STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

December 30, 2015

c/o Behavioral Health Administration
Spring Grove Hospital
55 Wade Avenue, Dix Building
Catonsville, MD 21228

Van T. Mitchell, Secretary
Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201

Carol A. Beatty, Secretary
Maryland Department of Disabilities
217 E. Redwood Street, Suite 1300
Baltimore, MD 21202

Dear Secretary Mitchell and Secretary Beatty:

The Department of Health and Mental Hygiene Mortality and Quality Review committee is required to issue an annual report pursuant to Health-General Article, §5-808, Annotated Code of Maryland. The enclosed report summarizes the actions of the committee and contains recommendations pertaining to the care provided to Maryland citizens who receive services through the Behavioral Health Administration and the Developmental Disabilities Administration. This report covers calendar year 2014.

If you have any further questions, please do not hesitate to contact me through Rachael Faulkner, Director, Office of Governmental Affairs and Communications, Behavioral Health Administration at (410) 402-8402, or by email at rachael.faulkner@maryland.gov.

Sincerely,

Jason Noel

Jason Noel, PharmD, Chair

Department of Health and Mental Hygiene

Mortality and Quality Review Committee

Annual Report

Calendar Year 2014

Larry Hogan
Governor

Boyd Rutherford
Lieutenant Governor

Van Mitchell
Secretary

Jason Noel
Chair

I. THE MORTALITY AND QUALITY REVIEW COMMITTEE

The Mortality and Quality Review Committee (MQRC) reviews the deaths of individuals in programs or facilities operated, licensed, or approved by the Developmental Disabilities Administration (DDA) and the Behavioral Health Administration (BHA), within the Department of Health and Mental Hygiene.[1] On July 1, 2014, the Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA) merged to become the Behavioral Health Administration (BHA). Any data in this report prior to July, 1, 2014 is from the Mental Hygiene Administration.

The MQRC's primary goal is to identify patterns and systemic problems within the DDA and BHA provider community and make recommendations to the Secretary regarding actions to prevent avoidable injuries and avoidable deaths and improve quality of care.

The MQRC meets at least three times per year. Meetings of the MQRC are closed to the public and all deliberations are confidential. All records and files of the MQRC, its deliberations, findings, recommendations, and database are confidential. Members[2] 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 and for giving information to, participating in, and contributing to the function of the MQRC or its subcommittee. Members do not receive compensation for service on the MQRC.

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

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1 Attachment 1: Health General Article, §5-801 – 5-810, Annotated Code of Maryland

2 Attachment 2: MQRC Membership

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 provides the public report to all service providers licensed by DDA, and those operating by waiver under Health-General Article, §7-903(b), Annotated Code of Maryland.

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 of DHMH, the Secretary of the Department of Disabilities, the Director of the DDA, the Director of the BHA, and to the Director of the OHCQ. The preliminary findings and recommendations are confidential and not discoverable or admissible.[3]

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 reportable incidents in the programs and facilities licensed or operated by the DDA and the BHA. 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.[4] 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), Forensic Residential Centers (FRCs), and community-based agencies licensed by the DDA. [5] All deaths and certain other incidents in programs covered by the policy must be reported to the following entities:

- The Office of Health Care Quality (OHCQ)

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

[4] 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.

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

- 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 reporting requirements for deaths occurring in an inpatient or residential treatment setting, residential crisis services, group home (including ALU), residential rehabilitation program, community supported living arrangement, and psychiatric rehabilitation program[6] is governed by Maryland Annotated Code Health- General Article §10-713 (2015). If a death of an individual in any of the aforementioned programs occurs, the administrative 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:
  - The Director of the Behavioral Health Administration (BHA);
  - The Health Officer in the local jurisdiction where the death occurred; and
  - The State protection and advocacy agency (Maryland Disability Law Center).

Under the provisions of the Maryland Annotated Code Health-General Article §5-801, *et seq.*, the OHCQ performs a review of each death of an individual with a developmental disability or mental illness who, at the time of death, resided in, or was receiving services from programs or facilities covered under the statute §10-713. The purpose of the review is to consider whether additional investigation is needed, especially if the incident is a death, in order to determine whether regulations have been violated. Two exceptions apply to the power of the OHCQ to conduct an investigation: 1) the OHCQ may not review the care or services provided in an individual's private home, except to the extent needed to investigate the services were provided in the home by a licensed provider; 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 review or investigation, the case is presented to the MQRC. The MQRC then reviews each death case, including any deficiency statements and documents

[6] Effective October 1, 2015 psychiatric rehabilitation programs are no longer listed in statute as required to report deaths to the Department.

pertinent to the case. If MQRC determines that further investigation is warranted, it 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. Once a request for information has been made, a provider of medical, dental, or mental health care, and of residential or other services, whether private or State or local governments, must provide access to that information. The MQRC may prepare questions for the provider agency, State Facility director or other relevant person.

