



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, M.D., Secretary

January 28, 2013

The Honorable Edward J. Kasemeyer
Chair, Budget and Taxation Committee
3 West Miller Senate Building
11 Bladen Street
Annapolis, MD 21401

The Honorable Norman J. Conway
Chair, Appropriations Committee
121 House Office Building
6 Bladen Street
Annapolis, MD 21401

RE: Annual Mortality Quality Review Committee Report, Calendar Year 2011
2012 JCR, Page 66, and HG § 5-808 (a)

Dear Chairmen Kasemeyer and Conway:

Pursuant to JCR, page 66, of the Joint Chairmen's Report, the Department of Health and Mental Hygiene respectfully submits the Annual Mortality Quality Review Committee report for calendar year 2011. The report reflects the required review by the Committee of cases of mortality, provides information regarding the causes of death, and includes the Committee's findings and recommendations.

If you have any questions regarding this report, please contact Marie Grant, Director of the Office of Governmental Affairs. She may be reached at 410-767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Attachment

cc: Gayle Jordan- Randolph, M.D.
Mr. Frank W. Kirkland
Ms. Marie Grant
Ms. Sarah Albert, MSAR #9338

Department of Health and Mental Hygiene

Mortality and Quality Review Committee

Annual Report

Calendar Year 2011

Martin O'Malley
Governor

Anthony G. Brown
Lieutenant Governor

Joshua M. Sharfstein, MD
Secretary

Keith R. Peterson
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. 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 no less than three times per year. Meetings of the MQRC are closed to the public and all deliberations are confidential. All records or files of the MQRC, its deliberations, findings, recommendations, and database are confidential. Members may not disclose what transpired at a meeting and are not allowed to communicate directly with a provider, a State Facility Director, a family member, or guardian of the individual who is the subject of a death review. MQRC members have immunity from liability for any action as a member of the MQRC 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

must include patterns and trends, goals, problems, concerns and final recommendations, and preventative measures. Specific individuals and entities may not be identified in the report. The DDA provides the public report to all service providers licensed by DDA, and those operating by waiver under Health-General Article, §7-903(b), Annotated Code of Maryland.

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

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. 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. 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.

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 Health-General §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 the 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 MQRC 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 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 2011, the MQRC met three times: March 21, 2011, August 15, 2011, and November 21, 2011. The MQRC reviewed a total of 200 reports of death (194 DDA cases and 6 MHA cases) for calendar year 2011. Of the 194 DDA cases, 23 were investigated on-site or administratively, and 171 were determined to need no in-depth investigation, and were deemed No Further Action (NFA). Please note that not all of the 200 cases reviewed involved a death that occurred in Calendar Year 2011. The death may have occurred prior to 2011. Of the 23 DDA cases fully investigated by OHCQ, all were recommended for closure by MQRC. Of the 6 MHA cases, all 6 cases were fully investigated and all were recommended for closure by MQRC. At the close of calendar year 2011, 196 of the total cases were closed and 4 cases remained open for further review (FFR) because Committee members requested clarification of certain aspects presented. The 200 cases that were closed in 2011 included 3 FFR cases carried over from calendar year 2010. The MQRC also reviewed the aggregate incident data for Calendar Year 2010.

Part One: Mortality

Table 1 compares the number of deaths that occurred in Calendar Year 2011 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 2011 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 2011 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 2011 were in the age group of 45-54, followed by the age group of 55-64.

Number and distribution of deaths by age group

TABLE 1: 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		
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

