IV

STATE OF MAINE

HUMAN RESOURCES COMMITTEE

Hearing on Augusta Mental Health Institute Issues held on February 2, 1989, in Room 113 of the State Office Building, Augusta, Maine

Carmen M. Thibodeau

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Augusta, Maine
February 2, 1989
9:20 a.m.

SEN. GAUVREAU - Will the Committee please come to order. Good morning. My name is Paul Gauvreau, I'm the Senate Chair of the Joint Standing Committee on Human Resources. To my immediate left is Rep. Peter Manning who serves as House Chair of this Committee. Today the Committee will continue the hearings into the Augusta Mental Health Institute. Before we resume questioning of Mr. Daumueller, I would point out that we now envision the hearings to go through today. Appropriations is meeting this afternoon and, as we know, the Department is scheduled to make its presentation regarding its supplemental budget. I've spoken with Appropriations this morning, they are amenable to really having the Department present to them at our convenience. It would seem logical for us to try to finish with Mr. Daumueller and allow Commissioner Parker a chance to respond to items she feels are appropriate to respond to and if we can do that this morning or early in the afternoon so we can give her a break and she can go upstairs to Appropriations later on in the afternoon. We would expect then to - if that can't happen, we would recess until Appropriations was completed with its review of the Department budget and we would then readjourn later this afternoon to complete the presentation of Commissioner Parker. On Monday we will readjourn and at that point we will hear presentations from advocacy groups and we will then go through Tuesday. We have invited the Department of Human Services to make a

presentation and we may well also invite the local probate judge who has, as you know, indicated a reluctance to refer wards in his custody or jurisdiction to AMHI. We would hope then to be in a position to conclude the hearings at the early part of next week. We have spoken to leadership in the House and Senate and we have been told that if necessary we should go on in Tuesday - through Tuesday and then allow Legislators to join the Maine Development Foundation -- later that day and the hope we can conclude our work early next week. That is the agenda we have at the present time.

I would also like to make a personal observation. I had occasion to read an article in one of the papers yesterday that dealt with some comments that certain legislators have made regarding these hearings. I'm certainly mindful that due to the sensitive nature of the discussions there is some controversy attendant to these hearings. But I was particularly disappointed in remarks of some legislators to the effect that the pace of these hearings was not at a very fast rate and I've thought about this a lot. We are dealing here with a population which is highly vulnerable and I think all of us realize that. I can't think of anything that comes before our Committee, any topic, which should be more insulated from the fracas of partisan politics than dealing with the stewardship of people in our acute mental health hospitals. It has certainly been a long-standing tradition for this Committee. Certainly when Sen. Gill chaired

the Committee and under Rep. Manning's leadership, Rep. Nelson, myself that this Committee has always done its work in a thorough disinterested and non-partisan fashion and I certainly pledge that will be the tone that this Committee will do its work this year. And so in that light I was disappointed by the remarks of some that - expressing irritation at the pace of the hearings. I think the people of Maine expect and, in fact, demand that this Committee and the Legislature do a thorough and comprehensive job of review so that we can, in collaboration with the Executive Branch of Government, fashion the most appropriate and responsive recommendations to ensure that we upgrade the conditions at AMHI.

With that we will now proceed to -

REP. MANNING - There will be a break because unfortunately the House three weeks ago had scheduled the House photo of - so sometime after the session ends today the Legislature - I mean the House members will have to leave and we'll be gone for probably twenty-five minutes and this is something that couldn't be delayed. The House photo is something that - it's a tradition in the Legislature and unfortunately it's very difficult to get scheduled. Last year - last - the 113th it took us until the second regular session because of people out sick, people away on business or something else, so where it was early in the session they scheduled it, so that's unfortunate, but we will be breaking.

SEN. GAUVREAU - And, also, I should note that the Senate does have some confirmation and some roll call votes during the course of this morning's session, so although we are all excused from attending the sessions, we will be notified -- roll call votes and I understand the Senate, around 10:30 or 11:00, will be considering certain judicial confirmations. With that why don't we then resume the questioning of Mr. Daumueller and if memory serves me correct, and it may not, Rep. Burke was poised to ask certain questions of Mr. Daumueller when we last broke and I believe that Rep. Dellert and Sen. Titcomb had also requested leave to ask questions, so why don't we proceed in that order.

EXAMINATION OF MR. DAUMUELLER BY REPRESENTATIVE BURKE

Q. Thank you and memory did serve you correctly.

Good morning, Mr. Daumueller.

A. Good morning.

Q. Basically, just to return to what we started to ask yesterday, you gave us quite a detailed review of your Friday reports which indicated on numerous occasions that you needed increased staffing, that there were serious problems that - on the February 26 one that the Commissioner should be involved in drawing up a plan to meet the problems that were encountered through Medicare review and I asked you what resources you had available to you in trying to meet the deficiencies that the Medicare review brought out.

A. Yes.

Q. Can you answer that again?

A. Well, basically the resources that were available to the Department under the -

Q. I'm sorry, you need to get towards the microphone because I don't think people in the back can hear you.

A. Okay. Basically the resources available to the Department of Mental Health and Mental Retardation were the resources that we could draw upon and that would mean if there were people in other facilities that we could call upon or contract monies or - monies or positions or whatever that we could move from one place to another. As it turns out, that actually worked out to one half time contract, all other dollars to fund one contract.

Q. One half time?

A. Yes. And of course -

Q. Physician?

A. Physician.

Q. And no new staffing of any other sort.

A. Right. The physician contract, of course, is a function not only of dollars but availability, so, I mean, there's two things that played in - particularly into the physician recruitment or acquisition problem. But there were - there was no - going to the Legislature at that time was not an option.

Q. Who decided it was not an option?

A. Well, the Commissioner - I think that was - it was clear from

conversations with the Commissioner that that was not an option.

Q. So, in essence, just to be clear on what you're saying, you specifically asked the Commissioner if it was an option to go to the Legislature to ask for more staffing and you were refused. The Commissioner was always apprised of exactly what you felt you needed in order to pull AMHI back on line.

A. She knew the areas that we needed to address, mainly physicians, clerical and activity staff. We talked about numbers and we talked about how many that might be. The way those - the way requests like that usually come about is that you sit down and you discuss the situation and then you are given the go ahead to go - to work something - you know, work up a request and usually that would be an associate commissioner and myself and whoever else would be involved. Then you would come back and present the request and go - that would then go to the Governor's office and if he were to approve it, then it would go to the Legislature. And clearly that was not an option at that time, going to the Legislature.

Q. Okay. But you and your associate superintendent felt as though this was a critical enough need that it should be brought to the Legislature and you were refused.

A. I think the question was are we going to be able to go, you know, is that an option and I think - maybe I'm too much of a team player or maybe I didn't make the case strong enough, I mean, I think I have to take my own - take some responsibility for that, but it was my impression that that was not going to be

an option that she would be able to pull off.

Q. So in your professional judgment then the plan that you ultimately brought down to Boston -

A. Had serious flaws, the serious flaws being not adding any clerical staff, not adding any activity staff and the - you know, adding a half time contract in the time frame that we had was reasonable, but it wouldn't project to HCFA that we were making a real strong effort in that area I don't think. And so our effort, in my opinion, while we did put the best spin we could on it, we tried to put the best face on it and try to sell it as hard as we could and went, you know, forward full bore, had some serious weaknesses or soft spots, if you will. Now, there's no one, including myself, prior to them coming back on the resurvey who could for sure tell whether or not we would - we would gain certification. We had an up and down history with HCFA. They don't give you -- numerical answers to your questions, in other words. How much understaffing - how much understaffed do you think we are for your purposes and they say, well, we'll let you know when we survey you. So if there are no guarantees when you say, well, three people will do it or five people or seven people, so they get at your staffing through the medical record documentation is basically what happens. So I'm not going to say - and it wouldn't be accurate - that I could guarantee that we would get Medicare under these conditions, because I think to some extent we were all surprised by the - let's say

the tenacity or the verocity of the surveyor's review of our facility. So I think we felt we probably weren't as in bad a shape as they felt we were. But clearly when they tell you that you're suffering from staffing shortages and they cite you for not having staffing, that is going to be a weak area when you don't add any staff. We did make some rearrangements, but there again there was - they weren't particularly significant.

Q. And certainly your recommendation that you needed 206 new -

A. That was much later in the game. I mean, that was in the fall.

Q. That was when you actually assessed the entire - you sat down and went through the entire facility and figured out where the deficiencies were?

A. That, too, was done, not as part of an open process with all staff being involved and this is me sitting down, because, well, at the time it would not have been the proper procedure to come out with and work up a large proposal at the same time we were putting a proposal before the Legislature, because that would be somewhat undercutting the - what we had on the table. But every time I've looked at our staffing and said what would the ideal situation be, it's always come up in my calculations to be close to, you know, within 10%, 200 positions, for roughly 383 patients. And that's just the fact of the matter. I mean, if you want one level of care throughout the facility and if you want certification and accreditation in a smooth pace and good communication and good documentation, you have to have the people to do it. For

example, right now, even today we're still running 25 people on overtime just one to ones and CORs and things like that having to do overtime on a 24-hour period. That's 25 people. When we were doing the study on the Commission - for the Commissioner on Overcrowding, it was less than that. I think it turned out to be 20 or maybe even less than that at times. So there's a lot of pressure and as time went on obviously the pressure and the expectations increased, so the amount that I think you could, quote, unquote, get away with escalated.

Q. So the proposal that was brought to the Legislature even in late summer or early fall, you still didn't feel that that was adequate.

A. That was not a proposal that was going to give us ideal staffing all the way around, no.

Q. Did you communicate that with the Commissioner?

A. Yes. Now, what - to be very clear what I did do, as I said yesterday, I submitted a proposal for 18 positions to deal with the Medicare specific recommendations and another proposal to deal with what I considered overcrowding issues and the development of a float pool to take care of overtime, and so forth. Those two pieces of paper went together, okay? One of those pieces of paper, the 18 positions, was forwarded to the Governor. Another was not. And the one proposal then as put into the contingency fund, the other was not. The one started off in roughly July, the other did not. And that's where we started. So my thinking

was we're going to revisit what we did in 1987, staff up Stone North Upper and do some backfilling of some positions and help with the overcrowding once again, some augmentation in some other areas. Now, that's how it was presented. We - it gets a little complicated, but the bottom line is then there was a go-ahead to - from the Governor's office to pursue a larger proposal and that, I believe, happened after the class action grievance that the union forwarded and there was a bunch of press activity at that time. The senior management team at that time was down at Sebasco Estates and - doing a senior management team retreat, as a matter of fact. That was the day before I was going out to Wisconsin for two weeks and during my trip out in Wisconsin I was maintaining phone contact and Rick Hanley and Victor Perreault were dealing with the staff request. And I was convinced at the time that there was no way on earth that we could not not put this over-crowding piece on the table, because things were that bad and I said so and I said if we didn't do it, it would blow up in our faces and it wasn't forwarded. Now, after Sebasco Estates things loosened up and in the conversation when I was out in Wisconsin with Ron Welch it came up that what we want to do as - put this in as a joint commission or a JCAHO proposal. At that time I said, well, that's really an overcrowding proposal. It doesn't - it wasn't intended to be the JCAHO, but if that's what you have to do to sell it, go ahead, but throw some more support in there and, you know, some things that will help us with JCAHO and work

with Rick and Vic on that end of it.

Q. So in essence -

A. And that's basically how - and looking back if I wanted to shoot myself, I think probably that's where I would do it is saying, yeah, go ahead and - go ahead with it because I also said that we've got to have those positions, we cannot not get those positions, so if that's what it's going to take to get it through, let's do it.

Q. So in essence you were being told don't ask for this right now, we'll ask for it later as part of a bigger package or we'll tell the Legislature we're under pressure for JCAHO approval.

A. No.

Q. Okay.

A. No. We said we want to frame this as a joint commission proposal.

Q. Hm-mm.

A. Okay? None of that other stuff was said.

Q. Okay.

A. And I said, this is not - this was submitted as an overcrowding proposal, but if that's what we have to do to sell it, it's so important we cannot not do it, because we absolutely need those positions. The other part of it is in - as I think I mentioned yesterday, that as I was presenting it, I was presenting that proposal as a way of getting to the 114th Legislature as a - you know, this will carry us through just like the 1987 thing did

and then it aimed for staffing ratios and things like that in the next Legislature. And I thought that would probably do it. And then the proposal was widened and the community piece was added and the Bangor piece was also added. I'm not sure when the go aheads on those pieces occurred, but it was some time, I think, in those two weeks. That in some respects alleviated my anxiety a little bit because, you know, there's a workload reduction piece in there, too, so that made it much more palatable and easier for me to deal with and I thought, well, okay, what we have to do now is bridge and hold together - hold AMHI together for - you know, maybe till spring of this year. And, as a matter of act, you know, if everything would come on line in the spring of this year, I think we'd be looking a lot better. What I mean by coming on line is I mean that in-patient piece and the reduction in workload, the reduction of 400 admissions and the reduction of census that would be - as part of that whole package, the most direct, of course, being the in-patient piece. And so I - you know, that's basically how it happened.

Q. So why then do you feel that you were dismissed? Do you feel as though you were pushing for more staff or pushing a proposal that was not - that they did not wish to back or, I mean, I'm -

A. Okay, over the summer we had a number of unfortunate incidents, which obviously would bring, you know, negative light on any administrator. And the other aspect of it was the - well, what

I feel is an all consuming concern over getting recertified for Medicare and the pace that that was occurring and I think probably what would be viewed as maybe foot dragging and not being cooperative on my part and I viewed it as trying to point out some of the problems and deficiencies that our system still had that - and we were not ready for Medicare for a whole variety of reasons, not the least of which is, again, unprecedented workload. I don't know if anybody has talked about admission statistics, but if you take calendar year 1986, there were 1,078 admissions, the next year, '87, there was 1,324, I think, and the year after was 1,524, so between '86 and - that's a 50% increase in admissions. Many of those admissions have medical problems. One of the - you know, over the summer the concentration, the emphasis became highly medical and it was to some extent in the early Medicare surveys. And, you know, I guess my feeling was that that area is still problematic and I think in terms of getting AMHI back on track, if there was anything that I guess I would do is I would quickly address the need for medical attention and that means MDs, doctors, you know, I would say straight out two doctors, two MDs through contract or through employment, whichever the case may be, or contract with a clinic or whatever kinds of coverage would basically - at least two more physicians to take care of and make sure that medical problems are followed up with. Right now I have two doctors, Dr. Castellanos and Dr. Rogers. And that's - now when one of those people go on vacation,

occasionally we can backfill. There's one individual who will come in and provide some coverage and that - but if that isn't available, then you've got one MD for the entire facility. And the - with the level of problems that are being identified with the difficulty and the patients that we get, their difficulty in expressing their medical needs in a coherent fashion and giving a good medical history is highly suspect. So on top of the need to provide medical services for three hundred and, let's say, eight people or seventy, depending on what the census is, we have a very difficult time in getting a decent straight history from them. So you have to, you know, do a great deal more investigative and detective -

Q. Okay. What I hear you saying, and feel free to correct me if I'm wrong, is that when we lost Medicare certification, even before we lost Medicare certification or just after losing it, you went in and said, this is what we will need in order to attempt to regain certification. In terms of staffing you were told you can have one more half time psychiatrist. You went down with such a plan - I mean, the plan was otherwise developed, but you went down with such a plan to Boston. They said we'll come and look at it again. They came. You weren't dead sure, but you were pretty sure that they probably would not recertify you given that there was no new staffing and the overcrowding situation remained essentially the same.

A. Yes, we had some bad conditions in terms of the numbers of

people -

Q. Okay. After certification was definitely lost in May, you went back and said, we need almost a hospital revamping, we need to get the whole hospital in line, not just Medicare. We shouldn't be just concentrating on Medicare assignment.

A. No, no.

Q. No, okay.

A. That's not true.

Q. Okay.

A. We set about immediately after that - the May 27th - to develop a plan to regain Medicare as quickly as possible, worked very closely with Ron Welch on developing that eighteen position proposal. Independent of that process, that's - I put together the overcrowding piece.

Q. Okay. You put together overcrowding piece, you went back to the Commissioner with the overcrowding piece.

A. Yes.

Q. You were turned down on the overcrowding piece.

A. Yes.

Q. Okay. You then began to feel as though none of your initiatives to pull the entire hospital on line were being accepted, but rather just - the emphasis is purely on regaining Medicare certification.

A. I was - yes, I think I was getting a bit frustrated at that time, yes.

Q. Okay. And at that time you also felt that they were trying to regain Medicare certification essentially with bandaid measures, eighteen staff here, you know, that kind of thing?

A. Yes, the point that I did try to go back to is that Medicare, yes, there are positions that directly affect Medicare and we can be directly excited in the survey, but there are also other conditions that play into Medicare having to do with the rush in the rest of the hospital and what's going on there and, you know, pulling back and forth and how that - so it works together. A hospital is a - it's a system and it's tough to separate out one section, but we did the best we could to separate out and focus directly on that eighteen positions for Medicare. I will say that, yes, that's - we expected that probably we'd get Medicare at that time.

Q. Essentially I want to know - I think the Committee wants to know, the Commissioner was always apprised of exactly what you felt the deficiencies in the entire hospital were and essentially said or outrightly said, go to the Legislature with a package requesting 206 new positions is out of the question.

A. That - to say it precisely that way wouldn't be correct. What would be correct is that we were all aiming towards working with the community, coming up with a smaller hospital, so we were all kind of on the same wavelength. We were trying to not over-emphasize the institute but keep it certainly safe and with reasonable quality. I had for the longest time talked about - I

mean, I've always talked about ideal staffing ratios and talking about the two to one staffing ratio, and so forth and so on, as would be at least where we should be in the middle corridor. The 206 is later in the fall and that is would - you know, she would not have been aware of that figure. I had mentioned the figure actually of 196 before, but, I mean, it's not - I did not go to her and say, we have to have 206 people. I think it's always been more a matter of, well, this is pretty much out of the question. I mean, to really staff up the facility is so far out of the question and it's such a high dollar amount that it's much better to go with the reduction in census approach. And so, there again, I guess I can, you know, take - shoulder some of the - some of the blame for that, too. I guess I should say, here's your $4 million request and, you know, demand that it be funded. I don't know that prior to - I don't know that in June if that would have been forwarded that any of us - you know, I probably would have been laughed out of this room if I was here. I think since the events of the summer, I think things have been brought into focus and I think maybe there's a different level of consideration.

Q. Okay.

A. One thing about - really what we're facing is the same thing that the whole - you know, you've heard of deinstitutionalization. We're going to take money from the facilities, we're going to put them in the institution. The big mistake that everybody makes is

that you don't double fund and put the money in both places until it happens. We're going through that right now and if there was any point, I guess, that I could make is I think what you have to do now is do some double funding and not worry about whether it was her fault or his fault, but say, what do we need to do now and let's do it. And double funding for at least a certain amount of time, and it's probably going to be two years, quite frankly, let's do that and bite the bullet and put some money in the budget and, you know, two years from now I think you all maybe pat yourself on the back and say it was a darned good thing.

Q. I understand your feeling of saying maybe I didn't make my case strong enough or we were also looking at building up community servicesand things like that. What I'm trying to find out and I'm not trying to say is it - whose fault is it, but what I am trying to find out is were there staffing requests made that were never brought to us. Was the Legislature never given the opportunity to say, yes, we think community services are important, but we also realize that there are some people who will be institutionalized who will need a good solid institution, who need the - the institution itself needing good staffing, so on and so forth. We - were we ever given the opportunity through the Commissioner to even hear that request?

A. In other words, was there a piece of paper that came in to - put on Susan Parker's desk and said here's - no, but what there were were conversations, is it possible to go back and

reinstitute the twenty-one limited period employees, yes, there was. Was there conversation about the activity staff in needing to put some people on, whether they are limited period or full time or whatever, yes, there was.

Q. So you made multiple requests for increased staffing, whether on paper or verbally.

A. Yes.

Q. And these requests were, in fact, turned down.

A. Yes. And I was not - I don't know how much she had to - you know, whether that was all hers, I don't know. I don't have the -

Q. Or whether that came from the Executive -

A. Yeah, I do not have -

Q. I understand.

A. Knowledge of the relationship or any instructions or whatever that are -

Q. Okay. Thank you. That's all I have.

A. Other than the ace - what I already talked about.

Q. Okay. Thank you. That's all I ahve.

SEN. GAUVREAU - Rep. Dellert?

BY REPRESENTATIVE DELLERT

Q. Thank you, Mr. Speaker.

Mr. Daumueller, to carry on with Rep. Burke, did you actually send a memo to Susan asking her for certain specific people?

A. No.

Q. Never specifically.

A. Not a memo, no.

Q. Did you -

A. We sat down in her office and talked about that, yes.

Q. I know, but did you ever sit down, write a memo, documented for the number of staff, where they were needed in all those instances.

A. In the - not in February and not - no.

Q. On those 206 that we're talking about now, you had a memo that said if we do not pass the 2.6 million, if the Governor - the Governor's package does not pass, then this is the plan we should have and did you involve all the staff in that plan or was that your plan?

A. No, we didn't. In fact, there was some concern about the existence of that memo and how widely it would be distributed and I assured the Commissioner that it was only us - three or four people.

Q. So, therefore, that was your idea, those 206 people.

A. Yes.

Q. So, therefore, is the paper correct in saying that we need 206 people now?

A. I think if - every time I've looked at it it comes out somewhere 10%, plus or minus, on that number and I think if you look at that number it talks about 35 - 25, 35 nurses, it talks about 25 nurses and you already heard me say, as a result of the joint commission which came in December, that it might be more like 30 to 50 nurses,

very well 50 - very well maybe 50.

Q. Right. Then who said in December that we needed 30 to 50 nurses?

A. The HAP surveyor - Hospital Accreditation Program surveyor, the nurse surveyor from joint commission when asked the question - she talked about nursing staffing and when asked the question, well, what does that mean, she said, well, you probably need about twice as many nurses as you have and with the type of patients you have and the acuity that you ought to at least have a nurse in every unit on every shift, particularly with the type of medications that are being distributed. You have medications that are being distributed by mental health workers who are not closely supervised or may be supervised by a nurse that's like through another doorway, so that she saw it as a significant problem. In looking then at the staffing pattern, I asked Vera Gills, whose the professional consultant for nursing, how many nurses would it take to come up with this, you know, one per every area and it came up to be 50. Now - well, that's how I did it.

Q. But that was just one person on the Commission - JCAH - that said that.

A. That's right.

Q. I'd like to go back to the rape case. You have a very fine procedure manual and policy - policy and procedure manuals over there, very effective. Do all the staff know about those

procedures and policies?

