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State of Maine

Human Resources Committee

AMHI HEARINGS

Room 228 Jan. 26th, 1989

State House

Good morning, welcome to the morning session of the H.C. Committee Meeting on Human Resources, my name is Paul Gauvreau and I serve as Senate chair and on my left is Senator Peter Manning who serves as House chair of the committee. The purpose of hearings today is an educational one to afford the committee members an opportunity to learn the (command) complex? nature of the problems that beset our mental health system in general with particular focus on the system at the Augusta Mental Health Institute and at the sister institute in Bangor, the Bangor Mental Health Institute. The purpose of the hearings today is for the committee to gain a better understanding of the problems which are present in our mental health system so that we can fashion appropriate (appropriations) recomdations to the legislature as far as any plan of correction for any particular _____ we might feel appropriate. We have for todays session requested that three individuals, Susan Parker, AMHI Superintendent Deutmiller and the present acting administrator of that facility, Dr. Walter Rohm. The committee will determine whether or not additional individuals will be asked to make presentations to the committee at the close of this afternoon following today's proceedings. I would like to introduce the members of the committee starting at my far right. Representative Mary Cathcart of Orono. Seated to her left would be Rep. Christine Burke of Vassalboro and then Rep. Peggy Pendleton of Scarborough and to her left is Jean Dellert of Gardiner, Senator Ed Randall of Machias, to my right is Senator Bonnie Titcomb of Cumberland County, and Portland and Rep. Edward _____ Bangor to his left and Rep. Michael _____ is seated to his left.

At this point the Committee is pleased to welcome Commissioner Susan Parker, whom I understand will make a prepared statement

to the committee. At the close of her presentation you will be invited to ask questions.

SP: Thank you very much Sen. Gauvreau. Good morning Sen. Gauvreau, Rep. Manning and members of the committee. I am Susan Parker, Commissioner of Mental Health and Mental Retardation. I am very pleased to meet with you this morning to discuss the situation at AMHI. Alot of things have happened at AMHI since my arrival in July of 1987. These events have painted a grim picture of a very troubled mental health insitution. First there was an investigation by the Commission on Overcrowding between Sept. and Dec. of 1987, which did in fact reveal serious problems of patient care as a result of a chronic overcrowding ~~or~~ and understaffing. Then there was the failed effort to retain Medicare certification between Feb. and May of last year. There were patient deaths during the summer of 1988 and then a follow-up investigation into patient care practices within the institution and lastly an on-going assessment of patient care by the Department of Human Services for 47 of their wards under the care of adult protective services. The fact is that history has finally caught up with us. We are here this morning to discuss with you how we got into this serious situation but we're also here to discuss with you how we intend to get out of it. The following is an anecdote which illustrates to me a grim but a very real solution to the sad situation. When I came back to Maine in July of 1987 to take this job I was told that in 1984 the mental safety net that was constructed over the bridge that connects the two parts of Augusta, separated by the Kennebec River, was constructed at least in part because AMHI patients were jumping to their deaths. That was a real indicator to me that something was exceedingly wrong. The census had been cut

in half at AMHI since 1973 under the social policy that swept the country called deinstitutionalization. This happened despite the fact that communities resources were very inadequate for people with mental illness not to mention their families. Problems became worse during the late 70's and the 1980 because a comprehensive plan for the delivery of comprehensive services had never been developed. When you look at it, people with mental health and mental illness problems haven't had much choice all these years except to return to the institutions and it doesn't surprise me one whit that many were desperate enough to jump off the bridge. Think about their families. But obviously the metal safety net can't be the only solution.

Nancy, could we have the first chart.

The chart that will immediately rest on the easel here will illustrate the actually the staff to patient ratio at AMHI and it will show what has happened since fiscal year 1980. This will illustrate quite clearly that the lack of planned community services has had it's impact on AMHI. Since 1984 AMHI has been adding nearly 2 patients per month to it's base population. At the close of fiscal year 1988 the facility admitted an all time record number of people, that of 1477. Between 1980 and the spring of 1987 despite the influx of patients to AMHI a total of 17 staff were added to the facility. Quite obviously the staff/patient ratio has fallen steadily over a 5 year period. My arrival here in July of 1987 coincided with the 8th Medicare visit in 4 1/2 years in which officials either warned the administration that AMHI problems needed to be fixed or the facility would fail in its certification until corrective action was taken. I would also

+96 people
+17 staff

like to point out that at the same time the sister institution up in Bangor was also experiencing its problems. The resources at BMHI have been severly strained. Among other problems a month prior to my arrival long standing management difficulties erupted into extreme employee dissatisfaction that was about to result in an employee who was about to suffer a reprimand. Diciplinary action I think it was called. The protest that occurred at BMHI needed to have immediate attention from the central office the department. We provided that. Fortunately we have succeeded in making some high level management changes in March of 1988 which have helped to eleviate the strain on the Bangor Mental Health Institute.

And now I would like to move on to another topic. Specifically the State Mental Helath Plan and the investigation into the overcrowding situation. Alot has been said over the last couple of weeks about the administration not providing information to the legislature. I am really disturbed by that. I would like to describe what we've been doing over the last year and a half and I think once you have heard what I've had to say you will agree that we have, in fact, collaborated with the legislature regarding the situation at AMHI. The 113th legislature understood that there was no comprehensive plan in Maine nor was there adequate understanding of the conditions at AMHI and BMHI. Two pieces of legislation were passed. The first mandated that the State Department of Mental Health and Mental Retardation should put together a state plan. Secondly, the 113th legislature established a commission to study overcrowding. These two events occured just prior to my arrival. When I took office I knew that we had serious problems in the Mental Health field and that the both the planning effort and the study of the institutions required

urgent attention. Just to give you an illustration of the degree to which these two items assumed priority status in my administration, let me also tell you that this department must oversee the Pineland down in Pownal, the Military and Navel Children's home in Bath, the Aroostook Residential Center up in the north, the Elizabeth Levinson Center in Bangor as well as BMHI. Those 6 institutions or facilities as we sometimes call them, combined with the community programs within the Bureau of Mental Retardation, Mental Health and Bureau of Children with Special Needs combine to give us alot of issues to deal with on a daily basis. Because mental health was such a priority in my administration some of these other situations have really assumed a, not a secondary status, but not the highest of the high priorities that we have with mental health. Nevertheless, senior staff, that is, 10 different individuals I call senior staff within the department were mobilized and I appointed several people to work with me to participate in the commission to study overcrowding. We committed significant time and resources to participate beginning Sept. of 1987. The members to the commission were the Commissioner, the Director of the Bureau of Mental Health and the Superintendents of AMHI and BMHI. From July through Dec. we prepared volumenous documentation. Much of it was on request, some of it was not and oral testimony on the physical plants of the institutes, the patient charecteristics, the admissions procedures and pressures and treatment issues. We also participated with Commission members in actual site visits to the institutions in which staff advocates, legislative members and citizens described in painful detail the impact of overcrowding and under staffing on patient care. During some instances, specific cases were cited, although the identity of the patients was not revealed. This was done in order to give

Info. Sept - Dec. 1987 re: OVERCROWD

Was it a crisis? No need for more study - Act on that info why not?

Committee members the more graphic sense of the reality of the institutes. During Jan. of 1988 the Commission devlivered it's interim report detailing the serious staffing problems at AMHI and BMHI and their impact on patient care. However, the Commission concluded that the response should be not to add more beds or staff to the institutes, rather the emphasis of the commission was to expand community resources.

NOT SO)

Secondly, we initiated the long over-due state wide planning process which is now the basis for our expanded Mental Health Service system initiated in the Sept. special session. Under the agess of the Governor's Mental Health Advisory Committee, specifically the Plan Development Committee, we agreed amongst ourselves that we would sponsor regional planning and to that end the Commission on overcrowding, and in its report, did express confidence in the design of our planning project as well as the anticipated outcome to that project. In the early months of 1988, in addition to our continued participation on the commission as it studied the community service needs, the department conducted 10 public forums in all reaches of the State and engaged over 1200 people in assessing needs and devising solutions in order to build a comprehensive Mental Health system in Maine. I, and top staff, attended each public forum. We presented the findings of the public forums as well as the planning efforts of the regional groups, directly to the Commission. Progress on the plan was reported on an ongoing basis and in July we actually distributed the results, not only to the Commission on Overcrowding but the Mental Health Sub-Committee on Appropriations and the Human Resources Committee as well as to individual legislatures who had interest in that. Although our original time table was to present a proposal to the 114th legislature for the 1990/1991

wasn't enough to fund this

ors

bienium the process was speeded up when we requested a $6.6 million dollar appropriation in the Special Session in Sept. to initiate plan activities this fiscal year. In our opinion people and patient care issues could not wait.

And now I will move on to conclusions about the State Mental Health Plan and the overcrowding conditions.

It seems to very clear to all of us, the Department, the Commission and other knowledgable people that the only permanent solution to severe overcrowding and understaffing is to provided badly needed community services to mentally ill persons and their families. Unfortunately, this approach, that is, the building of community services takes far more time than all of us would wish. Within weeks after the Commissions' conclusion that the answer was not to add beds or staff, Medicare indicated for the 9th time in 5 years the presence of serious problems in some of the units at AMHI.

NOT THE CASE;

And now to move on to a Medicare cronology.

The series of events regarding Medicare were as follows:

On Feb. 23rd Medicare actually decertified AMHI, which means that unless we succeed in addressing the problems in a follow-up survey we would loose funding. Medicare surveys do not have precise and quantifiable standards and it was, therefore, difficult to measure our deficiencies against a standard that was numerically something we could actually look at. It's a moving target. Nevertheless, in view of past Medicare survey results and in the context in a slight downward trend in average daily population - Ralph, may we have the

population chart please - we decided we could regain certification and the Superintendent of AMHI drew up a plan of correction. In March and April we reported our progress to the Mental Health Advisory Committee and Human Resource Committee members met with Commission on Overcrowding the day before we actually presented our plan of correction to the Federal Government and the Health Care Financing agency administrators in Boston. We were greatly encouraged when Medicare decided that the plan of correction was sufficient for them to believe that AMHI was in compliance with the conditions cited and they agreed to conduct a follow-up visit. The Health Care Financing Agency Officials could easily have said the Plan of Correction was inadequate. They chose not to do that. They believed that the detail and the plan of correction was sufficient to merit a follow-up survey, thus they would not be wasting their time. We thus proceeded, greatly encouraged by their response with the corrective actions. We were very optimistic. However, during the period when AMHI's staff were attempting to implement the plan of action and the patient population began increasing just when everyone expected it to decrease as it had in the past years and the chart to my right and to your left explains what I am talking about. If we look at the red line which is calendar year 1988 we need to look back at the difference between May and June. The follow-up survey was May 29. You will see that the census between April, May and June was going up slightly. That affected the units for which we were seeking full Medicare recertification. That unit including that unit included the Admissions Unit. At the end of the Medicare follow-up visit at the end of May we were informed that AMHI was decertified. Yes we were surprised. All indications were that preparations were going well. Still unable to precisely measure how far short we were of

certification, we called in a consultant who was familiar with Medicare who confirmed that, in fact, the standards had become were being more strictly interpreted and helped us to evaluate our position. I publically said that we would re-apply for certification within the minimum 90 day time limit and asked the Superintendent to prepare a staffing plan that would permit AMHI to both regain Medicare certification and retain accredidation status with the Joint Commission on the Accreditation of Health Organizations. In fact, I sent Ron Welch, the Associate Commissioner for Programs to AMHI to work with Superintendent Daumueller on building the solution. At foremost in our mind was improving patient care. The solution developed and within three weeks of decertification key legislatures were consulted regarding a proposed appropriation request and of our intent to implement action by funding positions from the Governor's Contingency Fund. This plan began the third week in June to immediately address some of the more serious problems at AMHI and we reported to the Governor of the year long that the year long planning process called for a comprehensive mental health system. The Governor made the decision to speed up the comprehensive planning process by requesting $6.6 million in the special session, which included $1.5 million and 65 staff positions for AMHI. Since then we've been forming we've been focusing on improving patient with the added pressure of needing to reapply to Medicare. And now I shall move onto the deaths in August.