In accordance with Health-General Article, §5-806.1, Annotated Code of Maryland, the OHCQ provides aggregate incident[7] data to the MQRC every three months. A sub-committee of the MQRC reviews the aggregate incident data. Findings and recommendations for 2014 are included in this report.

IV. MQRC ACTIVITIES AND STATISTICAL INFORMATION

In 2014, the MQRC met three times: April 9, 2014; July 28, 2014; and October 27, 2014. The MQRC reviewed a total of 183 reports of death (177 DDA cases and six BHA cases) for calendar year 2014. Of the 177 DDA cases, 176 were investigated on-site or administratively. Please note that not all of the cases reviewed involved a death that occurred in Calendar Year 2014. The death may have occurred prior to 2014. Of the 177 DDA cases fully investigated by OHCQ, all were recommended for closure by MQRC[8]. At the close of calendar year 2014, 183 of the total cases were closed and three cases (State residential cases-SRC) remained open for further review (FFR) because Committee members requested clarification of certain aspects presented. The cases that were closed in 2014 included one FFR case carried over from calendar year 2013. The MQRC also reviewed the aggregate incident data for Calendar Year 2013.

Part One: Mortality

Table 1 compares the number of deaths that occurred in Calendar Year 2014 among individuals receiving DDA or BHA services, to the number of deaths among all Maryland residents by age group. Data indicates that among all Maryland residents, the majority of deaths that occurred in 2014 were in the age range of 85 years and over, followed by those in the range of 75-84. By

7 "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.

8 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.

comparison, among people served by DDA, the majority of deaths in 2014 were in the age group of 55-64, followed by the age group 45-54. Among the people served by BHA, the majority of deaths in 2014 were in the age group of 55-64, followed by the age group of 45-54.

Number and distribution of deaths by age group

TABLE 1: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR BHA SERVICES IN 2014 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2014

Age Group (years)	Deaths of All Marylanders in 2014	Deaths of Individuals Receiving DDA Services in 2014	Deaths of Individuals Receiving BHA Services in 2014
<1	476	0	0
1 – 4	75	0	0
5 – 14	91	1	0
15 – 24	504	10	1
25- 34	910	19	3
35 – 44	1,279	27	6
45 – 54	3,272	45	10
55 – 64	6,220	57	20
65 – 74	8,144	33	5
75 – 84	10,532	18	3
85+	14,184	6	2
Not stated	-	0	0
Male (all ages)	22,771	129	28
Female (all ages)	22,917	87	22
Total Deaths	**45,688**	**216**	**50**
Total Population	***	**16,408**	**175,537**

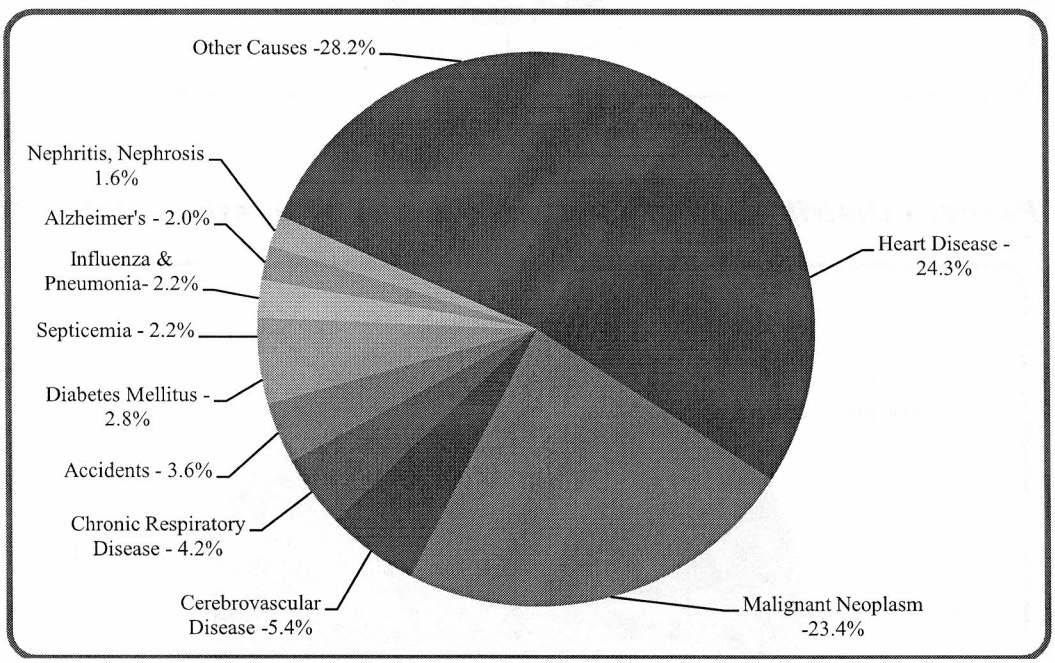
****Waiting for information from Maryland Vital Statistics***

