IV

STATE OF MAINE

HUMAN RESOURCES COMMITTEE

Hearing held on Augusta Mental Health Institute issues
February 1, 1987

Maralee L. Kaler

TABLE OF CONTENTS

Augusta, Maine
February 1, 1989
9:10 A.M.

SENATOR GAUVREAU - This is the third day of hearings into the status of conditions at the State's acute care mental health facility in Augusta. This morning we have asked the former Superintendent of AMHI, William Daumueller, to make a presentation to the Committee. The hearing today will run from nine A.M. until noon; and at this juncture we are still uncertain as to whether or what the schedule will be for the Committee for tomorrow. As you recall, at the close of the hearing yesterday the Department had requested our intervention with the Appropriations Committee to perhaps postpone the Department's budget presentation and I understand that that request has been communicated to the Appropriations Committee. We have yet to receive a response. We hopefully will have that this morning so we'll know more as we go along.

I would also point out that this afternoon in Appropriations the Department of Human Services will be presenting its supplemental budget and there will be a major announcement at that time dealing with use of residential facilities. So, for those on the Committee that have time this afternoon, it may be worthwhile to go down to Appropriations and hear Commissioner Ives' presentation.

At this point I am pleased to recognize Mr. William Daumueller, as I say, the former Superintendent of the facility at AMHI. Good morning, Mr. Daumueller. We have your prepared statement. And, do you wish to make a statement prior to questions from the Committee?

MR. DAUMUELLER - May I make the prepared statement?

SENATOR GAUVREAU - You certainly may.

MR. DAUMUELLER - Thank you. I'll start there and of course I'll answer any questions you have after that.

Senator Gauvreau, Representative Manning, Members of the Human Resources Committee, my name is William Daumueller, former Superintendent of Augusta Mental Health Institute. I'm here today because I'm convinced that the needs of Augusta Mental Health Institute require the immediate, personal and collective attention of the Legislature.

AMHI faces many serious problems and pressures, few of which are within the facility's ability to control. The unique role of the state hospital, the extreme workload, the physical plant, mental health system and internal organizational issues are a few of the areas that I'd like to touch on.

First, the State Hospital role. As you know, the State Hospital is the safety net for the mental health system and as such can't hang out a "No Vacancy" sign when things get tough. This "court of last resort" function, while frustrating is clearly a necessary one until appropriate alternatives are developed.

Workload pressures. There have been dramatic increases in workload consisting of substantial increases in admissions, a continuing high census and the increasing number of severe medical problems and other labor intensive care needs being identified and having to be accommodated.

Unfortunately, the workload reduction expected to result from the establishment of a 20-bed - 20 inpatient beds in southern Maine which would admit acute, involuntary parients has not

materialized and appears stalled. This inpatient program, combined with other funded options, was designed to reduce the AMHI population from last year's average of 361 to an average of 319 patients.

Simply stated, current staffing is not sufficient to provide the documented high quality care and treatment which meets all the standards and expectations placed on the facility.

The result of this understaffing is the use of shortcuts in documentation and care provided; less individualized attention and care; high levels of overtime, stress, burnout and turnover. Good competent and caring staff can look bad when overwhelmed.

Physical Plant Issues. The physical plant at AMHI while being cited for its beauty and upkeep is generally inefficient, has serious deficiencies in terms of risk management and has a large number of patient rooms which would not meet current state licensing standards. In addition, both JCAHO and Medicare have pointed out the problem of exposed pipes which are evident throughout the facility and for the need for remedial action. The events of this summer also point out the necessity for cooling of AMHI buildings during hot weather.

System Issues. Unfortunately, there is no real incentive for local providers to divert patients from AMHI, just as there is no system of care where the funding of mental health services is directly tied to those doing the planning, contracting and gate-keeping. This incentive issue may be the most difficult part of the puzzle to solve but probably is well worth the effort.

Obviously, Medicare standards are now being vigorously enforced and JCAHO is also under pressure to become more aggressive in their surveys. Some would argue the motivation is quality. Some will argue that it's money. But, the fact is the surveys will not get easier in the near future.

Internal Issues. The Admission Unit, given its increased workload, limited physical space and relatively large staff has become a resource drain and a bottleneck. The patient living areas, office space and program area is severely limited. Patients not directly discharged from that unit then must transfer treatment tems causing some very real problems with continuity of care and the documentation of that care required by Medicare and JCAHO. The situation begs for change.

