MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Behavioral Health Administration
55 Wade Avenue - Dix Building SGHC - Catonsville, MD 21228
Barbara J. Bazron, Ph.D., Deputy Secretary / Executive Director

July 19, 2018

Robert R. Neall, Secretary
Maryland Department of Health
201 West Preston Street
Baltimore, MD 21201

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

Re: Health-General Article § 5–808—Mortality and Quality Review Committee Annual Report

Dear Secretary Neall and Secretary Beatty:

The Maryland Department of Health Mortality and Quality Review Committee is required to issue an annual report pursuant to Health-General Article § 5–808 of the 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 2016.

If you have any further questions, please do not hesitate to contact me through Lisa Fassett, Office of Governmental Affairs and Communications, Behavioral Health Administration at (410) 402–8449 or lisa.fassett1@maryland.gov.

Sincerely,

Stephanie Bell

Stephanie Bell, Chair
Mortality and Quality Review Committee

Enclosure

cc: Sarah Albert, (MSAR #9338)

Maryland Department of Health

Mortality and Quality Review Committee

Annual Report

Calendar Year 2016

Larry Hogan
Governor

Boyd Rutherford
Lieutenant Governor

Robert R. Neall
Secretary

Stephanie Bell
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 Maryland Department of Health (MDH).[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 MHA.

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 of MDH regarding actions to prevent avoidable injuries and deaths and to 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 within MDH. BHA 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 deaths, 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. DDA provides the public report to all service providers licensed by DDA, and those operating by waiver under Health-General Article §7–903(b) of the 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 the MDH, the Secretary of the Department of Disabilities, the Director of DDA, the

[1] See Attachment 1, Title 5, Subtitle 8, of the Health-General Article of the Annotated Code of Maryland (2015), *infra*, p. 13.
[2] See Attachment 2, 2015 MQRC Membership, *infra*, at 18.

Director of BHA, and the Director of Office of Health Care Quality (OHCQ). The preliminary findings and recommendations are confidential and not discoverable or admissible.[3]

III. THE DEATH AND INCIDENT DATA REVIEW PROCESS

The MQRC is one link in the process of reviewing deaths and reportable incidents in the programs and facilities licensed or operated by DDA and BHA. The review process begins with a report of a death or a reportable incident to OHCQ and other appropriate agencies.

DDA has reporting requirements for deaths and incidents in their programs and facilities governed by statute or policy. 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, Forensic Residential Centers, and community-based agencies licensed by DDA.[5] All deaths and certain other incidents in programs covered by the policy must be reported to the following entities:

- OHCQ;
- DDA;
- family, legal guardian, or advocate(s);
- case manager or coordinators of community support;
- Disability Rights Maryland (the state protection and advocacy agency);
- local health department;
- law enforcement; and
- Office of the Chief Medical Examiner.

The reporting requirements for deaths occurring in an inpatient or residential treatment setting, residential crisis services, group home (including assisted living unit), residential rehabilitation program, personal support services, shared living services, and psychiatric rehabilitation program[6] is governed by Health-General Article § 10–713 (2015). If a death of an individual in any of the aforementioned programs occurs, and the person is not on hospice care, the administrative head of the program or facility must report the death:

- immediately to the Secretary of MDH 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 BHA;
    - the health officer in the local jurisdiction where the death occurred; and

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

[4] Developmental Disabilities Administration, Policy on Reportable Incidents and Investigations (Jan. 15, 2013), online at https://dda.health.maryland.gov/Pages/Developments/2015/10220201%20FINAL%20PORII.pdf (all Internet materials as last visited May 18, 2018) (the Policy on Reportable Incidents and Investigations was revised and reissued in December 2001, April 2003, October 2003, July 2005, July 2006, August 2006, October 2007, and January 2013).

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

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

- the state protection and advocacy agency, Disability Rights Maryland.

