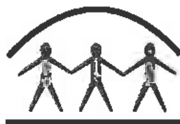

Penn-Mar Human Services

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December 6, 2010

John M. Colmers, Secretary
Department of Health and Mental Hygiene
201 W. Preston St.
Baltimore, MD 21201

Catherine A. Raggio, Secretary
Maryland Department of Disabilities
217 E. Redwood St., Ste. 1300
Baltimore, MD 21202

Dear Secretary Colmers and Secretary Raggio:

Please find enclosed the Eighth Annual Report from the Mortality and Quality Review Committee (MQRC). This report reflects the required review by the committee of cases of mortality during calendar year 2009 for those persons receiving services funded through the Developmental Disabilities Administration and the Mental Hygiene Administration. The report summarizes the actions of the committee and contains recommendations pertaining to the care provided to Maryland citizens who receive services through these State Administrations.

The committee delayed the submission of this report until this date to allow the time required in reformatting data collection. Prior annual reports indicated the cases reviewed by the MQRC within that reported year without regard to the year in which the death occurred. Through the elimination of the backlog of cases for review, the data can now reflect the 2009 calendar year in which a death occurred, as well as, assuring each case was reviewed within that calendar year. Any actions for prevention or corrective action taken by the administrations could now be more accurately analyzed for outcomes.

If you have any further questions, please do not hesitate to contact me directly at (410) 343-1069 or kpeterson@penn-mar.org or through Stacey Diehl, Director, Office of Governmental Affairs, Mental Hygiene Administration at (410) 402-8449, or by email sdiehl@dhmh.state.md.us.

Sincerely,

Keith R. Peterson, Chair

cc: MRC Committee Members
Brian Hepburn, Director, MHA
Michael Chapman, Director, DDA
Nancy Grimm, Director, OHCQ

The official Registration and financial information of Penn-Mar Organization may be obtained from the Pennsylvania Department of State by calling toll free within Pennsylvania, 800-732-0999. Registration does not imply endorsement.

A copy of our current financial statement is available upon request by contacting Penn-Mar Organization, Inc. Documents and information submitted to the State of Maryland under the Maryland Charitable Solicitations Act are available from the Office of the Secretary of State for the cost of copying and postage.

Department of Health and Mental Hygiene

Mortality and Quality Review Committee

Annual Report

Calendar Year 2009

Martin O'Malley
Governor

Anthony G. Brown
Lieutenant Governor

John M. Colmers
Secretary

Keith R. Peterson
Chair

TABLE OF CONTENTS

THE MORTALITY & QUALITY REVIEW COMMITTEE ………………………………. 3

I. REPORTING REQUIREMENTS ……………………………….. 4

II. DEATH AND INCIDENT DATA REVIEW PROCESS ……………………………….. 4

III. COMMITTEE ACTIVITIES AND STATISTICAL INFORMTION ……………………………….. 6

IV. FINDINGS, DISCUSSION AND RECOMMENDATIONS ……………………………….. 13

V. APPENDIX ……………………………….. 14

I. THE MORTALITY AND QUALITY REVIEW COMMITTEE

The Mortality and Quality Review Committee (MQRC) was established in the Department of Health and Mental Hygiene (DHMH) through legislation effective October 2000, and codified in Maryland Annotated Code, Health General Article § 5-801 through §5-810. As originally enacted, the statute focused on the examination of deaths of individuals in programs or facilities operated or licensed by the Developmental Disabilities Administration (DDA). Subsequently, in 2001, the statute was amended to also require the MQRC to review deaths of individuals in facilities or programs operated or licensed by the Mental Hygiene Administration (MHA). In 2006, Chapter 268 of the Senate Bill 734 became effective. Chapter 268 of the 2006 General Assembly requires the MQRC to review aggregate incident data regarding facilities or programs that are licensed or operated by the DDA or operating by waiver under 7-903(B) of the Health General Article. This annual report of the MQRC encompasses 2009, the ninth year of the Committee's activities. Subsequent annual reports will be published at the conclusion of each calendar year.