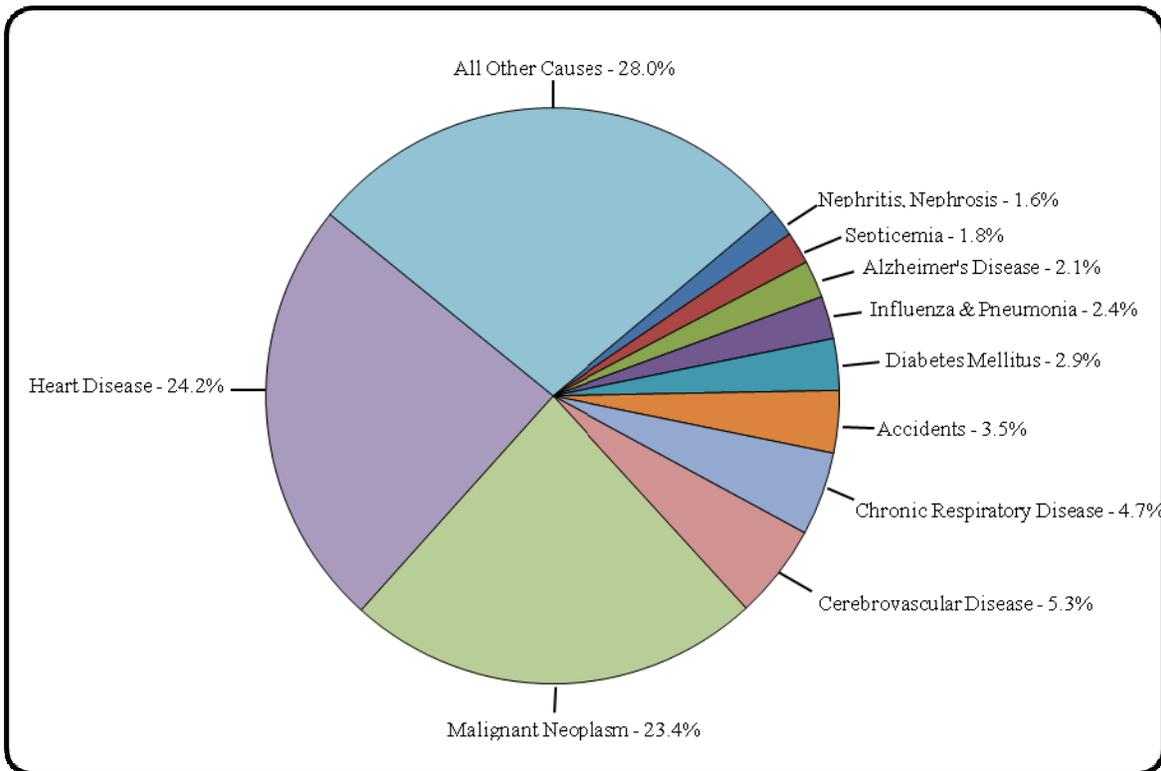
Table 2, and the pie chart graphs that accompany it, list the top ten leading causes of death that occurred in calendar year 2011 among individuals receiving DDA services and compares those causes of death to the top ten leading causes of death among all Maryland residents. Since there were only six (6) MHA cases reviewed by the MQRC in calendar year 2011 and staff were able to obtain only eight (8) additional death certificates for the forty-eight (48) MHA consumers who died in the community, the vast majority of the MHA-related deaths for 2011 fall into the category of All Other Causes.

TABLE 2: TOP 10 LEADING CAUSES OF DEATHS IN 2011

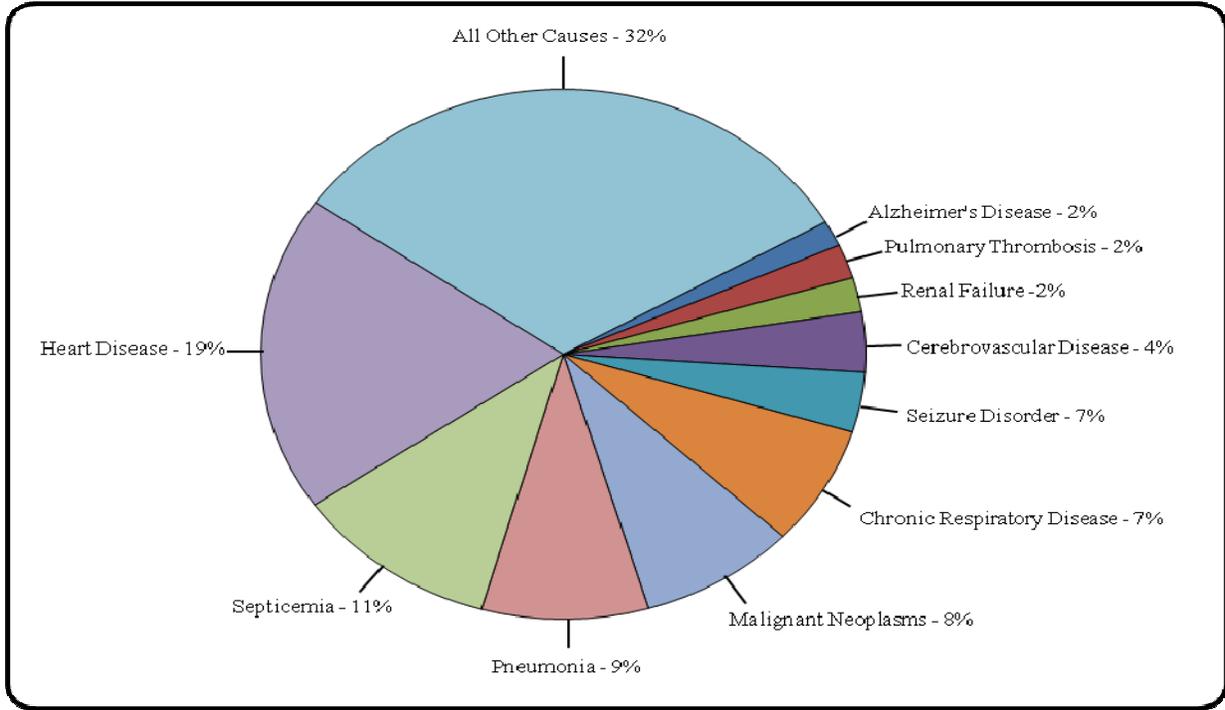
Rank	Leading Causes of All Marylanders Deaths 2011	Leading Causes of the DDA Deaths 2011	Leading Causes of the MHA Deaths 2011
1	Heart Disease	Heart Disease	All Other Causes*
2	Malignant Neoplasm	Septicemia	Heart Disease
3	Cerebrovascular Diseases	Pneumonia	Malignant Neoplasm
4	Chronic Respiratory Disease	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	

