STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor · Michael S. Steele, Lt. Governor · S. Anthony McCann, Secretary

January 20, 2005

The Honorable Ulysses Currie
Chairman, Budget and Taxation Committee
3 West, Senate Miller Building
Annapolis MD 21401-1991

The Honorable Norman H. Conway
Chairman, Appropriations Committee
Room 131, Lowe House Office Building
Annapolis MD 21401-1991

Re: Joint Chairmen's Report 2004, Page 84, Report on Staffing Patterns and Inspections Work Plan

Dear Chairmen Currie and Conway:

The Office of Health Care Quality (OHCQ) is the agency with the Department of Health and Mental Hygiene that is responsible for monitoring the quality of care in Maryland's 8000 health care facilities and community residential programs. During the 2004 budget hearings, in light of lost positions and budgetary constraints, legislative leaders expressed concern about the staffing patterns in the OHCQ and the ability of the agency to complete statutorily mandated inspections and surveys. The budget committees requested the Department to provide a work plan including a prioritization of workload for fiscal years 2005 and 2006. The committees also requested that the Department evaluate and project staffing requirements for the OHCQ that would be necessary to complete all State and federally mandated inspections. Attached is that report.

When I came to the Department in October, I quickly learned of the staffing shortfall in this most critical area. Clearly, the loss of positions and the staffing shortages have resulted in a decreased ability to complete surveys and to provide timely response to consumer complaints. Please be assured that I am committed to addressing the OHCQ staffing issues. This year, even with our current fiscal challenges, we were able to include four additional full-time positions in the OHCQ operating budget. We are also evaluating priorities and workload demands to ensure that we are deploying staff to areas which are most sensitive, such as assisted living, group homes, nursing home and hospital surveys, where we can truly impact quality of care and health and safety of our citizens. I will continue to monitor this.

I hope this report addresses your concerns. If you or your staff have any questions, please call me at 410-767-6505 or Robyn Elliott, Director of Government Affairs at 410-260-3190.

Sincerely,

S. Anthony McCann
Secretary

Enclosure

cc: Ms. Carol Benner, Director, OHCQ
Ms. Robyn Elliott, Director, Office of Governmental Affairs
Ms. Kimberly Mayer, Policy Analyst, OHCQ

DEPARTMENT OF HEALTH & MENTAL HYGIENE

Robert L. Ehrlich, Jr, Governor
Michael S. Steele, Lt. Governor
S. Anthony McCann, Secretary

OFFICE OF HEALTH CARE QUALITY
WORK PLAN FOR FISCAL YEARS 2005 AND 2006

Report to the Senate Budget & Taxation
and the House Appropriations Committees
As required by the April 2004
Joint Chairmen's Report – Operating Budget

JANUARY 2005

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Introduction

During the 2004 session, legislative leaders expressed concern about the staffing patterns at the Department of Health and Mental Hygiene's (DHMH) Office of Health Care Quality (OHCQ) and the lack of resources being directed to certain inspections. The Senate Budget and Taxation and House Appropriations Committees requested that the OHCQ provide a report on its work plan for Fiscal Years 2005 and 2006 inspections and, in consideration of the reduction of resources, an explanation of how the OHCQ is prioritizing its workload. The Committees also requested that the report include an analysis of staffing levels that would be required in order for the OHCQ to complete all of its federal and State mandated inspections in these respective fiscal years.

This report will provide: an overview of the OHCQ and its responsibilities; history of the increases in mandated activities; insight into current challenges; impact to Maryland's healthcare system if the OHCQ cannot complete its mandated activities; analysis of current staffing levels; and, work plans developed by the OHCQ for Fiscal Years 2005 and 2006 inspections to assure the safety of the health care system.

Overview of OHCQ

The OHCQ is the agency within the DHMH charged with monitoring the quality of care in Maryland's 8,000 health care and community residential programs. The OHCQ is currently staffed by 187.4 dedicated professionals that range the full spectrum of health care providers including physicians, nurses, dietitians, sanitarians and experts in the areas of developmental disabilities, alcohol and drug abuse, and mental health.[1] The mission of the OHCQ is five-fold:

1. ***To protect Maryland citizens through regulation and enforcement of federal and State laws.***

The OHCQ is the State's health care facility licensing and certification agent. Through licensing, a facility gains the authority to operate or do business in the State; through certification, a facility obtains the right to participate in the Medicare and Medicaid programs. The OHCQ uses State and federal regulations, which set forth minimum standards for provision of care and conducts surveys to determine compliance. Depending on the program or regulated entity, surveys are conducted by a team of professionals (nurses, physicians, sanitarians, dieticians, or other experts) over a course of one to five days. When problems or deficiencies are noted, the OHCQ prepares a deficiency report, sends it to the facility and then conducts a resurvey to determine that actual corrective action has taken place. If a facility fails to correct problems and is unable or unwilling to do so, the OHCQ may impose sanctions such as license revocation, fines, bans on admission or other restrictions on the operating license. For these reasons, it is imperative that surveyors have

[1] As of November 23, 2004, the 187.4 position count for the OHCQ includes: 183.4 FTE authorized positions and 4 contractual positions. Of these positions, 15 are vacant and OHCQ is either actively recruiting or pursing hiring freeze exemptions and/or reclassifications. This figure also includes administrative and support personnel.

excellent investigative and clinical skills and can prepare sound survey reports that are fair, accurate and legally defensible. The OHCQ regulates 8,000 facilities or programs and conducts about 5,000 surveys annually.

