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STATE OF MAINE

HUMAN RESOURCES COMMITTEE

Hearing on Augusta Mental Health Institute Issues held on January 31, 1989, in Room 228, State House, Augusta, Maine.

Carmen M. Thibodeau

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Augusta, Maine
January 31, 1989
9:10 a.m.

SEN. GAUVREAU - Good morning. My name is Paul Gauvreau, I am the Senate Chair of the Joint Standing Committee on Human Resources. To my immediate left is Rep. Peter Manning of Portland who shares the Committee from the House side. This is the second day of hearings the Committee is holding relating to the problems attendant at the Augusta Mental Health Institute.

Prior to resumption of the hearing, I'd like to address an issue which came up at the very end of Thursday amongst Committee members. There was some concern that some materials were not fully distributed to all members of the Committee. My understanding is that now all members of the Committee should be in the possession of similar documentation. There have been apparently ten of these briefing books prepared rather than thirteen, so what I suggest we do is make sure that at least we distribute them in a fashion so all members of the Committee can look on. There are two - there's one in from of Mark Sirois. Okay. Do all members have access to the briefing book? Okay.

I received this morning a document which purports to be the response of the AMHI medical staff giving a response to the AMHI advisory panel which dealt with the investigation of the various deaths at the facility and I will ask Committee staff during the course of the day to reproduce this document and make it available to members of the Committee as well. And I would suggest the protocol - that any documentation which is used

by any member of the Committee in the course of these hearings be available to all members of the Committee, that anything prepared outside the Committee format is your own separate work product, but if you introduce it and discuss it or make reference to it in the context of the hearings, it should be deemed Committee property and available to all members of the Committee.

Are there any questions regarding that protocol? Hearing none and seeing none, we have asked - we being Peter and I - have asked for leave to be excused from attending the sessions this morning at ten o'clock. I understand there are some roll call votes relating to confirmations in the Senate and we've asked those to be held until the very end of the Senate session so the Senators can be excused from the Committee for the purpose of voting on the roll calls. I do not believe there will be any roll calls in the House today, but I would ask the Staff of the Committee to check with the House to make sure there are - if there are roll calls, obviously, you'll be excused from the Committee responsibility for the purpose of going to the roll call. And I would be remiss if I did not introduce to the full members of the Committee our new Committee Clerk, Mark Sirois, welcome on board.

At this point, I think we are ready to resume the presentation of Commissioner Parker, unless there are any other questions. As you recall, when we broke on Thursday afternoon, the Committee had completed questioning relating to the issues of decertification at AMHI. Now today's focus with Commissioner Parker will be on

the whole class of issues referred to as quality of care. Now, Commissioner Parker has requested the Chairs and we have granted her request to allow Dr. Walter Rohm to return to the institution to make his rounds and attend to his medical duties this morning, so I would ask members of the Committee to refrain or hold your questions from Dr. Rohm until this afternoon when he will return, so we'll allow him to attend to his medical duties.

At this point we'll again - let's open up the hearing relating to issues on quality of care and, again, welcome Commissioner Parker.

COMMISSIONER PARKER - Thank you, Mr. Chairman. If you so permit, I would like to open up with a series of comments.

SEN. GAUVREAU - Certainly.

COMMISSIONER PARKER - Good morning, Senator Gauvreau, Representative Manning and members of the Committee.

Before we begin I would like to make some brief comments that I believe will help us to continue this dialogue in a way that will most benefit AMHI patients.

I'm sure that you understand that our staff are under a lot of pressure to get the new programs underway that will eventually help reduce AMHI's overcrowding. This is an especially stressful time for staff, because AMHI is functioning without a super-intendent. However, I do believe that the staff and the Committee can all use this time productively if we lay out for you what steps we have taken to get AMHI back on its feet and then receive reactions and input from this Committee.

The seven hours of questioning on Thursday truly resulted in a fragmented description of what we've been doing and I'd briefly like to paint for you the big picture.

As I said last week, AMHI is a very troubled institution. It's plagued by serious problems of overcrowding and years of inadequate attention and underfunding. We can't change those problems overnight. However, there's no question that this Administration and this Legislature are committed to making the changes happen as quickly as is humanly possible.

In the past fifteen months AMHI has received a level of direction and support which truly is unparalleled in the last decade of the hospital's history. In less than a year and a half we have approved ninety-one staff and millions of dollars in community resources to alleviate overcrowding in contrast to the seventeen staff in the preceding years.

If we take a look at this chart done in blue, what you'll see are the years from 1980 to 1989. The title of the chart for those of you in the gallery is AMHI Annual Admissions and Full-time Equivalent Positions. What we see is, looking at the blue bar, annual admissions have continued to rise. They dipped briefly in '86. However, what we see from the period of time 1980 through 1985, while the admissions went up, the staff full-time equivalents continued to go down. However, beginning in 1987 the trend clearly changed. While the admissions continued to go up and, yes, even further than the previous high in 1984, we also see that the numbers

of staff also continue to go up, following the trend of the admissions.

A total of $27 million is being appropriated for a thirty-three-month period between October, 1988, and June 1991. We have adopted Maine's first truly comprehensive mental health plan, the product of thousands of hours, very hard work by staff, by 1,200 volunteers and consumers. We have also created an independent commission to oversee the implementation of this plan.

An important question is, though, however, what plan do we have for putting these resources to work and getting AMHI back on its feet.

The plan for AMHI is dynamic. It is composed of a series of very concrete actions begun months ago and updated as other significant events have taken place. The long-term goal of our plan is summed up in the conclusions of the Commission on Over-Crowding in its interim report delivered to the Legislature in January, 1988. The aim - to develop the badly needed community resources for mentally ill persons and their families so that AMHI can fill its proper role as a public psychiatric hospital.

Certain actions in our plan are aimed at bringing AMHI's admissions unit into compliance with Medicare and are contained in the plan of correction prepared before Medicare decertification in May, 1988. These actions, as you heard Thursday, were amended and eighteen staff were added to AMHI and paid for out of the Governor's contingency fund during the period of June to mid

September, 1988.

The more comprehensive plan was completed incorporating all prior actions in the form of our state mental health plan distributed in July '88, which served as a basis for the additional staff request approved in the September, 1988, special session.

When an unusual number of deaths occurred in August during a short period of time, I ordered a series of internal and external investigations which resulted in recommendations which now have been incorporated into our plan. The plan has now been expanded to include yet another set of recommendations, those that have come out of the DHS, that is, the Department of Human Services investigation into the wards of adult protective service who reside at the Augusta Mental Health Institute.

All of the actions I am describing constitutes a plan for AMHI that has one purpose, to improve patient care and treatment. A critical question is how well are we progressing with it. The answer is not nearly as well as I would like. Over the past few months I have seen increasing evidence that AMHI has not had the kind of managerial direction and leadership that could get the institution back on its feet. So in early January I asked for Superintendent Daumueller's resignation to pave the way for some high level management changes.

We must remember that AMHI, a public psychiatric hospital, is the third largest hospital in the State of Maine and that in addition to the special psychiatric needs of patients, it has

many of the same complex needs that large hospitals have. It is a 380-bed hospital with nearly 700 staff of psychiatrists, psychologists, physicians, nurses, social workers, therapists, support people, which include dieticians, housekeepers and hundreds of others involved in patient care.

Strong managerial direction is absolutely vital to the development and implementation of sound operational plans for such a large hospital and I do not believe that we have had it.

When I referred to a crisis last week, I was referring to a current crisis in management. The serious underlying conditions at AMHI have been known to us for a long time and I believe they have actually improved over the past year and a half. However, my confidence in the plans we adopted for dealing with these conditions and the pace with which plans have been moved along has been undermined by the growing evidence of weak management at the top.

To deal with this current management crisis we are in the process of identifying and bringing in outside expertise to analyze AMHI's management capability, focusing on such areas as organizational efficiency, staff deployment, administrative practices and communications systems. We need someone to come in who has a fresh perspective and who has experience in dealing with the complex needs of a very large specialty hospital. This analysis will provide us with a sound basis for evaluating the plans we have in place.

As I told you on Thursday, many affected groups have been proposing solutions to AMHI's problems. Until we have objective and expert analysis, however, it is not possible to determine whether our plans are flawed and in need of change, such as those proposed, or to determine whether progress is simply a matter of strong and aggressive leadership at the top to make our plans work. We can be assured that any recommendations that come out of this effort will withstand scrutiny by experts in hospital management and those others who are versed in mental health care and administration. Thank you.

SEN. GAUVREAU - Thank you, Commissioner Parker.

EXAMINATION OF COMMISSIONER PARKER BY SENATOR GAUVREAU

Q. Now, I understand that you have spent I guess the last eighteen months or so in working with various groups in crafting an overall mental health plan, the objective of which is to reduce the census at the state's acute care institutions and augment community base resources. Based upon the information the Committee received on Thursday, it would appear that there will be an interim period of time when those objectives in the short term would not be realized and that, in fact, there seems to be justifiable evidence that substandard levels of care exist to some degree at AMHI and so the question which I would posit would be, what in the short term would you propose that the Governor and Legislature do to raise the standard of care, to address the most salient concerns which have been discussed

frequently over the last few weeks until such time as the hoped-for benefits of the long-term plan are realized.

A. I would propose that we continue with the persent schedule and action plan that we have concerning the community programs. Many of you know that in September we presented you a time line for the actual development of those community programs. We are still in observance of the time lines that you were given.

Secondly, I would propose that we, as I just said in my opening remarks, that we continue with our discussions with management firms that are highly skilled in hospital administration and work with them to help us evaluate the different solutions that will come on the table. We are in absolute recognition of the fact that the issues at AMHI are those of a large, highly complex organization and those pertaining to a speciality hospital.

Q. Well, I guess the concern that the Committee members have at this point, which I have heard from a number of people in the community who do not ordinarily involve themselves in any matters of politics or government, there seems to be a developing perception in the community that we are tolerating and expensing substandard level of care at AMHI and that, frankly, I don't believe people are prepared to wait much longer before the State takes concerted action to address those concerns. And I can - it's fair to predict that if that's the perception of the community, those same concerns are shared by the membership of

the Legislature. And last week I did ask you in terms of your time frame or had you a particular plan proposed to this Legislature and you indicated that you would be planning on meeting with the Committee and developing in a collaborative vein a response, but I think it's important that we have a definite time frame and that the Committee knows when specific proposals will be forthcoming. I understand you apparently have engaged a consultant to offer an independent perspective in terms of the problems that AMHI has, but we need to know specifically when would you be ready to come to the Legislature and offer a particular plan of action.

A. Senator, so that the public record does show, in the Department we have interviewed three possible firms that are very versed in psychiatric hospital management. We have two other interviews to conduct. I have two proposals sitting in my office now. We are waiting to get the full picture via the other interviews. It would be timely, I would think, in two to three weeks to come - to meet with your Committee to discuss the various options in these proposals and to work with you on what the recommendations are.

Q. So, is it your understanding that within that two or three week time frame you would have had an opportunity to select a firm to assist the department in restructuring AMHI with a service delivery system and then in that time frame to make focused proposal to this Committee as far as where do we go from

there?

A. Recommendations, that's right.

Q. And have you - is it your position that you may approach the Governor or you may recommend funding or modifications in the budget based upon the discussions with this Committee and based upon the discussions with your consultant?

A. From what we see now, Senator, the actual cost for the consulting is affordable and we can handle that through internal means. As far as financing of possible recommendations, that is, solutions to extant problems, I think it's a bit premature to speculate how that may work, but we would be happy to work with you on what those recommendations are.

Q. I just mention this because it seems to me that there'll be strong sentiment in the Legislature to have a particular plan of action with the specific funding proposal before appropriations to consider during this Legislative session.

A. Yes.

Q. I'd like to call your attention, if I might, to the report which was prepared by Commissioner Ives relating to the assessment on public wards who are residing at AMHI. That report, I believe, is dated 11/9/88. Do you have in your materials - Susan, do you have that report?

Now, in the past concerns have been raised regarding individual identifying materials contained in the Department Report and I understand that the report has been redacted to excise the

particular names of any residents. And, frankly, although I'm very much concerned, of course, with the individual cases, I think my concerns are at this point directed toward the specific response to the Department with respect to the recommendations. Now, the recommendations can be found, I believe, at Page 8 of the DHS Report and there are, in fact, some ten specific recommendations to the public ward - regarding public wards rather. And then there are nine specific recommendations to then Superintendent Daumueller and then there are recommendations, two in number, pertaining to training and policy development at the institute. Can you indicate to the Committee what the formal departmental response was to this report and what actions have been taken to date to address or respond to the various recommendations?

A. The first thing that happened, the leadership of AMHI were asked to put together a response to the DHS full report and they have done that. They posit and I concur that this report does not yet include the results of independent consultants who are also engaged by the Department of Human Services to actually examine various clients in question here. I know in particular there is a report from a psychiatric consultant and the results of that particular report have not found its way into this report. And we feel that we would rather wait until the entire finding, you know, which does include the consultant report, is part of the record here and then to make a formal response.

That is not to say that certain highly specific and concrete actions have not occurred, because they have. For example, the - let me pick out one here. Number 9, this particular recommendation emanated from what I will call Case #9. This individual - individual's teeth were knocked out in 1984. At the time this particular individual did refuse treatment and at that time also the Department of Human Services was not guardian for this individual. This individual also, when queried, wishes to remain a resident of AMHI. She - the individual continues to refuse dental care and most treatment and she has the opportunity to move about AMHI very freely. That is not to say that dental care and the use of dentures is not something that has not been addressed. However, in this particular case that is the background.

Q. So your understanding is that the resident has declined dental services?

A. Correct.

Q. With respect to the others, putting aside the whole issue of making institutional changes, these are all patient specific and address particular problems in their care. Has the Department - aside from #9, has the Department responded or changed the environment or made particular corrective procedures to address the needs of the other nine patients that are listed here in this report?

A. Regarding Number - Recommendation #10, as I alluded to and referenced in my opening statement, there are several solutions

that have come forth from the affected parties at AMHI. And as I also stated, we are in the process of reviewing thoroughly each one of those and I also stated that in order to evaluate correctly, we need the assistance of a firm that has an outside perspective before we're willing to recommend sweeping environmental changes. Now, there is another level of environmental change and that concerns, for example, #1, recommendation that emanated from #1. I believe that individual, which is Case #17, was the subject of intense questioning last Thursday by Representative Burke. We allow as how this particular incident was not handled particularly well and we concur with most of the recommendations made by DHS. We will collaborate fully in actually meeting them. Policies that define staff role and responsibility are indeed well defined and the nurse on evening duty did not state that she has supervisory responsibilities over physician assistants.

We also reiterated, and I believe it was Dr. Rohm that did so, the male patient involved was removed to forensic where he now stays. It is part of that individual's treatment plan that he should not reside on a co-educational unit.

Training sessons have also been scheduled with Adult Protective Services staff regarding how actually to handle situations like this, including the reporting requirements. Training is planned with the Augusta Police Department on managing potential legal violations. Human sexuality as a topic area has been added to

the training curriculum for staff. And perhaps most importantly of all, inexperienced registered nurses will not be - will no longer be placed in charge of specific wards and I don't mean wards of Adult Protective Services, I mean wards as living units.

Q. So if I understand, we've gone now from the cases dealing with public ward specific problems to the generic recommendations on training and policy development.

A. That's right, that's right. And in so doing under A on Page 8 I have referenced Recommendations 1 and 3.

Q. Recommendation 1 on the bottom of Page 8 and Recommendation 3 on the top of Page 9, is that -

A. Well, perhaps we have different versions, Senator. I'm working off the complete recommendations dated November 9.

Q. I have that. We're referring again to the public ward recommendations.

A. Right.

Q. One and three. Okay. Now, if I understand correctly, regarding the public wards, the Department has taken some action with respect to Cases #1, #3

A. Nine and ten.

Q. And 9 and 10, and 10 being a rather generic recommendation, the first nine being patient specific. Does that mean by implication that the Department has taken no action at this juncture regarding Cases 2, 4, 5, 6, 7 and 8?

A. Let's see. On the instance of Recommendation #8, which shows as Case #22 in my summary sheet, this particular individual - the

recommendations that she needs a recliner in order to ease the swelling, I believe that has been done.

Q. When you make reference to Patient #22, perhaps there's a document we don't have, we have the summary, we don't have the full report.

A. It's probably - it's the same person, but it's just a different way of numbering. You've got - these are Recommendations 1 through 10 and the case numbers that I'm reading are for the actual case numbers as assigned by the Department of Human Services so I'm transposing when I respond to you.

Q. Okay. Now, this report was dated the 9th day of November. Can you indicate to the Committee or do you have information as far as the time frame on when a particular corrective action was brought to bear by your department?

A. Let's see. In regards to the case regarding the recliner, that - I think that question was raised about May 26 and the issues having to do with that person were begun to be resolved in September of 1988.

On the - let's see, Case Nos. 1 and 3, that particular incident occurred on a Friday evening. That was April the 21st and on 4/15 remedial actions began to be taken. Actually remedial actions began to be taken earlier than that as far as understanding how the reporting ought to be a little different, but they waited until Monday morning to begin to understand how it is the different events needed to play out so that the event would not

repeat itself.

Now, I have given you kind of a manager's overview of this particular case and I know the more specific dates as far as, for example, the sexuality training and the date by which the decision was made to no longer place inexperienced RNs in charge of wards, that information, I think, would be had by Assistant Superintendent Hanley, if you're wanting a precise date.

Q. Well, I'm just trying to get a general overview in terms of what action we've taken to date. Now, I understand that you've refrained in part from responding pending the filing of reports from the consultants of the Department of Human Services.

A. That's right.

Q. And my concern here is that although we may, in fact, affect broad based generic changes in the institution upon technical reports yet received, obviously we should immediately address problems identified as far as patient-specific cases are concerned. And so I guess what I would be very interested in today is whether we have - specifically how we have responded to these various - these cases.

A. Okay.

Q. And if we haven't taken appropriate response, I would like an explanation of why we haven't and I would like immediate action taken on these issues. I understand that apparently some of these issues were not - were known to the Department prior to 11/88. You

made reference to the rape case we know is different with April of '88, but there were other cases, the Case #8 with the - the lady with the recliner, that was known as of May 26 of '88, is that correct?

A. Hm-mm.

Q. And so I guess if these problems were of some long-standing nature, I think we'd like an explanation from Mr. Hanley or someone as far as why the prolonged delay in responding to apparently meritorious complaints regarding the level of care being administered.

A. Let me start, Senator, to give you an overview of the actions taken and I will then ask Rick Hanley to amplify should I have inadvertently left anything out. On - first of all, the AMHI staff who have been concerned with all of these patients have not had ample time to fully respond. However, that has not stopped the process from moving forward, which is several key meetings have actually happened with the Department of Human Services personnel to review what we consider to be a preliminary report. And we began the review actually referencing the twenty-one referrals noted above and which are the subject of this report.

On the issue of staff shortages, which is Recommendation #10 on your Page 8, there is acknowledgement that perhaps staffing is not sufficient for carrying out sophisticated programs such as that needed by one individual with extreme head injuries. That

individual now, however, has either been transferred or is about to be transferred to a more appropriate facility in Massachusetts and our people worked very hard to piece together what the funding for that placement would look like.

For another individual who was noted in the report as suffering due to staff shortages, this patient has been referred to the Senior Rehabilitation Unit where he can be more closely observed and his medical needs addressed in a more comprehensive manner.

The other two instances of staff shortages which were cited occurred on the Nursing Home Unit and this unit has staffing that is well in excess of what the Medicare requirements are for the unit. However, given the numbers of Level 3 patients, there still are times when there's insufficient staffing for individual feeding programs and the like and we're working on that.

Now, a second point is regarding the notification that was actually rendered to the public guardian regarding medication and behavioral changes to allow for proper authorizations, staff have been reminded of the need for such notification prior to actual changes in treatment. A memo will be sent to key staff along with the latest copy of the DHS authorization guidelines. For the precise date we'll have to ask Rick Hanley for that.

A third point is of the three cases in which current placement of AMHI was not felt to be optimal, one of these individuals has been placed in a boarding home. For the second individual, the actual AMHI staff disagree that an outside placement should be attempted as this patient has a poor medical prognosis and has

expressed his desire to remain at AMHI where the staff have a very caring relationship with him. In fact, this is the patient that I earlier referenced has been transferred to the Senior Rehabilitation Unit for oversight of this medical condition. There are other medically fragile people who do reside on this unit.

And the third instance in which the recommendation was made for a more highly structured ward for a person who is highly disorganized, this does not appear feasible and efforts are being made to adjust medication, and so forth, to allow perhaps for some compensation for this patient's incontinence, but the hoped-for approach would be to relieve overcrowding on the current unit so that more structure can be applied within the ward setting.

A fourth action concerns progress notations. There's at least one case in which follow-up treatment appears to be inadequately documented in the progress notes section. In the other two instances there's some confusion on the part of the DHS review team as to the required frequency of documentation, particularly on the Intermediate Care Facility Unit.

On the fifth item, and this regards terminology, the types of language that one uses to communicate the meaning of "long term care status" has been clarified with DHS and another term, medicinal misadventures, has been clarified. There is an additional record referenced which we would agree is inappropriate and this also will be addressed.

Now, a sixth item concerns follow up on doctors' recommendations,

development of a system for follow-up after the physician issues his or her order. The AMHI people believe that this citation represents an isolated case and an adequate system currently does exist for monitoring the physician's orders.

A seventh action which AMHI staff have done, in the one instance where medical follow-up was felt to be inadequate, in fact the two issues noted had already been attended to by the time the review took place and apparently this was not picked up by the review team.

And the eighth entry involves incident reports and it was an incident report that the DHS people could not locate. The report, in fact, that was not able to be found in the case record was, in fact, located in another location but was not in the proper place.

Q. Let me just pose a few more questions and then open it up to the full Committee. With respect to the survey or the assessment which was done by DHS of AMHI, is that an ordinary action taken by the Department routinely? Does it monitor or assess the care given to its wards or, if you know, was this rather extraordinary occurrence based upon the controversy and the issues relating to AMHI?

A. I believe that the Adult Protective Services Unit of the Department of Human Services has the responsibility to periodically oversee the various statuses of the clients under their charge. I am not sure whether this particular survey at this particular time was the product of other events or - the product of other events in public perception. What I would rather believe is that

the Adult Protective Services staff feel very strongly about monitoring the care of their clients that they deemed it timely to go in and carried out the survey. We are looking forward to a productive partnership with them and we do not regard interest and surveying by Adult Protective Services as anything except the proper thing to do.

Q. Has anyone from the Department of Human Services expressed reluctance at placing other wards at AMHI as a result of the apparent concerns regarding the quality of care at the institution?

A. Commissioner Ives and I have met several times and our respective staffs in our two central offices have met several times and we do agree that the results of the Human Services assessment have pointed out issues that we know are at AMHI. We are in concurrence, but I do not believe that DHS has decided to not refer its clients to AMHI.

Q. Is it fair to say that DHS has major concerns or reservations about the quality of care, but has not yet finalized its response dealing with shortcomings?

A. That's fair.

Q. And do you have a particular time frame when you would expect to receive from the Department of Human Services the completed survey with the psychologist's recommendations?

