Department of Legislative Services

Maryland General Assembly
2005 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 702 (Senators Teitelbaum and Kelley)
Finance Health and Government Operations

Developmental Disabilities Administration - Prioritization System for Investigations

This bill requires the Developmental Disabilities Administration (DDA), in conjunction with the Office of Health Care Quality (OHCQ), to adopt regulations establishing an investigation prioritization system for specified serious reportable incidents as defined by DDA.

The bill takes effect July 1, 2005.

Fiscal Summary

State Effect: None. The change would not directly affect government finances.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The investigation prioritization system will focus on reports of abuse, neglect, serious injury, and medication errors that threaten the health, safety, and well-being of individuals receiving DDA-funded services in State-operated and DDA-licensed community programs.

DDA must seek input from individuals with disabilities and their families, licensees, and advocacy organizations in developing the regulations, prior to publishing the regulations in the Maryland Register for public comment. The regulations must define and address:

(1) the procedures and timelines providers must follow when reporting serious reportable incidents and deaths to DDA and OHCQ; (2) DHMH's protocol to determine the necessity to investigate a serious reportable incident that takes into account the severity of the incident, the quality of the licensee's internal investigation, and the number and frequency of serious reportable incidents reported by the licensee to DHMH; (3) the specific roles and responsibilities of each governmental unit involved in any follow-up investigations that may occur due to a licensee's report of a serious reportable incident or death; (4) methods of investigations; (5) time lines for responding to and investigations of serious reportable incidents and deaths; (6) time lines for issuing specified reports, including corrective action plans, to DDA, the licensee, mortality review committee, Medicaid fraud unit, individuals receiving services from the licensee involved in the incident and their guardians or family members, and others; and (7) OHCQ and DDA follow-up protocols to ensure corrective action has been implemented by the licensee.

Current Law: In addition to any other required license, a person must be licensed by DDA before providing the following services to an individual with a developmental disability or a recipient of individual support services: day habilitation services; residential services; services coordination; vocational services; more than one family support service; more than one individual support service; and more than one community supported living arrangements service.

If a person is licensed or certified by another State agency or accredited by a national accreditation agency to provide services to an individual with a developmental disability or a recipient of individual support services, the DDA director may waive the license requirement.

DDA, or its agent, must inspect each site or office operated by a licensee at least once annually and at any other time DDA considers necessary. DDA must bring any deficiencies to the attention of the executive officer of the licensee or, in the case of an intermediate care facility-mental retardation, the State Planning Council and the State-designated protection and advocacy agency.

Background: There are approximately 3,220 licensed DDA programs in Maryland that provide day habilitation services, residential services, services coordination, vocational services, family support services, individual support services, or community supported living arrangements services. However, not all licensed programs receive DDA funding.

A licensed DDA provider is required to identify, report, investigate, review, correct, and monitor situations and events that threaten the health, safety, or well-being of individuals receiving services from the provider. In the case of serious reportable incidents (such as physical, sexual, or psychological abuse or inhumane treatment), the licensee is required to self-report the incident to OHCQ and to the DDA regional office either by fax or e-

mail within one day of discovering the incident. The provider then is required to conduct its own investigation into each incident and then submit a report on the investigation's results to OHCQ and the DDA regional office within 21 workings days. OHCQ does not prioritize what is investigated by the provider.

Current policy does not mandate that OHCQ investigate every self-reported incident. OHCQ reviews the quality of the report a provider submits to ensure that the provider conducted a thorough investigation. If OHCQ does not believe the provider's report is adequate, OHCQ may choose to do its own investigation. OHCQ receives approximately 4,700 provider reports annually. From those reports, OHCQ conducts approximately 400 investigations.

In addition, OHCQ receives an average of 100 complaints annually from a family member or a neighbor of a person receiving DDA services. OHCQ investigates all of these complaints, responding in less than four days to a complaint.

Additional Information

Prior Introductions: None.

Cross File: HB 651 (Delegate Costa, *et al.*) – Health and Government Operations.

Information Source(s): Department of Health and Mental Hygiene, Department of Legislative Services

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