2. To develop standards for delivery of care

The OHCQ constantly reviews national quality standards and adjusts Maryland's regulations for health care facilities accordingly. The OHCQ evaluates the information it receives from the survey process, including the identification of patterns of care and reports this to policymakers so that laws may be passed, repealed or updated. In any given year, the OHCQ supports the Department's legislative activities by responding to inquiries and preparation of testimony on a myriad of subjects, as well as developing new quality standards or evaluating current standards for at least three to four programs.[2] In addition, the OHCQ staffs a variety of mandated workgroups or other stakeholder forums that are brought together to advise the Department on policy matters or to develop new regulations.[3]

3. To educate providers and consumers.

In Fiscal Year 2004, staff of the OHCQ participated in more than 100 educational programs on a variety of regulatory issues. Staff also regularly participates in workgroups and meetings sponsored by provider and advocacy organizations.

4. To respond to complaints and concerns from the public.

The OHCQ is the primary resource for consumers who raise issues or who have complaints about quality of care in health care facilities or community residential programs. Every year, the OHCQ receives and investigates thousands of complaints. When appropriate, OHCQ is able to intervene directly on behalf of a citizen or constituent to facilitate communication or dispute resolution.

5. To improve quality in Maryland's Healthcare Facilities and Community Residential Programs.

In 2000, the OHCQ added this goal to its mission. Although unique for a regulatory agency, this goal has been widely accepted and praised by a variety of stakeholders and partners. Notably the OHCQ developed a special survey for nursing homes that focuses on technical assistance and consultation, which won a national best practices award. The OHCQ put in place initiatives to improve culture in nursing homes, such as Wellspring, which is a national

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[2] In Fiscal Year 2004 and Fiscal Year 2005, OHCQ prepared regulations on Hospital Patient Safety, Paid Feeding Assistants in Nursing Homes, Nursing Referral Services Agencies, Infection Control in Nursing Homes, Nurse Practitioners in HMOs, Quality Standards for Adult Medical Day Care, and Assisted Living Manager Training.

[3] In Fiscal Year 2004 and Fiscal Year 2005, OHCQ either sponsored or convened the State Advisory Council on Pain Management, the State Advisory Council on Organ and Tissue Donation, the Assisted Living Forum, Adult Medical Day Care Workgroup, Behavioral Management Protocol Workgroup and Nursing Referral Services Agency Workgroup.

training model for nursing homes. The OHCQ encourages the development of Family Councils. Clinical Alerts are distributed when we identify potential problems related to care or patterns of deficiencies.

INCREASE IN MANADATED ACTIVITIES

In 1988, the Office of Licensing and Certification Programs (OLCP) had a staff of 79 and regulated about 2000 facilities. Its focus was nursing homes, hospitals, home health, hospice and other federally regulated programs. The budget for the OLCP was heavily supported by federal funds and there was little State only activity.

In October 1989, the Maryland Disability Law Center (MDLC), the State's designated protection and advocacy unit, filed a lawsuit against DHMH alleging that the Department had failed to provide quality care to persons with disabilities. These citizens lived in Maryland's 900 community residential programs that were funded and regulated by the Department through the Developmental Disabilities Administration. In November 1989, the Secretary transferred the regulatory units from the Department's Mental Hygiene, Developmental Disabilities and Alcohol and Drug Abuse Administrations to the OLCP, adding 39 staff and about 2000 additional regulated entities. The intent was to put an arm's length distance between the regulatory and programmatic staffs and to improve the regulatory process. Shortly after the transfer of staff, legislative auditors evaluated the survey process for the group homes for persons with developmental disabilities and determined that the unit was understaffed. Efforts to increase staff were made, but with the recession in the early 1990's, any gain in staff was quickly erased.

In 1992, the regulatory unit for the Laboratory Administration was transferred to OLCP adding 6 staff and 2000 regulated entities.

In 1996, the assisted living law was enacted. It was unknown what impact the new law would have on OLCP. Thus, the fiscal note for the new law was minimal. The assumption was that the Department of Aging and the Department of Human Resources would continue to survey programs that it had previously regulated and that new resources would not be necessary.

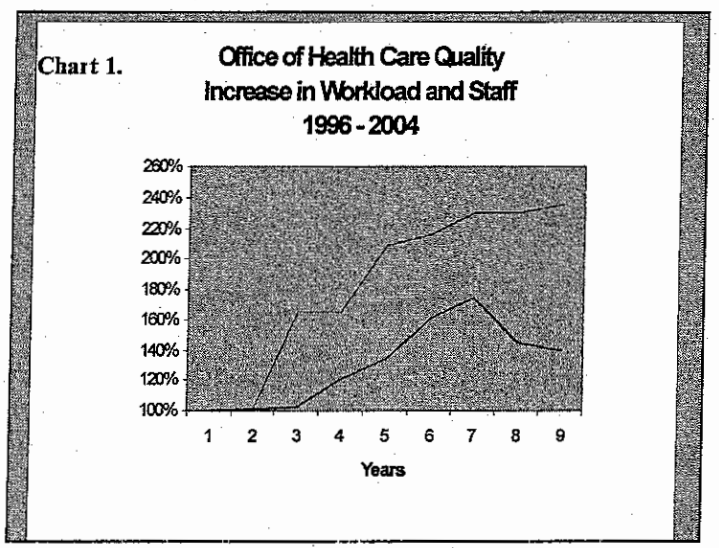
Table 1. Increase in Mandated Regulatory Programs 1996 – 2004

Year	*Program*	*No*
1996	Assisted Living	2000
	Birthing Centers	5
	Major Medical Equipment	151
	Ambulatory Surgery Facilities	323
	Dialysis Centers	121
1998	Organ and Tissue	70
1999	HMO	9
2000	Second Nursing Home Survey	250
	Nursing Home Complaints within 10 days	800
	Mortality Review - DD population	150
2001	Mortality Review -MH population	150
2002	Nurse Staff Agency	550
	Pain Management Council	
2003	Nurse Staff Registries	55

As the new assisted living regulations were implemented, the nation experienced a significant growth in assisted living programs. At that time, Maryland was aware of approximately 800 assisted living programs that were regulated by three State agencies; by 2004, there were more than 2000. In addition, budget cuts over the last eight years have

caused the local Area Agencies on Aging and the local departments of social services to stop their survey activities and turn them over to the State.