*End Stage Liver Disease, Hepatic Encephalopathy, Leukemia, Homicide, Chronic Respiratory Disease (Per official information on Certificates of Death)

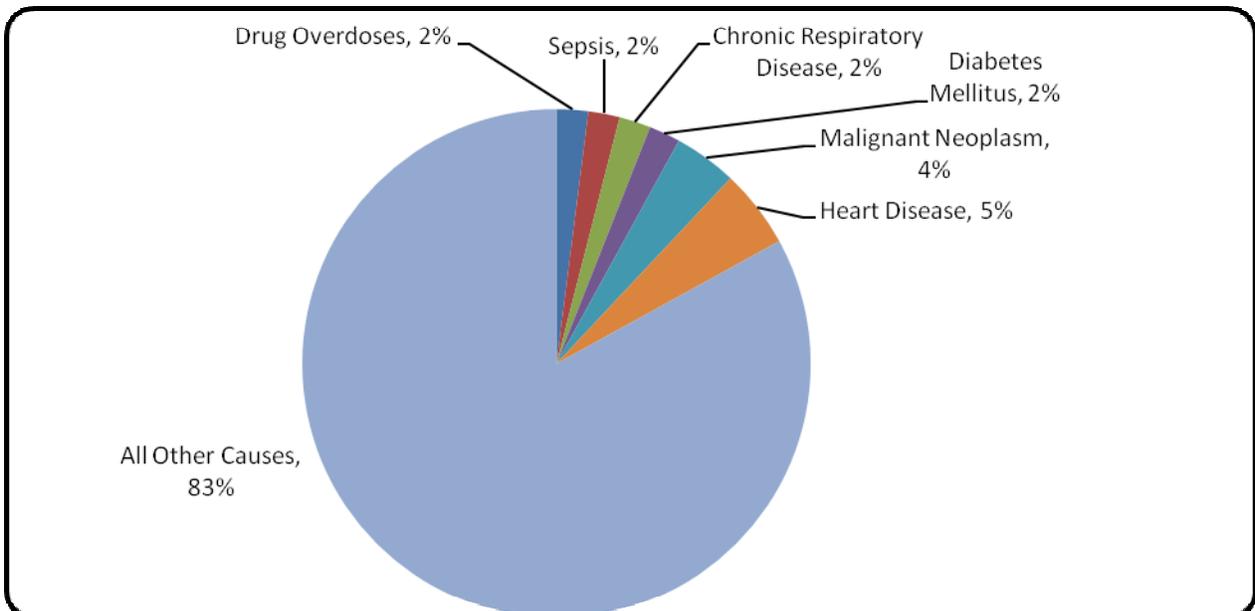
Percent Distribution of Leading Causes of Death – All Maryland Residents 2011



***Percent Distribution of Leading Causes of Death –
DDA 2011***



***Percent Distribution of Leading Causes of Death –
MHA 2011***



**Chart reflects categories listed on Reports of Death as received from service providers and/or family members of individuals who were receiving (or had received) services from MHA.*

TABLE 3: 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

TABLE 4: NUMBER OF DEATHS OF INDIVIDUALS RECEIVING DDA OR MHA SERVICES IN 2009 COMPARED TO THE NUMBER OF DEATHS AMONG ALL MARYLANDERS BY AGE GROUP IN 2009

Age Group (years)	Deaths of All Marylanders in 2009	Deaths of Individuals Receiving DDA Services in 2009	Deaths of Individuals Receiving MHA Services in 2009
<1	541	0	0
1 - 4	67	0	0
5 - 14	100	1	3
15 - 24	574	12	5
25- 34	818	10	12
35 - 44	1,452	19	31
45 - 54	3,690	35	56
55 - 64	5,721	48	46
65 - 74	7,065	23	21
75 - 84	10,921	12	12
85+	12,812	5	4
Not stated	2	n/a	0
Male (all ages)	21,581	92	97
Female (all ages)	22,182	73	93
Total Deaths	43,763	165	190
Total Population	5,699,478	16,468	116,779

Tables 5 and 6 list the top ten primary causes of death for years 2010 and 2009 among all residents of Maryland, and those served by DDA and MHA.