Table 2, and the pie charts that accompany it, list the top ten leading causes of death that occurred in calendar year 2014 among individuals receiving DDA and BHA services and compares those causes of death to the top ten leading causes of death among all Maryland residents.

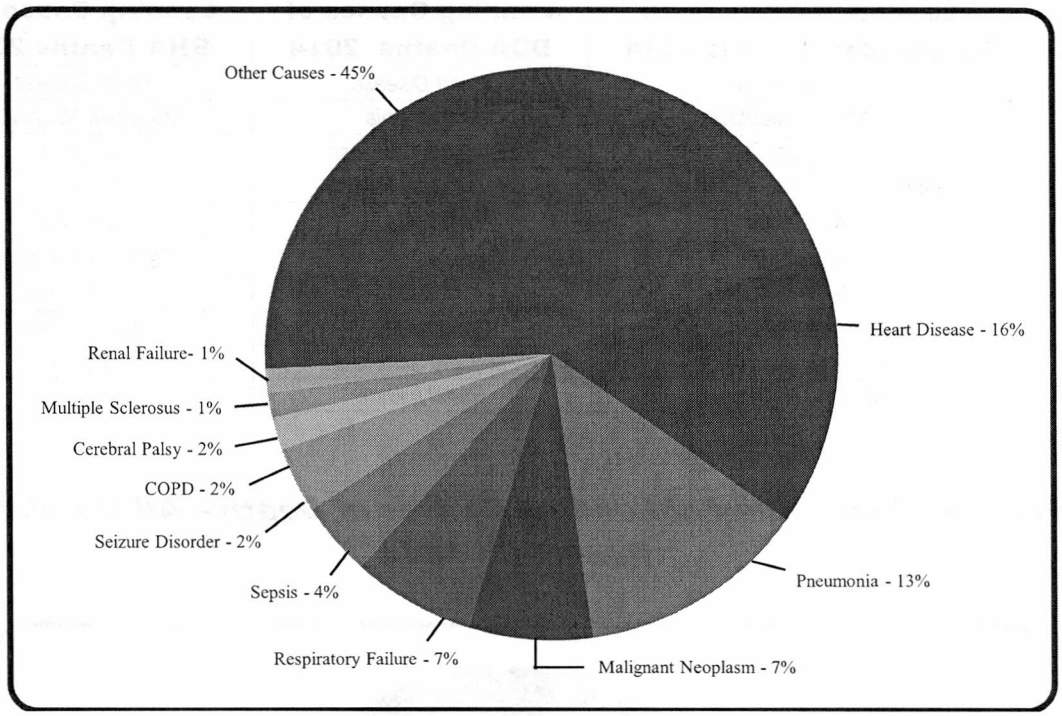
TABLE 2: TOP 10 INDIVIDUAL CAUSES OF DEATHS IN 2014

Rank	Leading Causes of All Marylanders Deaths 2014	Leading Causes of DDA Deaths 2014	Leading Causes of BHA Deaths 2014
1	*Heart Disease*	*Heart Disease*	*Heart Disease*
2	*Malignant Neoplasm*	*Pneumonia*	*Malignant Neoplasm*
3	*Cerebrovascular Diseases*	*Malignant Neoplasm*	*Accident*
4	*Chronic Respiratory Disease*	*Respiratory Failure*	*Suicide*
5	*Accidents*	*Sepsis*	*Intoxication*
6	*Diabetes Mellitus*	*Seizure Disorder*	*Respiratory Failure*
7	*Septicemia*	*COPD*	*Renal Failure*
8	*Influenza & Pneumonia*	*Cerebral Palsy*	*Pneumonia*
9	*Alzheimer's Disease*	*Multiple Sclerosis*	*Sepsis*
10	*Nephritis, Nephrosis*	*Renal Failure*	*Homicide*