The purpose of the MQRC is to prevent avoidable injuries and avoidable deaths and to improve the quality of care provided to persons with developmental disabilities or mental illnesses. To achieve this purpose the MQRC performs the following duties:

1. Evaluates causes or factors contributing to deaths in facilities or programs operated or licensed by MHA and DDA or operating by waiver under §7-903(b) of this article;
2. Reviews aggregate incident data regarding facilities or programs that are licensed or operated by the DDA or operating by waiver under 7-903(B) of the Health General Article;
3. Identifies patterns and systemic problems, and ensures consistency in the review process; and
4. Makes recommendations to the Secretary of DHMH and the Secretary of Disabilities regarding actions to prevent avoidable injuries and avoidable deaths and improve quality of care.

Members of the Committee are appointed by the Secretary and include: a licensed board certified physician in an appropriate specialty; a psychopharmacologist; a licensed physician on staff with the DHMH; two specialists, one in the field of developmental disabilities and the other in the field of mental illness; two licensed providers of community services, one for persons with developmental disabilities, and one for persons with mental illness; two consumers, one with developmental disabilities and the other with mental illness; two family members, one representing a consumer with developmental disabilities and the other representing a consumer with mental illness; the Deputy Secretary of Behavioral Health and Disabilities or the Deputy Secretary’s Designee; the Director of the Office of Health Care Quality (OHCQ); a licensed physician representative from the medical examiner’s office; a licensed nurse who works with persons with developmental disabilities in a program operated by a State licensed provider in the community; and three members of advocacy groups, two for persons with developmental disabilities and one for persons with mental illnesses.

The terms of the members are determined at the time of appointment. The terms range from one to three years. A member may not serve for more than two consecutive full terms. The Secretary may remove any member of the Committee for good cause. Members do not receive compensation for service on the MQRC.

The MQRC is staffed by DDA and MHA, units within DHMH. DDA and MHA employees who staff the MQRC are not members of the MQRC or the subcommittee of the MQRC.

The statute requires that the MQRC meet no less than three times a year. A majority of the members of the Committee must be present to vote on decisions related to cases reviewed. The Director of the OHCQ does not vote on the disposition of an individual death case previously reviewed by the OHCQ. Meetings of the MQRC are closed to the public and all deliberations are confidential. All records or files of the MQRC, its deliberations, findings, recommendations, and database are confidential . Members may not disclose what transpired at a meeting and are not allowed to communicate directly with a provider, a State Facility Director, a family member, or guardian of the individual who is the subject of a death review. MQRC members have immunity from liability for any action as a member of the MQRC or for giving information to, participating in, or contributing to the function of the MQRC or its subcommittee.

II. REPORTING REQUIREMENTS

The MQRC is required to prepare a report for public distribution at least once a year. The annual report must include aggregate information that sets forth the numbers of deaths reviewed, the age of the deceased, causes and circumstances of death, a review of aggregate incident data, a summary of the MQRC's activities, and summary of findings. Summary findings should include patterns and trends, goals, problems, concerns and final recommendations, and preventative measures. Specific individuals and entities may not be identified in the report. The DDA provide the public report to all service providers licensed by DDA or operating by waiver under §7-903(b) of this article.

In addition to the annual report for public distribution, the MQRC or its subcommittee may, in its discretion, at any time issue preliminary findings or make preliminary recommendations to the Secretary, the Secretary of Disabilities, the Director of the DDA, the Director of the MHA, or to the Director of the OHCQ. The preliminary findings or recommendations are confidential and not discoverable or admissible.[1]

III. THE DEATH AND INCIDENT DATA REVIEW PROCESS

The Mortality and Quality Review Committee is one link in the process of the review of deaths and certain reportable incidents in the programs and facilities licensed or operated by the DDA and the MHA. The review process begins with a report of a death or a reportable incident to the OHCQ and other appropriate agencies.

The DDA has reporting requirements for deaths and incidents in their programs and facilities governed by statute or policy. The DDA issued a *Policy on Reportable Incidents and Investigations* which became effective July 29, 1999.[2] The purpose of the policy is to protect individuals from harm and to enhance the quality of services provided to them. The policy applies to all State Residential Centers (SRCs) and community-based agencies licensed by the

[1] Md. Health – General Code Ann. §5-809; Md. Health – Occupations Code Ann. §14 –501 (2001).