A. I would think that that is only a few weeks away, several weeks, two to three.

Q. Finally, we've heard in the press apparently the Probate Judge

in Kennebec County, Mitchell, has taken a rather extraordinary action of sending wards under his custody to other facilities than AMHI and do you - have you received any reports specifically with the - from the Probate Court relating to the particular cases he was concerned about or do you understand - what is your understanding as far as the reason that Probate Judge Mitchell has taken that course of action.

A. First of all, the Probate Judge's office has not communicated directly with my office and as far as I know what I know about his position is what I've read in the newspaper.

Q. Is there any effort being taken by your department now to inquire of the Probate Court as to the reasons he took that rather drastic action?

A. We feel that the thorough assessment that was rendered by the Department of Human Services and the resulting recommendations have augmented our own information and understanding about care and quality of care at AMHI for these twenty-one people and we feel that working with DHS and, yes, in concert with the Probate Judge's office that we best get about the task of solving the problems, so we do not take issue with the report that his office issued.

Q. If I understand you correctly, a lot of what we're talking about we're in the process of establishing new protocols and a new service delivery system, but the concerns that I've heard this morning is that to some particular patients their needs have

not yet been addressed and wouldn't it be logical to refrain from referring individuals to AMHI for the time being until we can put in place immediate corrective action to make sure that until the final reforms are brought to bear we raise the level of care to a decent level at AMHI.

A. Senator, I would disagree with you that of the individuals and the presenting problems that have been identified, many of these needs are now being met. However, that is not to say that all needs are being met and, yes, I think that we have a critical policy decision before us as a department and the policy decision involves who is AMHI best suited, you know, to take care of.

Q. It just seems to me that to a significant extent the public faith in the institution has been shaken over the last few weeks and, I mean, a number of people have approached me who do not ordinarily involve themselves in any public policy matters and expressed major reservations about the institution and I think that when actions are reported like the Probate Judge's action or perhaps the DHS survey, it only bolsters or exacerbates the concerns that we are not perhaps providing now the kind of care we feel we must as stewards of that institution, and although are mindful that we're working toward long-range reforms, I still have concerns at this moment that we haven't taken all appropriate measures to address the immediate concerns which were identified in the DHS survey report.

A. As I said in my opening remarks, Senator, AMHI indeed is a

very troubled institution and it's plagued by serious problems of overcrowding and years of inadequate attention and neglect and we can't change those conditions overnight. I further stated that we are in process of interviewing various firms that are highly skilled in the running of a specialty hospital and one of some magnitude and when those interviews are finished and the recommendations are completed, we will be most happy to discuss with you steps that can be taken to improve patient care and by you I clearly mean the Human Resources Committee.

A. Thank you. Are there any questions of the Committee at this time of Commissioner Parker?

BY REPRESENTATIVE MANNING

Q. Susan, a follow-up on that, have you gone out to bid with these consultants?

A. Not yet. We are in process of interviewing them, just looking at them, seeing what they have to offer. Because they are highly - because they're engaged in highly specialized work, it's worth it from a manager's perspective to thoroughly interview and understand what they might have to offer. That is down the road.

Q. How far down the road? I mean, I know how state government works and that's the problem with me.

A. As I also said in the opening remarks, Rep. Manning, the first look at potential costs here are that, one, it's affordable, and, two, we can quite likely handle the bringing in of such a firm internally and that should speed up the process, given the

nature that the work will be contained within the Executive Branch.

Q. Do you have the ability to go right straight out, get that consultant, go through state government?

A. There is such an ability. I believe it's called a sole source contract.

Q. I want to get back to your 1989 supplemental budget, in other words, what's going to carry you through from - till June 30th, 1989. What have you put in for the supplemental budget?

A. Are we talking for the entire Department or for AMHI in particular?

Q. AMHI in particular and the community.

A. Okay. The supplemental budget is what's being heard next Thursday and what I will have to do is ask for a sheet of paper that's behind me. Rep. Manning, do you want the request or the recommendations?

Q. Well, the supplemental budget from what I understand and I'm not -

A. Are you talking about the supplemental budget as in Part II or the -

Q. Supplemental budget is something that gets you through the year 1989.

A. Yeah. We need the emergency request.

Q. Well, the emergency request.

A. All right. What I have here is the Part II that we referenced last Thursday. All right. Would you like all items?

Q. Well, obviously - well, I don't know. Yeah, run down the whole item - the whole list of items.

A. Okay. The title, Fiscal Year 1989 Emergency Request, which we will present -

Q. And I'm assuming when you say request, the Governor has okayed these requests.

A. Pineland Center, 310,000, reinstating of several positions. Pineland Center, Workers' Comp, Bangor Mental Health Institute, Worker's Comp, lab equipment for JCAHO compliance, Bureau of Mental Health, Medicaid state share to compensate for some federal adjustments in the block grant, the central office, state forensic service processing evaluations, central office, what's called the food account, that's food in the six institutions, central office, the fuel account, Bureau of Children with Special Needs, Medicaid seed and block grant reductions, the Elizabeth Levenson Center, Worker's Compensation, Military & Naval Children's Home, which is in Bath, if you don't know, Worker's Compensation, Military & Naval Children's Home, pre-adolescent housing, it's a refurbishing of part of that facility to begin to take some of the hard to handle kids who are on the street, but age eighteen and above.

Q. So there's nothing for AMHI at all then in there.

A. Not in the emergency request.

Q. And you don't think there should be anything in there - let me ask you this. Did you request anything for AMHI?

A. Excuse me, I'm conferring. There's an issue with the all other budget and the addition of 500,000 and we're still evaluating whether or not we need more, we need less, and I truly think for amplification on that what we would need to do is to talk about the function of AMHI in the all other budget and to go into some - maybe more description about the all other budget at the facility.

Q. Okay. If my face is strange, there are about a hundred strange faces out here. Do you want to explain that again?

A. Yeah. I'm going to have Ron Martel do it, because it goes into the highly technical nature of an all other budget and some of the costs and, you know, overruns that happen and then we will talk about why it's not in an emergency request.

EXAMINATION OF MR. MARTEL BY REPRESENTATIVE MANNING

MR. MARTEL - Good morning. In September there was an appropriation to AMHI in the all other category which included slightly over $500,000. Half of that appropriation was the projected cost of three additional professionals, the other half, approximately $250,000, was the amount that we projected we would be short this year in the all other category, having nothing to do with additional professionals. Having, for the most part, everything to do with Worker's Compensation. So half of the amount appropriated in September would have appeared in this emergency request had there not been a special session in September.

Q. So what you're saying now is when we okayed $6.75 million last

year, we were making up for emergency pieces that normally go sometime between now and about the middle of April to get us through the rest of the year?

A. Well, we took a look at AMHI's budget for the year and clearly it was because of overcrowding and because of the additional costs it was not adequate, and so the request was made at that time and funded.

Q. The question is now that's six month ago, there is nothing now in the all other account that you're asking for for AMHI or community base corrections - yeah, community base mental health.

A. As an emergency request.

Q. As an emergency request.

A. That is correct. L.D. 24 does not have any request for Augusta Mental Health.

Q. Were you asked to deappropriate anything in the 19 - the budget that would end in 1988 to help out in any way, shape or manner this - any money that you're getting now in this supplemental - in this emergency budget.

A. The budget that - the year that closed in June of '88?

Q. The current budget we're in now, were you asked to deappropriate anything?

A. Not that I can recall.

Q. Okay.

A. I would have to check, but I don't remember anything, no.

Q. So in other words, to make up for the shortfall, the emergency,

you weren't asked to deappropriate anything.

A. No, not that I'm aware of, no. Our total request in L. D. 24 totaled approximately $2.2 million for the Department.

Q. Were there other requests that you had for the emergency budget that were not funded by the Governor's Office?

A. No, every request we submitted in October was recommended at the level that we requested except for one, food. We requested $100,000 and the recommendation, as reflected in L. D. 24, is $75,000. That was the only difference from our request as submitted in October of '88.

Q. Okay. So it's safe to say then to get us through this - from now until June 30th, you're not looking for any additional - at this stage of the game you're not looking for any additional people, monies, not only at AMHI, but at the community mental health areas.

A. No, we're not looking for any additional funds for community mental health in the current year. We are looking at AMHI's all other to see if the original projection as done last September, in advance of the September 15th special session, will be adequate to meet the needs for the entire year. That is the 250,000 additional that was appropriated in September, we are currently looking at that to see if that will be sufficient.

Q. And when will you let Appropriations know that?

A. Thursday.

Q. Thursday.

A. If there is indeed a need for any additional funds -

Q. Well, I mean, we're forty-eight hours away, I mean -

A. I understand that, but the problem is that some of this information takes time to gather. We are taking a look at it now and if there is a need for additional resources that are not reflected in L. D. 24, the Committee will be advised on Thursday.

Q. At this stage of the game you don't - you can't say whether you're going to go for additional dollars.

A. That's right.

Q. Forty-eight hours away from the hearing at one o'clock on Thursday?

A. I don't know why forty-eight hours would make a difference.

Q. Well, I mean, it just seems to me that -

A. As long as we know the information prior to the hearing.

Q. I would just seem to me, Ron, that, you know, at this stage of the game you people would need to know - you would know.

A. I want to make sure that the information is as accurate as possible.

Q. So there's nothing in the supplemental budget or what I call the supplemental budget, Part II and Part I or down the road, supplemental or emergency, I guess, so there's nothing really in there for community mental health.

A. For the current fiscal year, no.

Q. Let me ask you a question. Word has gotten back that some of

the monies had gone out in September to the community mental health. Have you held any of that money up to anybody because of this hearing?

A. No, but - no, not that I'm aware of.

Q. I'm under the impression that a phone call went to the Department last week wondering where the money would be and that it was stated that because of this hearing that monies would be held up for the time being because maybe we would shift.

COMMISSIONER PARKER - Absolutely not.

MR. MARTEL - No, absolutely not.

Q. In 1989 - 1988 emergency budget, January '88, last week you stated you submitted a budget, but the budget, from what we understand, was only for Worker's Comp.

A. The emergency request for FY '88?

Q. Yeah, to finish you out till June 30th, 1988.

A. For AMHI?

Q. AMHI and community base.

A. I don't remember. I really don't. I may have the information here with me if you'd like me to dig it out. That sounds right, but I don't know.

Q. Okay. I'd like to speak to Susan.

EXAMINATION OF COMMMISSIONER PARKER BY REPRESENTATIVE MANNING

Q. Susan, if that's the case, if no money was put in last year, can you tell us why?

A. When you say last year that is FY -

Q. Well, to get us through to June of 1988.

A. Yeah.

Q. I mean, the only thing that was emergency was the - was the Worker's Compensation.

A. Well, to get us through June, 1988. We must remember where we were at in our planning process and to reiterate some - or to say again what I've said before, the commission that studied overcrowding began its work - I think it was September 10th, 1987, culminating in a recommendation to the Legislature January -

Q. But Susan -

A. Yes.

Q. To correct you one statement. The supplemental budget or the emergency budget is usually gone over in the Governor's Department and in yours early in the fall.

A. That's right.

Q. Our final recommendation did not come out until December, so what I'm saying to you - and that's a legislative recommendation and not an executive and what I'm saying is are you relying on the legislative branch of government or are you relying on the executive branch of government.

A. What I'm doing is trying to work collaboratively with the legislative branch of government using the best expertise that we have in the executive branch with the best expertise the legislative branch has.

Q. In 1987, the fall of 1987 you were putting your emergency budget

together.

A. Right.

Q. Were you requested from the Governor's Department to deappropriate $3.9 million from your budget?

A. I don't recall.

Q. You weren't asked to find ways to - savings of $3.9 million?

A. I - without going back and consulting, you know, all the file materials, it's not something that comes out to me. I do know that we were asked as department heads to look at all ways of using our dollars more efficiently and one of the ways that we chose to do that was to look at how extensive - how extensively Medicaid and Medicare, particularly Medicaid with its favorable match, how extensively it was being used to actually pay for needed services in the field of mental retardation and mental health. And what we did was to look at services that we were providing and what we discovered was that many of these services that were 100% paid for by general fund also qualified for Medicaid match. Therefore, we were able to stretch the use of general fund dollars further by coming up with creative ways to expand the Medicaid participation in the financing of services.

Q. Okay. I'm going to ask you - then you were not asked to find roughly 4% of your budget or roughly 3.9% of your - $3.9 million in your budget to cut out of your budget to use for other priorities.

A. We were asked to look and we were asked to look at possibilities

of how we could identify savings and we were greatly encouraged because general fund dollars are relatively scarce to be creative with how it is we could free up general funds and I just explained the method that we did, but, yes, we were asked.

Q. I understand, but what I'm wondering is the Governor's Office did not say to you, I need to have you go back, I need to have you take a look at your budget, I need to have you see if you can shave $3.9 million.

A. That kind of direction is done routinely as a way to make sure that we are managing in the best way we can with the use of general fund dollars.

Q. If that's the case then, what you're saying is the Governor wants you - wanted you to take a look at ways that we could cut and yet you've already mentioned that we are - this Department has - over the years has not put in - or I should say, not the Department, this Legislature has not put any money that was needed as you indicated by those charts.

A. No, to say again, Rep. Manning, he did not say cut, cut, cut. What he said was are there ways we can make general funds go further, which is a very sound basis for - or a very sound directive that is given to top managers.

Q. Decertification in 1988. After the surveyors left AMHI, they went to BMHI.

A. Yes.

Q. The question - he's not here and he asked me this the other

night - is if AMHI felt - Dr. Rohm said that he felt that when they left that things had changed, if AMHI had felt it, how come BMHI - we never heard anything about BMHI?

A. Up at Bangor Mental Health Institute the surveyors looked at the Admissions Unit. That is there - as I said last week, a distinct part. That is the only area of the hospital Medicare looked at. The admissions pressure on BMHI is very much less than the admissions pressure on AMHI, therefore, it was a bit easier for them to actually engage in the preparations for the reviewers.

Q. I'd ask you another question concerning decertification. You had indicated on Friday - or Thursday that one of the reasons why you feel that they were tough on us is because the Governor interceded in 1987, went over their heads and went to Baltimore to HCFA, is that right? And if that's the case, why did the Governor go over their heads in the AMHI situation?

A. Perhaps I was a bit too candid, Rep. Manning, in telling you, you know, the full story on what happened at Pineland. At Pineland we were in perfect compliance with where we needed to be in order to preserve that Medicaid funding. AMHI, as I stated to you very clearly on Thursday, we were not in compliance. I did say that the deficiencies cited were not inappropriate.

Q. Have we used all the administrative means with HCFA? In other words, do we have appeal - have you - I'm not that familiar, but there's usually, as in state government, if you pull money from

somebody, they have an appeals process and things like that.

A. Hm-mm.

Q. Same way I would assume with HCFA. Have you used every means possible to appeal what -

A. There are - there is only one other means possible if you do not like the findings and that is to go through an administrative law judge. Our Assistant Attorney General, Linda Crawford, investigated the case law using the vehicle of an administrative law judge. She determined that the cost of doing that and the time required would be inordinate and her recommendation to us was that we proceed, you know, with the April meeting in Boston on April 12th and see what came of that. And because there is a substantial body of case record on working with administrative law judges within the Social Security System, her recommendation was well founded on data and hard experience by other states.

Q. So you felt, one, that it would take too long.

A. And that the cost -

Q. And the cost would be prohibitive.

Q. Prohibitive, correct, and it was not just a matter of cost. It was the issues of staff time and taking staff away from the problems at hand.

Q. At this stage of the game why don't we adjourn.

SENATOR GAUVREAU - No, keep on going. We'll just go up and vote

REPRESENTATIVE MANNING - Okay. The senators have to go vote. Are there any other questions? Rep. Dellert.

BY REPRESENTATIVE DELLERT

Q. Yes. Thank you. Commissioner, I'd like to hear from someone who was in a senior management position under the prior administration. Does the current management in fact permit the Department to deal anymore quickly or effectively with the problems at AMHI?

A. Okay, then I would need to call on Ron Welch for that, who was also Associate Commissioner for Programs under my predecessor Kevin Concannon.

EXAMINATION OF MR. RONALD WELCH BY REPRESENTATIVE DELLERT

MR. WELCH - I guess the essence of your question is to compare management approaches. I think I describe - I would think I'd describe the approach in the previous administration as one of giving managers pretty much a free hand in managing their individual institutions or bureaus. They were administrative islands I guess would be a good way to desscribe it. However, if there was an issue of concern, of smoke or fire flared up, the Commissioner would get involved routinely in those cases. I guess if I'm comparing that to today, the approach Commissioner Parker takes is one of a more pro-active nature. She employs a management team that has more day-to-day working relationships with the various superintendents and bureau directors. And in terms of its efficiency I think was part of your question, how well does it work?

Q. Yes.

A. Well, I guess the upside of having an involved management style is that you're on top of the issues of the day, more on a regular basis. The downside is that you discover problem areas perhaps sometimes more quickly than you can address them. That's part of the nature of having an open system, I guess. I guess by and large my assessment would be that the approach to managing the Department today is very appropriate for the demands of the day. The Department has grown dramatically in recent years and requires this type of hands on mangement. Does that -

Q. Yes, thank you.

BY REPRESENTATIVE MANNING

Q. Ron, stay up, please. If that's the case, you're talking about hands on administration, i.e., senior management, i.e., clinical director, i.e., superintendent, i.e., you, Ron Martel. If those are the cases and the clinical director on Friday indicated to us that he had a feeling that things had changed in February when they came and supervised and did this survey, then why is that any - I mean, I don't understand. Those are the people you're supposed to be listening to. That's hands on. It seems to me that - he admitted that things had changed and yet the Department is saying that we never knew things changed until June. I mean, you can't have it both ways. You can't have hands on and know what's going on and then say to me that in June - when people admitted last Thursday that things had changed and the

thing that went to HCFA back on April the 12th said things had change, why all of a sudden things change in June when hands on people know things have changed, why didn't you people listen?

A. I was at the exit conference at AMHI in February and heard the results of the surveyors and it was clear to me at that time that there was a new emphasis on how surveys would be conducted and that was an emphasis that was understood increasingly by all of us in the senior management team. I think what you're referring to is a comment that Commissioner Parker made on Thursday that it wasn't until June that we called around other states to confirm whether or not our observations were accurate and it was then that we said, yes, indeed, after talking with four or five other states, this is a new development. So we need -

Q. Why did you wait until June? I mean, why didn't you start in February?

A. Because we had just come out of a survey that really put us against the wall.

Q. But, I mean, according to the narrative, and I indicated on the other day, in terms of Medicare certification we are convinced that many state facilities such as ours are having to make difficult adjustments. This is your - this is the Department sending this material to HCFA saying on April 12th, you know, it just seems to me that when you've got hands on people and hands on people say to you in February, hey, things have changed, that things have changed and if that's the style that this Commissioner

has and this Administrative has, then they ought to listen to the people at the time and not wait until June and call up other states and say, hey, did things change in your state? I mean, you had a feeling in February, you put it down in April, you got booted out in May and in June you're calling other states and saying something's changed here, how about you?

A. If all of our assumptions were accurate, I think the ultimate testimony to that is the letter from HCFA of April the 12th were they tell us there's enough reason for them to come back and take a look at the hospital. So until they did come, we had no reason to believe that we couldn't do the job with the planner correction prepared by the superintendent and his staff.

Q. I might add senior staff?

A. We were involved in critiquing the final document.

Q. So senior staff had the same -

A. We were briefed on it.

Q. You were briefed, but you didn't have any expertise to put into it.

A. No, that - most of that plan was developed in the hospital.

Q. By one man.

A. I believe there probably was additional staff input in that process.

Q. And who would those staff input be?

A. I don't know. I would have to defer to the former superintendent.

Q. Well, Rick, were you involved with that?

MR. HANLEY - To some extent, yes, I was.

Q. Okay. Any other questions? Representative Pendleton.

EXAMINATION OF COMMISSIONER PARKER BY REPRESENTATIVE PENDLETON

Q. I just have one question for Commissioner Parker, if I may. Commissioner Parker, last week there was some concern that this Committee -- about how you could be on top of a situation that was going on at AMHI and still only have monthly meetings with your senior staff. Could you explain that a little better to us?

A. I'd be pleased to. First of all, I did explain to you that we have a structure that's called the senior management team. There are approximately eleven members. Those members are each of the superintendents of the large facilities, the two associate commissioners, my assistant and the three bureau directors and the medical director. I depend on a personal relationship with each one of them in order to sustain active dialogue. Now it's totally in error to think that I only talk with each one of my superintendents once a month. That's totally inaccurate. Telephone, meetings, projects, there is a constant two-way dialogue going on between and amongst all of us.

We have numerous examples. For example, Pineland two weeks ago was the subject of a rather intense discussion concerning use of one of its buildings. Despite other activities, despite a high priority in mental health, I met with the superintendent and the board of visitors. We resolved the problem. I would

estimate that approximately six hours of my work week was spent in the resolution of that issue. Many phone calls occurred before, many phone calls occurred after, correspondence passed back and forth.

There are daily communications. Each day I receive a daily census that identifies by facility and by ward the numbers of people. Attached to the census sheets are any notations that may describe an incident that the Commissioner should know about and I should say an incident that does not fall into a Classification 1 which is the type of incident that I hear about immediately. There are several occurrences that I need to know about immediately.

Frequently in the last eighteen to twenty months I have received phone calls over the weekend. Perhaps the most telling phone call was the night that Bill Twarog, the mental retardation administrator from Norway was shot. I received a phone call at 4:00 a.m.

On several instances I have received phone calls from superintendents no matter the time or day or night, no matter whether it's a working day or not, concerning individuals who may be absent without leave and into some sort of difficulty, incidents that may have resulted in some type of accident or other matters. Other matters may concern the environment of the facility.

I also require a weekly report. Each superintendent and bureau director must write a weekly report that is short, to the

point and it is in my office by approximately eleven o'clock on Friday morning. I read the text of the weekly report. It gets folded in with the other weekly report and sent off to the Governor's office. I have weekly management team meetings. They generally occur Monday morning unless the Legislature has superceded the time. I also have meetings of the entire senior management team on a monthly basis. We each as a team member have responsibility for devising the agenda. Issues of the day, issues of the month are put onto the agenda. Indepth discussions occur. And to cite an example, our working with the Health Care Financing Administration. I stated that we regularly meet on policy issues. Not everything falls into a neat agenda, not everything falls into or can wait for a particular schduled meeting.

The institutes, both of them have boards of visitors. They will be phased out as of June 30th. However, the boards of visitors and the governing body, the boards of visitors met quarterly, the governing body met monthly. We get together on a regular basis for agenda items that are appropriate to those two structures. The board of visitors at the Augusta Mental Health Institute was composed of people who are citizens and interested others to the workings of the Mental Health Institute and I met regularly with that body.

Another way of staying in touch with the events and with the issues of patient care quality is the fact that we have

established as of last spring an office of quality assurance and quality assurance is a function that, when executed properly, will result in our ability to answer the question, how well are our programs working to make life better for the people in the institutions. There are people whose job it is within AMHI to do nothing but quality assurance. We have a director of quality assurance in my office. He reports directly to Ron Welch and from there to me. I hear firsthand his perspective about how well quality is moving and he is here today.