Percent Distribution of Leading Causes of Death – All Maryland Residents 2014



Percent Distribution of Leading Causes of Death – DDA 2014



Percent Distribution of Leading Causes of Death – BHA 2014

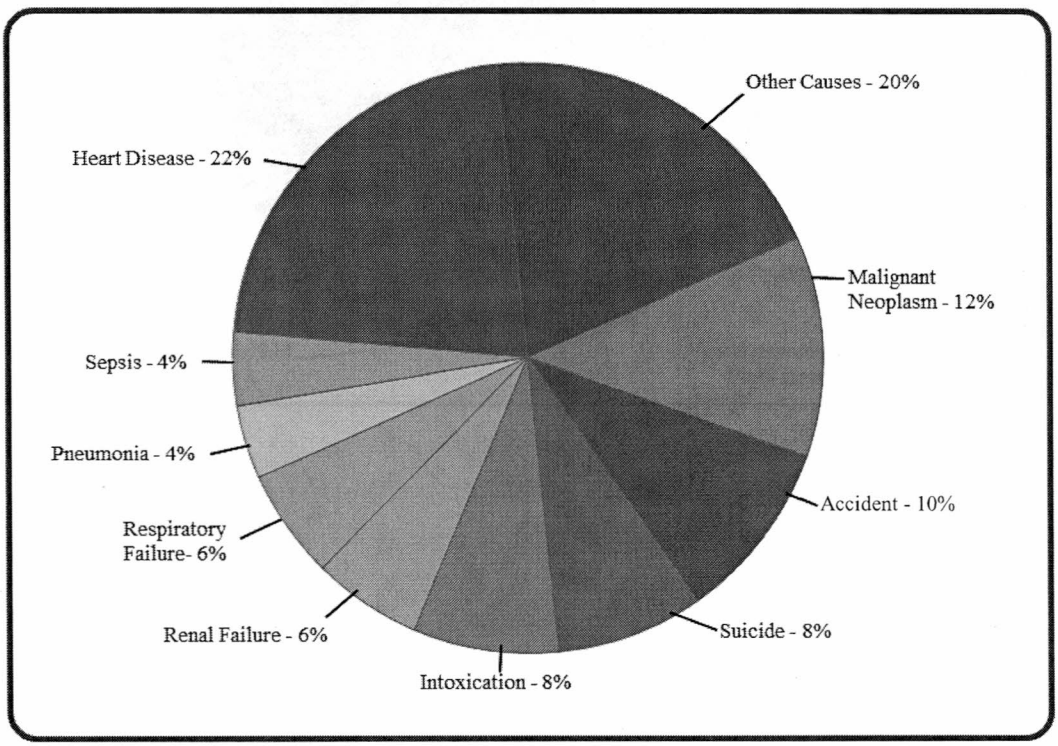


TABLE 3: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR BHA SERVICES IN 2013 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2013

Age Group (years)	Deaths of All Marylanders in 2013	Deaths of Individuals Receiving DDA Services in 2013	Deaths of Individuals Receiving BHA Services in 2013
<1	474	0	0
1 - 4	72	0	0
5 – 14	77	2	1
15 – 24	542	14	1
25- 34	906	18	4
35 – 44	1,199	12	7
45 – 54	3,289	33	23
55 – 64	6,101	52	19
65 – 74	7,849	38	10
75 – 84	10,529	19	4
85+	14,402	8	1
Not stated	4	0	0
Male (all ages)	22,504	108	38
Female (all ages)	22,940	88	32
Total Deaths	**45,444**	**196**	**70**
Total Population	**5,928,814**	**16,120**	**157,069**

TABLE 4: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR BHA SERVICES IN 2012 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2012

Age Group (years)	Deaths of All Marylanders in 2012	Deaths of Individuals Receiving DDA Services in 2012	Deaths of Individuals Receiving BHA Services in 2012
<1	458	0	0
1 - 4	76	0	0
5 – 14	81	0	1
15 – 24	568	14	1
25- 34	832	19	5
35 – 44	1,229	20	5
45 – 54	3,305	38	15
55 – 64	5,966	55	17
65 – 74	7,268	18	6
75 – 84	10,307	14	3
85+	14,013	3	0
Not stated	7	0	0
Male (all ages)	21,740	115	30
Female (all ages)	22,370	66	23
Total Deaths	**44,110**	**181**	**53**
Total Population	**5,884,563**	**15,897**	**149,939**

Tables 5 and 6 list the top ten primary causes of death for years 2013 and 2012 among all residents of Maryland, and those served by DDA and BHA.

