SB 699

Department of Legislative Services

Maryland General Assembly
2005 Session

FISCAL AND POLICY NOTE

Senate Bill 699 (Senator Teitelbaum, *et al.*)
Education, Health, and Environmental Affairs

Mortality and Quality Review Committee - Serious Incidents

This bill renames the Mortality Review Committee within the Department of Health and Mental Hygiene (DHMH) the Mortality and Quality Review Committee and expands the committee's duties to prevent serious incidents in facilities or programs licensed by the Developmental Disabilities Administration (DDA) or operating by waiver.

The bill takes effect July 1, 2005.

Fiscal Summary

State Effect: Expenditures could increase by $511,800 ($427,200 general/$84,600 federal) in FY 2006, including one-time costs for developing an automated incident reporting process. Future years assume annualization and inflation.

(in dollars)	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Revenues	$0	$0	$0	$0	$0
GF Expenditure	427,200	268,500	284,800	302,300	321,300
FF Expenditure	84,600	88,500	92,600	96,800	101,300
Net Effect	($511,800)	($357,000)	($377,400)	($399,100)	($422,600)

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

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The Mortality and Quality Review Committee must evaluate the causes or factors contributing to serious incidents in facilities or programs serving individuals with developmental disabilities. The committee must make findings and recommendations to the Secretary of Health and Mental Hygiene and DDA on the prevention of avoidable deaths and serious incidents, systemic quality assurance needs, and the improvement of quality of care.

DDA must adopt regulations to define "serious incident" for abuse, neglect, serious injury, and medication errors that threaten the health, safety, and well-being of an individual receiving services funded by DDA in State-operated community programs licensed by DDA.

On review of a death report, if the committee or its subcommittee determines further investigation is warranted, the committee/subcommittee may request an onsite follow-up review by the Office of Health Care Quality (OHCQ) within six months of the committee review. The review would be designed to ensure the safety and health of other individuals in the facility or program operated or licensed by the Mental Hygiene Administration (MHA), DDA, or operating by waiver.

OHCQ must develop an analysis of the aggregate data on trends and patterns of serious incidents verified by DHMH and other complaints disclosed by a facility or program operated by DDA or operating by waiver. OHCQ must submit an analysis to the committee once every six months. The committee must review each analysis provided by OHCQ and make findings and recommendations.

The committee's annual report, in addition to being made public, must be distributed to any facility or program operated or licensed by MHA or DDA or operating by waiver. The report must include a summary of OHCQ's analysis that was provided to the committee and the committee's findings and recommendations.

Current Law: The Mortality Review Committee's purpose is to prevent avoidable deaths and to improve the quality of care provided to persons with developmental disabilities. The committee must: (1) evaluate the causes or factors contributing to deaths in facilities or programs operated or licensed by MHA and DDA or operating by waiver; (2) identify patterns and systemic problems and ensure consistency in the review process; and (3) make recommendations to the Secretary to prevent avoidable deaths and improve the quality of care.

OHCQ must review each death of an individual with developmental disabilities or with a mental illness who, at the time of death, lived in or was receiving services from any

program or facility licensed or operated by DDA or operating by waiver or any program approved, licensed, or operated by MHA. OHCQ must submit to the committee a final report for each death within 14 days of completing the investigation. The committee must review each death report or appoint a subcommittee to review the death report and make recommendations to the full committee. On reviewing the death report, if the committee or its subcommittee determines a further investigation is warranted, the committee or subcommittee may request additional information.

At least once annually, the committee must prepare a report for public distribution. The report must include aggregate information that sets forth the numbers of deaths reviewed, the ages of the deceased, causes and circumstances of death, a summary of the committee's activities, and summary findings.

Background: The Mortality Review Committee reviewed a total of 191 death cases (180 DDA and 11 MHA) during 2003. The leading causes of death were: diseases of the heart (such as heart disease and heart attacks) 51; influenza and pneumonia, 33; malignant neoplasms, 15; other diseases of the respiratory system, 12; septicemia, 11; accidents, 10; cerebrovascular disease, 9; epilepsy, 7; nephritis, nephritic syndrome and nephrosis, 4; and psychotropic drugs, 4.

There are approximately 3,200 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.

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 working 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 these reports, OHCQ conducts approximately 400 investigations. Of these 4,700 reported incidents, OHCQ estimates that 1,500 will be "serious incidents." OHCQ assumes that it will resolve 75% of the serious incidents

without an onsite investigation. The remaining 25% (375) will require onsite investigations to be completed within 30 days of the date the incident was reported to OHCQ.

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

State Expenditures: Expenditures could increase by $511,788 ($427,199 general/$84,589 federal) in fiscal 2006, which accounts for a 90-day start-up delay. This estimate reflects the cost of hiring three nurses to conduct onsite inspections of providers serving developmentally disabled individuals, one research statistician to analyze the data on trends and patterns of incidents, one health policy analyst to write the reports every six months that are submitted to the committee, and one secretary to provide administrative support. It also assumes $221,103 in one-time costs for establishing an automated incident reporting process to log and prioritize reported incidents. It includes salaries, fringe benefits, travel costs, one-time start-up costs, and ongoing operating expenses. The information and assumptions used in calculating the estimate are stated below:

- OHCQ investigating 375 serious incidents (25% of 1,500 serious incidents reported annually);
- 20 hours per investigation; and
- 38% matching federal funds for salaries.

Salaries and Fringe Benefits	$241,537
Automated Incident Reporting Process	221,103
Operating Expenses	38,618
Travel	10,530
Total FY 2006 State Expenditures	**$511,788**

Future year expenditures reflect: (1) full salaries with 4.6% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

Additional Information

Prior Introductions: None.

Cross File: HB 991 (Delegate Hubbard, *et al.*) – Health and Government Operations.

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

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ncs/jr

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