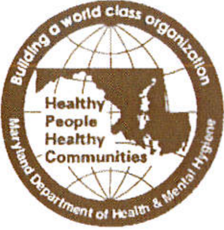

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, MD, Secretary

December 16, 2013

c/o Mental Hygiene Administration
Spring Grove Hospital
55 Wade Ave., Dix Bldg.
Catonsville, MD 21228

Joshua M. Sharfstein, MD, 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 Sharfstein and Secretary Raggio:

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 Mental Hygiene Administration and the Developmental Disabilities Administration.

If you have any further questions, please do not hesitate to contact me through Stacey Diehl, Director, Office of Governmental Affairs, Mental Hygiene Administration at (410) 402-8449, or by email at stacey.diehl@maryland.gov.

Sincerely,

Jason Noel, PharmD, Chair

Department of Health and Mental Hygiene

Mortality and Quality Review Committee

Annual Report

Calendar Year 2012

Martin O'Malley
Governor

Anthony G. Brown
Lieutenant Governor

Joshua M. Sharfstein, MD
Secretary

Jason Noel, PharmD
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 Mental Hygiene Administration (MHA), within the Department of Health and Mental Hygiene.[1] The MQRC's primary goal is to identify patterns and systemic problems within the DDA and MHA 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 MHA and DDA administrations within DHMH. MHA and DDA employees who staff the MQRC are not members of the MQRC or the subcommittee of the MQRC.

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

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

2 Attachment 2: MQRC Membership

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 Disabilities, the Director of the DDA, the Director of the MHA, 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 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.[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)
- 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

[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).

The reporting requirements for deaths occurring in an inpatient or residential treatment setting, residential crisis services, group home, residential rehabilitation program, and psychiatric rehabilitation program is governed by Maryland Annotated Code Health- General Article §10-713 (2011). 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 Mental Hygiene Administration;
  - 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 §5-802, which establishes the MQRC, the OHCQ performs a review 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 §10-713. The purpose of the review is to determine the need for further on-site or administrative investigation. The purpose of an on-site or administrative investigation is to determine if any deficient practice or failure to comply with regulations occurred, especially as related to the death. Two exceptions apply to ability of OHCQ to conduct an 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 review or investigation, the case is presented to the MQRC. The MQRC then reviews each death case, including any deficiency statements and documents pertinent to the case. 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, 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[6] data to the MQRC every three months. A sub-committee of the MQRC reviews the aggregate incident data. Findings and recommendations for 2012 are included in this report.

IV. MQRC ACTIVITIES AND STATISTICAL INFORMATION

In 2012, the MQRC met four times: February 22, 2012, May 21, 2012, September 20, 2012, and November 26, 2012. The MQRC reviewed a total of 207 reports of death (196 DDA cases and 11 MHA cases) for calendar year 2012. Of the 196 DDA cases, 50 were investigated on-site or administratively. Please note that not all of the 196 cases reviewed involved a death that occurred in Calendar Year 2012. The death may have occurred prior to 2012. Of the 50 DDA cases fully investigated by OHCQ, all were recommended for closure by MQRC[7]. Of the 11 MHA cases, all 11 cases were fully investigated and all were recommended for closure by MQRC. At the close of calendar year 2012, 205 of the total cases were closed and 2 cases remained open for further review (FFR) because Committee members requested clarification of certain aspects presented. The 205 cases that were closed in 2012 included 2 FFR cases carried over from calendar year 2011. The MQRC also reviewed the aggregate incident data for Calendar Year 2011.

Part One: Mortality

Table 1 compares the number of deaths that occurred in Calendar Year 2012 among individuals receiving DDA or MHA 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 2012 was in the age range of 85 years and over, followed by those in the range of 75-84. By comparison, among people served by DDA, the majority of deaths in 2012 were in the age group of 55-64, followed by the age group 45-54. Among the people served by MHA, the majority of deaths in 2012 were in the age group of 55-64, followed by the age group of 45-54.

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6 "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.

7 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.