Recommendations. While much has been made of AMHI's loss of Medicare and the timetable for regaining that funding, the problem at AMHI is not the loss of Medicare. The problem is providing quality and service in an atmosphere of high demand and high tension. I contend that in these circumstances you should put Medicare at the bottom, or at least the middle of your list of priorities. Concentrate instead on the overall quality of care and what it will take to restore it. Actually, you've already made a tremendous start by funding a historic piece of legislation last September. It was a great beginning that all can be proud of but it was only a beginning. Given the current circumstances, I think it is imperative that action be taken quickly and in a bipartisan manner to alleviate problems which are all too painfully

obvious. Mental illness has no party lines and the importance of doing the right thing far outweighs the need for finding ultimate blame. I'm convinced that there is more than enough blame to be placed all around. The important consideration is what will be done now. And obviously I have some thoughts on that subject.

First of all, it is vital that the Legislature be fully informed of the problems at its facilities on a regular and timely fashion. Results of all surveys and plans of correction should be forwarded to the Human Resources Committee for your review and analysis. Given the immediate situation and the various points of view, it may be very appropriate to hear directly from AMHI medical, professional and other representative staff regarding problems, needs and solutions.

Secondly, it is time to set standards of care which translate into staffing ratios based on admissions, number of patients and their care needs. This is one way of taking the subjectivity out of staffing requests. As you are probably aware, the State Hospitals are not licensed by the State of Maine, setting them apart from all other hospitals. Licensing state operated facilities would be another method of keeping informed and setting quality thresholds. The danger is that once these standards are set, the true cost of quality inpatient care will be all too graphically clear.

Thirdly, AMHI staff are currently formulating what they feel are their staffing needs. I would urge you to ask to see

those requests. Look at the justification from AMHI professionals and monitor their progress through the system. Lowering the workload would of course be a much better solution to the AMHI staffing problems and would generally make for a much more therapeutic environment; but the promise of less workload will not care for the patients currently residing in our facilities. Exploring the reorganization of AMHI into geographic programs should also be pursued as a way of dealing with the Admission Unit "bottleneck" problem and reducing the need for professional staff. At the same time, this would address many continuity of care and documentation issues.

Fourth, continue the pursuit of a facility in Southern Maine which could take all the admissions from Cumberland and York Counties currently going to AMHI. This facility could provide all the acute care for this catchment area and only transfer those patients needing longer term or more specialized care. If private facilities can't or won't do it why not a public facility?

In a realted matter, it may make sense to look closely at the trade-offs between office space needs of the State and the physical plant problems such as exposed pipes and summer cooling. This would be particularly fruitful if new construction is being contemplated as a means of solving office space problems. Conversion of AMHI to office space and building new patient care facilities would open up a number of options including three smaller state hospitals. Obviously, cooling of buildings and the covering of exposed pipes require some affirmative action.

Finally, I would suggest that you struggle with the very real need to find ways to tie together the funding, gate-keeping, planning and budgeting for a given catchment area or at least find some workable incentives for mental health providers to utilize the least restrictive forms of care and minimize the utilization of the state hospitals. This will, of course, be a challenge but may very well be worth the effort.

To close, I would like to thank you for this unique opportunity to express my views to you and I urge you to build on what you already have started in last fall's special session by immediately patching the 'safety net' until a true system of care comes together.

That's the long and short of my prepared text. I assume there will be questions here on.

SENATOR GAUVREAU - Thank you, Mr. Daumueller. Let me start off the questioning and others may follow.

EXAMINATION OF MR. DAUMUELLER BY SENATOR GAUVREAU

Q. It is apparent from your comment this morning that you are in concurrence with the long range plan as embodied in the legislation adopted last fall regarding augmenting the community mental health system, is that correct?

A. Absolutely. From practically the day I set foot in Maine, I've been expousing exactly the kinds of things that you see in the budget package. So, I fully support what the direction is. Full utilization of community-based services, providing care in the least restrictive setting possible and maintaining quality

in our institutions at the same time.

Q. It would appear to me, based upon the last two days of hearings, that the Department remain strongly committed to that same goal toward augmenting the community-based mental health facilities in our state. So in that area you are in total agreement.

A. I would say if we were trying to stack up where I agreed and disagreed with the Department and the people who work in the Department, I would say you would find a 95 to 98% agreement in what should be done.

Q. That's an important point, I think, to stress is that you are basically supportive of the initiatives which the Department has brought forth. Now, you did make reference though in your prepared statement for need to immediately address staffing ratios and other urgent patient care issues. And, I think that might be one of the areas where perhaps you might depart from the current thinking of the staff at AMHI. Now, who would you recommend to set up the various standards of care or the staff ratios which you suggest?

A. Well generally I think you have to ask the people who do the work, the professionals that are involved. So, for physician coverage I think you'd ask physicians at Augusta Mental Health Institute and Bangor Mental Health Institute. What is it the physician is expected to do and about how much time does it take and basically back into staffing ratios that way. One thing that may not be factored in just taking that approach would be what kinds of expectations do you have that the patients see a physician

or how often should a patient see a physician. How often should a patient see a social worker in addition to looking at what they're already doing. I think you have to factor in what you want them to do over and above what they're currently doing. But, - so, I think you can back into staffing ratios in that manner.

