# **Department of Legislative Services**

Maryland General Assembly 2006 Session

#### FISCAL AND POLICY NOTE Revised

House Bill 831

(Delegates Costa and Hubbard)

Health and Government Operations Education, Health, and Environmental Affairs

### Mortality and Quality Review Committee - Reportable Incidents of Injury

This bill changes the name of the Mortality Review Committee to the Mortality and Quality Review Committee within the Department of Health and Mental Hygiene (DHMH) and adds additional duties for the committee.

The bill takes effect July 1, 2006 and terminates September 30, 2009.

### **Fiscal Summary**

**State Effect:** The impact of the bill's additional duties and reporting requirements is small enough that it could be handled with existing resources.

Local Effect: None.

Small Business Effect: Minimal.

### Analysis

**Bill Summary:** The bill requires the committee, in addition to current duties, to review aggregate incident data regarding facilities or programs that are licensed or operated by the Developmental Disabilities Administration (DDA) or operating by waiver. The committee must make recommendations to the Secretary and the Secretary of Disabilities to prevent avoidable injuries and avoidable deaths, and improve quality of care.

The Office of Health Care Quality (OHCQ) must provide aggregate incident data to the extent practicable to the committee once every three months. When providing it, OHCQ

must identify trends and patterns that may threaten the health, safety, or well-being of any individual. The committee must review the data and make findings and recommendations to the department on system quality assurance needs. The committee may consult with experts as needed. The committee may issue preliminary findings or make preliminary recommendations to the Secretary, the Secretary of Disabilities, the Director of DDA, the Director of the Mental Hygiene Administration or to the Director of OHCQ.

DDA must provide the report to the facilities or programs that are operated or licensed by DDA or operating under a waiver.

OHCQ, DDA, and the committee must submit a report to specified legislative committees by January 1, 2008, including: (1) the impact of providing reportable aggregate incident data on the operations of the Developmental Disabilities Complaint Unit; (2) the impact of the committee's review of aggregate incident data on the quality of care; (3) the infrastructure required to provide additional information on trends and patterns for other reportable incidents; and (4) the methods by which information regarding avoidable injuries has been disseminated to facilities or programs operated or licensed by DDA or operating under a waiver (in which departmental licensure is not required to operate such programs).

**Current Law:** There is a Mortality Review Committee within DHMH whose purpose is to prevent avoidable deaths and to improve the quality of care provided to persons with developmental disabilities. The committee must evaluate causes or factors contributing to deaths in facilities or programs, identify patterns and systemic problems; and make recommendations to the Secretary to prevent avoidable deaths and improve quality of care. The committee is staffed by DHMH. The committee must prepare a report for public distribution at least annually. The report must include aggregate information that sets forth the number of death reviews, the ages of the deceased, causes and circumstances of death, a summary of the committee's activities, and summary findings.

**State Fiscal Effect:** The provision of aggregate incident data could be handled with existing OHCQ budgeted resources. DDA could provide the required reports to licensed facilities or programs using existing budgeted resources. The bill has no fiscal impact on the Department of Disabilities.

## **Additional Information**

Prior Introductions: None.

**Cross File:** SB 734 (Senator Teitelbaum) – Education, Health, and Environmental Affairs.

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

Fiscal Note History:	First Reader - March 6, 2006
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Analysis by: Susan D. John

Direct Inquiries to: (410) 946-5510 (301) 970-5510