During August, while implementing activities funded from the contingency fund and preparing for the special session 5 deaths occured. We ordered an internal examination by AMHI physicians and in mid-Sept. I appointed Dr. Ulrich Jacobsen to the post of Medical Director attached to the Commissioners Office. His

first assignment was to conduct a more in depth review of the cases and in Oct. he recommended to me that three of them be further investigated. I then appointed an Advisory Panel in Oct. which reported its finding in Dec. indicating that one death could well be attributed to the heat and making extensive recommendation to improve medical and phychiatric care. Three physicians in an unprecedented action also were referred to the Board of Medical Registration based on finding from the first two phases of our investigation.

And now onto the topic of the Department of Human Services assessment of wards at the institute.

In early Sept. I was informed by the Dept. of Human Services that it would be initiating an assessment of the safety and medical care of its 47 wards at AMHI under the care of the Adult Protective Services wing. In mid-Sept. DHS provided us with a preliminary results and informed us that it would be adding more investigators in order to speed up the assessment. Because preliminary results pointed to serious problems with care for the wards. Subsequent to these developments the two deparments have been working very closely together to identify the serious problems of the wards. The Sept. 1988 Special Session, that is on Sept. 15 and 16, the legislature appointed or approved the request of the $6.6 million dollar package which set in motion the state the building of the state wide comprehensive community and institutional mental health service plan. A new independent Commission on Mental Health was also created to replace the department advisory bodies. Currently our Part 1 budget includes the addition of $20.3 million dollars over the previous bienium to continue all acitivities initiated this fiscal year. We are now evaluating

4 mos gone by since then.

the effect of the Sept. package on AMHI's ability to deliver a higher standard of patient care.

And now, where do we go from here? The events since last May, the Medicare decertification, the patient death's, the panel investigation into patient care practices and the DHS assessment of care for the wards tell us that the years of neglect have indeed caught up. (91) additional staff over the past 18 months are helping us to cope with admissions that will continue to rise until community resources have begun to have the effect and until the VA hospital in Togus is able to restore it's previous level of service. Throughout the past year many affected groups have come forward to offer their solutions, each convinced that their solution is the best possible. In the absence of any widely accepted standard for care of institutional health care services, it is extremely difficult to judge among competing proposals. However, we have made a high level change in management and I will shortly convene a team to design and carry out a thorough review of patient needs and staffing capability. We intend to adopt standards which will provide a more solid base for arriving at such critical decisions. We'll look at all management options. What I urge this committee to keep in mind is, however, is that the long term solution is precisely what the Commission on Overcrowding has concluded. We need better care located in the communities, although not at the expense of Maine citizens living in the institutions. We will if we fail to do that we will never recover from chronic overcrowding.

And this concludes my statement. I would be pleased to respond to questions.

(MS = Male speaker)

-----Unknown speaker with unknown question (male)

Susan, umh in the course of questions will not in any way intimate decertifications personal views

SB: Right

federal dollars. Many people have it became recently apparent to you or others in your deparment that we were to recertification which, of course, would result in the loss of federal dollars. I know that 1988

When did you know question.

and the question was asked prior to that time were there warnings that we were likely to

SB: Because AMHI had periodically gone through it's difficulties with Medicare and had always marshalled staff, you know such a manner as to requalify for Medicare it was not thought that this particular review would result in anything that we needed to worry about. We knew that we were on thin ice with medical records but at the time of the review in Feb. we had no idea of the increased stringency with which existing standards were being interpreted. That did not become clear until much later, in fact, after May 29th. We were very optimistic in our efforts that we could do this, that we would

put all our efforts into it. I had great confidence in the abilities of the AMHI leadership, including Supt. Daumueller to actually do what was needed to be done. I think a fair statement to say that we were all exceedingly optimistic and had no information to cause us to be otherwise.

------Unknown male speaker

SB: I don't recall that we sent the actual correspondence's over. I do know that later we talked about many issues concerning the institutes, including the increasing once again increasing employee dissatisfaction at BMHI, the employees dissatisfaction within AMHI and the resulting effects of that. And because Medicare is one aspect of management that most certainly would have come up as a discussion topic.

--------Unknown male speaker
How many beds do we have at AMHI which are Medicare certified?

SB: Presently we have none.

That's right

SB: Under the optimal conditions as we are now looking at them, 30 beds would be certifiable by Medicare and they are all located on the Admissions Unit. One other point I would like to make about legislators being informed of Medicare. On March 10th the Governor's Mental Health Advisory Comm. had a meeting, it's monthly meeting, at which individuals, including Rep.

Manning attended the meeting and this was an annual event wherein the Governor's Mental Health Advisory Comm. invited members of the Human Resources Comm. to participate with them and at that time a thorough you know description of the Medicare situation was rendered.

Male speaker: Now as to that meeting one impression on those that you would be recertified.

SB: As of March 10th?

Yes

SB: We understood that we would be decertified but the usual and customary reaction to such a letter is: Well, alright, now we put together a plan of correction and the plan of corrections whole sole purpose is to let the Health Care Financing Agency Administrator's know what we intend to do in order to correct the deficiencies which they have cited.

Male speaker: I understand that recertification in 1986

SB: Right, and I even earlier than that.

MS: so your impression was that if we formulated a reasonable plan of corrections we would likely or could ward of decertification on time.

SB: Absolutely

MS: Now, you made reference to changing the standards or more

rigid interpretation Could you elaborate on this.

SB: Yes. Medicare as also Medicaid two programs within health care financing have recently undergone umh what best can be termed as re-medicalization. What that means is that the umh government is looking at it's standards and holding umh participants in the Medicare program more accountable for the medical aspects of participation. As you know, policy fluctuates during the years and for a long time in the field of mental health and particularly the private the public psychiatric hospital there has not been an emphasis on medical care, rather, there has been there was previously an emphasis on rehabilitation. Medicare has gone full circle. It has now begun to more stringently emphasize the medical aspects to their standards and that is why, when we discussed medical records and the different standards that were out under that particular condition umh we are forced to conclude that they are looking at us more stringently because what had passed before was no longer acceptable.

MS: specifically what plan of correction was formulated by the department to respond to the

SB: umh huh umh huh

Before I do that I would like to acknowlege that you are correct, that we did not receive notification from the government until March 23rd. There was a exit interview on Feb. 23rd. and it took them a month to write us the letter. So you were correct.

MS: So that you received formal notification March 23rd.

SB: 23rd of March

MS: but the verbal communication as of the 23rd. of Feb.

SB: what what they generally say they don't pin themselves down, they generally say umh we feel that this is out, this is out, this is out. They will go through a list of deficiences and then they will advise you that they will return to Boston umh and talk about this amongst their team and conclude you know whatever they will conclude and then let you know by mail So roughly there is a month in there where you're wondering if you made it or didn't make it but you know in the best spirit of planning what one tries to do is to anticipate umh based on what you hear from an exit interview and put the proper you know corrections in place.

MS: March 10th meeting with the Mental Advisory that there were concerns

SB: Was an intelligent conjecture.

MS continues: and based upon that intelligent conjecture what proposed plan of correction was formulated?

SB: Well, it was an extensive umh plan of correction and perhaps the best way depending on the level of detail that the committee wishes to hear I should call someone else up here who is who is more fluent with the actual technicalities. Is that acceptable?

MS:

SB: OK. Dr. Rohm. Umh this is Walter Rohm the acting Superintendent of the Augusta Mental Health Institute.

Dr. R: I would like to add to Comm. Harper's statement about the change between that occurred between 87 and 88 and professional standards. The main emphasis was that the of the standard that the treatment has to be was used literally was previously the psycho-social team approach was quite acceptable for a psychiatrist, could be a part-time participant in the treatment planning and the carrying out the treatment plan. The new interpretation demanded that the psychiatrist direct the team, be the prime mover of the treatment planning and carry out the major part of the treatment. This meant, immediately, that more psychiatrists' time was needed. Er as you probably all know psychiatrists are very difficult to recruit. At that time we were down minus 4 psychiatrists which we would consider a bare bone minimum psychiatric coverage. We are still short 2 at the present time, but we were able, by sheer luck, to hire a half time contract psychiatrist. So instead of having one psychiatrist and two physician assistants on the Admission Unit we were able to face the May visit with one of the half psychiatrist. Hoping that they would somehow relent in the literal interpretation of the psychiatrists position of direct supervision and treatment. The other plan of correction was that intensive training to improve standards for social services to review the way you are allowed to do assessments and examinations are recorded. The Medicare demands a much more stringent and

detailed examination documentation of the examination. Then in the average practice of would be required. The another aspect was that we did not sufficiently document the things you were doing. Supervision of physician extenders, we revised the admission format, the psychiatric assessment format; specifically making it mandatory to address issues that Medicare demands, which in the past Medicare would make a recommendation you should pay more attention to this and that. Now they say it isn't fair. You don't meet the standard. Considerable time and effort were spend in training programs, with consultants to bring our treatment plan documentation in compliance with the rather elaborte Medicare standards and this is an ongoing process and er there were some shifts of acitivity staff because there was a lack of activity staff in the opinion of the Medicare surveyers, which actually went at the expense of other parts of the hospital, but at this time and during that time we couldn't take any steps to get additional staff. And we intensified our recruitment effort for psychiatrists which we are still doing at the present time. Any other questions?

MS: If you felt that your activity staff was suffering and you moved your activity staff of the institution to satisfy Medicare with the understanding that funded the hospital why didn't you request activity staff for the other people. You just indicated that you

Dr. R: I'm not quite sure the detail of this of this operation. I think what happened is, now that I recall correctly we changed the time assignment for the er for the er acitivty staff. That they would be available at times when there was a lack of acitivities and from this

reassignment I recall now, there was some resistence, reluctence and some complaints from staff because they would have to work evenings and weekends and this was (pause) and this was done.

I think my statement was incorrect, that it was strictly at the expense of other parts of the hospital. I think it was more efficient utilization of activity staff by our having less or fewer hours being worked between times when the patients were active with other things and having them work weekends and evenings where there were more, rate of acitivites.

MS: Why do you feel they didn't notify you standards.

Dr.R: The standards are the same, the only things the interpretation changed.

MS: The what changed?

Dr. R.: The interpretation changed.

MS: Were you notified by any other institutions that you know of mental health centers, anybody that Medicare all of a sudden changed their

Dr.R: I think we were one of the they changed their surveyer changed it from the National Institute of Mental Health who had the contract I think a few months we were surveyed to a private group in Baltimore. We were the first ones to be certified by the new group with the new directions the old standards. And we said look, 4 1/2 years ago we had the same things and this was adequate and

they said yes this is true but we are a different group now and we have different instruction.

MS: You felt at that time, you were on board at that time

Dr.R: Yes

MS:, you felt at that time you didn't need to come to the legislature for any additional dollars.

Dr. R: Well, you mean between Feb. and when they came again.

MS: yes

Dr. R: We were we were reassing the situation

Charles P. Pray
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"ORMATION ON SUSAN B. PARKER, NOMINEE FOR COMMISSIONER OF THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Ms. Parker is knowledgeable in both mental health and mental retardation. She has extensive experience working as an advocate for programs for the disabled and is currently the Executive Director of the New Hampshire Developmental Disabilities Council. In that capacity she supervises five full time staff and coordinates others who are working on grants outside of the agency. She is very well liked in her current position and respected for her many capabilities. "Remarkable" is the word that the Chairman of the Council used when describing her.