Between 1996 and 2004, the General Assembly passed a variety of new regulatory programs, which required the already understaffed agency to conduct more work. **Table 1** (located on page three) describes the new programs with the number of affected programs and **Chart 1** (to the left) shows the increasing gap between number of staff and the workload. **Table 2** (located on page five) shows the change of staff in various units from Fiscal Year 1996 through Fiscal Year 2004.



In 1999, the United States General Accounting Office (GAO) released a report criticizing the federal nursing home complaint process.[4] Maryland was one of four states cited to make the point. At that time, some complaints alleging actual harm were taking up to 180 days to investigate. The federal government responded by increasing federally mandated work and required all states to investigate complaints within 10 days.

In 2000, sweeping statewide nursing home reform legislation was enacted. The bill mandated additional licensure standards for Maryland nursing homes and an additional annual survey of nursing homes by the OHCQ. An additional 40 position identification numbers (PINs) to conduct nursing home surveys including timely complaint investigations were authorized.

OVERVIEW OF STAFF

Over the years, the OHCQ has experienced fluctuations in staffing. **Table 2** shows the types of staff and the change in their numbers from Fiscal Year 1996 to the present. These changes reflect the merging of programs into the OHCQ (such as the licensing, approval or certification functions for Mental Health, certification and licensure programs for Alcohol and Drug Abuse, licensure programs Developmental Disabilities, licensure programs for Laboratories) and the increase in State and federally mandated work. This table also shows that OHCQ began to experience decreasing of its staffing levels in Fiscal Year 2003.

[4] Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents. (GAO/HEHS-99-80, March 22, 1999).

Table 2. Change in OHCQ Staff by Unit Fiscal Year Actuals									
	1996	1997	1998	1999	2000	2001	2002	2003	2004
Administration & IT	15	15	15	15	19	21	20	17	17.6
Technical Assistance	0	0	0	0	3	8	8	6	5
Nursing Homes	38	38	35	45	50	72	75	61	57
Group Homes (DD)	31	31	31	39	39	42	44	43	37
Assisted Living	6	6	10	17	22	22	37	36	30
Ambulatory	11	12	12	12	12	12	12	10	10
Alcohol/Mental Health	11.8	11.8	11.8	12.8	12.8	12.8	12.8	11.8	11.8
Laboratory	13	13	13	13	13	13	13	11	10[5]
Hospital/HMO	4	4	4	4	5	7	7	7	6
TOTAL	**129.8**	**130.8**	**131.8**	**157.8**	**175.8**	**209.8**	**228.8**	**202.8**	**184.4**

The largest fluctuation of staff appears in the Nursing Home Unit. In Fiscal Year 2001 and Fiscal Year 2002, some 40 positions were added in response to the inability of the unit to complete its workload. Many of these positions were cut or abolished before they were even filled.

Table 3 shows the distribution of staff among three different categories – professional or surveyor, administrative or managerial, and clerical or secretarial. Clerical and managerial staff account for about 11 or 12 percent of the total staff each or about 23 percent of the total staff together. The remaining 77 percent of the staff are the heart of the organization, the surveyors and professional staff, such as a medical director, physician advisor, chief nurse, assistant attorney general, complaint intake coordinator, abuse coordinator.

Table 3. Distribution of OHCQ Staff by Unit Fiscal Year 2003 Actual				
	Total	Managers	Professional or Surveyor	Clerical or Secretarial
Administration	19	5	11	3
Technical Assistance	5	1	4	0
Nursing Home	59	8	48	3
Group Home	42	3	35	4
Assisted Living	37	1	30	6
Ambulatory	11	1	8	2
Alcohol/Mental Health	11.8	1	10.8	0
Laboratory	11	3	5	3
Hospital	7	1	4	2
TOTAL	202.8	24	156.8	23

The Office's professional staff provide many different essential services to ensure the continuity of the survey process including offering technical assistance to the surveyors, participating in informal dispute resolution and testifying at hearings. The clerical or secretarial staff ensures that the paper flow and legal documentation for over 8,000 health

[5] As of July 1, 2004, the PIN for the manager of this unit was abolished. Thereby, reducing the total number of FTE authorized positions for OHCQ for Fiscal Year 2005 to 183.4.

care provider licenses, including annual or biennial applications, and respective fees are collected, processed and maintained appropriately.

The Administration Unit, as indicated in **Table 3**, includes a total of 19 staff. This category includes 7 information technology staff, the Office Medical Director, Assistant Attorney General, and Chief Nurse as well as one policy analyst, regulations coordinator, fiscal officer, personnel manager, executive associate, 3 secretarial staff and one building security officer.

While **Table 3** is based on Fiscal Year 2003 data, Fiscal Year 2004 data is proportionately the same. The loss of 18 PINs between Fiscal Year 2003 and Fiscal Year 2004, has made it necessary to pull surveyors into the office to do administrative work as well as to deploy some administrative staff to the field to conduct surveys.