[2] The *Policy on Reportable Incidents and Investigations* was revised and reissued in December 2001, April 2003, October 2003, July 2005, July 2006, August 2006, and October 2007.

DDA. [3] All deaths and certain reportable incidents in programs covered by the policy must be reported to the following entities:

- The Office of Health Care Quality (OHCQ)
- Developmental Disabilities Administration (DDA)
- Family/legal guardian/advocate(s)
- Case manager/resource coordinator
- State protection and advocacy agency (Maryland Disability Law Center)
- Local health department, and
- Police

The MHA reporting requirements for deaths occurring in a an inpatient or residential treatment setting, residential crisis services, group home, residential rehabilitation program, or psychiatric rehabilitation program is governed by Maryland Annotated Code Article Health General §10-714 (2009 Replacement Volume). If a death of an individual in any of the aforementioned programs occurs, the administration head of the program or facility must report the death:

- Immediately, to the Secretary and the sheriff, police or chief law enforcement official in the jurisdiction in which the death occurred; and
- By the close of business of the next working day to:
  - Director of the Mental Hygiene Administration;
  - Health Officer in local jurisdiction where the death occurred; and
  - State protection and advocacy agency (Maryland Disability Law Center).

Under the provisions of the statute establishing the MQRC, the OHCQ performs an investigation of each death of an individual with developmental disabilities or mental illnesses who, at the time of death, resided in, or was receiving services from programs or facilities covered under the statute. The purpose of the death investigation is to determine any deficient practice due to regulatory non-compliance. Two exceptions apply to the OHCQ death investigation: 1) OHCQ may not review the care or services provided in an individual's private home, except to the extent needed to investigate a licensed provider that offered services in the individual's home, and 2) unless a member of the Committee requests a review, the OHCQ may choose not to complete an on-site investigation of a death if the circumstances, based on review and reasonable judgment, are readily explained and require no further investigation.

Once OHCQ completes its investigation, the case is presented to the MQRC. The MQRC then reviews each death case including deficiency statements and documents pertinent to the investigation. The MQRC may request additional information and documentation including individual records, service of care records, medical records, discharge summary, autopsy reports, medication administration records, and any deficiency statements and plans of corrections if it determines further investigation is warranted. Once a request for information has been made, a provider of medical care, including dental and mental health care, a state or local government agency and a provider of residential or other services must give access to that information. The MQRC may prepare questions for the provider agency, State Facility director or other relevant person, or may request the attendance of the provider, director, or other relevant person at a MQRC meeting.

[3] The reporting requirements also apply to those agencies operating by waiver under Md. Health –General Code Ann. § 7-903 (b) (2000).

Per the current Statute, the OHCQ provides aggregate incident[4] data with investigation results to the MQRC every three months. A sub committee of the MQRC reviews the aggregate incident data. Findings and recommendations are included in this report.

IV. MQRC ACTIVITIES AND STATISTICAL INFORMATION

In 2009, the MQRC met 6 times in January, March, April, June, August and October. The MQRC reviewed a total of 695 death cases (233 DDA cases and 462 MHA cases) for calendar year 2009. Please note that not all of the 695 cases occurred in Calendar Year 2009. They may have occurred in years 2005 – 2009. Of the 233 DDA cases, 52 cases were fully investigated by OHCQ and 181 cases were recommended No Further Action by OHCQ[5]. Of the 462 MHA cases, 41 cases were fully investigated and 421 cases were recommended No Further Actions by OHCQ. At the close of calendar year 2009, 691 cases were closed and 6 cases remained open for further review (FFR). The 691 cases that were closed in 2009 included 2 FFR cases carried over from calendar year 2008. The MQRC also reviewed the aggregate incident data for Calendar Year 2009.

