HB 1268

Department of Legislative Services

Maryland General Assembly
2000 Session

FISCAL NOTE

House Bill 1268 (Delegate Hubbard)
Environmental Matters

**Mortality Review Committee -
Deaths of Individuals with Developmental Disabilities**

This bill establishes a 12-member Mortality Review Committee within the Department of Health and Mental Hygiene (DHMH) to prevent avoidable deaths and to improve the quality of care provided to persons with developmental disabilities within facilities or programs operated and licensed by the Developmental Disabilities Administration (DDA). The committee must: (1) evaluate the causes and factors in DDA facility deaths; (2) identify patterns and systemic problems and ensure a consistent review process; and (3) make recommendations to the DHMH Secretary to prevent avoidable deaths and improve the quality of care.

Fiscal Summary

State Effect: General fund expenditures increase by $75,400 in FY 2001. Future year expenditures reflect annualization and inflation. No effect on revenues.

(in dollars)	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
GF Revenues	$0	$0	$0	$0	$0
GF Expenditures	$75,400	$90,000	$94,200	$98,500	$103,000
Net Effect	($75,400)	($90,000)	($94,200)	($98,500)	($103,000)

Note: ( ) = decrease; GF = general funds; FF = federal funds; SF = special funds; - =indeterminate effect

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The bill requires the Office of Health Care Quality (OHCQ) to review and investigate each death under the committee's jurisdiction. The OHCQ cannot investigate or review cases of death in an individual's private home, except to the extent needed to investigate a licensed provider that offered services at that individual's home.

The Mortality Review Committee must: (1) either review each death report provided by OHCQ or appoint a four-member subcommittee to conduct the death report reviews and make recommendations to the full committee; (2) request certain additional information when deemed necessary; (3) request the attendance of providers or others at committee or subcommittee meetings when needed; and (4) not communicate directly with a provider, a State Center Director, family member, or guardian of the deceased individual, except to request attendance at meetings as in (3) above.

The Mortality Review Committee must prepare a report at least once a year for public distribution and is allowed to issue confidential preliminary findings or recommendations at any time. The yearly report is prohibited from containing the identity of specific individuals or entities, but must include: (1) the number of cases reviewed, the causes/circumstances surrounding the deaths, and the ages of the deceased; (2) a summary of the committee's activities; and (3) a summary of the committee's findings including patterns, trends, goals, problems, concerns, final recommendations, and preventative measures.

At the request of the committee chair or subcommittee, medical care providers, agencies, and residential service providers are required to give the committee access to information regarding the individual whose death is being reviewed. Committee members and those persons providing the information, participating in, or contributing to committee functions will have immunity from liability under State law.

Except for the information included in the public reports, records and files of the committee must be kept confidential and are not discoverable. In addition, the committee members are prohibited from disclosing meeting content.

Current Law: None applicable.

State Fiscal Effect: The bill requires OHCQ to review each death record and conduct an investigation. The reports from OHCQ must contain information useful to the committee or the subcommittee for making recommendations. There are approximately five to nine deaths monthly among the developmentally disabled that will require investigation, data collection, a report, and possible follow-up as requested by the committee.

The Department of Legislative Services (DLS) advises that the bill's provisions could be accomplished with two positions (one health facilities nurse and one office secretary), at a cost of $75,386 in fiscal 2001. This estimate reflects the cost of the two positions and the bill's October 1, 2000, effective date. It is based on the assumption that the majority of DDA facility deaths are attributable to existing conditions and are unlikely to require extensive field investigation. In most instances, a determination can be made without field work through the use of telephone interviews and pertinent medical records research. This estimate includes salaries, fringe benefits, one-time start-up costs, and ongoing expenses.

Salaries and Fringe Benefits	$61,471
Operating Expenses	13,915
Total FY 2001 State Expenditures	**$75,386**

Future year expenditures reflect (1) full salaries with 4.5% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

The Office of Health Care Quality advises that general fund expenditures could increase by $165,399 in fiscal 2001, which accounts for the bill's October 1, 2000, effective date and includes four positions (two nurses as field investigators, one survey coordinator at OHCQ headquarters, and one support staff) to produce information for the committee. This estimate does not include staff directly assigned to the committee, which can be accomplished by DHMH using existing resources.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene (Office of Health Care Quality, Vital Statistics), Department of Legislative Services

Fiscal Note History: First Reader - March 14, 2000
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