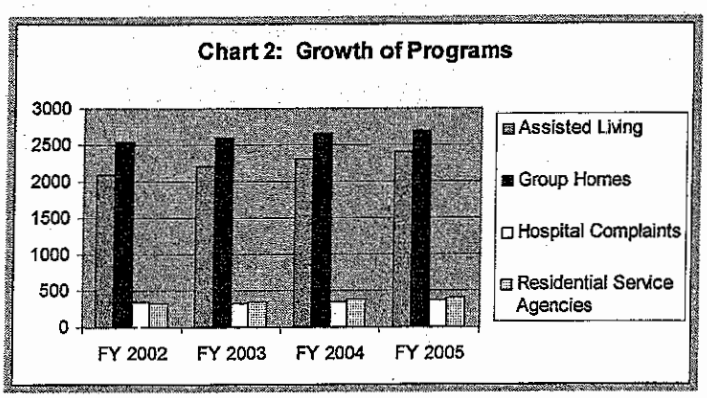
TODAY'S CHALLENGES

The OHCQ is experiencing difficulty completing its statutorily required work. Several factors identified below have contributed to this:

- ***Federal Budget:*** The OHCQ works under contract with the Centers for Medicare and Medicaid Services (CMS) to conduct federal certification work. Up until the late 1990's, CMS would usually pay for all work that the State agency conducted on its behalf, regardless of the federal budget allocation. In 2000, CMS dramatically increased federal nursing home survey requirements. At the same time, CMS began to limit the State's ability to earn federal funds and limit the earning power to the fiscal year allocation.

- ***Increased requirements:*** Since 1996, State law has required an additional 15 new regulatory programs. Adequate funding or resources to effectively implement or operate the respective regulatory program have not always accompanied these mandates. We have, to the best of our ability, tried to patch together a regulatory presence in each program it operates. As a result, we are struggling with our current workload.[6]

- ***Increased growth of certain programs:*** Several programs have increased significantly in volume. This has required initial surveys to license new providers as well as to maintain routine periodic surveys. For example, in 1990, there were approximately 1000 group homes for individuals with developmental disabilities; today there are more than 2000. **Chart 2** shows the growth of several programs within the OHCQ.



[6] New programs and requirements for the last five years are noted in Table 1 located on page three of this report.

- ***Increased public expectation:*** Because of high visibility cases and increased media coverage of regulatory and health care issues, the public officials and citizens have increased expectations of regulatory agencies. It is not uncommon, following an announcement of poor care, for a reporter or elected official to say to the agency, "*How could you let this happen?*"

- ***Difficulty with recruitment:*** The majority of surveyors with the OHCQ are nurses. The nursing shortage has affected our ability to recruit and retain qualified staff. As a state agency, our ability to keep pace with special incentives offered in the private sector – such as competitive salaries and signing bonuses – simply do not exist.

- ***Reduction of Personnel:*** The OHCQ has lost 50 PINs over the course of the last three fiscal years. In Fiscal Year 2003, the OHCQ lost 27 PINs because of the legislatively mandated Departmental PIN cap. In Fiscal Year 2004, the OHCQ lost another six PINs due to the statewide PIN cap as well as an additional 14 PINs were eliminated through vacancy cuts. In Fiscal Year 2005, OHCQ lost three PINs due to statewide PIN cuts and one due to the closure of Crownsville Hospital Center. The statewide hiring freeze is also contributing factor to our inability to complete our mandated activities. While OHCQ is able to obtain hiring freeze exemptions for clinical staff, the approval process is somewhat slow. The delay typically makes recruitment for critical positions, such as surveyors, more difficult.

IMPACT ON MARYLAND

These challenges present the OHCQ with dilemma. The lack of adequate resources makes it difficult for the OHCQ to complete its required work. At the same time, there is major impact on Maryland's healthcare system if the OHCQ cannot complete its mandated workload. The risks to the health care system are wide-reaching and include, but are not limited to:

- Loss of federal funds if nursing home surveys are not completed on a 12-month cycle for certification.

- Loss of public confidence if complaints are not investigated in a timely manner.

- Deterioration of quality of care.

- Possible criticism from the GAO similar to what was experienced in 1999 regarding the nursing home complaint process.

- Public outcry from citizens that "government is not doing its job."

- Inability of regulated entities to secure liability insurance or receive third-party reimbursement for services provided.

The statewide hiring freeze and cost containment initiatives have seriously strained our operations and made it paramount to balance regulations with other efforts to improve quality

of care. Therefore in Fiscal Year 2004, because of these challenges and the potential impact on Maryland's healthcare system, we began focusing our efforts on those programs that have the greatest impact on people's lives. While we remain committed to improving the quality of care in all of Maryland's healthcare facilities and residential programs, we are placing an emphasis on those programs that have direct impact on people's lives in order to ensure the safety of frail, vulnerable persons.

ANALYSIS OF STAFFING LEVELS

At the request of the chairmen of the General Assembly's budget committees, the OHCQ has conducted an analysis of labor needs required to perform all mandated surveys.

Retention of Federal Expert to Conduct Our Analysis. The OHCQ was privileged to mentor a senior management intern (SES) who was on rotation from CMS with extensive experience in personnel management and human resources from February 2004 through April 2004. The OHCQ labor analysis project was assigned to this individual as part of their internship. The data collection was conducted by the intern and if where appropriate, compared to other data. **Table 4** located below describes how the data were collected and how staff overage or shortfall was determined.