She also has a great deal of experience with federal agencies, grantsmanship, planning and negotiations, and management. Her educational background is superior and includes a Masters in Planning, a double-major Bachelors in English and French; a teaching certificate; and follow-up courses in planning.

She has been elected/appointed to a wide variety of Boards including the Board of the National Association of Developmental Disabilities Councils; The Executive Board of the National Association of Social Workers; Advisor to the Office of Health & Developmental Services in Washington, D.C,; and Advisory Committee member to the New Hampshire Governor in his personnel negotiations with the State Employee's Association.

In addition to her four year tenure with the DD Council, she has also worked for the Grafton County Human Services Council and as a mental health planner in Massachusetts.

In speaking with members of Maine's DD Council, no one had specific information on her or had worked directly with her. They did say they had heard favorable remarks on her abilities. Dean Crocker, former Director of the Advocates for the Developmentally Disabled in Maine, has worked with her in the past and said she is a good choice and is a very capable and competent person. He also felt she would be interested in looking at a "community" perspective for Maine's disabled as opposed to "institutional" approaches.

Ms. Parker's current supervisor indicated that Ms. Parker is a [redacted], but that she (the supervisor) was able to work with her very well in spite of that difference.

The one weakness I can see is that Ms. Parker does not have experience supervising a large number of employees or running a large department. Her background is with managing small independent organizations. However, her management, planning, grantsmanship, and general administrative talents seem to be considerable. When I asked her current boss about her supervisory talents, she said she felt Susan was up to handling a large agency with many employees. She based this conclusion on Ms. Parker's abilities and intelligence.

Possible questions for Ms. Parker:

1. What is your background as a supervisor? Do you anticipate any differences between supervising a staff of five and supervising a staff of over 100? What do you think will be the difference and how do you expect to proceed?

2. Comment on the move to deinstitutionalize that began in the early 1970s. Do you feel that deinstitutionalization is still the best approach?

3. There is currently a discrepancy between the pay that direct care workers receive in our institutions and what is received in the community for the same work. How do you think this can be resolved?

4. Your experience appears to have been mostly in smaller organizations, advisory in nature. How do you feel your skills will carry over into a Department the size of the Department of Mental Health and Mental Retardation?

5. What is your experience in preparing, presenting and managing large budgets?

AUGUSTA MENTAL HEALTH INSTITUTE

WILLIAM C. DAUMUELLER, ACSW, SUPERINTENDENT

Central Office: Hospital Street, Augusta *Telephone:* 289-7200
Mail Address: Box 724, Augusta, Maine 04330

Established: 1834 *Sunset Review Required by:* June 30, 1992

Reference: Policy Area: 03; *Umbrella:* 14; *Unit:* 194; *Citation:* 34-B M.R.S.A., Sect. 3201

Average Count—All Positions: 614 *Legislative Count:* 633

Organizational Units:

- Admission Unit
- Young Adult Unit
- Adult Unit
- Older Adult
- Pre-Discharge Unit
- Forensic Treatment Unit
- Adolescent Unit
- Alternate Living Program
- G.R.O.W. Workshop Programs
- Medical Infirmary
- Nursing Home
- Evaluation/Research
- Staff Development
- Hospital and Business Services
- Health Sciences Library
- Professional Consultants
  - Nursing, Social Work, Psychology, Activities

PURPOSE: The Augusta Mental Health Institute is mandated to treat adults who require intensive 24-hour psychiatric services from the following counties: Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, Waldo and York. In addition, the Institute provides inpatient psychiatric treatment to adolescents from throughout the State. All services are provided without regard to race, creed, color, sex, national origin, ancestry, age, physical handicap or ability to pay.

The Augusta Mental Health Institute is the only facility, for these counties, mandated and equipped to provide care and treatment in a hospital setting to the following categories of patients: those who require involuntary hospitalization; those who require a secure setting; those who require extended periods of inpatient treatment and/or rehabilitation; those committed under the criminal statutes for observation, care and treatment; and those who require certain highly specialized programs not available elsewhere. The demand for mandated services is such that voluntary admissions have to be refused, delayed or diverted to assure suitable accommodations for those most in need. In some cases, the lack of appropriate community alternatives requires that Augusta Mental Health Institute accept additional acute patients on a voluntary basis.

ORGANIZATION: The Augusta Mental Health Institute was established in 1834 as the Maine Insane Hospital, and was the only public mental hospital in Maine until the opening of a second hosptial in Bangor in 1901. In 1913, its name was changed to Augusta State Hospital and in 1973 to its present designation. Throughout most of its history the Institute provided the only public mental health services, except for the Veterans' Administration Hospital, to the people of southern and central Maine. The development of the community mental health centers in the 1960's resulted in a redefinition of the Institute's role. It stands today as a necessary and valuable part of the comprehensive mental health system which provides a broad range of services to Maine residents.

The Augusta Mental Health Institute is organized on a system of functional treatment units in order to meet, as effectively and efficiently as possible, the needs of mental health clients in the counties previously mentioned. Each of the functional units is responsible for the total treatment and rehabilitation of its patients:

A. Admission Unit: The 30-bed unit is primarily an intensive assessment, diagnostic and crisis intervention service, offering short term treatment such as chemotherapy, group therapy, activity therapy, and occupational therapy. Except for forensic patients and adolescents, approximately 50% of our patients are discharged within 7-9 days. This rapid stabilization and discharge function requires carefully planned aftercare services which are provided by various mental health agencies throughout the state.

B. Forensic Treatment Unit: At present, the 33-bed Forensic Unit is divided into an 8-bed high security section and a 25-bed medium security section. The 8-bed section provides short term intensive diagnostic and treatment services in a secure setting for individuals referred from the courts for observation, care and treatment and for civil admissions from state and county correctional facilities. Those found Not Guilty by Reason of Insanity (NGRI's) or Incompetent to Stand Trial are generally treated on the medium security area unless otherwise indicated. The staff of this Unit monitor all legal hold patients, regardless of treatment unit or release status.

C. Adult Program: This 45-bed program focuses on treatment and social intervention to adult psychiatric patients up to age 45. Most patients in this program are being served in a long term outpatient or community based programs with occasional inpatient episodes being necessary.

D. Young Adult Program: A 45-bed short term intensive psychiatric program designed to meet the needs of patients 18-30 years of age. Many of these patients are best described as the young chronic mentally ill with the special problems of substance abuse and other social problems.

E. Adolescent Unit: This 24-bed unit provides comprehensive diagnostic and treatment services in an inpatient setting to all those mentally ill Maine youths (ages 12-17) whose problems have not or cannot be resolved through less restrictive alternatives in the community.

F. Older Adult and Other Special Treatment Populations: A 40-bed milieu program for clients over 52. This program focuses on remotivation, improvement in basic functional skills and is individualized by additional treatment modalities specific to assessed needs. Services accommodate the needs of the head injured and hearing impaired who are part of this program.

G. Pre-Discharge Unit: Closely aligned with the Alternative Living Program, this unit houses patients needing little structure and supervision and emphasizes those skills related to living independently or in less structured group living situations. This unit also has the capacity to expand or contract as our patient population and staffing dictates.

H. Alternative Living Program: The Alternative Living Program consists of six houses or apartments on the grounds with a capacity of 40 patients. Each house provides a small, supportive, homelike group setting which more closely parallels the experiences that the patients are likely to encounter in the community. The goal for the individual is to reach the highest level of independent functioning possible, with the ultimate goal being community integration.

I. Therapeutic Activities: A multi-disciplinary group of action oriented therapies that provide a means for individuals to go from a dysfunctional to a functional state. Occupational therapy, recreational therapy, movement/dance therapy and art therapy, are among those professions currently represented at AMHI under the umbrella of Therapeutic Activities. Adult educators are available to provide skill development, formal academic training and many leisure time skill enhancement courses.

J. G.R.O.W. Workshop: This comprehensive workshop program utilizes any funds generated over and above the wages paid to workshop clients to expand rehabilitation opportunities. Clients with disabilities comparable to those of AMHI patients are referred from the community mental health centers, Divisions of Vocational Rehabilitation, Bureau of Mental Retardation and other mental health related agencies. By extensive utilization of this modality, patients who would have remained untreated or whose treatment may have been inappropriate and ineffective have reentered the world of productive employment in varying degrees of self-sufficiency.

K. Nursing Home Unit: The patients housed in this 70-bed Unit are impaired both physically and behaviorally. Their disabilities are such that they cannot currently be served in community nursing homes or other alternative settings. However, a social work and nurse team recently established by the Bureau of Mental Health and housed at AMHI will provide consultation and education services to community nursing homes with the goal of assisting them to maintain psychiatrically impaired patients in community nursing homes.

L. Infirmary: The 16-bed Infirmary provides a Medicare certified general hospital level of care, at less cost than would be incurred by a transfer to a general hospital. Those patients requiring surgery or intensive care are transferred to the Kennebec Valley Medical

tape # 2

Um, ---------- have to have a at least a high school education and uh we run them through um training programs it would -------- um a mandatory training would include things such as CPR, uh what we call Nappy wich is non abuse physical and psychological intervention uh they go through a CNA program which uh is I believe uh it's over a 100 hour program um they go through an introduction to mental Health which is kind of a basic um nursing skills program, which is an 88 hour program. So they have a fair amount of training in addition to whatever experience they might have had comming in.
The CNA training um our standard is that be completed within 6 months of employment. Uh, as an example just recently in September we were able to bring on 31 mental health workers um roughly the first week in October um we were able to complete their training, including CNA and CPR training and other training by November 22nd. So that and that was another massive effort to um

female Parker

(can't decifer)
I'm talking this past fall.

different speaker-"What period of time did this trainig take place in?"

"Within the first six months of employment, but generally it would happen in the first three months.

different speaker" I have a question concerning patient care what percentage of the care of the patient is put upon this Mental Health workers, um what percentage of the time are they required to (can't decifer) of patients ? all the time ? out of contact all the time? what would you say would be the percent?

Uh it's a very high percentage, I don't have a time study, but I would say that it is the bulk of the direct eye-to-eye contact with the actual patients is carried out by our mental health worker, and other nursing personnel.

different speaker-"But what do you who suddenly come up with an unusual chronic problem (can't decifer) the discression of these nurses and mental health workers who know them (can't decifer)

The mental health workers are in the nursing, under nursing supervision under licensed supervision, uh when the patient comes into the hospital, the licensd nurse staff person uh completes the nursing care plan. And that essentially is the plan that the mental health workers follow for each patient. So that, they are given guide to patient care, by uh registered nursing staff who complete that assessment. And they are supervised regularly by a licensed nurse staff.

different speaker-"but feasably, at the end when several days go by,when you still need a mental health worker 3/4ths (can't decifer)

That certainly could happen with some patients, yes.

"um as far as treatment in packages of patients do you have treatment plans when the patient comes in, the patient is assessed and then a treatment plan is set up with a period of time the individual will be here. Assuming it's a certain estimated period(can't decifer)

where you have an assessment of the ability and the problems uh how are you going to deal with things, (can't decifer) Is this absolutely?

Yes it is, um for those patients who come into the admissions area proper, um they would have an initial treatment plan -----within the first five days of hospitalization. Uh that technically you can say that every patient has a treatment plan beginning at the time they come into the hospital which would consist of the initial uh phsician assessment, and the initial doctor's orders whatever that might be weather it is for medication um placement in constant observation so treatment begins in a sense, immediately. Prior to that initial conference to develop that treatment plan within the first five days assessments are done by social service, psychology, uh at times the activities staff may have uh had time to do an assessment also and those assessments, including the psychiatric evaluation that's been completed within the first, well a full pcychiatric evaluation is required within the first sixty hours of hospitalization. Those assessments are forwarded into that initial treatment plan, which includes uh theraputic rehabilitated modalities or treatment approaches beyond just kemotherapy, or medication which might include continuing social assessment uh group therapy with one of our chaplains or psychologists uh in a range of activity therapys.

different speaker (can't decifer)

other speakers? (can't decifer)too much noise.

speaker (can't decifer) My question would be um based upon initiation of it would appear (can't decifer)

Female new speaker" the answer to the first part of the question is yes, and i would also reiterate that the letter from Stanton Collins of April 15th 1988, wherein he says that a credible aligation exhists, that AMHI is now in compliance with the two special conditions for participation in pschriatic hospital program for medicade gave us good reason to be optimistic. At this time I would like to um ask assistant superintendent
Hamlin to continue with his discussion.