One thing about staffing ratios. There are basically three things - I'm oversimplifying - that play into the need for staff: how many patients you have; what's the turnover, admission and discharge rate; and, the acuity or the level of care need. So, you have to factor in each of those. I think you can make a rudimentary start and it's not as sophisticated by factoring in admissions and census. I do think the care needs are very important, but I think if you had to pin your hat on something, I think turnover and number of patients and the expectations that you have for them to deliver a certain amount of service to a given patient. That would be what I would concentrate on.

Q. I understand and appreciate your concern that in articulating various standards we obviously have to - as a predicate we have to establish overall objectives and goals for our facility. And, I think that's what Commissioner Parker was saying the last couple of days that she wanted to contract with a management firm or consultant for getting into the nitty-gritty in terms of re-structuring patient services at AMHI. Are you suggesting that we do this in an interim setting until we can agree upon long-term goals?

A. Yes.

Q. Now, what type of time frame would you think is reasonable or would be needed for the State to develop meaningful standards delaing with staff ratios and whatnot at the facility?

A. Well, there is some work going on in that area. But, I think medicine, social work, psychology and nursing. I think using the staff there, I think you could come up with a well reasoned approach in 30 days.

Q. Well, if I understand you correctly, within a month or so you feel we would be able to come up with a meaningful set of standards by which to deliver patient care services at AMHI?

A. A set of standards for how many people should be at AMHI, yes.

Q. So that the Legislature in deciding whether or not we need to augment the staffing complement at AMHI, you're saying we should be able to get a meaningful idea or direction within 30 to 45 days.

A. Yes. Now, the problem of course always is when you ask the people who are working on the inside and they're coming to you with a request, the argument can always be made 'well, they're just feathering their nest or just padding their needs' or 'how do we know that that's what you really need'. So, using external individuals to provide oversight to the kinds of staffing suggestions that are being recommended is, I think, a matter of - it certainly makes sense to do so. So I'm not particularly opposed to that.

Q. Let me ask you this. A concern which I have is that in our

justifiable desire to engage in a thorough review of the management team at AMHI and reassess our goals, we are perhaps not putting enough time and attention on immediate patient needs as we look at long-term objectives. And, I would be loath to sacrifice any quality in current patient care. So my primary concern is to devise a strategy whereby we can ensure the people of Maine that current residents at AMHI are receiving appropriate care while we embark on this worthwhile objective to do long-range planning.

A. Well, it's my understanding that the current staff at AMHI are looking at their immediate care needs either as we speak or prior to our speaking. I believe that process is either in place or finished.

Q. Then you have made reference to - you approved the idea of engaging in an outside consultant to come in and critique the system to add, I suppose, a degree of credibility so no one can be accused of 'feathering his or her nest'.

A. I think that is - the level of outside involvement is really the level to which you feel, in my opinion, is the level to which you feel it needs to be. So that whatever staffing ratios or levels are set that you can agree with and you can say yes this is what we want. This is the kind of facility that we feel we want to operate in Maine and these are the staffing levels that we're going to support. So, if we have 'X' number of patients in admissions of a certain level of acuity, this is the number of people we expect to fund. And, if - you need, I think, to have

some level of comfort with that concept. So, if you find out it costs - would cost you an extra four million dollars, let's say, to run Augusta Mental Health Institute to meet all the standards that you would like to have met, you have to have some comfort with that.

Q. So, just to paraphrase what you're saying is we could devise a set of interim standards and then refer to an outside consultant. This is all something we could do in the course of this particular legislative session in your judgement.

A. Yes. And, even if you don't do the standards. I would like to see that. That's been something I've wanted to see for a long time. But, even if you didn't do the standards you can deal with the interim request which is based on the collective wisdom of the management team at AMHI. Current team. I think you have to have some faith in the people who are doing the work.

Q. You had mentioned at the outset of your statement that - on page 1 - you mention that a workload reduction which is expected, because we had thought that roughly 20 or so inpatient beds would be established in Southern Maine that has not materialized.

A. Right. This is something - again we've talked about it for some time as being an excellent idea and I guess various providers have been contacted at various times. This is something that would have direct and immediate impact on AMHI and a direct and immediate impact on the number of staff that are needed. If you take away roughly 400 admissions and drop the census, the problems at AMHI are going to be minimized substantially.

Q. You feel that if we establish some 20 or so inpatient beds in York or Cumberland Counties that would translate into a yearly reduction of around 400 in a sense?

