ODH setting and passing away = answer questions under "D")

1. Copy of DC/Autopsy/Coroner Report/Supplementary Medical Certification (was coroner notified)
2. Location of Death
3. Death Expected/Unexpected - DNR (order, reason)
   * type: DNR-CC or DNR-CCA
   * what date was it put in place and for what diagnosis or reason
4. What DD services was individual receiving?

Different sections are populated based on the Type of death selected.

By entering the report this way, you can ensure that all needed information is addressed in an easy to read format.

Entering Final Report
Most commonly incomplete questions

#1 Has the Coroner been notified

#3 Death Expected/Unexpected-DNR (order, reason)

#5 Describe in detail 72 hrs. prior to death or hospitalization (72 hour prior to hospitalization if died in hospital) Why in hospital?

#8 &10 Med/Psych Diagnosis prior to death

#12 Aspiration/Pneumonia/Respiratory Failure cases

Example of 72 hour description

- **Saturday 9/25/17** - When staff arrived for second shift, individual was watching TV. He ate dinner, took a shower, took meds then had a snack. Overnight shift documented he woke up twice during the night to use the bathroom which is not uncommon for him. No health issues were reported overnight during third shift.

- **Sunday 9/26/17** – He woke up ate breakfast and took his meds. He went to get a haircut, out to lunch and then to watch a sporting event. He came home, ate dinner and took a shower. After his evening meds, he had ice cream. Overnight shift documented he got up four times to use the bathroom. No health related issues reported during 3rd shift.

- **Monday 9/27/17** - He woke up, ate breakfast, took his medication and went to workshop. Workshop noted that he had a good day and there were no complaints of him not feeling well or acting out of the ordinary during the day. Bus driver indicated that he was fine on his way home from workshop, was smiling and talking to other individuals on the way home per usual with no complaints. When he got home and was walking off the bus, staff noticed that he was breathing heavier than usual. He went in the house and rested at the counter before walking to the couch where he started to vomit. He then started to kneel and staff helped him to the floor. He then became unresponsive. Staff called 911 and began chest compressions until paramedics arrived. When EMS arrived they continued CPR. He was transported to the hospital via emergency squad and admitted.

- **Tuesday 9/28/17** - He passed away as a result of what appeared to be heart related issues.
System Strengths

- Nationally recognized system
- Thorough reviews of care they were provided in their lifetime
- 797 death cases closed in 2017
- Relationships developed with Coroners, Hospitals, EMS Directors, Physicians
- Quality data that drives supports

98% of all 2016 death MUs have been closed.

System Challenges

- Length of time it takes for a case to get closed by DODD
- The length of time for autopsy report
- The medical questions are posed so long after the person has passed away.
- The complexity of the medical questions that are being posed frustrate the IAs.
- Why cant hospitalization be changed to a death
- Developing timely Alerts for families, individuals, APSI,
- Neglect when person does not administer CPR
- How can we enhance system
The purpose of the Mortality Review Committee is to review deaths to identify and address any case specific, provider specific or system-wide issues that could improve the care provided by others.

The Mortality Review Committee reviews:

- All Accidental and Suspicious Death Examples: choking, fire, motor vehicle accident (current or effects of previous accident).
- Deaths associated with abuse or neglect
- Special Referrals (MUI Staff, Physicians, CB)

Some of the data reviewed:

- Deaths by Provider, county, developmental center, living arrangement, Level of DD, Age, gender, cause and comparisons to other Ohioans.
# 2016 Deaths by Adverse Reaction - Sample MRC Reports

<table>
<thead>
<tr>
<th>Cause</th>
<th># Adverse in 2016</th>
<th>Living Arrangement</th>
<th># Adverse in 2016</th>
<th>% of 2016 Pop. Served</th>
<th>% of total Adverse Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choking</td>
<td>16</td>
<td>Family Home</td>
<td>17</td>
<td>71%</td>
<td>25%</td>
</tr>
<tr>
<td>Vehicle Accidents</td>
<td>13</td>
<td>ICF/DD or Licensed Facility</td>
<td>12</td>
<td>7%</td>
<td>17%</td>
</tr>
<tr>
<td>Drowning</td>
<td>3</td>
<td>Own Home/Apt</td>
<td>4</td>
<td>14%</td>
<td>6%</td>
</tr>
<tr>
<td>Fall</td>
<td>6</td>
<td>I/O Waiver</td>
<td>28</td>
<td>23.00%</td>
<td>41%</td>
</tr>
<tr>
<td>Fire</td>
<td>2</td>
<td>Level 1 Waiver</td>
<td>2</td>
<td>16%</td>
<td>3%</td>
</tr>
<tr>
<td>Homicide</td>
<td>4</td>
<td>TDD Waiver</td>
<td>1</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Suffocation</td>
<td>9</td>
<td>Nursing Facility</td>
<td>5</td>
<td>1%</td>
<td>7%</td>
</tr>
<tr>
<td>SIDS</td>
<td>0</td>
<td>Foster Care/Other</td>
<td>0</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Medication Reaction</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Overdose</td>
<td>4</td>
<td>Total Adverse Deaths 2016 =</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Accidents</td>
<td>9</td>
<td>Total Deaths for 2016 =</td>
<td>959</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td>3</td>
<td>% Adverse deaths 2016 =</td>
<td>7.19%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Population Served 2016 = 92,604
2016 Deaths by Cause: Sample MRC Report

Total: 959
Ohio Dept. of Dev. Disabilities
MUI/Abuser Registry Unit
2/16/17
Ave. Age of Death: 51

Deaths

- Death Certificate Pending
- All other Causes
- Brain/Other
- Diabetes
- Stroke
- Seizure
- Liver Disease
- Dementia
- Kidney Disease
- Lung Disease
- GI Issues
- Infections
- Cancer
- Congenital Diseases
- Accidents and Adverse Actions
- Aspiration Pneumonia
- Pneumonias
- Insect Disease

2016 Deaths marked "Congenital Syndromes" - Sample MRC Report

- Cerebral Palsy
- Muscular Dystrophy
- congenital anomalies
- Tuberous Sclerosis
- Short Gut Syndrome
- Pontocerebellar Hypoplasia
- Pelizaeus - Merzbacher
- Mucopolysaccharidosis Disease
- Lissencephaly
- Friedrich's Ataxia
- Edward's Syndrome (trisomy 18)
- Cloves syndrome =
- Agammaglobulinemia

- Total: 38
2016 Deaths - Sample MRC Report

2016 Deaths by Gender

- Male: 56%
- Female: 44%

Total: 959
Ohio Dept. of Dev. Disabilities
MUI/Abuser Registry Unit
2/16/17
Ave. Age of Death: 51

92,604 individuals enrolled as of 12/31/16
38% = Females enrolled
62% = Males enrolled

2016 Deaths by Level of DD

- None: 27%
- Mild: 20%
- Moderate: 21%
- Severe: 15%
- Profound: 17%

None includes children 5 and under

2016 Percentage of Age at Death Compared to Population Served - Sample MRC Chart

- Total: 959
- Ohio Dept. of Dev. Disabilities
- MUI/Abuser Registry Unit
- 2/16/17
- Ave. Age of Death: 51

Under 1: 1.46%
1-4: 3.13%
5-14: 3.02%
15-24: 14.70%
25-34: 14.75%
35-44: 19.48%
45-54: 21.17%
55-64: 25.86%
65-74: 15.95%
75-84: 8.76%
85+: 8.47%

Ave. Age of Death: 51
Resources


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