Could I, just interrupt here? I have some questions on the correspondence of Mr. Collins.

Female: Mr. Collins? yeah.

Male: yes um I have (can't decifer)

Female: My own interpretation of credible alligation means that the plan of correction contains adequate substance which would allow them to feel that they would not waste their time in resurveying a facility. They'll review it for content then match that content against the list of deficiencies and thought we were definately in the right(can't decifer)

Male: Um did you have any vote from Collins or anybody else at this point uh or any corespondence that in fact (can't decifer)

Female: No they never they, that's a practice, they never say that anything is forthcomming. What he did say, as we left the room on that uh Tousday or Wedensday was that it looked to him

like the plan of correction was adequate. That's all he said, they never make promises.

Male: Susan now I understand you were present and Susan Collins was present together with Dr.Rohm

Female: No, Susan Parker was present with Dr. Rohm Susan Collins is (can't decifer)

Male: (can't decifer)

Female: oh no uh Linda Crawford, the assistant Attorney General

Male: that does make a (can't decifer)

Female: yes.

Male: now Dr. Rohm apparently represented the institution?

Female: as the clinical Director and (can't decifer) represented it as the Superintendant.

Male: (can't decifer)

Female: Yes he was.

Male: ok. Were there any other members or people present from our department?

Female: It was we four.

Male: Uh you also mentioned that (can't decifer)

Female: Um the mention that I made was not Marvin Chapman, although he has done extensive consulting work with the Augusta Mental Health Institute as well as BMHI the consultant in question that I think your, the question your posing, is Alvira Branns and she is a person who in fact, once worked for the health care financing administration, and now works for the National Institute of Mental Health. She wasn't just a worker at (can't decifer) she was a person in charge of such reviews. In she knows intimately, you know the policy shifts and the subtlties of HICVA reviewing and the personnel involved. And I had learned of her through contancting with other states and also the National Institue of Mental Health and had her up her to give us a critique of our review. This was a process critique um as apposed to content. She actually make the comment that she felt that our content was quite good. And that is how we first substantiated you know from a person outside of Maine that the stringency was uh the stringency of interpretation indeed had effected us.

Male: When you said she gave you a process critique-

Female: well she

Male: does that mean that she (can't decifer)

Female: No, she did this and we had her up the end of June. Not the end of June, but the first half of June. Now you may be reffering to another consultant who had come in, I did not mention Mr. Chapman in my cr-

Male: I'm not going to be very specific. I was referring to the, I thought there was a consultant to aid your department in crafting the plan of(can't decifer)

Female: That um we'll have to ask Rick Hamler about. It's a typical behavior that Institutes, when they have to go through a review actually do hire consultants.

male: OK, so your not personally aware of who you you(can't decifer)

Female: No I'm not

Male: OK thank you.

Female: It could well have been Mr. Chapman because he comes here frequently.

Male (can't decifer)

Female: Yup, yup, could I just risk the other five points and then call the assistant Superintendent up?

Male: (can't decifer)

Female: I shall. Um the second one is extensive work was done with medical staff to improve the documentation of physician involvement this occured during February and March of 1988. The third point is that Dr. Buck a ferensic psychiatrist was removed of his duties at the Maine State Prison thereby adding one day of psychiatric time per week for the pourpose of physician extended supervision and patient care. This happened on April 12th of I'm sorry, that happended on April 7th 1988. We added one psychiatrist of twenty hours through contract for the admission unit coverage with no nurse or other coverage do to duties. And this was on April 12th. Another point is that we revised and improved the socialwork documentation standards and set up social service audit system to monitor compliance. That was March 28th 88'. And lastly they increased the capacity of the theraputic activities department to provide regularly scheduled activities during evenings and weekends. This was April 19th 88.

Male: Can I ask(can't decifer) who was specifically was involved in(can't decifer) corrections?

Female: The oversight or they oversee of a plan of corrections is always the superintendant. Um assistant Superintendant Hamly can tell you to the degree in which he was involved.

Male: (can't decifer)

Female: No, we the way our department runs is that I am reported to by a Superintendant and he or she would simply convey the fact to me that this is happening.

Male: So it's fair to say that that's why Mr. Daumueller was the Superintendant of the institution.

Female: that's not-

Male: So it would be fair to say that you asked Mr. Daumueller

to in fact um appear (can't decifer)

Female: that's correct. Occasionally um if there are policy issues that need settling um I will dispatch I would and associate commissioner for programs or administration to the task.

Male: Um I know you've (can't decifer)

Female: I will have Associate Commissioner Welch answer those, he has done an analysis from the central office (can't decifer) of what's been done and when.

Male: Is it your impression (can't decifer) up and running now? or

Female: Yes.

Male: So you understand all these forms have-

Female: mmm, right.

Male: OK (can't decifer)

Female: The uh information that I have received as late as yesterday, is that we still have somewhat to do on getting the medical records shaped up in order to endour a successful review.

Male: Do you have the time frame at this point that you could give to the committe as to when (can't decifer)

Female: No. No. Um, Senator based on what information that I did receive yesterday, I really need to get back with the people who put it together at AMHI, and work with them to figure out what that time frame ought to be. They did a , we have had consultant help comming in from someone who is very skilled at reviewing records uh to determine weather or not they are acceptable to Medicare. And his report also has just landed on my desk. And I really need to reevaluate the various types of information that have come over from two quarters to find out weather or not um we can do it immediately is it one month away, two months away. As I did point out to the committee, uh the request to health care financing administration to come resurvey us um assumes that we must be perfect on all points.

Male: It was also my understanding that(can't decifer) Is that correct?

Female: that correct (can't decifer) 90 day period of compliance before we are able to actually um make application.

Male: No, when they come back for the uh what they call a focused survey, we had to have been in compliance for at least thirty days. Because what they do is they look at the prior thirty day period. So that (can't decifer)

Female: mmm. In order to answer the time frame question, I would have to (can't decifer) consensus back here. Uh I don't know the answer off the top of my head um what do you think?

Male: I think we can talk with you about what needs to be done

in our perspective probably within two to three weeks. Let me just state that (can't decifer)

Female: Thank you. Why didn't I get personally involved? you mean? because there are six institutions that we are running, in addition to the three community sets of programs. If I got involved in the development of every single plan of correction, I would lose the ability to exurt an oversight over all aspects of this department fuctioning. Therefore, I have people um who are members of my senior management team, who are people to whom the task is delegated of exerting that oversight. I always have to understand all things that function in this department for me to put a member of ours into the actual crafting of a plan of correction would take me away far too much from understanding the other pieces.

Male: I just, you know I just think (can't decifer)

Female: Peter this is... I was very ...

Male: (can't decifer)

Female: That I don't think things were neccessarily faring very well. Let's recap some of the um issues that have beset this department since July of 87. Um we very rarely lost medicade at Pineland and when I say we very rarely lost it, we came within a 1/2 an hour of having the guillitine go down on $10 million dollars and the way we pulled that out and this particular situation arose from the fact that happened in November of 1987. Pineland had gone through many surveys by Medicade.

Male: (can't decifer)

Female: well I'm going to...

Male: (can't decifer)

Female: that happened in November, then we moved up to January, February we're readying for a legislative season. By the time, by the time we got to February March and April, things at the Bangor Mental Health Institute are in a state of dissaray. I had, I had initiated very many management changes at BMHI and I made a change in the top management of BMHI the middle of March. I was extremely concerened about the patient quality care quality there, as I was at the Augusta Mental Health Institute. I had absolute faith in the Superintendant and his top staff, that they could put together quality plan of correction that would meet muster with the Federal government.

Male: These medical records? um what was the, how long did it take (can't decifer)

Female: The um

Male: (can't decifer)

Female: I would have to look back, I believe they are. Now

Male: (can't decifer)

Female: Do we have the (can't decifer) when everybody was filled? Pull that out

Male: All three have been filled as of today um all but six had been filled as of the third week of November.(can't decifer)67.5 three of which were under contract. We currently have one of the contractor clients for a psychiatrist (can't decifer)

Female: That's the Medicare portion of the package.

Male: All those positions were filled uh

Female: July, August, September.

Male: Why is it that we're still having problems with (can't decifer)

Female: It has to do with the fact that staff on team A and team B within admissions, team A does not adequately understand yet how to put together a treatment plan that is written in behavioral terms what that means is, they don't know how to write a treatment plan that um that contains language that describes how they will know a patient attains certain goals. How has a patients behavior changed as a result of the intervention given by the clinical staff. It takes a great deal of trying to get to understand how to script how to write treatment plans in behavioral terms. They have had three training sessions. The first training session occured in September. The second one was later that fall and the last one, actually the last one was not a training session, it was a feedback session. That I attended on January 4 89' uh conveyed the fact to me that, only 1/2 of the treatment team understood how to write in behavioral terms.

Males: (can't decifer)

Female: I think that's fair.

Male: Susan, can you, you had indicated earlier that you had no (can't decifer)that was in a meeting?

Female: Right. March 10th.

Male: you were all there?

Female: Yes. yes. With your permission Mr. Chairman I can give you the minutes of that meeting.

Mr. Chairman: I'd appreciate it. Did you notify anyone else, besides the Human Resourse Committee (can't decifer) legislative leadership of Appropriations Comm.

SB: I do not recall that I notified the leadership. What we did was to explain the fact that we had you know suffered decertification but as I had mentioned previously we were very optimistic based on AMHI top staff history that we could regain Medicare through an aggressive plan of action or plan of correction and as I recall the meeting of the Governor's Mental Health Adv. Comm. those plans were described and I also recall that Dr. Rohm was the person describing.

MS: I'm sure you said you did notify appropriations.

SB: I do not believe we did because at that time we were very

optimistic that we could regain it. And as I had previously stated this was prior to understanding that an increased degree of stringency was being attached to the standards interpretations.

MS: I just wanted to follow-up on the letter since you gave us a copy of the April 15th letter. The reason I'm asking questions from these letter is because when I was going through the packet of materials, past reports and the things we've gotten over time and the new material, this particular letter that came March 23rd and we didn't have the April 15th letter but this seemed to me the most significant thing and an early notice of what the intent of the department was. They were definitely going to terminate April 22nd and that you had to address certain things, in fact, it got down to the point in the letter to paraphrase is that they weren't even asking you to correct things. They were just saying that there had been so many problems and so many deficiencies we are going to terminate April 22nd. Now you said in response to that questions I asked you before that you had received this April 15th letter and that it was very favorable. It's a very short letter and I mean on the basis of the meeting of April 12th apparently you had met or someone had met, maybe Mr. Daumueller had met with Stanton Collins on the 12th of April and corrective actions outlined in your plan of correction we have determined that a credible allegation exists at Augusta Mental Health Insti. is now incompliance with two special conditions of participation for psychiatric hospitals. End of paragraph. Second para. We will therefore arrange for an unannounced follow-up survey of AMHI sometime in the near future in order to provide sufficient time for this process we are extending, -----not eliminating,---- extending the termination date for AMHI from April 22nd. to May 22nd. Now they end up actually terminating on May 29th. and they give the name of Mr. Winerman and his phone number including the obviously you could call Stanton Collins. If I'm misunderstanding the letter correct me, but it seems to me they are saying you still a long ways to go. We are not eliminating the termination requirement we are just entending it in order for you to implement this plan and they say at this point you have only implemented two .....am I understanding this correctly.