A. I prefer to have a 40-bed unit in Southern Maine; but 20 beds would be a great help. And I'd like to - if every admission from York and Cumberland would go to that facility it would take a lot of what we're dealing with at AMHI out of the AMHI situation. In other words, a State Hospital such as AMHI is now an acute facility providing acute care for 800,000 people - a population of 800,000. That's a big job. And, what's happening is that people are having to go - you know, travel miles up the road for maybe a three-day or a five-day stay. Half the people who come to Augusta Mental Health Institute are out within ten days. So, there's a tremendous number of people who are there for ten days or less and a significant number of people who are there for let's say three days or less; and certainly, those three-day admissions - you still have to do the admission physical, all the assessments, throw together some semblance of a treatment plan and discharge plan. That's a tremendously labor-intensive piece of work. So, that acute admission discharge work is something that's been our Achilles heel.

Q. Now, perhaps you can help me and the Committee. Was this 20-bed piece ever submitted to the Legislature for consideration for funding?

A. It's in the - the funding for that is in the September package. It's five or six hundred thousand. I could be corrected on that

and due to be on line February 1, I believe.

Q. February 1 of this year or next year. Today?

A. Today.

Q. Do you have any knowledge on what factors might have stalled the development of those 20 beds?

A. Well, okay. There's two things. One is - in Southern Maine there's a private provider, Jackson Brooke Institute, which is a special hospital and there are a number of general hospitals. The one that probably is most readily able to do it - you'd have to talk to them about this, but I understand there is some willingness, would be Jackson Brooke. They are a special hospital as is AMHI. We're classified as an institute for mental disease. Anyone who is eligible for Title 19 Medicaid is not eligible for services provided in an institution for mental disease. So, anyone between the ages of 22 and 64. That's a federal statute. If you're in a general hospital, in the psychiatric unit of a general hospital and you're between the ages of 22 and 64 and eligible for medical assistance, then you do get funding. So, the advantage of having a general hospital provide this acute service is a financial one and it would be less burdensome to the State. The private might be able to get up and running faster and would probably require a special CON process.

Q. A special CON process?

A. I believe so. I believe it's part of it.

Q. So, there are two different options we would have. We could either contract with JBI or we could encourage the development

of a private facility for that population.

A. Yeah, or you could decide to do something public. But, there again, that would be a major undertaking. And, it would take longer than having someone who is currently in existence to start.

Q. Okay. And, I guess I had asked what factors had retarded the development of those inpatient beds.

A. In a general sense I think general hospitals are reluctant to take that role on and there are issues of liability and, quite frankly, want to. Not every general hospital wants to get into the business of taking involuntary patients. So, it's not something that every general hospital feels is part of their mission. In fact, there'd be very few that I think feel it's part of their mission.

Q. I think it would probably be a larger medical center that would be able to take on that responsibility. They would have perhaps diverse labor populations available to them to meet that population's need.

A. Right. And there's all sorts of - there are other issues. This was discussed fairly extensively in the Commission on Overcrowding. Issues of training and recruitment exist in the private sector as well as the public sector. I think recruitment issues may be even stronger and the recruitment more difficult in the public sector. But, recruiting psychiatrists for inpatient care is not an easy task, even for the private general hospitals.

Q. We appreciate that. Let me just switch the topic a little bit here. And, I understand and appreciate that your overall concern is to enhance quality of care; but part of our concern in these hearings is to explore the reasons for the decertification of our 30 or so beds at AMHI and whether we could have taken action earlier to foreclose that possibility or prevent that from happening.

Now, as I understand it, the State received formal written notice on or about the 23rd of March of last year from HICFA that as the result of recent surveys AMHI would be decertified for Medicare as the result of problems with record keeping, staffing and I believe there was a problem with the admissions unit as well.

A. Yes. We had sought certification for basically 86 beds, for the Admission Unit which was 30 beds, the infirmary which is 16, and the older adult program which was categorized as a 40-bed unit.

Q. Now, it's my understanding from Department presentations earlier in these hearings that there was a shift in emphasis at the national level and the standards were more rigidly applied. And, basically focused - veered from a team approach to more of a physician-oriented approach. And, as a result of that the Department has told us 'we were found lacking' and that was a primary factor in our decertification. The question I would have to you is since you were Superintendent at the facility I believe from 1985 through -

A. April, 1986.

Q. Through January '89. When was your earliest knowledge or awareness that HICFA would be moving to a different interpretation

of its standards on certification?

A. Well, I think in September/October - the last day of September/ first day of October in '86 - we were being - we were one of the first hospitals to be surveyed under a new process essentially. Where it gave the surveyors more latitude. Frankly, I don't understand completely what the difference is myself, but they'd talked about that and they did say that they had more latitude and they did say that they were finding us in compliance but they weren't happy with our staffing and we did not meet the standard for nusing staffing at that time. And, so they would then be scheduling a follow-up visit. Actually it turned out to be two follow-up visits - one I believe in April and one was in June I believe.