Under the provisions of Health-General Article § 5–801 *et seq*., 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 § 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 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 whether the services were provided in the home by a licensed provider; and (2) unless a member of the Committee requests a review, 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. If 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, OHCQ provides aggregate incident data[7] to the MQRC every three months. A subcommittee of the MQRC reviews the aggregate incident data. Findings and recommendations for 2016 are included in this report.[8]

IV. MQRC ACTIVITIES AND STATISTICAL INFORMATION

In 2016, the MQRC met four times: February 29; June 13; August 8; and November 14. The MQRC reviewed a total of 204 reports of death (194 DDA cases and 10 BHA cases) for Calendar Year 2016. Of the 194 DDA cases, all were investigated on-site or administratively. Please note that not all of the cases reviewed involved a death that occurred in Calendar Year 2016. The death may have occurred prior to 2016. Of the 194 DDA cases fully investigated by OHCQ, 193 were recommended for closure by the MQRC.[9] At the close of Calendar Year 2016, 203 of the total cases were closed and one case remained open for further review because committee members requested clarification of certain aspects presented. The cases that were closed in 2016 included four for-further-review cases carried over from Calendar Year 2015. The MQRC also reviewed the aggregate incident data for Calendar Year 2016.

[7] "Aggregate incident data" means information or statistics maintained by OHCQ on the reported incidents of Level III serious injuries at health care facilities. Health-General Article § 5–801.
[8] See *infra*, at 10–11.
[9] Effective April 2008, OHCQ implemented the Prioritization Protocol of Incidents of Death. This protocol reflects statutory requirements under Health-General Article § 5–805 and it augments DDA's Policy on Reportable Incidents and Investigations and OHCQ's Incident Screening Committee Guidelines.

Part One: Mortality

Table 1 compares the number of deaths that occurred in Calendar Year 2016 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 2016 were 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 2016 were in the age group of 55–64, followed by the age group 65–74. Among the people served by BHA, the majority of deaths in 2016 were in the age group of 55–64, followed by the age group of 65–74.

Number and distribution of deaths by age group

Table 1: Number of deaths of individuals receiving DDA or BHA services in 2016 compared to the number of deaths among all Marylanders by age group in 2016

Age Group (years)	Deaths of All Marylanders in 2016	Deaths of Individuals Receiving DDA Services in 2016	Deaths of Individuals Receiving BHA Services in 2016
<1	478	0	0
1–4	65	0	0
5–14	95	2	0
15–24	679	10	2
25–34	1,288	21	2
35–44	1,500	17	3
45–54	3,459	47	6
55–64	6,713	60	11
65–74	8,987	48	9
75–84	10,908	15	2
85+	14,698	0	2
Not stated	0	0	0
Male (all ages)	24,738	121	27
Female (all ages)	24,137	99	10
Total Deaths	**48,884**	**220**	**37**
Total Population	**6,016,447**	**16,909**	**195,367**

Table 2 and **figures 1–3** list the top ten leading causes of death that occurred in Calendar Year 2016 among individuals receiving DDA and BHA services and compares those causes of death to the top 10 leading causes of death among all Maryland residents.

Table 2: Top 10 individual causes of deaths in 2016

Rank	Leading Causes of All Marylanders Deaths 2016	Leading Causes of DDA Deaths 2016	Leading Causes of BHA Deaths 2016
1	Diseases of the Heart	Pneumonia	Heart Disease
2	Malignant Neoplasms	Heart Disease	Malignant Neoplasm (Tie)
3	Cerebrovascular Disease	Malignant Neoplasm	Pneumonia (Tie)
4	Accidents	Respiratory Failure	Intoxication (Tie)
5	Chronic Lower Respiratory Diseases	Sepsis	Accident
6	Diabetes Mellitus	Alzheimer's	Other Causes
7	Alzheimer's Disease	Dementia	
8	Septicemia Influenza & Pneumonia	Cerebral Palsy (Tie)	
9	Septicemia	Down Syndrome (Tie)	
10	Nephritis	Renal Failure	

Figure 1: Percent Distribution of Leading Causes of Death—All Maryland Residents 2016