SP: Let me clarify. There are only two conditions in the entire set of standards of Medicare. There are two conditions: Patient Records medical records and staffing. All the standards, every single standard falls out of each of those two conditions so if they say that a credible allegations exists that we can meet the conditions that is indeed exceedingly favorable.

MS: And if that is favorable and they do not do anything but extend the termination wouldn't that be a large sign to both you and whoever the Supt. was and any staff involved that we still have a ways to go to eliminate the terminatin.

SP: We always know we have a ways to go that is why we go to the you know the rigor of compiling a plan of correction. The interpretation of the March 23rd letter. You are correct. It doesn't make you feel very good when you read it as an administrator, but there were no surprises in there based on what they had told us in the exit interview. We knew that we had a long way to go and that we also knew from the exit interview one month prior what the deficiences were so by

that time we were already deep into the actual formualtion of a plan of correction. The Health Care Fin. Admin. is not know for sending love letters to any of us. They always, you know, paint a scenario that is not terribly positive and this of course sets the stage for you know any subsequent action which may occur that is not in our favor.

MS: I don't want

SP: There is if I could please point out there are certain phrasiologies in any letter from Health Care Fin. that are peculiar to that agency and you once you have experience with this agency you learn to interpret what those phrases are.

MS: I don't want to intimate that there not they can't be difficult to deal with. I can understand that but it is obvious that you had or Mr. Daumueller had a meeting at least with Mr. Stanton

SP: Collins

MS: and that there was some communications not only in written form but obviously in personal meetings and the possibilities of conversation with people with their questions and it seems to me that if you understood that possibility would be that they would be very strict with these rules that you would make the necessary communications with them either privately in meetings or publicly through correspondence that says, you know, what do we have to do to specifically, are we doing enough and just keep that conversation going.

SP: I believe I can't say for sure whether or not telephone communication did not happen between the Supt. or the Asst. Supt. and the Health Care Fin Agency. You know, as I said I had enormous confidence at that time in AMHI's ability to put together a plan of correction that would pass muster and also at that time as I just said I was not aware that there was a movement afoot, shall we say, that a more stringent interpretation of the standards would be levied on us. I learned that the first week in June.

MS: I would like to get back to the questions of the federal government stifening their requirements. And I'm looking at this chronology which, I don't know, where did this come from. Was this from your department.

SP: I don't know what you're looking at

MS: It's a chronology of events

SP: Yuh

MS: OK I'd just like to go back over it for a second because in July 1987 it says here that Medicare fully certified AMHI. Then the next indication that there seems to be some problem is that following Feb. for the Medicare annual visit it says AMHI not certified. Was it during that interim during July 1987 and Feb. 23rd. 1988 that the federal government sitffened their requirements was that the period when that happened?

SP: umn I'm not sure the precise date Rep. Rold I don't know that answer because I'm not privy to what happens in the

highest reaches of HICVA. I know

MS: but I mean the fact is that you were fully certified in July.

SP: Yes

MS: then in Feb.

SP: I see what you're saying

MS: in Feb. they moved they came here and they didn't certify us. I assume if the reason was one of the problems that you were having was that they had stiffened the regulations that by Feb. they had already done that. Is that correct.

SP: They certainly had done that by Feb. I think during the year or even 6 months to a year preceeding Feb. 88 they were in the process of stiffening the interpretation.

MS: So, but back in July we were meeting their standards

SP: Right

MS: and then between July and Feb. something happened so that we didn't meet them in Feb.

SP: Right

MS: so I assume that's when it happened.

SP: Right

MS: A couple of other questions about then. One, I just I would like to get your opinion of the stiffening of these standards umh. Was this just some bureaucratic Mickey Mouse thing or is this something that was terribly important for patient safety and and care.

SP: I wouldn't characterize it as bureaucratic Mickey Mouse. I think there was substantial concern on the behalf of certain Congressional members, I referenced what Lowell Weicker earlier that said that Medicare and Medicaid were not enforcing their own regulations strictly enought, therefore, the federal government was unwittingly privy to creating less than perfect conditions in institutions.

MS: but from your personal point of view as the Comm. of Mental Health then you feel that probably these stiffened regulatiopns were a good thing?

SP: I think they're a good thing if they're fairly interpreted and we the states are given ample time to get in compliance. I do not think it a good thing to force through an estate, unannounced and, you know, let the chips fall where they may.

MS: Ok, so by February 23 of that year you knew that those Federal things were in place and I guess one of the things that puzzles me a little bit, is some of the sensational things that we've heard, that the deaths at AMHI, the supposed abuse, and rapes and soforth, occured in August almost or more a half year after these were in place. I just wonder if there's any

relationship between uh, sticking to you standards, and the fact that that these sort of sensational things happen or the standards were stiff and I just...

SP: First of all one correction. I did not know that the stiffened until June.

MS: But in February...

MS& SP: (can't decifer)

SP: But I didn't make the connection, none of made the connection in Maine that this had happened because of incruel stringency. We did not neccessarily know that we just knew that we weren't in compliance.

MS: Weren't in compliance with what?

SP: That we were not in compliance with uh the medical records condition, and the staffing conditio.

MS: But when they came out in February, which (can't decifer)

SP: That's what I mean. We all renew after the February exit interview was, that we were not in compliance with those two conditions. At that time we had no notion, that things were being you know, more stricktly interpreted, therefore, when we put together a plan of correction it was done with the idea that we would formulate the plan of correction as we had in the past.

MS: Here in July, you get certified then you come to February and the Feds come and say we're not going to certify you, but you don't know why?

SP: Well yes we do know why. We know that the staffing condition and the medical record condition is not in. Now, I may be missing some information here, and perhaps...

MS: So are you saying that between July and February, that deteriorated?

SP: That what deteriorated?

MS: The staff and medical records because um, what your saying is, in July it was OK, February it wasn't, but you didn't know that the Feds had changed until the following June.

SP: Right. I am not willing to say that the staffing had deteriorated what I think we, I need to here is what the Assistant to the Superintendant might say about the differences in um look at how the Feds looked at the staffing, in February, compared to last July. Also how they looked differently at the medical records.

MS: OK but again I had assumed that you would have known in February, that they had made some changes in their standards.

SP: The standards...

MS: The reason why you were having a hard time dealing with it.

SP: Standards again did not change. The interpretation of

the standards changed.

MS: You did not know that in February?

SP: I did not know that in February.

Ms: OK.

MS: (can't decifer)

SP: yes.

MS: (can't decifer)

SP: You are saying that you were not present the do-, well I my reader would disagree with that point. Excuse me?

MS: Let me point out because it says(can't decifer)

SP: OK.

MS: and it says and subsequently Human Resourses Committee members began to arrive sharply (can't decifer) to allow everyone to arrive get coffee and settle down. (can't decifer)

SP: OK, you are correct Representative------

MS: (can't decifer)

SP: May I also point out that in previous administrations and perhaps we need to collaberate it from people before me. That the Legislature had not been routinely notified of pending Medicare decertification. Unless it was thought that the solution to remedy that involves staff. At that time, we did not believe that staffing was necessary.

MS: I just I would think, that if your inviting (can't decifer) Weather you do need money or you don't need money. If there's ----- to the Mental Health Advisory Council which has not people who are elected which are not people that you have to cut in front of to (can't decifer).

SP: Should we adopt a new policy between the department and -----

MS:It isn't a (can't decifer) the Governors Mental Health Council which (can't decifer) by Gov. Mckernen and Gov Brennan(cant't decifer) I heard this a couple days ago, (can't decifer) and I think most people who sit on the committee(can't decifer) I don't remember is because we were never told who had the meeting.

SP: Would also point out that the Governors' Mental Health Advisory Committee is created by statute and these people do have an oversight function over the department.

MS: They have the Advisory and that is the reason why my commission the one I formed last year was (can't decifer)

Female voice: (can't decifer)

SP: Do like a kind of (can't decifer) yeah ok.

MS: We had several staff members uh in the February time period that were actually punching (can't decifer) we were very much wondering if they would give us credit (can't decifer) one thing we did coactively, after they left we proceeded to convert the classification from Mental Health Worker to Correctors to properly recognize the (can't decifer)

SP: Would you like further explanation from Assistant Superintendent Hanley?

(can't decifer)

SP: What are you talking about? February 23rd? No I did not. I will have to ask the folks behind me who did.

Female: I (can't decifer)

SP: Representative Burke we have so many reviews by health care financing as well as the department of Human Services wich is the HICVA state agency in Maine. Now it would by ni impossible

Tape: 3

(FS = Female Speaker)

FS: When you lost the funds what happened next?

SP: We recongized that our plan of correction didn't do the trick. Now I'll tell you from the Comm.'s level what I did and then it may be seemly to ask Asst. Supt. Hanley to speak it from that perspective. What I did was to ask the Supt. for a solution. What do we need in order to 1: up the quality care but secondarily to allow us to recapture Medicare and the result of that was a staffing plan that called for 15 staff plus three under contract. The three under contract involved two physicians and one psycologist.

FS: So after you lost the recertification you realized that you needed more staff. More staff was not recommended prior to loosing?

SP: That is right

FS: And who's so so the Supt. never suggested more staff

SP: The questions levied to the Supt. was give us you know give us the plan for correction. He didn't necessarily say that we needed more staff in order to retain Medicare at that tune. However, after we lost it it became painfully aware that we needed to do something in order to regain Medicare for 30 beds out of a total facility of 383 beds and upon that kind of request he gave us what I just said. The staffing plan for 15 plus 3 contract. And thereupon we were obviously working very closely with the Administration and Governor McKernan made a decision to let not wait any longer on this and lets begin to fund this out of the Governor's contingency fund. I do recall on June 16th that I phoned various members of the Human Resources Comm. as well as the co-chairman of the Comm. to study overcrowding as well as the co-chair people of appropriations to let them know of this decision and what the dollar value was for that.

MS: So at that point in time were seen as first and foremost patients

SP: patients, that's right

MS: care and secondarily at regaining Medicare .

SP: That's right

MS: Were you aware then of all of the horrendous things that have gone on since that time.

SP: No (pause) I was aware of you things, you know of patient incidences that are reported on a daily bais via our census form.

MS: (can't make out)

SP: That's right, that's right umh I was aware that

Office of Advocacy attached to the Commissioner's office. I was aware that that individual had been seeing things in the hospital and he had been working with the Supt. on a very regular basis to umh at least tell him what was going on. Now

MS: With the incidents that you were aware of because they come in a daily report.

SP: Um huh um huh

MS: so then you were aware of things like patients receiving beatings from other patients.

SP: I was not. I don't recall that I think you're referencing the Department of Human Services Report. I can't with certainty because I don't have photographic memory on my on my incident report I don't if anything like that ever appeared I just know occasionally incidences are reported there have been very few, you know, over the two years.

MS: Would it be appropriate for one of your senior staff people or someone (shuffling papers) that a 74 year old woman is raped on your on your

SP: Of course it would be. Yes

MS: control.

SP: The Supt. came to me several days after it had happened and told me about this incident and I believe we were in a meeting over at AMHI when I learned of it.

MS: And your response

SP: I was pretty shocked.

MS: what were your professional response, or administrative responses.

SP: My administrative response was find out why and find out who and take care of it. Make sure it doesn't happen again.

MS: did you intervene yourself at that point.

SP: That's a commissioner intervenes by saying you know, look into it, take care of it, let's not have it happen again. That is an intervention.

MS: Was that just purley a normal intervention. Did you call senior staff people togther.

SP: We several of us in senior staff were togther when we first heard about this and were uniformly shocked.

MS: No specific crisis intervention team was then

SP: alright I because my information is perhaps more superficial then you need I would need to have someone from AMHI come forward to tell you what it is AMHI's response was.