TABLE 5: TOP 10 INDIVIDUAL CAUSES OF THE DEATHS 2013

Rank	Leading Causes of All Marylanders Deaths 2013	Leading Causes of DDA Deaths 2013	Leading Causes of BHA Deaths 2013
1	*Heart Disease*	*Pneumonia*	*Heart Disease*
2	*Malignant Neoplasm*	*Heart Disease*	*Intoxication*
3	*Cerebrovascular Disease*	*Malignant Neoplasm*	*Malignant Neoplasm*
4	*Chronic Lower Respiratory Disease*	*Sepsis*	*Respiratory*
5	*Accidents*	*Septic Shock*	*Pulmonary*
6	*Diabetes Mellitus*	*Respiratory*	*Suicide*
7	*Influenza & Pneumonia*	*Seizure Disorder*	*Pneumonia*
8	*Septicemia*	*Dementia/Alzheimer's*	*Accident*
9	*Alzheimer's Disease*	*Pulmonary*	*Stroke/Hypertension*
10	*Nephritis, Nephrosis*	*Cirrhosis*	*Seizure Disorder*

TABLE 6: TOP 10 INDIVIDUAL CAUSES OF THE DEATHS 2012

Rank	Leading Causes of All Marylanders Deaths 2012	Leading Causes of DDA Deaths 2012	Leading Causes of BHA Deaths 2012
1	*Heart Disease*	*Heart Disease*	*Heart Disease*
2	*Malignant Neoplasm*	*Pneumonia*	*Accidents*
3	*Cerebrovascular Disease*	*Malignant Neoplasm*	*Intoxication*
4	*Chronic Respiratory Disease*	*Sepsis*	*Pneumonia*
5	*Accidents*	*Chronic Respiratory Disease*	*Malignant Neoplasm*
6	*Diabetes Mellitus*	*Choking*	*Multi-Organ Failure*
7	*Influenza & Pneumonia*	*Accidents*	*COPD*
8	*Septicemia*	*Renal Failure*	*Cerebrovascular Disease*
9	*Alzheimer's Disease*	*Alzheimer's Disease*	*Suicide*
10	*Nephritis, Nephrosis*	*Seizure Disorder*	*Choking*

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 (PORII, latest revision, October 2007). Reportable incidents are reviewed within OHCQ according to guidelines formalized in Appendix 6 of PORII. 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 investigation initiated within four working days, and a "C" level investigation initiated within 30 working days of assignment. Discriminations employed for investigation include the severity and type of incident reported, the track record of the licensee, characteristics and number of consumers served, 21-day internal reports, etc. Additionally, it should be noted that, although mandatory, incidents are self-reporting, resulting in some incidents going unreported.

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 incident (abuse, medication error, fracture, etc.), upon investigation, was found to have occurred. "Unsubstantiated" means that the alleged incident, upon investigation, did not occur. Each investigation may also result in a report of deficiencies (a "Statement of Deficiencies [SOD]"). If no non-compliance issues are noted during the investigation, a closure letter stating 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 is required. If the POC is not deemed acceptable, a revised plan of correction for the cited deficiencies is required. Appendix 6 of PORII requires that "A" priority investigations receive follow-up review from OHCQ. Incidents with a "B" or "C" priority classification may receive follow-up review based on the final recommendation of the coordinator.

V. FINDINGS, DISCUSSION AND RECOMMENDATIONS

FINDING #1: Although it was the second leading cause of DDA deaths in 2014 (after ranking first in 2013), pneumonia remains among the top cause of mortality among DDA clients.

Recommendation: The DDA should continue its ongoing efforts to ensure that agency clinical and direct care staff advocate for regular immunizations as indicated.

FINDING #2: Respiratory issues continue to rate high as a cause of DDA deaths (4th leading cause) and BHA deaths (6th leading cause) and in 2014.

Recommendation: The DDA and BHA should continue its ongoing efforts to ensure that Agency clinical and direct care staff advocate for regular immunizations as indicated.

FINDING #3: In 2014, malignant neoplasm was the third leading identified cause of death among DDA clients (7% of deaths) and was the second leading cause of death among BHA clients (12%).

Recommendation: Agencies should promote appropriate cancer screening as recommended by clinical guidelines (e.g. mammograms, colonoscopies, prostate exams, etc.) among their clients. Incident reporting for deaths from malignant neoplasm should include required fields where the history of cancer screening is included so that death investigations include this information.

FINDING #4: The MQRC has noted an ongoing trend related to response of direct staff in choking or cardiac arrest emergencies. In many cases, an investigation revealed that the appropriate life support measures (e.g. CPR, Heimlich maneuver) were not carried out, despite the staff having been documented as trained in these procedures. The Committee has postulated the minimal training and refresher requirements for emergency care do not allow ample opportunity for staff to be prepared to respond appropriately in a crisis.

Recommendation: Agency practicum training for CPR and choking should be carried out at an increased frequency for all staff. The trainings should reflect the most recent guidelines for emergency interventions, as these have changed over time. Trainings should be live and supervised by certified trainers so that practice is gained with hands-on procedures. The use of computer or on-line certification/recertification training should be avoided.