Q. Of '87?

A. Yes.

Q. And, as the result of those follow-up visits the State, I understood, did take sufficient corrective action. We did add additional positions and we did address enough concerns to retain the certification status.

A. Yes. As a matter of fact, like I told you, I came in April of - April 22nd I started as Superintendent. On the second of May - actually, go back a little bit. My job interview was on February 11th which just happened to be the exit conference for Medicare. So, my job interview was delayed even - and that was the Medicare conference. I started in April.

Q. Did you have a warning, perhaps, of things to come?

A. No. Actually, no I didn't. And, so on the 2nd of May we got the notice, the written notice, that we were being decertified. But, in that notice what they said was if you feel you're in compliance, turn in a plan of correction and we'll come back and do a resurvey. So, what happened there is a request for staffing was put together with the Department assistance and it just so happened that you were in a session - the end of May it was - I guess it must have been - and did approve a section of staffing which was given and then the surveyors came back on May 29th and found us back in compliance. Then the September/October survey came about and we were found to be in compliance but barely so and that the nursing staffing was out and they would do a follow-up.

Q. This was again in '87 - the fall of '87.

A. Yes. This is '86. Then you move to '87 and that's where in January we started having a census and admission spike - fairly unusual and fairly rapid escalation in the numbers of patient census. At the same time we were in the midst of establishing the medium security unit you had authorized in the Legislature; so we had just completed a reorganization in February and established -

Q. That's the forensic unit?

A. That's the forensic unit. It used to be an 8-bed unit with up to at times 14 or 15 people in it. We then converted that to a 33-bed unit with a high security and medium security section. Then in early March things were getting pretty bad and Kevin Concannon and Ron Welch asked the Governor to come through and take a tour. At which time he had a chance to see beds in the

hallways, severe overcrowding and he was told of understaffing. We worked on a proposal. Actually, myself and staff worked pretty much that weekend and Ron Welch was there also; and we put together a series of proposals and made a strong recommendation for one that included 58.5 positions. This was taken forward and ended up being a request for 54 limited-period positions. Then, that request was taken to the Legislature, but instead of being 54 positions it was turned into 27 permanent positions and 30.5 limited-period positions which would evaporate on September 26th of 1987. So, in addition to those limited-period personnel, there was a community piece built in and that was I think it was 31 community residential beds. And, that was designed to bring our population down.

Q. In terms of the deficiency being cited back in '86 and '87, were they of the same nature which were cited in 1988 or were they different?

A. Partially. The big emphasis in anything prior to February of '88 was nursing and records - nursing and documentation. And, I think people will tell you that everybody has trouble with records and documentation in Medicare surveys. However, we seemed to maybe have a little more trouble than others. They had not been enamored with our treatment planning process for some time. So, there was an emphasis change in the February survey; and although they gave us a couple of hints about medical leadership in the last survey saying they like to see a little more leadership in the physicians leading the team. But it wasn't anything

like the kinds of comments we got in February.

So, Medicare - we got our 54½ positions and we recruited a goodly number of them, I guess. On May 28th Medicare came back as a follow-up to the previous survey. They found us still not in compliance in May. Then, in June - coming back in May we were still coming off this tremendous rash of census and admissions and the conditions, of course, were perfect for not getting certified at that time. Well, in June things settled down very nicely and for most of the summer of '87 things were in pretty reasonable shape and there were really only a couple of spikes in the fall which concerned us. There were some significant spikes, but they were only spikes and they didn't last a great deal of time. So, our population and everything went down in June. In July they came back and did the follow-up survey and found us back in compliance. This was primarily nursing that they were looking at.

Q. Are you saying it was primarily due to the fortuitous decline in the census at AMHI that we managed to -

A. Two things: staffing and decline in census. So then in September of '87, the limited-period personnel that we had evaporated. There wasn't any real way of making a case to not have them evaporate when you look at the numbers - the census - and what we had told the Legislature what would happen and so forth. So, we had - in a way it was good luck and in a way it was bad luck. We had a decline and a fairly easy summer. So,

things were not that difficult over that summer.

Coming into the fall, then, we had a situation where Susan was informed that we needed to look at cost savings. Find methods of saving funds. And, the Department of Mental Health and Mental Retardation's share of that cost savings was, I believe, 3.9 million dollars.

Q. When you say Susan was informed for the need of cost savings, I assume that means that someone from the Executive Branch informed the Department that there was an effort to try to effect savings.