MS: Actually, I'm more looking for what your response, your as commissioner what your response was other than to say "let's

not have this happen again.

SP: I asked I asked to know what the staffing was surrounding the incident, why was there a lapse, why was there no supervision.

MS: Was a written report every made to you to give you the answers to these questions.

SP: I don't recall, but it may well have. I just don't recall.

MS: Did you receive a letter in August from the Maine Advocacy Services.

SP: I received many letters from the Maine Advocacy Services.

MS: They cite a letter that they sent to you in August

SP: umh huh

MS: that was never responded to and then they wrote a subsequent letter on with numerous recommendations

SP: yup

MS: for action by you and I was wondering if response.

SP: I don't recall not responding. I know that Laura Petavello, the director, has been in my office several times and she also has been with us as we have reported out the finding of the so-called death panel or the advisory panel to look into the AMHI deaths and there has been communication back and forth. Now I don't recall specifically not answering letters. I know that several responses have been called for, in fact, there is one on my desk now that merits a response as soon as I have time to do it and it came in about three days ago.

MS: Is this the one that called for unh for example referrring Dr. Rohn also to the medical board for license repeal in that he was also involved with patient care and both patients died or

SP: I do believe that letter does contain that particular sentence.

MS: and your plan of action.

SP: My plan of action is that I will not refer Dr. Rohn to the Board of Medical Registration. The other three physicians that were referred to the board of Medical Registration came as a result of recommendations from other physicians reviewing the individual cases for which the three were individually responsible.

MS: internal review

SP: I am not, I am referring to two phases of a review carried out first by Dr. Jacobson and secondarily by people who are very much outsiders to the usual business of the department and

deaths that do occur in institutions not just institutions but in hospital. That second phase of the review was begun in Oct., concluded the middle of Dec.

MS: So now your peer review of the deaths of the patients within the facility. Was there any type of review initiated to review the cases where patients, other than Depart. of Human Services, where the patients were were alledgely receiving beatings from other patients, where a 74 year old woman was raped

SP: Yes I understand

MS: was there a review of these kinds of things.

SP: There was an internal review at AMHI.

MS: Ordered by you.

SP: It's a common AMHI when it has you know incidences going on reviews those incidences also we have an office of Advocacy that has a job to do. The job of the chief advocate who I think is sitting right back here, who is accountable directly to me is to bore in on these and to render umh an impartial, you know, view to me about what happened and they do numerous and I might may I also say, that it's not only to AMHI but it's advocates who are sighted at Pineland, and in our other facilities.

MS: So when they bring this to you as Comm. your response is?

SP: My response is that this is uh certainly descriptive of a bad situation and it is another source of information that leads me to feel that this institute is in trouble, I used I think someone Rep. Clarke used the word crisis earlier and that changes are most definetly in order. Now I said earlier, also, that I was in the process of evaluating several proposals that had come from groups who have been impacted you know, by the various things going on at AMHI over the last 18 months and I will tell you that solutions will rest in those proposals and we're needing to put together a group of people to you know, take a more thorough look at not the incidences, that for the record but how we can solve some of these very, very severe problems.

MS: My problem with this seems to be exceedingly slow. The problems, in fact, seem to go from bad to worse and your senior admin. staff

SP: no

MS: still only meets with you once a month. I have a real problem is the only word I can

SP: OK, well I think what we maybe want to do here is to look at the umh time frame during umh the time frame of these incidences that occurred for the different wards under DHS guardianship. Now all the incidences that are cited did not happen during the month of Sept. Yes the review happened during the month of Sept. but the incidences may have happened sometime before that I they I'm sure didn't cluster together neatly such that we are able to say umh that certain things are as problematic as they look. Yes there not good but we

need to be clear about time frames. Also you know, the deaths in August, which I did cite as one of the problems that umh has given us grave concern umh institutional deaths do occur. Now I do not say that to minimize the fact that 5 people did die during August, but I will share with you that the numbers of deaths for the last umh 10 years or so have ranged between perhaps a low of 18 a year to a high of perhaps 27. Now I can get you the precise numbers because

MS: I don't doubt that with the number of patient deaths

SP: right

MS: again umh I I am very well aware of some of the side effects of the psycho drugs and I am not a psychiatric nurse umh and I also know that you with patients who are receiving pshychtrophic drugs that certainly a psychiatrist and definetly people who work in psychiatric hopsital should be aware that patients who are receiving such drugs are at risk during a heat wave. Again administratively there seems to be no anticipation of that as a problem and very belated response after the facts.

SP: I would point out to you that it was I who convened this panel of outsiders to look into this. That was done on Oct. 19th and they took approximately 6 weeks to go through a very complex examination of three different incidences. The finding of this panel was that one death was clearly heat related. Now I know that Dr. Jachobson here can speak with much more depth and authority than I can on the medical reasons contained within these umh different incidences.

MS: I still again I go back to umh physicians, nurses, anyone dealing with that facility in which patients are receiving psychotrophic drugs have to be aware of some of the umh side effects

SP: yes

MS: of those drugs. Umh they they don't necessarily have to anticipate heat wave, but most psychiatric hospitals that again with which I am familiar umh have air-conditioned spots so that the patients who are at risk can can make use of those kinds of places.

SP: umh huh yup. OK, I am going to call Dr. Jachobson up here because I want the record exceedingly clear about the nature of the investigation into the heat related deaths and his findings.

Dr. J. I'm I'm very glad to be able to comment on this particular issue because I did make it a point of significant study including search of the literature, ah, a view of this issue in the larger context and particularly in the context of the very unusual weather of last August. Let me just say as an introduction that it is my belief that the people of Maine and that includes the average everyday citizen as well as the professional did not have an appreciation of how a heat wave like that could be dangerous to people. We live in vacation land, people come here to get away from the heat. I think most people in Maine just did not think it was dangerous. I happen

having chosen those two weeks for vacation because even being on the lake was a very uncomfortable. I much preferred to sit in an air-conditioned room in my home. What I'm saying is that most Maine people would have said "I love this hot weather, I can't get enough of it". They did not really appreciate what this was doing to people in institutions. I don't think that the mental health system had a deep appreciation for how serious the situation was and I start from that premise to try to play out what really happened. I think there has been alot of distortion in the press about this very issue. The heat wave was a very real thing. People did develop heat stroke. It is my belief that it was a new phenomenum not previously encountered. We had no history of a patient actually suffering heat stroke at AMHI prior to Aug. prior to the summer of umh last year. I hesitated on Aug. because actually there was a case of heat stroke in July and it was treated very promptly and appropriately once it was recognized. There were a total of 5 patients in the hospital that suffered heat stroke. All were treated very promptly. One developed brain damage, wound up in coma at Mid-Maine Medical Center and eventually died of pneumonia, but there were 5 cases of actual heat stroke. That was recognized by the staff. The response once heat stroke was recognized was very rapid, very well carried out and it's my belief that the individuals involved should be commended for the kind of care they provided. But, nevertheless, the general preception was that this was not a dangerous situation. We did not know the actual heat on the wards. We did not know how dangerous this really was, and it wasn't until these events occurred, the actual deaths, in the early part of Aug. that there might be a real problem affecting directly the care of patients. That's my introduction.

FS: If I may,

DR.J: Please

FS: Before a nurse gives a medication to a patient he or she has to know the side effects of that medication and has to watch for those side effects. The fact that there was a long period of time before the the side effects were recongnized, in fact, the side effects umh or that the heat stroke was happening as a result of those side effects is is to me inexcusable. The psychotrophic drugs are known, and have been known for at least the past ten years to inhibit the ability of the body to sweat. People in institutions have long been recognized as being at risk in any kind of an institution when there is a heat wave. People in the general public are recognized for being at risk when there is a heat wave or else they would not print on the weather reports the ozone content and the pollution content of the air. Even in vacationland. Maine Maine get high temperatures like other parts of the country just happens to cool off at night most of the time but that was the problem this summer is that it did not cool off at night. Patients in any institution are recognized as being at risk and especially in a psychiatric institution. And if the nurses were not aware of this the physicians, the psychiatrists had to have been.

DR.J.: The panel discovered that they were actually not aware of it.

FS: And when the panel discovered that of course 5

DRJ: No. Five patients did not die of heat stroke. One patient died of heat stroke. There were 5 cases of heat stroke and 4 recovered without any damage whatsoever.

FS: OK

DRJ: lets just get the facts on the table.

(SP: from background) She doesn't understand that there were 5 deaths and there not the same people.

DRJ: there not the same people.

UNKPER: right

DRJ: 5 deaths and 5 heat strokes are not the same people.

FS: The other 5 people who died had a complicating factor of heat.

DRJ: No they didn't. Two had absolutely no connection with the heat whatsoever.

FS: And this through an internal review you found this out or the external review.

DRJ: I did an external review. I did my review as medical director of the dept. I'm external to AMHI. I'm with the department but I'm external to AMHI. I did a preliminary review and based on my review I determined that 3 of the 5 patients that died in Aug. ought to have a further review. Now let me just say there have been some references to why were there five I thought there were four, and this argument has gone on in the press also. There were four initial patients that became the focus of attention. When I was given my assignment, I included the fifth patient, because he happened to die in the month of August and I said I might as well look at all the cases that died in August to be complete. Out of those five two, in my opinion, had absolutely nothing to do with the heat but totally seperate issues. But three were in some way in my mind related to the heat. Based on that, that determination my recommendation was for further study. And it was then that the open process began of naming a panel publically and having them charged with investigating those three deaths in detail. And the results of that were delivered to the public.

FS: and coroner reports on the patients who died cooberate your feeling that the patients, all the patients had no(can't decifer)

DRJ: Well it's a deficult finding to do post-op. The one patient who did die subsequent to heat stroke, who actually died of pneumonia uh, carries a secondary diagnosis of heat stroke but that was established as a result of the clinical record the medical examiner can not make a diagnosis of heat stroke because it's made on the basis of the elevated temperature. And unless he has a medical record that indicates what the actual temperature was then the post mortum findings are such that would point directly to the cause of death being the heat stroke. He'd do it on a clinical basis. There were no autopsy findings that would support the diagnosis of heat

stroke in and of itself and in fact I had asked Dr.Ryan weather they actually were any cases of heat stroke reported to his office, and the answer was no. I had subsequently found out from vital statistics that there had been a number of heat strokes reported as secondary diagnosis in the state of Maine for the year 1988 and I'm still encouraging them to generate more statistics to get a better idea of what that is. So there were some distortions and I think some confusion about wich patients are we talking about what phenomenon is really going on. I hope it's clear now.

FS: Somewhat. My next question is then, have you made recommendations that air conditioning be installed that there be increased staff education about the effect of psychophobic drugs that the

DRJ: Representative Clark I made those recommendations when I happed to be present at a medical staff meeting at AMHI. Immediately after the incident occured that was I believe, August 10th.

REP.CLARK: Did you tell (can't decifer)that these were your recommendations?

DRJ: I indicated the need for air conditioning and cool areas in the hospital immediately and that was done on the following day. I subsequently told Commissioner Parker my concern that this was a poorly understood phenomenon, and that training of staff was going to be essential before next summer so that it does not repeat itself.

REP. CLARK: Thank you. Commissioner Parker, if I can talk to you for a moment again um, the question that I have is administratively and (can't decifer)

SP: Worker poor administrative staff together we don't put all administrative staff together because that would be an inefficient use of our sources we pull those chief people together who are directly responsible. And that included the Superintendant the doctors at the Augusta Mental Health Institute at that time were accountable to the Superintendant.

REP CLARK: and your senior administrative staff.

SP: My, would you like to, yeah. My senior administrative staff include the Superintendant of AMHI, the Superintendant of BMHI, the Superintendant of Pineland Center, the director of the Bureau of Mental Health, the director of the Bureau of Mental Retardation the Bureau of Children with Special Needs, the Assistant to the Commissioner and the two associate commissioners plus the Medical Director.