Number and distribution of deaths by age group

TABLE 1: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR MHA SERVICES IN 2012 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2012

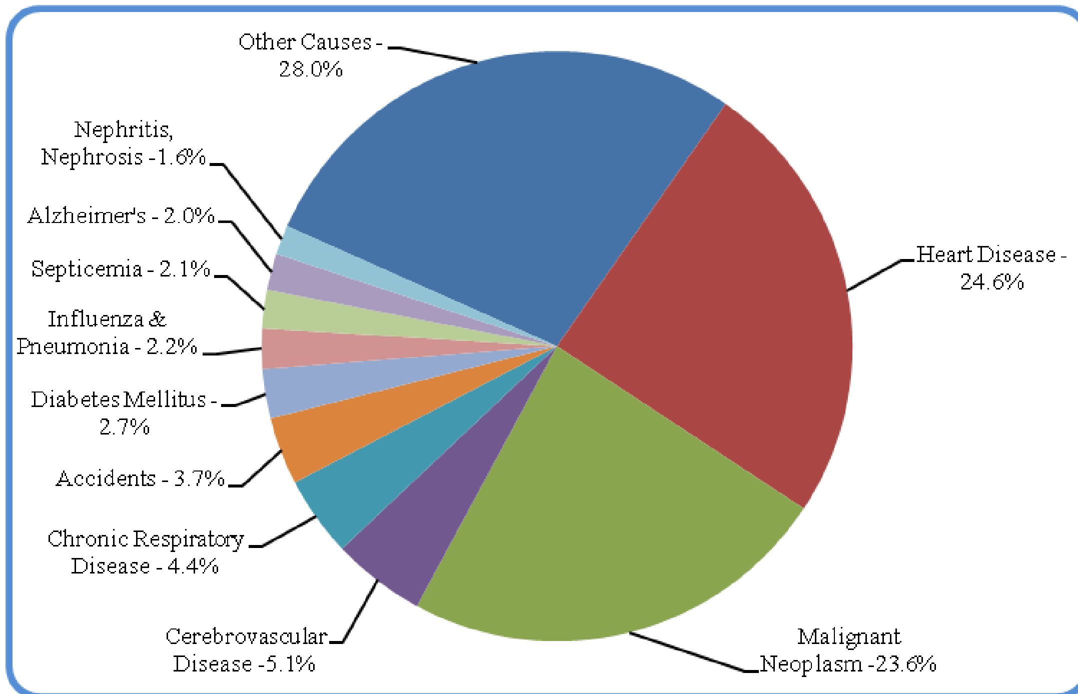
Age Group (years)	Deaths of All Marylanders in 2012	Deaths of Individuals Receiving DDA Services in 2012	Deaths of Individuals Receiving MHA Services in 2012
<1	458	0	0
1 - 4	76	0	0
5 – 14	81	0	1
15 – 24	568	14	1
25- 34	832	19	5
35 – 44	1,229	20	5
45 – 54	3,305	38	15
55 – 64	5,966	55	17
65 – 74	7,268	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**

Table 2 and the pie chart that accompany it list the top ten leading causes of death that occurred in calendar year 2012 among individuals receiving DDA and MHA services and compares those causes of death to the top ten leading causes of death among all Maryland residents.