FINDING #5: The Committee recognizes that unanticipated deaths may be caused not by deficient practices from DDA or BHA provider agencies, but from improper actions from individual licensed or certified personnel. These cases are referred, often after initial review by OHCQ, to licensing boards or other bodies for further follow up.

Recommendation: To the extent possible, the provider agency should hold its certified staff and licensed professionals accountable to their discipline's practice acts and codes of ethics. The provider agency should exercise its obligation to report to the appropriate

professional board any certified/licensed personnel whose actions are a breach of their scope of practice, a violation of their code of ethics or whose actions may be implicated for contributing to an individual's death. It is imperative that reporting to professional boards occur promptly so that the risk to other individuals is minimized. Once referred, the agency should have access to information related to the disciplinary action taken by the licensing board.

FINDING #6: Decisions regarding medical treatment and end-of-life care are often not informed by a sound, predetermined process. There are often medical decisions that are made under duress by family members or surrogate decision makers. In a few unfortunate cases, the Committee has reviewed reports of measures that were carried out inconsistent with existing MOLST or DNR orders.

Recommendation: As part of regular ongoing individual planning, provider agencies should inform and update treatment teams and staff on issues of guardianship, health care agent/surrogate decision maker responsibility, and MOLST orders. Any missing or incomplete information in these areas should be recognized and resolved during the annual IP process. If this information is current and complete, it should be communicated to all staff so that they are aware of how to proceed for medical decision making or in an emergency situation.

ATTACHMENT 1

Maryland HEALTH-GENERAL Code Ann. § 5-801 (2015)

TITLE 5. DEATH
SUBTITLE 8. MORTALITY AND QUALITY REVIEW COMMITTEE.

§ 5-801. Definitions

(a) In general. -- In this subtitle the following words have the meanings indicated.

(b) Aggregate incident data. -- "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.

(c) Committee. -- "Committee" means the Mortality and Quality Review Committee.

HISTORY: 2000, ch. 470; 2006, ch. 268.

§ 5-802. Established; purpose

(a) Established. -- There is a Mortality and Quality Review Committee established within the Department.

(b) Purpose. -- The purpose of the Committee is to prevent avoidable injuries and avoidable deaths and to improve the quality of care provided to persons with developmental disabilities.

HISTORY: 2000, ch. 470; 2006, ch. 268.

§ 5-803. Duties

The Committee shall:

(1) Evaluate causes or factors contributing to deaths in facilities or programs:

(i) Operated or licensed by the Developmental Disabilities Administration;

(ii) Licensed by the Behavioral Health Administration to provide mental health services; or

(iii) Operating by waiver under § 7-903(b) of this article;

(2) Review aggregate incident data regarding facilities or programs that are licensed or operated by the Developmental Disabilities Administration or operating by waiver under § 7-903(b) of this article;

(3) Identify patterns and systemic problems and ensure consistency in the review process; and

(4) Make recommendations to the Secretary and the Secretary of Disabilities to prevent avoidable injuries and avoidable deaths and improve quality of care.

HISTORY: 2000, ch. 470; 2001, ch. 640; 2006, ch. 268; 2014, ch.460; 2015, ch. 469.

§ 5-804. Composition; terms; removal; expenses; staff; chairperson; quorum; meetings

(a) Composition. -- The Committee shall consist of 18 members appointed by the Secretary, including the following:

(1) A licensed physician who is board certified in an appropriate specialty;

(2) A psycho pharmacologist;

(3) A licensed physician on staff with the Department;

(4) Two specialists, one in the field of developmental disabilities and one in the field of mental health;

(5) Two licensed providers of community services, one for persons with developmental disabilities and one for persons with mental illnesses;

(6) Two consumers, one with a developmental disability and one with a mental illness;

(7) Two family members, one representing a consumer with a developmental disability and one representing a consumer with a mental illness;

(8) The Deputy Secretary of Behavioral Health and Disabilities or the Deputy Secretary's designee;

(9) The Director of the Office of Health Care Quality;

(10) A licensed physician representative from the Medical Examiner's Office;

(11) A licensed nurse who works with persons with developmental disabilities in a program operated by a State licensed provider in the community;

(12) A member of an advocacy group for persons with disabilities; and

(13) Two members of advocacy groups, one for persons with developmental disabilities and one for persons with mental illnesses.

(b) Terms. --

(1) The term of each member appointed under subsection (a) (1), (2), (4), (5), (6), and (10) of this section is 3 years.

(2) A member who is appointed after a term has begun serves only for the rest of the term and until a successor is appointed.