A. Well, there is a - every staff is to sign off that they have read various policies and procedures, so there's a sign-off and that's kept, so it's there. It's the expectation that the staff do read the policy manuals. As human nature is, you may find people who will sign off that they've read something and haven't read it.

Q. All right. Did the nurse the night of the rape know of these procedures? That's on page 19.10 in your procedure manual. Had she read that - the way of reporting those procedures?

A. I don't know the answer to that specific question, I honestly don't. I know that - I will tell you about - you know, the thing about the rape case is that that incident was screwed up from the moment it started till the moment it ended, whenever you might say it ended and, you know, I was part of that and there were a lot of people along the way and we would freely admit that that was poorly handled and the communication didn't flow. There were a number - you know, a number of key mistakes. There has been some remedial action taken in a number of areas, but clearly that was certainly not the high point of good procedural work.

Q. When did you call the police and the guardian?

A. I did not call the police and the guardian.

Q. Isn't that part of the procedure?

A. I'm sorry?

Q. Isn't that part of the procedure for you to do that?

A. For me to call, no. I would never call the police or the guardian.

Q. Who would do that?

A. Depending on the time of day, the NOD would probably do it or the physician or physician extender. Again, it depends a little on the time of day, you know, because if it happens in the daytime, it might be the social worker.

Q. But you were ultimately responsible for the procedure part of it.

A. Sure.

Q. When did you notify the Commissioner since it happened on Friday night.

A. I think probably the next Monday, in the morning report.

Q. And yet it should have been done - it says in your procedures, I believe, it should be done fairly soon after the -

SEN. GAUVREAU - Excuse me, do we have a copy of the procedures manual to which you're making reference?

REP. DELLERT - No. Would you like a copy of it?

SEN. GAUVREAU - Well, it's in your possession, I'd like to see that.

REP. DELLERT - No, I don't have it in my possession, I'm sorry.

SEN. GAUVREAU - I see. Well, perhaps I could ask then that sometime during the course of the hearings someone from the Department, perhaps today, can make available to the Committee the referenced -

REP. DELLERT - Page 19.10.

SEN. GAUVREAU - Okay, thank you very much.

REP. DELLERT - I'd like to ask about - some more about staff training. Do you conduct the staff training with your staff?

A. Do I conduct it?

Q. Yes, do you start the series of staff training? Do you make sure that there is staff training on all floors and on all shifts?

A. We have a staff development department that is responsible for setting out staff curriculum.

Q. Yes.

A. Okay, if -

Q. And particularly for the treatment plan for the admissions. Has that staff been trained for that?

A. Well, for that group we had a special training in - after the February survey and after that training and after the second decertification, one nurse was assigned full time to work on treatment planning and documentation with the admission unit.

Q. Did you do any post testing after to see how well they were doing in their training.

A. Post testing on training, well, there were audits that were conducted on various aspects, yes.

Q. On all levels, all shifts and all departments, do you kow?

A. What would happen is that Diane Duplessis and some other staff would do audits of records and look at records and see if people were doing well or not and then feed that back to those

people and the supervisors.

Q. I also wondered if those procedure manuals were on all floors or where would they have to go to look at the procedures?

A. Well, in your procedure manual there's - it lists all the areas, but there should be a procedural manual on every floor, yes. On every unit and then department heads and there's at least fifty, I think.

Q. I wonder, how often do you visit the wards, how often do you go on each floor?

A. Well, it depends on what's happening at the time, but I would try to get out at least once a week.

Q. On all shifts?

A. Well, I have visited on all shifts, yes.

Q. So that you would know how things were going?

A. Not as much as I'd like. I think that, you know - I think that I would have liked to have gotten out a lot more. I think - I felt a little office bound and buried, to tell you the truth, but I did get out and I think - especially when I felt I could.

Q. So how often would you say, once a week or -

A. Well, when you say every unit, every ward, how often. God, I don't know. I think it goes - it would go in spurts. There'd be times it would be, you know, three and four times a week and then there might be times when there wouldn't - you know, I wouldn't get out for a while, so, oh, geez, I don't know.

Q. I just wanted to -

A. Weekly or - you know, ten days or so, I couldn't give you an exact number on that.

Q. I wondered how familiar you were with some of the night problems.

A. The nights is the least - you know, obviously nighttime would be the least visited clearly. I think you'll find that a lot everywhere.

Q. Prior to your coming to AMHI, what was your hospital management experience?

A. An 88-bed acute facility.

Q. Did you have supervision over psychologists, psychiatrists, physicians?

A. Yes.

Q. Directly? Direct supervision?

A. Yes.

Q. Were you ever part of the JCAHO or Medicare -

A. Yes.

Q. Plan?

A. Yes.

Q. You had submitted plans on that before?

A. Yes. One of the three hospitals and three facilities in Wisconsin that were accredited under the Community Mental Health Program.

Q. When you're referring to the understaffing, how were you going about thinking of - or getting those positions filled. Were you talking with - trying to - in trying to staff your positions,

were you talking to all the unit leaders, finding out what they really needed?

A. I'm not sure I understand your question exactly.

Q. Well, you were talking about the many, many places where we're understaffed, did you talk to the unit leaders and talk about how you might find those positions?

A. How we might find them?

Q. Yeah, or -

A. Well, you can't find them if they're not allocated.

Q. Okay. After they're funded did you -

A. After they're funded, oh, yeah, well, we didn't have a lot of trouble. Mostly they were mental health workers or activity aides or recreational aides and so those filled fairly rapidly. There were only a few critical areas of staffing, LPNs, RNs, psychology, psychiatry, did I miss anybody, OT and COTAs were difficult to fill, but so those - there are some professional areas that were difficult to fill, but most of the positions are fairly easily filled.

Q. Are there any positions now that could be filled where you have money for but are not filled?

A. Yes, I believe there were a number of LPNs, a couple of RNs, I think, two or three RNs, there's a contract physician that is not completely filled and COTAs, I think there were two of those. There may be some others.

Q. So there are some more positions that we could - some more

people that we could bring on line.

A. Yes.

Q. If we could find them.

A. There are some vacancies. In other words, there are some staff vacancies.

Q. Yes.

A. But you will always find staff - a certain number of staff vacancies, yes.

Q. Thank you.

SEN. GAUVREAU - Thank you. Senator Titcomb.

BY SENATOR TITCOMB

Q. Good morning.

A. Good morning.

Q. Listening to your discussion about the response to the rape that took place, I have to question what brought about this lack of procedural appropriateness during the time after this patient was raped. Why do you think that happened? Why do you feel there was so much -

A. I think because the NOD wasn't informed right away is the primary factor. The NOD is pretty experienced and I think would have handled that had it come up sooner.

Q. So you're saying that this particular NOD was not -

A. No, no, I'm just saying I think that the delay was - I think the NOD did not hear about this until 5:30 or - 5:30, I think it was 5:30.

Q. So she was not notified.

A. Yes, and that was the key factor in this whole thing is that had she been notified, I think maybe many of the mistakes that were made would not have been made. It was an inexperienced nurse that probably shouldn't have been working in the first place unsupervised and, not only that, she was not feeling well and I think - so that was poorly handled.

Q. I have some questions -

A. I think indirectly you can look at the availability of substitute staff as an underlying factor, but it was not, in my opinion, a staffing - in that situation it was not related to the fact that the event happened, because there were a number of staff right down the way and so it -

Q. I have a question about the male patient who committed the rape. Now, I've asked this question before and I'm going to ask it again. It was indicated to me that this patient had been involved in March in numerous incidents of sexual assault against individuals. You mentioned yesterday that March was a month of numerous assaults. Can you recall whether this individual was involved, why you specified March was being a month of particular concern.

A. No, I can't, but the way you could get the answer to that question would be to look - and every morning there's a - what we call a morning meeting and it's formally called the Administrative Executive Board. What it is is the people who report to me

generally get together and hear reports from the various unit directors as to what has occurred, what incidents occurred, are there some needs to make some adjustments, and so forth. That report then outlines events that had happened and in turn those are reported to the Commissioner's office. It would be on there if it was reported.

Q. Okay. I have requested that, so I was just curious to see if it got -

A. To answer your question, I do not know the answer to that question.

Q. Now, we've spoken about the team that works together at AMHI and what is correct protocol within the team once the correct procedure for requesting things -

A. That's - that would be a different - there'd be my team and then the Commissioner's team and I would be one person on the Commissioner's team.

Q. Okay. Your team, am I to believe that those are those people that are within the hospital that are actually doing, in one way or another, the hands on work with the patients or the -

A. They're the - the unit directors and the chiefs of the disciplines.

Q. Can you summarize in as few words as possible what you were hearing from these people during the time that these problems were building up. What was the message that you were getting from the people that were in your team concerning the conditions,

what their concerns were, what their frustrations were, were they voicing them to you and, if they were, what did they say?

A. They were saying that we were understaffed and having overtime problems or acuity problems, and so forth and so on.

Q. Were they concerned about the well being of the patients?

A. At various points I think - again, there's an ebb and flow, but at times I think there's more and less feeling of in and out of control and it kind of ebbed and flowed. In other words, things seemed to break down at times.

Q. Now, did you express this concern - and I know you've been asked this before and then Rep. Dellert asked you again if you had done it in the form of a memo. But did you specifically relay these concerns to the Commissioner and let her know that there was concern, that it was ebb and flow, that it was out of control and that there were indeed people on your team that were concerned about the care of patients?

A. I think what you can put your fingers on are the Friday report series, okay, and that you can clearly identify. There are various conversations, verbal conversations about that, that we would talk about what's going on at AMHI. I can't tell you what day I said what.

Q. Okay. I just wanted to -

A. Over a long period of time, but -

Q. A general review.

A. But, you know, the Friday report is more of the formal summary

for the week.

Q. So although you did not give specific numbers, you did express the degree of concern about the situation.

A. I think so, yes.

Q. Why do you feel - and, again, this is going to be just an opinion question, but why do you feel that the Commissioner was reluctant or refused to go beyond your discussions and actually ask for the funding that would be necessary to have the help that would provide the quality degree of care.

A. A couple of opinions, and these are opinions, I think there was a background of trying to not coming up with requests. In other words, I think that there was an emphasis on not putting forth requests, let's say, last spring. In addition to that, I think the thrust of the department and the emphasis is on moving from the institution to the community and emphasizing community as much as possible and to take workload away from the institutions through means. Frankly, we had been talking about this in-patient business, if we could get it going, in southern Maine. It's not something that came up in September. It's something that's been talked about I know since February, because I mentioned it in February that it was on hold, so it must have been being talked about in the fall of '87 as a possibility and I think that had been repeatedly discussed as something we'd like to bring about.

Q. But I feel particularly troubled with - I understand the value of the community programs and I certainly commend that sort

of direction and agree that that would be the long-range goal of trying to alleviate the crowding problem, but are you saying that in spite of the fact that in the interim between our goals and when we get there that the situation at the hospital financially was not being addressed, that there were not requests going in to solve that problem there to keep those people safe and cared for. Is that an accurate assessment?

A. I think the most accurate way of saying it is that requests were not going to be accepted.

Q. By whom?

A. By the Department and I think I talked about that before. I mean, that's what - that we had a meeting to talk about staffing in February. Obviously nothing came of it and it's - you know, you'd have to believe that I sat there and said we didn't need staffing at the meeting specifically called to talk about staffing to believe that I wasn't asking for staff.

Q. When the census is 370, what do the living quarters look like? Patient living quarters.

A. Well, you'll have 370 - and depending on how it's distributed, of course, but you'll have people very crowded -

Q. What could they look like.

A. Crowded and not a lot of space between beds and oftentimes rooms that should have one might have two and rooms that have two might have four or three, rooms that should have four might have seven.

Q. Are people stepping over each other?

A. We try to - we've tried very hard to not have that occur, but there were some instances where beds were jammed up to where the safety office or our other personnel would be concerned about egress and we tried to address those as quickly as we'd identify them.

Q. And my last question, I believe, is who is Victor Perreault?

A. He's the retired hospital services administrator, the hospital - chief of hospital services I believe is the title. That's the person who would have maintenance and the housekeeping and dietary and ancillary departments, plant services.

Q. Is it true that you approached Victor Perreault and asked him to do an assessment of the air conditioning needs and an estimated cost?

A. Oh, yes, it is.

Q. And could you tell me what the results of that study were?

A. Yes.

Q. And when that took place, when your request was issued.

A. Well, it would have been before - it would have been between the patient deaths in August, which would have been August 6th, I believe, and August 25th. The result was the memo that I sent to the Commissioner - the estimate that he came up with at that time was 1.6 million for air conditioning.

Q. Do you feel that with his experience of the plant itself that that estimate could have been used for at least a base figure

for budget request for air conditioning?

A. Well, that was the idea that this was something of significance and needed discussion and review at the cabinet level and that these were estimates and they were estimates, but, yeah, I think so. Now, subsequent to that Victor's replacement had another group come in and it came out 750,000 per building and I talked about that on our September 22nd meeting, so you've got estimates between roughly 1 1/2 to 3 million in terms of air conditioning.

Q. My last question, simply because it's so glaring and it bothers me intensely. Do you feel that it is appropriate that at this point there is still not a budget request in for air conditioning to adequately protect the patients during the heat of the summer.

A. Well, I think we'd all feel better if there were.

Q. The patients more so I think than we.

A. Well, I don't want to underestimate the necessity for doing, you know, a thorough job of looking at - it's a large plant and it's not just going through and saying it's going to cost 3 million, but I think it would be nice to have a budget that we could count on.

Q. Which we don't have now.

A. Right.

Q. Thank you.

SEN. GAUVREAU - The order of questions at this point is Rep. Hepburn, Rep. Clark, Rep. Rolde, Rep. Cathcart, so

Rep. Hepburn is up now.

BY REPRESENTATIVE HEPBURN

Q. Thank you, Senator. I want to look a little bit at the DHS report. Do you have that with you? It might help if you do or maybe we can get a copy for you if you don't.

A. If you've got one that we can operate off the same paper, I think - I was trying to follow along with what I had the other day and I could not.

SEN. GAUVREAU - This is the DHS assessment?

REP. HEPBURN - Yes, that's correct. Basically on Page 8 is what I really wanted to look at in terms of recommendations by the Department and specifically the recommendations to the superintendent and, you know, in kind of a forward looking way here I want to just see, you know, where we are and what's been done and what might be done. A lot of these things seem to be pretty administrative, they would seem to me at least, and perhaps, you know, you could tell me what you think about them or what has been done, what might be done, needed to correct it. And I'd kind of like to just kind of bang right on down the line starting with - in Part B there at the bottom of Page 8 on Question 1, the first - the clinical staff at AMHI should assume immediate responsibility for the pro-active - pro-actively and aggressively addressing the problems of Mr. Blank's inappropriate sexual activity with female staff and patients. Mr. Blank and other patients deserve protection from this dangerous behavior. It's my understanding

that Mr. Blank was moved after the sexual incident to a different ward. Was there a new policy implemented as a result of that incident? What - did anything change? Were there policies that weren't being followed initially? Maybe you can tell us.

A. Yes, the sexual abuse protocol was rewritten by the professional - consultant for professional nursing. The patient was transferred and under the - under Dr. Buck and you heard directly from him the other day. I don't know if you want to hear more about that. He would have done the review of medications.

Q. All right. Well, we won't - no need to dwell on that one I guess. There's a couple of others here that are important. I just want to - unless you have some more you want to say about it.

Question 2, for example, initiate a full review of psychotropic medications, the treatment team look at Mr. Blank's medications. That was done, I assume?

A. I believe so, but -

Q. You're not quite sure.

A. I'm not quite sure. Okay, what was done - now I know what was done. The male patient was moved to the Forensic Unit, written protocol was developed, meetings were held with DHS regarding patient-to-patient abuse reporting which was a problem with them at that time. Training sessions are scheduled with Adult Protective Services staff. Training is planned with the Augusta Police Department on managing legal violations. Human sexuality is being added to the mandatory training and inexperienced nurses

will no longer be assigned. I think that was the practice and that was an exception to the practice and it's something that shouldn't have occurred, but there is a specific protocol or policy that that will not happen.

Q. That inexperienced RNs would not be in charge of an entire ward?

A. Right.

Q. And that speaks to Recommendation 8?

A. Yes. That could in some instances get to be a little easier said than done. If you had, let's say, some sick calls and you were trying to hire overtime to cover a unit that they will, I believe at this point, probably call in maybe unit directors or something to avoid this, but it may not be the easiest thing to abide by depending on the level of sick call or whatever that's being covered at the time.

Q. Okay. Since we're looking at that now, it says the superintendent should examine the current practice of placing any inexperienced RNs in charge of an entire ward, so and so no longer works alone, but the larger issue needs to be examined. Did that happen? Did we look at that?

A. Which number are -

Q. That's recommendation 8 on Page 9.

A. Yes, I think that's the larger issue - that policy to make sure that nurses are properly oriented and have some experience before they're placed in charge of units is the policy that we're

talking about.

Q. And that's - you think that's happening now or -

A. Yes.

Q. Good. Let's look at -

A. There were some -

Q. Yeah.

A. Okay, well, go ahead.

Q. No, I - go ahead.

A. I was just going to say there were some issues about having single sex units, and so forth, I think, that would be fairly difficult to implement at this point.

Q. That would - we'd be looking at Recommendation 4 basically if we're talking about single sex units, to explore the creation of single sex units for patients with a history of inappropriate sexual behavior or activity, excuse me.

A. Right. I think every time you form a different - you know, a separate unit you create a number of problems, especially if it's what we would call a distinct part, as it has staffing implications and the - just the space - you know, the crowding issue would create some real problems in single sex units and so the single sex units tend to be, in the hospital, the Adolescent Unit and the Forensic Unit.

Q. Okay, so that was pretty much -

A. Well, adolescence being male on one side and female on the other, but co-ed together. The rest being -

Q. On the same floor or area.

A. Yes.

Q. But for the most part then Recommendation 4 was rejected. I mean, as something -

A. It is not practical at this point, right.

Q. Okay. Recommendation 3 at the top of Page 9, superintendent initiate an internal review to determine Mr. Blank's repeated documented incidents of sexual activity were never addressed, it says, despite requests from staff. That's pregnant with meaning there. What do you want - what can you say about that. It says they weren't addressed.

A. I can't give you a good answer to that.

Q. Okay. Let's look at Question - Recommendation 4 then, superintendent and staff will explore the - okay, we looked at that, I'm sorry. No. 5 is address the confusion about roles and responsibilities of staff as well as supervisory duties. Do you think there was a confusion in terms of roles or responsibilities of the staff say in the last year?

A. I think Walter Rohm may have - or Rick may have answered that question - this same question about that. I don't think that there is that much confusion about responsibility to staff. I think there were some comments in there about who said who reported to who and I don't think there's any question of who the physician extender reports to. I think maybe the confusion was at a time the NOD is in administrative charge of the facility on that watch,

but - and may have said that everybody reported to her. I think that was one of the confusions, but I don't think that there was any lack of clarity as to who the physician extender reports to.

Q. Well, it seemed that during the sexual incident or the rape that's just been referred to, there was a breakdown at that point and I'm sure that's -

A. Well, the break that - what happened when I got a hold of the situation is that the report was that the protocol had been completed blown, the patient had been bathed, evidence was gone and what do we do now and I said, oh, God, get Tom Ward in, because I - you know, you can argue that he was not the person who should have been doing this because that's not his job. Frankly, I think at the time he was the one person I felt that could straighten it out and admittedly you can say chain of command wise that maybe was - that he - that shouldn't have been thrust on his shoulders. He certainly would have wanted to know about it anyway, but I felt that - and he has done some what you'd call social work for us in some cases, trying to get people into another facility who were inappropriate for our facility and I felt - I viewed that as this is one of those cases where it was going to take some advocacy social work to straighten out and I felt that he was the person for the job and I think did a good job of trying to straighten out was a real mess.

Q. It does seem like it was quite a mess. It seemed that

communications broke down at almost every level in that particular incident. It broke down in terms of reporting the incident to the nurse on duty, it broke down in the fact that the superintendent - the Commissioner didn't find out about the incident until Monday morning when the incident happened Friday night.

A. Yes.

Q. I mean, it was - when did you find out about it? Maybe you've answered that already.

A. I think it was 7:30 or so - I think it was 7:30.

Q. What day was that now?

A. That would have been Saturday morning.

Q. And why didn't you call the Commissioner on that?

A. Basically I didn't feel at that time that this is something that she needed to be bothered about at that - on this weekend and that's - looking back, I probably should have called her.

Q. Yeah, I think that's probably correct. Question - the Recommendation 7, AMHI address the need for improved documentation. Okay, we've had documentation that has been beat around here these last few days like there's no tomorrow, but current form is inadequately completed by staff and, therefore, does not accurately capture necessary information -- the incident report form should be considered. Adult Services and the patient advocate will be making suggestions in the development of this form. Does the patient advocate do that?

A. Yeah, I've looked at it myself and showed a draft to our

professional consultant and then we did eventually weight his - Rick? Is it done?

MR. HANLEY - It is not done yet. We have met once with DHS and we'll be meeting again tomorrow to discuss some of the other incidents as well as the report.

MR. DAUMUELLER - There is - one of the problems in revising the form is the coding of the incidents and trying to track them with - and computerize them which is what we're in midst of and I know coding was something we wanted to be able to follow events over time so that not to have to throw out the old data, so that was, from our point of view, one of the things that we were concerned about. From the advocate's and the DHS point of view, I don't know what they would have suggested, but they haven't suggested anything yet.

Q. The patient advocate hasn't suggested anything?

A. No.

Q. Okay.

A. There was a change in patient advocates, oh, geez, I don't know, a couple of months ago.

Q. We've already looked at Recommendation 8. Recommendation 9, assure that all charts and patients under the guardianship or conservatorship contain fluorescent sticker -- case, name, address, phone number. That's a pretty basic clerical kind of thing. Did that happen, do you know?

A. I know the guardian - the guardianship is in the - on the face

sheet of the chart. I don't know if we're using fluorescent stickers or not.

MR. HANLEY - We are, but we've asked that all the public wards be reviewed to make sure that that's in place and we have requested and received most of the Probate Court orders which will go in the record section of the chart.

Q. So do you think that - based on those recommendations, obviously you've looked at those and seen them. Is this indicative that you need more staff, do you think, all these recommendations, these nine things, is that what that tells us? That the institution needs more staff?