A subcommittee of the MQRC was established to review statistics, identify trends and participate in the analysis of the statistical information. In the past 8 MQRC annual reports, data of cases that were presented for review in the given year was compared with case statistics presented and reviewed by the MQRC in previous years, and with general population statistics for a given year. During calendar year 2009, concerns were raised regarding the validity of comparing statistics on the cases reviewed by the MQRC during a calendar year period, as some cases reviewed within the calendar year pertained to deaths that occurred in prior years. Comparisons, therefore, between cases reviewed within each calendar year would not be a true reflection of the progression of factors within a given calendar year. As a result, the subcommittee recommended to the full committee that the MQRC annual report for 2009 will reflect only the trends in reportable deaths and incidents that have occurred within each calendar year of 2007, 2008 and 2009.

<u>Part One: Mortality</u>

Table 1, 2, and 3 compare the number of deaths that occurred in calendar years 2009, 2008 and 2007 to the number of deaths among all Marylanders in 2009, 2008 and 2007, respectively. Data indicates that among all Maryland residents, the majority of deaths that occurred in 2008 and 2007 were in the age range of 85 years and over (2.25 per 1000 of total population in 2008 and 2.20 in 2007), followed by 75-84 years (2.01 per 1000 of total population in 2008 and 2.00 per 1000 in 2007). Data for 2009 is not yet available pending the Vital Statistics Administration annual report. In comparison, among people with developmental disabilities (DDA population), the majority of deaths in 2009 and 2008 were in the age group of 55-64 years (2.91 per 1000 of total population receiving DDA services in 2009 and 2.14 per 1000 in 2008) followed by the age group of 45-54 years (2.12 per 1000 in 2009 and 2.03 in 2008), In 2007 the majority of deaths occurred in the age group of 45-54 years (3.15 per 1000) followed by the group of 55-64 (2.50 per 1000). For those individuals receiving services from the Public Mental Health System (MHA population) in 2007 through 2009, the highest rate of death occurred in the age range of 45-54

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[4] "Aggregate Incident Data" means information or statistics maintained by the Office of Health Care Quality on the reported incidents of Level III serious injuries at health care facilities, per Health General Article § 5-801.

[5] Effective April 2008, the Office of Health Care Quality implemented the Prioritization Protocol of Incidents of Death. This protocol reflects statutory requirements (Health-General/Title 5) and it augments the DDA's Policy on Reportable Incidents and Investigations and OHCQ's Incident Screening Committee Guidelines.

years (0.82 per 1000 in 2007, 0.86 per 1,000 in 2008 and 0.48 per 1,000 in 2009) followed by the age group of 55-64 years (0.59 per 1,000 in 2007, 0.65 per 1,000 in 2008 and 0.39 per 1,000 in 2009).

Number and distribution of deaths by age group

TABLE 1: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR MHA SERVICES IN 2009 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2009

Age Group (years)	Deaths of Individuals Receiving DDA Services in 2009	Deaths of Individuals Receiving MHA Services in 2009
<1	0	0
1-4	0	0
5 – 14	1 (.06 per 1000)	3 (.03 per 1000)
15 – 24	12 (.72 per 1000)	5 (.04 per 1000)
25- 34	10 (.60 per 1000)	12 (.10 per 1000)
35 – 44	19 (1.15 per 1000)	31 (.27 per 1000)
45 – 54	35 (2.12 per 1000)	56 (.48 per 1000)
55 – 64	48 (2.91 per 1000)	46 (.39 per 1000)
65 – 74	23 (1.39 per 1000)	21 (.18 per 1000)
75 – 84	12 (.72 per 1000)	12 (.10 per 1000)
85+	5 (.30 per 1000)	4 (.03 per 1000)
Not stated	n/a	0
Male (all ages)	92 (2.58 per 1000)	97 (.83 per 1000)
Female (all ages)	73 (4.43 per 1000)	93 (.80 per 1000)
Total Death	**165 (10.01** per 1000)	**190 (1.63 per 1000)**
Total Population	**16,468**	**116,779**

Note: 2009 data for all Marylanders not yet available pending DHMH Vital Statistics Administration's report

TABLE 2: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR MHA SERVICES IN 2008 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2008

