Senate Health and Welfare Committee

February 4, 2016

S. 40

Laura Pelosi, MMR on behalf of VAHHS, VHCA

- Opposed to S. 40 to the extent incorporates review of deaths of vulnerable adults that occur in health care and long term care facilities.
- Facilities are heavily regulated entities at the federal and state level.
- Untimely deaths are reported to DLP, APS, CME, and can also be reviewed by relevant professional licensing authorities.
- Investigations by multiple authorities are common, and can lead to regulatory action including corrective action, penalties, and loss of Medicaid/Medicare certification, as well as professional disciplinary action against a licensed professional.
- Facilities have internal quality review teams that assess incidents and adjust policies, procedures and practices accordingly.
- Vulnerable adult is defined in 33 V.S.A. §6902 to include an individual 18 or older who is a resident of a nursing home or other licensed facility, patient of a hospital or psychiatric unit, or has received personal care services for more than one month, or is impaired for a variety if enumerated reasons.
- The majority of deaths that are reported occur in facilities, and the pool of cases to be reviewed are those already reviewed as necessary pursuant to federal and state law- §6962(b)(1)- review will include this deaths that are the subject of an APS investigation, was the subject of a CME investigation or under the jurisdiction of CME, or whose death was due to or suggesting abuse or neglect.
- Additional review by the type of team envisioned in the bill is duplicative, unnecessary, will subject to providers to more burden without any clearly identified corresponding benefit.

- **The bill should exempt from review those deaths that occur in a health care facility as defined in 18 V.S.A. §9432(8) and long term care facilities as defined in 33 V.S.A. §7102(2).**

Additional concerns about the bill:

- §6961(b)(1)- membership of the review team- no hospital or long term care facility representation. Makeup of the team as proposed does not contain the relevant expertise that would be necessary to understand the operations, practices, policies, and care delivery.
- §6961(c)- meetings are to be convened by the Attorney General's Office, the chief law enforcement office, which underscores provider concerns about the intent of the bill- enforcement minded rather than educational and informational.

- §6962(a)- the Team is given the authority to determine its own policies and procedures for the review of deaths – this should be clear so that providers understand what procedures will be used- it should not be subject to the discretion and whim of the team.
- §6962(b)(2)- allows for initiation of a review before the conclusion of a pending APS or law enforcement investigation or criminal prosecution. Again raises questions about the intent of the bill, does not mesh with the critical confidentiality provisions §6963 which protect the proceedings and records of the team from discovery or admissibility as evidence in a civil or criminal case.
- §6962(3)- allows the team to determine which criteria it will use to select which deaths to review- again, the team should not be given the discretion to determine this as it sees fit. The criteria to be used for selection should be clearly spelled out in the bill.
- §6963(a)- need to know whom on the team is responsible for maintaining records and confidentiality, and how.
- §6963(b)- this section needs to clearly state that no person or provider shall be identified.
- §6964 needs to include language that makes it clear that provider peer review material and internal quality assurance and review material is exempt from access by the team. This section should also make it clear that protected health information cannot be produced unless it otherwise meets disclosure requirements under the patient privilege law. This section should also clearly state who on the team has the authority to request information from 3rd parties.