A. Well, I think there's staff and there's organization and if you don't have staff things fall apart because, you know, as I said before, I think good people look bad under bad circumstances. I think they go together and I think if you're under - you can have good people in place and even good policies in place and, by the way, there are a lot of policies in place that maybe people think - don't think there are that are in place. So it's a combination. I think when you're - if you look at - while this incident I think does point out systematic things, I think part of the systematic that's pointed out is that you don't have ward clerks on each unit for upkeep of charts, and so forth, so who's going to do it. It falls to the mental health worker. Now, are they going to take the laundry down the hall or get the laundry cart off the - out of the hallway or are they going to take the patient down to

the clinic or are they going to work with the patient or are they going to, you know, put things in the chart and those are some of the choices that people have to make and that's where some - where you get some breakdowns in systems. You know, I think many of the things that break down are clerical, bookkeeping types of events, but you've got basically a situation where people who shouldn't have to be doing that are doing it, mainly direct care personnel, mental health workers or even nurses in some cases.

Q. All right. Concerning the cutting of staff that we've just been batting around a lot, now, it's been talked about before, but I just want to cover some areas again. The - it came down from the Executive Department, they asked you to cut staff, is that true?

A. No, they said can you take a 4% across-the-board cut.

Q. They asked you if you could.

A. Yes.

Q. Okay. And you said.

A. No.

Q. Okay.

A. And then I also said that - then we worked on some other options in terms of contracting, are there some things that we can contract out that we're currently operating that would save money, were there some savings to be had in terms of combining forensic units and it turns out that none of those options wree really top notch options and eventually the revenue

enhancement came about and that took everybody off the hook, essentially, for having to make cuts.

Q. Okay. So they didn't come back to you after you said no and said you must do -

A. No, no.

Q. So that was a basic kind of probably cabinetwide management tool that said, well, let's cut 4%.

A. Well, yes, I think to fund the priority package I believe is -

Q. Pie shape.

A. It's a $15 million package.

Q. Okay. And so in terms of a cohesive plan to ask for more staff, the only real plan on paper that was submitted to the Commissioner was the one that tracked the - that went along with the September 22nd memo, is that correct?

A. No, that would be the June - the June request.

Q. Okay. There was a written request -

A. Oh, yes.

Q. Okay.

A. That was all in writing.

Q. And how many positions did that request again?

A. That would have been - it started off with 60.

Q. Okay. And that was considered to basically be addressed by the September special session.

A. Yes. And that's what the - the proposal eventually was built on that.

Q. Okay. There just seems to be a lot of confusion or allegations that, you know, there are all these requests for staff and they're always being turned down. I mean, it seems to me that the only time anything appeared on paper and got to the Commissioner's office she got it.

A. The only time anything got to the Commissioner's office on paper we got it after the news media heated up the situation, that's when we got it.

Q. But, you know, I realize there was - in the weekly reports there was - you know there were mentions of, well, we could use more staff and, you know, but we can probably hang on. I mean, if I was Commissioner, I wouldn't look at that as a mandate. I mean, I would look at that, well, you know, he's having a tough time over there, but, you know, I guess it's okay. I haven't got a request for staff. I mean, there's no packet with trends and graphs and predictions of decertification, all this kind of thing. I mean, to the best of my knowledge you didn't put in a formal request for staff or a written request between February and May, is that correct, of last year?

A. As I said yesterday, on January 27th we met as the governing board of Augusta Mental Health Institute. We discussed the need for staffing and a special meeting was set up to discuss that very issue and I did ask for staff, but we didn't go into - we didn't have a special - I didn't have a written request for a number of

staff. What I was asking basically was can we go ahead and can we - in other words, can we open the window. We operate a lot on windows of opportunity, I guess is the way - and is there a window of opportunity that we can go for.

Q. Okay.

A. That's what happened in June. The window of opportunity presented itself.

REP. MANNING - Rep. Clark?

BY REPRESENTATIVE CLARK

Q. A couple points of clarification and then I want to talk about real people that are in this institution. Do I understand correctly that while - that the rape protocol that Rep. Dellert referenced was developed after the August incident?

A. There was a rape protocol that was developed a couple of years beforehand that everybody seems to know what's in it and recall but couldn't find. And then a rape protocol, after nobody could find the protocol, was developed after the rape case.

Q. That would be consistent with Dr. Rohm's comment that there was no protocol then - on Thursday.

A. There was a protocol that was written a couple of years earlier and it was in a memo form.

Q. But nobody knew where it was.

A. And that's true.

Q. So that it wouldn't be in this notebook that Rep. Dellert is referencing.

A. That's right. So you can say that there is no protocol, although everybody swears there is or was one.

Q. And it wasn't followed.

A. And it certainly wasn't followed, right.

Q. Okay. It seems to me that when I read and I listen to - look at the literature on troubled families, a lot of discussion about the no-talk rule. Can you talk a little about the no-talk rule in the Department? Was there a no-talk rule. Let's start there.

A. Okay. Basically the no-talk rule in terms of the department, if you will, would be that members of the department would not independently communicate to the Legislature and if a legislator would call or make an inquiry of me that I would inform the Commissioner of what was said and asked and there was no - it was not said, however, that you would not give information to the Legislature. There was - if they asked a question, you could answer, but you were not to pitch the Legislature independently of the Executive Branch. In other words, you would do whatever - conversing you would -- with the Commissioner and the Associate Commissioner, there would be a departmental position and that position we'd all support. We'd fight about whatever would be within the team.

Q. Did you feel that there was the opportunity within the team to fight bfore you went public?

A. The opportunity is always there to fight. I mean, you just fight, so to say that there was no opportunity, I guess I couldn't

say that. You just have to decide you're going to fight.

Q. Okay. If as a state legislator I had arrived at the front door of AMHI on January 1st, what would have happened? As a legislator, not as a patient.

A. I think we would have taken you through, explained the program, anywhere you wanted to go basically. We did have a very - we do have an open-door policy basically within certain parameters, but - and those have to do with patient rights and respecting their privacy, and so forth. But anytime a legislator or anyone else, for that matter, that would make an inquiry, would be able to go through, talk to people, have their questions answered. I don't think there would be any problem with that.

Q. So if I had arrived on January 1st and said to you, Mr. Daumueller, as superintendent of this institution what do you need to make this run, would you have been allowed to answer that, do you feel?

A. I probably would have said fewer patients or more staff. I think I've never deviated from that. The long-term solution has always been, you know, to come up with what we ideally want in a facility is fewer patients, make a smaller facility, hopefully, or enrich the staffing ratios, but the best way to enrich the staffing ratios, and we would - there again, we're in agreement with the Department, I think, would be to bring down the population. The problem with that is in reality in really working - looking back is not double funding. Double funding is the -

Q. Even if there's double funding, I guess I'd like to talk a little more about that. Let's take a snapshot at any one point in time. We've got 375 patients housed in the hospital, is that correct? How does that break down? Where are they? Are they chronically mentally ill, are they acutely -

A. Seventy are in the nursing home, 70 in the nursing home. Depending on what part - time of the year it would be, we have 70 nursing home, you would have right now roughly 32 or 3 in senior rehab, I suppose.

Q. Tell me what that is.

A. That would be the combination of infirmary and the unit that was newly established, a 20-bed unit, so I think those two together would be about a hundred and -

Q. Is this rehabilitation for physical or mental illness?

A. The concentration there is physical illness and the need for nursing home care, either at the skilled nursing facility level or the intermediate care level.

Q. And how is that different than in the nursing home beds, the 70 nursing home beds?

A. It would be the same only a little higher level of care.

Q. And the rehab is higher or the nursing home is higher?

A. Rehab would be higher, because it combines the old - the medical/surgical/infirmary unit which is like a medical/surgical hospital and a nursing home. So that would be like 103. You have probably 35 or 40 in the alternative living program. You have

depending again probably now somewhere around 21 or 22, I would guess, in the adolescent program, somewhere around there. And then you'd have - on the Admission Unit it's up and down, but probably would average - now it's starting to average between 25 and 28, somewhere in that range, I would imagine. Then you have the Forensic Unit, that's roughly 33 and they stay pretty much around that level. Then you have the four units that were - is young adult program. That's been running about, I think, 48. The older adults - the adult program runs 55 to 60. And so the 48 is about three over what we'd like to see there. The 55 to 60 is about 10 to 15 over what we'd like to see in that unit. Older adult, recently since we made the change and since I left around that time - what's that -

MR. HANLEY - 47

MR. DAUMUELLER - Okay, so it's running - it runs about 47, that's about seven over what we would like to see that unit. And then Stone North Upper is kind of an overflow area that has 12 staff attached to it and that's running about 24 patients.

Q. On those four units, what's the median length of stay? I guess I'm having trouble when all these numbers get floating - thrown around, whether we have a fairly stable population that goes in and out or whether we have a long-term chronic population -

A. You have both. You have some - some of the more chronic and that's one of the problems on the adult program is that some of these people are longer term patients. I think the younger

group has a little higher turnover and the Admission Unit, of course, has the highest turnover of all and so there's a selecting process that goes through is once you get past the Admission Unit your length of stay - the prospect for length of stay being longer is greater, but even there you have people who are going to come in, be in for a while, thirty days or so, and move out and then you have another group that's going to be in for a much longer time and the care needs of that group - you know, the care needs are fairly high.

Q. For the long-term group you're saying are high or for the short term.

A. For some - particularly some on the adult program, there's many very chronic, very difficult patients who - to get them to move you have to do a lot of work with them or provide them, you know, heavily supervised residences.

Q. Okay. So let's go to this older adult unit. You've got 55 or 60 people on it. Is that right?

A. That's the adult unit.

Q. Yeah, okay. Let's talk about that unit. You don't want to even guess on a median length of stay on that unit, huh?

A. I'm guessing about eighty, but -

Q. Eighty days?

A. Yes.

Q. Okay. Tell me what goes on in that unit.

A. Well, you have a large group of people who have an activity

schedule, some off the unit, some on the unit. Many of the patients who have - you have privilege levels, three levels of privilege, people who cannot leave the unit, people who can leave, you know, quite freely and then some in between. Those who can leave freely have much more access to the various hospitalwide programs. We have the canteen, the activity resource center and you'll have activities scheduled for the patients on the unit and opportunities for certain people to go to activities. So activities is a big part of their -

Q. Give me an example, what you mean by activities. What are they doing here?

A. Well, now we have a gym. They might be doing phys ed, they might be doing - in the activity resource center they might be recreating, playing games or, you know, they might be in the library reading or they might be in some structured activities, games, they might be making - doing some kind of crafts or making, you know, pottery. There's a fairly substantial amount of that.

Q. Do those people eat on the unit? Is food brought in?

A. There's a kitchen on the unit,yes.

Q. And so they eat in a communal dining room.

A. Yes, which at 55 and 60 patients is quite crowded.

Q. You didn't talk at all other than recreation about what kind of therapy these people are getting. Who are they seen by?

A. Depending on who it might be, they might be seen by a social worker. They might be seen by their physican or physician extender.

There are psychology - psychologists, they might be seen by a psychologist, either individual or by group. There is limited numbers of groups that - for activities of daily living and other kinds of discussion groups. But the level of active psychiatric treatment that you would maybe expect to see is fairly limited and if you go back in history, one of the reasons AMHI was cited for being a top notch facility is because of the educational and therapeutic programs that were in place at one time, SLT structured learning therapy and a number of things which were very much geared to activities of daily living and helping people learn how to cope with the environment that they would be entering into, how to cope in interpersonal relationships, so to speak. So over time the mental health workers and the staff who were assigned to those programs were pulled back to the units to provide basic care and treatment and so if you find me struggling to come up with a long laundry list of therapy, you know, that any individual patient is going to get on any given day is not a lot there.

Q. If we were going to take those sixty people out of the hospital, what kinds of living - what kinds of situations would we be looking for?

A. Well, the most desirable for the majority of our population, the best judgment - our best judgment are the six to eight, you know, depending how it's structured, group homes which are relatively heavily staffed. In other words, that there's constant and significant supervision and some in-the-home treatment, if you

will, some opportunities for some growth and training right in the facility, yet opportunities for interaction in the community so that people would be well integrated into the community. This is - this may be somewhat traditional and, you know, maybe not as contemporary as some people would like to view things, but this is what I think the majority of our in-house staff would say would be the most - the base - that would be the base line for people who could come out of AMHI. In support of that, in the vocational - people need to have vocational aspects to their life, so that means work or work training and that's extremely important for successful adjustment and people need to have some recreational outlet, so there needs to be some fun in a person's life and you have to be able to get to those things, so there's an element of transportation. So there's, you know, housing, vocational services, recreational services and case management. In other words, people following along with the person in the community to see that they're getting what they need, their needs are being met and that something is actually going on in their lives that's meaningful. And that - and when people see that their lives has some meaning, I think that's their best chance of adjusting.

Q. If you created -

SEN. GAUVREAU - Excuse me, I'm going to have to break in here, because we've received word from the House that the annual House photo is about to be taken and as a courtesy to the House

members of the Committee, I'm afraid we'll have to recess at this time. Since it takes between thirty minutes to one hour to do the photo at the very best, I should ask that the Committee recess.

REP. MANNING - I think what we ought to do is recess until say 12:30.

HEARING ADJOURNED AT 11:00

STATE OF MAINE

HUMAN RESOURCES COMMITTEE

Hearing on Augusta Mental Health Institute Issues held on February 2, 1989, in Room 113 of the State Office Building, Augusta, Maine.

Norma Morrisette

I N D E X

REP. MANNING: Neil, you were next.

EXAMINATION OF MR. DAUMUELLER BY REP. ROLDE

Q. Mr. Daumueller, a couple of questions. You said, when you were questioned about the problem of asking for money for staff, and you got the sense back that that wasn't going to go anywhere, that presumably the administration wanted to keep expenses down so that was not an approach that they were going to take and that one of the things they were going to do was - and I'm going to quote your own words - is reduction in census approach, which was the idea of beefing up community services and therefore easing the strain on AMHI. And when that came to the legislature in September, if I remember correctly, out of the $6.5 million that we gave them, something like three million was supposed to go into community services.

A. Yeah, three and a half.

Q. Now that approach does not seem to have worked, because if I understood the chart correctly that we had, the admissions now are the highest that they've ever been, even after all the time between September and February for those projects to go into effect. You also had talked about the proposed 20-bed unit down in southern Maine, and when I questioned you about that yesterday, you were sort of vague as to what had happened with that, and I assume that nothing, essentially, has happened with that. I guess one of my questions was, since this was very critical to AMHI's problems, how much were you brought into either designing what was to be done out in the community or in implementing it? Were you informed of

anything that was going on?

A. I would inquire periodically as to the progress, and the response was that there was some thought that something could come on line as early as the end of last year or the early part of this year, and that looked fairly favorable, and I can't tell you when it stopped looking favorable, I think it may have been November or December, as I understand it, maybe it looks more favorable now. So if I'm saying it's kind of been up in the air and questionable, it has been up in the air and questionable, although it looked real favorable at the time we were expressing that that was part of the budget. So it looked very good at that time, in September, let's say.

Q. And we are talking about the 20-bed unit or -

A. Yes.

Q. Or are you talking about other -

A. Twenty bed - yes, in southern Maine. I was under the distinct impression that that was a very realistic thing to happen at one or two or three facilities.

Q. So where is that now? I mean, do you have any sense?

A. I have a sense, but there are people from the department here -

Q. Who are specifically working on it, but you -

A. I was never involved in that.

Q. You really weren't involved in that -

A. At all, no, but I understand there is some work being done in that very specific area with a specific provider at this time.

Q. Okay. Now I want to ask you a very loaded question.

A. Gee, that will be a switch.

Q. And what I wanted to ask you, and this is your own feeling, do you feel that there has been an attempt to make you a scapegoat for the problems at AMHI?

A. Well, I guess I've said it on the air and in front of God and everybody. I guess it would be hard to say that I didn't feel that way to some extent, and to some extent I feel that way. That's not to say I don't have - you know, I am not saying that I am not part of the problem or I don't have any culpability. I just think that there are a lot of things that play into the problems that are at AMHI and the mental health system as a whole, and one of the big factors is there's a lack of money in both, at the community and at the institutions, and I think that's the bottom line, that there just isn't enough funding to do what people would like to see done. And one of the reasons - I guess the main reason I'm here, in the God's honest truth, I mean, it's not to say that I shouldn't have been fired, that is not it, that's not an issue and never has been for my appearance here. Susan Parker has every right to put anybody she wants to in that position, and one who serves in that position serves at the will of the Commissioner, so that's not even a debate. This is not about getting my job back or anything like that. This is about what's needed to make things right. For whatever reason they were wrong in the past, and for whatever reason led up to it, I think that there's a need for some action and fairly rapid action and fairly significant action. I think the - if you read the stuff that was given to you in the

proposal, the 6.5, it does talk about additional needs and the need - the anticipation that there would be additional requests coming to you, because there are needs out there and the package that you got is a great start and it's the most it has been funded for a long time but it isn't going to do it. It's not enough. It wasn't enough then and it certainly isn't enough now, and in order to make things right and to put together the kind of system that I think you want and the kind of system that I want, which emphasizes community-based care, treating people in the least restrictive setting and having quality institutions and facilities, it's going to take more money. And so we can find people to blame for the failings, but the bottom line is how much are you going to be willing to pay in terms of quality, because I hear you, very concerned about quality, and as you well should be, but that quality does cost money. And yes, there are management issues involved, but there are also resource issues involved, and I think the resource issues, in many respects, create some of the management issues. That's the bottom line, that's why I'm here, and that's what I hope you will focus on and respond to. My sense is that you and many other people in the legislature would be willing to respond to that and possibly one of the struggles at this point is how and what is it that we do now. And if I could focus your attention on what needs to be done, I would say you're going to have to do what I call double-funding, or fund the institutions more heavily maybe than we would like in the overall scheme of things because you don't want to emphasize the institutions, but you need to have good quality institutions, and you need to put money in the

community in order to move people from institutional care into community care. That's a big job and it's going to take some time, and so you - you know, if everybody does the right thing, I think there's going to be a heavy influx of dollars for a period of, let's say, two to five years, until you can get to the point where you can honestly make tradeoffs and say let's move money from the institution to the community, because once you beef up the institutions then you have a whole other set of problems about how do you move institutional resources into the community. There's labor unions that have to be considered and there's people who have jobs and so forth, and you know and I know that that's not an easy issue to tackle but it needs to be addressed in any kind of long-term plan. There needs to be the resources and you've got to build them up in the institutions. At the same time you've got to put money in the community, and over time then I think you can make transfers, but you can't - if you're treating people in the State Hospital for $135 a day on average, you're not going to be able to make that movement from the institution to the community because the institution is underfunded, and so you start taking away from there, you know, you're just going to kill the institution. And if I'm the bearer of sad tidings, I'm sorry, but I think that's the story that needed to be told, that's the reason I came forward to ask to tell it. It wasn't about a lot of other, the side issues that maybe are more noteworthy and catch more press and so forth. I hope I answered your question.

Q. Thank you.

EXAMINATION OF MR. DAUMUELLER BY REP. CATHCART

Q. Mr. Daumueller, are there any widely accepted standards for mental health institutions, such as the patient/staff ratio? What kind of standards when you made those judgments were you basing it on?

A. Well, there are different articles that cite staffing ratios, and there are different things like consent decrees, there was a recent one in Texas, that lay out staff/patient ratios. There's your own Pineland consent decree that gives you some kinds of guidelines as to how you might staff facilities, and I don't think that's a totally outrageous approach to take and it does give you an assurance of quality. That's a real prolem, because the joint commission really doesn't take that on as a cause, Medicare will not take it on as a cause, and it's very difficult for public facilities, state facilities, county facilities, all sorts of public facilities to make the case to legislators or to councilmen or selectmen or whatever as to what the needs really are because it is subjective. So the answer to your question is, there aren't very many good standards, good national standards, to go by. There's some ballpark figures and there is, again, some specific articles that tell you what might be good staffing, and it does depend on admissions. A simple ratio would be how many patients to how many staff, but you have to factor the turn-over and the acuity. If I've given you a longer answer than you wanted, I'm sorry about that, too.

Q. That's okay. Let me ask you this - I'm not just interested in that, but if I as a legislator wanted to know, say, how I would like it to be at AMHI, I mean therapy, occupational things, activities for patients, where would I go for a standard of what a good mental health institution should provide?

A. Well, you could start right at home and go to the professionals who work there. They're by no means lacking in intelligence and insight. I think they could give you some reasonable standards allowed to do so. I can throw out some numbers, I think. In terms of mental health worker types, you'd count your number of patients and just - that's the number of mental health workers I think you ought to have. In terms of physicians, probably rough - medical doctors, I think probably one to a hundred and round off up, so that would be roughly one to four at AMHI. And social work, under normal circumstances it would be roughly one to twenty patients, but then you have to factor in how many admissions that you would want them to take. And then to those figures you have to throw in how much therapy do you want included and make sure that you have the staff either on the units or set up a separate staff to provide those, like college campus courses or therapy groups and so forth. So, I mean, I have a number of ideas as to the staff who work at AMHI who could - I don't think it takes that long to come up with some ballpark recommendations.

Q. I was hoping you would tell me there was one book like this that would tell me exactly.

A. I wish there were. In the nursing home - the nursing home

standards do give you standards, but, quite frankly, those are very low, and when you're dealing with the type of patients with behavioral needs to attend to, those tend not to be very good standards.

Q. Thanks. Everything that I've read and learned since starting to research this situation tells me that there has been, at least the past year, a constant staffing crisis at AMHI. Would you agree with that?

A. Yes. The first time we looked at staffing patterns, it came up that we needed - and this was the first time I ever went through the exercise, and that we probably needed 154, put in a request in for 54 saying that this is - we'd phase into it and we were concentrating on therapy, providing this off-ward therapy and activities, day living, structured learning, therapy, that sort of thing. You know, that went through the mill and got cut back and then trade it off for the spike in admissions for '87, so our focus at that time wasn't doing the therapy and some of the nuances of care became safety and containment and that sort of took over from going back - in a sense we were trying to go back in time to recapture some of what we had lost over the years. So, yeah, there's some staffing needs that have crossed administrations and crossed years and so forth.

Q. In the past few days I've heard a fair amount about the reduction in the number of Medicare beds, and I know that at present if we were to go for recertification, tell me if this is wrong because I want to get this explained a little more, we

would be asking for 30 beds to be recertified. But originally last - a year ago, say, as I understand it, there were 80 Medicare beds at AMHI, and then in the -

A. Yeah, it went from 222 to 202 to 86 to - well, basically 16, and then try and reinstitute 30.

Q. In your Medicare narrative, when you went to that meeting in Boston last April, you stated that you were willing to reduce the number of Medicare beds from 80 to 76 at that time. And then somewhere, I'm not clear right now where in there it went to 30.

