HB 78

Department of Legislative Services

Maryland General Assembly
2001 Session

FISCAL NOTE
Revised

House Bill 78 (Delegate Hubbard)
Environmental Matters Economic and Environmental Affairs

Mortality Review Committee - Deaths of Individuals in State Facilities and Programs

This bill requires the Mortality Review Committee and the Office of Health Care Quality (OHCQ) (subject to exception) to review the death of any individual with a mental illness who resided in or was receiving services from any program or facility approved, licensed, or operated by the Mental Hygiene Administration (MHA). The bill also changes the number and composition of the members of the committee, and places reporting requirements on certain individuals.

Fiscal Summary

State Effect: General fund expenditures are expected to increase by $216,600 in FY 2002. Future year expenditures reflect annualization and inflation. No effect on revenues.

(in dollars)	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Revenues	$0	$0	$0	$0	$0
GF Expenditure	216,600	267,900	282,000	297,000	313,100
Net Effect	($216,600)	($267,900)	($282,000)	($297,000)	($313,100)

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 Secretary of the Department of Health and Mental Hygiene (DHMH) to report the death of any individual with a developmental disability or a mental illness, who resided in or was receiving services from any program or facility licensed, operated, or approved by DDA or MHA, to the Mortality Review Committee within 24 hours of notification of the death. Upon notification of the death of such an individual, the administrative head of the program or facility where the individual died is required to report the death immediately to the Secretary of DHMH.

The number of members on the Mortality Review Committee is increased to 18, which must include specialists and others who are in the field of or who represent those with mental illness as well as those with developmental disabilities.

The committee is required to review the death of any individual with a mental illness who resided in or was receiving services from any program or facility approved, licensed, or operated by MHA. OHCQ is also required to review such deaths but may choose not to do so based on the circumstances of the death. OHCQ may not review the care or services provided in an individual's home, except to the extent needed to investigate a licensed provider that offered services at that individual's home.

Current Law: Existing applicable law applies only to the deaths of individuals with developmental disabilities who resided in or received services from any program or facility licensed or operated by the DDA or operating under a waiver from the director of DDA. The Mortality Review Committee consists of 12 members.

Background: Chapter 470 of 2000 established a 12-member Mortality Review Committee within 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.

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 persons; (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.

State Expenditures: The bill requires OHCQ to review each death. The reports from OHCQ must contain information useful to the committee or the subcommittee for making recommendations. The Mental Health Administration (MHA) estimates that there are approximately 150 deaths a year among the mentally ill that will require review, possible investigation, data collection, a report, and possible follow-up as requested by the committee. OHCQ currently reviews the deaths of 65 to 70 developmentally disabled individuals annually.

General fund expenditures could increase by an estimated $216,640 in fiscal 2002, which accounts for the bill's October 1, 2001 effective date. This estimate reflects the cost of five new positions: two health facilities nurses, one office secretary, and one coordinator at OHCQ headquarters; and one administrative specialist at MHA. It includes salaries, fringe benefits, one-time start-up costs, office furniture and equipment, and ongoing expenses. The information and assumptions used in calculating the estimate are stated below.

- About two-thirds of all MHA facility deaths will require field investigations, which on average takes about five days each; the other one-third of facility deaths are unlikely to require extensive field investigation and can be reviewed through the use of telephone interviews and pertinent medical records research.

- The increased workload and staff within OHCQ will necessitate a coordinator and administrative support.

- The bill applies to programs or facilities licensed or operated by the Developmental Disabilities Administration and MHA.

- MHA will have increased record keeping and reporting requirements and have to staff the newly enlarged committee.

Salaries and Fringe Benefits	$184,874
Operating Expenses	31,766
Total FY 2002 State Expenditures	**$216,640**

Future year expenditures reflect: (1) full salaries with a 6.5% increase in fiscal 2003 and a 4.5% increase each year thereafter, with a 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene (Office of Health Care Quality, Mental Hygiene Administration, Developmental Disabilities Administration), Department of Legislative Services

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