I also listen to the chief advocate. If - I have organizational charts with me which may help you. The chief advocate is attached directly to my office and he has several people working for him, one of whom is stationed at the Augusta Mental Health Institute and the findings and the different cases that the advocate works on are given to the chief and from the chief to me and that occurs on a regular basis. I have met several times with the chief advocate - not several, probably more than several - to discuss what the patient care situations are within our large facilities.

Lastly, I receive very regular input from staff. Yes, there's a superintendent, yes, a superintendent has many people reporting to him or her. I also talk to other staff who work there. I talk on a regular basis with the clinical director, with the president of the medical staff. In fact, in an unprecedented move by a Commissioner, I met directly, beginning two months ago, with the entire AMHI medical staff and the

president of the medical staff and I have determined that we will meet on a regular basis for as long as we need to do it.

I also hear - when I do visits to facilities I hear directly from staff and I must say that these staff are not shy about getting to the point fast and telling me their perspective and I very much value that. So that is ten ways I stay in touch with what's going on throughout this 2,300 member department that is flung all over the State of Maine.

Q. So in other words, if I were the superintendent of one of the facilities, I would have some kind of direction, I'd have a job description or some kind of direction on when to call you and you said there were different levels of critical elements that you'd be called, like Level 1 call, Level 2 call, Level 3 call?

A. The incidents that happen within AMHI are classified into one of four classifications and depending upon the severity of the incident, I may or may not be called and this is a protocol also that applies to notifying the Attorney General as well as other members of the wider law enforcement community.

Q. So in the case that we discussed before about the rape, if I were a nurse at that facility and I discovered that the situation had occurred, I would then, by protocol, call who, the superintendent, doctor, who would I call as a nurse and then how would it go up the line to get to you.

A. Depending on the time of day, you - the nurse would be

notifying the NOD, you know, the nurse on duty, the person - if it's after 6:30, that person would be notified by the chief of the ward, if it was an RN in charge of the ward. From there it goes directly to the superintendent.

Q. And then he in turn would call you?

A. Right.

Q. Thank you.

REP. MANNING - Michael?

REP. HEPBURN - Mr. Chairman, thank you.

BY REPRESENTATIVE HEPBURN

Q. Continuing with the case of the rape a little bit here, I guess that hits home a little bit with me because it's my understanding that the individual who was the victim of that lived in Skowhegan for a while. I heard somewhere that - I think I saw it in one of the documents here that the rape occurred on April 12th, is that correct?

A. Correct.

Q. That was Friday night? It was in the evening or -

A. Evening, eleven thirtyish.

Q. And you were called shortly thereafter?

A. I was not. I did not hear about it until at least Monday.

Q. You didn't hear about it until Monday. Do you know if the superintendent was notified? What happened? Does anyone know?

A. I think you'd have to ask the former superintendent those

questions.

Q. I see. Is that something that - I would imagine that a crime of that magnitude would be reported to the police in a fairly timely manner, too, and was that - do you know if that was done Friday night or -

A. I think that may have lapsed into Saturday. I need to pull out the incident sheet. It was not done as soon as it might have been done. The case record here references the fact that the nurse on duty, given this was a weekend and after 6:30, never received the call until 11:30 a.m. The incident happened between 11:20 p.m. and 11:45 p.m. And I'm going to call on Rick Hanley to tell me when the police were involved, time and place, please.

MR. HANLEY - It was late morning, September 10th, the Saturday following.

COMMISSIONER PARKER - September - we're talking about April?

MR. HANLEY - No, actually it was September 9th that it occurred and the following morning, late in the morning, the police were notified after the patient advocate had been called to come to the facility.

Q. Okay. I picked the wrong date, I guess. Is it a September event, is that what it was? This occurred in September?

COMMISSIONER PARKER - We're fixated on April 12th and 15th.

Q. Yes, that's right, it must have been -

A. I beg your pardon, it's September.

Q. Now, you mentioned someone was notified, Commissioner, I heard you say someone was notified at 11:30 a.m. the next day. Who was notified at 11:30 a.m.

A. What I said was that the nurse on duty was notified at 5:30 a.m. the succeeding morning. This happened on a Friday night, the incident happened between 11:20 and 11:45.

Q. Now, the nurse on duty, is that an individual that's actually on the premises or can -

A. Yes.

Q. That person being on duty at home.

A. No, no, that is a person who was on premises, who sits at the front near the main entrance to the facility.

Q. Okay, thank you.

REP. MANNING - Any other questions? Bonnie.

BY SENATOR TITCOMB

Q. I have several questions. In that particular case, in the rape case, were appropriate individuals present for the victim of that rape, psychiatric counseling after this happened? What was the medical procedure, psychiatric procedure after it was understood that she had in fact been rape?

A. That evening the victim stayed in her room and somewhat later was visited by one of the ward staff people and the clothes were changed. The clothes were sent down to the laundry. For the exact time of medical intervention and examination, I'm going to ask Rick Hanley that.

Q. I'm looking for some sort of psychiatric counseling, comforting after this took place. I'd like to know what the time frame was, if and when that did take place.

MR. HANLEY - The medical intervention, first of all, I think took place at roughly 5:30 or so the following morning. As far as supportive counseling, I believe that one of our psychiatric therapy instructors did meet with this woman on that Saturday morning. I couldn't tell you exactly the time. So there was some support offered. And I would also point out that while we had already acknowledged that the entire incident was not handled as well as it could have been that staff did attend to this woman immediately afterwards. Some of the things that they did would not have been recommended by the police in terms of protocol, preserving evidence, and so on, but staff did immediately attend to this patient out of their concern for her and offer support and care, cleaned here up, and so on.

Q. So she actually did not receive medical attention from a doctor or a psychiatrist or psychologist until the next day.

MR. HANLEY - I believe that's correct. The incident occurred around change of shift on Friday night. I believe that the medical - the first medical attention would have been early that next morning.

Q. Okay. Thank you. I have several other questions, not specifically relating to that issue, but you spoke before about budget requests and Medicaid. I have a question, Commissioner, concerning Medicaid

on your free standing non-residential programs. Now, am I correct in information that has been given to me that as of November 30th that the federal government will no longer be paying two-thirds of those costs?

A. Free standing what, Senator?

Q. Your non-residential community programs.

A. No, that's in the field of mental retardation.

Q. Yes.

A. Yeah. I understand that a letter saying something similar to that has been received by DHS. What is the date you referenced?

Q. November 30th would be the retroactive -

A. 1988, the retroactive date?

Q. Yes.

A. That's the date that you corroborate, Ron Martel?

MR. MARTEL - Yes.

COMMISSIONER PARKER - Yes, we understand that that represents a policy change by Region 1 Health Care Financing Administration and this policy change was made after that very same Region 1 set of decision makers decided that free standing day habilitation programs could be financed by HCFA.

Q. So what are we looking at? And I know that's not directly connected to AMHI, but what are we looking at for costs that have not been budgeted to meet that two-third lapse that we now have in those services?

A. First of all, although the letter has been received, what I'm

going to do is refer to Ron Martel. There, I think, is some talk of an appeal action. Would you care to elaborate?

MR. MARTEL - Several of our staff in the Bureau of Mental Retardation which have met with the Bureau of Medical Services within the Department of Human Services and have concluded that the action taken by HCFA, that is freezing payments as of November 30, they haven't denied them. They've frozen them, which is a slightly different approach, that their action is inappropriate. It's - a position paper has been prepared and is going to be presented to Commissioner Ives and Commissioner Parker either this week or next and various approaches are being explored, one of which would be an outright appeal of that position.

Q. I was under the impression that this particular procedure for utilizing Medicare funds is one that was not recommended, that it's one that other states have run into problems with and, in fact, New York State had to go to court with to get those funds.

COMMISSIONER PARKER - I think if we look at all fifty-four states and territories, we find that other states have successfully worked with Health Care Financing Administration to seek - you know, for financing of day habilitation. It's an example of uneven policy, although, yes, there are not many states that have availed themselves of that opportunity.

Q. How many exactly are there?

A. Nineteen.

Q. And how many at this point have been cleared to receive those

funds?

MR. MARTEL - There were nineteen states as of either October or November of '88 that were, in fact, receiving funds for the Medicaid program for that service.

Q. My last question concerning this is have - in anticipation that we may not indeed get those funds and we may not know until later in the spring, do you have any anticipation of what the cost might be to the State that at this point we're not planning on?

COMMISSIONER PARKER - I think it seemly to say that we are planning on ameliorating this issue. However, the steps that we need to take first need to be discussed between two departments; that's the Department of Human Services and the Department of Mental Retardation. Commissioner Ives and I are scheduled to meet the - I believe it's the first of next week to discuss this issue. Now, the outcome of our conversation I can only speculate about, but there is considerable feeling that we need to remember the track that we had as far as decisions and to at least talk with Health Care Financing as representatives of two departments to see what the score is.

Q. I assume you'll be keeping us updated on -

A. I would very much like to do that.

Q. Thank you. In reference to the outside consultation that you are presently seeking, could you let me know when you began seeking this service and - well, basically, when did you begin

looking into an outside consultation?

A. The middle of December.

Q. I have kind of a question that I know has been raised a number of times and it's one that I would really - it would help me in the hearings as we proceed. It would be my perspective that two years ago that you were the outside consultation coming in with a fresh perspective on the whole situation. Now, two years later with many problems that have continued, we're looking for an outside consultation. Could you tell me what exactly your role as Commissioner is and where your responsibilities lie and how much indepth into the problems that have existed for some time at AMHI, do you feel you are responsible to go.

A. When you were out of the room as a Senator attending to other affairs I went through what the nature of my interaction is as a Commissioner with members of the - with members of the team that works together to actually do the affairs of the Department and I predicated my statement - or prefaced my statement by saying that anything that happens in the Department is overseen by a trusted individual who is a member of the senior management team and I underscored the fact that I have solid professional relationships with each member of the senior management team and with the degree of trust that we have, there is a constant two-way dialogue going on between me and the remaining members of the different pieces of the system. I also said that because of this openness and because of the fact that there is a great

many opportunities for two-way conversations there is very little of a policy setting nature that escapes and we frequently interact, the different members of the team and me, on - concerning issues of the day, issues of the week, issues of the month. Now, there are a variety of vehicles that we use to accomplish this communication. One is the daily census sheet and I told your peers on the Committee that incidents are reported on that sheet which do not fall into the most serious category. Those incidents are reported to me immediately.

I also hear on a weekly basis in concrete language descriptions of what went on in the three institutions, the three bureaus. We also have weekly staff meetings in the central office. Very often the weekly staff meetings are followed up by project meetings where a superintendent may attend if the project concerns his or her actual facility. I gave as an example a couple of weeks ago Pineland went through an issue concerning the use of one of its buildings. Approximately six hours of my time was spent the first week in January in working with not only that superintendent, but also the boards of visitors of the Pineland facility in ameliorating that set of issues. We also, in the large facilities, have a monthly governing body meeting and we have boards of visitors meeting on a quarterly basis. The agenda for the governing body meetings get into issues that clinical staff have, issues that occur due to, you know, a manager's interest. We discuss a great many things indepth at these meetings.

I've also established an office of quality assurance, the sole purpose of which is to develop information designed to answer the question how well are these programs working on behalf of the clients entrusted to our care. I have a director of quality assurance that is attached to the central office who also works directly with quality assurance staff within the large facilities. The information that he has is given to me and it complements the information that I received from the office of the chief advocate. As you know, the office of the advocate contains people who are out stationed within the facilities such as AMHI. Direct information descriptive of patient care status comes to me via the chief advocate.

Now, your other question that you referenced had to do with how involved am I. I would say very.

Q. So my last question would be, in light of the fact that if I had ten children and one was particularly troublesome, not neglecting any of the others, I would pay particular attention to the one child that needed help. How frequently do you actually get onto the floor at AMHI and work with the people there, seeing what the problems are firsthand.

A. Due to the management structure, I wish to reiterate for this Committee that I place full trust in the office of superintendent and I depend on the superintendent to have what I call hands on management grasp of situations on the various wards. I have - that is my perspective as a manager. That is the way business

should be done. I augment that position with visiting wards myself. Now, the visits that I make often are impromptu and by impromptu I mean unannounced and I have done that, as you would say, more frequently now that we have determined that one of the ten children is having some problems. Before last summer I visited and did extensive touring perhaps a half dozen times in the course of, you know, nearly a year. Since that time I have come to the wards when I thought it appropriate.

Q. Thank you.

A. Fridays, Sundays, late night.

SENATOR GOUVREAU - Before we go further, I've made inquiries whether we can open the windows to try to alleviate the heat and apparently all the windows are sealed for the winter season and I was told that the air conditioning, if it exists, is to be activated. I don't feel the presence of it, but I've been told that steps are being made to activate that. I would also suggest that if there is not any noise coming from the hallway perhaps we would leave the outside doors open to at least supply some degree of ventilation in the room.

Representative Burke.

BY REPRESENTATIVE BURKE

Q. Commissioner Parker, good morning. I have a few questions regarding basically what you have just been outlining as you are in contact with AMHI, and so forth. You detailed this morning very articulately how often you meet with managerial people,

and so on, my question then is do you feel as though you were always apprised of exactly what was going on at AMHI?

A. Exactly what was going on? I feel that I was - I have been in the past adequately informed about the major events that go on at AMHI and similar - let's leave it at major events. I trust my members of the senior management team. We have a protocol in place that allows for a free flow of information. They're generally - there is no caveat on what can't be said, therefore, it's incumbent on anyone who is one of the appointed top managers to let me know if something unusual has occurred and that goes for incidents in the Classification #1 area as well as other things that may fall through, you know, any attempt to classify.

Q. So you feel as though you were always kept up to date on that information?

A. I do, with some exceptions.

Q. Would you care to elaborate on those -

A. The exception that has come to the fore is the situation about the woman who was raped.

Q. But all the other situations were, in fact, accounted to you.

A. Situations concerning patients unless there was an incident or the superintendent deemed it of such a nature that I should know about it, I would not have known about it. I rely on the judgment of the superintendent when it's necessary to let me know about what's going on with individual patients.

Q. And you were happy with or you were satisfied that the

superintendent was, in fact, letting you know during his tenure?

A. Not during the entire tenure.

Q. When did you become dissatisfied?

A. Late fall. I became disenchanted late fall, because at that point new information had come to the fore, new information in the form of the findings from the advisory panel and the findings from the DHS assessment.

Q. And did you at all at that point in time counsel the superintendent as to how you wanted things handled?

A. The superintendent visited our office on a regular basis and we would talk about the - we would talk about events of the month, in this case the DHS assessment, and he would describe to us how the reviewers were doing their job, how the survey process was going, how the communication was between AMHI staff and DHS staff.

Q. I'm not sure that that quite answered what I was looking for. When you became dissatisfied, when you were becoming disenchanted with the way that the superintendent was conveying information to you, did you, in fact, counsel him on how you wanted information conveyed?

A. It was not so much how the information was being transferred, it was more a confidence in the command of information that was possible. And I counseled on several occasions the fact that I felt that a more hands on approach could benefit him in his understanding of all the activities that may be happening on the ward. I counseled that getting out of the office and spending

significant time on the wards was a desirable thing to do.

Q. So if I'm understanding you correctly, up until late fall you were satisfied with the way he handled things and felt he was out of the office and on the wards enough and then in late fall became disenchanted.

A. I made the comment to him about gaining a better grasps of what was happening on the wards perhaps as early as last summer. The dissatisfaction does not happen overnight. It is a slowly evolving process and it's a painful process and it's painful because in order to stand up and face the rigors of running an institution as well as running a department of this magnitude and scope, it's necessary that we trust each other to a very, very high degree. Therefore, when information comes to the fore that causes you to begin to rethink and to question the trust that you have placed, it's extremely - it's an extremely slow moving evolution and it needs to be that way because one doesn't wish to be unfair. One wishes and hopes that what you are beginning to perceive is not so. Therefore, every effort at benefit of the doubt is given.

Q. Certainly. And I'm sure that every benefit of the doubt was given. What I'm questioning then is if you were not confident that your superintendent was providing you with the information that you needed or responding appropriately to incidents that might have happened, how did you receive this information?

A. It varies. The - we have to look at the information on the

table as coming to my office sequentially, beginning with the findings of the May 29th decertification and understanding the full implication of the deficiencies cited. Following that came Dr. Jacobsohn's first phase report dated October 19th of issues pertaining to certain aspects of medical practice and intervention. Following that came the results on December 16th of the advisory panel made up of many outsiders to look at the physician practice and handling of three particular cases identified by Dr. J. As I began to look at more and more of the information, I began to see that there were some repeats, repeat observations. By the time the Department of Human Services assessment came, many of the observations, recommendations in there did resonate with findings that had already been brought to my attention December 19th. And at that time by the middle of - end of November, middle of December I very much felt that my sense of confidence was shaken.

Q. So in essence then you were meeting with various people all the time about - frequently about the AMHI situation and meeting with the superintendent and working out solutions with the superintendent for the AMHI crisis.

A. As I stated earlier, AMHI's crisis is a crisis in management. Further, regarding a DHS assessment, when surveyors come in from another agency, it is the superintendent's job to actually - or superintendent's job to oversee how that process is going, but not to be invasive, because the process is owned by another agency and that was his job. He did that. It was also his job

to come up with responses to the DHS assessment and give me a status report concerning, you know, the actual implementation of those recommendations.

Q. So through various means you understood what was going on at AMHI.

A. Yes, I did.

Q. And you conferred with the superintendent about ways to correct the situations.

A. We must remember the management structure in the Department. If I was not doing it personally, I cannot do everything personally, then the two associate commissioners deal with certain aspects of AMHI. The associate commissioner for administration would - on a typical issue would deal with matters of personnel and administration. The associate commissioner for programs would deal with issues of patient care quality that may have surfaced through, for example, in Medicare survey and a resulting decertification.

Q. Again my question is more you felt as though you knew what was happening and you were meeting regularly with the superintendent and both sharing back and forth ways to remedy the situation, is that correct?

A. We were sharing back and forth either through me - to me directly or through associate commissioners' different events that had gone on and we understood together that certain remedies needed to be put in place.

Q. And some of those remedies were suggested by you or by the

superintendent?

A. It depends which ones we're talking about.

Q. Well, no, I'm just asking who - in essence then there was a repartee, there was a dialogue between the two of you that indicated what kind of corrective measure should be taken.

A. Representative Burke, there is an intensive dialogue that goes on between the Commissioner's office and the superintendent and the principal people within the Commissioner's office are privy to the information that describes the status of facilities such as AMHI.

Q. So the superintendent then - well, let me rephrase this. Why then specifically was the superintendent dismissed?

A. It is impossible to run a department such as this when issues that are of supreme importance such as patient care when a chief executive officer does not have 100% confidence in an individual's ability to lead an institution through the throes of intensive problem solving and it was my observation that Superintendent Daumueller, while a very compassionate and caring and a very nice person, is better suited not to lead a complex hospital with the types of issues that it has and the specialty - the specialty interventions that are needed to put it back on its feet. He is better suited to, I think, working in an environment that doesn't have quite so many problems that need to be addressed all at once and it's an issue of management - management style, how he wishes to do business, how he is most comfortable doing business.

Q. Given then that he was dismissed but that you have a working knowledge then of the situation there and the corrective measures that you essentially wanted taken, I'm a little bit confused then as to why it's taking - what the management teams that you have taken - I assume you've taken RFPs for these management teams to come in and look at your situation.

A. We are not at that stage yet.

Q. What stage are you at?

A. I will reiterate my response to Rep. Manning about ninety minutes ago and that response described the outside - the outside help that we are gaining. We are at the stage where we are talking, we the executive branch, are talking to various firms who are very skilled in the specialty of running a large psychiatric facility and we, at the same time, are looking at solutions that have been proffered by various groups who are affected by AMHI's situation. What we will do is to finish the discusion and we have to date talked to three consulting groups. We will finish this discussion and we will then understand what vehicle we need in order to acquire this help. In fact, do we need to, you know, use a certain method of contracting versus another method of contracting. And I also stated to Sen. Gauvreau that I would expect to have recommendations available and be able to present those recommendations coming from such a consulting firm fairly soon and I said two to three weeks.

Q. My question then comes again, you felt that the superintendent

was, in fact, not implementing the recommendations or the policies that you wanted implemented, didn't have the management style that was required to implement new policies or to maintain AMHI in the condition that it should be maintained and yet you're now taking studies or -

A. Not studies.

Q. You're taking ideas or looking for ideas from various management teams to figure out what's needed.

A. Not exactly.

Q. Okay.

A. What we are not looking for is to pay for another study. We don't need that. I described in my opening remarks that AMHI is the third largest hospital in the State of Maine. It has ten different departments. It has 693.5 staff. It is by anyone's observation a specialty hospital. It also has a unique set of problems that need to be solved. It is our observation that the best expertise available rest with people who are also engaged in the operation of specialty hospitals of a psychiatric nature and who understand hospital administration. This is not a study that we're talking about. This is bringing in specialists who know inside and out hospital administration who can take a look, who provide an objective view and who can recommend to us steps to take on the short term. This is not a long-term affair. This is something we can do on the short term and intend to do.

Q. So again -

A. This is general management. Many of the issues that this Committee has raised in the last nine hours of questioning and responses have concerned unique situations going on at AMHI that have resulted in certain issues, such as the DHS assessment, the advisory panel that I convened in October. What we now need to do is to look at the total operation of the facility and understand how to do business in a more - I think a more productive way. Many of the issues that have been raised in Medicare by DHS, by the advisory - in the advisory panel findings concern issues of documentation, communication and general record keeping. That is general management - the scope of the solution rests with general management and we must bring in someone who has a track record who understands how to do this perhaps in a better way than we now know how to do it. We are doing our darnedest and the staff there are doing their darnedest to keep up with the demands on them for patient care.

Q. Then again if you know exactly what you need from a management team, why is there no RFP done yet.

A. We are not at that stage and to reiterate, we are not at that stage because we need to finish talking with these individuals and then to determine, based on their observations, remember they're specialists, their observations will be those of a specialist. It could be that there is one unique firm out there that is unlike the other three or four, therefore, because they do possess a unique set of characteristics, perhaps a request for a

proposal may not be necessary in accordance with the Administrative Procedures Act.

Q. I fail to understand how, if you know what you are looking for that you cannot put out an RFP.

A. I feel very strongly that as a stewart of public funds in the State of Maine and also as a top executive person that we need some outside expertise that has a track record in the specialty of mental hospital administration and that is the expertise that has yet to come in and give us its perspective and subsequent recommendations. We have not yet had the benefit of that.

Q. So although you know - you feel you know what your problems are and where they lie, you are not - still not ready to put out an RFP.

A. There's a certain amount of, I think, information that gets passed when a specialty group comes in and asks you very, very drilling questions about management in a large hospital and it's a process that I believe as a chief executive officer that we must go through in order to understand how a consultant group - not a consultant group, but how a specialty group might feel. This is - this is part of responsibly evaluating all options. After that is done, and I - to reiterate, this is not a long-term process, to responsibly do it, we must talk to this individuals, obtain their recommendations and then, as I offered Sen. Gauvreau, come and talk to your Committee.