A. 86 to 70. There were three units -

Q. Maybe I got that backwards.

A. Yeah, the 30-bed admission unit, the 40-bed older adult program and the 16-bed infirmary, and we were saying at that time that the infirmary was one that has a - that's under a different provider number. And so as a matter of fact, probably to this day it still remains a Medicare unit.

Q. Okay. As I understand it, today we do have 16 Medicare beds.

A. Yes.

Q. When and how is the decision made to go from 70 to 30? Could you just explain that? Who made the decision and what was the reason for that?

A. The reason for it is to try to give us the best sort for certification. The decision is basically a jointly held decision amongst, let's say, myself and the Commissioner, the Associate Commissioner.

Q. And was there a plan - after you decided that then, once we got

recertification for those 30 beds, we'll start trying to work up so we get more Medicare beds back?

A. No. There was a plan to create the senior rehab unit and convert that to a -- licensed SNF ICF unit which would generate revenue and also create a better environment and create a treatment program more conducive to the care and needs of the people we were dealing with. So in that respect, it was almost like getting Medicare on the older adult program, we'd be getting dual licensed nursing home beds on the senior rehab program.

Q. It is confusing.

A. It's hard to make it any -

Q. But in a way, it seems to me, that since we reduced the number of beds to 30 that - we've been throwing around a sum of $41,000 a day that the state is losing in Medicare funding, and isn't it really true that we lost a lot more than that by reducing the amount of beds? That's just where I'm not clear at all.

A. The 41,000, I think, would be Medicare for the older adult population and the admissions unit, and Medicaid for those over 65, and they're roughly equal numbers, 650 apiece, I think. Okay, to get Medicaid funding for people between the ages of - over the age of 65, you have to be in a Medicare bed, okay? So you have to have a Medicare certification. So when Medicare was thrown out for the older adult program, we also lost Medicaid for those 65 and older. Now the same rules don't apply to those zero to 22 that Medicaid will pay for if you're joint commission accredited and have active treatement. So those are the requirements for the

zero to 22 population. So what was the plan? Certify the 30-bed unit for Medicare and convert what used to be the older adult program with Medicare funding, convert that to a more appropriate in terms of care given and get Medicaid funding for a bunch of people who weren't getting any funding and make up the difference that way. So that was a good move, still is, and it makes sense.

Q. That helps a little, but I had one other thing. The JCAHO funding, I think you said yesterday that you thought that if we didn't make some increases in staffing, we would really be in danger of losing that accreditation in October?

A. Joint Commission. Yeah, the difference between Medicare and the Joint Commission in terms of how they view things is one is a governmental agency that's kind of a watchdog of public funds and tends to be, you know, fairly hardnosed. The Joint Commission is a private organization which certainly - you know, accredits people voluntarily, you volunteer to do it, although in reality you pretty much have to do it to get some kinds of funding. They will give you much more rope and much more correction time and handle you in a much more consultative fashion than will the current Medicare surveyors. Medicare is no longer a consultation program, it's strictly enforcement and funding. The Joint Commission does have a consultive role and they see their role as consultive as well as one of enforcing their standards.

Q. But you still are saying that we are in jeopardy of losing that from the Joint Commission next October?

A. Yeah, we expect to receive a number of contingencies, and some of those contingencies will relate to staffing, and nursing staffing is one of those areas that was particularly mentioned in the Exit Conference.

Q. I don't know how much you know about the BMHI situation. I know that they got the letter in December reaccrediting them for three years but there was something like 160 or 170 odd contingencies -

A. 143, I think.

Q. How many, 143? They seem similar to the ones that AMHI would have, a lot of medical record problems and a lot of staffing shortages, so would you say just from knowing that they also probably are in jeopardy unless something -

A. Well, the Joint Commission - the staffing proposal for Bangor in the budget came after the Joint Commission survey, so their request may have reflected more Joint Commission needs and address more of those specific areas. I'm not real familiar with what's going on at Bangor, and the department would be in a much better position to answer that question, but I think that 1.6 was much better aimed in the Bangor situation towards the Joint Commission because they had the survey.

Q. Okay, because their inspection, or whatever it was called, was last July, wasn't it?

A. Yes.

Q. And so they did have a chance to come in --

A. I don't know if they have any additional needs or not.

Q. Just one last question. Of course, you could take the rest of the day on this, but if you can make it brief, anybody in the kind of management position you've held probably would have a vision, you sit back when you have a chance and you think how would I like it to be. Can you tell us just in a couple of minutes what your vision would be, not just for AMHI but for mental health services in the State of Maine?

A. I would like to see Maine have a system of mental health care whereby there was a local or a distributed or regional approach to planning and budgeting and gate keeping. Money would come from a central source and be given to them. I would like to see the budget that goes to AMHI primarily in their hands, so that they would then be in the position of purchasing care from the State Hospital, or not purchasing care from the State Hospital. If they chose to build a group home and house eight people that would reduce their need to provide in-patient care, great, and that would create - by doing that you would create an incentive for someone whose got - I've got a budget and I've got gate keeping responsibility. If I have those two things, then I can make some reasonable choices at the local - at a local or at least a regional level as to what should be done. If I don't have that, if I've got gate keeping only and I don't have the money, then I say, well, send them to the State Hospital, why not, why should I have to break my back keeping people out of the State Hospital when I can just send them to the State Hospital, the patient's gone, what the heck. I'm not saying that that's the attitude, but

I'm just saying, to kind of dramatize the point, that an incentive for finding the most cost-efficient and effective way of providing care lies almost exclusively with the state, which is a very centralized situation right now. It's very difficult from Augusta to try to do mental health planning, budgeting and make gate keeping decisions in that kind of a setting, so that's the first thing, set up a system of care. And, of course, the other thing I'd like to see is that any kind of - the initial care or acute care, if you will, the kind of stuff that comes into our admission unit, as much as possible handled in the locality from which people come. Now, granted, there are some problems with that. Not every general hospital is going to want to get into this business at all. There are a few that will, but where possible, that should happen, and it happens best where the people have the money and the planning and the gate keeping responsibility of working with the general hospital because they've got an incentive to work with them. And so they might put lots of time and energy into developing that contract and having the case management and everything in place for people who are in that kind of an in-patient setting, so as much as possible, local in-patient. And then you get into the need for a large variety of services so that people can live in the community, that means residential options, vocational options, recreational options and transportation options, and, of course, medical followup, you know, medication, medicine, medical followup. So that's - if you read the blue book, there's a lot of all that in there. As I see the role of the State Hospital, it would be less

the acute program that it currently is and more of a secondary and tertiary backup to what's going on in hopefully local or a more regional process. It doesn't make sense for us to have this specialized program because there's only maybe one or two people who would need it, but if you take a whole catchment area, you can have programs which specialize in certain things, you know, like a man - I'm throwing out head injured. I'm not throwing it out because I think head injured people should be in the State Hospital, I think that's probably not where they should be, in fact I'm convinced that's not where they should be, but there are various target groups that might fall out that would be inefficient for a local community provider to fund or try to plan our budget. So basically a smaller role for the State Hospital and over time keep making it as small as you can. Have some kinds of bridging mechanism for the employees and the people who work at state hospitals to move from institutional settings to community settings. I hope I didn't take too much time, but that, in a nutshell, would be what I would like to see, and a very open process of decision-making and planning and so forth as to what the needs are and then you've got a good system, and I think you've got a lot of the pieces of that system right here.

REP. CATHCART: Thank you.

SEN. GAUVREAU: Thank you. The next questioner will be Representative Clark.

EXAMINATION OF MR. DAUMUELLER BY REP. CLARK

Q. Thank you. When we broke at lunchtime I was asking you to take

us to your older adult ward where you said there were 55 to 60 patients. How many of those patients at any one time would you say would meet the definition or the description that you just gave of active treatment? Maybe I should back up. What would you define active treatment? You used that term when you were responding to Representative Cathcart.

A. Active treatment is a planned, purposeful, coordinated approach to care using an interdisciplinary team and carried out by that team. So you assess the patient, find out what they need, you put the plan together, you implement the plan, assign responsibilities and you carry that out. You write progress notes. Those are all evidence of active treatment and it depends on how strict you want to be with the definition of active treatment. You can make a case for active treatment in many of the cases of those people, but in reality, the kind of treatment that we'd like to provide is not particularly prevalent. Truly individualized care, truly following up on all the things that people plan for the patient, I don't think that that's being delivered in anywhere near the level that the staff and everybody else would like to see.

Q. When you're cited for deficiencies in terms of charting, are they really not citing you as much for the charting itself but for the fact that you have not planned or don't have the personnel to carry out that plan, is that really what that is?

A. The chart is the evidence that the surveyor has that something happens or doesn't happen, so when the chart shows that the assessments

aren't proper or that the treatment planning is not based on the assessment, or the progress notes don't seem to reflect back to the treatment plan, or that progress notes don't reflect very much happening with the patient, all those are indications that the care is not where it should be. And so the question is, is it just charting, the technique of charting is part of it, yes, but, no, it isn't just charting.

Q. So in essence, when we get cited for bad charting, we're really getting cited for the fact that we don't have the people to do the work that the reviewer wanted to see on the chart?

A. That's my opinion, yes.

Q. Thank you. One other question. We've talked a little bit about models here. We talked about the medical model and we talked about the rehab model. Was it your intention as the superintendent that all of your wards would operate on this same model or did they operate on different models?

A. Well, they're all pretty much operating on the medical model. I think in our hearts we'd all like to operate a little more on the rehabilitation model, okay, so there's a lot of us who are conflicted about this. And Medicare and the Joint Commission are all telling us the medical approach, doctor-nurse approach, but the things that I think really help people get through their illness and live successfully in the community are - come out of this rehabilitation model, that in some ways it's from AMHI's past, the structured learning therapy and the good linkage with providers and so forth. So I have definite ambivalence about moving

so much to the medical model, but I think we're forced into it, I don't think we have much choice. I think that's the way the world is. If you want to be a hospital, if you want to have joint commission, if you want to have Medicare, then you are going to have to be a hospital.

Q. Would it be correct for me to say in your opinion that at the current time AMHI would not - does not meet any of the - that none of those models really prevail?

A. I think we run, generally, on the medical model, and there are some -

Q. Except that you've told us that we don't have medical physicians and we don't have enough psychiatrists -

A. Yeah, and that creates some problems.

Q. We don't have enough nurses, so how can we be running on a medical model?

A. Well, you can run on the medical model and still not -

Q. Without the people, huh?

A. Yes.

REP. CLARK: Thank you.

SEN. GAUVREAU: Representative Pederson.

EXAMINATION OF DR. DAUMUELLER BY REP. PEDERSON

Q. Bill, I was interested in your - you must have a team effort then on your level at the hospital, and would you describe what your team would be at that level at the hospital?

A. Four inter-directives, the discipline heads, which would be medicine, that would be the clinical director, the social work,

psychology, activities. The assistant to the superintendent is in that team, as is the chief of hospital services. We also bring in personnel and research evaluation. That's the general team. Those are the people that report to me, basically.

Q. Was it that team that would help you to make decisions on your level then, as far as you would say is the amount of people that you would need in that type of thing?

A. Yes, they are. Unfortunately, one of the fallouts of preparing our package was the amount or lack of involvement in the team, simply because it was fairly tightly held and close to the vest and operating outside of our normal process of development of goals and objections, which run in parallel to that, and whose finish date was after the date of the proposal submission. So in some respects our proposal was outside of our planning effort.

Q. There was an incident that I read of the head of the hospital that involved a lady that had a broken hip and she did not get any medical attention for something like 24 to 48 hours, and I believe that she was also under the psychiatric supervision of Dr. Rohm. Do you happen to recall that incident?

A. No. This could be one where - when you say it didn't get medical attention, was not seen by a physician or didn't get an x-ray?

Q. I was under the impression that she did not - was not seen for medical attention or an x-ray.

A. I would think that the nurse did an assessment, a clinical assessment, and perhaps there were no clinical indications of a

break and then it was discovered. That has happened. I'm not sure which case you're referring to.

Q. I'm not either. I read this and I've been looking and looking to get the particulars on that to verify that. I just thought I would ask you that. I'm still looking, and pershaps I will come up with it.

A. Yeah, that's probably from what the DHS - see, I don't have all the papers relating to the DHS actions, that's not part of my -

Q. And I believe - now, we've talked a lot about accreditation and JCAHO and HCFA, is it possible that they can come in and survey one section of the hospital and actually only be interested in, say, maybe your admitting ward and not really be interested in anything else?

A. Yes. In fact, that's their instruction. They are to look at only the distinct part coming under Medicare and services that would relate to that distinct part.

Q. So, in other words, they would not be surveying the rest of the hospital?

A. Right, unless they did a full survery. Normally, if you have Joint Commission, you have what is called deemed status, and then Medicare will only survey you on two conditions of participation, staffing and medical records. If you get selected for a followup survey or a special survey, they may do the whole Medicare survey, which is very much like a Joint Commission survey. So then they would go through governing body and quality assurance and infection control and all those other things that the Joint Commission go throug

but normally they would just do the ones - just do the two conditions and accept your Joint Commission accreditation as being sufficient.

Q. I'm a little confused. The Joint Commission could also do the same thing?

A. No.

Q. They do the whole hospital?

A. Yes, they do basically everything. Medicare says, yeah, you can do everything but we want to still take a look, for psychiatric hospitals we still want to look at staffing and medical records.

A. Okay. I wasn't sure whether the Joint Commission would come in and say, well, all we're going to, you know, credit you on is your one ward with this inspection.

A. No, in fact that's one of the major differences. They're looking for assurances that there's a single level of care for any given group of patients, so they're looking for equality of care across lines, across units.

Q. Now that you are no longer connected with operation, do you have an opinion on the - if a consent decree was advanced for the mentally ill, do you think that would be helpful? I would assume that that would address not only the hospital but the community.

A. Outside of a suit, outside of like a class action suit and just say we're going to agree to do this and it's like the Pineland decree?

Q. Yeah.

A. Yes. I think if it could be done outside of the antagonism and the horrible upheaval and looking - constantly looking backwards of a court hearing, to come up with some general agreement as to what should be done and put that in some kind of a binding document, yeah, I think that would help.

Q. Okay.

A. And I'm not saying that it has to be a consent decree, I'm just - I think it's horrible that you have to have a consent decree, if that's what someone would call it, but basically an agreement between the state and somebody else that this is what's going to happen, I would think that that would be helpful.

Q. I belong to a family group and one of the concerns from time to time is the emphasis put on one ward of a hospital and reducing the care that has been given other places, and this happens in various ways. I think we see that as an impact on the HCVA accreditation. When you attempt to get a certain ward accredited, you tend to pull staff from other areas and beef it up, and this reduces the care that is ongoing in the other areas. I have some people that were very concerned when they started the forensic unit, that it seemed to reduce the level of care in the rest of the hospital at that particular time. Do you recall that?

A. Yeah, what happened there is that in some respects it did. It was a legislative - you know, that was the will of the legislature to establish that unit, which we carried out and completed it February 19th, I believe. Because of the security of that unit and putting - trying to put a program together, I think we have a fairly decent forensic program, I think maybe one

of our better pieces there. It did perhaps pull - it did pull some people from other areas and enriched that staffing level maybe at the expense of some other areas.

Q. This is kind of like some of the other things, that we're mandated to do certain things and sometimes not given the resources. Was that a situation - was that a comparable situation?

A. Yeah, the funding for that program was - that preceded my coming, so that was in place.

REP. PEDERSON: Okay, thank you very much.

SEN. GAUVREAU: Representative Pendleton.

EXAMINATION OF MR. DAUMUELLER BY REP. PENDLETON

Q. Mr. Daumueller, when you took your job at AMHI, were you presented with a job description? Do you have a written job description or was there a written job description for superintendent of that facility?

A. There was a job description. I don't - yes.

Q. Okay. This morning Representative Dellert and Representative Burke alluded to a policy book and a procedure book. Who is responsible? And you said that there was one - I guess there was one procedure, maybe, that was missing from the book, nobody could find it. Who is responsible to have those two manuals prepared?

A. Ultimately, I am. I think the superintendent is responsible for most everything that goes on in the facility, whether he does the job or sees that it's done or attempts to see that it's done, so the responsibility is there. In terms of who does it, generally the policy manual is kept by the assistant to the

superintendent, although there is Policy Manual A, which is one set, and B, which is another, which is more clinically oriented policies, which is primarily kept up by the professional consultant for nursing.

Q. And previously you were alluding to the Friday reports that all department heads send in on Friday, I guess, to the central office. Were you using this Friday report as a vehicle for requests or recommendations, is that possible?

A. The Friday report is to give an assessment of - it's like the pulse, the weekly pulse of the operation and to reasonably accurately reflect what went on of interest or that I felt should be reported.

Q. So that would not be a vehicle for a definite request for anything, is that what you're saying?

A. No, no. That would be a way of portraying conditions.

Q. Then yesterday you alluded to a December 9th memo, and you said in that memo you made recommendations and requests. You said you had made a request for additional staff, December 9th.

A. No, September 22.

Q. '88. This was the one - the subject was the JCAHO.

A. Okay, all right.

Q. I'm a little confused, because the December 9th memo is not a request for additional staff, it doesn't look like, because it says -

A. No, I don't recall saying that I made a staff request on December 9, I said September 22, I think.

Q. I wrote it down December 9, I put memo, because I was keeping a chronological list here. Perhaps you misspoke?

A. What's in there - what that memo is is the Joint Commission survey impact on our readiness for Medicare. That outlines what - you know, my analysis of what the impact of Joint Commission was on our readiness for Medicare, and it indicates that the Joint Commission had - the survey had some cost implications in it, and I just briefly outlined them at the bottom. Have you got the memo?

Q. Yes.

A. Okay, where it talks about the areas, physical plant, the pipes and emergency power and other life safety issues, staffing, our reduction in patient load, RNs, housekeeping, and then I say that MDs, clerical, QAs not specifically suggested but implied as areas of need. Now I don't call that a staff request.

Q. Okay, so this is not a request and it's not really a recommendation either, it's just a report?

A. That's a report and an alert that there are implications -- there are resource implications to the Joint Commission survey.

Q. So in it you said the list is long but not overwhelming when taken one item at a time.

A. Hm-mm.

Q. So I'm just wondering, maybe I would get confused or mixed messages, because if someone said to me, you know, this doesn't look good, we need this, this and this, and then they said but it's not overwhelming, is it possible that maybe the communication wasn't strong enough, is that a possibility? Could some of these

things maybe have occurred because there was not a strong demand on the situation?

A. Well, I guess there's the English language and saying what you think you mean and saying what you mean. I think I've pretty much said what I meant here and the list is long. In other words, I expected to see a list of 150 contingencies or whatever, or something similar to what BMHI got. Most of those things, they're laundry lists and a lot of them can - you know, are administrative items that can be handled fairly readily. At the same time, amongst that list of long laundry lists, most of which taken one at a time can be handled, there are some resource implications, and that's what's at this summary.

Q. Okay. So you weren't really flashing any red lights then. I mean, this doesn't sound like you - you know, you weren't really excited because you said it's not overwhelming, we can do this piece by piece by piece, so you weren't like, yeah!!, we've got to do this or we're dead?

A. Well, I don't know that I would read this that way. I wouldn't read it the same way you're describing it. You wouldn't -

Q. You think this is pretty exciting?

A. What's that?

Q. You think that this is a pretty demanding memo?

A. I'm saying that in reading this memo you would look at it and you would say that there are resource issues that Joint Commission had brought to our attention, and I don't see how you could read it and get any other conclusion.

Q. I'm more excitable than you are.

A. The other thing is, we had a conversation about this memo also. In that conversation I also pointed out that I thought that Joint Commission was in reality more of a problem than Medicare because it applied to the entire facility, and we're trying to gear up the entire facility as a - you know, that's a big, big problem.

Q. So did you tell that to Commissioner Parker and say, look, we've got a big, big problem here, but that's not in writing?

A. Yes, and I was told - well, no, it's not in writing.

Q. It's a conversation.

A. I was there. I can tell you what I said and what was said to me, that - I particularly remember that one well.

Q. Okay.

A. The comments on that comment - my comment was that we simply didn't manage the survey properly and that had we managed the survey properly, this stuff wouldn't have been cited because we would have had a different nurse surveyor or something.

Q. A different nurse -

A. Do you remember the comment about New York?

Q. Yeah.

A. Negotiating their survey with Joint Commission?

Q. Yes.

A. And I didn't know that that was possible, and so maybe I'm stupid.

Q. No.

A. If it is possible, fine, I didn't know that, but that was the conclusion that she arrived at, basically poor management for not setting the survey up better so that we'd pass it.

Q. I see.

A. By arranging for a nurse surveyor of a different - with psychiatric experience.

Q. Background, because this nurse was hospital oriented and you were looking for a psychiatric -

A. Yeah, but then the standards are hospital oriented because they're called a hospital - HAP standard, it's a hospital accreditation program standard. It's a tailored survey that includes the HAP standards, the consolidated standards, which are more psychiatrically oriented and come from a different section JCAH, and the long-term care standards which apply to the nursing home section.

Q. And then again on February 11th you had a meeting and you said you gave a packet of materials and a fact sheet, and at that time you said we're on the edge of disaster.

A. Yes.

Q. But then I thought I heard you say on February 12th you said things had calmed down. Is that true, the very next day everything was just kind of -

A. What I said was we are on the edge of disaster with no reasonable resource response for an influx in patients, which is true, and then I also said for the first two weeks of January things have calmed down but we have every reason to expect from past

experience that they would heat up again. That's not a quote, but that they would again get more - get busier.

Q. Okay. Perhaps I - could I have just put down the wrong date maybe?

A. Okay, let's see - after a fairly extreme January, things seem to have calmed down for the first two weeks in February. From previous years, however, we have every reason to expect substantial increases in admissions and high census due the first quarter.

Q. So that was on February 12th?

A. Yes. And then the next report, after a heavy weekend in terms of admissions, we're back to the 365 census level, acuity consistent with recent past and a bit more crowded than we would like coming into our Medicare survey.

Q. I just - in your job description, did you have the responsibility of overseeing the financial management of AMHI? Is that part of your duties?

A. Financial management, there are a couple of areas where there's significant central office oversight. Finance is one of them, finance and personnel is one of them. To answer your question, yes, but there's an awful lot of central office oversight in the area of finance, personnel, data processing.