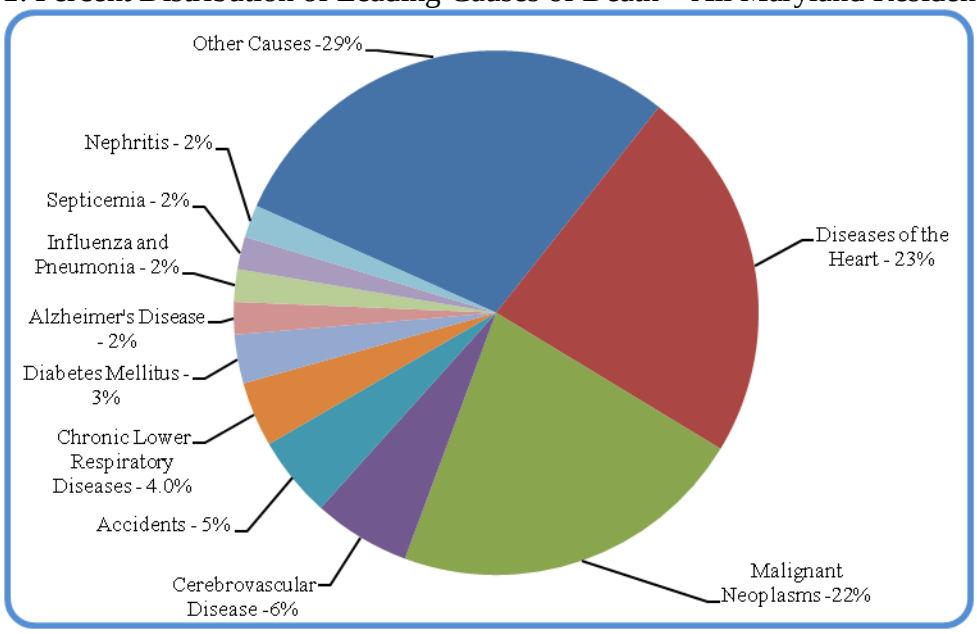

Figure 2: Percent Distribution of Leading Causes of Death—DDA 2016

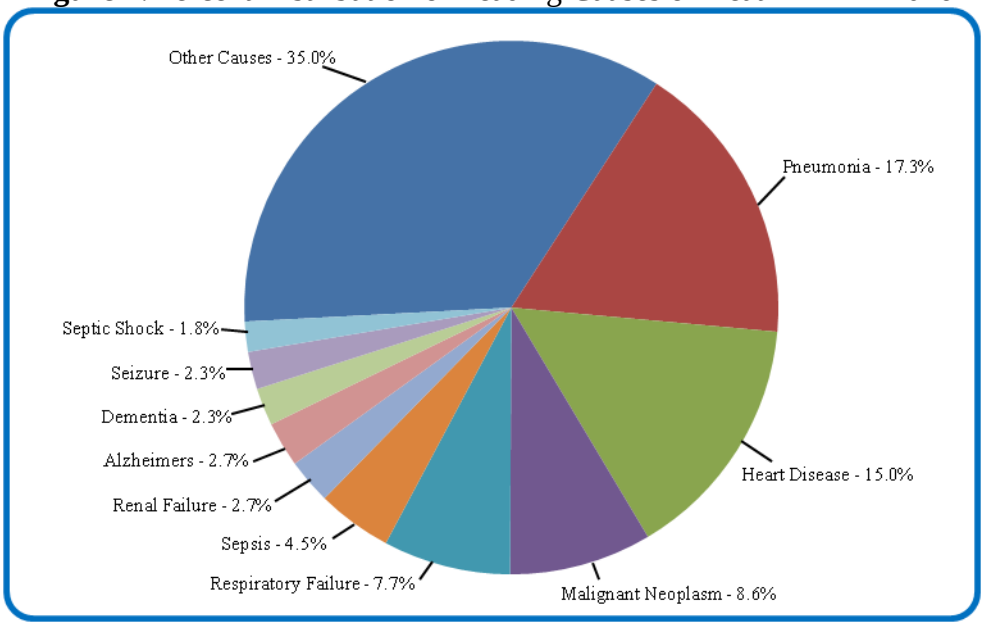

Figure 3: Percent Distribution of Leading Causes of Death—BHA 2016

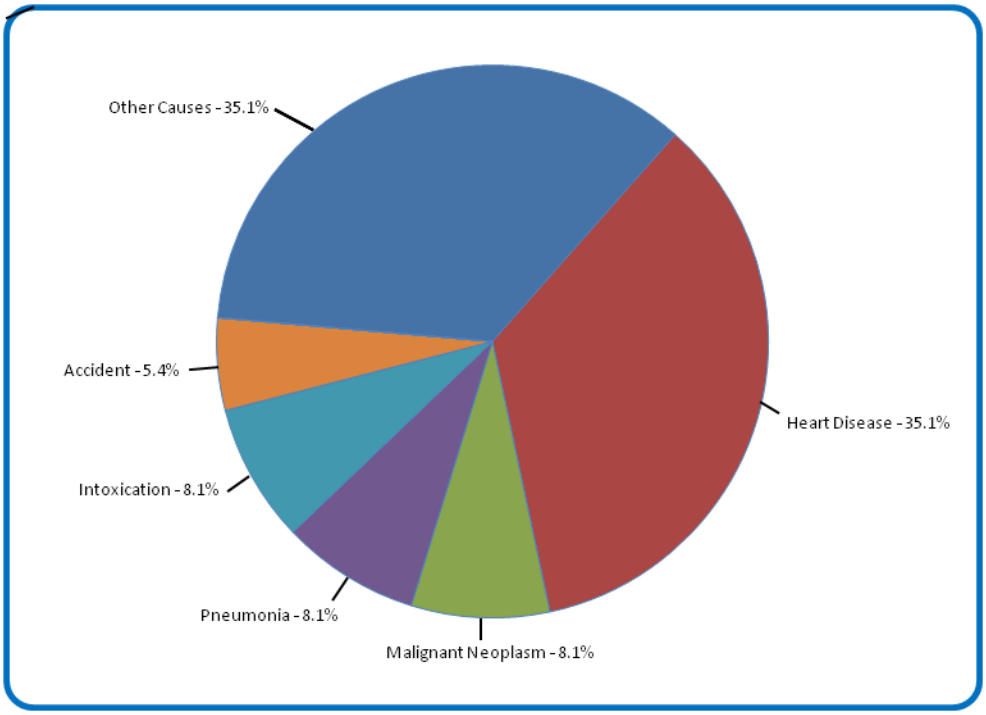

Table 3: Number of deaths of individuals receiving DDA or BHA services in 2015 compared to the number of deaths among all Marylanders by age group in 2015

Age Group (years)	Deaths of All Marylanders in 2015	Deaths of Individuals Receiving DDA Services in 2015	Deaths of Individuals Receiving BHA Services in 2015
<1	491	0	0
1–4	86	0	0
5–14	101	1	0
15–24	605	13	1
25–34	1,065	20	4
35–44	1,287	23	5
45–54	3,264	39	3
55–64	6,391	70	30
65–74	8,393	43	6
75–84	10,615	15	0
85+	14,932	2	0
Not stated	0	0	0
Male (all ages)	23,742	129	28
Female (all ages)	23,493	97	21
Total Deaths	**47,235**	**226**	**49**
Total Population	**6,006,401**	**16,791**	**199,000**

Table 4: 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	0
Male (all ages)	22,771	129	28
Female (all ages)	22,917	87	22
Total Deaths	**45,688**	**216**	**50**
Total Population	**5,976,407**	**16,408**	**175,537**

Tables 5 and **6** list the top 10 primary causes of death for years 2015 and 2014 among all residents of Maryland, and those served by DDA and BHA.

Table 5: Top 10 individual causes of the deaths 2015

Rank	Leading Causes of All Marylanders Deaths 2015	Leading Causes of DDA Deaths 2015	Leading Causes of BHA Deaths 2015
1	Heart Disease	Heart Disease	Heart Disease
2	Malignant Neoplasm	Pneumonia	Malignant Neoplasm
3	Cerebrovascular Diseases	Respiratory Failure	Suicide
4	Chronic Lower Respiratory Disease	Sepsis	COPD
5	Accidents	Malignant Neoplasm	Intoxication
6	Diabetes Mellitus	Cerebral Palsy	Pulmonary Failure
7	Influenza & Pneumonia	Alzheimer's	Cerebral Issues