Q. It seems that it is - that there are very lengthy delays in this whole process, that you become dissatisfied or disenchanted with your superintendent in the summer, early fall -

A. I didn't say late summer. I said late November, early December.

Q. I believe that, in fact, you did mention the summer months that there was some disenchantment there and then you became significantly disenchanted in late fall and then he was subsequently dismissed in January. Here we are at the end of January and we still are not in a position where we're submitting RFPs. This - if you have been in touch with exactly the problems that AMHI has had for the length of time that you say you have been, I see this as a lengthy delay.

A. I don't share that view, Rep. Burke, and to reiterate, to say again for the public record, unhappiness, disenchantment, whatever the word, with a top manager that you have become very close to is a slowly evolving process and extreme dissatisfaction did not register until much beyond the summer. Extreme dissatisfaction registered late November, December, and I wish that put on the public record. It's a short period of time from December to the very first week in January.

SEN. GAUVREAU - Representative Cathcart?

BY REPRESENTATIVE CATHCART

Q. Commissioner, going back to the rape in September, I'd like to ask some specific questions, but you have admitted that that

was not handled well, so I'm willing to just not pursue that and waste any time. But since that time have you put a rape protocol in place at AMHI and also at the other institutions under your Department?

A. I've got to ask you a question. Is that permissible?

Q. Hm-mm. Okay with me.

A. I don't know what a rape protocol is.

Q. Most hospital emergency rooms that I've had experience with have rape protocols. They don't do a thing such as take the patient's clothing to the laundry and they do notify the police that a felony has been committed, etc.

A. All right. There is an established procedure, you know, within AMHI for that and the - subsequent to this particular event a written policy was developed.

Q. And is that true for all the institutions, Pineland, BMHI where a rape might occur?

A. I'm trying to see my policy book. I can't answer that. I will have to look for the information and get back to you.

Q. I'd just say - I'd like to say that there is that kind of protocol. Onto the staffing shortage again, I have read so much stuff in the last week, back to the decertification - HCFA that claims there's a staffing shortage at AMHI. The reaccreditation report, though AMHI got its reaccreditation, they did mention shortage of staff there. I spoke last night at length with a woman from our district who works at BMHI and she stated the same

kinds of things that I read in a letter here that I have - I don't know if you've seen it - from Charles Ferguson, the president of the local at AMHI and from Charles - what's his name - Sherbourne, the Maine coordinator of the American Federation of State County and Municipal Employees. All of this testimony about people having to work overtime when somebody is sick or out for some other reason, workers getting burned out, difficulty of hiring more nurses because they can go to work at Eastern Maine Medical down the street for more money, I'm just convinced that there is a staffing shortage and that this is an emergency situation and wonder if you really believe that there is a shortage of staff at these two institutions. And if you do, then how and why have you decided not to seek emergency funding this year to hire more staff, pending, of course, outside consultants and a real plan for making things different. I mean, I don't want to hear that again, but to me this seems like an emergency -

A. Well, I think you just answered your question.

Q. Situation and I don't understand why you're not seeking funding for right now to -

A. Rep. Cathcart, I am waiting for the results and the recommendations from an outside and objective view on hospital administration and particularly administration and patient care vis a vis the defined patient need that exists at the Augusta Mental Health Institute. Earlier on I did say that several solutions have come forward, you know, from various quarters within

the Augusta Mental Health Institute. Some of those solutions include need for staffing. At this time need for staffing, increased staffing is not being ruled out.

Q. But you are not planning on Thursday to ask for any money this year -

A. The nature - no, no, no no. The nature of Thursday's hearing for the Department is one of three budget hearings that we will go through. This is technically - correct me, Ron Martel, the first hearing is for the emergency funding, the second hearing that will be sponsored by Appropriations is on Part I, that's ongoing funding, and the third hearing probably to be scheduled in March is for Part II. That's the changed portion of the budget.

Q. I understand that.

A. All right.

Q. But it seems more of an emergency situation that you do need more staff now.

SEN. GAUVREAU - Are there other questions of the Committee, please raise your hands if you have several questions. Rep. Pederson and then Rep. Boutilier.

BY MR. PEDERSON

Q. Commissioner Parker, I'd like to go back. Some of the information that I have on the instance of the patient that was raped, what specific actions did you take with the person - the perpetrator?

A. Rep. Pederson, I've been over this once, but with the

indulgence of the Committee Chairman, I will do it again.

Q. Well, let me just say then the information I have might differ with yours. I understand that the man was placed in the Forensic Unit after the September assault, is that correct?

A. Correct.

Q. Where he received no treatment for his assaultive behavior other than two or three talks with a social worker. This resident was subsequently returned to his regular unit for fifteen-minute periods which were then lengthened to one hour, visits with one on one supervision. For unknown reasons he was returned to his unit from the Forensic Unit in November or December and the one on one supervision was discontinued. This resident then sexually assaulted another female resident, but was thankfully discovered in the act so the resident was not actually raped -- that the - it was entered in the woman's record that she was promiscuous and the man again was placed in the Forensic Unit. Is that true?

A. What I will have - what I will do after I make the following remark is to ask the assistant to the superintendent to come forward. My understanding is that this individual currently resides on the Forensic Unit and within the treatment plan there has been sufficient mention of the fact that he should not reside on a co-educational unit. Now, Rick, could you amplify that, please?

MR. HANLEY - Rep. Pederson, your information is primarily accurate. After the rape - the alleged rape, this individual was placed on

the Forensic Treatment Unit where his medications were assessed, and so on. The plan at that time was to begin transitioning, reintegrating him to his home unit. That began in short blocks and had extended to hour blocks at which time he was under close observation with fifteen-minute checks. There was another incident, a very unfortunate incident, in which he was found in a bedroom with a female patient who was also a DHS ward and it was substantiated that nothing had occurred. But following that incident he was permanently transferred to the Forensic Treatment Unit.

Q. Okay. Thank you. I have another question for Commissioner Parker. I was interested in the article in the Maine Times which indicated that you had a meeting with the Governor's Commission on Mental Health and it indicated that you had two different copies of a report and that somebody had a copy that wasn't so-called sanitized?

COMMISSIONER PARKER - Yes.

Q. Can you comment on that?

A. I would thank you, Rep. Pederson, for giving me the opportunity to report on the text in that editorial. First of all, the fact - the inference that one is a sanitized version, hence covering information, is absolutely inaccurate. More to the point, the verson that does not contain certain descriptions was essential because, as we know, the - there are three patients whose cases were put under the microscope by highly qualified

medical people. The material that was in the so-called sanitized - so-called real version contained very descriptive information about those individuals and we would have been outside the - we would have gone against our own rules of confidentiality had we made public that particular version and that is absolutely inappropriate to do when you have people entrusted to your care governed by rights, rules, etc.

Secondarily, there are other issues in that editorial that I feel were the product of an outsider observing and do not reflect the truth. One of them is that I was in disfavor of David Gregory assuming the post of chairpersonship. In fact, I am delighted that David Gregory is in the post of vice chairpersonship because of his sound advocate status and reputation and I would point out to the members of the Committee here that the Maine Commission voted on whom they wanted to fill the vice chairmanship and it was - his selection was the product of a vote.

Thirdly, it was reported out in that editorial that I appeared to be upset when I left, that nothing could have been further from the truth. I had to leave for another scheduled meeting.

And a last piece of information, I am looking forward to going to the next meeting. Thank you.

Q. I have a comment. You say that certain information cannot

be given to the Commission on Mental Health and yet you do have a setup where they can go into the institutions unannounced and look at - see what's happening?

A. Yes, they can. They are part of a statutorily established body and they may, with the proper arrangements, visit anytime day or night. The issue at hand, Rep. Pederson, is the written description that would identify the three patients in question who are the subject of this advisory panel's probe.

Q. I would like to ask another question about the - your plan, in other words, when you had the - Mr. Daumueller and you decided that he should - you were disenchanted, did you have an action plan to state exactly to him what had to be done and how to correct the situation so that perhaps your relationship with the director could have been perhaps repaired or he would have better positively known exactly where he stood and what he needed to do?

A. There is a job description pertaining to the Office of Hospital Superintendent and that's the guiding document, if you will, that determines who does what, why, and to whom they're accountable. As I earlier stated, the former superintendent and I and/or members of my top management team, the two associate commissioners, met on a regular basis to talk about issues that needed repair and we often came together to talk about how to, you know, fix Medicare. However, I will close by saying that I put a great deal of trust and faith in the expertise that a superintendent has and I must do that. And if patient care quality

and the ability to lead are foremost concerns of a chief executive officer, then we must have people who can do that.

Q. And I have another question as to the people - you have many services, as you've stated, that work with you to help you to - your management team, the other advocacy services and I have information that the Maine advocacies have written you a letter, very concerned about the incidents and what was happening at AMHI and they had gone a very long time without a response. Is there any reason for that?

A. I don't know which letter you're referring to, Rep. Pederson. I know that - let me see, reconstructing time. In September and October and I think one other time I met personally with Laura Pedovello, the Director of Maine Advocacy Services, and we talked through the content of at least one letter.

Q. Okay. I believe I read about the fact that you did have a meeting and that after that forthcoming they've never had a response.

A. That also appeared in the Maine Times and they also referenced an issue concerning Pineland and the consent decree and how the consent decree is out of compliance as we speak and that simply is not so. They also referenced failure to respond to a couple of letters having to do with Pineland, that also is not so.

Q. Thank you.

SEN. GAUVREAU - Representative Boutilier?

BY REP. BOUTILIER

Q. Commissioner, I have several questions I first want to

address. Is Dr. Rohm going to be back later this afternoon?
SEN. GAUVREAU - Yes. We had agreed, the Committee did, prior to your arrival, Representative, that we would allow Dr. Rohm to make his rounds at the hospital this morning.
REP. BOUTILIER - Several of the questions, if you need to, you can defer to Dr. Rohm, but I'd prefer you take a shot at them if you can and Rick Hanley is obviously welcome to step in if he feels the need. The first one, in determining - when you have a slot open for an RN position, what tends to be the length of time to recruit that position and to fill it? Have you estimated how long it takes you to do that?
A. I don't even think we need to estimate. I think we can ask people who may know more precisely than that. We are beginning to see an increasing difficulty in recruiting RNs to not only AMHI but BMHI, which is part of a statewide and nationwide nursing shortage. Let me refer directly back here. Ron Martel, can you answer that more precisely?
MR. MARTEL - I don't have the information with me.
Q. Would it be safe to say that you could do everything from one day to one year to fill a position?
MR. MARTEL - I think one year would be extreme, although I'm sure it has happened.
Q. Would it be extreme to say seven months, eight months?
MR. MARTEL - I guess if I were to give you an estimate of the time frame it normally takes to fill RN positions is what we're

talking about. I would say anytime from a month to six months and I think you'd capture the majority of the vacancies.

Q. A continuation of that question, if through accreditation processes it was determined that you needed to fill a number of RN positions and you knew that those accreditation standards needed to be met, wouldn't it be safe to say that you'd have to begin the process of recruiting and filling positions at least six months prior to make sure that you would cover all of that area?

COMMISSIONER PARKER - That's assuming that the lag is six months. I think we can cite to a recent experience when the Legislature did give us sixty-five positions with three contracted plus another sixty-four or five at BMHI and the experience at BMHI was that we did fairly well in recruiting for those nurse positions and were filling pretty much on schedule, maybe a little bit off.

Q. On schedule being what length of time?

A. What I want to do is to reference a phase-in sheet that shows column by column by position the date we wanted to fill it and the date actual and I know that we have that supporting information here.

Q. Okay.

A. I now have it. Nurse III, we were looking for three of them. The effective date by which we could have filled was October 1, we filled it October 3. On the issue of a Licensed Practical Nurse, there was one, the effective date was October 15th, we filled

it the same day. This is a status report of January 13th '89. This shows another LPN. Effective date was 10/15, that position is vacant.

Q. Was the reason for the quick recruitment and placement of those the fact that the only thing lacking was not the person, but the funding for the position? There were people there to fill those positions, there just was no money to pay them?

A. I think it was a combination of things, the first being that the personnel department at AMHI worked very hard to do all the paper work that's necessary in a business or a bureaucracy and had the paper work ready to go the minute the Legislature sounded the gavel for acceptance and I think their foreward thinking and advanced preparation went a long way in our ability to fill these in a very timely fashion.

Q. We've obviously received a lot of material concerning all of these things, but I was just struck by the superficiality of some of the material. We really weren't getting into the heart of the matter on some of the items, especially those dealing with staff and patient care and I wanted to bring up something having to do with two cases. One, some colleagues of mine on the Committee have already asked about the rape case, but I was concerned about staff that were dealing with that instance. It's my understanding in some of the background checks that I did that there was a Nurse I position that was in charge that particular night and that they individual was very new, extremely new, and that they had already

performed an eight-hour shift and were in the middle of the second shift, actually and hour and a half, two hours into their second shift, which they had been forced to take, told that if they did not take that second eight-hour shift that their position would be frozen. I have two questions. One, in the case of nursing shortages around the state, obviously for someone to fill a second shift immediately following with the threat of having their position frozen is not conducive to quality care or quality performance and I'm wondering how rampant that type of incentive is used to keep staff on more than one shift.
A. Taking apart your question into a couple of comments, first of all, you are correct that the nurse in charge of that particular ward was inexperienced. We stated earlier, perhaps before you came into the room, that this incident was not handled particularly well and concur with most of the recommendations made by DHS and will collaborate fully in actually doing what we need to do to fix it. The policy that emanated, came out of this particular incident is that inexperienced nurses such as the Nurse I will not be placed in charge of a ward. To your point of freezing positions, and so forth, we - through the word that we did at the Bangor Mental Health Institute beginning August of '87 where we convened ten task forces, one of which was to look at expressly at some of the practices of mandated staff from one ward to a second ward or freezing staff, because we went through an intensive examination of BMHI and personnel practices, we fully

understand that such practices do often represent a disincentive.

Now, to a third point which is what did AMHI do in response to this particular nurse who was frozen and had to pull a subsequent shift, I will call on Rick Hanley to answer that piece of it.

MR. HANLEY - The nurse who was involved in that particular situation was moved to daytimes and worked under the supervision of an experienced nurse. And as the Commissioner just mentioned, we have established a clear policy in nursing that inexperienced nurses will no longer cover those kind of evening shifts or any shift before they have the requisite experience.

If I could just go a little further, although I'm not the staffing expert at the hospital, the issue of freezing and mandating overtime and pulling staff from their home units to work in other units to cover situations that are seen as being critical, that still does occur among the mental health worker ranks and to some extent among the licensed nursing and LPN coverage. One of the pieces of the staffing allocation that we received in September was used to establish a 13-member float pool and I won't stand here and tell you that that has completely eliminated freezing and pulling, but our staffing coordinator substantiates that it has had a positive impact. It has not eliminated mandatory overtime, but we have used the float pool to fill in areas where formerly a staff person might have been pulled off their regular unit to go and cover.

Q. Again, Susan or you can answer the next question. In a

recent Wall Street Journal article it was stated that JCAHO was - how do I use the term - making more strict, rigidly enforcing, however you want to put it, their regulations and that that effective date for that new interpretation of current regulations would occur approximately July 1. There is some difference of opinion as to when it will actually be implemented, that's correct, because of some concerns on Capitol Hill. But, having had that, the fairly well publicized change, and it's been in several periodicals since the Wall Street article, do you feel there's any change that's significant enough in joint commission's regulations to merit additional requests for staff or any changes on your end as far as dealing with those changes?

COMMISSONER PARKER - In fact, we've already begun to deal with those changes and in our testimony Thursday you heard from Dr. Jacobsohn about the remedicalization of standards, both JCAHO's and Medicare. The instruction last June that was given to the superintendent regarding needs for staffing was phrased thusly. Give us a solution that will result in the regaining of Medicare as well as the retaining of JCAHO, given, you know, the implication being given the changes that are in the offing and that is what was done. The 65-person staffing package was predicated on the assumption that JCAHO was in the midst of changing.

Q. Do you - you are currently - the hospital - AMHI is currently accredited by the joint commission.

A. Yes, it is.

Q. Do you feel that you are in danger of losing accreditation?

A. We went through a rigorous review with these new standards being applied on December 1st and 2nd and I can only speculate what the outcome is. I am cautiously optimistic that we will retain our JCAHO accreditation, however, there are no rose-colored glasses on.

Q. I would hope not, because it is my understanding that in one particular area in accreditation in terms of JCAHO's feelings concerning 24-hour coverage by RNs that AMHI would have serious difficulties in meeting that particular requirement and, in fact, would have to hire an additional forty RNs to meet that requirement. It would seem to me that if that is necessary, that almost immediately you'd have to request funding and begin to implement a recruiting tool and retaining those existing people in those positions to meet that criteria.

A. I understand that the standards applied to AMHI by the joint commission on that particular issue were the so-called hospital HAP standards, Hospital Accreditation Program. What I am concerned about that, I am concerned enough to have talked to the head of probably the largest mental health system in the world and that's the Commissioner in the State of New York. I know from him, and he was the test case in the country, that it is possible and the joint commission is accepting of the fact that the general hospital standards must be cautiously applied to

a publicly funded psychiatric facility and because New York has just undergone a survey or if it has not just undergone or perhaps it's in process, we are anxiously awaiting to see how they fare, because the State of New York was able to negotiate the type of standard that was applied to their public facilities and I say this as added information for your Committee, because I think we have some future planning to do for JCAHO and how to work more collaborative with it, given its changes.

Q. You are also aware that if we do happen to lose JCAHO accreditation even momentarily that we would also be forced to decertify in terms of Medicaid, is that correct?

A. That is the situation called deemed status.

Q. So it would seem to me that if we are even close to losing accreditation through the joint commission that that would be a very serious - serious instance and we'd take -

A. I concur that that would be serious.

Q. And would necessitate the direct implementation of some plan by the Commissioner, correct? I think you've been very consistent in your stand that the Commissioner should take a more oversight view and not a direct managementstyle in terms of the various institutes, whether it be BMHI or AMHI, but I think you would have to agree that in terms of prioritizing your own budget, in terms of determining where monies are best spent within all of your institutions, in terms of how you deal with specific cases that affect accreditation in terms of where you're spending those

requirements, that would be under your purview.

A. That would be what, I'm sorry?

Q. That would be under your purview. You believe that would be definitely -

A. As far as what -

Q. The party to charge?

A. Pots of money go to pay for what in a prospective budget package?

Q. Yes.

A. That is under my purview.

Q. In terms of prioritizing - and I understand you have gone through the budget prior to coming in today, but I'm not going to need to get back in the specifics. In terms of community resources and alternative placements, you obviously had to prioritize, if you wanted to put money into those things versus additional money at AMHI or BMHI, correct?

A. Are you referencing Part II or back on Part I?

Q. I'm not referencing either budget specifically. It's not a hypothetical, but I am saying when you sit down and deal with your budget, you have to look at do I want to spend a lot more money at AMHI, BMHI or do I want to spend a lot -

A. That's right.

Q. And some at community -

A. That's right.

Q. So you prioritize depending on what the impact is going to be.

A. You make policy decisions.

Q. Have you sat down to determine what the impact of extensive financing of community based services or alternative placements would be on your institution at AMHI?

A. When we put together the plan that resulted in becoming the budget request, the legislative document presented to the Legislature in September of '88, calculations were made on the net effect of certain community services and the net effect of those services on admissions at AMHI.

Q. What did you see that net effect to be?

A. Well, looking specifically at one of the services that is very much on schedule though not fully implemented because the start-up time is such, if we look at the community in-patient - the in-patient service to be placed in the community, we asked the Legislature and received a request built on the fact that if we had a 20-bed facility and the average stay was two weeks, we could quite likely divert a substantial number of referrals coming from York and Cumberland County. The plan is to establish a community in-patient capability in those two counties and we are on track with doing that. For specific numbers I would call on - if you're interested, I would call on Robert J. Harper who is the Bureau Director of Mental Health.

Q. And when he speaks to that I'll just mention what the number is I have found to be stated by many people affiliated with AMHI and that is that if you had proper funding of those community

resources that due to the acuteness of many of the patients, only approximately twelve in the current census we'd be able to put into alternative settings and I want him to address that particular concern.

A. Okay. Jay are you here? This is Jay Harper, the Bureau Director for Mental Health.

MR. HARPER - Thank you. If I understand your question correctly, as part of our community package we requested $500,000 to make available one or two options for us to pursue. One is the direct purchase on a case-by-case basis of clients who were suitable for an in-patient care facility, but rather than provide them as the only facility choice AMHI, provide them beds that may be available in the community.

The other option we're pursuing, and I think it represents the long-range option for the State to pursue, is the actual construction and involvement of contracting for specific facilities for those patients. The twenty beds that we could purchase with that money on an ongoing basis would be for clients that would be acceptable for AMHI or for this facility. It's not limited to twelve that would be drawn down from the AMHI population as it stands now.

Q. Would you agree that in relative terms that there's a very small portion of the population at AMHI that could be removed and placed in alternative settings?

MR. HARPER - Absolutely not.

Q. You do not agree with that?

A. Absolutely not.

Q. I would ask through the Chairs that we be provided by you and by the Commissioner with a little more information as to what specific programs you think would address a substantial portion of the AMHI population. I'd be very interested to see that. I still have some more questions for the Commissioner.

SEN. GAUVREAU - Rep. Boutilier, as a matter of logistics, Appropriations will begin a hearing on the budget at 1:00 p.m. and I spoke with their staff person and understand that they need around one hour, I guess, to get the room somewhat in shape for the afternoon session. I know that Jean had a question as well. Are you going to be short or long do you think? I've just got to manage this -

REP. MANNING - Why don't we adjourn.

SEN. GAUVREAU - Why don't we adjourn at this juncture so that it will allow the people here to set up the room for Appropriations at 1:00 p.m. This is their room after all. And we will formally reconvene and allow Brad to finish his questioning at 1:30 p.m. Now, I believe we're going to move to Room 105 of the State Office Building, because Appropriations has already booked hearings on the budget for this afternoon, so we will resume at 1:30. However, I would caution members of the Committee to remain for a few moments to discuss some other procedural matters and we will resume the formal hearing as such as 1:30 p.m.

in Room 105.

COMMISSIONER PARKER - May I make a closing statement? Is that acceptable?

REP. MANNING - Well, you've still got plenty of time to talk this afternoon, because if you do it so something else is going to be brought up or are we just going to continue -

COMMISSIONER PARKER - No, it's not new information, it's just reintroduction.

SEN. GAUVREAU - And how long -

COMMISSIONER PARKER - Thirty seconds.

SEN. GAUVREAU - Sure go ahead.

COMMISSIONER PARKER - Thank you, Mr. Chairman. I would like to conclude this morning's testimony by simply stating again that there are several different plans in effect, namely, about six of them, and they are built on the idea that patient care quality and the improvement of same is absolutely vital if we're going to continue to do a responsible job. I wish you to know that I am in -, you know, I accept full responsibility for what's happening and I look forward to continuing this discussion this afternoon so that we can look further towards solutions.