REP CLARK: OK, so you..

SP: We do not pull everybody together when a series of incidents like this or a similar incident happens we pull together the affected members and yes, we problem solve. There is a ventilation study going on now in the state government to look at the needs of AMHI. Now it's a known fact that burocrocies may not work terribly fast, but they do work. But we need to keep on them. The Bureau of Public Improvements is part of the Department administration whenever AMHI as a facility needs a change in its physical plan we can make the

recommendation that this change occur but we have a higher authority that we must go to, its called the Bureau of Public Improvements and they must sign off on the need for this sort of study. And that is what has happened and that is what they are doing.

REP CLARK: As Commissioner, do you essentially can expedite a number of things by emphasising them, by

SP: Believe me they have been emphasized.

REP CLARK: Well not too long ago you told me you were unaware of a number of incidents so how....

SP: And I said to you, that many of these incidences as exemplified in the Department of Human Services reports goes back several months to maybe even as much as a year. Now, when I learned of the findings of the DHS report which was let me see, probably last week when I saw the report in its fullness, I simply said this is another in- another set of instances that point to fact that we have major problems at AMHI and yes we need an aggressive solution and from an executive branch agency may I say that we're entertaining several different solutions and I would be most happy to involve this committee subsequent to this hearing in the discussion of those.

REP CLARK: Um, my last question you know, and I'll hand it back over to others, um if you mentioned the fact that we have you (can't decifer)

SP: Bureau of Public Improvements. It's called Bippy.

REP CLARK: So you have ---- for comming in, or (can't decifer)

SP: I am hopeful that it will result in that but first we must go through the assessment of what ventilation needs must go where. AMHI as an institution is a sprawling physical plant and perhaps some areas lend themselves to air conditioning, perhaps some areas lend themselves to air ventilation systems that are able to move vast currents. I am not an engineer. But just a minute, I am not an engineer who understands air flow and dynamics. Therefore, I must rely on people outside of our department to give us the reccommendations on what would be most effective to achieve a certain end.

REP CLARK: But you have now roots that patients on psychophobic drugs can be housed can be (can't decifer)

SP: Dr. Jacobson could you take that one? Because she's talking about individual patients and probably individual cases.

DRJ: Actually AMHI has had air conditioned rooms for some patients for a number of years constant observation rooms are at least two of them that I know of are air conditioned. And when a problem is identified, those rooms are used for air conditioning they were inadequate in size and number for the problem of the heat in August in the middle of July to the middle of August. Once it became apparent that there was a serious heat problem, AMHI was able to obtain a number of window air conditioners and install them. Unfortunately the heat wave was over a few days after that. It was one of those things where the correct response came but it was a little late. You know that the, even though it was terrible weather

it only lasted four weeks. It seemed like an eternity at the time. We really expected each next day to improve the situation but once the air conditioners were installed there was only a matter of a few days and we were back to normal Maine temperatures.

REP CLARK: So anticipating the result of your studies, of ventilation studies and things like that you had put money, um, requested money in the budget for...

DRJ: No. No money has been requested to my knowledge. What has been requested is an engineer study of what is needed to control the quality of the air in the buildings at AMHI that house patients. Because of the fact that it is a 150 year old building it's built of granite and you know granite retains heat there are some very special characteristics of the building and it's not enough to just put air conditioners in you really have to look at it as a larger engineering problem.

REP CLARK: Which is fine but did you include money to appropriatley intervene when the study is completed. In your budget.

DRJ: I don't think that's been targeted yet. Is that right?

MS: We've discussed, with the bureau of Public Improvements, the scope the possible dollar scope of that project. A (can't decifer) to determine what the cost will be and exactly what areas need to be ventilated more adequately. Um we heard as high a number as two and a half million dollars to air condition the entire facility. And so until we know exactly what the cost will be there is no specific request, that I'm aware of at this time.

REP CLARK: (can't decifer)

SP: Not necessarily because I think there is clear recognition in all phases of government that something must be done. Which leads me to a point. and that is that the litney of things you know you raised some very good questions there are plans for each one of those. You did not raise new information. But you raised some very good questions about each one of those items.

REP CLARK: Thank you. Actually when I (can't decifer)

SP: Well the panel the advisory panel that I appointed on October 19th resulted in a series of recommendations. Those recommendations have been passedon to the AMHI medical staff. The medical staff is assuming more leadership for the maintenance of AMHI the DHS report which you may have read about that was released yesterday contains a plan of action in it on how the department of Human Services and the Dept. of Mental health and Mental Retardation will work together to do a better job of monitoring those words under the guardianship of adult protective services.

FM: But as Commissioner, you have not really got a handle then on the specific plans of action that will result.

SP: Yes I do have a handle on it. It is a process. And the process in this sense is just as important as the content and I hold certain key individuals accountable for the execution of

each one of those recommendations. In the case of the panel that elicited its slanders in December concerning the three deaths that it investigated thouroughly I am holding the clinical directors, Owen Buck, and William Sullivan through the acting Superintendant Walter Rohm directly accountable for that implimentation and for moving up the chain, Dr. Jacobson has oversight of all areas of medical involvement in our institutions and he is a part of that process.

MS: Yes we're (can't decifer)

FS: (can't decifer)

SP: and my intention in passing out the minutes of that March 10th meeting was that I understood that chronology were important and I thought that particular meeting might identify a vehicle where legislators were involved.

FS: (can't decifer)

SP: OK OK. Dr. J. oh Rick Hanley, beg your pardon oops medical records and reporting.

FS: (can't decifer)

MS: I had talked earlier today about the plan that we started last March which is on going we have as far as medical records we have implemented a process wich I think should improve and is improving the documentation from the time the patient comes in the front door. The, one of the clerical staff persons that we were able to get through the legislature we have beefed up our medical records clerical component and so we now, and also very schedules so that admission notes, for example, are transcribed by 8:00 in the morning. So that when the physician for the admissions unit for example the overall clinical director comes in in the morning he has that admission note from the evening before in his hand when he sits down to reinterview the patient and review the work of the person who did the admission. We have developed a new neurological exam form and that is being monitored the use of that. Claudia Shultz coordinator has been part of her duties have been shifted to monitoring medical records compliance on the admissions unit as well as her duties throughout the rest of the hospital we have beefed up order recommendations. One of the deficiencies that was noted was that we were not building treatment plans that were based upon patients strengths and it's very easy when you work with acutely and chronically mentally ill people to focus on their deficit areas and that not look at the restraints that they posess. So we have been orienting our staff and monitoring the compliance with building treatment plans that are based upon the strengths the assets that that person brings with them to the hospital. Treatment plan procedures have been revised as I mentioned this morning to make it more likely that a solid assessment or group of assessments will feed into that comprehensive treatment plan we have had consultation going on for the last three months or so on the admissions unit also on our adolescent unit. As far as treatment planning and documentation and that has been I think extremely useful. We've been working with both the teams on the admissions unit to give a better sense of the disciplinary process, which is in part what Medicare is looking for. They want position direction of the process they want to see that the team comes together discusses, interviews the patient

discusses the assessments and comes up with some kind of a consensus plan so that the whole team is moving in the same direction, but under the direction of the medical staff. Those are a few of the things that we've done. We have several people now who are doing auditing and not just, like our patient care coordinator who reviews charts and gives feedback retrospectively to staff we are moving very quickly in the direction of getting an audit which means you have to look at a chart look for weather the strengths and assets are there weather the progress notes relate back to the treatment plan and so on and when we find a deficiency, we are going immediately to the person and correcting that deficiency. So theres not so theres (can't decifer)is shortened up a great deal. Now just one other example before I stop we've been of course in the medical staff area we have improved our monitoring of progress notes which are to accompany every physicians order. That is one of our standards. Recently we completed a medical review of 632 doctors orders and of those 632, 630 had a progress note. Now, that's not to say that every one of those progress notes was A-1 quality, but they were there and we're moving very strongly in the direction of assessing the quality not just quantity of notes and the time limits, but also the quality of our documentation.

FS: (can't decifer)

MS: Yes it does. For the new staff that come in we have enhanced the medical records documentation. A piece of our orientation program. We thought that that was an area where alot of staff were keyed into writing kind of daily care notes. Patient slept well, ate well and so on. We have included a stronger component in our initial charting orientation for new staff that goes really to the heart of quality observations and documenting based on those observations. Adressing the treatment plan and the nursing care plan.

FS: (can't decifer)

MS: I'm sorry, you mean when the patient moves from one floor to another or a staff person is pulled or moves to another floor? They are, the initial training that we have done reached all areas of the hospital we didn't want to focus just on the Medicare distinct part. and We used a train the trainers model. There was a group of 44 who are initially run throught the training and the intent has been that they would go back to their individual units and work with their treatment teams on documentation. So there is some kind of outreach in that sense.

FS: (can't decifer)

MS: We are on the admissions unit right now we are evaluating the teams on an ongoing basis. Both the team process and the product of the documentation. We I think have work to do, in other areas of the hospital. We don't want to neglect the rest of the institution.

MS: (can't decifer)

SP: 64.5 to AMHI

MS: (can't decifer)

SP: Yeah there were several physicians that (can't decifer) now there were a variety of mental health workers at through levels one physician three, that's the top level of physician allowable the state government. There was um, one psychologist too persuing your theme of psychiatrists once we knew that Medicare was gone MaY 29th, we did make arrangements for the bringing back of Owen Buck from the Maine state prison to you know, give his one day a week. And we also added a half time psychiatrist to help us out. Within the Medicare package itself there were two psychiatrist. they are under contract and that is what was referenced earlier that we have to, because there is such a possity of psychiatrists in Maine, we have to go through a national brokerage location farm to find people who can come in once it's an arduous process, but it is doable and we have found some good people that way, both at BMHI and at AMHI.

MS: (can't decifer)

SP: At this time... end of tape.

Tape #4

MS: I am not trying to tell you that there are no medical record deficiencies in the way that progress has reported. We've recognized that there are deficiencies. Within the resources that we have, we're trying to do our best tot correct those.

Female: I have just one more question(can't decifer)

MS: The patient to whom the secondary diagnosis was heat stroke? No.

FS: (can't decifer)

MS: No he was not. No.

can't decifer

MS: a general feeling that everyone felt the (can't decifer)as you know (can't decifer)

MS: Go ahead and ask and I'll tell you afterwards.

MS: (can't decifer)

MS: Boston is the regional office there technically disbursed from the Maryland central office.

MS (can't decifer)

MS: We get notice a matter of two to four weeks ahead of time.

MS:(can't decifer)

MS: Yes

MS: (can't decifer)

MS: It traditionally has been two or three people, most recently two, and we have had repeat visits from the same people I think one of wost surveys three or four successive reviews.

MS: you had these people show up on February 23rd (can't decifer)

MS: No. They were not.

MS: OK. So perhaps part of the fear was that (can't decifer)_

MS: Well, they were certainly certainly hardnose, I think there was some um indication in um that list a couple of the earlier surveys that certain things were acceptable one month, six months later were not acceptable.

It was not saying that you could say yes there was a definate trend, but it did appear that, for example, on survey would have gotten our nurse staffing back up to snuff that was I believe in May. May of '86. When the team came back, a different team came back in September of that same year for there anual survey we were certified, but they thought that our nurse staffing was not adequate and it was exactly the same number of registered nurses as we had had in May of that same year when we were fully certified. Again interpretation of the staffing versus the patient need kind of approach.

MS: (can't decifer)kind of reestablished the fact that there was (can't decifer) general feeling in the departments(can't decifer)

MS: I think there were some clues, I don't know that it really hit us over the head, that there might be this pattern but there were some clues along the way.

MS: evidently by the end of May (can't decifer)

MS: Yes.