TABLE 5: TOP 10 LEADING CAUSES OF THE DEATHS 2010

Rank	Leading Causes of Death for All Maryland Residents 2010	Leading Causes of the DDA Deaths 2010	Leading Causes of the MHA Deaths 2010
1	Disease of the Heart	Influenza ²	Disease of the Heart
2	Malignant Neoplasm	Pneumonia ²	Accidents
3	Cerebrovascular Diseases	Disease of the Heart	Malignant Neoplasm
4	Chronic Lower Respiratory Diseases	Septicemia	Diseases of the Respiratory System
5	Diabetes Mellitus	Malignant Neoplasm	Suicide
6	Accident ¹	Disease of the Respiratory System ³	Cerebrovascular Diseases
7	Influenza ⁴	Epilepsy ³	Influenza ⁴
8	Pneumonia ⁴	Cerebrovascular Diseases	Pneumonia ⁴
9	Septicemia	Alzheimer's Disease	Septicemia
10	Alzheimer's Disease	Accident ²	Liver Disease

Notes:

1. Accidents included 2 deaths from choking.
2. – 5. Cause of deaths tied for per cause, per population.

TABLE 6: TOP 10 LEADING CAUSES OF THE DEATHS 2009

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

Notes:

1. Accidents included 2 deaths from choking.
- 2.– 5. Cause of deaths tied for per cause, per population.

In 2008 and 2009, influenza was the second leading cause of death for people receiving services from DDA. In 2009 and 2010, there was a greater effort to educate providers and

people receiving services regarding vaccines. This may have contributed to the fact that influenza was not even in the top ten causes of death for people receiving services from DDA in 2011.

In 2009, the ninth leading cause of death for people receiving DDA services was Bowel Obstruction and Perforation. Training is now offered several times each year for providers and their staff regarding this. This cause of death was also not in the top ten causes of death for people receiving DDA services in 2010 or 2011.

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 regulation 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, additional plans of correction for the cited deficiencies are required. Appendix 6 of PORI 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 200 reports of death (194 DDA cases and 6 MHA cases) in calendar year 2011. All cases were thoroughly reviewed by OHCQ and validated by the MQRC to require no further action.

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:

CAUSE #1: Diseases of the heart was the leading cause of death for DDA clients in 2011.

Recommendation:

Clients in the DDA system, as well as the providers who serve them, should be regularly reminded of the importance of maintaining a healthy heart and a healthy cardiovascular system. Attention to quitting tobacco, diet, exercise, and good sleeping habits are the most effective ways to avoid heart-related health problems.

Additionally, clients and providers can avoid heart-related health problems by quitting smoking and / or the use of any tobacco products. "According to the Centers for Disease Control and Prevention (CDC), at least 6,841 Marylanders are estimated to die prematurely every year due to cigarette smoking." Cigarette smoking affects every organ in the human body, including the heart. It is recommended that clients in the DDA system as well as providers take the time to access the Maryland Quit Smoking website to learn more and to locate resources to help them quit smoking found at http://fha.dhmf.maryland.gov/ohpetup/SitePages/tob_quit.aspx. DDA will communicate with providers and consumers on available tobacco control resources.

CAUSE #2: Septicemia continues to be a leading cause of death for DDA clients.

Recommendation:

A strong focus on continuing education for provider agency staff in the area of infection prevention is strongly recommended as a way to reduce the mortality rate of DDA clients due to septicemia. Through in-service trainings and promotional materials (posters, etc), the staff's level of awareness can be raised on this critical issue.

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.

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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

- Keith Peterson, Chair, licensed provider of community developmental disability services

Committee Membership

- Joanna D. Brandt, MD, Board Certified Psychiatrist
- Jason Noel, Pharm D., Psychopharmacologist
- 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
- Vicki Mills, Developmental Disability Consumer
- Katie Rouse, 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
- VACANT, the Deputy Secretary of Behavioral Health and Disabilities designee
- Dr. Tricia Nay, Director of the Office of Health Care Quality designee
- 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, Member of an advocacy group for persons with disabilities

- Dan Martin, Member of a mental health advocacy group
- Vacant, 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

Lisa Hovermale, MD, Licensed Physician, MHA and DDA Liaison

Tricia Nay, MD, Licensed Physician, OHCQ

Mary Crouse, RN, OHCQ

Bill Vaughn, RN, OHCQ