SEN. GAUVREAU - Thank you, Commissioner. We will then recess the hearing portion of the Committee meeting for today until 1:30 p.m. at Room 105 of the State Office Building which is down across the tunnel.

HEARING ADJOURNED AT 12:00 NOON

STATE OF MAINE

HUMAN RESOURCES COMMITTEE

Hearing on Augusta Mental Health Institute Issues held on January 31, 1989, State House, Augusta, Maine.

Norma Morrisette

I N D E X

Augusta, Maine
January 31, 1989
1:30 p.m.

EXAMINATION OF DR. ROHM BY REP. BOUTILIER

Q. I wanted to ask you about two specific cases, one being the rape case. It's my understanding, and you weren't here in the morning, but I asked the question of the Commissioner concerning the experience of the nurse who was on at that particular time, and that it was a fairly new nurse, very new nurse in a Nurse I position. It's my understanding in some work that I did checking into this case that that particular nurse, after hearing of the alleged rape, did not report that for six and a half hours until after the occurrence of that. Now that contradicts your statement the other day, last week, when you said that there was an immediate response to the rape, and I'm wondering if you could address that and -

A. The immediate response was to the rape victim, I think. The rape victim was appropriately taken care of. What was not taken care of was the forensic police aspect of it. There was a complete lapse of several hours on that.

Q. Okay, because I also was under the impression from some work that I had done to find out more specifically about the case is that not only was the reporting of the alleged rape six and a half hours late but that the assessment of that patient, the person who was allegedly raped, was actually more than six hours after the fact and, again, that contradicts what you said. You said that immediate attention was paid to the victim, that's not what -

A. Well, she was given psychological support, she was examined,

she was cleaned, but the actual examination determined - to determine the forensic aspect of it, this was delayed.

Q. The second issue was - there was an article and I don't know whether it was the Sunday paper or the Kennebec Journal or one of those papers, but it talked about a patient who had severe incontinence and was placed in a room the farthest away from the toilet facilities. Now in the case of short staffing and an individual is not getting the supervision that they need, that can be related to short staffing, there's no doubt about that, but if someone comes in with incontinence and is assessed to be that, that it would clearly be a management problem if that person is put in an area of the facility that's the farthest away from the bathroom facilities. Can you address that issue?

A. I think it was corrected after it was brought to the attention of the staff.

Q. That same person apparently had some intestinal disorder. Were they given clinical treatment in a reasonable length of time?

A. I cannot answer this question.

Q. What is the ongoing assessment of patients as they come in as to whether they need clinical assistance, if any?

A. The ongoing assessment of patients, they are seen by the admitting psychiatrist or the physician assistant at night. In the morning I go over with the - my physician assistant over every admission, determine the appropriateness and the immediate management. Then around eight o'clock, the admission unit psychiatrist, or one with the admission unit psychiatrist sees the patient. At that time, the admission note is dictated by the

night - evening/night physician, typed and in his hands, and he can determine the immediate treatment needs, condition, after - on the ward. Then there is a physical examination if it's not performed right on admission. It will be performed within 24 hours.

Q. Although that's the policy, do you think you are staffed appropriately to meet that policy of yours?

A. We meet the policy in 90 percent of the time.

SEN. GAUVREAU: What was that response again, please?

REP. BOUTILIER: He said he met it 90 percent of the time.

SEN. GAUVREAU: Thank you.

REP. BOUTILIER: My last concern is a case where an individual was given an anti-psychotic, Sorental*, are you familiar with that drug?

A. Yes.

Q. In this particular case, again it was cited by a newspaper and it was something that I'd been looking into already, but the newspaper stated that the individual was being given 300 milligrams per day, and this is - primarily it's a treatment for alcoholism, correct? Sorental*, correct?

A. No.

Q. It's not - Sorental* is not a treatment for alcoholism? They were given 300 milligrams a day. Then were then off of Sorental* for four days, and then came back onto the drug at a much higher dosage. Are you familiar with the case that was cited in the paper?

A. I don't recall that.

* Spelled phonetically.

Q. And this individual - the same individual, a female, had been observed and documented to be involved in sexual conversations with staff members?

A. I think I know who the patient was. What's your question?

Q. Well, the question is that Sorental* usually causes a great deal of disorientation and dizziness as one of the side effects, would you agree with that?

A. Not necessarily.

Q. Not necessarily.

A. Disorientation, no.

Q. This same person, though, was documented to have fallen asleep while on the toilet, they were documented to be disoriented in the hallways, experiencing a lack of balance. Are you familiar with that? Is that what happened in that particular case?

A. This can happen, but this is not a frequent side effect.

Q. But in this specific case that you just recalled, did that happen?

A. I don't think so.

REP. BOUTILIER: Okay. I have no further questions of Dr. Rohm.

EXAMINATION OF COMMISSIONER PARKER BY REP. BOUTILIER

Q. Susan, I wanted to go back onto the questions I was mentioning before in regards to what you played as your role, and that has been as a supervisor of all of the department rather than involved in the day-to-day administration. And along that line, I think in terms of a facility that has clearly had staffing problems, that funding for education of staff would be something that you would

prioritize as being very important, would that be - would I be correct?

A. Yes. I feel that an often left out component of management and, you know, paying attention to the staff is staff development and training.

Q. Do you know what the account - and Ron can step in and answer - do you know what the exact amount is of monies that are set aside within the AMHI budget for education?

A. I'll have to defer that one to Ron Martel, but first I would like to mention that AMHI, under the aegis of Dr.Jacobsohn in his current role as Medical Director but formerly as the Director of the Forensic Service has an interest - a special interest of his is the fact that education must occur for various clinical people practicing the disciplines, and several years ago he started a program called Grand Rounds in which he has been able to collaborate with the residency program from the University of Vermont that is sited down at the Maine Medical Center in Portland, and between Maine Medical Center and AMHI, they can combine resources and bring in some very, very good people and provide these Grand Rounds programs on a monthly basis and the results are then video-taped and forwarded to BMHI. But for the particular cost, I would refer to Ron Martel, if you have that in your -

MR. MARTEL: I don't remember what it is, but not counting staff time on the clock, I would guess that it's probably twenty or twenty five thousand dollars a year.

Q. That you have set aside in the AMHI budget for education. How

much of that money to date has been used?

MR. MARTEL: I haven't the foggiest idea.

Q. Okay, no idea. I'd be interested to see your figures for what that is.

Susan, there are two programs that were implemented under Commissioner Concannon, and I believe that Frank O'Donnell and Peter Ezzy would know specifically, and Peter Ezzy's job was to be a contact between two particular programs, St. Joseph's College and the University of Maine in Augusta and your department in terms of educational funding and programs.

COMMISSIONER PARKER: Hm-mm.

Q. In terms of the St. Joseph's program, there were three parts to that, and they provided for courses to be provided at the Augusta - in the Augusta area. It allowed for tuition reimbursement for ten slots for people being an RN to go to the --, and it provided for a continuing ed, which would be non-credit courses but would be continual education of the staff. The cost of that program on an annual basis for ten slots and the two other things that I mentioned was $5,000 a year.

A. Yes.

Q. You chose to defund that and to not redo the contract that had been consistent under Kevin Concannon. You haven't explained to me what you -

A. Okay, let me update you.

Q. But I understand you have not reiterated the contract.

A. I'm familiar with the program you are talking about. In fact,

the nursing consultant, Vera Gillis, and I have spoken on at least three occasions recently, and as you quite likely know, she is a proponent of that, as we are.

Q. And isn't Frank O'Donnell and Peter Ezzy and several people at St. Joseph's -

A. Both Frank O'Donnell and Peter Ezzy, some of their responsibilitie have changed a good bit since my predecessor was commissioner. However, Peter Ezzy still has an interest in staff development and training, and Frank O'Donnell does carry out some of the staff development and training programs. I have switched his accountability to that of Ron Martel, because much of the staff development and training function is an outgrowth of taking care of various personnel matters. Back to the point, however, the St. Joseph program is an important one, and I'm losing track of time because I've been here so much, but either last week or the preceding week I gave the directive to Ron Martel to see what we could do for the St. Joseph's program, and I can't speak to whether or not there is a contract in place, but I recognize the value of this project and there are - in fact, I spoke with an RN who was assigned to admissions, and this was a Friday that I visited AMHI, who was doing the eleven o'clock shift, and he spoke to me directly about the worthwhileness of this program and he sure hoped that I could get it back onto a track. Subsequent to that, or the next Monday, I spoke with Ron and asked him to see what we could do.

Q. So you have come to the conclusion that it is a worthwhile program and that it should be reinstated?

A. Absolutely, it should be reinstated. I'm just not sure whether or not it totally lapsed. What is the status?

MR. MARTEL: The contract itself with St. Joseph expired June 30, 1988, along with the funding. It was federally funded under a manpower grant, so it was a funding issue. Many of the individuals that were previously enrolled in the program have continued to be enrolled in the program. As recently as two weeks ago -

COMMISSIONER PARKER: Right.

MR. MARTEL: We processed an invoice - or two weeks ago or whatever it was - representing the cost through the date of that invoice.

Q. And what was that total cost?

MR. MARTEL: I don't remember.

Q. Approximately $1,500 or so?

MR. MARTEL: Give or take.

Q. And why has the department refused to pay it up to this point? Are you in the process of paying it?

MR. MARTEL: It's a question of not having the resources that were in place beyond June 30, 1988.

Q. It seems to me that when you have a total program that costs $5,000 a year for ten slots, plus several other programs associated with it, that there is some way to pay that. I mean, you've already told me you have $25,000 set aside in education. It's my understanding that there's at least $20,000 remaining in that account. If that's the case, you could pay at least for the reinstatement of the program for the next biennium easily, if not continuation beyond that, and that's ten slots that could help alleviate your staffing shortage. Fifteen hundred dollars is a

very minute bill compared to the costs we're going to get from decertification because of lack of staffing. The same goes for the UMA program that has the same program for mental health workers and LPNs that want to increase their education. That has a similar low cost versus what the benefit is, and again you've not chosen to reinstitute the contract for that.

MR. MARTEL: My only comment to that is, the funds that we're utilizing to pay the invoices are coming out of the central office account, which is substantially lower than the All Other budget within the institution itself. It's certainly within the superintendent's authority to expand the staff development budget by $5,000 or $10,000 by transferring from other places within the hospital, so I think it's a little bit -

Q. Or take unused funds within that account and pay for that service.

MR. MARTEL: Well, it's a little bit misleading to suggest that the $5,000 couldn't be paid. We have a $2.2 million budget at AMHI, and I would submit that if it's as high a priority as people seem to believe it is, then you're right, somehow, some way it could be paid.

Q. The last thing I want to bring up, Commissioner, is, again, consistent with your statement that you've been primarily prioritizing and overseer of the whole department and not been involved in the day-to-day goings on at the department - at the institution. It would seem to me in that instance that if staff and the superintendent came to you and said we need X-amount of staff to meet our requirements, we need this kind of staff level to be

properly certified and properly covered for patient care, but if you do not have a direct role on a day-by-day basis and you put more emphasis in terms of what their role is and their abilities to call the shots, that you would take their recommendations with a great deal of security in knowing that they're doing the right thing and fund them at that level and not say, well, I'm sorry, we can't afford that, we can't do that, when you've not involved yourself in the day-to-day operations. Could you explain to me and to the Committee members that are interested, if the superintendent, Daumueller, or whoever the superintendent prior to he or after he comes to you and says we need this amount of staff to be properly staffed, would you feel your role would be to accept it as it came to you or to cut it beyond that without having that day-to-day role.

COMMISSIONER PARKER: I feel if I don't have a day-to-day role, it is logical - it is logical that I would, as I said earlier this morning, rely on other expertise, and in point of fact, that's what happened. To cite an example, after we lost Medicaid certification on May 29th, two weeks later, in June, I sent the directive to the superintendent and said, please put together a package that will allow us to regain Medicare and retain JCAHO. That staff at AMHI, in fact, put together a package citing a certain number, and the number that they presented us didn't change and still has not changed, and that was the package resulting in the 65 additional staff, so you are correct in that, making the observation that I do rely on people who are in key management positions to come forth with solutions.

Q. Is Dr. Rohm involved in the preparation of the budget for the institution? Is he involved in the budgetary meetings determining the priorities of funding?

A. He is involved to an extent. I think the exact extent we ought to ask him about.

Q. Dr. Rohm, have you in the past been directly involved in the preparation of the budget?

DR. ROHM: In the past, no.

Q. Previous to Commissioner Parker's position, were you involved directly in the implementation and the preparation of the budget?

DR. ROHM: No.

Q. There has been no Commissioner that you have ever served under that you have had a direct role in preparation of the budget?

COMMISSIONER PARKER: Representative Boutilier, he has been appointed to his post since February of '87.

Q. As acting superintendent?

A. No, February '87 as clinical director and then January as acting superintendent.

Q. And my last question, in terms of the institution's importance and the amount of monies that we talk about with any kind of decertification that occurs at AMHI or BMHI, do you not think it would be appropriate to have the superintendents of the institution, which you place a lot of power in their hands in terms of running the facilities, don't you think it would be appropriate for them to come directly to the legislature and speak on what requests they would like to see and be able to answer

questions and justify those requests, rather than going through your office and having you come up and speak for what is not - has been in the past not your day-to-day contact and allow them as superintendents to give the justification for the funds requested?

A. I look at this department as a department that is made up of many operational components. The field of mental health requires many varieties of service in order to make it work. The primary tenet to making a mental health system work well for people with mental illness and their families is the fact that all parts of the system work together. A critical part of that system is, one, the institution and, two, the communities. The programs that are designed in the communities and also the programs that exist in the institution, particularly those programs that relate to transition, that is people moving from the institution back to the community, or vice versa, must work together. Therefore, I think that much more cohesion, that is the ability of a program to work with another program will be reinforced if the institution is a part of a larger system. Consequently, I think it's highly advantageous to have a superintendent function as part of a larger team wherein general mental health and mental illness issues are discussed and to come with us to the legislature to directly present the case before Appropriations. That is not to say, however, that superintendents ought not to sit on committees, such as the Commission to Study Overcrowding, or other policy oriented committees charged with coming up with solutions. They

should do that, and they should do that and be forthcoming with whatever information is necessary for that committee's activity.

REP. BOUTILIER: Thank you.

SEN. GAUVREAU: Thank you. I really hate to do this, but we now are aware that the meeting which was going on in Room 113 has ended and that there are apparently many people who are in the halls who are unable to obtain access to this hearing, and as a courtesy to the public, I think we should utilize the largest hearing room available.

REP. MANNING: Also, for the public knowledge, there is amplification in that room, so everybody in back will hear what is being said.

SEN. GAUVREAU: It may take us a while, so we'll reconvene at approximately ten past two.

(OFF RECORD)

REP. MANNING: Jean, you have a question?

REP. DELLERT: Yes, I have several questions. Thank you. I'd like to ask some questions of the Commissioner, if I may.

REP. MANNING: Sure, go right ahead.

EXAMINATION OF COMMISSIONER PARKER BY REP. DELLERT

Q. I'd like to talk about management plans, including the transfer of patients, standards for restraining, taking of patients' vital signs, and if we had a management plan, who would be in charge of that plan? Would all levels of the staff and all shifts be made aware of these protocols and really whose responsibility is it to see that all these are in place?

A. It's the superintendent's responsibility to make sure all of

these are in place. You had several parts to your question.

Q. Yes. Do we have a plan for the transfer of patients, the standards for restraining patients.

A. Is there a policy in place?

Q. Yes.

A. The finding of the advisory panel, composed of the medical experts, one of their recommendations, particularly using one of the patients as the example, was that there was not an adequate transfer policy in place for moving a patient from one ward to the infirmary and from the infirmary vice versa. With that transfer policy also was the recommendation that certain communication issues be improved. The other one was the restraint policy?

Q. Yes.

A. Yes, at AMHI there is a restraint policy on the books. There is also a department-wide restraint policy.

Q. Was it being followed carefully or was it - did all the staff know about this policy?

A. I don't believe that - at least judging from the findings of the advisory panel, that all the policies were actually being practiced, despite the fact they were on the books.

Q. Then I have another question. Some states, like Massachusetts, have a plan for refusing certain patients, like a dementia patient -

A. Yes.

Q. That would be better served in some of the community settings. Do we have - have we filed that kind of a plan?

A. As a management team in the central office and also the acting superintendent at AMHI, we are just beginning to discuss the fact that there are possibly diagnostic categories that do exist that are inappropriately served at the Augusta Mental Health Insitute, and several weeks ago I did direct the medical staff to draw up a listing of those diagnostic categories.

Q. Then if we had such a plan, then we might move more patients, or as they come in we might even move patients into the communities then. So there is a need for the community based -

A. There is very definitely a need for the community-based services. In fact, one of the cornerstones of the design underpinning o the community package and the institutional package that was presented to the legislature in September '88 was the fact that they must work together, and there are several programs in the community piece of the mental health package that are designed expressly to divert admissions from AMHI to the community, and the idea is that diversion occurs before someone arrives at the front door. An example of one of those types of services that can act as a diverting agent would be intensive case management and also crisis services. Crisis services must be available 24 hours a day, and the idea is that a crisis worker would be very knowledgeable about resource and would be able to direct that individual to the resource that would help the individual when the need was there, not to wait until Monday morning at 8:30.

REP. DELLERT: That's all I have at the moment.

REP. MANNING: Michael?

REP. HEPBURN: Yeah, just as a matter for the committee here, throughout a lot of the morning I've been hearing a lot of the same answers that we had been hearing on Thursday and earlier this morning. Perhaps it might be wise if we set some kind of limit on as far as how long we want to go with these people. We've got an emergency budget request on Thursday, and a lot of the criticism this morning had been that perhaps they weren't moving fast enough with some of the reforms that maybe we should be doing, and maybe we're part of the problem rather than part of the solution in the fact that we're keeping them here all day. Do you suppose we could look to something like that, maybe ending with the department at three or something?

REP. MANNING: Well, Michael, to respond to you, quite frankly, if they're not ready for their emergency budget now, they'll never be ready, but yes, we'll try to make this - try to get this going.

REP. HEPBURN: I'm not trying to block out the debate here. Maybe we could even submit questions in writing or something if we had to if we have additional questions. I'm sure, certainly, some will continue. I'm just a little bit concerned that's all.

REP. MANNING: Go right ahead and ask your questions.

REP. HEPBURN: I'm all set. I just wanted to make that -

REP. MANNING: Any other questions? Bonnie?

EXAMINATION OF COMMISSIONER PARKER BY SEN. TITCOMB

Q. Trying to get a perspective on whose responsibility is what and whose responsibility is not, I'd like very much, Commissioner,

if you would be willing to draw out for me, and I requested the blackboard, my past history as a teacher, I like to see things in writing, I would like to have a hierarchy written from the basic mental health workers up, who is accountable to who?

A. Okay. What I would like to do, Senator, is to pass you out two organizational charts. The first represents the department's organizational chart, and the second one is the AMHI organizational chart. Now, who has the backup here on the AMHI org. chart?

Q. My second question would be, looking at all of these papers here, on which page would we find those workers from the hospital who were involved, say - let's take the rape instance. Where would those workers be on all of these pages, so I can see whose responsibility the decisions of that day really were and where those decisions were being made?

A. Let's turn to the last page. This is the one concerning the Augusta Mental Health Institute itself. The first - separate out your Augusta Mental Health Institute one. Then look at the sheaf of papers that started with the first page called the Commissioner's Office. Turn to Page 2 of that and I'm going to walk you through. It's Page 2. The second page should be DMH and MR government structures. The first page is Commissioner's Office. If we start with the first page and the Commissioner's Office, you'll see that the residential facilities are listed. You see Pineland, Augusta, Bangor, etc. There is a solid line that goes straight up to the Commissioner. That is descriptive of a direct relationship between the superintendent and the commissioner. Turning to Page 2, you see the - again, a box that denotes the Commissioner's

Office. You see three fingers off to the left, AMHI, BMHI and MNCH, Military and Naval Children's Home. This shows the citizen advisory committee to AMHI. Just separate that out for a moment. Now let's move to the Augusta sheaf, the AMHI sheaf. You will see that at the top of the page, holding it on the horizontal, is the superintendent. A straight line connects the Superintendent's Office with four prongs, the Chief of Hospital Services, the Clinical Director, the Assistant to the Superintendent, and the various treatment programs. The treatment programs go down to the right, on the right-hand side of your page. The unit in question would have been on the right-hand side of the page. You will see that whoever is in charge of that unit would have a reporting responsibility to a unit director. The unit director, in turn, reports up to the superintendent. That's a solid line that follows all the way through. You also note that there's a dotted line between the unit directors and the clinical executive board. I have just described for you what the reporting path should be. Look again on the right-hand side of your page. These are various programs down the right-hand side, Admissions Unit, Young Adult Unit, Adult Unit, Forensic, After Care, Nursing Home, Clinic and Infirmary. Those are each of the treatment programs. Again, each of those units has a director. We heard earlier testimony this morning that said that an RN was on duty from the eleven o'clock shift change on. That person - that RN would have reported to a unit director. The unit director would report up to the superintendent.

Q. That was quite an answer. I expected something rather simple.

A. It's not a simple organization, it's a complex hospital.

Q. Well, it may not be a simple organization, but I think there are some simple facts, and that is somewhere along the line there are some holes in this program and there are people that are being raped and people that are suffering poor mental health care because of it, and I'm having a very hard time getting all the papers and not getting down to the specific reasons why these holes are existing, and it seems like nobody is accountable. It's easy to see it on paper, but I want to know who is accountable. Does the buck stop with you? If those patients were my constituents, I would want to know who I was going to blame for a lack somewhere in this system that is laid out very beautifully on paper.

A. Well, Senator, the buck clearly stops with the Commissioner, we know that, no one disagrees with that. I don't disagree with it.

Q. Then I have some questions.

A. But there are several checks and balances in this complex organizational design that are there for very good reasons, and those good reasons are that accountability needs to occur very close to the action where the patient care occurs.

Q. I think that's probably very -

A. And we have discussed this morning that this RN who was inexperienced was a major - she represented a weak link in that accountability. Due to her inexperience, she may have not been cued in to the necessary attention. We have taken the blame, and

by saying for the public record this incident was not handled well. We concur with most of the recommendations made by DHS and will continue to collaborate with them.

Q. I understand that there was a weak link there, but my concern is that I'm seeing so many weak links, I'm wondering who is going to be responsible to pull this whole thing together and how long are we going to wait to ask for the budget request to make it possible. I still haven't heard about air conditioners, we're still doing a study. We suffered upstairs for a very short amount of time with a very relatively low degree of heat, and this next summer, I guess I have some questions about will there be money for air conditioners. Will there be money for the changes that are going to have to take place to fix the links that are risking people's safety.

A. I would very much like to comment on what we're doing around quality, and I can assume that yours was a question as well as a statement. First of all, we're in the process of choosing an engineer. We are working with the Bureau of Public Improvements to do so. It will require - we should have an engineer who can be hired to actually do the survey. We will hire in two weeks. The survey will require approximately one month, and the report will include recommendations regarding cost estimates, still within the time that this legislature is in session.