Q. But did you have people reporting to you on a regular basis regarding actual versus budgeted expenses, people - you know, because you were overseeing other people? I imagine you must have had like unit -

A. Chief of hospital services, yes.

Q. Okay, and you must have had probably some put in - you know, input from the different units -

A. Yes.

Q. From the, you know, heads of the units.

A. Yeah, when it comes to putting in our budget, yeah, they all sit down - sit down with each department and go over their needs for the year and so forth.

Q. Whole communication type system?

A. Yes, each department was - you sit down with - you know, each department would sit down with the chief of hospital services, go over their budget and, you know, it's a fairly detailed document. I would look at that to some extent but generally deal with the larger document.

Q. And how often were you able to sit down with the different people when you did this planning, when you went over the budget, the actual budget versus the -

A. With the financial people?

Q. Yeah, with your staff people. You know, you would sit down and do this and then you -

A. I don't know, three or four hours or so on a budget, I guess, with the financial people after it's put together, after all the departments have come together and gone over their budgets. I don't know if I'm - I may not be getting the thrust of your question. Is the question do the department heads have anything to do with their budget or have a -

Q. Yes, and how often you - you know, they were able to give their input.

A. On their budget, the budget is a cyclic thing, okay, and the chief of hospital services would meet on a daily basis with his staff, and the chief of hospital services is every day at the table, as is about nine or ten other people.

Q. Then if you were significantly over your budget, or you were under your budget after you meet with your financial people, then I'm understanding you correctly that you would report that to central office, which would be the commissioner, is that right?

A. Well, one of the things about our budget is that we've never had a budget that was in any respects a reality, because from virtually the time it's conceived, you know that it is going to be back in your lap the following year coming up with a request for additional funds. It's one of the frustrating things, that the budget process essentially says tell us what you need and then, well, that's too much, now here's what we're telling you that you're going to need and you put this into your request. I think they call it target budgeting or something, but the department is basically given a target, and so that filters through the ranks, but it's not a zero-base budget or anything where you say this is all our needs and it goes up the thing and it gets pared back up the line. Bascially, it comes back to you and then you resubmit it as a budget that fits the target allocations.

Q. But if you were like really over that budget or under that

budget that already had been planned in your day-to-day operation, like if I was a nurse and I came to you said, geez, we're short this and this and it's not budgeted, you would know that?

A. I would know it or I could find it out pretty quickly.

Q. And then that would be reported to central office, if it was significant?

A. Not particularly. You know, that - no, not necessarily. The central office would know about it anyway because they get - they have their allocation sheets and it shows we're over or under. Probably Ron Martel would have a better sense of whether I was over or under a budget more than I would.

REP. PENDLETON: That's all, thank you.

EXAMINATION OF MR. DAUMUELLER BY SEN. GAUVREAU

Q. Mr. Daumueller, we heard some reference from Representative Pendleton to an assessment which apparently was crafted by you in response to a JCAHO evaluation. Is that document - do you have that document? I was looking for it a few moments ago. Apparently you made - that was a memo from you to Commissioner Parker, is that the document to which reference is being made? When did the JCAHO accreditation team come to AMHI last fall?

A. Their Exit Conference was December 2.

Q. And this was dated December 9 in direct response to that assessment, is that correct?

A. Yes.

Q. And is it your position that in the body of this memorandum you communicated to Commissioner Parker the potential for loss of

Medicaid funding?

A. The bottom of Page 2.

Q. Under the summary?

A. Yes, and that's in outline form. I tried to highlight the dollar items.

Q. You say, with this concerted effort our chances are fair but shaky, increasing with time and decreased workload, we're shooting at a moving target. But you say that - within the body of the memo, you make reference to the possibility of a loss of Medicare or a loss of accreditation which would remove our deemed status.

A. I think I said I felt we would get it and - with many contingencies, and then the thing with Joint Commission, I still don't - I don't think we'll lose Joint Commission. What we'll have are contingencies. The implication - the financial implications are, if we're to meet all the contingencies that are cited, that there will be dollar implications to meet those contingencies. Joint Commission, I think you - if you will, you can string them along or they will go a long ways with you before they finally cut you off in terms of their accreditation, so they will give you some time to correct the deficiencies, unlike Medicare.

Q. Right, I understand that. And I heard the commentary relating to the need to augment RN staffing complements by 40 or 50 to address JCAHO concerns. Were there other focused staff - staffing configurations that -

A. Well, they specifically mentioned housekeeping, and the reason they mentioned housekeeping is the weekend coverage and the

fact that certain nursing personnel were having to augment housekeeping personnel, and so they saw it as taking away from the direct care that those people should be rendering, and so they felt that we should beef up our housekeeping staff and relieve direct service care providers from that task.

Q. And you told us this would be a delayed effect, they would probably come in with an accreditation with contingencies. You were looking at six months or nine months out as far as that occurring?

A. Yeah, about nine months from the time of survey, I think is the schedule. We would probably find out what they said in 90 days to 120 days, three to four months.

Q. So this was the time bomb that was made reference to yesterday and Representative Boutilier indicated that we may have to come back in in a special session, and if, in fact, we have an accreditation with many contingencies?

A. If my judgment is correct, you can call it a time bomb. In other words, there's a problem there that is not addressed.

Q. Now, there's been many questions asked in terms of how you communicated your concerns to the Commissioner. Did you, in fact, personally communicate your concerns regarding potential JCAHO accreditation with contingencies to Commissioner Parker?

A. That was the meeting that I referenced.

Q. Okay, and that was sometime in the month of December, shortly after the survey team came in?

A. Yes.

Q. And was it your impression that she understood the potentiality of a loss or a diminished status of JCAHO accreditation?

A. At that point, it was my impression that she didn't have much credence in what I had to say and that she wasn't buying that and felt that it was just a mismanagement of the survey.

Q. So she - it was her - you felt she didn't take seriously the potential of loss of JCAHO accreditation because she felt the survey wasn't done in an appropriate fashion?

A. She felt it wasn't managed properly, yes.

Q. And you felt personally that she was aiming some of her concerns at you?

A. Clearly, yeah.

Q. Well, how was that meeting resolved? What action did she indicate she would take to determine whether a re-survey should occur or in other ways the accreditation should be reviewed?

A. That wasn't a particularly productive meeting. I don't precisely recall what, if any, outcome there was.

Q. Well, I thought after four days I'd be rather tired at this juncture, but I am surprised. If I understand correctly, that shortly after the JCAHO accreditation team came in, that you, by written correspondence to the Commissioner and then by verbal communication, indicated that there was a likely - a significant possibility that we would either lose JCAHO or more likely we would have JCAHO accreditation but with many contingencies which would have a price tag.

A. Many contingencies, and without resources would not be able to

meet those contingencies, but even if we didn't meet them, we might be able to, you know, play it out longer but -

Q. So I guess the real issue - what action did you understand she would take in response to that report?

A. I didn't think she'd take any action.

Q. Did that surprise you?

A. No.

Q. Did you feel at that time that you had little credibility with Commissioner Parker?

A. I think at that time, yes.

Q. Now you left the department on or about January 11th of this year?

A. Yes.

Q. To your knowledge, had any action been taken to address the concerns in the JCAHO accreditation or a report?

A. No. I do know that staff had met to look at staffing. I've mentioned that right at the beginning. I know that -

Q. But if I understand you correctly, it was your impression that Commissioner Parker thought the problem was more glitch in the way that the survey was conducted than in the actual underlying conditions at AMHI?

A. Yeah, basically mismanagement of the survey, yeah.

Q. I suspect we'll have to take that up with Commissioner Parker. Thank you. Could I ask that this be reproduced for me and other members of the committee may want to have that document. Please make it up for the entire committee. Now aside from the issue of

the RNs, assume for sake of argument that your interpretation of the assessment is accurate and that we are looking at a potential of multiple contingencies as a predicate for JCAHO accreditation. What aside from the RN staffing complement, what other issues must the state address to avoid any such contingencies?

A. There's a very - one of the primary thrusts of JCAHO is the leadership of the medical staff as well as quality assurance throughout, in the medical proper as well as other clinical departments. There have been a number of attempts to devise quality assurance indicators and so forth, and the real problem has been finding someone to go through and dig this stuff out and just to be able to do it, and it's a manpower issue in terms of quality assurance personnel to go through and do qualitative audits in the area of pharmacy, our pharmacy or the pharmacy is not computerized, so there aren't a lot of ways to do good provider profiles and so there's a lot of difficulties in trying to put together a real slick quality assurance program.

Q. Well let me very quickly - we have to report to the legislature on how to so-called fix the problems at AMHI.

A. Yes.

Q. I think that's a quite ambitious task in what we've heard the last week, but I want to, as best as I can, make focused recommendations -

A. Okay.

Q. And so - and maybe it's unfair, and if it is tell me, to put you on the spot now and say what - if it's too copious a task, maybe

we could reduce that to writing at some other point, but I would very much like to know your impression on what actions the state must take to address the gravamen of the JCAHO survey.

A. Okay, one area is just a generic data processing area, and that's a need to maybe upgrade that, and to devise some clinical applications for data processing as opposed to strictly administrative, take some of the load off the direct care workers and try to make their life a little easier. And also, in some respects, produce some records which are not written by hand and impossible to read and have some more things - more of the record come out in the form of typed material. I think that would be nice. The area of quality assurance is going to take some manpower, I think.

Q. I see. So you mentioned those in the memo to Commissioner Parker? I've got - I have them now. Okay, I'm sorry, I didn't find them earlier. So that is a fair summary of what you feel one must do?

A. Yeah.

Q. And do you have an impression as to the numbers of staff which might be involved to address these concerns?

A. The specific ones that relate to Joint Commission, you - I believe we discussed maybe four or so QA people, and that may be four or five or -

Q. Quality assurance?

A. Quality assurance people. Housekeeping, I think 16 housekeepers would get you weekend coverage.

Q. Sixteen, and that's for weekend coverage, primarily?

A. Yeah.

Q. Okay.

A. That would get weekend coverage and backfill some housekeeping areas. Nurses, I think we talked about 50, and there - perhaps somewhere between 30 and 50 but 50 is the number that keeps coming up. But what's really going to impact on the quality of life of the patients is mental health workers, and, of course, that's the big number. That's where I talk about one for one basically. That's where a lot of the cost is.

Q. And that's the number of the 206 or whatever the number that comes up?

A. Yeah.

Q. Two hundred and six mental health workers?

A. No, no, I think it was about 100 mental health workers, and there was housekeeping in there, physicians.

Q. We only have two physicians serving the entire hospital community?

A. For medical problems, yeah.

Q. And based on what your understanding of what JCAHO was, what should we have?

A. Well, I think we should have four.

Q. A total of four or four more?

A. Four total.

Q. So two more?

A. Yeah.

Q. How about psychiatrists?

A. Probably 14 to 17 psychiatrists.

Q. And we currently have six?

A. We currently have ten.

Q. So we need to add another four to seven psychiatrists?

A. Right.

Q. Now were these mentioned in the memo or in some other documents or communicated to Commissioner Parker, the actual numbers of people?

A. The numbers of people, that would be September 22nd, and that's when I gave my off-the-top-of-my-head estimate of need for Joint Commission and quality of care and Medicare and everything else, but with the idea that isn't it great that we're going to reduce the population, so that was the other side of it. It's kind of like let's weigh the balance.

Q. Now we came into session, I thought it was the earlier part of September of last year.

A. September 15, I think.

Q. So were we out of special session by the time that you had that discussion with Commissioner Parker?

A. That was after the special session.

Q. Okay. So did you acquire the knowledge of the need for the additional people contemporaneous to or after the special session, or was that known prior to the special session?

A. Well, I think my estimate of 206 is - roughly conforms to what I had felt for some time.

Q. Well, we had a total package of 128 people, or 130, whatever it is, that dealt with the entire acute care mental health system. Now, was - of those 206 people, were any of those included in the package which went to the legislature in the special session?

A. That would be over and above the special session.

Q. Did you - for my benefit here again, I've been in and out, when did you tell Commissioner Parker, or when did you advise Commissioner Parker of the need for those additional 206 positions in reference to the special session date?

A. That was - for 206, after the special session, and although -

Q. After the special session?

A. Well, I had mentioned it offhand that I felt that the last time I had done such an exercise, I think it came out to about 196, and I had mentioned that.

Q. When did you initially mention the 196?

A. Well, I think I maybe mentioned that a number of times, basically, in conversation relating the high cost of upgrading the facility versus the much better option of reducing the population.

Q. Would it be fair to say that among the several times you've mentioned that to Commissioner Parker, you mentioned it before September of '88?

A. The one mention that I can clearly, unequivocally remember was to Ron Welch, but I -

Q. And have you a time frame for that?

A. It was before the special session, but I don't - well, okay.

Q. I'm just asking if you can recall. That's okay.

In any event, after the special session, you were of the opinion that we needed 206 positions?

A. Two hundred and six positions or reductions in workload.

Q. Or a reduction in census, yeah.

A. To do everything that I thought people wanted and expected of us, and after having the hindsight of the patient deaths and the added scrutiny that was upon us, so after all that had happened, yeah.

Q. Now let me - see if I get this all straight. The 206 positions, are they what you deem we need to meet JCAHO accreditation, or are they what you feel we need to administer appropriate quality of care at the institution?

A. That was to roughly do both. I think if you look at the Joint Commission recommendations, I probably would have had to make some amendments in light of the nursing recommendation and the subsequent followup.

Q. So in any event, as the department was framing its current budget request for this year, by the fall of '88 you had communicated to the department and to the Commissioner that we did need to add on around 200 positions to the department to meet these issues?

A. It was framed to care for 383 patients. To do everything we should do, this is what we should have. It's a better option to reduce the population, and if that's successful, this isn't necessary, okay? So if we drop the population down and primarily, you know, through the -

Q. But it seems that aside from steady prayer, there seems to be little likelihood that we're going to reduce the census at AMHI to levels around 310 or 320, or whatever we deem appropriate.

A. Well, that was becoming more and more apparent as time went on.

Q. And what's most disconcerting is that the numbers at the institution were in the 360s and 370s, and from the chart the Commissioner gave us last week, there seems to be no relief in sight.

A. Not unless there's a rapid development of an in-patient program.

Q. And in your judgment we're not likely to see anything that's going to bring us about a rapid decline in the population in the short term absent that kind of in-patient program?

A. Absent that kind of in-patient - the rapidity of it, it will take some time to develop.

Q. It just seems to me that, having sat here for a better part of four days, the department has seriously underestimated the likely census of AMHI, and along with others, I agree that the long-term plan makes sense, but I just don't think that people are being realistic in terms of the short term.

A. It would be fair to say that there may be some miscalculation in that area, but the design of it and the thrust of it was positive, but the implementation is a problem.

Q. And the other issue that everyone has poked at over the last three or four days has been the whole issue of resource availability, and you've told us that the environment or the climate was such that requests for significant staffing would not be looked on with great favor, is that true?

A. Yes. Well, and it was true in September of '88, also.

Q. You folks have been asked to make a 4% cutback in your - at AMHI, which you resisted.

A. Yes.

Q. But you took it by negative implication that one ought not to ask for a 4% increase in your budget.

A. Yes, and I think it was specifically said that there wasn't any staff going to be allocated for AMHI, that AMHI was not in the picture for additional staffing.

Q. With the benefit of hindsight, do you believe that you could more forcefully have made a case to Commissioner Parker, given all the conditions, that you could have made a more forceful case to Commissioner Parker and department officials for additional staffing to meet these needs you told us about?

A. In hindsight, probably, I think so. I wish I had - you know, I guess if I was going to be fired or, you now, asked to leave, I think of all the things that I feel bad about is that maybe it wouldn't have happened some time ago if that's what the result would have been.

Q. But is it also fair that the environment in which you were working on was not conducive to your making those requests for additional people?

A. Yes.

Q. The fact that you were basically working under a certain finite number of - amount of resources, would that be a fair statement?

A. I think it was more like a ceiling and not being in the area of priority and that just wasn't going to happen. Anything we would do would have to be done within the department's ability to manage its internal resources. I mean, that was the message.

Q. And there was a reluctance - at least from your perspective, was there a reluctance of the department to come before the legislature and make a case for additional positions?

A. Well, the department couldn't do that independently of itself.

Q. It would have to have the Governor's approval?

A. Yeah.

Q. But my question was, were you of the impression that the department could approach the Governor and could come to the legislature and ask for additional positions?

A. It was - that was not my impression.

Q. Now you told us that when you had your discussion in December of '88 with Commissioner Parker, that she gave little weight to your assertions of likely JCAHO accreditation status, jeopardy.

A. Yeah, I think she felt that basically that's just the way nurses are, or that this type of nurse is that way or that, again, we didn't manage properly the survey. It was difficult for me to understand precisely what she meant. She did reference the New York - a conversation with New York, someone from New York that had somehow effectively managed that. Of course, New York has millions of people and quite a few more million dollars to the Joint Commission and perhaps might have more leverage than Maine would, but I had no knowledge that that was possible.

Q. Let me just go back to make sure that I'm clear. I'm jumping around, I'm now going to June of '88. You told us that you had requested 18 positions for the so-called Medicare certification issue which were approved by the department and the Governor. Now,

you also mentioned that you had another piece which was rejected which would deal with so-called quality of care staffing ratios.

A. Overcrowding.

Q. Overcrowding, and I wasn't clear whether you were going - were you recommending 42 or 60 additional positions in that piece?

A. It would total 60.

Q. So 18 plus 42 would be 60.

A. Yeah.

Q. Okay. Now, ultimately, AMHI ended up getting 65 positions in the special session.

A. Yes.

Q. So I guess the question I have is, were those 65 roughly the 60 that you had made reference to in June?

A. Yeah, I mentioned that, the conversation that I had from Wisconsin to Ron Welch, let's frame this as a Joint Commission, we want to do the Joint Commission thing, and I said, well, this is - we want to take your piece and put it together as a Joint Commission piece, you know, basically work from your proposal. And I said, well, my proposal was an overcrowding piece, but if that's what it takes to do it, let's go do it, we need the 65 positions. What you should do is - Rick has my stuff, I left my proposal or my sheets with him, Rick and Vic, work with those guys and come up with some additional support staff which would enhance our Joint Commission chances.

Q. But you're saying now that even with the new positions in place, at least authorized, we're looking at 200 positions, or something in

that order to address long-term issues of JCAHO accreditation?

A. JCAHO, Medicare, and a general overall quality expectation that you have advocates and you have DSH and you have medical oversight, and basically in the context of what has gone before, yes. So it wasn't specifically Joint Commission, it was quality of care, Joint Commission, just where should we be in this - to be a, you know, relatively state of the art, very contemporary program providing active treatment and individualized care.

Q. I want to again shift focus to the future. You mentioned in response to one of the members of the committee earlier in the day that what we ought to do is bite the bullet and basically double-fund services at AMHI, is that correct?

A. Yes.

Q. So what you're talking about is maintain the effort begun last fall for a strong, viable community-based mental health system?

A. Absolutely.

Q. But at the same time you're talking about, at least for the next few years, infusing substantial resources to make sure that we do have good ratios, staff ratios, we do have good care until, hopefully, the long - the benefits of the long-term plan can take effect?

A. To really make it work, I think you've got to upgrade the facility on the short-term, and the community, more than what's been done in this initial package.

Q. And that if we don't do that, short of some fortuitous decline in the census, which seems unlikely, we're likely to have some

major problems with Medicare and Medicaid and JCAHO?

A. You now, obviously if something isn't done, the population is just going to keep going up.

SEN. GAUVREAU: Thank you. Are there other questions of the committee? Representative Manning?

EXAMINATION BY REPRESENTATIVE MANNING

Q. On the JCAHO there was talk about - I guess from what I heard you just talking to Paul about, it was basically Susan questioned the staffing, whether or not we had enough nurses and things like that. She kind of questioned you and said, well, New York renegotiated or did something. That was concerning staffing, right?

A. Yes.

Q. Okay. That would have been the RN staffing. Would that also have included the housekeeping?

A. No, we didn't get much past the RN staff.

Q. You didn't get what?

A. We didn't get much past the RN staffing issue.

Q. Okay. But how could they not talk about the physicial plant? I mean, you're talking about locking fire doors, break away toilets and showers, ALP fire exits, exit lights, other life safety things, automatic emergency power generator. I'm under the assumption then that if the power goes out at - in the area - in the vicinity of AMHI all the power goes or -

A. Well, it's a manual start. They're looking for automatic switch-over. I think that was about $100,000, but there might be an equivalency. Some of these things you might be able to have an

equivalency; in other words, it's like an exemption, but it wasn't clear that that was possible when they left, and I don't know that it is. I think Dick Bisson was going to check on that.

Q. Do you know whether other - if they're asking you to do that, then I'm assuming the 42 or the 44 hospitals that are in the - throughout the state, the general hospitals, they must have the same criteria.

A. Yeah, it's basically the life safety - those are the life safety code issues and building issues.

Q. Yet nothing was put into the budget, Part II Budget at all to address it, nor the emergency budget which is being heard sometime this afternoon?

A. No. You remember, they did come on December 2nd, so I assume my budget meeting on Part II was September 22nd, so much of the Part II work would have been done before the Joint Commission came in. But I don't think there's anything in the budget.

Q. Well, I think I heard distinctly the other day that the only thing that's being proposed at AMHI and Mental Health is the $20 million that translates from the 6.75. So whether or not - you know, if there was ever discussions, I would assume that Commissioner Parker would have told us on Thursday that they were going to try to address some of these JCAH standards. In the past couple days, I've got the feeling that you're the one where the buck stops and that the MDs over there, including the psychiatrists, the assistant superintendent, and nobody - in other words, you ran everything and yet there's no line of responsibility

for anybody else? I mean, all hell broke loose, but yet nobody else is responsible except for you. I don't know if you want to answer that. That's an editorial question, but that's the sense that I got, that everything that went wrong was your fault and nobody else's fault, and therefore we ought not to be looking at the clinical directors or the MDs or the associate commissioners or the commissioners or the Governor's office or anything like that. That's just an editorial. When your weekly memos went to the Commissioner's office, do you know who in the Governor's office was reading those? Do you know if anybody in the Governor's office was reading those?

A. I had heard at one point very early in the game that they were read faithfully. But, there again, I really have no knowledge of that, because they were emphasizing getting them in and getting them in on time and not - not doing them, so it was important for us to do them faithfully.

Q. I'm just curious, because I think you used the word to Representative Pendleton, you know, common English, you read those yesterday. I think a high school educated person would assume that, after listening to some of those, that there was something wrong. Maybe I'm wrong, but it would seem to me those were in plain English, indicating there were a number of increases in the census, the acuity of the people going in there was going up, and it just - I just don't understand where two years ago, 1987, March of 1987, the Governor of this State walked through AMHI. Out of that meeting, the Governor asked Ron Welch, who was then acting

commissioner, and I think probably yourself, to come up with some limited position people to get over the hump during that first four months, five months, six months, or the honeymoon, as we called it back in those days, so that the legislature could deal with it on a long-term basis. Those particular individuals were let off, are no longer in employment as of September.

