F I S C A L I M P A C T R E P O R T

SPONSOR Fischmann **ORIGINAL DATE** 02/23/11 **LAST UPDATED** **HB**

SHORT TITLE Enact "Medical Harm Disclosure Act" **SB** 383

ANALYST Esquibel

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY11	**FY12**		
	$50.0-$65.0	Recurring	DOH/Patient Safety Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Non-Rec	Fund Affected
FY11	**FY12**	**FY13**		
	$50.0-$65.0	$50.0-$65.0	Recurring	DOH/Patient Safety Fund

(Parenthesis ( ) Indicate Revenue Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY11	FY12	FY13	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total		Unknown	Unknown		Recurring	General Fund/DOH

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Public Regulation Commission (PRC)
Department of Health (DOH)
Medical Board (MB)

SUMMARY

Synopsis of Bill

Senate Bill 383 (SB383) would enact the Medical Harm Disclosure Act. This act would establish a requirement for hospitals, outpatient facilities, nursing homes, and intermediate health care facilities to report medical harm to patients that occurred in their facilities to the Department of Health (DOH) within five days of occurrence, or if an emergent threat, within 24 hours. If the health care entity has multiple divisions or subsidiaries, reporting of medical harm would be required by each division or subsidiary.

Health facilities will be required to create facility-wide patient safety programs to routinely review patient records for medical harm, analyze these events to determine if they were preventable, and implement changes to prevent future occurrences. Facilities will also be required to provide an annual summary of its patient safety program to the DOH.

Under the proposed Act, facilities are required to inform patients, their agents, parents, guardians, or surrogates of the medical harm event prior to the required reporting to the DOH. The facility would be required to interview the patient, family members and parties responsible for the patient about the medical harm event and document this in the patient's medical record. If the medical harm event contributed to the patient's death, the facility will be required to include that event as a contributing cause on the patient's death certificate.

The legislation requests that the DOH establish a "medical event advisory committee" that would include a consumer, medical professional, epidemiologist, member of the New Mexico Hospital Association, member of the New Mexico Medical Review Association, an infection control specialist, a health insurance underwriter, a representative of a consumer advocacy group, a researcher from a state university, a representative of the New Mexico Board of Nursing, and a representative of the New Mexico Medical Board. This committee is to assist DOH in developing the processes to carry out this legislation.

In addition, under the provisions of SB383 DOH would be required to do the following:

- quarterly, check the accuracy of information reported;
- annually, conduct random reviews of health facility medical records;
- disclose to the public its methodologies, analysis and validation;
- quarterly, publish the details of fines assessed against facilities for non-reporting;
- annually, submit a report to the appropriate legislative committee that includes recommendations;
- publish the report on the DOH web site;
- include in the report health facility specific data on medical harm events in a stratified data format, that is in plain language;
- quarterly, provide information pursuant to its regulatory duties accessible on the DOH web site;
- investigate a report concerning an ongoing threat or imminent danger within 48 hours;
- ensure compliance with this Act as a condition of licensure;
- the DOH Health Facilities Licensing and Certification Bureau shall collect and share the information while protecting patient confidentiality;

- promote awareness for consumers and families by including reporting information on posters that must be posted in facilities, the DOH website, and on any Health Facility Licensing & Certification correspondence.

FISCAL IMPLICATIONS

Senate Bill 383 creates the "patient safety fund" and adds a patient safety surcharge to licensure fees charged to health facilities administered and collected by the Department of Health. The patient safety surcharge would be set up to $1 for each licensed bed or up to $5 per license for facilities not licensed by beds. This surcharge will be used to establish the patient safety fund to be used by the DOH to carry out the requirements of the Medical Harm Disclosure Act created by SB383.

The Department of Health (DOH) indicates the amount of revenue estimated to be generated through the SB383 proposed annual patient safety surcharge on licensing fees DOH charges to health facilities is estimated to generate between $50 thousand and $65 thousand. DOH indicates this revenue may not be adequate to cover costs that will be associated with implementing this legislation.

Continuing Appropriations Language

This bill creates a new fund and provides for continuing appropriations. The LFC has concerns with including continuing appropriation language in the statutory provisions for newly created funds, as earmarking reduces the ability of the legislature to establish spending priorities.

ADMINISTRATIVE IMPLICATIONS

Additional administrative staff would be required by DOH to oversee and manage the activities of the Medical Event Advisory Committee proposed in SB383 and to research, develop and promulgate the new rules that would be associated with this legislation.

Affected providers might also be required to add staff, processes and procedures for collecting and reporting this information at each of their facilities.

OTHER SUBSTANTIVE ISSUES

DOH indicates the reporting of medical errors is an important issue and is fundamental to error prevention according to the Institute of Medicine. The focus on medical errors that followed the release of the Institute of Medicine's report *To Err Is Human: Building a Safer Health System* (1999) focused on the suggestion that preventable adverse events in hospital were a leading cause of death in the United States. This report emphasized findings from the Harvard Medical Practice Study (1991) that found that more than 70 percent of errors resulting in adverse events were considered to be secondary to negligence, and more than 90 percent were judged to be preventable. The IOM report also emphasized the importance of reporting errors, using systems to "hold providers accountable for performance," and "provide information that leads to improved safety".

ALTERNATIVES

DOH suggests a process similar to the Health Facility Acquired Infection voluntary process could be a first step and would be less costly and impacting for DOH and facilities as the processes proposed in SB383.

RAE/mew