Q. So we can expect a request for an air conditioning funding?

A. Mid March cost estimates and recommendations will be available.

Q. Now am I not correct in stating that a certain amount of

research has already been done on the costs of putting air conditioning even in just one area of the hospital?

A. We stated last Thursday, also for the record, that some very preliminary examination had been done of aspects of the hospital. It's a complex engineering task to look at the entire physical layout of a facility that has been around since 1840, particularly a facility that is made with granite that is no longer in use, particularly with the actual design of wards that are not of modern construction, and we need the special talent of an engineer who knows about some of the physics concerned with air circulation within facilities of this nature to come in and take a look at it.

Q. What is the time frame you're looking at for installation?

A. Mid March, Mid March, the cost estimates and the recommendations. I have not seen installation estimates, and I do believe that any installation projection for time is totally based on the assessment results for the engineering task itself.

Q. I understand what you're saying and I appreciate all of the routes that we have to go to get these things done. But, very frankly, if there are people that are still - and I'm sure that isn't even an if - the people who are still on these psychotropic drugs that so dangerously interact with severe heat, if there isn't a system in place, then we're going to go through another summer with the same sort of risks and hopefully not tragedies that we had last summer, and I, frankly, think that sometimes the bureaucracy of the whole system needs to be put aside and look

at the human elements where we have a body count. And I appreciate all you've been through Thursday and today and all of the technicalities, but I would like to put some of them aside every now and then and think about the human element, and it seems that too often we are not doing that, and that's the part I have a problem with, because I have to go home to constituents who might one day be at that hospital, and I feel as if we're missing the boat, we're not touching on the real people aspect, that is the issue that's hitting the newspapers and we're being held accountable for, and I feel real uncomfortable with it.
A. I disagree we are not concerned about the real human element. The reason I am here, I believe, is because the legislature has an interest in the human element and I am giving you as much descriptive information as you care to have concerning what we're doing to improve patient care quality. This morning I iterated six points that are designed expressly to take care of the human element. I began with a discussion of what we did in February of '87 regarding the addition of extra staff, as well as the creation of community alternatives. The last point I made in that series was to discuss the DHS findings and some of the recommendations that we are engaged in. However, what I would like to do now is to tell you two other elements that we are engaged in regarding meeting - or anticipating a heat wave for next summer. This I am reading. It's a memo, dated today, January 30, from the clinical director to the medical director of the department, in which it states that the nursing consultant, one Vera Gillis, is

putting the finishing touches on an addition to the mandatory employee orientation curriculum, and I referenced it this morning dealing with the recognition and management of the manifestations of heat-related disorders, and for the nursing policy manual, a similar item is in the works and here is some information concerning it.

On thermometers, if we remember the findings of the advisory panel, there were some issues about taking the ambient temperature, that's the temperature of the air, and there were apparently a lack of thermometers in the facility in order to do this strategically. One hundred were purchased and are installed in all wards. Except for the infirmary, there are approximately ten thermometers per ward. Development of a policy is now in progress.

Secondly, air conditioners. Sixteen were purchased in July and early August and three were reconditioned. The two constant observation rooms on admissions have had air conditioners for many years. In addition, all other ward areas have or will have two or three air conditioned areas.

Fans, third point. Fifty were purchased in July of 1988. I believe there is a date, according to Dr. Jacobsohn, on the date of the first training.

DR. JACOBSOHN: That's correct, yes, March 28th.

Q. Just a couple of questions specific to the budget. When you are drawing up your budget, do different departments - we asked this a bit earlier and I'm still not sure I understand completely

the procedure - do the various departments within AMHI become involved in the structure of that budget, what the needs are, what priority these needs are going to have when you go after monies?

COMMISSIONER PARKER: It is my understanding that the superintendent is in charge of how his or her budget might be developed and it varies -

Q. So actually the departments are not involved in - necessarily?

A. The central office portion of the department does not get involved with, at the early stages of development, a budget process that is evolving within an institution.

Q. So, basically, the decisions for AMHI would be left in the hands of the superintendent as to what the budgetary needs are?

A. There are various weigh stations along the process of actually developing a budget. You know, it's a give and take process once it gets through the steps within the institution. Do you understand -

Q. I understand what you're saying. I'm just wondering what direct role those people who are most affected by budget lacks within the hospital have in budgetary requests for the next year, or for the next session.

A. I have been assured that there is some input but it varies by institution, and I think Rick Hanley would be better suited to giving you a description of AMHI in particular.

Q. Well, I'm just - I'm curious mostly about your philosophy as a Commissioner in how these budget requests should take place, if not,

in fact, that those people that are working on the floors should not have some input in determining what things are needed and make sure that there's a vehicle in place to get those requests to you.

A. The vehicle in place for getting the budget to me goes up through the chain within an institution and it's a real comment on a manager's style, how he or she might involve people who are working at the direct patient level.

Q. So basically your policy -

A. I would favor that, yes, as a point of philosophy as a manager I would be most interested in promoting, and I am most interested in promoting budgets that reflect needs, real needs, and real needs as defined by patients.

Q. But that is not a policy right now, that that is part of a process that should and will take place, that it's up to the discretion at each institution of the superintendent?

A. The assurances that I am given by superintendents at all facilities reflect how they best see a budget development process. A budget development process from an institution is also based on history and how communication works in those particular institutions. When I receive a budget from a top manager, I always ask, does this reflect what you need.

Q. I guess that's the point where I begin to have a problem. In education, when we do our budgets, we put in requests for those things that we think we're going to need to work into our programs, and if there was no one there who routinely would take those

requests, it would be very difficult for us to know that the coming year, when we go into our classrooms and face a hundred some students, would those supplies that we need to provide good quality eduction be there, and I would think that it would be a priority that a budget philosophy and plan be in place so that those people who are providing the care on a basic level have some input into what their needs will be. I guess that's just a difference I understand what you're saying.

A. That is exactly -

Q. But it's evidently not a policy that is routinely adhered to, it's left to the discretion of the superintendent.

A. And that is precisely why in a management approach such as mine why it is vitally important to have people who are your appointees who share your value structures, who share to some degree a treatment philosophy that puts patients first.

Q. Well, I appreciate that. I have just one more question I would like to ask, if time allows.

SEN. GAUVREAU: Proceed.

SEN. TITCOMB: On the instance of the rape, who was the person who ultimately reported that rape to the authorities? Who was the person who got medical attention for the victim of that rape? And who was on duty at the time that might otherwise have been the person to do that?

A. When you say authorities, do you mean the police?

Q. I mean both the police and those members of the hospital administration or hieraracy that should have been notified.

I just would like to see a scenario of what took place and perhaps use that as a case study of where some of the problems are, because it appears to me that if the next day this woman was being treated for something that I believe should have been treated immediately, then there seems to be another weak link, and I would like to know where that - how that scenario took place.

A. Okay. In the course of this day, I have been - I have referenced this case three or four times. In order to not repeat the information that I have said, I would like Rick Hanley to offer a chronology of who said what and to give you the time element on that.

Q. Well, I understand it and I do recall your referencing it, but I'm still - after several times I still don't get a clear picture of how it took place.

A. Yes, you want the chronology.

MR. HANLEY: I'll try to be brief.

Q. Not necessarily, just complete, thank you.

MR. HANLEY: After the incident was discovered, we've already established that the nurse on duty did not immediately notify the NOD, the nurse who was on duty on that shift. The next piece in the sequence, the victim was cleaned and her clothing placed in bags and taken care of. The next piece in the sequence, as I understand it, is that at 6:30 in the morning on the 10th of September, the following morning, the woman was awakened by a mental health worker and again - and was bathed at that time, and

this - my understanding is that this occurred prior to an internal medical examination. The physician assistant who was on duty was notified of the incident at approximately 5:30 in the morning, and approximately 6:45 is my understanding, the woman received a medical examination.

The next piece in the process is that I believe the physician who was coming on was informed of the incident, and also the assistant OD who came on that next morning, and in the DHS account which I am looking at there are a couple of pieces missing, but my understanding is that - and I think that former Superintendent Daumueller could also flesh this out a bit, that he was notified by the NOD and came to the ward. At that point, my understanding is that he instructed that the patient advocate, Tom Ward, be notified. Mr. Ward came to the hospital, I believe, around eleven o'clock on that Saturday morning and at that point he became aware that the police had not been notified, and I believe also the guardian at that point, the public guardian, had not been notified. And my understanding is that Mr. Ward instructed that that occur.

SEN. TITCOMB: So my next question is what was the scenario for the man who was then taken to the forensic ward? What was the whole scenario with him?

MR. HANLEY: He had been seen that night by a mental health worker who had just come back from another unit, and about quarter of twelve on the 9th of September he was found by the staff person. He -

Q. Excuse me, who was the staff person? What role did that

person play? Was it a mental health worker?

A. He was a mental health worker, yes, I believe a Mental Health Worker II. The male patient was showered and changed, but that did not occur, I understand, until early the next morning, approximately five o'clock in the morning. And I am not exactly sure of the point at which he was transferred to the forensic unit.

Q. Do you know who made that decision?

MR. HANLEY: No, I do not.

Q. Okay, after he was up there, what length of time was he in the forensic unit before it was decided that he would be sent back? You said at intervals he came back onto the ward, but exactly what happened then?

MR. HANLEY: I cannot off the top of my head or from this - the description that I'm looking at give you exact dates of when he was first integrated back.

Q. Not dates, I just want generalizations at this point as to what period of time was he in the forensic unit and at what point and by whose authorization was he allowed to come back onto the ward, at which time another incident occurred?

MR. HANLEY: Well, it would have been, I believe, within the next three to four weeks that he was gradually being re-introduced to the ward, and that would have been a clinical decision that would have been made jointly between the clinical leader on the forensic unit and the attending physician on the North Psychiatric Unit.

Q. So those would have been the two individuals who made the decision that he was, in fact, ready to come back to the ward?

MR. HANLEY: I am not sure what involvement the clinical director had in that - in that decision.

Q. Does anyone know for sure exactly what - this is where the foggy area starts for me again. I hear too many well, I'm not sure and I think, and if we're setting up protocol for where we're going from here, do we know where we've been and what mistakes we've made, and this is - every time we come to this point and I don't feel as if I'm getting a specific answer to my question. Who was the person that decided that this male patient was ready to come back onto the ward where he then went on and attempted another sexual action, whatever it would have ultimately been?

MR. HANLEY: We can obtain the medical record and give you exact dates.

Q. I would like to have that.

SEN. GAUVREAU: I understand that will be provided to the committee.

MR. HANLEY: Yes.

SEN. GAUVREAU: Thank you.

SEN. TITCOMB: Thank you. That's all I have.

SEN. GAUVREAU: Thank you. Representative Rolde?

EXAMINATION OF COMMISSIONER PARKER BY REP. ROLDE

Q. Susan, you may already have answered this, and if so, I apologize for having to be in and out, but when we were in one of the rooms that we were in this morning there was a chart in front

of me and looking at that chart, and correct me if I'm wrong, but it looked like right now, in 1989, you have the highest census that you've had so far at AMHI, is that correct?

A. In 1989?

Q. Yeah.

A. Right. This one right here, that would still be census, wouldn't it?

A. Admissions are the number of people who actually physically come in. A census is who actually is staying there.

Q. All right, then you have the highest number of admissions?

A. That's right, and the point that I made this morning is that the - in the period 1980 through 1985, while the admission rate was going up the number of full-time equivalent staff, that's one staff person, were going down. However, in 1987 the trend began to change and the numbers of full-time staff began rising as the number of admissions were rising.

Q. Okay. What I wanted to get at is whether it's admissions or census or whatever, what does that portend, the fact that the admissions, after all this talk about an overcrowding commission and concern about the overcrowding and the legislature giving some money to beef up community resources, what does that portend for the future, the fact that despite all of these activities, the admissions are the highest that they've been since at least 1980.

A. Right.

Q. Is that a trend, is that because of population pressures, is it that the communities' resources haven't taken hold yet? What

do you see as happening?

A. It's a complex set of occurrences that are happening simultaneously, and the admissions are continuing upwards. In fact, given that we have one more day of January, it's looking as though we may have the second highest month on record for numbers of admissions. The admissions are coming from - or the majority are coming from the southern part of the state, combined with the Lewiston-Auburn area. We're seeing an increase in the acuity, that is the actual severity of the illness.

Q. So they're staying longer once they're admitted?

A. Not necessarily. Some of them are coming in, staying an average of six or seven days and then moving back out, often not even being referred from the admissions unit out onto the wards. We did a study in the statistician's department of AMHI to see if there was a correlation between population increase in York County and Cumberland and the numbers of admissions, and we found that there was not a direct statistical relationship between the two, which you think there would be given the behavior of populations. Many of the people coming in have polysubstance abuse issues, not necessarily, you know, a simple - not that psychosis is simple, but solely a psychotic condition.

Q. So what do you see happening? I mean, does this mean that the problems that we've been having are going to get worse?

A. I think that admissions are going to continue upward. They may begin to plateau off a bit. The community services that we are establishing via the legislative package last September will

begin to have their effects felt in April and May.

Q. Refresh my memory. How much was in that $6 million package for community services?

A. The total was 3.5 million.

Q. Okay. Has that already been spent or sent out to the -

A. Yeah, it's earmarked for the different services per the plan that we first presented to the legislature in July and the different tasks that needed to be done in order to establish crisis services --

Q. Do we have a list of that among all this mountain of paper?

A. We can get you a list if you don't have it.

Q. If we don't have it, I think it would be interesting to know how that money is being spent.

A. I thought we had forwarded you a list that showed the effective date of contracts that we're letting out. We're in the process now of publishing a number of requests for proposals. For your information, the January admissions figure, as far as number, is 146. Nineteen of those for the month of January are people who would otherwise have gone to the Veterans Administration Hospital. I know that last Thursday we did talk a bit about the potential effect of closing the psych wards at Togus on AMHI and we are seeing the effect. The percentage of veterans is increasing month by month by month, more so than in years previous.

REP. ROLDE: That's all. Thanks.

SEN. GAUVREAU: Thank you. Representative Manning?

EXAMINATION OF COMMISSIONER PARKER BY REP. MANNING

Q. Susan, you just indicated - you said something that caught

my fancy. Did I hear you just say that the RFPs for the community just went out?

A. They have gone out on - at several different dates, Peter. They - I can't remember the exact month they started, but I think it may have been as early as January. Each service, such as case management or crises, or the psych boarding homes have all been developed at a different rate of speed, and the request for proposals have been published on various dates.

Q. Could you tell me why it took so long? I was under the impression that when you came to us with a budget of 6.75 in September, that you were ready to roll at that particular time with community, some of which, I think, was, for instance, case managers, of which Holy Innocence in Portland has already got a proven track record and basically all they needed to have was additional people, I mean things like that. Why are we almost five months later still waiting?

A. I am very pleased to report, Representative Manning, that we are absolutely on target with the schedule. And I recall that in the process of briefing the Human Resources Committee in August, that we talked to you about that schedule. We gave you projected time lines. I will now read again what those time lines are. Regarding case management, a sum of 511,750 was allocated to that. The effective date of the various contracts is February 1, '89. The contracts have been awarded in York County, the Tri-County area, that is Lewiston-Auburn, Kennebec County and Bangor. The existing contract in Portland, and that's your

Holy Innocence reference, was amended to expand services, and the result of these actions will be to provide case management services for up to 525 mentally ill consumers.

Moving on to rehabilitation, which is a very -

Q. Can I stop you right here? Are you saying Holy Innocence got theirs quicker?

A. When there is a contract amendment, it means that you take an existing contract and you simply make a few changes in it, which will be quicker than issuing an RFP.

Q. So, any idea when Holy Innocence got their -

A. Jay Harper, do you know the answer to that precisely?

MR. HARPER: We did the contract amendment notification of them about 48 hours after the end of the session, and I think we finished the actual contract negotiations and changed the language and did new tables for their budget.

Q. So they've had theirs since roughly October, the first of October?

MR. HARPER: Yes, and as far as I know, they had one position vacant about a month ago and I think they have that filled now --

MS. PARKER: Another critical component of any service in the community involves crisis services. The Bureau of Mental Health has hired an additional six crisis workers to provided expanded services in York, Cumberland and Kennebec, and you heard me reference a couple of times that the bulk of admissions to AMHI come from York and Cumberland. These new staff will be joining the various projects by February. The money available for the

crisis services was made effective November 1, '88, as far as moving into the community.

Let's see, on the idea of basic support services, and this has to do with supported living, that was a sum of 423,000, and there are two dates here, February 1st and March 1st of '89. The Bureau anticipates amending existing contracts for services in Portland and Tri-County to establish one six-bed group home in each region. In addition, purchase of service money will be used to provide support services for up to 30 consumers. As we have discussed in briefings past, it is vital not only to have a bed in which to place someone, but you must place a variety of services around that individual so that they will have the necessary support in order to maintain life in the community. A bed is not simply enough. One of those important services that needs to be available, particularly for individuals that have not had ever the opportunity to go to work is in the - is along the idea of vocational support, and a sum of 397,500 was awarded to that effective February 1, '89. The Bureau requested proposals for supported employment coordination and the proposals have now been received and a contract will be awarded in the next two weeks, and we anticipate that the coordination for supported employment will be on line in March and these coordinators will match and link consumers with the actual variety of vocational rehabilitative services that are available in the different parts of Maine. Vocational rehabilitation as a service is something that receives a mix of federal and state funding. It is administered out of the Department of Human Services and there

is an interest by VR, as it's call, in working with people with psychiatric disabilities.

One of the most important components of this community package is in the area of maintaining staff people and making sure that your direct service staff people are taken care of. A sum of 1,186,250 was effective January 1, 1989, and the purpose of these dollars was to allow us to amend direct care contracts in order to provide increased salaries for direct care workers. A legislative committee, I guess it's been working approximately two years on the issue of staff retention and certain of the human services, found that the staff turnover is exceedingly high amongst direct service workers. When you have a high staff turnover, your ability to provide continuity of services is quite compromised. It is compromised because it takes time to, one, fill the position, and two, get that staff person up to speed. Consequently, raising the minimum wage, or the minimum salary level to an individual who is doing the all important direct service work has happened, and it has now been raised to $6.30 per hour. The money has also been used to help in recruitment, staff development, increased benefits and retirement programs in order to improve the quality of services by making it a more attractive option to work in direct services.

There's another area that has been given little mention through the years, and that's in the area of family support, and that was funded to a level of 20,000 effective February 1, '89. We have not but will issue a request for a proposal to provide

family support liaison services in the next week, and we anticipate a contract award by the second week in February. Families of people with severe and prolonged mental illness are often the unsung heros in service delivery, and the ability of an individual to maintain him or herself in the community is often assisted by families, but families also need some support, and in this state, we need to look at family needs and look at how we can continue to strengthen a family's ability to work with their family member who has the mental illness. If I can continue -

Q. Well, my concern is that some of these I thought were going to be out a little quicker, but that's all right.

A. But as I said, Representative Manning, the time lines that appear here are the very same time lines that we presented to individuals, such as the Human Resources Committee, who are interested in this package, before we went to the legislature in September.

Q. Okay. You talked about the air conditioning earlier from Senator Titcomb. Then what we're anticipating, that will not be in the Part II Budget but that will be in the Emergency Budget?

A. We have - as I said to Senator Titcomb, by mid March we will have the cost estimates and the recommendations from the engineering firm.

Q. But what I'm getting at is, you're going, did you say Thursday, in front of the Appropriations Committee?

A. Thursday to talk to our supplement budget request, and sometime in March for Part II.

Q. Okay, supplemental. The emergency budget proposal, when you do the emergency - you have an emergency budget proposal that gets

you by June 30th, right?

A. Right.

Q. Will you be anticipating asking for more money in that?

A. Not for air conditioning.

Q. Why?

A. In state government, the Bureau of Public Improvements has the administrative responsibility for buildings and what happens in buildings. I need some technical -

Q. Well, will they be asking in their emergency budget for the air conditioning?

A. I can't answer for them, Representative Manning. I was just looking around because I wanted some clarification from Ron Martel as to the responsibility of the Bureau of Public Improvements to initiate such a request. I don't know the answer to that.

Q. Could we find that staff, because the concern would be that if it's in Part II, by the time Part II is voted on and put into place July 1st, and quite frankly, I think you people did a heck of a job trying to find 15 air conditioners, because from what I understand, you couldn't find anything in Maine at all last summer, and where you found them, maybe we ought not to know because you can go back to them, but that's a concern I have, that it's an emergency piece of legislation, that it's funded before we leave here in July, and it's funded so that the RFPs or whatever needs to be done, it goes out so that when it starts getting hot, and it gets hot here, believe it or not, and sometimes in June, you know, I want to make sure we have air conditioning in that place this

summer, and that's something I think we need to - maybe Ron can - Ron, can you help me on something? On the air conditioning, that goes through the BEP or BIP or -

MS. PARKER: BPI.

MR. MARTEL: BPI.

Q. Do you know whether or not they will address that in their emergency budget?

MR. MARTEL: No. We had some discussions with them in the fall about attempting to estimate the cost of doing such a project, and they had one of their people do some rough estimates, and I think I mentioned last Thursday it was in the millions as a rough guess, and that's all it was.

Q. Well, what about just buying air conditioning?

MR. MARTEL: We did, we bought -

Q. Have we got enough?

MR. MARTEL: Have we got enough, I don't know.

Q. In other words, what I'm - I'm concerned that we're going to go through another summer. I think Senator Titcomb talked about the air conditioning, but I'm concerned we're going to go through another summer and it's going to be - and I know how state government works, it's going to be January, it's going to be 13 below zero over in AMHI and they're going to be putting an air conditioning unit in and that isn't going to help this summer. They're not going to do anything then this year, apparently.

MS. PARKER: I don't think we can say that for sure.

MR. MARTEL: The report is due on our desk in mid March.

Q. Are you going to be pushing to have that funded in an emergency

piece though?

MR. MARTEL: It's too early to tell, don't know. It depends on what the recommendations are. We're going to take a look at those and work with the Department of Administration and talk with this committee and administration.

MS. PARKER: Representative Manning, if the recommendations come forth that it is feasible and there is something that we can do, rest assured that we will push very hard to make that happen.

Q. I don't know whether you need central air conditioning, but I know you can get 18,000 or 20,000 BTUs and it can cool down a heck of a lot of areas, and stick them right in windows. There's enough windows over there.

Susan, back in September, did you indicate to us anything about the possibility - this is a followup to Brad's talk this morning, the possibility of losing JCAH and the new stringent requirements, were you - at that time was more a concern about just dealing with the Medicare?

A. In September, I think we - when asked the question, you know, by various legislative bodies, we mentioned that the design of the package, you know, the 65 for AMHI was done in response to a question that I laid out, and the question was, give us a program design, a staffing pattern that will allow us to regain Medicare and retain JCAHO, because we are anticipating, you know, a tough review. We discussed the fact that JCAHO was an upcoming event and that we needed to prepare for it.

Q. Apparently that was something I didn't hear, so I apologize if you said it, because that's why I questioned it. When you said it

this morning, it was the first time I had remembered hearing it.