Table 4. Nursing Home Labor Hour Analysis

Requirements	A. # of Facilities or Complaints	B. Survey Requirement per Year	C. Total Number of Surveys Required	D. Hours Required per Survey	E. Total Hours Required for Survey Activity (CxD)	F. Number of Surveyors Required (E/1480)	G. No. of Surveyors	H. Staff Overage or Shortage
Federal Survey	242	1	242	157	37,994	25.67	22.00	-3.67
Complaints - High Level Actual Harm	748		748	16	11,968	8.09	6.00	-2.09
Complaint Survey Follow-Ups	61		61	16	976	0.66	0.00	-0.66
Complaints - Moderate/Low Level Actual Harm or Potential for Harm	964		241	10	2,410	1.63	0.00	-1.63
State Survey	242	1	242	21	5,082	3.43	4.00	0.57
							Total Survey Staff Shortage:	-7.48

Methodology of Analysis. First, we prepared a list of basic regulatory activities for each unit. These activities included surveys, complaint investigations and follow-up surveys to determine if corrective action was taken. Column B notes the statutory requirement for the survey. Column C (Column A x Column B) represents the total number of surveys or units that were required in Fiscal Year 2003. For example, there were 242 federal annual surveys required for this time period. Column D represents the average time that it takes to conduct a survey. This includes travel time and report writing time. Column E, (Column C x Column

D), represents the total hours required for survey activity. Column F (Column E/1480) indicates the number of surveyors that would be needed to conduct this work.[7] Column G indicates the number of surveyors assigned to the activity and finally, Column H indicates the overage or shortfall.[8] The number of available surveyors in Column G is equal to the budgeted allocation of surveyor full-time equivalent (FTE) positions for Fiscal Year 2004.

It should be noted that the overage or shortfall is reflective of needs for surveyor staff ***only*** and does not include the necessary staff to provide clerical or supervisory support for the survey activity.

The complete data for all programs and activities can be found in Appendix A. For simplicity, the body of this report contains current number of surveyors, required number of surveyors and the overage or shortfall of surveyors.

Discussion of Staffing and Current Priorities

Long Term Care (Nursing Homes and Adult Medical Day Care). From 1999 through 2002, following a GAO Report that criticized Maryland's ability to conduct federal nursing home regulatory activities, the Governor and the General Assembly increased staff in the OHCQ and doubled the number of surveyors. Since then, budgetary restraints have prevented hiring and eliminated positions. Similar to the problems identified in 1999, the OHCQ is not meeting federal requirements. CMS requires an overall average of 12 months between surveys, with no survey exceeding a 15-month interval. For Federal Fiscal Year 2004, surveys of five nursing homes exceeded that time period. CMS also requires investigation of any actual harm complaint within 10 working days. The average time for completion of these complaints for Federal Fiscal Year 2004 was 31 days with some investigations taking as long as 45 or more days.

Chart 3. Long Term Care Shortage	
Current Number of Surveyors	33.50
Number of Surveyors Required	41.86
Surveyor Shortage	**-8.36**

Table 2 indicates that there are a total of 57 staff in the Nursing Home Unit, which includes staff dedicated for adult medical day care. There are 32 professional staff persons who are assigned to do survey work only. The unit also includes appropriate infrastructure necessary to support the surveyors' activities. This 25 member support system includes: one senior manager, one mid-level manager, six team leaders or coordinators who schedule surveys, assign and triage complaints and manage information required for federal and state purposes, one minimum data set (MDS) coordinator who handles monthly data reports received from each nursing home as required under federal contract, one nurse trainer who orients and mentors new surveyors, five clerical or secretarial support staff, one administrative officer who monitors the management of resident funds in each nursing home, three professional

[7] While the industry standard is 2080 hours per employee, this figure does not take into consideration leave, holidays or necessary in-service training. From 2080, 6 personal days, 12 State paid holidays, 36 in-service and training days, and 21 vacation days were subtracted resulting in the 1480 figure. This figure is not adjusted for sick leave.

[8] The number of available surveyors in Column G is equal to the budgeted allocation of surveyor FTE PINs for Fiscal Year 2004.

staff (a supervisor, health occupations investigator and a nurse) who manage up to 500 abuse cases per year, one staff attorney who prosecutes abuse cases, two professional staff (a coordinator of special programs and a nurse) who work with citizens to take and triage 2000 complaints over the telephone, and three surveyors who have not completed the mandatory federal training and certification program and, therefore, cannot survey alone.

The delays and lack of timely workload completion are directly related to the staff shortfall. To accommodate the shortfall, to minimize impact on peoples' lives, and to be as effective as possible, the OHCQ has set the following priorities and objectives:

- To maintain an overall 12-month average for nursing home surveys.
- To complete 100 percent of nursing home follow-up surveys within 30 working days of the alleged compliance date.
- To complete 100 percent of the AMDC licensure surveys within 24 to 30 months of the previous survey.
- To investigate any complaint of serious and immediate jeopardy within two working days.
- To investigate any complaint of actual harm within 30-days.
- To complete 100 percent of nursing home quality assurance surveys within six months of the last annual re-certification survey.
- To investigate 90 percent of the complaints alleging the potential of harm within 120-days of receipt.

Assisted Living. State law requires at least one survey per year in each of Maryland's 2000 assisted living programs.[9] In Fiscal Year 2004, the OHCQ was only able to accomplish 428 surveys or 3.9-percent of the required annual surveys. Although there are other reasons for the inability to accomplish this requirement, lack of resources is a primary concern.

Chart 4. Assisted Living Shortage	
Current Number of Surveyors	17.00
Number of Surveyors Required	40.74
Surveyor Shortage	**-23.74**

Table 2 indicates a total of 30 staff in the Assisted Living Unit. There are 17 professional staff persons who are assigned to do survey work only. The unit also includes an appropriate infrastructure necessary to support the surveyors' activities. This 13 member support system includes: three team leaders or coordinators who schedule surveys, assign and triage complaints and manage information required for State purposes, five clerical or secretarial support staff; one nurse who manages the help desk to provide technical assistance to assisted living providers; two professional staff (a nurse and an administrative officer) who work with citizens to take and triage 400 complaints and referrals, and two coordinators of special programs that provide various administrative services.

[9] Health-General Article, Title 19, Subtitle 18, Annotated Code of Maryland.