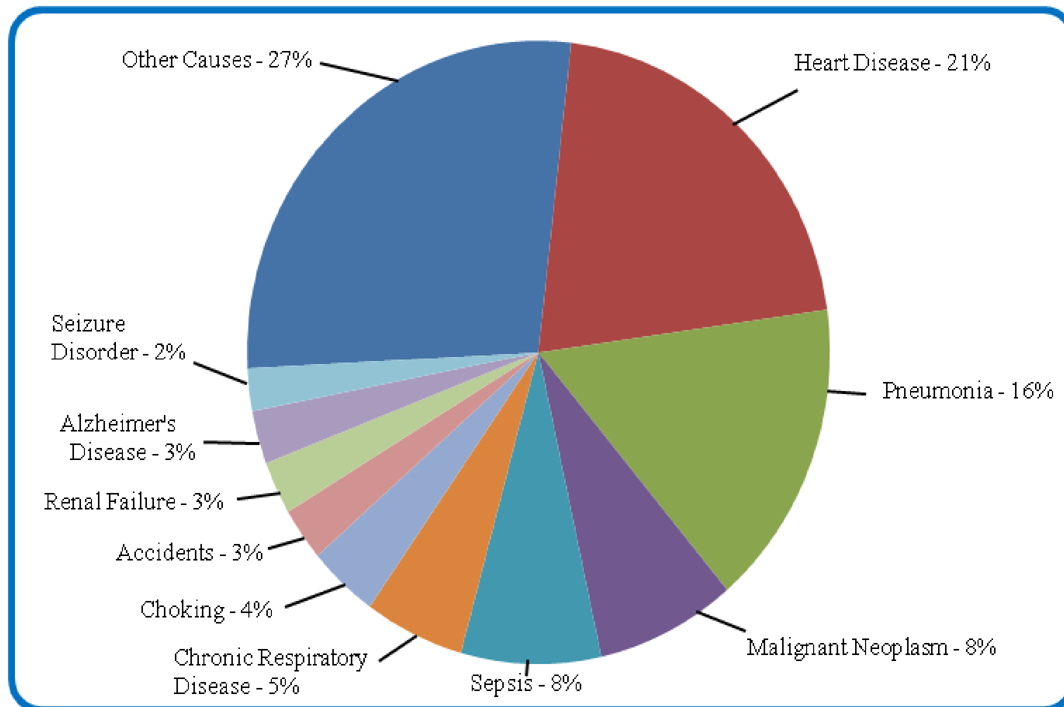
TABLE 2: TOP 10 INDIVIDUAL CAUSES OF DEATHS IN 2012

Rank	Leading Causes of All Marylanders Deaths 2012	Leading Causes of DDA Deaths 2012	Leading Causes of MHA 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*

Percent Distribution of Leading Causes of Death – All Maryland Residents 2012



Percent Distribution of Leading Causes of Death – DDA 2012



Percent Distribution of Leading Causes of Death – MHA 2012

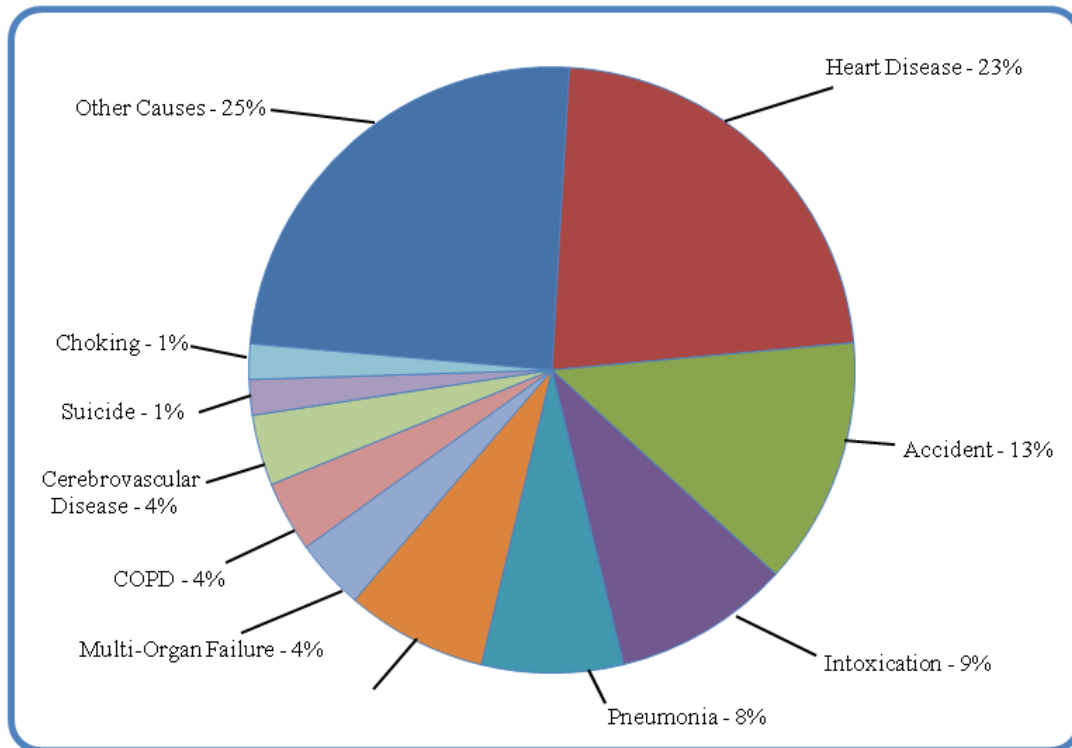


TABLE 3: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR MHA SERVICES IN 2011 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2011