Age Group (years)	Deaths of Individuals Receiving DDA Services in 2008	Deaths of Individuals Receiving MHA Services in 2008	Total Deaths in Maryland (2008)[1]
<1	0	0	*617 (.10* per 1000)
1-4	0	0	*88 (.01* per 1000)
5 – 14	2 (.06 per 1000)	1 (.01 per 1000)	*108 (.02* per 1000)
15 – 24	15 (.87 per 1000)	12 (.12 per 1000)	*641.11* per 1000)
25- 34	12 (.69 per 1000)	24 (.23 per 1000)	*796 (.14* per 1000)
35 – 44	10 (.58 per 1000)	45 (.43 per 1000)	*1,518 (.27* per 1000)
45 – 54	35 (2.03 per 1000)	89 (.86 per 1000)	*3,686 (.65* per 1000)
55 – 64	37 (2.14 per 1000)	67 (.65 per 1000)	*5,334 (.95* per 1000)
65 – 74	27 (1.56 per 1000)	28 (.27 per 1000)	*7,036 (1.24* per 1000)
75 – 84	21 (1.21 per 1000)	13 (.13 per 1000)	*11,330 (2.01* per 1000)
85+	7 (/40 per 1000)	3 (.03 per 1000)	*12,690(2.25* per 1000)
Not stated	n/a	0	*5 (.00* per 1000)
Male (all ages)	104 (6.03 per 1000)	144 (1.39per 1000)	*21,747 3.86* per 1000)
Female (all ages)	62 (3.69 per 1000)	138 (1.33 per 1000)	*22,102 (3.92* per 1000)
Total Death	**166 (9.63** per 1000)	**282 (2.72 per 1000)**	***43,849 (7.78*** per 1000)
Total Population	**17,237**	**103,833**	***5,633,597***

Note: Data provided by DHMH Vital Statistics Administration

TABLE 3: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR MHA SERVICES IN 2007 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2007

Age Group (years)	Deaths of Individuals Receiving DDA Services in 2007	Deaths of Individuals Receiving MHA Services in 2007	Total Deaths in Maryland (2007)[1]
<1	0	0	*622 (.11* per 1000)
1-4	1 (.06 per 1000)	0	*97 (.02* per 1000)
5 – 14	2 (.12 per 1000)	0	*125 (.02* per 1000)
15 – 24	7 (.45 per 1000)	7 (.07 per 1000)	*698 (.12* per 1000)
25- 34	14 (.90 per 1000)	12 (.12 per 1000)	*857 (.15* per 1000)
35 – 44	22 (1.41 per 1000)	41 (.42 per 1000)	*1,762 (.31* per 1000)
45 – 54	49 (3.15 per 1000)	80 (.82 per 1000)	*3,655 (.65* per 1000)
55 – 64	39 (2.50 per 1000)	57 (.59 per 1000)	*5.256 (.93* per 1000)
65 – 74	17 (1.09 per 1000)	31 (.32 per 1000)	*6,876 (1.22* per 1000)
75 – 84	12 (.77 per 1000)	12 (.12 per 1000)	*11,272 (2.00* per 1000)
85+	3 (.19 per 1000)	2 (.02 per 1000)	*12,374 (2.20* per 1000)
Not stated	n/a	0	*3 (.00* per 1000)
Male (all ages)	93 (5.98 per 1000)	130 (1.33 per 1000)	*21,487 (3.82* per 1000)
Female (all ages)	73 (4.69 per 1000)	112 (1.15 per 1000)	*22,110 (3.94* per 1000)
Total Death	**166 (10.67** per 1000)	**242 (2.49 per 1000)**	***43,597 (7.76*** per 1000)
Total Population	**15,547**	**97,379**	***5,618,344***

Note: Data provided by DHMH Vital Statistics Administration

Gender and Death Rate

Tables 4, 5 and 6 provide the gender and death rate per 1000 population of Maryland, DDA and MHA for the years 2009, 2008 and 2007.

TABLE 4: DEATH RATE PER 1000 POPULATION 2009

	DDA	**MHA**
Total	10.0	**1.63**
Male	9.58	.83
Female	10.6	.80

Note:

1. Total Maryland Population pending VSA 2009 report;

2. As of December 31, 2009, DDA services a total of 16468 people with 9603 being male, 6860 female, and 6 unknown.

3. As of December 31, 2009, MHA provided services to a total of 116,779 people, with 57,095 being male and 59,684 being female.