Some of the problems the OHCQ faces with the assisted living statute include:

- Overreaching Nature of the Program. The program is overreaching and attempts to regulate providers that are unable to meet standards. Surveyor time is spent teaching, training and providing technical assistance to providers.

- Sanction Rates are High. The number of sanctions is high compared to other programs. When a sanction is initiated, it is necessary to take surveyors away from their survey duties to prepare for prosecution and hearing.

- Agency Coordination. When the program was initiated in 1996, the intent was for the Department of Aging to survey all of the homes with 4 to 16 beds. Because of budgetary constraints, the local Area Agencies on Aging have turned this work over to the State further exacerbating the resource issue.

To deal with these issues, in 2003 the OHCQ began a major evaluation of the assisted living program. In the 2005 session, the Department plans to submit legislation that will redefine assisted living. This should make the workload of this program more manageable.

In light of the staffing problems related to this program, OHCQ has set the following priorities and performance measures:

- To investigate any complaint that alleges a serious and immediate jeopardy within two working days.
- To investigate any complaint of actual harm within 30 working days.
- To complete 100 percent of the licensure surveys of assisted living programs for facilities with 17 or more beds.
- To complete 100 percent of the licensure surveys for assisted living programs that participate in the Medicaid Home and Community Based Services Waiver for Older Adults.

Group Homes for the Developmentally Disabled. State law requires an annual survey of each group home licensed by the Developmental Disabilities Administration.[10] In 1989, the Maryland Disability Law Center (MDLC) filed a lawsuit against DHMH for failure to meet this requirement. For the past four to five years, the OHCQ has increased its survey activity to about 50 percent of what is required. Follow-up surveys to determine actual corrective action have been sparse. It should be noted that recent newspaper articles have focused again on quality activities in group homes and questioned proper regulatory oversight.

Chart 5. Group Homes for the Developmentally Disabled Shortage	
Current Number of Surveyors	26.00
Number of Surveyors Required	36.96
Surveyor Shortage	**-10.96**

[10] Health-General Article, Title 7, Subtitle 9, Annotated Code of Maryland.

Table 2 indicates that a total of 37 staff in the Developmental Disabilities Unit, of which 26 professional staff persons who are assigned to do survey work only. The unit also includes necessary infrastructure to support the surveyors' activities. This 11 member support system includes: one senior manager who also manages the assisted living program; three team leaders or coordinators to assign and triage complaints and manage information required for federal and state purposes, six clerical or secretarial support staff, and one administrative staff person that is temporarily being loaned to the Assisted Living Unit.

The delays and inability to complete mandated workload are directly related to the staff shortfall. To accommodate the shortfall, to minimize impact on peoples' lives, and to be as effective as possible, the OHCQ has set the following priorities and performance measures for Fiscal Year 2005:

- To conduct licensure surveys of 40 percent of the licensed providers.
- To complete 100 percent of the highest priority self-reported incidents.
- To investigate any complaint of a serious and immediate jeopardy within two working days.
- To investigate any complaint of actual harm within 30 working days.

Hospitals/HMOs. The Hospital and HMO Unit is relatively small when compared to other units within the OHCQ. However, increased responsibilities have made the unit equally significant as other regulatory activities. Five years ago, legislation granting consumers the right to appeal certain decisions made by managed care organizations was enacted. The law mandated that DHMH investigate all complaints in HMOs related to quality. In addition, this new legislation required the Department to conduct annual survey in all HMOs.

Chart 6. Hospitals/HMOs Shortage	
Current Number of Surveyors	3.89
Number of Surveyors Required	5.33
Surveyor Shortage	**-1.44**

Concerns have also been raised about patient safety in hospitals. Following the 1999 Institute of Medicine Report that indicated that as many as 98,000 deaths and one million injuries occur each year from medical errors, the General Assembly instructed the Maryland Health Care Commission to undertake a study of patient safety in Maryland. As a result of this effort, the Department initiated limited mandatory reporting of adverse events that cause death or serious disability in hospitals. Maryland's program is consistent with other State programs that are being implemented nationally. Currently, the OHCQ is receiving reports of about 100 adverse events per year. Although the hospitals submit a root cause analysis or internal investigation with the adverse event, it is imperative that the OHCQ continue to monitor these reports to ensure that proper actions are identified and taken.

In addition, because of the problems identified at Maryland General Hospital in January 2004, it is clear that additional oversight of hospitals, or at least the accreditation organizations that survey them, is required. Both of these new efforts, patient safety and oversight of accreditation organizations, will require new staff.

Finally, an important, but often unnoted responsibility of this unit is to conduct annual surveys of each of the ten State prison infirmaries. State law actually requires two surveys per year, but because of short staffing, the OHCQ is only conducting 50 percent of these surveys. The State mandated work is in addition to hospital complaint investigations and validation surveys that are required by CMS.

Table 2 indicates a total of six staff for this unit, of which four professional staff persons who are assigned to do survey work only. This unit also includes a support infrastructure necessary to maintain the surveyors' activities. This two member team includes: one program manager and one secretarial support

In order to better manage resources, the OHCQ has set the following priorities for the hospital and HMO unit:

- To evaluate all hospital adverse event reports and RCAs.
- To complete 100 percent of alleged Emergency Medical Treatment and Labor Act (EMTALA) complaints within five working days of receipt (Note: these were previously called "anti-dumping complaints.").
- To complete 100 percent of all hospital validation surveys requested by the CMS within the timeframe specified by CMS.
- To investigate any complaint of serious and immediate jeopardy within two working days.
- To investigate any complaint of actual harm within 30 working days.
- To investigate 90 percent of all complaint investigations requested by CMS within 45 calendar days.
- To complete ten annual inspections of the ten hospitals located within correctional facilities.