Age Group (years)	Deaths of All Marylanders in 2011	Deaths of Individuals Receiving DDA Services in 2011	Deaths of Individuals Receiving MHA Services in 2011
<1	493	1	0
1 - 4	63	0	0
5 – 14	91	1	0
15 – 24	586	7	2
25- 34	826	22	5
35 – 44	1,227	18	6
45 – 54	3,379	40	19
55 – 64	5,736	44	13
65 – 74	7,191	38	6
75 – 84	10,436	19	2
85+	13,619	1	1
Not stated	3	0	0
Male (all ages)	21,476	98	44
Female (all ages)	22,174	93	10
Total Deaths	**43,650**	**191**	**54**
Total Population	**5,828,298**	**21,382**	**140,648**

TABLE 4: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR MHA SERVICES IN 2010 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2010

Age Group (years)	Deaths of All Marylanders in 2010	Deaths of Individuals Receiving DDA Services in 2010	Deaths of Individuals Receiving MHA Services in 2010
<1	496	0	0
1 - 4	58	0	0
5 – 14	91	3	1
15 – 24	566	10	3
25- 34	791	15	12
35 – 44	1,274	12	19
45 – 54	3,398	27	39
55 – 64	5,865	40	41
65 – 74	6,992	26	19
75 – 84	10,627	17	9
85+	12,850	1	5
Not stated	3	0	0
Male (all ages)	21,122	91	81
Female (all ages)	22,134	60	67
Total Deaths	**43,256**	**151**	**148**
Total Population	**5,773,552**	**15,107**	**122,990**

Tables 5 and 6 list the top ten primary causes of death for years 2011 and 2010 among all residents of Maryland, and those served by DDA and MHA.

TABLE 5: TOP 10 INDIVIDUAL CAUSES OF THE DEATHS 2011

Rank	Leading Causes of All Marylanders Deaths 2011	Leading Causes of the DDA Deaths 2011	Leading Causes of the MHA Deaths 2011
1	*Heart Disease*	*Heart Disease*	*All Other Causes**
2	*Malignant Neoplasm*	*Septicemia*	*Heart Disease*
3	*Cerebrovascular Diseases*	*Pneumonia*	*Malignant Neoplasm*
4	*Chronic Respiratory Disease*	*Malignant Neoplasm*	*Diabetes Mellitus*
5	*Accidents*	*Chronic Respiratory Disease*	*Sepsis*
6	*Diabetes Mellitus*	*Seizure Disorder*	*Drug Overdose*
7	*Influenza & Pneumonia*	*Cerebrovascular Diseases*	
8	*Alzheimer's Disease*	*Renal Failure*	
9	*Septicemia*	*Pulmonary Thrombosis*	
10	*Nephritis, Nephrosis*	*Alzheimer's Disease*	

TABLE 6: TOP 10 INDIVIDUAL CAUSES OF THE DEATHS 2010*

Rank	Leading Causes of All Marylanders Deaths 2010	Leading Causes of the DDA Deaths 2010	Leading Causes of the MHA Deaths 2010
1	*Disease of the Heart*	*Disease of the Heart*	*Disease of the Heart*
2	*Malignant Neoplasm*	*Pneumonia*	*Accidents*
3	*Cerebrovascular Diseases*	*Malignant Neoplasm*	*Malignant Neoplasm*
4	*Chronic Lower Respiratory Disease*	*Septicemia*	*Suicide*
5	*Accidents*	*Disease of the Respiratory System*	*Renal Disease*
6	*Diabetes*	*Alzheimer's Disease*	*Influenza, Pneumonia & Septicemia*
7	*Alzheimer's Disease*	*Seizure Disorder*	*Pulmonary Embolism, Cerebrovascular Disease & Diseases of the Respiratory System*
8	*Influenza & Pneumonia*	*Cerebral Palsy*	*Unknown Causes & Cirrhosis of the Liver*
9	*Septicemia*	*Renal Failure*	*ALS, Diabetes & Chronic Lower Respiratory Disease*
10	*Nephritis, Nephrotic Syndrome & Nephrosis*	*Pulmonary Thrombosis*	*Dementia, COPD, AIDS & Parkinson's Disease*