A. That's my understanding.

Q. Now, Commissioner Parker told us that basically she interpreted that as a request to perhaps leverage federal dollars to Medicare or Medicaid more prudently.

A. I think she made a real - I think she did some really good work in that time period; but initially what happened was - well, one of the things that I was asked to do is what would I say to a four percent across the board cut at AMHI. Of course, I said that there's no way that we could - that I could do that professionally or ethically. There's no way that I could conceive of cutting back on staff at AMHI. Subsequently, all of us in the senior management team were asked to look for ways of saving costs. So my assignment was to look at how we might save costs in contracting various options out, various departments and combining the forensic unit at AMHI and Bangor. And, there was a couple of other things that we looked at - none of which looked very good to me. So, my recommendations were pretty lukewarm.

I didn't think we should do any of it.

Now, what Susan did, and much to her credit, was she emphasized revenue enhancement and very much focused on obtaining more federal revenue for what was already going on. And, saved, I think, all of her departments from having to make the cutbacks. I think they were all saved. I don't recall - I only fully recall what happened at AMHI.

Q. So basically you're saying that because the Department was able to maximize a leverage of federal dollars, that warded off any requests for cutbacks in the department, to your knowledge.

A. Also, though, what it did is kind of set a backdrop of how staffing requests might be viewed.

Q. You mean that perhaps requests for additional staff would not be viewed in the best favor?

A. Might not be welcomed. And in fact that was the message.

Q. Now, if I understand, we did in July of '87 secure a recertification.

A. Yes.

Q. And the following September those 30 or so temporary positions evaporated.

A. Yes.

Q. So, as of fall of '87 without attention to the request for parsimony in the Department, were you of a mind to recommend additional staffing as you were putting together the budget for the next year?

A. Well, I would say that there was - I broached the subject of the possibility of continuing the LPEs - limited period - or going back to them; but, again, it was not something that we could demonstrate that the need was there. We were at or below what we said we'd be at or below when we gave you the proposal. So we would be coming back saying we need more staff but we've accomplished what we said we would accomplish. It didn't make sense to us that the case could be made at that time and I could see the reasoning in that. So, I don't think there was anything untoward about not requesting staff in 1987.

Q. And, when was the next significant development regarding our problems with HICFA?

A. Like I said, there were a couple of spikes in November. Susan mentioned the Friday Reports which is one of the things that we all faithfully do either on Thursday night or Friday morning the first thing to essentially communicate the pulsebeat of what's going on in your operation. In November - November 13 of '87 - our census at that time was 372 and I did say that from past experience we know that there should be steady increase from now through March with potentially more difficult discharges due to cold weather and more difficulty in staffing units because of the holidays. This is an adverse trend of significant proportion. Now, I would also say that in subsequent weeks that things settled down also. So while there were a couple of those spikes, and I do mention them in my reports that these are adverse trends, they were momentary spikes. We did know that we should expect an

increase in the fall and in the early months of the year. At least the first quarter had been the pattern.

In January I think things started looking a little more grim. For example, on January 8th the weekly report talks about, 'On the last day of December we had 334 inpatients as of midnight. January 4, the Monday of the holiday weekend, there were 363. As of Thursday there are 364.' So, it's 334 to 363 - it's a 29 patient increase. If you look at the largest general hospital unit in the State - I think it's Maine Medical Center - I think that's 26 beds. I could be corrected, but it's right in there. So when you talk about 26 beds, you're talking about - it's like having a whole hospital pop in on you in a week. So, as of Thursday there were - admissions were running about 129 a month. This type of pressure does cause some degree of overcrowding, particularly in the young adult and adult units and occasionally on the admission unit. More significantly we have a number of difficult patients and fairly high degree of sick leave usage. Hopefully, by mentioning these problems in the report they will miraculously evaporate as they have tended to do in the last month or two. At the same time we're living on the edge of our ability to handle the numbers and types of patients we currently have.' That was January 8th.

January 15th - the same thing - the Friday Report. 'Census and admissions still remain high for the month with significant crowding issues on our young adult and older adult treatment units. We've had a great deal of acting out amongst the patient

population due to the presence of a large number of very difficult personality disordered patients who are experts at pushing all the right buttons.' Indeed, that is the case. 'To help staff members regain a sense of control, a number of meetings have been held and training sessions are being conducted to help the staff work through the dynamics that are going on. The interventions so far seem to have stabilized the situation.'