(3) A member may not be appointed for more than two consecutive full terms.

(4) The terms of the members are as follows:

(i) One-third of the members shall be appointed for terms of 3 years commencing October 1, 2000;

(ii) One-third of the members shall be appointed for terms of 2 years commencing October 1, 2000; and

(iii) One-third of the members shall be appointed for terms of 1 year commencing October 1, 2000.

(5) At the end of a term, a member continues to serve until a successor is appointed.

(c) Removal of member. -- The Secretary may remove any member of the Committee for good cause.

(d) Reimbursement for expenses. -- A member of the Committee:

(1) May not receive compensation for service on the Committee; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(e) Staff. -- The Committee shall be staffed by the Department.

(f) Membership limitations. --

(1) An employee of the Developmental Disabilities Administration or the Behavioral Health Administration may not be a member of the Committee or any subcommittee of the Committee.

(2) The Director of the Office of Health Care Quality may not serve on a subcommittee of the Committee or vote on the disposition of an individual mortality review that was previously reviewed by the Office of Health Care Quality.

(g) Chairperson. -- The Secretary shall select a chairperson from among the members of the Committee.

(h) Quorum. -- A quorum of the Committee shall be a majority of the appointed membership of the Committee.

(i) Frequency of meetings. -- The Committee shall meet not less than three times a year.

HISTORY: 2000, ch. 470; 2001, ch. 640; 2006, ch. 268; 2009, chs. 48, 49; 2014, ch. 460; ch 539.

§ 5-805. Evaluation of deaths of certain service recipients with developmental disabilities

(a) Review of death of certain service recipients. --

(1) Except as provided in paragraph (3) of this subsection, the Office of Health Care Quality shall review each death of an individual with developmental disabilities or with a mental illness who, at the time of death, resided in or was receiving services from any program or facility licensed or operated by the Developmental Disabilities Administration or operating by waiver under § 7-903 (b) of this article, or any program approved, licensed, or operated by the Department under § 10-406 of this article or any program identified in § 10-713(A) of this article.

(2) The Office of Health Care Quality 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 at that individual's home.

(3) Unless a member of the Committee requests a review, the Office of Health Care Quality may choose not to review a death if the circumstances, based on reasonable judgment, are readily explained and require no further investigation.

(b) Final report -- Submission. -- Within 14 days of the completion of each investigation, the Office of Health Care Quality shall submit to the Committee its final report for each death.

(c) Final report -- Review by Committee. -- The Committee shall:

(1) Review each death report provided by the Office of Health Care Quality; or

(2) Appoint a subcommittee of at least four members, one of whom shall be a licensed physician or nurse, to review death reports and report and make recommendations to the full Committee.

(d) Further investigation. --

(1) On review of the death report, if the Committee or its subcommittee determines that further investigation is warranted, the Committee or subcommittee may request additional information, including consumer records, medical records, autopsy reports, and any deficiency statements and plans of correction.

(2) The Committee or subcommittee may choose to prepare questions for the provider, State residential center director, or other relevant person or may request the attendance of the provider, director, or other relevant person at a Committee or subcommittee meeting.

(3) Except as provided in paragraph (2) of this subsection, Committee members may not communicate directly with the provider, a State residential center director, a State psychiatric superintendent, or a family member or guardian of the individual who is the subject of a death report.

HISTORY: 2000, ch. 61, § 7; ch. 470; 2001, ch. 29, § 1; ch. 640; 2006, ch. 268; 2014, ch.460; 2015, ch. 469.

§ 5-806. Requests for information

Upon request of the chairman of the Committee or subcommittee, and as necessary to carry out the purpose of the Committee, the following shall immediately provide the Committee or subcommittee with access to information and records regarding an individual whose death is being reviewed:

(1) A provider of medical care, including dental and mental health care;

(2) A State or local government agency; and

(3) A provider of residential or other services.

HISTORY: 2000, ch. 470; 2006, ch. 268.

§ 5-806.1. Office of Health Care Quality to provide and review aggregate incident data;

(a) Periodic data. --

(1) The Office of Health Care Quality shall provide aggregate incident data to the Committee once every 3 months.

(2) When providing aggregate incident data to the Committee, to the extent practicable, the Office of Health Care Quality shall identify trends and patterns that may threaten the health, safety, or well-being of an individual.

(b) Review. -- The Committee shall review the aggregate incident data and make findings and recommendations to the Department on system quality assurance needs.

(c) Consultants. -- The Committee may consult with experts as needed to carry out the provisions of this section.

HISTORY: 2006, ch. 268.

§ 5-807. Immunity from liability.