A. September 26.

Q. Yet, the same type of atmosphere was there one year later.

A. Yes.

Q. And yet nothing in the Commissioner's office put a red flag up, and yet nothing in the Governor's office, if the same type of atmosphere was there the previous year, I mean, I think if memory serves me right, you or somebody else had indicated that they were sleeping in the halls, and I think at that stage of the game -

A. March '87.

Q. Pardon.

A. March '87.

Q. March of '87, the census was going up again in January and February and March of 1988, yet there was no more limited positions put on, again, just to help you over the winter crunch. It seems to me, maybe I'm wrong, but is it traditionally that in the winter months the census tend to go up more than in the summer months?

A. Fall and - usually the first quarter, and maybe more recently it's beyond that.

Q. So yet although the Governor okayed limited positions in 1987 and they went out of effect in September, nothing was done with all these weekly memos.

A. Right.

Q. So what - and I think you indicated the staff was getting frustrated because they could not - they had seen the limited position people the year before, but yet the same crisis, the crisis of which at this stage of the game is called management, but back in those days a crisis was of the - was the dealing with the overcrowding, the same crisis existed in 198 - you know, the first part of 1988 as it had existed in 1987.

A. Right.

Q. The crisis of management that Commissioner Parker talked about really hasn't come on board until probably July or August of 1988, and yet the same limited position people were not put on. So maybe what we need to do is talk to somebody in the Governor's office to find out who in God's name was reading those memos and whether or not they need a course in reading. It seems to me that if in 1987 the Governor of this State put on those positions and in 1988 nothing was put on, somebody either in the Governor's office was letting the ball down or somebody in the Commissioner's office was letting the ball down. I want to get it perfectly clear, did you at any time write a memo asking for money to get recertified with HCFA? We talked about the weekly memos - the weekly notes or whatever those things are called. Those were never -

A. You have to use, as I would - and in courts you'd call it circumstantial evidence - in terms of what I was asking for and talking about after the February 23rd. If you look at those memos, you'd have to wonder what I was talking about, the soft spots in the area of activities and so forth.

Q. Well I'll tell you one thing, if I was the commissioner of this state, or I was somebody in the Governor's office of this state and saw some of those memos, I'd be wondering, especially in the fact that we were still in session until the 28th day of April of last year. So you never really wrote a memo? We don't have a memo that says I need, it's because back in September of 1987 you were asked a question, what would you do with a 4% cut at AMHI.

A. I think there have been discussions subsequent to the first -

Q. But that gave you the first real indication that -

A. Yeah, that this was going to be a tough year for mental health.

Q. This is the same year that when we left here on April 28th, that two months later all of a sudden this state has a $100 million surplus, right?

A. Well, whatever.

Q. Right. To get it perfectly clear and to get it on the record, if we lose JCAH, then the monies that go into the Medicare -

A. Medicaid.

Q. Medicaid, excuse me, Medicaid at AMHI, we will lose that also?

A. For those zero to 21.

Q. For those - again?

A. Zero to 21, so that would be the adolescent unit and the young adult unit and whatever - there's some question about the admission unit, since it's not Medicare, whether any money from Medicaid should go into it, but zero to 22 primarily.

Q. But there's a possibility of losing additional -

A. The nursing home would still receive Medicaid.

Q. So there is the possibility of getting decertified from JCAH sometime in - next fall?

A. There's a possibility. Again, I don't think that will - I think we'll get some -

Q. The problem is -

A. What we're going to do about the contingencies is going to be the problem.

Q. The problem is, we didn't think we were going to lose Medicare either.

A. Yeah.

Q. When we talk about hospitals in the southern Maine area, what will it take that is going to -

A. To really do the job?

Q. To really do the job.

A. I think it would be better to have a roughly 40-bed unit than the 20-bed we're talking about.

Q. What if we had the ability to split that.

A. Oh, that would be great.

Q. In other words, 40 beds in Cumberland and York, where there's

20 in Cumberland and 20 in York.

A. Yeah, there's no problem, it's just finding someone who will do it has been the biggest drawback, and then if you double the number of beds, then there's the financial impact.

Q. If memory serves me right, the monies that were put into the special session budget, which was roughly a half a million dollars, that was for the hospital component of that?

A. Yes, purchasing days of care.

Q. And that was supposed to go on line, I thought, if I heard Susan say the other day, February 1st. Do you know whether or not that's true or not?

A. That's as I understand what was projected in the -

Q. February 1st.

A. Yeah.

Q. And as of today, February 2nd, we still don't have anything on line?

A. Right.

Q. So what we need to do, really, is to take a harder look at the projection that we talked about back in the special session and probably double our money to - because I think at that time we were only talking 20 beds for $500,000, so you need to really take a look at doubling that to get to the 40 beds.

A. And it will be - I think the projection was probably based on - it may have been based on general hospitals, so if you would go with a special hospital, there may be some increases in the price.

Q. So if we go to a special hospital, that we can't get a Medicare

certification or -

A. Medicaid.

Q. Medicaid?

A. Yeah.

Q. Medicaid, then the $500,000 is strictly going to be general fund money, we won't have any matching money then.

A. The bottom line, it will cost you more to go with the special hospital, because you won't - the provider won't have the third-party revenue to offset the costs, so it will be more - it will cost more money, general fund money, yes.

Q. So if, per chance, the department comes back with a proposal that it's going to be a - for instance, a JBI, then we'll need to put more money into that because JBI is not able to get Medicaid?

A. Right. I don't know - I haven't sat and talked with them as to how much they think that it would cost, but there's probably a good chance of that. But, you know, if Jay is around, or someone else might answer that for the department. So the answer to your question is, it will cost more money. No matter how you frame it, it's going to cost more money to do it in a special hospital. Whether they can do it for what's in the budget now, I'm not completely sure, and 40 would be better than 20, because then I think you could, you know, have more assurance that you could take all the admissions and provide all the acute care. Twenty beds might do it, it might be a little snug, 40 would probably lock it up for you.

Q. When the Commissioner was here, she indicated that there is a

consultant or consultants were being talked to concerning the - what needs to be done at AMHI, and you also indicated that there is - the staff has already got together and taken a look at what might be needed over there. Am I right in saying that?

A. Yes.

Q. So between the staff already knowing now what they feel is there, and a consultant coming in, hopefully that would speed the process up so that we would be able to get some type of an emergency piece of legislation back from the department fairly quickly?

A. I would hope so.

Q. I guess to finish up, it's safe to say that when you were hit with surprise, what can you do with a 4% cut at AMHI, that set the stage for the last two years?

A. I think in many respects that's true.

Q. Knowing fully well that we were in a crunch - the budget was put together October of 1987, roughly, the supplemental budget for last year?

A. Roughly, yeah.

Q. Roughly middle of the fall?

A. Yes, we were having budget meetings.

Q. So roughly middle of the fall of 1987, after the limited position people had already gone through the cracks, you were asked, knowing fully well the year before we had a crisis at that time and it wasn't a management crisis, we were - you were asked to cut, try to cut, find a way to cut 4% from an institution such as AMHI, and that's translated in the last two years that an

institution such as AMHI was at one time asked to be cut 4%, when last year this state gave back to the citizens of the state $42 million. That's all I have, Mr. Chairman.

SEN. GAUVREAU: I just have one question in response to what Representative Manning had brought up. When she appeared before us earlier this week, I think for the first time on Tuesday, Commissioner Parker told us that she was contemplating and in fact was in the process of seeking out a consultant to perform an independent critique of the department and of AMHI to assist, and that she would basically defer in fashioning any plan of correction so styled until the management was brought on board. My question to you is, since you were there until January 11, '89, had you had any discussions with Commissioner Parker, or were you aware the department was considering deferring fashioning any plan of correction until the consultant or a consultant was brought on board?

A. I wasn't aware of the consultant.

SEN. GAUVREAU: That was the first I had heard of it, was this week, and so I was somewhat surprised by that revelation.

A. I heard it at the same time you heard it.

SEN. GAUVREAU: Thank you. Representative Burke?

EXAMINATION BY REPRESENTATIVE BURKE

Q. I just have a couple of quick questions, and it's just for my clarification more than anything. When you wrote the December 9th memo about JCAHO, did you use that in a sense as a - were you using the impending JCAHO findings as leverage or were you solely concerned about JCAHO findings in requesting new staff?

A. Was I using the Joint Commission as leverage for more staff?

Q. Right.

A. I would think so, yes.

Q. Okay. So you had been asking for staff and hadn't been getting it, so when you found the leverage of JCAHO you said, this is another reason why I need that staff?

A. Well, yeah, this is another outside group saying - telling us something, and I happened to agree with them, that we were understaffed.

Q. I'm, as I say, just clarifying. And your concern for the standards and the conditions prior to that has - you know, you've been citing the Friday reports and all as an indication for us that you had been concerned well before this December 19th memo, but the December 19th - I'm sorry, December 9th memo is an indication that you were trying to get leverage with the Commissioner or with whomever, the powers that be, that, look, if we don't get this increase in staffing, the conditions are just still going to deteriorate further and JCAHO will not accredit us?

A. Basically, they gave us another set of headaches. The Joint Commission dumped - well, they exposed another set of problems for us.

Q. Okay, thank you. That's all.

A. They uncovered problems, reiterated problems.

SEN. GAUVREAU: Representative Hepburn?

EXAMINATION BY REPRESENTATIVE HEPBURN

Q. Yes. I've been in and out a little today. Have we talked

about the $291,000 shortfall that's being talked about in Appropriations yet today? That was in, I guess, AMHI's All-Other account. What was the deal with that? Can you tell us about it? Martel seemed to be a little bit upset about that today, and I guess they had to add it on to the emergency budget request just at the end.

A. Well, we projected we'd be 758,000 or something like that overexpended when we originally prepared the budget and were allowed to up our budget somewhat, but not to the level - if we put it altogether and you took our first projection, it might be pretty close to what you're seeing now, what we actually projected at the time and what we were allowed to put in the budget.

Q. So it's your feeling that right along the Commissioner's office knew that this was going to be the level of a shortfall, 291, or maybe even up to 700?

A. Yes, we did - we were allowed to put additional funding in, but not to the level that we had requested or projected. I don't have my budget sheets here. This is one that's not easy to respond to. Right now I couldn't tell you exactly what the 291 consisted of. Do you happen to have the -

Q. No, I don't. All I know is that it was in the All Other account, and I don't even know what that means.

A. Well, All Other is contract items, supplies, expenses. Basically, there's personnel and All Other is fringe benefits and contracts and so forth, and the All Other budget, there's a lot more

flexibility or latitude. A lot of - a multitude of sins come out of the All Other budget. It's the one that you have flexibility with.

Q. Overtime, would that go into that account?

A. Overtime would come out of personnel. Workers' comp is usually one of the things that we're over on. I don't know if that - if workers' comp - how that plays into it. I think maybe that's been centralized, the workers' comp problem. I think that was taken out of the individual budget and centralized.

REP. HEPBURN: Okay, thanks.

SEN. GAUVREAU: Is it fair to say the All Other account would not be an appropriate vehicle to augment staffing configurations to comply with JCAHO, Medicaid or Medicare requirements?

A. No, it's when - when you do model lab tests, let's say, on the outside, you send patients to Kennebec Valley Medical Center or purchase a physician, for example, on a contract, that comes out of All Other. Three of our contract positions, those would come out of All Other. So when you said is it fair to say, I misspoke slightly, because there are three of those positions that are All Other, and some of the other things that go on at AMHI go on under a contract. So if you contracted with an independent provider or agency, you can add services to your program without going through personnel funds and have more flexibility.

SEN. GAUVREAU: We had discussed earlier, I believe, in February or March, the Commissioner had authorized, was it another one-half

position, contract position?

A. Right, that would be All Other.

SEN. GAUVREAU: That would come out of All Other?

A. Yes, and the contract - we used to have Owen Buck going down to the Maine State Prision, while we're now paying for that, for corrections, at the rate of, I think it's $700 a day or 750 a day, and so they go once a -

SEN. GAUVREAU: You people are reimbursing the Department of Corrections for Dr. Buck's services?

A. AMHI's budget is paying for the Maine State Prison psychiatrist one day a week, and we're contracting with an agency to provide that service. But it comes out of our All Other budget and the price is going up, so it's putting more of a strain on our budget.

SEN. GAUVREAU: Were there other questions of the committee for Mr. Daumueller? Representative Clark.

REP. CLARK: I need, I think, to have you repeat - this budget piece is new to me. What I'm hearing is that they're currently saying that there's a $291,000 shortfall, is that right, and you're saying that's not a surprise to you?

A. I pretty much figure we go back just about every year. The budgets as constructed, usually you can't live with them. I mean, do I stop sending people to Kennebec Valley? I mean, if people need it, I'm going to say yes, do it, and if it goes over the budget, then fine, get rid of me. No joke intended.

SEN. GAUVREAU: Is it fair to say that it's not an unusual occurrence to have to seek an adjustment in a subsequent financial

year to pay for these services?

A. Every - I mean it's happened every budget that I can remember that we've had a shortfall.

REP. MANNING: It's happened every year since I've been here, and I'm serving my fifth term.

A. If I sound like I'm less than enamored or less than real familiar with your budget, now you know why, because the financial management, it's kind of a joke in a way. You don't have a realistic budget to start from, so it's very difficult to manage one.

SEN. GAUVREAU: Are there other questions of the committee? Representative Dellert.

EXAMINATION BY REP. DELLERT

Q. You were talking about - Mr. Daumueller, about the community activity - community arrangement that you would like to see in regional offices, moving people out. I think I remember you saying earlier that's a very costly thing, it would be far more costly to provide all the services than keeping many of the patients at AMHI because we have to provide so many other --

A. I think however you put it together, a quality system, total system of mental health care that works the way people want it to work is going to cost money, and there are some structural mechanisms that you'd probably have to set up, and I wish that would have been part of the debate at the September session, quite frankly, is to face that very issue, because that was in the Blue Book and nobody seemed to recognize that fact, that the regional office structure was right there. That was part of the -

part of the request was to enhance one section of money and move the state lines that were doing that job into a regional office to provide regional oversight.

Q. You're saying you would give them the money though, so that would be another whole process of managing those monies?

A. Yeah, well there's an argument that, you know, when we're faced with very limited resources you make the argument, do you put it into administration or do you put it into service, and every one of us is going to say yes, let's put it into service, but when you take a step above and say how do we want - do we want a true mental health care system in this state and one that has on-site, you know, regional or some entity of local presence, there is going to be an administrative cost, yes, but there is also, at the same time, some incentives for those people, and at least incentives that can be structured. And you're going to get arguments about that from various quarters, so that's a hot political item, as I think I alluded to, and wasn't really saying it straight out, that there can be - might be a battle that's been waged before and it's one that will have lots of pros and cons and you'll be sitting there saying, oh, my God, what am I going to do with this because of the volume of argument about it.

Q. There was one other thing I wanted to clear up, too. You almost alluded - or maybe you stated that you would prefer to put money elsewhere than to recertify for Medicare. It may be like our ICFs - SNF and ICF beds might be a better -

A. Oh, instead of recertifying the older adult program, what we really in essence are doing is moving those patients to the section attached to the infirmary where those people who are used to dealing with medical problems will, number one, take better care of them, the frail elderly and medically ill will be apart from the more ambulatory patients, so they'll get better treatment. Not only that, if you certify there's a nursing home, then you can get Title 19 for those patients, and so I think - I still think that's a good idea, even in the face of all the problems.

Q. So maybe it would be better - are you saying then not to worry as much about Medicare, certifying for Medicare?

A. Yeah. I think the issue - the public issue at this point is quality of care and obviously reimbursement for care and being fiscally responsible and efficient is important. I'm saying, first, worry about the quality of care, then worry about the fiscal efficiency, and I think that's the important thing, because when we're talking finances, we're talking 30 beds. When we're talking quality of care, you're talking 370 or whatever it is.

REP. DELLERT: Thank you.

SEN. GAUVREAU: I'd like to clarify that just a little bit. Which population specifically did you refer to when you talked about moving that population into -

A. Stone North Middle, which was the older adult program, was Medicare certified. A number of the patients who were on that unit are now currently housed in what is called the senior rehab

program. What was the 16-bed infirmary and an additional 20 beds adjacent to that 16-bed infirmary now comprise what is called the senior rehab program. That program, the intent is to license that 36 beds as a dual licensed SNF/ICF program, which would then make it eligible for Title 19, assuming that the patients who are there need the services of either the SNF or the ICF level of care, and which those patients do, and thereby bringing in, I think, roughly $600,000 or so.

SEN. GAUVREAU: Of Medicaid monies?

A. Medicaid, yes. I think it was 600,000. The idea was it would basically make up for decertifying on the financial end. It would be a better treatment program and address many of the kinds of issues that you've been reading about in the paper, the medical issues, physical medical -

SEN. GAUVREAU: So you're saying that from a programmatic and a financial point of view, it makes sense to seriously consider pursuing the dual licensing of that population and accessing Medicaid money?

A. Yes.

SEN. GAUVREAU: And that might bring in $600,000 if we did that?

A. Yeah.

SEN. GAUVREAU: Is that an annualized figure?

A. Yes.

SEN. GAUVREAU: Thank you.

MR. MANNING: What would happen if that was certified as Medicare, that unit? Could that unit be certified as Medicare? I'm getting

a strange look from Associate Commissioner Welch, so I'm not quite sure.

MR. DAUMUELLER: No, it's not - it's a different thrust.

REP. MANNING: So it could not be certified as Medicare?

A. No, it's the difference between a nursing home and a hospital.

REP. MANNING: I just wanted to clarify that. But it still is costing us more than if we had those patients as Medicare patients? Medicare patients is 100% federally funded, right?

A. Well, the number - no, you lost about $650,000 in Medicaid and Medicare combined. There were only at any one time four, five, six, seven, maybe nine at one time on that entire unit that were eligible for Medicare, and the rest of them would be the 65 and over who have to - who are eligible for Medicaid, but in order to be eligible for Medicaid they have to reside on a Medicare certified unit.

SEN. GAUVREAU: Representative Dellert?

REP. DELLERT: I was just going to say, I think they've applied for that ICF but it hasn't - the CON is in for it.

A. The letter of intent is, I'm not sure if the application is.

REP. DELLERT: I thought it was.

REP. MANNING: Who certifies -

A. That would be DHS.

Q. Are they ready to go?

REP. DELLERT: It's in, it's in operation.

REP. MANNING: It's in operation?

A. Yes, it's already going - oh, is it ready to go?

REP. DELLERT: Yeah.

REP. MANNING: We are state government.

A. Yes.

REP. MANNING: Why can't one phone pick up - why didn't somebody pick up the phone and say we're ready to go, come over and inspect us?

A. Call bells and curtains are needed.

REP. MANNING: What is?

SEN. GAUVREAU: Cow bells and curtains?

REP. BURKE: Call bells.

MR. DAUMUELLER: It's getting that time of day.

REP. MANNING: So all they need is bells, call bells -

A. Call bells and a few other nuances of startup money which I had requested but it is not in the budget. On the other hand -

REP. MANNING: I would hope that if it's not in the budget, they're still going to find some way in their slush fund to find something.

A. By moving around, I think that's what was going to be happening.

SEN. GAUVREAU: Are there other questions of the committe of Mr. Daumueller?

REP. HEPBURN: One quick last one. In the press it was attributed to you that you were muzzled. All right? I don't know if you used that word or somebody used it or some Senator used it or whoever.

A. I didn't say that.

REP. HEPBURN: Okay but - you didn't say that?

A. No. It's simply a matter of being - I think it's been said

before, it's being a team player and being a loyal trooper, basically, and putting a positive light on what the current position is. I think some of that is very understandable and just simply common managerial, but it - obviously you don't - it is not well taken to speak up, particularly if it would be a legislative - I mean, flapping your gums in the break room is one thing, but talking to a legislative committee or on the public record, it would be severely frowned upon to be highly critical or in opposition to what was being proposed. That's not to say you're muzzled; it's just that you might pay for it if you did.

SEN. GAUVREAU: Any further questions? If not, I want to take this opportunity to thank you, Mr. Daumueller, for your presentations over the last two days, especially where you're not currently in state government, we recognize the sacrifice that you've made to provide information of help to the committee and we are all keenly grateful for your contribution in this area and we certainly will take your comments and you insights into perspective as we fashion recommendations to the full legislature. Once again, we thank you very much, sir.

MR. DAUMUELLER: Thank you.

SEN. GAUVREAU: At this point, my understanding is that the department is currently making its presentation to Appropriations for the supplemental budget, and therefore, because we would very much like to accord Commissioner Parker an opportunity to come back before the committee for clarification or to respond to any

statements made by Mr. Daumueller, I would suggest that we recess to a time uncertain. That time would be fifteen minutes subsequent to the close of the departmental presentation to the Appropriations Committee. And I would also invite the committee to go to Room 228 to hear the presentation of Commissioner Parker and the department. Thank you.

(RECESS)

SEN. GAUVREAU: Please come back to order. First of all, before I forget, I want to commend all the members of the committee for your steadfast attendance during the past days, some of them very trying, and I also want to commend the committee for the caliber of questions, the acuity of thought. I think that you've discharged your responsibilities in an excellent fashion. I'm proud to be on this committee and I'm very proud to have all of you as colleagues on this committee.

REP. MANNING: Just for the public to know that a couple of members are not here because they are on another commission dealing with nursing, one of which is Representative Boutilier, the other one is Representative Dellert, and they're headed for Bangor to have a hearing - commission hearing dealing with nursing. I'm assuming that's sometime tonight, so that's the reason why they're not here. And Representative Cathcart had indicated that she had made plans months ago and that she could not cancel these plans, so that's the reason why she's not here.

SEN. GAUVREAU: At this point, we had, by prior agreement, provided an opportunity for Commissioner Parker to come back again before

the committee to rebut or comment upon any observations or comments proffered by Mr. Daumueller, and we understand that approximately a half an hour ago, or about an hour ago now, the department completed its presentation to the Appropriations Committee that began about 1:00 or 1:30, and I was advised by a representative of the Governor's office that the Commissioner was in a discussion with the Governor and I was later advised that she would not be able to appear before the committee this afternoon. And I understand that Associate Commissioner Ron Martel is present - Ron Welch, excuse me - that Associate Commissioner Ron Welch is present and he may have a more specific reason why Commissioner Parker is unable to be with us here this afternoon.