TABLE 5: DEATH RATE PER 1000 POPULATION 2008

	DDA	**MHA**	**Maryland**
Total	9.63	2.72	**7.78**
Male	10.4	1.39	7.97
Female	8.58	1.33	7.61

Note:

1. As of December 31, 2008, DDA served 17,237 people with 10,001 being male, 7230 female and 6 unknown;

2. As of December 31, 2008, MHA served 103,833 people with 52,171 being male and 51,662 being female.

TABLE 6: DEATH RATE PER 1000 POPULATION 2007

	DDA	**MHA**	**Maryland**
Total	10.6	2.49	7.76
Male	10.4	1.33	7.90
Female	11.1	1.15	7.63

Note:

1. *As of December 31, 2007, DDA served a total of 15,547 people with 9603 being male, 6860 female and 3 unknown;*
2. *As of December 31, 2007, MHA served a total of 97,379 people with 48,922 being male and 48,457 being female.*

Cause of Death

TABLE 7, 8, and 9 list the top 10 primary causes of death for years 2009, 2008, and 2007.

TABLE 7: TOP 10 LEADING CAUSES OF THE DEATHS 2009

Rank	Leading Causes of the DDA Deaths 2009	Leading Causes of the MHA Deaths 2009
1	Disease of the Heart	Disease of the Heart
2	Influenza[3]	Accidents[2]
3	Pneumonia[3]	Malignant Neoplasm
4	Septicemia	Diseases of the Respiratory System
5	Malignant Neoplasm[4]	Suicide
6	Diseases of Respiratory System[4]	Septicemia
7	Cerebrovascular diseases	Influenza[5]
8	Alzheimer's Disease[6]	Pneumonia[5]
9	Bowel Obstruction & Perforation [6]	Renal Disease
10	Nephritis, Nephrotic Syndrome, & Nephrosis[6]	Cerebrovascular Diseases

Notes:

1. *2009 data not yet available pending DHMH Vital Statistics Administration report.*
2. *Accidents included 2 deaths from choking.*
3. *– 6. Cause of deaths tied for per cause, per population.*

TABLE 8 TOP 10 LEADING CAUSES OF THE DEATHS 2008

Rank	Leading Causes of the DDA Deaths 2008	Leading Causes of the MHA Deaths 2008	Leading Causes of death for all Maryland Residents 2008[1]
1	Influenza[3]	Disease of the Heart	Disease of the Heart
2	Pneumonia[3]	Accidents	Malignant Neoplasm
3	Disease of the heart	Malignant Neoplasm	Cerebrovascular diseases
4	Septicemia	Diseases of the Respiratory System	Chronic Lower Respiratory Diseases
5	Malignant Neoplasm	Suicide	Diabetes Mellitus
6	Disease of Respiratory System[4]	Cerebrovascular Diseases	Accident[2]
7	Epilepsy[4]	Influenza[5]	Influenza[5]
8	Cerebrovascular Diseases	Pneumonia[5]	Pneumonia[5]
9	Alzheimer's Disease	Septicemia	Septicemia
10	Accident[2]	Liver Disease	Alzheimer's Disease

Notes:

1. *Data provided by DHMH Vital Statistics Administration.*
2. *Accidents - primarily automobile related, 4 were choking related accidents.*
3. *– 5. Cause of deaths tied per cause, per population.*

TABLE 9: TOP 10 LEADING CAUSES OF THE DEATHS 2007

Rank	Leading Causes of the DDA Deaths 2007	Leading Causes of the MHA Deaths 2007	Leading Causes of death for all Maryland Residents 2007[1]
1	Influenza[2]	Disease of the Heart	Disease of the Heart
2	Pneumonia[2]	Accidents	Malignant Neoplasm
3	Disease of the Heart	Malignant Neoplasm	Cerebrovascular diseases
4	Septicemia	Influenza and Pneumonia	Chronic Lower Respiratory Diseases
5	Disease of Respiratory System	Suicide	Accidents
6	Malignant Neoplasm	Diseases of the Respiratory System	Diabetes Mellitus
7	Cerebrovascular diseases	Septicemia	Influenza[3]
8	Accidents	Liver Disease	Pneumonia[3]
	Bowel Obstruction & Perforation	Cerebrovascular Diseases	Septicemia
9	Choking	Diabetes	Alzheimer's Disease
10	Epilepsy	Renal Failure	Nephritis, Nephrotic Syndrome, and Nephrosis