A. Representative Manning, could I make one comment?

Q. Sure.

A. Okay. I want all of you to know that it is frustrating not to move faster, but I can't emphasize enough that every single day another step is actually being taken to improve patient care and another staff person is hired, another training session is held and another procedure is modified. And after years of problems, we really are making progress, and I think the course and discussion of this hearing and the content that has come before you shall illustrate that. However, I do take full responsibility for the pace of our progress. Consequently, since I do take that responsibility, I instituted a high level management change primarily because I felt we were moving too slowly, and I'm anxious to move ahead. I told you we were in a management crisis and I share with you the need to move ahead, and I believe we are.

Q. Susan, you talked about the hospitals. What is being done about working with the hospitals on the outside to take patients, i.e., Cumberland and York. What has -

A. The Bureau Director of Mental Health, in conjunction with the associate commissioner for programs and me, initiated some contact first through the commission to study overcrowding and their hospital subcommittee, and secondarily through our own work, and we have made contact with the Maine Hospital Association and have received indications from them that there are some general hospitals that are interested in working with us. However, there are systemic health care concerns that we need to work on. One would

concern physician liability; another one is the very real concern harbored by general hospitals, trustees often, concerning the nature of work with a patient who carries an involuntary status, but rest assured, we are moving ahead.

Q. Will we need to address the liability, as we talked about back in the fall of 19 - or the summer of last year when we talked - when I gave you the idea about putting some of those doctors right on the state rolls?

A. At some point we will need to address that. I should like to mention that Dr. Owen Buck, who is president of the AMHI medical staff, has just come in and he's here to answer questions on the - concerning the perpetrator of the rape case that Senator Titcomb raised. Would you like to speak with him?

Q. I'll defer to him, and I've got other questions. Do you want to come right up to the microphone, Dr. Buck, please?

MS. PARKER: May I introduce to you Owen Buck.

EXAMINATION OF DR. OWEN BUCK BY SEN. TITCOMB

Q. I guess we're stepping back to my request that took place a few moments before you evidently came in. What exactly was the scenario with the male patient? Who authorized what was done and what were the grounds upon which that authorization was given?

A. Okay, this particular patient has been a client of mine off and on for years. I presently run the forensic unit at AMHI and have done that for about two years. Prior to that I was working on a different unit at the hospital, and I have known this particular individual for nearly five years. He had been my patient on the

other unit before the forensic unit. This particular individual is very mentally ill, a very sick fellow. He had no prior history of sexual assaults. I have taken care of him through many bouts of severe illness, and this sort of thing was completely out of character for him. Let me just refresh my memory on dates. At the time of the initial episode he was not my patient. I had since moved from the unit where this fellow was to the forensic unit. After the initial episode where he sexually - allegedly sexually assaulted a female patient, he was placed in a constant observation room on the admissions unit, and the date on that was Setpember 10, according to the chart, and that was on a weekend. Two days later, on September 12, he was transferred to the forensic unit.

Q. Now at that point did he become your patient again?

A. Yes, he became my patient once again.

Q. But during the time of the incident, he was not - who was his physician at the time, his mental health worker?

A. I believe it was Dr. Victor Pentlarge.

Q. How frequently was he seeing this doctor? I mean what's the typical procedure? How many times a week would you expect that he would be seeing his doctor?

A. I'm not really sure. I know that we - we will have to priortize how often we see each particular patient. A patient who is quite ill, who is having a lot of needs might be seen daily. Someone else who seems to be fairly stable would be seen much less frequently.

Q. What would you guess would have been the frequency of this individual's visits?

A. I really couldn't even guess, I don't know how frequently he would

have been -

Q. Could a patient go two weeks without seeing his doctor?

A. Certainly.

Q. Three, four weeks?

A. Hm-mm. It's possible for the patient to be seen about the ward and you would say hello to the patient in passing, but several weeks might easily pass before you sit down and have a more formal evaluation session with the patient.

Q. How long could pass? What would be the maximum amount of time that could pass?

A. Well, the ceiling on it would be a period of - I believe one month, at one month intervals at that time on Stone North middle, I believe, we would have a formal disciplinary case conference.

Q. But would the patient be involved in that?

A. The patient would be involved, the patient's guardian, the whole treatment team.

Q. So it could be a month. Do you have any reason to believe that it had been that long with this male patient?

A. I could look to see if there are any notes. It will take a moment.

Q. I would like to know that, and I would also like to know, if there are records there, who was seeing the patient, what category of mental health worker was seeing the patient and was responsible for day-to-day treatment or therapy, if there was such a thing.

A. I only have progress notes here going back to December 20th of '88. The notes prior to that would have been taken out of this

binder and sent to our Medical Records Department just because there's so many pages here that they wouldn't fit.

Q. So you don't know?

A. I couldn't tell you. I would have to get that other binder out from our Medical Records Department.

Q. I think there's someone in the background who would like to comment on that.

A. Okay. Let me look one more place here.

Q. This is very important to me. It may seem like I'm just harassing you over one issue, but not even being in the medical field, I find it very hard to envision that someone can go into a mental health institute and not actually have a complete package of care, with regular visits by a doctor, with a specific program set out with an ultimate goal.

A. No problem, your question is a reasonable one. There are orders written by Dr. Pentlarge on September 9th.

Q. Now were those orders written by him after he had seen the patient or when there was a physician extender on hand or just a mental health worker?

A. This is a note written by him, so he -

Q. Can you tell, and I'm not asking you to read the note, but can you look at that and tell if that was written during an evaluation of the patient?

A. I don't believe this - this was not written during a formal evaluation. This looks like an order that would have been written on an as-needed basis.

Q. So having looked at some of the Medicare concerns, that was one of those specific concerns that was the most glaring upon my reading it, that those sorts of physician directives were often given offhand, not with direct physician contact with the patient, and I'm asking if that could have been a situation?

A. Could you repeat the question? I'm not sure I understand.

Q. Looking back at the report of Medicare concerns that brought about the discreditation of the institute, one of the most glaring reports I read over and over again were patient records, or lack thereof of patient records, and lack of a physician being present to make those records legitimate, that there was that contact with many patients, and I guess my big question is, how long had it been that a physician had actually had eyeball to eyeball contact with this man who then went on to rape an innocent patient, and if there's that gap there, if you don't have records of it, that's certainly reflective of the reports we got from Medicare. If you do have records, I would like to know what they say.

A. I would think that Dr. Pentlarge saw this fellow on September 9th. Our policy is that when an order is written about a patient, there should be a corresponding progress note, and I would expect that he saw the patient at that time. Very frequently we will see patients on an eyeball to eyeball basis, which is a very different thing from a formal sit-down conference with lots of team members. Very often it will happen that I'm walking down the hallway and I'll see this patient who doesn't look like he's doing so well, or some other patient will approach me with a problem, and I might

address something that way, even though their official case conference might be several weeks away.

Q. What if he looked like he was doing well. Would you feel that it was appropriate to grab his file and maybe make a notation about I saw so and so and he looked pretty good?

A. I would like to be able to do that. Usually, however, I'll be so flooded with more acute problems that I simply don't have the luxury of pulling out charts of patients who are doing well and writing down that so and so is doing well. If I do that, I'm taking away time to attend to more acute needs.

Q. I don't want to take away time to continue with what we started, but I do feel that there's still a good deal of question in my mind as to when that patient last was observed and evaluated by a physician. So on September 12th, this patient was brought - was taken to you in the forensic ward.

A. That's correct.

Q. And that was the first time you had seen him for some time?

A. It actually had been only a period of, oh, I think - it had been a relatively brief period, like a matter of months. I don't remember exactly the dates of the moves.

Q. But he was not in your charge?

A. He was not in my charge on that date.

Q. So at this point he went into your charge?

A. At this point he's back in my charge.

Q. Okay, what happened?

A. He's on the forensic unit, doing relatively well. As a matter

fact, to me he seemed to be doing about the best mentally that I'd ever seen the fellow. Let me check dates again here. On October 11, given the fact that this patient was doing quite well, and also given the fact that we have a mandate to treat patients in the most restrictive setting, we started transitioning him back to the unit from which he came. Now on the forensic unit we generally treat people who are legal holds. This would be persons who have been found not guilty by reason of insanity on various offenses, people who are incompetent to stand trial, inmates from jails or prisons. We have - we also provide a service to the hospital in that we will also house a non-legal hold patient who for one reason or another has been behaving too dangerously to be managed elsewhere in the hospital. This fellow was one of those, and our policy and procedure on those is that we take these people, stablize them if we can, and return them to the ward from which they came. And that seemed to be the case with this fellow, so we made a decision that we were going to try to transition him back. On October 11th, we started that process and what we did was we had him going back to Stone North Middle from one to three P.M. each day, and he was on 15 minute checks the entire period of time he was there, which means someone was checking on his whereabouts, keeping an eye on him.

Q. Was he receiving therapy, psychotherapy at that time?

A. Psychotherapy was not indicated for this particular patient.

Q. Was there some treatment for him other than a chemical treatment?

A. Chemical treatment was the treatment for this particular person.

Q. That was it, no psychotherapy. So basically if there -

A. The nature of this person's condition was such that psychotherapy would have not been a productive use of time.

Q. Okay, and not knowing his condition, it's hard for me to know what questions to ask, but did you feel that -

A. We did spend - let me just - one other. We did spend time discussing with him what had happened and reviewing with him about what he did to this female patient and how that was wrong and that was a totally inappropriate thing for him to have done, and he was able to express some remorse for what he had done. I just wanted to add that. That was not - I wouldn't call that formal psychotherapy but we did address the issue as best we could given this fellow's condition.

Q. Did you feel that there was something in his own development or his own state of mind that had brought on this type of behavior? If it wasn't a normal behavior for him, was there something that you could point a finger at that might have brought this on, or did it just occur out of nowhere?

A. I don't know why it occurred. I think it just came out of nowhere. As I mentioned, I have known this fellow for years and I've seen him be very sick and he would occasionally make some inappropriate comments to females or some inappropriate minor touching, but in terms of a violent assault, it's totally out of context here. He has no history of anti-social behavior, no criminal proclivities.

Q. How long was he there in the forensic ward?

A. Well, he arrived with us on September 12. He started this transitioning period on October 11th, as I mentioned, and then he attempted another - well, there was another alleged assault on - it was November 23rd, and at that point we cancelled our efforts to transition this fellow back to Stone North-Middle at all, and he's still on the forensic unit.

Q. I'm having a - at what time - on November 23rd you said he attempted another assault. Where was he at that time?

A. He was on Stone North-Middle during one of his visits over there, transitioning visits.

Q. So at no time was it ever decided that for any more than just a brief stay he would be in Stone North. Who made the decision that he was ready to go back to that ward even for a short period of time?

A. I did.

Q. So Dr. Pentlarge at no time was making the decisions for this patient?

A. Once he arrived on the forensic unit, I made the decisions on the basis of my evaluation of this fellow. In my opinion, weighing the risks and the benefits, the risks of a repeat episode of this sort of behavior and the harmful effects of keeping this fellow locked up in a maximum security unit, given the fact that we need to treat people in the least restrictive setting that we can, it was my decision that this was an appropriate thing to do and that we had done this in an appropriately cautious manner with appropriate safeguards. You know, there was a bad episode

in spite of those efforts, but it was my decision to go ahead with this effort to transition him back.

SEN. TITCOMB: Okay, I'll let someone else have a turn now.

SEN. GAUVREAU: Thank you. Representative Cathcart?

EXAMINATION OF DR. BUCK BY REP. CATHCART

Q. Dr. Buck, I believe I heard you say that as far as you knew the male patient had no history of sexual assaults or that kind of thing.

A. That's correct. I don't believe he had a prior history.

Q. Well I'm confused. I'm reading from Page 3 of the November 9th DHS report and under their findings, Item No. 2, the patient, an incapacitated male, under private guardianship, had a history of inappropriate sexual activity with the female staff and female patients. This behavior was well documented in his progress notes and and in the inter-shift report book. Other than changes in his medication there appeared to be no attempt to address this dangerous behavior in his treatment plan. No. 3, staff repeatedly removed Mr. (Blank) from female patient bedrooms, redirected him elsewhere, placed him in the quiet room or in SRC. This action taken by our staff served to protect other patients and Mr. Blank on an immediate basis but there was no plan for prevention of future incidents. I know that you are not the physician primarily responsible for him at this time, but it's hard to understand how if that was documented in his records at the hospital you weren't aware that there had been other instances of -

A. I think the instances being referred to here are verbal things, touching, an inappropriate behavior, to be sure, but not violent assaults.

Q. I suppose it's a judgment call; however, I would say a patient found in female patient bedrooms and touching inappropriately should be considered a danger to an incapacitated 76 year old woman patient.

A. Well, again, the sorts of things that he had done in the past were certainly inappropriate things, but they were not things that I would consider dangerous on the order of assaults, sexual assaults.

Q. Once he had committed allegedly rape, did you then consider him possibly dangerous?

A. I considered him possibly dangerous.

Q. But you felt that his freedom to go back on the regular ward was more important than the possible threat to the other females on that ward?

A. Well, it's not a question of importance. I think both are important. I had to weigh out how likely was it that he would do something like this again, how likely was it, that we could at least try him out and see how he did. My thinking was that there is a very good likelihood that we could successfully transition him back with some additional precautions.

REP. CATHCART: Thank you.

SEN. GAUVREAU: Are there other questions? Representative Burke.

EXAMINATION OF DR. BUCK BY REP. BURKE

Q. When you had the patient on the forensic unit, did you see him?

A. Yep.

Q. How often?

A. I probably saw him almost every day on the forensic unit.

Q. For formal sessions?

A. Not for formal sessions. Sometimes it would be a formal session, sometimes he and one or two other staff and I would go sit in the conference room, sometimes I would go down to his room, sometimes we would talk in the day room, a whole spectrum of intensity of contacts.

Q. With each contact was there a notation made in the chart?

A. I would usually make a note in the chart, yes.

Q. Were the nurses' notes or the mental health worker notes reviewed at that time?

A. Yeah, I would take a look at notes.

Q. Did any of those notes reflect this continued inappropriate touching?

A. Yeah, I think there had been some notes about it.

Q. So in light of the fact that the patient went from inappropriate touching to allegedly raping a patient on one unit, and he goes to your unit and, in fact, continues inappropriate touching, you still saw no reason to believe that he may, in fact, escalate to this behavior again in the near future?

A. Well, I didn't say that I saw no reason to believe, but I thought

it was unlikely that he would do something like this again. As I mentioned, this particular fellow had been doing these minor inappropriate things for a very long time, years, and had been on that unit for years without - the forensic unit is an all-male unit, by the way, so there wouldn't be any females there.

Q. There are no female staff members?

A. No female staff, no female patients on the forensic unit.

Q. Then I fail to understand how you can evaluate whether or not the patient will, in fact, escalate again.

A. Well, this is exactly the reason that we try transitioning somebody back with some precautions. I can't just leave him locked up in the forensic unit for the rest of his life and not try to get him back to at least a restrictive setting.

Q. In the least restrictive setting, did he again begin inappropriate touching, inappropriate comments, stopped only by authority figures?

A. My recollection is that that did happen on occasion. Let me check to make sure. Again, the progress notes in the chart here only go back to December 20th. I'd have to pull the previous records out of Medical Records.

Q. But a recollection of -

A. My recollection is that there were some of these minor things which were old behaviors, not associated with violence for this particular fellow, and it was certainly grounds to keep an eye on him and continue precautions

Q. How informed would you say the upper echelon - the upper management was of the - of the situation of this patient in particular

in that he might be a problem for the institution?

A. I think they were well aware that he was a problem for the institution.

Q. So you would say then that both the superintendent and the commissioner were aware that this was a tough situation?

A. Yes.

REP. BURKE: Okay, thank you.

SEN. GAUVREAU: Senator Titcomb?

SEN. TITCOMB: I just have a couple of questions that I forgot to ask before, and I don't know if you're even the person to answer then them. If you're not, I'm sure you can pass them on.

EXAMINATION OF DR. BUCK BY SEN. TITCOMB

Q. Do you have any figures on how many patients have died at the hospital since August?

A. August, no, I don't.

Q. Does someone here?

COMMISSIONER PARKER: We can get those.

DR. JACOBSOHN: Approximately 20 patients die every year at the Augusta Mental Health Institute.

COMMISSIONER PARKER: And in calendar year 1988, actually 18 died.

DR. JACOBSOHN: On the average of 20 a year.

SEN. TITCOMB: How many have died since August?

DR. JACOBSOHN: Well, I don't know but -

SEN. TITCOMB: Do you have any -

DR. JACOBSOHN: I would imagine a little over one per month, one to two a month. We can add it up. But that's a constant.

Q. So it comes to what, about 7 percent of the population?

DR. JACOBSOHN: Oh, no.

Q. No, excuse me, I'm sorry. What is the percentage of the population that dies yearly, of the present population?

MR. WELCH: We would base it on the admissions for the year. That's the total number of people served.

Q. Well, if you place it on admissions, I think I would like to have it based on population at the hospital, because people leave - do people leave? I mean, is this something that happens occasionally?

DR. JACOBSOHN: You have to understand that there are some elderly patients.

Q. Oh, I do understand.

DR. JACOBSOHN: Especially in the nursing home and there are always some patients that do eventually die, like all of us. That's part of the process, you know. It is unusual to have someone die at a younger age, that becomes an unusual event. So if you ask how many patients died, I can say, well, roughly 20 a year, because that's part of the attrition of any aging population.

Q. I understand that and -

DR. JACOBSOHN: It might be a different question, I don't know.

COMMISSIONER PARKER: Senator, 1.3 percent. It's 18 divided by 1,400.

Q. But 1,400 is?

COMMISSIONER PARKER: The number of admissions.

Q. Admissions, but I was looking for population which - okay,

that's another question. It would come up with a different figure, buy my question was really going to be what is the procedure that this hospital follows when a patient dies? What is the notification procedure? Do you - perhaps the Commissioner could answer that.

COMMISSIONER PARKER: That should be directed to Dr. Jacobsohn, the medical director of the department.

DR. ROHM: If I could add just one thing to Dr. Buck's presentation. This case was discussed at length with me and Dr. Pentlarge and after long consideration we decided this course of action, two hours a day with 15 minute checks, for the reasons Dr. Buck outlined.

Q. Thank you.

DR. JACOBSOHN: When a patient at the Augusta Mental Health Institute suffers from an illness or old age and is expected to die, then no formal procedures are involved other than a death has occurred in the hospital. When a patient dies on a psychiatric ward as a psychiatric patient that is routinely reported through a series of procedures to the Commissioner, to the Attorney General's Office, and as of the last couple of months, to me, so I want to know whenever there is that kind of a death. That's a new procedure because my position is new, but we've had a rather strict procedure for quite a long time, I think it's close to two years now, where any death under unusual circumstances, in other words, unanticipated death, will be reported to the Attorney General's Office and is also reported as a major incident.

Q. And what would be the procedure after that? I mean, are there

ever autopsies done?

DR. JACOBSOHN: That depends on the medical examiner, whether the medical examiner makes a determination that he will accept a case, or he may determine that there is no need for him to become involved, that becomes a judgment call of the medical examiner. My hope, my desire, is that all such patients should receive autopsies and it helps to resolve, it helps to clarify the cause of death. However, families are involved, and if the medical examiner does not accept a case, we cannot insist on an autopsy if the family objects. And unfortunately, quite often families do object. We are past the age where we took it for granted that anyone who died in the hospital should have a complete autopsy. It used to be a standard, it used to be a JCAH standard. It is no longer a standard, and I personally would like to see such a standard returned, but we have no authority to perform an autopsy unless we get permission of the family, and families traditionally have objected.

Q. Do you feel comfortable now that if there were a death such as took place last summer from the heat, that there would be a specific procedure followed immediately?

DR. JACOBSOHN: I believe so. I have had a number of conversations with Dr. Henry Ryan, he and I have a nice working relationship, we know each other, have known each other for years, and it's absolutely clear in my mind that if I had any doubts and wanted a medical examiner's - examination, complete autopsy with all toxicology, Dr. Ryan would do that for me. I have absolutely no hesitation in saying that.

Q. So do you feel that now, in the position that you're in, do you feel more comfortable with the procedure than you did pre-August, perhaps?

DR. JACOBSOHN: I think the events of August have helped clarify what we should be doing, and it has given some impetus to the standard that I've wanted for years, and that is to do complete autopsies in questionable cases, and I think I have that assurance from Dr. Ryan. There are not many cases that are like that. That's a rare event, relatively speaking, maybe two, three cases a year, no more than that, and that is not a burden on the medical examiner's office. They can handle that additional load without any difficulty. I think it would be a different matter if we were to apply that standard to everybody who died, and if every hospital in the state were to request that of Dr. Ryan, but certainly not these special cases.

Q. I appreciate your answering the question. I have one more question that I'm not sure who will answer it, but it has been told to me that in March of 1988 that there were 20 incidents of sexual assault in AMHI, is that true?

DR. JACOBSOHN: I have no - I don't believe there is a separate reporting of sexual assault. I've never heard that figure before. I don't know where that came from. Certainly I'm not aware of it.

Q. Well, I didn't think probably that you could be the person to answer. Is there anyone that would have indications as to whether or not that is an accurate figure? Could someone check on that

for me? I would appreciate that very much. Do you record and do a census on assaults?

DR. JACOBSOHN: Yes, all assaults have an incident report, and those incident reports can be looked at to see how many are in various categories. I think if there had been 20 sexual assaults, I would have heard about it. We would have all known about it.

Q. Well, could you let us please have a copy of that assault record?

DR. JACOBSOHN: Certainly.

Q. Do you classify rapes as assaults?

DR. JACOBSOHN: Absolutely.

Q. Is that the only thing that you -

DR. JACOBSOHN: Beg your pardon.

Q. Is that the only thing that you classify as an assault?

DR. JACOBSOHN: Oh, no, hitting would be considered an assault. Just one person hitting another person is an assault, that's an assault incident and we would record it.

Q. But you'd differentiate between the two, between a hit or an attack?

DR. JACOBSOHN: Well, I think if there was a sexual assault, it would rise to a higher level of awareness. It's just - it goes without saying that in a hospital such as the Augusta Mental Health Institute, where you have patients who are there because of major mental illness and who are considered as dangerously mentally ill, that you will have a certain number of assaults, that comes with the territory, that happens. However, if we were to see

something like a sexual assault, that's an entirely different situation than an occasional assault between one or another male patient. You know they do get into fights.

Q. So if I request that information from you, when I get it, I'll be able to clearly differentiate between somebody rapping someone else or an aggressive assault?

DR. JACOBSOHN: Absolutely, yeah.

Q. I would like that information, if I could have it, please.

DR. JACOBSOHN: I don't think that would be difficult.

SEN. TITCOMB: Thank you.

SEN. GAUVREAU: Representative Manning?

EXAMINATION OF COMMISSIONER PARKER BY REP. MANNING

Q. Susan -

A. Yes, I would like to clarify part of the answer regarding the different incidences, and AMHI does have in place incident reporting and classifications. I referenced those this morning, and what I am going to do now is to go through these categories with you, and I think Senator Titcomb will see how her question about categorization regarding different types of violence within institutions fits in.

The first category concerns fires and false alarms. There is a great deal of differentiation and description under here regarding the different types of nuisances of such a, you know, fire and false alarms. All these are carefully documented.