January 22. 'Past week the patient population spiked briefly creating some difficult situations regarding overcrowiding and staffing. Staff frustrations were high in that conditions were overcrowded and we were dealing with some extremely difficult patients who were successfully pressing all the right buttons. At times like these staff feel out of control and it is encumbered upon the unit leadership and administration to show a commitment to maintain control of the facility and design the strategies both on a unit basis and an individual basis. While things are still very busy, crowded and stressful, the situation has improved through some managerial interventions. At the same time we continue to stretch the limit of our capacity when census figures break the 360 level. Of course, depending on patient mix.' Then there's another note: 'Medical staff continues to be stressed - it should be stretched - very thinly. One solution under consideration is the reduction or eliminating the coverage of Maine State Prison by Dr. Owen Buck who is personally under great pressure because of his assignments. We are all working on some other options for consideration by the Department.'

So, then - so we're running into some problems. On January 27th we had a meeting that's called the 'Governing Body Meeting' and this is basically the Commissioner, the Associate Commissioners and the Clinical Director and myself and the Bureau of Mental Health comprise this. At this meeting the Commissioner and the Associate Commissioner for Administration was there as well as myself and Walter Rohm. Ron Welch wasn't there and at the time the Bureau Director position was vacant. Jay Harper hadn't been hired yet. At that meeting we had a conversation entitled 'Contingency plan to deal with high census acuity admissions and crowding' and discussion of reoccurrence of high census and the likelihood of this continuing through March or April took place with the additional issues of overtime, staff morale and attitude factors also being taken into account during the discussion. Action - it was decided that the Commissioner and Associate Commissioners would set a date for a meeting to deal with this issue by mid-February and that the Superintendent would supply concise illustrated documentation of current conditions.

January 29 is another weekly report. Census at 355, 11 short leaves, and let's see, the adult program had 60 patients with 8 on short leave and a maximum census of 55.

Just as a word of explanation, we - our treatment units - we have a bed count and then like a maximum count, our own internal maximum. So, the 45-bed unit had a 55-bed maximum and the 40-bed unit had a 45-bed maximum, our theoretical view of the most that you should put on the unit.

The adult program had 60 patients with 8 on short leave, which means they would probably return, with a maximum census of 55. So, that unit has been overcrowded for some time, but 60 patients is an awful lot for that area.

Back to Medicare. February 5th Friday report, we hear from Medicare during this week that they're coming on the 22nd and 23rd. Now, that's a surprise to us because the last survey was in June and we were thinking it would probably a year. In fact, we had made some phone calls to try and find out when it might be, but the response was they won't tell you. They'll decide when they come. So, we had kind of put together a process whereby we were revising and retooling our treatment planning process with the idea it would probably be close to June and that would be the end of this process. So we were a little bit disconcerted when they said that they would be coming because we were kind of in the middle of piloting a treatment planning system. So, that just causes some extra scurrying is what it did.

February 11 we had a meeting with - at the central office and I supplied them with basically a fact sheet and a packet of materials which indicated that a number of things - CORs, one to ones, 15-minute checks, SRC incidents, sick time and census on different units and mental health worker overtime and the amount of floating that was going on. All these indicators were up in significant proportions. And, the written material that I gave out said 'that conclusions during the month of January our patient

census increased, our admissions increased and patient acuity increased. Staff sick time also increased as did our mental health worker overtime. During this period of time patient treatment, safety and security, documentation and staff morale deteriorated. At the same time we have historically had high admissions and census during the first quarter of the year and staff do remember how nice it was when we had our extra mental health workers on LPE status. They and I feel trapped with no reasonable resource response should our census again peak. The Cumberland involuntary treatment option is also on hold. Data shows that our staff is working very hard at keeping our census stable and individuals out of the hospital longer; but we are still on the edge of disaster coming into our critical period. The residential options seem to be finally be coming on line but there's no current contingency plan for another large influx of patients. Objective: determine how we will respond to overwhelming patient influx and options intermittent LPEs - limited period - project workers, diversion, deflection, reorganization other.' So the idea was what is it we can do. The bottom line is always - it's been the same theme since I can remember. Less patients or more staff when things like this happen.

The outcome of that meeting was generally to attempt to work better with the existing resources at hand and any diversions or any additional things that could go on in the community would be attempted and we would continue to monitor and move along the

placement options that had been funded.

So, we're coming into the Medicare time now. February 12 I do say '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 through the first quarter.' Then I talk about the Medicaid survey for the psych hospital and their findings. They had some concerns with medical records.

Q. At this point, before you get to the 22nd, which I guess is the time of the census, you had voiced concerns about over-crowding; but had you made any specific - you told us about the - possibly transferring Dr. Buck from MSP to AMHI. But, had you made any other focused recommendations to the Department regarding additional staff?

A. Yeah. I had asked about the possibility of going back to the LPE - basically the same thing we had had in the fall.

Q. The 30 temps?

A. Yeah. And, if that wasn't reasonable, you know, could we do it contractually. Those things - basically, those things that would - that were in the purview of the Executive Branch to control and deal with in a short period of time.