Laboratories. The laboratory regulatory unit was transferred from the Laboratories Administration to the OHCQ in the mid-1990's. Although there are State laws and regulations governing laboratories in the State, oversight has primarily been under federal auspices and is federally funded. Similar to hospitals, State work has been left to accreditation organizations. Recent evidence suggests that federal and accreditation organization oversight may not be sufficient to ensure quality services. "Current workload requirements" are based on limited State oversight and may not be reflective of workload in Fiscal Year 2005 and later.

Chart 7. Laboratories Shortage	
Current Number of Surveyors	5.02
Number of Surveyors Required	5.66
Surveyor Shortage	**-.64**

Table 2 indicates a total of 10 staff in the Laboratories Unit, of which five professional staff are assigned to do survey work only. This unit also includes a support infrastructure necessary to maintain the surveyors' activities. This five member team includes: one team leader or coordinator who schedule surveys, assign and triage complaints and manage information required for State and federal purposes, one cytotechnologist, and three clerical or secretarial support staff.

The OHCQ has set the following priorities for the laboratory regulatory unit:

- To maintain federally required and budgeted survey activity.
- To investigate any complaint of serious and immediate jeopardy within two working days.
- To investigate any complaint that could result in actual harm within 30 working days.
- To process requests for licensure, permits and certificates within two months of application

Ambulatory Care Programs (includes Home Health Agencies, Residential Service Agencies, Nursing Referral Services Agencies, Nursing Staff Agencies, Hospice, etc). The ambulatory care program has grown significantly in the past 15 years. In 1988, there were approximately 150 programs; today there are more than 800. This is reflective of the change in the health care delivery system and the shift of institutional care to community based services. Home health agencies (70 of the agencies) are strongly regulated by CMS, and are surveyed at least every three years. Other entities, including residential service agencies (RSA), nurse referral services agencies (NRSA) and nurse staff agencies provide equivalent services, but are not held to the same standard.

Chart 8. Ambulatory Care Programs Shortage	
Current Number of Surveyors	6.00
Number of Surveyors Required	16.89
Surveyor Shortage	**-10.89**

Maryland, along with other states, has seen an explosion in the number and type of providers of home-based or community-based health care. Concepts like *aging in place* and other factors, such as the Olmstead decision, have resulted in an increase demand for these types of services, which have made it one of the fastest growing industries in the United States. With the increasing numbers of elderly, disabled and medically complex individuals living in the community, we expect to see more problems.

In January 2004, a case was identified of an RSA incorrectly preparing a pediatric medication that resulted in a child's death; in the summer of 2004, the OHCQ investigated a complaint where a nurse from an NRSA took a patient to a shopping mall and left the individual with severe dementia in car while she went to buy a dress. The client was found wandering in the parking lot.

Expansions of community and home based service waivers and the growing desire of individuals to remain in their own homes have resulted in OHCQ experiencing an increase in the number of applications from individuals, many of whom are not qualified, seeking to become licensed as community-based health care providers. Given the State's current discussions about managed long term care, we expect that this trend will continue. Therefore, quality oversight of these programs will become increasingly important.

Table 2 indicates a total of 10 staff in the Ambulatory Care Program, of which six are professional staff persons who are assigned to do survey work only. This unit also includes a support infrastructure necessary to maintain the surveyors' activities. This four member team includes: one team leader or coordinator who schedule surveys, assign and triage

complaints and manage information required for State and federal purposes and three clerical or secretarial support staff.

The delays and inability to complete mandated workload are directly related to the staff shortfall. To accommodate the shortfall, to minimize impact on peoples' lives, and to be as effective as possible, the OHCQ has set the following priorities and performance measures for the Ambulatory Care Program Unit for Fiscal Year 2005:

- To maintain overall 36 month average for home health agency surveys (federal priority).
- To investigate any complaint of serious and immediate jeopardy within two working days.
- To investigate any complaint of actual harm within 30 working days.
- To process requests for licensure within six months of application for RSA licensure and within eight weeks of application for other ambulatory care programs.

Conclusion

The OHCQ Labor-Hour Analysis, which contains data for surveyor requirements for each of OHCQ's regulatory units, is included in Appendix A. This analysis found, based on current mandatory federal and State statutory and regulatory requirements; the OHCQ is experiencing a surveyor shortage of approximately 55 FTEs PINs. The analysis does not consider any administrative, clerical, information technology personnel or other staff necessary to sustain survey activities.

Clearly, the loss of positions in OHCQ and the staffing shortages has resulted in a decreased ability to complete surveys and to provide a timely response to consumer complaints. The Secretary is committed to addressing OHCQ's staffing issues. As a first step, the Department was able to include four additional FTE PINs for OHCQ in this year's operating budget, even under these fiscally challenging times. OHCQ will continue to prioritize workload and efforts on those areas where it can have the greatest impact to protect Maryland citizens and improve quality.