MR. WELCH: The Commissioner wished she could have been here. We talked about, during the break, the amount of time she would need to prepare a response, especially to the comments that were made today by former superintendent Daumueller, and that the original half hour allotment time probably wouldn't suffice, and because of that, she would rather forfeit the opportunity to make an oral presentation at this point but would be willing to come back if the committee can schedule that in at a later date. And in any case, she would hope to be able to present written comments to the committee for your consideration.

In addition, if the committee wants her back to answer questions that were raised as a result of Superintendent Daumueller's presentation, she would be pleased to do that. It's just that

that's probably not going to be a likely occurrence this afternoon.

SEN. GAUVREAU: Thank you very much, Ron, and I would like to again take the opportunity to once again thank Commissioner Parker for her presentations during the course of the hearings. I think certainly it was a very difficult process for all of us, including Commissioner Parker, and we're grateful for her contributions and participation in the hearings.

REP. MANNING: For the record, I'd like to indicate that Commissioner Parker was here all day yesterday while former Superintendent Daumueller was here, and for unknown reasons left at ten o'clock this morning, when we started roughly at 9:30 this morning, and Appropriations did not go in until one o'clock. So she had the opportunity to be here until roughly one o'clock, when Appropriations did go in. And the emergency budget, for those who don't know, is a budget that is very small. It is a budget that just gets you by this part of the rest of the fiscal year, and I stand by my statement that if you don't know what your emergency budget is two weeks prior to going in front of Appropriations, then you'll never know what that emergency budget is. So if she feels that she had to be away to get studying for that emergency budget, I don't understand it. I asked both Representative Carter and Senator Pearson about that, and they concurred that those are budgets that it should be right off the top of your head and you really don't need to prepare that much for it.

SEN. GAUVREAU: At this point, it's now 4:00 p.m., and the remainder,

of our hearing schedule regarding the AMHI situation will be as follows: We plan to come in at nine o'clock on Monday for the purpose of hearing presentations from the Maine Advocacy Services, as well as from the internal advocate for the department, most likely Mr. Richard Estabrook, and we will then - we have invited the Department of Human Services to make a presentation relating to their wards and their concerns regarding treatment for their wards at AMHI, and that will occur on Tuesday. We had also invited Probate Judge Mitchell to attend as well on Tuesday, but now I am advised that he will be out of state for the balance or most of the month of February, so he'll be unavailable. I would expect at that point we'll conclude our hearings and allow members of the committee to join or to catch up with the Maine Development Foundation tour, which will begin on Tuesday, and we will then decide whether we'll begin committee workshops on Thursday or the following week. We're not really sure at this point, but we obviously have to reduce our thoughts and observations to writing and make a full report to the legislature, and at this point that's still fairly fluid.

I believe before we break for today though, that Representative Manning had a request.

REP. MANNING: Yes, and I'd like to ask Jay Harper to come forward and give us again a breakdown on the $8 million for the community side that was not funded in the Governor's Part II Budget.

MR. HARPER: I think I have it, basically.

EXAMINATION OF MR. JAY HARPER BY REP. MANNING

Q. Basically, last Thursday, Jay, the question that I asked was, over and above the 20 million what was requested, and I think the response was that there was 8 million that was asked for in Part II and that it was not granted by the Governor in the community side.

A. That's correct.

Q. And there's been a lot of talk in the last couple of days about community side, and I just want, so the committee has a better understanding now, after four days of questioning, what we need to look at of that Part II budget.

A. I'm pleased to be before the committee and glad to respond to that. The items that were requested by the bureau and the department to the Governor that were not included in the Part II request are as follows: There is a reduction that is taking place, it's a technical reduction, it happens every year between the states and the federal government relative to the block grant allotments provided the state. In fiscal year '90, that would be a little bit less than $74,000; in fiscal year '91 it's a little bit less than $99,000. To go to the fiscal year '90 and '91 residential development that we have started in the special session is $400,000 in fiscal year '90 and $512,000 in fiscal year '91.

Q. What was that again, Jay?

A. 408,000 in -

Q. No, no, what was it for again?

A. Oh, it's for the next round of residential development, which were -

Q. The next round -

A. Which are additional 6-bed group homes and additional independent living environments. There was also new rehabilitation services, peer support and family support. Those type of services were basically some social clubs, which are very important because they provide consumers a place to go and get some basic living skills and social and pre-vocational skills during times when they're not in regular day-structured programs. That was $181,000 in fiscal year '90 and almost $278,000 in fiscal year '91. There was the expansion of treatment services for deaf elderly, including crisis programs. In fiscal year '90, that was $1,609,891, and in fiscal year '91 that was $2,899,661. There was the cost of living increases for all the community agencies so we could at least hold the line and continue the same services we had relative to other inflationary pressures other than service costs. That 629,000 in fiscal year '90, 361,000 in '91, and the establishment of three regional offices for the bureau. As you know, the Bureau of Mental Retardation has six regional offices. It's one of the reasons that they can do about 200 units of development per year. We're lucky if we can do three, and that would be $425,000 in '90 and 437,000 in fiscal year '91. So the total package for the biennium comes to seven thousand, nine hundred fourteen thousand dollars and some change.

Q. Seven million.

A. Sorry, seven million.

Q. If you can do that for 700,000, we'll start tomorrow. Some of that that you indicated is things that - for instance, the cost of living of - I'm assuming those are direct service providers?

A. Yes, they are.

Q. Would that have been in the Part I budget, because if memory serves me right, the monies that we put together last year, the 6.75, part of those monies were for cost of living.

A. $1,140,000 was a base salary increase and not a cost of living. That was provided just for direct care workers in community provider agencies.

Q. I see.

A. In fact, we were trying to differentiate between doing some base salary increases and linking that to a training program to develop career ladders in the long run as opposed to just cost of living increases that should occur on an annual basis.

Q. Okay. You've heard in the last couple of days that the community area is really important and a number of things need to be out there. If the department is in the process of trying to get the hospital base portion of the - the in-patient portion of that money that we gave you, roughly a half a million dollars, one of the important things that we were always told, and I think people like yourself and others told us, that if we do have that hospital base thing going, that you still have to have a very strong community base portion of that so that that person who is in that 10 or 15 day setting in the in-patient, for instance at a general hospital or whatever, that the case manager would have

enough programs for that person when that person leaves there. What will happen if we do have that? I mean, is there enough money in the community base area now, because what I'm afraid of is, if we put money into an in-patient southern Maine facility, that the person will go in and that we'll have the same problems that we are finding out at AMHI, it's the revolving door, because there are no community base alternatives for that person when that person leaves the southern Maine facility.

A. Absolutely correct. All you would do is move the revolving door from Augusta to the new facility. The revolving door is people who come in and out who may need - because of an acute episode or situation, they do need an in-patient place to get through a crisis and restructure their lives and get remedicated or whatever. When they come out, they need all kinds of other supports to keep them out. Unless you provide the supports, they will come back with, in fact we find out, greater and greater frequencies to institutional care. It's very important to break them away from institutional care and to get other supports in the community.

Now we're doing development in the community, and by having the 20-bed capacity or sorts to the south, we will utilize that new community development but we'll fill it up, and then you'll find yourself moving towards the revolving door syndrome again. So you'll have a slight impact and then it will start moving back up again.

Q. If the legislature decided to take and fund Part II requests that were not funded by the Governor, and it was funded in the

Part II which goes into effect in July of 1988, it seems to me that if in September of - excuse me, July of 1989, it seems to me that in September of '88, when we gave you the 6.75, it's taken you at least until February 1 and maybe even later to get part of that community based area going, the money that we gave you.

A. It takes 110 days just for us to contract out if we use a fair RFP procedure.

Q. Wouldn't it be better for us to take a look at some of that community-base money that you've talked about, and it's 8 million over a two-year period -

A. Correct.

Q. And looking at that and funding that in an emergency piece of legislation that would get funded end of the month, you know, first of March, that 110 day lag period is speeded up. Because if we're talking 110 days, you're talking roughly three months, you're talking the summer months when people aren't around, so you're really talking sometime the first of November at the earliest before that community-based area gets going. What I'm wondering is, is it better for us to take a look at portions of that $8 million, put it in an emergency pack, get it out there, get it out there now, so that when the hospital portion gets going, the supplemental portion for the community is there and ready to go?

A. It would sound like it would be better, but there's one very important problem, and that is that the rate at which we're able to expend funds through contract procedures and do it appropriately so

we're not misspending money, and for us we've made the decision to write standards for contracts and put them into the contract language and use an RFP process which had not been done before. There's only so much work we can handle. The Bureau of Mental Health, there's only six professional people working in there. We put three and a half million dollars out on the streets with standards and evaluation mechanisms and training components in the last 110 days. That's three times the development the bureau had ever done before.

Q. Do you need additional staff?

A. If as part of the special package you're discussing would be included the regional office structure so we could bring the additional staff on line immediately to help prepare the RFPs and do the resource development such as MR has done, so you could do it in three differents region besides here, we could certainly do the development that you're speaking of and, in fact, we could even do it in a faster period of time.

Q. Because the way you're talking, if, per chance, we did fund the $8 million, it goes on July 1st, and we could conceivably be talking that really wouldn't get out to the communities until probably the first of January or the first of February of next year.

A. The whole amount, that's probably true. In fact, the $8 million is, in many cases, predicated not on a full 12 months' worth of funding. The annualized cost for this $8 million which you're - my Part II request becomes relatively substantial as the Part I

request rolls forward into outgoing years.

Q. So you're taking into consideration that you're not funding for a full year?

A. We have staggered schedules strictly based upon our ability to deliver the services.

Q. But in the Part - in the second year of the biennium, you would be funding as of November - as of July 1, right?

A. Correct.

Q. So that would be a 12-month budget rather than a five or six or eight month budget?

A. Correct.

Q. So what you would need to do it right would be some additional staff in-house to put monies - how about the quality assurance? That's up and running, I'm assuming.

A. The quality assurance is strictly limited by those same staff numbers. Basically, we're assigning people to have a contract responsibility so they would have an expertise in crisis stabilization. They would work on developing those contracts and they would work with someone who works on the program standards and the quality assurance for that. So we have pairs of people, one person doing QA, one person doing contract and program development.

Q. So what we would need to do then if we wanted to speed some of this stuff up is not - so that it would be done and done right, would be to also supplement some people in the central office?

A. Absolutely. I mean, there's an inherent cost of doing business,

and I think if the effort is to try to insure that you're having the best expenditure of your limited dollars, then one of those costs that should be incurred, I believe, is the cost that guarantees that you plan it properly, develop it properly and assure through licensing or quality assurance that you're getting what you're paying for.

Q. Let me ask you this. If we put somebody - if we put X-amount of people in central office, are they - do we need full-time people who will be working in future years or do we need just somebody to help speed up the process? In other words, do we need to go out and get contract people to help you out to get this thing going faster, or do we have to put full-time people on and there's enough work for those full-time people for the next 18, 20, 30 years?

A. You could do a contract but I think that would be an expensive way to go in the long run. I think there's an inherent structural deficiency in the system in terms of the people we have to do the job we want and to do it right. This request, which is for 12 people, is what is left of an original request that I made for - when I was trying to put together a model system of what I would do in the state, which was 21 people. I could easily keep 12 people fully employed and busy for this year and the next decade.

Q. Okay that was the point I was trying to make, Jay. I just didn't want us to hire somebody and then after six months or so we didn't need them and -

A. No. Let me give you an example of something that we would like

to be able to do that we can't do. We collect a lot of information from our contractors presently, and we are unable to do a very good job of collating it and assessing it and finding out exactly what it's telling us about who we are serving and how we serve them. Every once in a while we take the luxury of stopping everything else we're doing during the day and look at some of those numbers. I have the Mental Health Center that served 1,347 people in a six-month period, and 97 people were my targeted population of seriously mentally ill. Now, that raised to me the question about what's the difference between 97 people and 1,347, was that a good expenditure of resources. I would like to have people that had the ability to say it's a poor expenditure of resources given priorities of need. You need to move money from one place where you have it to a different area of the state or a different type of service. We don't the luxury to do that now. Even efficiencies within our given dollar amount would be gained by having the additional staff that could take the time to do that analysis and redo the program development.

Q. And they would also probably be able - just that alone would probably be able to help out in the revolving door syndrome.

A. Absolutely. And the other side of the story is that by having the people that can take the time to develop programs that are designed from the day start to be Medicaid eligible, we can immediately tap the federal revenue stream that we do not do in complete effectiveness now.

Q. So quite frankly, hiring 12 people like that might be saving

us megabucks - not megabucks but bucks?

A. I would say hiring 12 people like that and given the other part of the package would save you megabucks.

Q. Megabucks, okay. I don't think I have anymore questions. My concern was, we've heard for two days community, community, community, not only by Superintendent Daumueller but I think also by Susan, so I think it's - that's the reason why I wanted you to come on, to explain what was in the Part II budget that wasn't funded by the Governor and for us to have a better idea. If, per chance, you could reduce that to some numbers, writings, and get it back to us, we'd appreciate it.

A. Certainly.

Q. Thank you.

EXAMINATION OF MR. HARPER BY SEN. GAUVREAU

Q. Jay, can you tell me how many people would be served under the proposed Part II request which was not approved?

A. In some areas I'd like to make it clear that what we mean by a definition of service, we've attempted to use to the greatest extent possible national research bases that tell us about services and what they're anticipated effect is. So some of the names and numbers I'll give you are anticipated numbers of people being served, and some of them, however, when you're doing residential development, you know that a bed is a bed and you have one person, so some of them are more solid than some. The way I've done this was a way that in my own mind I was trying to get at going from the fiscal year '89 request in September and

how it looked as you laid out the next two years, the continuum of development that we had proposed at that point in time.

The crisis stabilization program that was funded in September we hope will have an anticipated effect statewide of deflecting 240 admissions per year from both of the institutions. The fiscal year '90-91 effect would add an additional deflected admissions from institutions. The crisis stabilization program, when combined with the intensive case management which was funded in the special session would add an additional 200 admissions being deflected. So statwide it means that you'd have the capacity between crisis programs, which offer you a less intensive temporary place to hold people rather than going to AMHI, which is the only place they have now, with case management of 840 people being deflected from the entire system statewide. Now I don't know how much of that potential we will actually see, but we know that looking at other state statistics, it's certainly doable, other states have done it.

Q. So let me just back you up here a little bit. The number you gave us was 648?

A. It's 840 total when you do the fiscal year '89, '90 and '91 combined crisis stabilization with case management. The case management was funded in the special session, the crisis stabilization was part of the Part II request that was not supported.

Q. That was not. And so I heard you say that - with respect to the crisis stabilization, that one of the Part II requests,

or the component of the Part II request attributable to crisis stabilization funded, that you would have been able to deflect, you project, 480 additional admissions to both BMHI and AMHI?

A. Four hundred.

Q. Four hundred?

A. Yes.

Q. And you've told us - the 840 figure total you gave us, was that assuming you had received the Part II funds?

A. Yes.

Q. So how many now are you projecting will be deflected given the package which was approved in the special session?

A. Two hundred and forty of that 840.

Q. Now do we have any way of breaking down roughly of the - well, let's see. There would be a variance then of around 600 positions, if I understand correctly.

A. That's correct.

Q. So those 600 positions which would have been deflected, those admissions would have been deflected if the entire package were approved. How many of those would be attributable, say, to AMHI as opposed to its sister institution of BMHI?

A. I'm not sure of the exact percentage breakdown, but it's clear the way we've structured the case management and the crisis programs in the plan, that the majority of the impact would be in the southern tier of the state, which is the AMHI catchment area.

Q. So that it would be fair to say at least four to five hundred

admissions would have been deflected from AMHI?

A. I would say 50%, yes, would be a safe number, so of the 840, 400.

Q. And if you know, what's the annualized figure now for admissions at AMHI? Fifteen hundred to twenty five hundred?

REP. ROLDE: Fifteen hundred.

MR. HARPER: And it's important, Senator, to not stop with just this component because there's other parts that have to be in place to provide the supports.

Q. I'm mindful of that, Jay, but that's - if you take four to five hundred people admissions away, you're looking at a one third reduction in your admissions, if I hear you correctly.

A. That's correct.

Q. And so that would obviously have a very significant salutary effect in terms of the overcrowding at AMHI.

A. That is correct.

SEN. GAUVREAU: Thank you. Representative Rolde?

MR. HARPER: Do you want the rest of the package?

SEN. GAUVREAU: Oh, I'm sorry, yes, tell me more.

REP. ROLDE: Is that what got funded or didn't get funded?

REP. MANNING: It did not get funded.

SEN. GAUVREAU: This is the Part II that did not get funded.

MR. HARPER: The residential component that did get funded will have the impact of taking 12 clients presently on AMHI wards out. That would be the long-term chronic clients that would be there and we're providing an alternative bed for them other than

AMHI. In addition, part of the package that was funded would fund 30 additional revolving door clients either to be taken out as they're going through the admissions unit at AMHI or when connected to the crisis and the case management provides them a longer-term option to go than just a short-term crisis stay.

The '90-91 package would include an additional 12 to be taken directly off the wards and an additional 70 revolving door people in more permanent housing. And I think if you remember the presentation we made in September, we talked about going from the existing 130 beds that are in the mental health system, and so you have an idea of what that is, the Bureau of Mental Retardation develops 200 a year. We have 130 in the whole system. It would add another 124 beds over the three-year period, so it's virtually doubling the amount of community beds that we could have the potential of purchasing.

The social club piece would support 70 to 80 people with pre-vocational and basic living skills, and those skills happen to be the key skills that we're finding out in order to keep people out. That's what allows them on their own to work with case managers and interact with the system and keep themselves connected.

The vocational skill program for - which was fully funded in '89 is annualized in our Part I '90-91. There's going to be 150 people per year.

The elderly part of the package, which is a very important

part given the new federal OBRA requirements that we have, in addition to the fact that all the states have an aging population that we're dealing with in the mental insitutions, it would add 7 more coordinators statewide. We're not sure what the impact would be for deferring people from either the geriatric unit at AMHI or BMHI, except that we've told those people that that's their primary job, to see if they can do anything about that.

In-patient services, which is the most fascinating one in its difficulty in this state to try to bring off but also is the most rewarding one if it ever gets off the ground completely, 20 beds would defer 520 admissions from AMHI. The problem is, and I would like - if you don't mind me speaking a little about the problem, we started arranging and setting up contract arrangements to purchase beds as of January 25, a few days ahead of what our schedule was to start doing in-patient stuff in the community. There is only 8 beds a day available in the entire state in the AMHI catchment area that you could buy.

SEN. GAUVREAU: This is in community hospitals aside from specialty hospitals?

A. Yes. If you don't get to that hospital - if you don't get to the right hospital at the right time of the morning with your patient, the bed has a good chance to be gone by the end of the day. We've been checking the hospitals on a weekly basis to see whether that goes up and down.

Q. Well, let me ask you, Jay, is there anything that you would recommend, shall we say, to provide an incentive to hospitals

to develop additional beds for their population? We know it's a hard to manage population, we know there could be problems with the reinbursement formula, but are there things we can do to provide incentives for hospitals to come in and propose bed expansions for this population?

A. I would be pleased to make a bureau recommendation to you. Michigan has the same problems, and they have, I think, a fascinating way of dealing with it. They require through their CON process that their Department of Mental Health have absolute sign off on any and every CON in the state. If you want x-ray equipment and you're in a targeted area where they need in-patient psychiatric beds, you come in and negotiate with the Department of Mental Health.

MR. ROLDE: That's wonderful, that's great, I love that.

REP. MANNING: I'm not sure that the Representative from York could quite buy that, although it would help, probably, in his catchment area.

MR. HARPER: It's very important, as we've had discussions, I think, to understand either the severity of the incentives that you may need if you really want to involve existing players in the game, or realize the fact that you're going to have to go out and build or purchase or renovate your own 20-bed facility to get these 20 beds. That's exactly what we have come to. You have to convince at hospitals the medical staff that they want to take on an in-patient psychiatric unit, and then if you ask them to do involuntaries, they've got to go that extra step, and then

they've got to convince their administrative structure to go to the board of trustees, which has all kinds of other community pressures on them and they may not want to be involved in the psychiatric in-patient game. So if you're not willing to hold their feet to the fire, you have to understand that you play by their game and they tell you whether they want to do the service or they don't want to.

REP. MANNING: Jay, where are the eight beds?

A. Today?

SEN. GAUVREAU: They're changing every day.

MR. HARPER: For the southern part of the state, there is one at Maine Medical Center, zero at Kennebec Valley Medical Center, two at St. Mary's, zero at Maine Medical, three at Southern Maine Medical, two at Regional Memorial, and zero at Pen-Bay. At Regional Memorial, by the way, they have an 11-bed capacity but they can only fill eight, their own choice, because they've not been able to recruit a second psychiatrist and they would lose their JCH accreditation by doing that. There are four beds available in the northern part of the state, but it's a long haul from AMHI to Aroostook County.

The last part of the component for the '90-91 that was not supported was deaf services for people that are mentally ill. And just so you can have an idea of what the impact might be on that, we're estimating that up 200 admissions at AMHI alone are people who come in with some kind of a hearing loss, and it's very important when you're trying to provide services to people

that you're able to take in in a holistic approach not only what all their other needs are, but you could communicate with them over what their problems and their issues are. The money we were asking for was to purchase additional services of people who can do sign and do training programs with doctors and social workers and nurses that interface with people who do have some degree of hearing loss. Not all are completely deaf, but it's a very significant phenomena, it's one that's very often ignored in many states.

SEN. GAUVREAU: So that what you're saying with that population, the deaf AMHI population, is that it's hard for them to maintain community placements because of a -- of resources that - people who in fact are trained in sign who can communicate with them?

A. Absolutely.

Q. And so you would -

A. This state, by the way, is a national leader in deaf mentally ill services. We have a couple of programs that specialize in that. Many states have none whatsoever. We are often called on to provide consultation through our deaf services coordinator.

Q. Now in terms of the deaf services again, will you tell me what was the price tag in FY '90 and '91 for the - the deaf services for the mentally ill.

A. I don't have them broken down by the subcomponents that I just did. They're broken down in either rehab services or treatment service, so it would be part of the treatment service

component, as is the in-patient.

Now the numbers that I gave you, it's important to realize that any one client might be using all of those services. You could have a deaf mentally ill person who uses a crisis program, has a case manager, is living in a residence that we're supporting and periodically needs to use an in-patient bed that we're supporting. The most important, I think, from your perspective of dealing with AMHI is the fact that if you could fill 20 beds every day in another agency, you'd reduce that admissions flow to AMHI by 520.