8	Alzheimer's Disease	Septic Shock	Multiple Issues
9	Septicemia	Multiple Sclerosis	Septic Shock
10	Nephritis/Nephrosis	Failure to Thrive	Multiple Sclerosis

Table 6: Top 10 individual causes of the deaths 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

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.[10] From the many incidents reported, the OHCQ Triage Unit and the weekly Incident Screening Committee must determine which incidents are to be further investigated, and the priority for on-site investigation, with an immediate jeopardy priority investigation initiated within 2 working days of assignment, a high priority investigation initiated within 10 working days, and a medium 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 called a Statement of Deficiencies. If no noncompliance 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. If the agency's plan of correction is determined by OHCQ to be acceptable, no further action is required. If the plan of correction is not deemed acceptable, a revised plan of correction for the cited deficiencies is required. All immediate jeopardy priority investigations must receive follow-up review from OHCQ.[11] A 10% targeted sample of incidents with a high priority classification will receive follow-up review.[12]

[10] Policy on Reportable Incidents and Investigations, supra, at 12–13. (Reportable incidents are reviewed within OHCQ according to guidelines formalized in the Report Incidents Section).
[11] See *id.*, at 14.
[12] *Ibid.*

V. FINDINGS AND RECOMMENDATIONS

Finding #1: Based on multiple case investigations conducted by the committee in 2016, the risks of Dysphagia and vaccinations to the developmental disability community continue despite a DDA memorandum that was distributed to all providers and entities addressing the risks of Dysphagia in 2014.