A person shall have the immunity from liability under § 5-637 of the Courts Article for any action as a member of the Committee or for giving information to, participating in, or contributing to the function of the Committee or subcommittee.

HISTORY: 2000, ch. 470; 2006, chs. 44, 268

§ 5-808. Annual public report; preliminary findings or recommendations

(a) Annual public report. --

(1) At least once in a calendar year, the Committee shall prepare a report for public distribution.

(2) The report shall include aggregate information that sets forth the numbers of deaths reviewed, the ages of the deceased, causes and circumstances of death, a review of aggregate incident data, a summary of the Committee's activities, and summary findings.

(3) Summary findings shall include patterns and trends, goals, problems, concerns, final recommendations, and preventative measures.

(4) Specific individuals and entities may not be identified in any public report.

(5) The Developmental Disabilities Administration shall provide the report to the facilities or programs that are operated or licensed by the Developmental Disabilities Administration or operating by waiver under § 7-903(b) of this article.

(b) Preliminary findings or recommendations. --

(1) In addition to the public report issued under subsection (a) of this section, the Committee or its subcommittee may at any time issue preliminary findings or make preliminary recommendations to the Secretary, the Secretary of Disabilities, the Director of the Developmental Disabilities Administration, the Director of the Behavioral Health Administration, or to the Director of the Office of Health Care Quality.

(2) Preliminary findings or recommendations shall be confidential and not discoverable or admissible under §1-401 of the Health Occupations Article.

HISTORY: 2000, ch. 470; 2002, ch. 19, §9; 2006, ch. 268; 2014, ch.460.

§5-809. Record keeping; confidentiality; discovery

(a) Maintenance of records. -- The Committee shall maintain records of its deliberations including any recommendations.

(b) Records generally confidential; independent information. --

(1) Except for the public report issued under §5-808(a) of this subtitle, any records of deliberations, findings, or files of the Committee shall be confidential and are not discoverable under §1-401 of the Health Occupations Article.

(2) This subsection does not prohibit the discovery of material, records, documents, or other information that was not prepared by the Committee or its subcommittee and was obtained independently of the Committee or subcommittee.

(c) Testimony of involved persons; independent information. --

(1) Members of the Committee or a subcommittee of the Committee, persons attending a Committee or subcommittee meeting, and persons who present information to the Committee or subcommittee may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting.

(2) This subsection does not prohibit a person from testifying to information obtained independently of the Committee or subcommittee or that is public information.

(d) Prohibition on disclosure by involved persons. -

(1) Except as necessary to carry out the Committee's purpose and duties, members of the Committee or subcommittee and persons attending a Committee or subcommittee meeting may not disclose:

(i) What transpired at a meeting that is not public under this subtitle; or

(ii) Any information that is prohibited for disclosure by this section.

(2) This subsection does not prohibit the discovery of material, records, documents, or other information that was not prepared by the Committee or its subcommittee and was obtained independently of the Committee or subcommittee.

HISTORY: 2000, ch. 470; 2002, ch. 19, § 9; 2006, ch. 268.

§ 5-810. Closed meetings

Meetings of the Committee and subcommittees shall be closed to the public and

not subject to Title 10, Subtitle 5 of the State Government Article.

HISTORY: 2000, ch. 470; 2006, ch. 268.

ATTACHMENT 2

2015 MQRC MEMBERSHIP

Committee Chair

- Jason Noel, Pharm D., psycho pharmacologist

Committee Membership

- Stephanie Bell, licensed provider of community developmental disability services
- Joanna D. Brandt, MD, board certified psychiatrist
- Mary G. Mussman, MD, licensed physician on staff with the Department
- Diane Coughlin, specialist in the field of developmental disabilities
- Donna Wells, specialist in the field of mental health
- Jen Carberry, licensed provider of community mental health services
- Edward Willard, developmental disability consumer
- Clarissa Netter, mental health consumer
- Curtis Royster, Jr. family member representing a consumer with a developmental disability
- Rosamond Dove, family member representing a consumer with a mental illness
- Rhonda Callum, the Deputy Secretary of Behavioral Health designee
- Patricia Tomsko-Nay, MD, Director of the Office of Health Care Quality, Ex Officio
- Michael Peskin, MD, Licensed Physician, DHMH
- Patricia Aronica, MD, MD, licensed physician representative from the Medical Examiner's Office
- LaVon Magruder, RN, licensed nurse who works with persons with developmental disabilities in a program operated by a State licensed provider in the community
- Carol Fried, a member of an advocacy group for persons with disabilities
- Richard Davis, a member of an advocacy group for persons with developmental disabilities
- Dan Martin, member of a mental health advocacy group

Committee Counsel

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