***** *This is the correct Table for calendar year 2010. This table was incorrect in the 2011 Report*

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 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 the reporting of incidents, although mandatory, is a self-reporting process, 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 type of alleged incident (abuse, medication error, fracture, etc.), upon investigation, was

found to have occurred. "Unsubstantiated" means that the type of 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 may be 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 both the investigator's or coordinator's recommendations.

V. FINDINGS, DISCUSSION AND RECOMMENDATIONS

The MQRC reviewed 207 reports of death (196 DDA cases and 11 MHA cases) in calendar year 2012. Of the 207 cases, 205 were closed and 2 remained open for further review (FFR).

From an assessment of the data and the supporting documentation, the following factors were noted as issues for which specific interventions may be effective in the prevention of serious incidents:

FINDING #1: **Heart Disease was the leading cause of death for both the DDA and MHA populations.**

Recommendation: As in the general population of Marylanders, heart disease was the leading cause of death in 2012 for the clients of DDA and MHA. A greater emphasis on prevention is needed. Attention to diet, exercise, and lifestyle changes (especially smoking and tobacco use) should be promoted throughout both systems. As in the general population, public education and community awareness campaigns should focus on the benefits of healthy eating, moderate physical activity, and most importantly, the health benefits of a tobacco-free lifestyle.

FINDING #2: **Pneumonia was again among the leading causes of death in 2012.**

Recommendation: A strong focus on continuing education for provider agency staff on all aspects of pneumonia, and ways to prevent it, are strongly recommended as a way to reduce the mortality rate of DDA and MHA clients due to pneumonia. Promoting the benefits of getting an annual flu shot and a Pneumovax vaccine as indicated should be an expectation of all service providers in the DDA and MHA systems.

It is also recommended that provider agencies work with their physicians to investigate the possibility of administering flu shots and Pneumovax vaccines in advance of the flu season given the heightened vulnerability to pneumonia of DDA and MHA clients.

Finding #3: **Sepsis continues to be a leading cause of death for the DDA population as compared to the overall Maryland population. This bears further scrutiny.**

Recommendation: Addressing the causes of sepsis and providing the corrective actions to prevent it should continue as a high priority for all DDA providers. The striking divergence between the DDA population and the general Maryland population is an ongoing cause of concern.

ATTACHMENT 1

Maryland HEALTH-GENERAL Code Ann. § 5-801 (2011)

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 operated or licensed by the Mental Hygiene Administration and the Developmental Disabilities Administration or 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.

§ 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 Mental Hygiene 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.

§ 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 Mental Hygiene Administration under § 10-406, § 10-901, or § 10-902 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.

§ 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; consultants

(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.

§ 5-806.1. 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 Mental Hygiene 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.

§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

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
- Barrett Cisney, licensed provider of community mental health services
- Edward Willard, developmental disability consumer
- Clarissa Netter, mental health consumer
- Joyce Lipman, family member representing a consumer with a developmental disability
- Phyllis Zolotorow, family member representing a consumer with a mental illness
- Darrell Nearon, PhD, JD, the Deputy Secretary of Behavioral Health and Disabilities designee
- Patricia Tomsko-Nay, MD, Director of the Office of Health Care Quality, ExOfficio
- Zabiullah Ali, 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
- Dan Martin, member of a mental health advocacy group
- Ernest Smith, member of a developmental disabilities group

Committee Counsel

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

Mortality Incident Review Committee

Michael Bluestone, MD, licensed physician, MHA and DDA Liaison
Patricia Tomsko-Nay, MD, Licensed physician, OHCQ
Mary Crouse, RN, OHCQ
William Vaughan, RN, OHCQ