> **Recommendation**: Redistribute this memorandum as a reminder of the risks concerning Dysphagia. The committee has requested that DDA nurse representative, Debra Goldberg, and DDA quality enhancement representatives review the memorandum before redistribution.

Finding #2: A case reviewed by the committee in 2016 highlighted the deficiency of neglecting to notify the delegating nurse of a person's choking behavior, which led to a lack of protocols in place for staff to follow, such as training. There was also a lack of evidence that risk assessments had been done either before or after the choking incident. In this case, the nurse along with the physician should have been advocating for further study on the choking behaviors and appropriate studies on choking.

> **Recommendation**: Nurses should participate in the individual plan meetings with families via written report or face-to-face. This should be system wide. Regulations need to be clear as to when the delegating nurse is to be included in the care of the patient.

Finding #3: A person's disability is listed on the death certificate as the cause of death rather than the death event. In the committee discussion at the November meeting, a question was posed as follows: "Why isn't the actual cause of death listed on the death certificate?" The response given was "this way of reporting cause of death is increasingly becoming a common practice. The Pathologist [and] Technician document what they can visibly see or what is already being reported."

> **Recommendation**: Death certificates that have inaccurate information reported as the cause of death should be identified and tracked and added as a reporting measure on the annual report.

Finding #4: There is a growing concern that there is a lack of continuity of care for patients in a DDA home when a patient is admitted and then discharged by a hospital. The treating medical professional may not be aware of the patient's medical history. When the patient is discharged from the hospital, the lack of knowledge of the patient's medical history may cause the treating medical professional to improperly discharge the patient.

> **Recommendation**: Additional training of staff to increase the best practice of bringing face sheets when going to emergency or medical appointments. It is encouraged to assure that the medical book follows the person when emergency or medical appointments are needed. This is indicated in the Medication Technician Training Program.

Finding #5: Do-not-intubate (DNI) and do-not-resuscitate (DNR) instructions are not consistently being reported in the charts. The lack of reporting DNI and DNR instructions may cause confusion among staff and patient family members. The lack of reporting DNI and DNR instructions has caused patients to be put on DNI or DNR only to be taken off by their family members.

> **Recommendation**: Memoranda have been issued to DDA providers regarding the need for DNI and DNR instructions to be in place to avoid such concerns during an end-of-life event. A new memorandum should be issued reinforcing the importance of having this information in the patient's record. To monitor the frequency of occurrence, DNI and DNR information (included or missing) in cases that are reviewed by the MQRC should be tracked and added as a reporting measure in the annual report.

Finding #6: Cases were reviewed that indicated that both choking and resuscitation status (*e.g.*, DNR) may have played a role in the death of the patient.

> **Recommendation A**: Guidance or policies should be developed by MDH on overt choking and recognition of airway obstruction during cardiopulmonary resuscitation (CPR). The guidelines or policies should encompass how to handle overt choking and recognition of airway obstruction with individuals who have a DNR status and other resuscitation statuses.
>
> **Recommendation B**: Staff should be trained to recognize potential airway obstruction and on the impact on resuscitation efforts.

Finding #7: The number of deaths from choking during meals in 2016 suggests that varying interpretations of physician diet orders related to food texture and size could contribute to choking events.

> **Recommendation**: A standardized diet protocol that specifies preparation parameters for texture and size should be adopted and implemented. Implementation should include staff training and a mechanism to assess staff adherence to the standardized protocol.

ATTACHMENT 1

2015

Annotated Code of Maryland

HEALTH-GENERAL ARTICLE

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

- Stephanie Bell, licensed provider of community developmental disability services

Committee Membership

- Joanna D. Brandt, MD, board certified psychiatrist
- Diane Coughlin, specialist in the field of developmental disabilities
- Roger Peele, 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 person with a developmental disability
- Rosamond Dove, family member representing a person with a mental illness
- Rhonda Callum, the Deputy Secretary of Behavioral Health designee
- Patricia Tomsko-Nay, MD, Director of OHCQ, Ex Officio
- Michael Peskin, MD, Licensed Physician, Maryland Department of Health
- 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, Maryland Department of Health