SEN. GAUVREAU: Representative Rolde.

EXAMINATION BY REP. ROLDE

Q. A number of things. In September we gave you $6.5 million, of which I understand about $3 million was for community services?

A. 3.6.

Q. Okay. And as you say, the key piece was the 20 beds.

A. Hm-mm.

Q. Now I assume that that money has not been spent, is that correct?

A. That is correct.

Q. Okay, so you've got - how much was that?

A. $500,000.

Q. That was 500,000. Has the other money been spent?

A. There's $150,000 for after-care services and underserved areas that just presently the RFP is being developed, and there's

$50,000 for standardized assessment process.

Q. But all the rest of the money has been spent?

A. All of the rest has either been spent or proposals are coming back in in response to RFPs. They only amount to $35,000.

Q. Wait a minute.

A. Not spent is 500 plus 150 plus 50 - 700,000.

Q. 700,000 out of three million?

A. Out of three million, and 35,000 we're just in the process of contracting for now.

Q. But all the rest has been spent?

A. All the rest has been contracted out.

Q. And as far as we can see, it hasn't really had an impact because the admissions are the highest that they've ever been.

A. Correct. The contracts have basically just been concluded in the last three or four weeks, and now -

Q. Three or four weeks?

A. That's right, and now starts the process of those vendors hiring up additional staff and training them to our standards and then going forward with the program.

Q. Now on the 20-bed piece, which seems to have been the most critical, when that was proposed, had nobody talked to any of the hospitals ahead of time to see whether this was a possibility? We talked about CON. Did anybody talk to the hospitals about the Maine Health Care Finance Commission, whether they could actually even do what you are asking them to do, whether they could fit that into their requirements?

REP. MANNING: Representative Rolde, if I could cut in here. Two years ago, in July, Ron - Ron Welch and I met with Jim Castle, and I asked Jim what the philosophy would be and told him to go out and find, you know, places, and said that I, meaning me, would back them at 100%, including over and above the Medicare rate, cutting CON completely out of the picture if we could find some institution that was willing to go and take on a 20-bed or a 30-bed facility, you know, that it wouldn't even be in the CON development account, it would be just go build it. I have not heard back from Jim Castle since then and I don't think - I'm not sure whether the department has heard back. But I gave him my word that that's the way I would look at it, knowing fully well that that would - I mean, we're talking about the state and cutting it down.

REP. ROLDE: Was the department aware of that?

REP. MANNING: The department was there that day. That was in May. It was Ron Welch and myself, and I forget who else was there, waiting - we formed a hospital subcommittee to deal with this very subject, and that was in July, right after we got out in July of 1987. Nothing that I know of has ever occurred back from the Maine Hospital Association.

REP. ROLDE: I've heard from two other people who are not connected with hospitals who said that they could conceivably work in this area or this type of an in-patient thing, and that's Tom Kane from York County Counseling and Jack Rosser from the Spurwink School, and I don't know if they've ever been touched base with

for setting up this kind of a situation. Was it basically the department was just looking for a place that was - that had a facility already and was going to take patients on a one-to-one basis, or were you looking for a specific 20-bed unit or -

MR. HARPER: All the above. We were looking for 20 beds, hook or crook, any way we could get it. We have talked to Tom Kane. In fact, he has investigated two site possibilities for us and we have a meeting with him next Thursday. We've talked of providing medical backup for him from either JBI or Maine Medical. We have talked specifically to Jackson Brook, who has a second floor administrative space unit that was 20 beds. It was modified for administrative purposes and they're willing to unmodify it and put it back into clinical services and allow us to have it. There are some very interesting revenue problems around both of those that need to be addressed.

REP. ROLDE: Through the Maine Health Care Finance Commission?

A. No, through - between the state and Medicaid. If you were to go to Jackson Brook, we would have to pay the full freight. It's a specialized hosptial, they do not apply for and cannot get participation from the federal program. If we run a unit that only has the medical backup provided by a private service but through a mental health center, such as York County Counseling, we can start from the beginning with a program that's a hundred percent Medicaid eligible. The impact on the services would mean we budgeted for the full cost for the 20 beds; if we used the Medicaid approach, we might be able to get more than

20 beds out of it for the same dollar amount in the budget.

Q. But you'd have to be getting a free-standing unit then, or someplace new. It seems to me that would have more capital costs than $500,000.

A. The $500,000 capital cost part could be easily financed through the Maine Housing Authority if we call it a secure residential treatment facility as opposed to an in-patient facility, and that is an approach that New York State has taken. It's not an - it's a very complex problem, it's not an unsolvable enigma. I mean, we looked into it before we made a proposal to the legislature. We understood there was an easy road and there was a hard road, and we chose to try to go the hard road first, which is to make full use and get - and there's a reason in the long-run strategy to try to get community involvement and participation in our solution. That's where the solution will be for the long term, and the sooner we get them involved and participating, the better.

The easy run would have been to just take the $500,000 and go pick a building independently of other support mechanisms and bring them to it. But we allowed ourselves the flexibility of going in either direction but to get 20 beds.

Q. So what's the timetable now? I mean, any light at the end of the tunnel as to when this might go on line?

A. Well, we have - what was very important is that we anticipated not doing the in-patient stuff until this month, and the reason for that was we wanted the crisis stabilization program in place and case management, so that the crisis stabilization program could

act as a triage point for people going through normal hospital emergency rooms, which usually is their way to get to AMHI, and look at those people and say, by the way, we have two other options we can offer you. You can either go to a crisis program or you can go to this other hospital bed. That's now in place for Portland.

Q. Crisis stabilization.

A. Crisis stabilization and their ability to purchase from Jackson Brook and some other hospitals beds on an as-needed basis. We're meeting with Southern Maine Medical to make the same arrangement between our crisis program, Southern Maine Medical's emergency room and York County Counseling for their ability to purchase beds both up north and also across the state line into Portsmouth. It's much easier when you're in Kittery to go across into Portsmouth and get the services than it is to come all the way up to JBI or to AMHI. We're trying to do things that make sense for where families need to go for distances, and also consumers and patients.

Q. Where would you be doing it in Portsmouth?

A. Portsmouth Pavilion. JBI is to get back to us, as is York County Counseling, with budget proposals around the stand-along 20-bed units in about three or four weeks, and at that point we'll know whether we need to go to -- or not or whether or not we need to come back to Representative Manning and ask for a favor here.

REP. MANNING: A waiver.

A. A waiver and a favor, right.

REP. MANNING: For those who don't know, that's a big step for Representative Manning.

SEN. GAUVREAU: Are there any other questions of Jay at this time regarding the package?

EXAMINATION BY REP. CLARK

Q. I'm suddenly getting lost in the time line here. Is this last year's Part II budget or next year's Part II budget?

A. This was last year's special session request in September that funded all these programs.

Q. Right.

A. So the programs we brought up on line between September and just recently was the crisis stabilization programs, which basically just augmented the three that the state presently runs, and all of the case management contracts have been let out and signed now.

Q. Okay. So then all those programs are folded into the Part I budget that we're going to be hearing next month?

A. That's right.

Q. When you talked about Part II budget requests that were denied -

A. They were not supported.

Q. That were not supported, that's this coming cycle?

A. That's correct.

Q. Can you describe for us what happened on that? Where did they get not supported?

A. I jump up and down a lot in front of the Commissioner, as she jumps up and down a lot in front of me to make sure we both are doing the best job we can, and I sold her in terms of our budget package that we wanted, and she fully supported it. What went on from that point forward, I assume, is that at cabinet meetings and working with the executive budget branch, decisions are made about what priorities get supported and don't get supported. The message that comes back to the bureau directors or the superintendents is whether you were or were not supported at that level. It does not mean that anyone is saying the request was an illegitimate request or not a worthy request, it's just whether or not it fit into the priorities, and that's how I perceive it. So after we had done the budget information and we knew that budget meetings took place between all the commissioners and the Executive Branch, they came back to us and said ours was not being supported.

Q. Given what we've talked about in the last week about the situation at AMHI, what kind of predictions - what are we looking at two years down the pike? What's the next crisis coming here? Are we going to be up to -

A. I think that the resolution of the crisis is certainly in the hands of both the Legislature and the Executive together, and that's the only way to solve the crisis.

One of the things that has to be made very clear is what it is that AMHI is. Is it an in-patient psychiatric hospital and

you're going to fund it and run it and have standards for a hospital, or is it providing a lot of other services to the community because there are other agencies that need those in-patient type of services. As long as it can be anything for anybody, which bascially it is now, I think you're just going to be substituting in the long one crisis with another later on. I don't know what it would be, but I would just guess that. Other states have experienced this. We're not unique or new at that, and the way out of it is to say what the hospital does and who it does it to and what the standard is you want it done for and then you fund it, and sometimes that's an expensive standard and some states have chosen just to do custodial care and do not participate or try to get other types of standards, and it's an inexpensive standard.

Q. We've been talking about treatment models, if you will. What's the current literature in the psychiatric community about appropriate treatment models?

A. For in the community? There's an article that just came out in the last month that is a wonderful article. I xeroxed it and sent it to the bureau staff yesterday. What it says is, and it's most important and I think it's very in line with what our approach has been, is that you have to be careful not to follow around the latest buzz words and treatment models, which for right now, for us, it's called psychosocial rehabilitation. Psychosocial rehabilitation assumes that people can go along and be treated in a way that has a rehabilitative component to it,

and many people can that years past were thought that they couldn't. What happens is, they have a tendancy to go too much overboard in that direction, and we need to realize that every patient needs a look at individually and decide whether they can fit into that model or not. Some people do need - I'm not one of the people who believes you can deinstitutionalize everybody. You may not have big institutions, you may have little institutions, but that institutional type of environment, 24-hour very intensive care, will be needed for some human beings, and I think that that's there. There's a danger to go one way or the other. So right now what we're trying to do, and what the literature is finally beginning to say is to strike a balance, and the way you strike that balance is spend a lot more time at the assessment end and looking at people as individuals and try things and do things slowly and incrementally but provide a holistic approach in terms of support services to them if you want success, whatever their success is going to be, not necessarily my success for them. That's where it's at. It's not an easy place to be at, because before the answers were real simple. You medicated them or you locked them up or you let them loose on the street and people thought that was the answer, but I think we've learned a lot from a lot of unfortunate mistakes.

Q. Do we have the techniques to do that kind of assessment?

A. One of the other things that's really interesting about this field is what - is needing to say what you don't know and be honest about that instead of pretending that you have all the

answers. We have - there are assessment processes that are much better now than they were just five years ago, much less ten years ago. We know a lot more about people. There are decisions that will be made that - in the example of the case of the adult at AMHI involved in terms of an alleged sexual assault where you make your very best guess on all the data provided you and you might find out that you're wrong, or you have an unfortunate incident that accompanies that guess.

We think the assessment instruments are pretty good now for people working in the communities and stuff like that, and what's most important is, though, that you have the ethical value structure of all the people working with them to say you stick with the patient, you stick with the client, and when the system fails or they fail or you made the wrong guess, we don't kind of give up and go away, nor do you necessarily regress, but you readdress all the issues again reassessing the line. To me, that's the most exciting thing about the area of psychosocial rehabilitation, is it says you have this cyclical thing that allows you to go on and on and on, learn from mistakes and not just repeating successes as if that's the only model that does work. I'm confident that there are instruments out there that work very well. We're going to find out very shortly. We're about to implement some standardized ones in the next few months.

REP. CLARK: Thank you.

SEN. GAUVREAU: Representative Pederson.

EXAMINATION BY REPRESENTATIVE PEDERSON

Q. The success that you were speaking about, if the proper things were in place, such as the case management and the providers, that the person - a lot of clients would have to have basically 24-hour supervision of some nature, and that might be in an apartment setting, it might be in a home setting, and then they would go to supervised functions, whether it would be social or vocational, and it would be easy to pick up those people whenever they tend to have psychosis or they tend to have a problem, then you could get them to the hospital and treat that, or maybe you could even treat it in the setting that they were if it was such that they could discontinue their routine and be treated because they are not capable of being in that routine. Isn't that basically the things that you're trying to provide with your community -

A. Absolutely. The most expensive single component in terms of what the existing system looks like compared to the one that we're proposing is, it's a very elaborate crisis stabilization program that allows us to find through case managers who may be looking at a client they are working with and say this person is beginning to act in a way where we've seen this pattern before, we know that they're heading towards probably a crisis situation. Or a family member may call and say I have a family member who I can tell is heading towards a crisis, and we can make some very sophisticated choices about intervention. The choice in the past used to be go to the emergency room and go to AMHI. The

choices we want to make are, you may want to go to the emergency room, you may want to have a crisis team come to where you are and help you out there. You may want to have that person dropped off at a crisis stabilization point and we'll take them for two or three days and help them through that period and then reintroduce them to where they are. Or you may want to, in fact, say go to AMHI or an in-patient facility.

Q. And the one thing I wanted to say was that along with that is the client quite often without that close supervision could either be drinking coffee and end up being up all night and could not attend whatever function that he normally would like to attend during the day, and he would then also be putting himself right into a psychosis within a short time. There are different things that would upset them. Stress is one of the things that can upset a client very quickly, and without that close supervision - and nobody would know that they were in a problem and then the problem becomes much greater and you have a much longer period of time to get them back to stabilization. Is that your understanding?

A. Absolutely.

SEN. GAUVREAU: Representative Rolde.

EXAMINATION BY REPRESENTATIVE ROLDE

Q. Jay, could you describe a crisis stabilization unit to me? How would that work?

A. Sure. We have -

Q. Is it a place or -

A. Well, if we have a full Part II funding, it will be places

everywhere, for each region in the state, for mostly the urban areas because that's where it makes sense to do it and you have to have transportation to it.

Basically what we're trying to do is design a system that allows in every region, for example in York, you would have 24-hour crisis telephone service for both families, professionals or a person in crisis to call to get not an answering machine and not an answering service but to have people that are there that are licensed practitioners in the field to help work out how to best solve that crisis situation. Tools that are left available to them are to say - when they hear the situation, it might be from a family member, say fine, you keep your family member there with you and we will contact other professionals we have on an on-call basis or we know where they are in the community and we'll send them to you. Or you can say, if you can take that family member and bring them to whatever address it is, and right now we have three sets of crisis residential apartments, one of which is in York, say you drop them off or get them any way you can or we'll come pick them up and bring them there, and they can stay there and they're watched and they're handled by professionals on a 24-hour basis. They're not sent into AMHI to get through the crisis, they're still in their own community. And if the situation doesn't escalate to the point where crisis stabilization is not going to work, you keep them there and they go. We're talking about basically apartments that are available in the community.

Q. So this is somewhere where - let's say somebody was having a psychotic episode. They would go there, they might get medicated and stay for a couple of days and then - is that a possibility?

A. Sure. A very real scenario, I think, is that you have a person that comes out of AMHI, they have medications, they start to feel real good, they're taking their medications and they feel so good they stop taking their medications, and stopping taking the medications perpetuates for them a crisis. They go into a crisis. The case manager knows that that's what the problem is but it's three o'clock in the morning. You take the person and you put them into a crisis apartment. They're being monitored for 24 hours, or whatever it is. At the next available time, you get to a psychiatrist, you have the meds reviewed, you sit down with the client you're working on and put them back on medication and hopefully the crisis is passed.

SEN. GAUVREAU: Are there any further questions at this time of Jay Harper? If not, I understand you will be forwarding to the committee the - a copy of the written -- the Part II request which you have made reference to?

MR. HARPER: Yes, sir.

SEN. GAUVREAU: Thank you very much for taking the time with us this afternoon. We certainly appreciate it.

MR. HARPER: Thank you.

SEN. GAUVREAU: At this point we will then close the hearing for this afternoon, and our calendar, as I said, is to meet next Monday and Tuesday, and with all things going according to track,

we should finally be able to close the hearings sometime on Tuesday and then allow the membership to join the Maine Development Foundation tour. Are there any requests of any members of the committee for other documents or other materials between now and next week so that I can have the staff work on that over weekend?

REP. CLARK: Incident reports?

SEN. GAUVREAU: Incident reports, can you specify?

REP. CLARK: I'd like to include March of '88, and probably August.

SEN. GAUVREAU: Is that confidential?

REP. CLARK: I would like to know repetition, though, even if they're code numbers.

SEN. GAUVREAU: You don't want to identify it, you just want to know what happened?

REP. MANNING: Have you adjourned for the day?

SEN. GAUVREAU: Yes, we have.

REP. MANNING: I have one more quick question. I wanted to speak to Noreen.

SEN. GAUVREAU: Representative Manning has other questions -

REP. MANNING: I have one quick question, Noreen.

EXAMINATION OF NOREEN JEWELL BY REP. MANNING

Q. In the last couple of days people have - the superintendent had indicated that those memos were sent on to the commissioner's office. Were they also sent on to the Governor's office. Do people in the Governor's office read those memos?

A. I really don't know and I'll find out whether or not - what

we get from departments are direct copies of all the memos from all their divisions. I don't know but I can get an answer for you.

Q. Do you have somebody who is a liaison from the Governor's office to -

A. I'm liaison to the department.

Q. How long have you been the liaison?

A. November or December, I guess, for a year now.

Q. November or December of last - in 1988 or 1987?

A. '87.

Q. So do you know whether or not you read those memos?

A. I read what comes out of the department. I don't know - I would have to go back and look at what the commissioner -

Q. Did any of the memos that - the weekly memos that we talked about, do any of those sound familiar to you?

A. I don't know how to - I'd like to take a look at the memos that he sent and the ones that I get and I could answer it. If you're asking whether the commissioner keeps us informed, I have always felt confident -

Q. No, my question is whether or not somebody in the Governor's office reads the weekly memos.

A. I read the commissioner's memos that she sends to the department, and what I would have to find out for you is how much of the information that gets to her actually ends up getting to me. I doubt that I'm reading -

Q. Why would she change anything that -

A. I'm talking about changing, I'm talking about extracting. I

doubt that -

Q. Why would she take anything out?

A. I would not be particularly interested in reading every memo or weekly or monthly report that comes from every division and bureau from all of the departments for which I am liaison. Do you see what I mean?

Q. You're the liaison -

A. No, I rely on the commissioner to keep us informed.

Q. I want to get this straight. You don't think it's appropriate to read every single weekly report that comes out of AMHI, BMHI, Pineland, the Elizabeth Levenson Center and the Children's Hospital, the Children's Center in Bath?

A. I expect to be kept informed on all of that. All I'm saying is, I don't know what the nature of or the size of weekly or monthly or periodic report is that comes from not only all of those but all my other departments and bureaus and divisions.

Q. What other departments are you liaison to?

A. Human Services and Community Services.

Q. So the three departments -

A. And Labor, the Department of Labor.

Q. But there is no other - the Community Service doesn't have institutions and Human Services doesn't have institutions, do they?

A. No, they have Bureau of Social Services, Bureau of Health -

Q. So you feel that it's not important to read the weekly memos of those institutions?

A. Peter, do you mean all of the weekly memos that anybody would

ever give the commissioner?

Q. No. My question is, the weekly memos that go from the superintendents of BMHI, AMHI, Levenson Center and others that was told to us yesterday that they go to the Governor - they go from Daumueller's office to the Commissioner's office and that they also go on to the Governor's office.

A. Right. I read everything that I get from the commissioners and they do keep me updated and informed on all of their bureaus. What I don't know -

Q. Do you know whether she extracts anything?

A. I don't know, Peter. I have never looked - I have never gone in and looked at all of the memos that they get from -

Q. But you do read them?

A. I read everything she gives me.

Q. Okay, thank you.

SEN. GAUVREAU: Thank you, Noreen. I do recall at some point, I'm not sure who requested, maybe it was Brad, there was some request that we reproduce the so-called Friday reports, and I spoke with you about that. My problem is, I don't know what time frame we're looking at.

REP. MANNING: Well, Mark will reproduce them tomorrow.

SEN. GAUVREAU: No, no. I mean at what point in time do we begin the Friday reports?

REP. BURKE: He started giving the chronology in February, or January is when I started writing down my chronology of '88.

SEN. GAUVREAU: So are we looking at '88? Are we looking at Friday

reports in '88?

REP. MANNING: I think we ought to go back to as early as September of '87.

REP. BURKE: Do we need each one or can we take one from each month, because it seems that oftentimes they were repetitious, but, you now, it's fine -

SEN. GAUVREAU: It wasn't my request. I thought it was Brad's. Okay, rather than reproduce thirteen separate compendia on Friday reports, why don't we reproduce one, and then if people want -

REP. MANNING: Why don't we make this - the department - Ron Welch has those, because the department has those weekly memos.

MR. WELCH: Yes.

REP. MANNING: And those are the same weekly - are those the same weekly memos - the same weekly memo that comes from the superintendent's office, does that same weekly memo then go on to the Governor's office?

MR. WELCH: Typically, yes. There will be some exceptions to that. Sometimes the superintendents get a little carried away with detail on issues that aren't really major highlights, and those might be deleted. The important thing is that it's a report to the Commissioner, who then picks what she considers to be the major issues in the report to the Governor.

REP. MANNING: Do you have those copies that go to the Governor?

MR. WELCH: Sure. The weekly highlight reports?

REP. MANNING: Yeah, that go to the Governor?

MR. WELCH: Yes.

REP. MANNING: Okay, could we have a copy of the - I would like to have a copy of the weekly reports from the middle of September of 1987 until January 1 of this year.

SEN. GAUVREAU: Does that sound like a gigantean task or can you achieve that fairly quickly?

REP. MANNING: Let me put it this way, if we could have it done by Monday, that would be all right.

MR. WELCH: One copy?

REP. MANNING: One copy, and then I'd like to have the copies of the same period of time, if he has them, from September of '87 until the first of January of this year. Do you have weekly copies of that, Bill?

MR. DAUMUELLER: Sorry.

REP. MANNING: Do you have weekly copies of - the weekly memo from September of '87, roughly, until - you could give that to our clerk?

MR. DAUMUELLER: They're in.

REP. MANNING: They have them already, okay.

SEN. GAUVREAU: So there are two sets of reports, one is from the superintendent to the commissioner and one is from the commissioner to the Executive Office, is that correct?

REP. MANNING: Yes.

MR. HARPER: What were the dates you wanted?

REP. MANNING: September 1, 1987, until January 1, 1989, and that would be what goes to the Governor's Office, not the commissioner's - not what goes from the superintendent to the

commissioner, what goes to the Governor's Office.

SEN. GAUVREAU: Are there any other requests from the committee for documents or anything else between now and Monday? If not, I think we're ready to adjourn for the day, and once again, thank you very much for your time and your efforts.

HEARING ADJOURNED AT 5:05 p.m.