Mortality and Quality Review Committee

Annual Report

Calendar Year 2018

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]

The MQRC's primary goal is to identify patterns and systemic problems within the DDA and BHA provider community and recommend actions to the Secretary of MDH to prevent avoidable injuries and deaths and improve the 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 a 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 a summary of findings. Summary findings should include patterns and trends, goals, problems, concerns, 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, at 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 Deputy Secretary of DDA, the Executive 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]

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[1] See Attachment 1, Title 5, Subtitle 8, of the Health-General Article of the Annotated Code of Maryland (2015), *infra*, p. 11–16.

[2] See Attachment 2, 2015 MQRC Membership, *infra*, at 17.

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

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:

- Office of Health Care Quality (OHCQ);
- DDA;
- Family, legal guardian(s), or advocate(s);
- Case managers 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 Health 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:
    - The Executive Director of BHA;
    - The health officer in the local jurisdiction where the death occurred; and
    - The state protection and advocacy agency, Disability Rights Maryland.

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[4]Kirkland, Frank. *POLICY ON REPORTABLE INCIDENTS AND INVESTIGATIONS*, 15 Jan. 2013, health.maryland.gov/ohcq/dd/docs/10.22.02.01 FINAL PORII .pdf. (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.

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, 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 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 summaries, 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 residential or other services, whether private, 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 2018 are included in this report.[8]

IV. MQRC ACTIVITIES AND STATISTICAL INFORMATION

In 2018, the MQRC met four times: February 12, May 14, August 13, and November 26. The MQRC reviewed a total of 189 reports of death, with 100 being administrative review cases. Of the cases reviewed by the MQRC in 2018, 183 were from DDA and six (6) were from BHA. Please note that not all the cases reviewed involved a death that occurred in Calendar Year 2018; the death may have occurred prior to 2018. The MQRC also reviewed the aggregate incident data for Calendar Year 2018.

Part One: Mortality

Table 1 compares the number of deaths that occurred in Calendar Year 2018 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 2018 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 2018 were in the age group of 55–64, followed by the age group 45-54/65–74. Among the people served by BHA, the majority of deaths in 2018 were in the age group of 55–64, followed by the age group of 45–54.

[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 9–10.

Number and distribution of deaths by age group

Table 1: Number of deaths of individuals receiving DDA or BHA services in 2018 compared to the number of deaths among all Marylanders by age group in 2018

Age Group (years)	Deaths of All Marylanders in 2018	Deaths of Individuals Receiving DDA Services in 2018	Deaths of Individuals Receiving BHA Services in 2018
<1	432	0	0
1–4	66	0	0
5–14	76	5	0
15–24	563	12	1
25–34	1,336	25	2
35–44	1,622	22	3
45–54	3,306	42	7
55–64	6,842	70	12
65–74	9,290	42	5
75–84	11,569	25	2
85+	15,557	9	0
Not stated	10	0	0
Male (all ages)	25,749	147	25
Female (all ages)	24,912	105	7
Total Deaths	**50,668**	**252**	**32**
Total Population	**6,042,718**	**17,484**	**288,022**

Table 2 and **Figures 1–3** list the top 10 leading causes of death that occurred in Calendar Year 2018 among individuals receiving DDA and BHA services and compare those causes of death to the top 10 leading causes of death among all Maryland residents.

Table 2: Top 10 individual causes of death in 2018

Rank	Leading Causes of All Marylanders Deaths- 2018	Leading Causes of DDA Deaths- 2018	Leading Causes of BHA Deaths- 2018
1	Diseases of the Heart	Diseases of the Heart	Diseases of the Heart
2	Malignant Neoplasms	Pneumonia	Intoxication
3	Cardiovascular Disease	Respiratory Failure	Respiratory Failure
4	Accidents	Malignant Neoplasm	COPD
5	Chronic Lower Respiratory Diseases	Sepsis	Malignant Neoplasm
6	Diabetes Mellitus	Renal Disease	Pneumonia
7	Alzheimer's Disease	Seizure Disorder	Smoke Inhalation
8	Influenza & Pneumonia	COPD	Homicide
9	Septicemia	Cerebral Issues	Schizoaffective Disorder
10	Nephritis	Alzheimer's	Hemorrhage