Notes:

1. *Data provided by DHMH Vital Statistics Administration.*
2. *– 3. Cause of deaths tied per cause, per population.*

In 2008 and 2007, diseases of the heart were the number one leading cause of death for all Marylanders with Malignant Neoplasm and Cerebrovascular Diseases being the second and third leading causes of death. For people served by DDA, in 2009 and 2007, diseases of the heart were the number one cause of death followed by influenza and pneumonia. In 2008, Influenza and/or Pneumonia was the number one primary cause of death with Disease of the Heart being the second primary cause followed by Malignant Neoplasm, Septicemia, Epilepsy, and Cerebrovascular Disease. It is noted that deaths caused by influenza and pneumonia, bowel obstruction and perforation, epilepsy, and septicemia occur at higher rates for people with developmental disabilities when compared with the general public. For example, Influenza and Pneumonia were listed as the number 7 leading causes of death for the general public in Maryland, they were the number one leading causes of death for people with developmental disabilities in 2008 and 2007. Diabetes Mellitus, the number 5 primary cause of death in 2008 and number 6 primary cause in 2007 for Marylanders was not listed in the top 10 primary causes for people with developmental disabilities. In addition, for people with developmental disabilities, the number of deaths attributed to accidents decreased in 2009 and did not hit the top 10 primary cause list (vs. the 10th cause in 2008 and eighth cause in 2007).

Among individuals with mental illness in 2007 through 2009, the number one cause of death was diseases of the heart with accidents and malignant neoplasm being the second and third leading causes of death. In 2007 the fourth leading cause of death was influenza and pneumonia, while in 2008 and 2009 the fourth leading cause of death was diseases of the respiratory system. However suicide is consistently the fifth leading cause of death for all three years listed for individuals receiving mental health services in the Maryland Public Mental Health System.

TABLE 10 compares cases in which the cause of death was intentional self-harm (suicide) for people served by MHA across 2007, 2008 and 2009. The table breaks down the suicide by method used.

TABLE 10: CASES WHERE INTENTIONAL SELF-HARM (SUICIDE) WAS THE CAUSE OF DEATH (MHA) 2007-2009

SUICIDE METHOD	MHA 2007	MD 2007	MHA 2008	MD 2008	MHA 2009
Drug Overdose (intentional self harm)					
Alcohol Overdose					
Poly Substance Intoxication					
Hanging	4		4		6
Asphyxiation	3		1		
Jumping					1
Gun Shot	4	231	6	259	2
Carbon Monoxide Intoxication	1				
Self-Cutting			2		1
Drowning					1
Other & Unspecified		277		234	
TOTAL	**12**	**508**	**13**	**493**	**11**

Note: 2009 MD data not available

Part Two: Aggregate Incident Data

For providers supporting individuals with developmental disabilities, incidents are reportable according to guidelines established by DDA's Policy on Reportable Incidents and Investigations (PORI, latest revision, October 2007). Reportable incidents are reviewed within OHCQ according to guidelines formalized in the appendix 6 of PORI. From the many incidents reported, the OHCQ Triage Unit and the weekly Incident Screening Committee (ISC) must determine which incidents are to be further investigated, and the priority for investigation, with an "A" priority investigation initiated within two working days of assignment, a "B" priority initiated within four working days, to a "C" level investigation initiated within 30 working days of assignment. Discriminations employed for investigation include the severity and type of incident reported, track record of the licensee, characteristics and number of consumers served, 21-day internal reports, etc. Additionally, it should be noted that the reporting of incidents, although mandatory, is a self-reporting process with question that some incidents may go un-reported.