Secondly would be environmental disasters; thirdly would be criminal behavior by AMHI patients or on AMHI grounds; for example,

murder, rape, physical assault, brandishing weapons, burglary, robbery, major vandalism, stolen vehicles, drug sales, abuse or exploitation of patients, minor theft or vandalism. The fourth category references self-abusive behavior, suicides, serious suicidal gestures, serious suicidal gestures without injury, self-abusive behavior requiring medical attention. Fifth is injuries to patients, staff or visitors. Sixth is death, and this includes any suicides, any death in the nursing home or infirmary which is unattended, any death on the psychiatric unit, death of any staff or visitor on the grounds of AMHI and death of any staff member.

Another category is the miscellaneous problems or incidences, an incidence which is high profile or likely to bring immediate press attention, other problems account which affect patient care or AMHI's public image.

The last category concerns those individuals who may be absent without leave, and there are subsets under here, including legal hold, a person who is a legal hold, i.e., a resident on the forensic unit who is absent beyond the time allotted, any involuntary patient who is not accounted for, a voluntary patient who is considered dangerous to self or others, a voluntary patient who is not considered dangerous, and someone who is absent and all point bulletin notice has gone out.

SEN. TITCOMB: So I'll have some extensive reading when I get those records. Are those records complete? I mean, I'm listening to how difficult it is to keep records, and those are a lot of

categories.

COM. PARKER: There are a lot of categories and there would be a spearate file in here regarding those incidences.

DR. JACOBSOHN: They are not clinical records, they're statistics, they are of a different nature.

MR. HANLEY: We have an incident reporting form which has several different categories, and you're fortunate that we were just able to computerize those and they're much easier to sift out.

SEN. GAUVREAU: Representative Manning?

BY REPRESENTATIVE MANNING OF COMMISSIONER PARKER

Q. Susan, earlier in the day, whether it was this afternoon or this morning, I guess it must have been this morning according to my notes, you indicated that all of your staff members, including institution heads, reported to you weekly by memos and that you read all those memos and sent the memos also on to the Governor's Office so the Governor's Office would be aware of what's going on in each institution.

A. I described them by saying that they report to me weekly the events within their different area of responsibility, and we call them weekly reports. They do not have a format called a memo format.

Q. Well, I mean, whether they're memos or reports, basically you get them every week, read them every week and then send them on to the Governor's Office, is that right?

A. That's right.

Q. In reference to the superintendent's memos, did he at any time

ask for additional staff last year, like in February or January or March.

A. The weekly report would not have been the vehicle in which to propose additional staff. Rather, the typical entry would be a description on the census, the admissions, any unusual events on the wards, perhaps a description of the severity of illnesses that would be on admissions, particularly those requiring one-to-one constant observation or use of seclusion. He would typically report out progress on Medicare, or preparations for a particular survey, be it Medicare, JCAHO and on and on. There was quite a variety of material that got included in as part of the weekly reports.

Q. When you saw the weekly reports and you started to see the increase in census at AMHI, what was your reaction at that time and what was the Governor's Office reaction at that time?

A. I will speak to my reaction. First of all, the weekly report is not the only avenue I had to understand that the census was rising and the admissions were rising. We frequently talk about such matters. We did a lot of talking about that last May, last June and through the summer months, although the census and the admissions began to tail off in July. My reaction is, as any administrator, it's why is it happening, what do we need in order to deal with it, how long will it continue, what has the history been, and how does this compare to the preceding month, six months ago and to the same time last year.

Q. Did the superintendent at any time send you memos, not weekly

reports but memos, asking for additional staff or asking for additional dollars to be put in for staff in February, March, April, May, June, as the census started climbing?

A. There was no memo sent to me directly concerning that.

Q. So he never asked for additional staff at all?

A. During that time frame, that is correct. I never received a memo directed to me asking for more staff.

Q. Okay. Earlier in the day you had talked about one of the areas that I guess you were - I guess the word is not disappointed but were a little upset with the management style of the superintendent, and that happened to be at the time, I think, I forget who it was, they brought you back - you said, you know, was it in December, was it in January, you went back as far as -- I think you said even in August, or July or August or September, I'm not quite sure.

A. I specifically stated, if I might clarify, and I did not use the word upset, I first used the word disenchanted and I never used the word distressed - I specifically stated for the public record that I began to be disenchanted later on in the fall, I went on and said late November, early December, and it was after -

Q. But you also said that you were disenchanted a little at the time of the rape incident, which was in September.

A. I had some quite pointed questions about that, yes.

Q. Did you send a memo to the superintendent at that time indicating your disenchantment?

A. I do not use memos to convey disenchantment, I use direct conversation.

Q. Today, you basically have opened up your statement by saying that we're in a crisis situation, and the crisis situation is management rather than what you had anticipated last week, and last week we never heard the word management crisis, we heard just plain - I think they asked you whether or not - one of the members asked you whether or not we were in a crisis, and you had indicated yes, right now we're in a crisis.

A. That was Representative Clark, and the context in which the word use clearly conveyed the fact that it was a management crisis. In my opening remarks today, I decided to use the phrase management crisis because that accurately depicts the situation.

Q. Okay. So what you're saying is then, with a new management style, that the hospital will get back to some semblance of normality, I would imagine, and I say that because I know it's very difficult, and that includes without any additional staffing or without any additional monies going into AMHI, am I right in saying that?

A. What I stated this morning, Representative Manning, was that several proposals are on the table. They have come from people from various - in various places within AMHI who have suggested solutions. I said that our next management step is to bring in a consulting - a consultant who is well versed and has a proven track record in running psychiatric hospitals or general hospitals who can properly assess with us how to get AMHI back on its feet

again.

Q. They could basically come back and say that there needs to be a wholesale restructuring and also basically laying off of certain personnel, right?

A. I don't know that that's true. I think to speculate is entirely premature at this point. I also stated that I am open to all recommendations, and I would be pleased to come before this committee three weeks hence, when these recommendations are in hand, and talk with you about them.

Q. So you're anticipating then to go back to the Governor's Office, if need be, if this consultant comes back in and says there needs to be another massive infusion of money at AMHI, you're anticipating going back to the Governor's Office and informing the Governor that that's what the consultant is saying, and that we need to put it in this year?

A. I will absolutely inform the Governor of these recommendations, whatever they may be.

Q. I'd like to bring you back to another thing that you talked about earlier in the day, and that was at the time of decertification you had indicated, and I guess it was the time probably in May when they finally came back and took the certification away from us, you had indicated that you talked to Linda Crawford, who was the Assistant AG representing you, and at that time Linda Crawford indicated that the - I remember I asked you whether or not you should appeal that, whether or not Linda Crawford - she indicated that, I guess, it would be (1) too long and (2) costly to do that. Am I right in saying that? And this was in June -

A. You are right in saying it as far as you have gone, and I further stated that Linda Crawford based her opinion on the experience in other states of pursuing the avenue of going through an appeals process with an administative law judge.

Q. Okay, so she basically went on past records of other states that it would be too costly and that it would take a long time to do?

A. That was her opinion. She said that it was a very - it took an enormous amount of time and that it would take a great deal of staff time away from the facility that already needed, you know, some assistance with staffing. Remember, we're talking summer here, June, and we felt at that time it would not be a prudent management decision to pursue it.

Q. Did she think we had - did she think at that time we had the ability to win an appeal?

A. She made no observation about that one way or the other.

Q. Did you think that was strange?

A. No, not at the time.

Q. I think it's strange. I think if I've got an AG, the first question I'm going to ask him is have I got the ability to win this appeal. Was that question ever asked - did you ever ask her whether or not we could win an appeal?

A. We talked generally about an appeal, and she, again, reiterated the hardships that other states had been through in pursuing such a course. We didn't talk specifically win/loss and percentages attached to both.

Q. Okay. I'd like to bring up one more thing, and this is my gut reaction and it's a reaction that was expressed to me by somebody who I looked towards mental health issues in this legislature, and they had a concern, and maybe Dr. Rohm, if he could address it, is whether or not at this particular time, while we are in a management crisis at AMHI, whether or not Dr. Rohm has the ability to not only (1) be the clinical director, (2) be the ongoing acting superintendent and still - as you pointed out this morning - do 40 patients. I mean, are we stretching Dr. Rohm to the point where even at this time that's a tough job to do right now, I mean both acting director and clinical director and holding that down?

A. Dr. Rohm has kindly consented to take on the responsibilities associated with an acting superintendent. To the post of clinical director, he has asked Dr. Owen Buck and Dr. William Sullivan to share those duties. A succinct answer is that, yes, it's a tough assignment to move from one position to another.

Q. So he's not really doing all what he's - he's not doing as much clinical, we have other doctors sharing it? I think that needs to be cleared, because when people start to hear that, and I heard - you know, I expressed that. Just as - while I was walking in, while I was late, I had somebody who said to me, isn't that an awful lot for one person to do, and I said, geez, I never thought about it, but as I went on today - so he is sharing the clinical areas now with two other doctors?

DR. ROHM: Yes --

Q. Okay, and the role that you had this morning, for instance, you were on rounds and I guess you said you had - Susan said you had 40 to 50 patients?

DR. ROHM: Well, I've given those to Dr. Buck, but I have other duties to do.

Q. Do you have any patients under you right now that's assigned to you like Dr. Buck had talked about?

DR. ROHM: No, not directly.

Q. Not directly.

DR. ROHM: But I still have to supervise their physician extenders, they're under my supervision, and I do this the first thing in the morning.

Q. Okay. That was just a concern, because I don't think it was clarified for us, and at least it wasn't for me. I was assuming (1) you were doing clinical, (2) doing the acting superintendent's work, and (3) having - I thought you said she had a caseload - somebody told me this morning they had a caseload of 40 people and I assumed that that's - that's not right then, that's good, I'm glad to hear that, because I don't know how one man could do that in a 24-hour period.

DR. ROHM: The other aspect is that - the present arrangement is predicated that we will be able to hire under a short-term contract -- to do some of the work - Dr. Sullivan's work, so he gets relief from that.

Q. We keep talking about these part-time contracts. Are these people who are in the community who are willing, for instance, to

give eight, ten, twelve, fourteen hours a week?

DR. ROHM: No, we are talking, these contract people, through national agencies.

Q. The head hunt is found for us?

DR. ROHM: That's right.

Q. Are they willing to come up here and spend 40 hours a week?

DR. ROHM: I was looking for a minimum of three months to six months, and I found one, who works on the admissions unit, and she has agreed to work - to stay for an extended period of time. They are difficult to find. The one month psychiatrists are easy to find. Many of these take sort of busman's holidays. They come for a month, they are usually highly qualified - (inaudible). I was assured it would be much easier to find the one-month psychiatrists. We are negotiating for one right now.

Q. Let me ask you a question. Susan, maybe you could answer, or somebody. I think Ron had been involved - Ron Martel, you've been involved with the head hunters, right? You indicated back in -

MR. MARTEL: Through the contract process.

Q. Yeah. Is one of the things we need to do is take a look at increasing the salaries of these people? I mean, can we - you know, we keep talking about the quality of life in Maine, but the quality of life, if it were not - if they're getting ten or twenty thousand dollars less, I mean, do we need to take a look at - for instance - if psychiatry is so hard to get - across the board, including Dr. Rohm and everybody else in the system, do we need to take a harder look at that to give them like we did -

for instance, we talked about, I think, nursing, we gave more money to nursing last year, we gave more money to the mental health workers and others. Has there been any thought about trying to take them a block ahead, to where we can - you know, it's competitive to, say, New York State but yet you're in the great State of Maine and life is a little easier in Augusta compared to, say, the middle of Queens, New York, or something like that? I guess, Dr. Jacobsohn, you're ready to answer that.

DR. JACOBSOHN: I'm actively involved right now in the survey of actual hiring conditions throughout the nation, and it's a very mixed bag. I always thought people wanted to come to Maine, but it turns out not everybody wants to come to Maine. There are a few exceptions, like myself, who do want to come to Maine but most people don't. Now we have to compare more with states like North Dakota, Nebraska, that are seen as cold, far away places.

Q. Have you gotten the tourist bureau involved with this, so they would know today it's 50 degrees out and it's January 31st?

DR. JACOBSOHN: I know, it's a wonderful day, it really is, but it is hard to recruit psychiatrists. Part of the reason is there's a national shortage, there actually is a shortage of well-qualified psychiatrists, and Maine has had a tradition, over the last ten years at least, of hiring only well-qualified psychiatrists. We will not compromise on that and I don't think we should. So we are attempting to reassess what ought to be the salary scales, and I'm involved with the personnel department right now on that issue.

Q. So salaries could be - could help play in bringing some in?

DR. JACOBSOHN: It might, it might very well. As I say, it's a mixed picture. It ranges all the way from where we are now to much higher than where we are now. Some states have a much larger system that's more entrenched. They are able to get by with lower salaries. Some states that have smaller systems, that have less of a pool of professionals, who don't have their own medical schools, such as Maine has, we have no natural source of physiciatrists, we have to import them from outside.

Q. Have we worked at all with any of the educational forgiveness loans? Have you looked into that field where we could actually -

DR. JACOBSOHN: We actually have a three-pronged approach.

Q. I mean we did - this committee dealt with the nursing issue last year where the Governor's program basically was paying for three years the student loan program. I mean, is there any thought of doing -

DR. JACOBSOHN: There is a history of that not working out too well across the country. NIMH used to do that, the Public Health Service has done it, some of the larger states did that. The history is not very good. You find out that most physicians who have gone through that will buy out of the program rather than do the service. So it's not a reliable way of doing it. My own view is that we need to develop a long-term relationship with the residency training program. That, I think, is years down the road but it could be done, theoretically it could be done, it may actually be done in practice. I think there's a lot of sentiment that

psychiatrists in training ought to be getting some of their training in the public sector. We have an intermediate problem of finding line psychiatrists that are well qualified to occupy the positions that we have and those positions that have just been added, and then we have an immediate requirement of getting psychiatrists on board to fill the spots until we're able to do the recruitment. Recruitment with psychiatrists usually means six months to a year in developing a single application. It's very complicated. They move, they have families to move, they relocate, they have major decisions to make about their careers. It's very difficult to bring somebody on board. It takes about six months to a year of negotiation and of advertising and promoting in Maine. In the meantime, we have to have a rapid fix, and that's the one that Dr. Rohm has been talking about, the rent-a-doc approach of trying to filling the gaps on a temporary basis until we're able to get the full-time psychiatrists. I still feel that it's basically sound to have full-time psychiatrists as part of a regular stable medical staff in our institutions. I think that is good for the institution and it provides stability and a good standard of care.

Q. On Thursday night we talked about - on Thursday we had our meeting and Thursday night the Governor's State of the State address. He talked about $20 million. I just want to make sure that the $20 million that he's talking about is the same $20 million that we talked about earlier today, that there is really no infusion of new monies, it's just a continuation of the $6.75 million.

COMMISSIONER PARKER: That is correct.

Q. So there's absolutely no infusion, okay, because I had people come to me and say why - you know, isn't there going to be $20 million, and unfortunately, I said, no, there isn't - there is but there isn't. The $20 million would have been in there anyways because they had to have it in there, but I just wanted to make sure that that -

COMMISSIONER PARKER: Representative Manning, a point of clarification for you. At my request, I had Ron Welch telephone Linda Crawford to see if she might be available to give you added information concerning the possibility of an appeal. We find that she is out of state attending a family matter and, consequently, we can give you any other information later.

Q. Okay, maybe later we can talk to her.

SEN. GAUVREAU: I have a few questions and I hate to ask them because the day has been so long. I don't think I'll take too much longer, and forgive me if this topic area was discussed in some detail, because I have been running back and forth to another committee during the course of the afternoon.

COMMISSIONER PARKER: First, can I thank you for the table that I'm sitting at after 14 hours?

SEN. GAUVREAU: Certainly.

COMMISSIONER PARKER: My right knee has gone, knee lock from standing at a podium. Thank you.

EXAMINATION OF COMMISSIONER PARKER BY SEN. GAUVREAU

Q. I'd like to go back just briefly to the whole issue of staffing, and if it were discussed before, please refresh my recollection, but

can you tell us what is the current staffing configuration at AMHI, and I'm referring specifically to a breakdown of nursing to patient ratios, psychiatric nurses, medical nurses, mental health workers, OTs, recreational aides, as well as social workers.

A. Here we go. AMHI has a total of 693.5 staff, total positions. There are 12 psychologists, 23 social workers, 60.5 registered nurses, 28 licensed practical nurses, 10 physicians, 306 mental health workers, 18 occupational -

REP. BURKE: Excuse me, you're going way too fast.

COMMISSIONER PARKER: All right, I'll start at the top and I'll give you percentages - 12 psychologists, 1.7%; social workers, 23, 3.3%; RNs, 60.5, 8.7%; LPNs, 28, 4.0; physicians, 10, 1.4; mental health workers, 306, 44.1; occupational therapists, 18, 2.6; ward clerks, 3, .4%; physician assistants, 9, 1.3%; clerical, 37, 5.3%; custodians, 33, 4.8; dietary, 38, 5.5; other direct care, 28, 4.0; and support services, 88, 12.7. May I point out, this does not include the three lines that are under contract, two physicians and one psychologist.

SEN. GAUVREAU: And in terms of our ratios, are those congruent with applicable HCFA or JCAHO standards, or are those standards institution specific so that there is no one set of - one set ratio?

A. There are no nationally accepted standards, but what I would like to point out is that in your L.D. 2685, passed last September, which also created the Mental Health Commission, in that L.D. there is the expectation that this department will develop standards

that will result in our ability to give you what the staff to patient ratios ought to be given the particular needs of patients in a particular ward. We are in the process of developing those standards.

Q. And in terms of that legislation, is there a specific time frame in which the department is to proffer the recommended ratios?

A. I believe we were given in excess of a year, and the deadline is July 1, 1990.

Q. And is the department to work in tandem with the Commission on Mental Health in fashioning those standards?

A. The Commission on Mental Health has a Subcommittee on Institutions, and, yes, we would be involving them in the review of things at various stages in the drafting stage.

Q. And I understand that the burden of the complaint from HCFA's point of view dealt with lack of documentation, record keeping and lack of physician/patient contact, there was too much use of intermediaries. But did HCFA criticize the current staff ratios which we had in force at AMHI as of February and March of last year? Was that a factor which led towards decertification?

A. The Health Care Financing Administration, in its standards, does not use numbers that say you need X-number of psychiatrists to work with X-number of patients; rather, they look at the indicators, which are standards, but the indicators of care, and that is how they come to look at medical records, the treatment planning process, the progress notation, and in actually looking - when a surveyor actually looks at those three categories under the

medical records condition, they look at the quality and they - once they reach a judgment about that quality, they posit that if things aren't up to their standards, then it must be due to a lack of staff. But there are - to say again, there are no standards that say for every 30 patients there should be one psychiatrist.

Q. So what you're saying is that it's more of a qualitative assessment than it is a quantitative assessment per se?

A. Yes.

Q. Now obviously this committee is being asked by the legislature to provide meaningful guidance in terms of where do we go from here. Although we've heard some concerns regarding perhaps specific individuals over the last couple of days, the real question, I suspect, which is on people's minds in this state is not who did what but what do we do now to get ourselves out of this mess, and so just to summarize, I guess, you had mentioned that you hope within a period of two to three weeks you would have completed the process whereby you would contact the various management firms and be in a position to make some concrete and specific recommendation to this committee on how to improve the situation at AMHI, is that correct?

A. Yes.

Q. And if I understand correctly, when you meet with Appropriations on Thursday, you will not recommend new money items but you will not categorically rule that out, is that correct?

A. If asked the question.

Q. And basically what you're saying, if I'm correct, is that you will defer to the advice of the management team or the consultants with whom you contract before you make specific recommendations?

A. As I said, I am open to all recommendations at this point.

Q. Now currently, obviously, there is a vacancy in the superintendent position at AMHI. We have an acting superintendent, a Dr. Rohm. At this point, do you have any particular timetable when you would plan to nominate or name a new superintendent of that institution?

A. I am eagerly awaiting the recommendations of a firm skilled in the management of a specialty hospital. I think it premature to name anyone, because we can liken AMHI to a patient and this patient does have a management crisis, and I think we are best suited to directing energies to stablize the patient and understand together what the necessary interventions are in order to get AMHI back on its feet. Then, I think, it's time to start about - to start to think about a search process that would result in finding another superintendent.

Q. The concern I have, and I guess I voiced it earlier in the day, was that there appears to be some glaring gaps or we're providing in some areas, at least, what could be categorized as substandard care to some patients, and my primary concern now would be that we take prompt action to upgrade those standards. We have to take a look at the long view in terms of upgrading the overall institution, but I wouldn't want to lose sight of the fact that we have, as we discussed this morning, complaints regarding particular patient care, and they apparently haven't been fully addressed, so I just want to

leave you with that concern. And it would seem that given the great deal of attention which this particular problem has aroused in the Maine press, as well as the people in Maine, it seems that it would be beneficial to proceed quickly with naming a new superintendent so that we would have a specific direction and specific guidance in terms of the stewardship of this particular institution.

A. Senator, I feel quite strongly that the management direction of AMHI needs to be charted anew. We are in the process of doing that. I listed earlier the different plans that we have in place that are working on aspects of AMHI management. In order to identify what characteristics we might be looking for in a superintendent, it is first necessary to assess all aspects of AMHI's need. Some people are strong in one area, some people are strong in other areas, and I think we really need the advice of an outside objective party to give us facts and various options about how we might proceed, and then we can develop a profile of what the superintendent might look like based on not only that but the other inputs that must come to us from advocacy groups, from family groups and from patients themselves, as well as the workers.

Q. In terms of this consultant to whom you refer, do you contemplate that within two or so weeks you would have that firm or that entity on board?

A. Two weeks -

Q. I'm not in any way saying 14 days. I don't want to set a time frame in terms of what your plans are.

A. As I said to you this morning, we are prepared to move very quickly on this. We have interviewed three possibilities so far. We have another possibility to interview, then we need to decide how actually to get them on board. We are looking at working with them very, very soon. Yes, I think it's possible. I won't promise it, it's very possible.

Q. And that once we do contract with this entity, we would then go about the task of constructing a plan of correction?

A. That's right. We probably won't call it a plan of correction, because it sounds a bit like Medicare.

Q. But whatever the critter is -

A. It will be a plan.

Q. We'll have to get to work on it with --

A. That's right.

Q. I think it's fairly safe for me to speak on behalf of the other members of the committee that we would certainly be interested in meeting with that entity, whomever it might be, and providing our input in terms of whatever help we can offer in terms of getting AMHI back on its proper footing. Thank you very much, Commissioner Parker, for answering a wide-ranging number of questions, some of them very focused, over the last few days. It's certainly difficult, I'm sure, for you and your staff to have to have undergone this process, as it is for the committee. It's a very important process. I think we all share the notion that there will be a salutary end that will improve the system of mental health in the state as a result of these hearings. Are there any other questions

of committee members or Commissioner Parker at this time? If not, once again I thank Commissioner Parker. Since it is now twenty five minutes past four, it would not seem appropriate to call anybody else before the committee at this time.

(OFF RECORD REMARKS)

ADJOURNED AT 4:25 p.m.