Figure 1: Percent Distribution of Leading Causes of Death—All Maryland Residents 2018

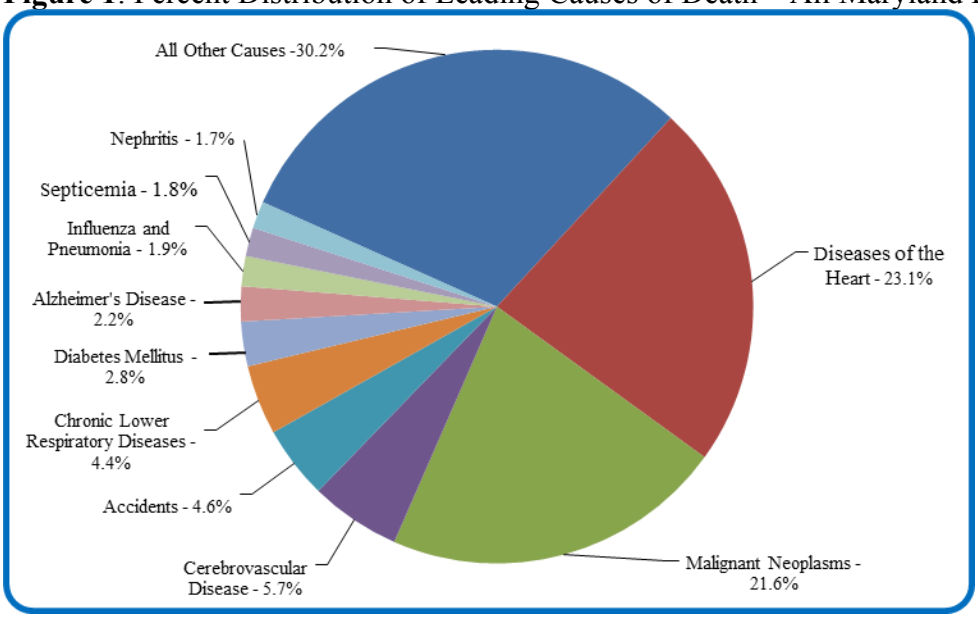

Figure 2: Percent Distribution of Leading Causes of Death—DDA 2018

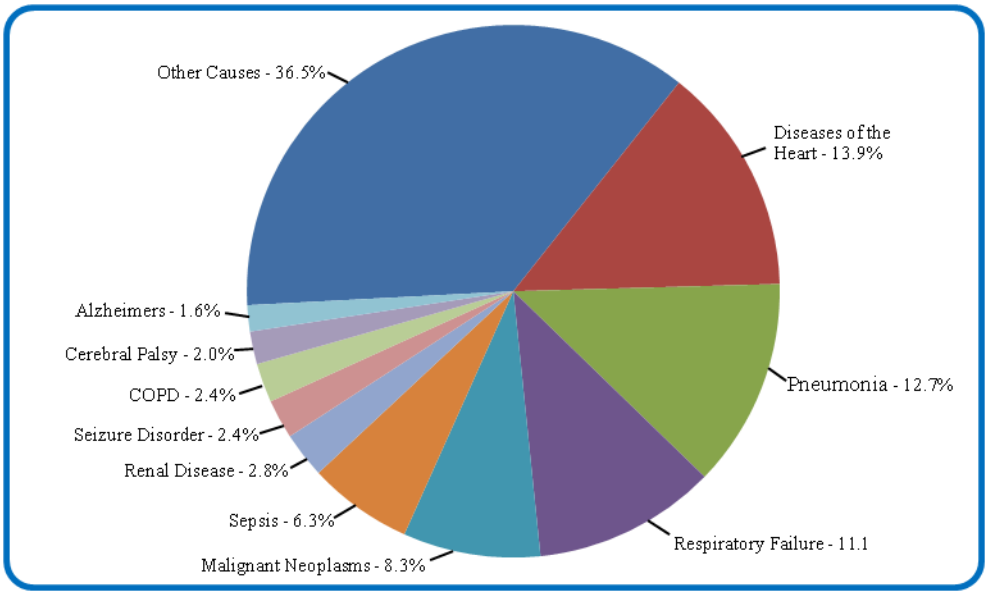

Figure 3: Percent Distribution of Leading Causes of Death—BHA 2018

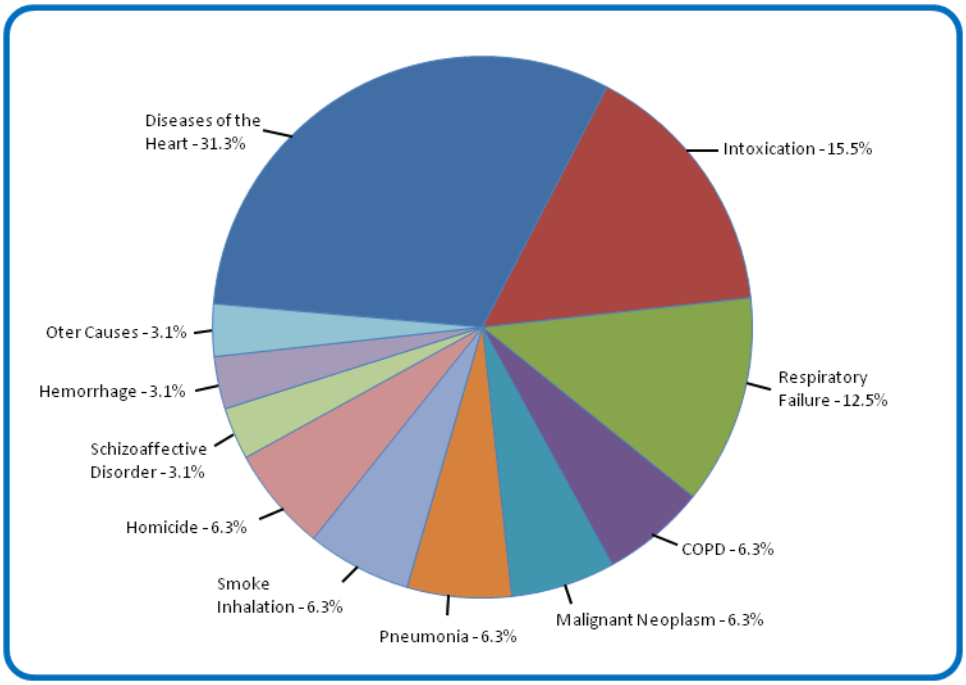

Table 3: Number of deaths of individuals receiving DDA or BHA services in 2017 compared to the number of deaths among all Marylanders by age group in 2017

Age Group (years)	Deaths of All Marylanders in 2017	Deaths of Individuals Receiving DDA Services in 2017	Deaths of Individuals Receiving BHA Services in 2017
<1	462	0	0
1–4	69	0	0
5–14	87	3	0
15–24	656	13	2
25–34	1,419	16	3
35–44	1,532	18	3
45–54	3,376	50	8
55–64	6,806	59	12
65–74	9,218	51	6
75–84	11,060	17	4
85+	15,318	3	1
Not stated	6	0	0
Male (all ages)	25,378	132	23
Female (all ages)	24,627	98	16
Total Deaths	**50,009**	**230**	**39**
Total Population	**6,052,177**	**16,940**	**272,456**

Table 4: 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**

Tables 5 and **6** list the top 10 primary causes of death for years 2017 and 2016 among all residents of Maryland, and those served by DDA and BHA.