Those incidents that are assigned for on-site investigation by OHCQ may yield a "substantiated" or "unsubstantiated" classification. In this context, "substantiated" means that the alleged type of incident (abuse, medication error, fracture, etc.), upon investigation, was found to have occurred. "Unsubstantiated" means that the alleged type of incident, upon investigation, did not occur. Each investigation may also result in a report of regulation deficiencies (a "Statement of Deficiencies [SOD]"). If no non-compliance issues are noted during the investigation, a closure letter, identifying that no deficient practices were noted, is sent to the provider agency. When deficiencies are cited, the provider/licensee must submit for approval a plan of correction (POC). If the agency's POC is determined by OHCQ to be acceptable, no further action may be required. If the POC is not deemed acceptable, additional plans of correction for the cited deficiencies are required. The Appendix 6 of PORI requires that "A" priority investigations receive follow-up review from OHCQ. Incidents receiving a "B" or "C" priority classification may receive follow-up review, based on both the investigator's or coordinator's recommendation.

V. FINDINGS, DISCUSSION AND RECOMMENDATIONS

No clear trends in incidents or resultant deficiencies are evident from the over 2,600 incidents and complaints reported for 2009. A large majority (85-91% in calendar years 2007-2009) of reportable incidents are thoroughly reviewed and determined to require no further action. The bulk of the remaining cases are investigated on-site (10-12% for the years 2007-2009), with the remainder (.9-3%) referred to other entities for follow-up. There are, on average 345 cases assigned each year for on-site investigation by OHCQ. The incident types determined for review by the MQRC Aggregate Incident Sub-Committee: medication errors requiring licensed health care practitioner (LHCP) intervention, serious injury requiring LHCP intervention, and inappropriate restraint usage, constitute slightly less than half (42-46%) of the reported incidents and 3-6% of the incidents assigned for on-site investigation. It is clear, however, there is a recognizable need for additional reviewers/staff assigned to OHCQ to more adequately investigate and review reported cases. From an assessment of the data and supporting documentation, the underlying factors to most severe incidents result from the following:

- Lack of sufficient direct care staff,
- Lack of sufficiently trained direct care staff,
- Insufficient or detrimental communications (e.g. between staff to staff; staff to consumer) leading to "power struggles" and conflict.

Based on the overall findings, the Committee recommends that steps should be initiated to address the following:

- Flu Shots – A reminder should be sent sent to providers, both MHA and DDA, to encourage them to assist their clients in obtaining flu shots
- Record keeping – An alert should be sent to DDA providers in particular, regarding record keeping practices. More details should be included, especially when dealing with bowel obstruction situations
- Regional nurses for DDA should be included in the review process

VI. APPENDIX

MORTALITY REVIEW COMMITTEE MEMBERS

Committee Chair:

- Keith R. Peterson, Chief Executive Officer – Penn Mar Human Services

Committee Members:

- Zabiullah Ali, MD – Assistant Medical Examiner - Chief Medical Examiner's Office
- Joanna D. Brandt, MD. Psychiatrist
- Doug L. Boggs, Pharm D. – University of Maryland
- Barrett L. Cisney – Chief of Evaluations and Compliance services - Mosaic Community Services, Inc.
- Diane K. Coughlin – Executive Director of UCP of Central Maryland
- Nancy Grimm – Director of Office of Health Care Quality - DHMH
- A. Joyce Lipman – Family member representative
- LaVon J. Magruder - Registered Nurse
- Cristy Marchand – Executive Director - the Arc of Maryland
- Vicki A. Mills – Self Advocate
- Mary G. Mussman, MD, Office of the Deputy Secretary for Health Care Financing – DHMH
- Joan M. Rumenap, MBA, Director of Special Projects – Abilities Network
- Susan R. Steinberg, Esq., Director of Forensic Services - DHMH
- Donna C. Wells – Executive Director, Howard County Mental Health Authority
- Phyllis S. Zolotorrow – Family member representative

Committee Counsel:

- Kathleen A. Ellis, Deputy Counsel, Assistant Attorney General, Office of the Attorney General-DHMH