MS: (can't decifer)I just want to (can't decifer) I wanted to change the subject slightly um, I (can't decifer) I think is of interest to me in your opinion someway to make your own judgement. If you could just set yourself(can't decifer) and deal with the following issues: one (can't decifer)time frames or particular issues that they might notify or even put in writing but you not be notified of that, and weather you feel (can't decifer)

SP: um, when you say communication, what do you mean by that?uh talk to her?

MS: well it seems to me by the documents I've asked you questions about before and the material that I've read, that there are some things that some staff members viewed as important and significant in terms of the way the regulations were being interpreted and the situation at the to yourself said many many times that one you didn't read that particular section and didn't expect the (can't decifer) and that you didn't actually come to that (can't decifer) until June. So there's either there either lacking a proper communication between those who vote those reccomendations, or their just not, have not been pushed enough to make sure that you are privy to those kinds of pieces of information.

SP: No. On the fact that I haven't read what it is, I didn't know what you were reading from. Once I figured out that it was an introduction to the plan of corrections, indeed I had read that. Um if hindsight was twenty-twenty, and I wish it was, I said that once before um perhaps we should in the department engage in more written communication you know one to the other. I am so mindful of the time bind on the senior staff that I rely on verbal communication a great deal. Between and amongst the various inner staff members to communicate what's happening and what's not happening.

The issue of the standards interpretation of the standards again if hind sight were twenty-twenty I wish that we had been tougher on ourselves at that point. But truely you know you have heard from Mr. Hanley and heard from Dr. Rohm and you've heard from me now there was constridation, perhaps, about the stringency or constridation about how stringent these standars would have been interpreted. And I would point out that that constination is shared by my peers across the country it still continues. You know I talked with a gentleman from Tennessee last week and there in the throws of a discertification I wish I had assumed a worse case senario and sort of layed it down and said damn it you know this is a tough situation and let's treat it like that. If we had done that, um perhaps things would have been different. But I can't predict. None of us can predict.

MS: Well I don't speak for the panel, but I think we're all concerned with not only fact finding in terms of what went wrong but also where do we go from here?

SP: Where we're going from here is that we're going to assume that it's a worse case senario and that they are interpreting the standards with this medicalized prism in front of their eyes and we will execute the preperations with that in mind.

MS: But in terms of communication between staff at the facilities, and you (can't decifer) Do you see, or do you desire any changes in the way it's worked(can't decifer)

SP: I am confident that the communication that happened last February and preceding last February as well as what happens now, that the communication is full of meaning and allows us to know what goes on. Now meetings are important that's true. But what's more important than meetings is the willingness and the ability of people who work under you to say gee, maybe I don't know how to do this after all. I think one of the absolute benefits of this hearing, and I say that having gone through a number of hours here is that we now have some you know collaborators perhaps in the legislative branch, who are more (can't decifer) of what Medicade, Medicare are all about, and what the you know the process is for the reviews. Having said that, I think if communication can approve, I'd like to use up more of your time , than I have in the past. I know on several occasions last year I talked to the co-chair people of this committee and I said I would like to come and do a briefing we did that a couple of times and I know that that becomes particularly important once appropriations sets it's schedule because this committee um with this level of information now about a program will be very much better fitted you know to see the policy side of the appropriations question. I would be looking for opportunities to do that with you all.

MS: and the last point of it, and the reason I mentioned that again between the various groups is that Dr. Rohm did when Representative Manning asked him a question he suspected a change, it obviously was (can't decifer) on you suspected that, and I would think that in terms if I had been in your position and found out at this late a date, someone directly involved in that he being clinical director and there were several others obviously that fought their big changes but I if I didn't know about it as Commissioner I would have been concerned as to what system was there (can't decifer) was apprised of those changes

I guess I'm just looking for something a little more specific on your part as to what you are going to do to avoid those situations in the future it was made pretty difficult. A different situation in terms of being aprised to various parts ...

SP: I think, you know particularly given what we've been through with AMHI and now the the honest knowledge that there is a change that has been inclimated Federally that will be much more strict, then how the reporting comes back. In my world of management, I call that a feedback group. I mentioned earlier that the Associate Commissioner for programs is in charge of monitoring all the external reviews. I think what we will do is to take steps to make sure that the feedback is given to me and all of us on a regular basis and regular doesn't mean once a year it would be more like twelve to fifteen times a year, on how we're doing meeting the certain standards as we have to think about undergoing another review. I know as we speak there is um, the Department of Human Services has scheduled two reviews at AMHI and I think they ar comming as soon as next week, the next two weeks. Definately we need to know you know this all um raises the question of the funding mix, that we're using to finance these multiple services um, the cost it actually takes to participate in Medicare and it is a cost, you've heard about it from staff uh, how we're doing on drying down Medicade you know, and our ability to do that depends directly on how well we're fitted you know to actually qualify for the money.

MS:(can't decifer) Is it a rule making process?

SP: No. It's not a rule making process it's an administrative decision that will then an Institues SuperIntendant can then put into motion. That Superintendant usually um, talks with individuals throughout the department to make certain decisions.

MS: Uh, when you presented the budget, for '88 in a special session, um, you recommended (can't decifer)

SP: Yes I did.

MS: and uh you were at that time(can't decifer)

SP: Yes we were.

MS: I'm surprised(can't decifer)

SP: Yes. and that was one position from each and what , the rational behind it is that we needed three positions to build a quality assurance unit that would benefit all the aspects of this departments functioning particularly the mental health units and Representative Penderson given me a great opportunity to talk about how several months after I arrived here I layed the plans for establishing a highly beefed up and strengthened unit that would put into place, methods that would allow us to answer the question how well are our services doing on behalf of people with mental illness and mental retardation,it's not a paper shuffle.

It is an actual evaluation that will occure that we that we sponsor to answer those questions. Now you may know that both BMHI and AMHI have quality assurance people. But they do the quality assurance internal to those institutes prior, there had been no mechanism for the product of those evaluations to answer the important question about patient care. They've been a vehicle for bringing that back to the central office. Consequently, here we were doing our budget, doing our policy stuff, with no direct feedback between the two. Not good. And that particular position that came from both AMHI and BMHI was used to create, you know, the positions that were needed in order to make sure that our internal evaluation system could get up and working, and I am very pleased to be able to tell you that last October we hired a highly qualified individual in quality insurance who is doing a remarkably well given you know, that we are spading the ground for the first time and putting together a system wide evaluation. Further this individual has spent much time at AMHI advising consulting with the um, AMHI quality assurance staff and is a great help because he is so knowledgeable about the Medicade Medicare regulation and also the JCAHI requirements. It's a good investment.

MS: At that time(can't decifer)requested previous positions(can't decifer)

SP: Well they came back, we came back in September and upped the anti by 130.

MS: The other thing I'd like to be a little more knowledgeable about is that right now we're only talking about (can't decifer) at AMHI..

SP: Yes. Yes. Thirty beds that um, are now without their Medicare funding out of 386.

MS: and previously the (can't decifer)

SP: We had 86 and there were a couple of decisions were made to not go after Medicare funding for those, primarily because on one unit there were I see, like four people who would be Medicare eligable and it was not deemed to be worth the staff effort because of the cost to go through it for four people, exuse me Ron Martel has the exact numbers.

Ron Martel: We had 86 beds certified after the May decertification we were left with sixteen. There were 78 cute psychiatric beds represented by two wards one a thirty bed unit, one a forty bed unit. A sixteen bed infirmary certified for medical surgical care. Which is certified as of today by Medicare.

MS: How does that affect the previous thing (can't decifer)

SP: The 125,000 lost per month? Why don't you talk for that one.

MS: These thirty beds come back, is that going to replace that one?

Ron Martel: Not entirely, no.

MS: The other thing is that what do you think about having, is that as far as we can go as far as involving federal funds for A(can't decifer)

Ron Martel: No. It is not. In terms of Medicare certification, uh, we think it is appropriate to certify or recertify just the admissions unit which is at now just how we have it at Bangor Mental Hospital and have had for many years uh, we working very strongly with a consultant to increase the Medicade reembursement to the general fund and over the past year 1.2 million dollars has come back in. Net federal dollars the general fund. As a result of that effort, in addition an additional three thousand dollars per year is being generated this year. As a result of that effort, our daily rate has gone from $62.00 to $86.oo so there was much that was able to be done in terms of Medicade what we've been discussing for many hours here today, has been primarily Medicare uh..

MS: (can't decifer)

SP: Well um, I think we're on the right track here. I earlier made reference to the fact that the comprehensive plan that we spent a year putting together resulted in a blue print that called for developement of additional positions at AMHI and BMHI as well as extensive developement in the community. Now the percentages, Rick help me out is it 60-40? That 60 percent of the admissions to AMHI are first time admissions and 40 percent are repeat.

MS: Roughly (can't decifer)

SP: Forty and Sixty

MS: How does that compare with say where we were a year ago? Is it in the same ballpark?

MS: Roughly the same, but it's considerably higher than we were say 70 or 80.

SP: And the reason is I think you'd agree Representative, that it's higher is that there has been an alarming possie of services in the community. Now if you like we can go through a status report on where we are at on community developement.

MS: I have some knowledge..

SP: Yes. I thought you might.

MS: I just have one other question I have some people that are interested in STIGMA and they (can't decifer)

SP: Well I am very embarrassed to own that and I must tell you that I am guilty, and it happened at a time when I was exceedingly nervous in my Old New England (can't decifer) came out. And I know better than that and I don't you know in my heart I don't feel that way. So that was an unfortunate remark and I apologize.

MS: (can't decifer)

Female Voice: Can't decifer)

SP: No. No no no um, we see all patients in need of care equally. I do not you know, none, neither I nor any of my people at the senior staff level differenciate you know, whose client is whose. I mean we need to deal with these people. If anything we understand that if a referral comes from child protector services, or adult protective services that um, that referral may or may not be appropriate but the larger problem may rest with weather or not the proper services is available in the state of Maine. It's that kind of question that we go through.

Female Voice: (can't decifer)

SP: I don't know where you got the figure Representative of two hundred and fifty.

Female Voice: I was subtracting the numbers(can't decifer)

SP: Oh, the thirty from everything else?

Female voice: yes (can't decifer)

SP: No. I see what you are saying. No let me be clear on that I said to you earlier when you persued your first line of questioning you asked me directly, weather or not I thought AMHI was in a direct state of crisis I said yes I do. And then I went back and reviewed why I thought that. Now I should tell you that the Commissioner of Human Services and the Commissioner of mental health meet, we meet regularly and we met I think it was last week on the issue of the DHS referrals and thinking about certain steps that need to happen and I am confident as Assistant Superintendant Hanly said, that there is good colaberation between those two agencies and the staff people who are doing it. Now, on the issue on my management style, I'm not just exactly sure of what you are referring to, but I believe in a style of management that does not distance me from what's going on at the grass roots level now we understand that I have a very large department to run and I can't know everything about everything I wish I could, I can't. I do absorb a fair amount of detail but I have put together, and I did this in July of '87 a senior management team I listed out the ten or eleven members of that team and each member of that team is intrigal to the total operation of that department and we operate by the crito that quality information has to get around to all of us and that is why we meet on a frequent basis. Also stylistically, we are very direct with one another if we have issues , if we have problems we understand that it is a no surprise mangement that's not something that we tolerate. We expect our peers to be upfront and to level. And it's also understood that, if I feel like I should visit a hospital at odd hours of the day or night, that I am able to do that and that is no regarded by members of the team as a threat. And that's part of the trust level we have to have in order to keep our courage in the face of fighting the real enemy which I'm sure you'll agree is mental illness.

Female: (can't decifer)

SP: No. How many have I had with Rollin Ives? Well we started on this I'm going to say late August early September, late August. Around this one DSH issue uh, Commisioner Ives and I have many things in common one of them is Medicade, Medicare. Children and Foster care.

MS: (can't decifer)

SP: I'll be there. Work it out.

MS: (can't decifer)