Table 5: Top 10 individual causes of the death in 2017

Rank	Leading Causes of All Marylanders Deaths- 2017	Leading Causes of DDA Deaths -2017	Leading Causes of BHA Deaths -2017
1	Diseases of the Heart	Diseases of the Heart	Diseases of the Heart
2	Malignant Neoplasm	Pneumonia	Respiratory Failure
3	Cerebrovascular Disease	Sepsis	Suicide
4	Accidents	Malignant Neoplasm	Accident
5	Chronic Lower Respiratory Diseases	Alzheimer's	Sepsis
6	Diabetes Mellitus	Cerebral Palsy	Homicide
7	Alzheimer's Disease	COPD	Renal Disease
8	Influenza and Pneumonia	Hypoxia	COPD
9	Septicemia	Seizure Disorder	Schizophrenia
10	Nephritis	Parkinson's Disease	Intoxication

Table 6: Top 10 individual causes of the death 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	

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.[9] 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 people 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.[10] A 10% targeted sample of incidents with a high-priority classification will receive a follow-up review.[11]

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

V. FINDINGS AND RECOMMENDATIONS

Starting with this report and moving forward, this area will be broken down into two categories to address newly discovered findings and to distinguish those that have been recurring over the past several years.

Newly Discovered

Finding: There have been several incidents where end-of-life could be attributed to the lack of appropriate care/follow-through on the part of the Delegating Nurse/Case Manager (D/CM) leading up to the death event. In several cases, this has resulted in the delay of care for deaths that could have potentially been avoidable.

> **Recommendation #1**: Create a standard triage protocol for D/CMs to follow for illnesses that potentially require emergency care.
>
> **Recommendation #2**: Putting procedures in place to adequately address D/CMs who fail to attend DDA's required RN D/CM trainings.
>
> **Recommendation #3**: Creating more standard protocols for D/CMs to address recurring medical issues in nursing care plans.

Ongoing Findings

Finding #1: For several years, the causes of death listed in the DDA mortality report have put diagnoses of the deceased person (*e.g.*, Cerebral Palsy, Down Syndrome, etc.) as the primary cause of death. The information in the DDA mortality report, generated by OHCQ, is drawn from the official death certificates that were furnished to DDA and in many cases do not address the actual death event.

> **Recommendation**: Listing a diagnosis as a primary cause of death may conceal a clear end-of-life event that has not been addressed in the case of the person who died. The MQRC recommends greater clarity regarding the primary cause of death as recorded on death certificates for persons served by DDA.The real end-of-life event must bee captured on the death certificate as opposed to the diagnosis of the deceased person.

Finding #2: There has been a notable increase in choking deaths over the past few years. DDA implemented training on choking and dysphasia several years ago that was effective in lowering this number, but the training is currently only required once. Several of these deaths can potentially be attributed to inconsistencies in altered texture diet protocols, which may lead to someone receiving the wrong diet intervention.

> **Recommendation**: That DDA revisit this important issue, and either do follow-up communication through a memo or education alert and discuss the possibility of requiring a refresher training every few years to keep the information fresh. A further recommendation is that CPR trainers are reminded to spend time training staff how to discern choking and airway obstruction more thoroughly and to emphasize that a choking emergency is not "covered" in a DNR order. In addition, the committee recommends that

protocols be developed to ensure that other medical professionals understand the DDA definitions of altered texture diets so that people are receiving the appropriate interventions.

Finding #3: 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. This has caused some patients (13% of deaths in the previous calendar year) to receive all life-sustaining measures only to be taken off a few days later by family members.

Recommendation: The MQRC recommends ongoing guidance to DDA providers regarding the importance of DNI/DNR information and a clear procedure for these cases.

ATTACHMENT 1

2018

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 healthcare 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 the 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 psychopharmacologist;
(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 the 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 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 a summary of 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 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 from 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

2018 MQRC MEMBERSHIP

Committee Chair

- Stephanie Bell, licensed provider of community developmental disability services

Committee Membership

- Eric Levey, MD, board-certified licensed physician
- Alan Sheehan, specialist in the field of developmental disabilities
- Laryssa Creswell, specialist in the field of mental health
- Jen Carberry, licensed provider of community mental health services
- Triniece Gillom, DDA Self-Advocate
- Clarissa Netter, BHA Self-Advocate
- 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
- Jed Miller, MD, Licensed Physician, Maryland Department of Health
- Patricia Aronica, MD, MD, licensed physician representative from the Medical Examiner's Office
- Florence Ndi, 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
- Jason Noel, Pharm.D, psychopharmacologist
- William Patten, 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