

Testimony on Oversight of Group Homes
by Dr. Tricia Tomsco Nay, Executive Director and Acting Medical Director
Office of Health Care Quality
Bernard Simons, Deputy Secretary for Developmental Disabilities
Department of Health and Mental Hygiene

Hearing before the House Health and Government Operations Committee
January 28, 2015

Chairwoman Conway and Members of the Committee,

Thank you for the opportunity to provide testimony regarding the oversight of group homes for medically fragile foster care youth that are licensed by the Department of Health and Mental Hygiene (DHMH), surveyed by the Office of Health Care Quality (OHCQ), and funded by the Department of Human Resources (DHR).

OHCQ has established a page on its website for information about these providers. The page contains legislative updates, reports, deficiency statements, plans of correction, and reference materials. Please see:

<http://dhmh.maryland.gov/ohcq/SitePages/GroupHomesOversight.aspx>

In our testimony today, we will review new recommendations, report on the progress of past recommendations, and discuss the status of providers.

It is important to understand that medically fragile children have very complex and evolving psychological, social, and medical needs requiring around-the-clock care and supervision. These children might need a motorized wheelchair for mobility, a feeding tube to receive nutrition, and a ventilator to support breathing. A recent review of 36 medically fragile children in Maryland revealed that they took as many as 35 medications each day and required 3,600 medical visits per year. That's an average of 100 medical visits for each child, each year. Though many medically fragile children remain with their families or in foster homes, the children we are discussing are in a group home.

What was the outcome of the task force?

In November 2014, Bernie Simons, the Deputy Secretary of Developmental Disabilities, and Tricia Tomsco Nay, Executive Director and Acting Medical Director of OHCQ, convened the Task Force on the Quality of Services for Individuals with Developmental Disabilities. DHR and the Governor's Office for Children were integrally involved in this group. In addition to our current initiatives, the task force proposed three recommendations. Today, we are sharing these for the first time. The recommendations are:

1. For the medically fragile foster children in group homes who are enrolled in the Rare and Expensive Case Management (REM) Program, DHMH will require that the REM case manager coordinates each child's care and communicates with all involved.
2. DHR and DHMH will work together to develop and implement transition plans for medically fragile foster children to ensure a smooth transition to appropriate services at age 21.
3. By April 2015, DDA will implement a financial incident reporting system for DDA providers, similar to the process implemented by DHR for children's providers.

What is the process on past recommendations?

In October 2014, DHMH released a report, Review of Services for Medically Fragile Foster Care Youth, which included five recommendations:

1. OHCQ recommends clarification and documentation of the roles and responsibilities within and between agencies that provide oversight to these providers (January 2015).

Documents explaining the roles and responsibilities of the involved agencies and their coordination will be posted on the OHCQ website in early February.

2. Each government agency should maximize data point collection for each oversight activity it carries out. Analysis of those data should be shared with other agencies, as appropriate, through formal processes (June 2015).

The agencies continue their work toward this recommendation.

3. The initial licensure process for programs for medically fragile children should be reviewed and revised to ensure that applicants have a sustainable business model (February 2015).

The agencies continue their work toward this recommendation.

4. As the lead on investigations of complaints and self-reported incidents, OHCQ should develop formal processes to ensure that coordination with other agencies occurs in a timely and consistent way (January 2015).

In addition to regular communication between agency staff as issues arise each day, OHCQ and DHR have scheduled weekly calls to review the status of on-going issues.

5. The children's unit at OHCQ should receive an additional position to serve as a coordinator to implement these recommendations and ensure oversight over the medically fragile children's homes (December 2014).

OHCQ received a new position and is waiting for it to be posted. Of interest to the Committee, on February 4th, Carol Fenderson will be joining OHCQ as the Deputy Director of State Programs. Her oversight will include the developmental disabilities children's unit. Ms. Fenderson's 27 years of experience in public human services, including her tenure at DHR as Contracts Manager, will serve the State well.

How did state agencies review the death of a medically fragile child at Lifeline?

In May 2014, OHCQ conducted a survey at Lifeline, Inc. that revealed health and safety concerns. An OHCQ surveyor indicated to Lifeline that there were significant concerns that would likely lead to an enforcement action. Shortly thereafter, Lifeline indicated that it would close. DHR and other agencies developed a transition plan to address the needs of each child and relocated all of the children by early July 2014.

In July, a medically fragile child at Lifeline died. The death certificate lists the cause of death as complications of cerebral palsy which was due to a remote head trauma that the child sustained prior to entering the foster care system. The manner of death is homicide because it was due to the trauma. As is usual in homicide investigations, the States Attorney's Office is not releasing the autopsy report to the public at this time. Prior to finalizing the death investigation, OHCQ staff reviewed the death certificate and autopsy report, and discussed the findings with the Office of the Chief Medical Examiner. There was no evidence that the death of this child was related to actions or inactions on the part of Lifeline.

Is Second Family, Inc., currently in compliance with the regulations?

OHCQ has issued multiple deficiency statements to Second Family, Inc., since July 2014. The provider has submitted acceptable plans of correction for all of these deficiencies and is currently in compliance with the regulations. OHCQ will continue to perform unannounced relicensure surveys and to investigate complaints and self-reports at Second Family, as well as the two other providers, Center for Social Change and Total Quality.

What is our common ground?

DHMH continually strives to protect the health, safety, and welfare of vulnerable populations while efficiently and effectively utilizing our limited resources. While progress has been made, there are still improvements to be implemented. It is essential that everyone's voice is heard in this process -- individuals with developmental disabilities, family members, friends, advocates, providers, associations, government agencies, legislators, and other stakeholders. Our common ground is the individuals that we serve. We examine the issues from different perspectives, and it is only through our combined efforts that we will succeed in enhancing the quality of services for individuals with developmental disabilities. We look forward to working with the legislators and other stakeholders on our common goal. We thank you for your continued attention to this very vulnerable population.