APPENDIX A

Analysis of Staffing Levels at OHCQ

OHCQ Labor-Hour Analysis

Requirements	A. # of Facilities or Complaints	B. Survey Requirement per Year*	C. Total Number of Surveys Required	D. Hours Required per Survey	E. Total Hours Required for Survey Activity (CxD)	F. Number of Surveyors Required (E/1480)	G. No. of Surveyors	H. Staff Overage or Shortage
Long Term Care								
Nursing Homes								
Federal Survey	242	1	242	157	37,994	25.67	22.00	(3.67)
Complaints - High Level Actual Harm	748		748	16	11,968	8.09	6.00	(2.09)
Complaint Survey Follow-Ups	61		61	16	976	0.66	0.00	(0.66)
Complaints - Moderate/Low Level Actual Harm or Potential for Harm	964		241	10	2,410	1.63	0.00	(1.63)
State Survey	242	1	242	21	5,082	3.43	4.00	0.57
Adult Medical Day Care								
Initial Surveys	20	1	20	22	440	0.30	0.25	(0.05)
Renewal Surveys	114	0.5	57	34	1,938	1.31	0.65	(0.66)
Complaints	50		50	18	900	0.61	0.50	(0.11)
Expansions	17	1	17	14	238	0.16	0.10	(0.06)
Assisted Living								
Initial Surveys	695	1	695	45	31,275	21.13	6.00	(15.13)
Renewal Surveys	1178	1	1178	18	21,204	14.33	7.00	(7.33)
Complaint Investigations	355	1	355	22	7,810	5.28	4.00	(1.28)
Developmental Disabilities								
Site Surveys	2500	1	2500	16	40,000	27.03	14.00	(13.03)
Unnanounced Health & Safety	178	3	534	6	3,204	2.16	2.00	(0.16)
Incident Investigation	4786		398	20	7,960	5.38	7.00	1.62
Annual Death Investigations	135	1	135	13	1,755	1.19	1.00	(0.19)
Annual Death Investigation Backlog	100	1	100	13	1,300	0.88	1.00	0.12
ICF/MR	4	1	4	120	480	0.32	1.00	0.68
Hospitals & HMOs								
Validation Surveys	3		3	210	630	0.43	0.43	0.00
Within Correctional Facilities - Surveys	11	2	22	25	550	0.37	0.30	(0.07)
Within Correctional Facilities - Complaints	5		5	8	40	0.03	0.03	0.00
Federal Complaints	28		26	24	624	0.42	0.42	0.00
State Complaints	360		360	8	2,880	1.95	1.70	(0.25)
UR/Credentialing, Other Reviews and Surveys	70		70	2	140	0.09	0.00	(0.09)
Mortality Review - Psych Hospitals	28		28	8	224	0.15	0.07	(0.08)
Hospital Follow-Up Surveys	20		20	8	160	0.11	0.01	(0.10)
Patient Safety								
Review of Patient Safety Plans	70		70	3	210	0.14	0.00	(0.14)
Mandatory Reporting RCA Review	100		100	4	400	0.27	0.00	(0.27)

OHCQ Labor-Hour Analysis

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Patient Safety Program Surveys	70		70	8	560	0.38	0.00	(0.38)
Health Maintenance Organizations								
Surveys	9	1	9	110	990	0.67	0.67	0.00
Complaints	46		46	5	230	0.16	0.16	0.00
Residential Treatment Centers								
Complaints	28		28	8	224	0.15	0.10	(0.05)
Validation Surveys	14	0.2	3	10	30	0.02	0.00	(0.02)
Ambulatory Care Programs								
Home Health Agencies	53	1	53	100	5,300	3.58	2.65	(0.93)
Home Health Agencies - Complaints	14		14	25	350	0.24	0.00	(0.24)
Dialysis Centers - Surveys	120	0.33	40	46	1,840	1.24	1.75	0.51
Dialysis Centers - Complaints	23		23	21	483	0.33	0.00	(0.33)
Hospice Care Programs - Surveys	32	1	32	43	1,376	0.93	0.00	(0.93)
Hospice Care Programs - Complaints	4		4	21	84	0.06	0.00	(0.06)
Ambulatory Surgical Centers	316	0.33	104	18	1,872	1.26	0.60	(0.66)
Outpatient Physical Therapy	154	0.33	51	18	918	0.62	0.00	(0.62)
CORF	12	1	12	18	216	0.15	0.00	(0.15)
Portable X-Ray	10	1	10	18	180	0.12	0.00	(0.12)
Residential Service Agencies	319	1	319	27	8,613	5.82	1.00	(4.82)
Major Medical Equipment	171	1	171	18	3,078	2.08	0.00	(2.08)
Nurse Staffing								
Renewal Surveys	576	0.33	190	3	570	0.39	0.00	(0.39)
Nurse Referral Service Agencies	60		60	2	120	0.08	0.00	(0.08)
Laboratories								
Independent Labs and Hospitals - Survey	162	0.29	47	19	893	0.60	0.39	(0.21)
Independent Labs and Hospitals - Complaints	34		34	22	748	0.51	0.51	0.00
Independent Labs and Hospitals - Validation	50	0.1	5	81	405	0.27	0.27	0.00
Phyiscian Offices	488	0.5	244	10	2,440	1.65	1.57	(0.08)
Cytology - Profeciency Testing	61	1	61	13	793	0.54	0.52	(0.02)
Cytology - Surveys	61	0.1	6	8	48	0.03	0.03	0.00
Coagulation	15	1	15	7	105	0.07	0.07	0.00
Cholesterol Testing	18	1	18	7	126	0.09	0.09	0.00
CLIA Waiver	35	1	35	13	455	0.31	0.31	0.00
Proficency Testing	1000	1	1000	2	2,000	1.35	1.01	(0.34)
Tissue Banks	8	1	8	11	88	0.06	0.06	0.00
Complaints	20		20	14	280	0.19	0.19	0.00

OHCQ Labor-Hour Analysis

Requirements	A. # of Facilities or Complaints	B. Survey Requirement per Year*	C. Total Number of Surveys Required	D. Hours Required per Survey	E. Total Hours Required for Survey Activity (CxD)	F. Number of Surveyors Required (E/1480)	G. No. of Surveyors	H. Staff Overage or Shortage
Community Mental Health								
Licensed Provider Surveys	113	1	113	24	2,712	1.83	1.80	(0.03)
Approved Provider Surveys	84	1	84	24	2,016	1.36	2.00	0.64
						150.63	95.21	(55.42)
*Key for Column B:								
1=Annual								
.5=Every 2-Yrs								
.33=Every 3-Yrs (Periodic)								
.15=15% of the Total								
.10=10% of the Total								