Q. What was the answer?

A. Well, the answer is obvious - no.

February 19th. Now, we're starting to come to the survey time. 'After a heavy weekend in terms of admissions we're back up to 365 census level. The acuities are consistent with recent

past and we're a bit more crowded than we'd like coming into a Medicare survey. Medicare will be here on 22 February and will give their first exit conference on the 23rd. We expect staffing to be okay, although these surveyors might notice the reduction of mental health workers and the increase in census and acuity. Hopefully, this will not be a significant problem. The area of medical records will probably cause us more difficulty. As a matter of fact we are in the midst of changing our treatment planning process through the use of a pilot project and Medicare's early appearance is creating some additional scurrying.'

So, we were basically trying to reorganize our treatment planning and kind of got caught in the middle of reorganizing. But - so that causes some - it complicated our life. Medicare came on the 22nd and 23rd.

On the Friday report of the 26th, and then I'll go back a little bit. 'This week's census remained high at 366. As of today admissions are running about equal to the previous six or seven months. Our acuity has been high particularly in the infirmary area. Staff continues to handle these large in a very professional manner. Medicare survey - Medicare was here for their annual review on Monday and Tuesday indicated to us that the staffing and medical record conditions were out of compliance. Physician coverage and physician supervision of physician extenders, inadequate documentation and monitoring of patient records, active treatment and the amount of activity time on the Medicare

distinct parts were all cited as problem areas. A plan of correction will be developed with a close oversight involvement of the Commissioner and the Associate Commissioners during the next seven to fourteen days. The long-term issue is, of course, the extent to which AMHI participates in the acute and short-term hospitalization for rather substantial mid and southern Maine catchment area. Lack of involuntary options of the major population the size of Portland, Lewiston/Auburn and Augusta put AMHI in the position of being a very much active rather than secondary tertiary facility. It is this acute short-term hospitalization that most readily lends itself to public / private partnership and utilization of general hospitals.'

Q. If I can just stop you. This is your February 23rd note - February 26th Friday report.

A. Yes. It's right after the survey.

Q. If I heard you correctly, at least in your mind there was a credible threat of decertification as of - a verbal notice at least - in February of '88.

A. We knew that we were not going to be certified at the time of that exit conference. They always give you a real good idea. What they do say, however, is that before we can give you official notice we have to send this back to the office and they'll give you the official notice. They always leave themselves room for changing or if they found a gross error in something - one of the surveyors did or whatever - they could change it. I would say you're 95% sure when they leave.

The other thing that we - Dr. Fong, who was the physician/ surveyor, was heading up to Bangor and forgot his materials. And, so like any dutiful superintendent would do, I happened to notice the typed report that he was sending to his superiors and so I copied that off and we gave the - he may have come down or we may have it sent up. I forget how we did that; but we made sure he got his material in tact of course. We had a copy of it which made it a little easier for us to develop a plan of correction. It was kind of humerous at the time; maybe less so now.

So, we started working on a plan of correction. Now, you have to keep in mind that we were cited for not having enough psychiatrists and not having enough activity staff. And, in my mind, there was a problem in clerical staff. That was not a citation from Medicare. That was my own conclusion and the conclusion of the administrative staff. So, on March 4, the weekly report, 'census remains high ranging from 369 to 358. Admissions contine to be fairly even at 120. March figires to be our heaviest month with some previous history of heavy April workload.'

'Medicare survey. We're currently in the process of addressing the medical record deficiencies highlighted in the Medicare exit conference. We have set up a plan of correction with the tag numbers - that's according to the standards - with the tag numbers for the standard, the deficiency, the plan of correction, the responsible person, the time frame for completion. We are working with the Department on matters relating to resource allocation.'

March 7th - the next week - 'our census is running extremely high. Patient acuity is very high due to the small number of very difficult individuals. As of today we are at 376 patients and residents. There were 42 admissions in the first nine days of the month which would equal 145 admissions if the pace continued; and there were numerous patients needing one-to-one coverage and 15-minute checks. The weekend is coming up and could bring us back near the 400 level if we would have an influx of current admissions that are severely ill and not homeless street people needing shelter.'

'Medicare. Our activities to correct Medicare deficiencies are in full swing with a substantial plan of action in various stages of implementation. The most ticklish area at the present time is staffing requirements and activities which mandates evening and weekend activities on a seven-day week basis.'

March 14 - 'census is still almost 370. Medicare plan of corretion: work continues in correcting deficiencies not yet officially cited from our last Medicare survey. Staff seem to be pitching in to solve the medical records portion of the problem. Shortages of activities, psychiatry and clerical staff are the most troublesome, but various options are being developed with the involvement and assistance of the Commissioner and Associate Commissioners.'

March 25 - 'census in mid to high 60s.'

April 1 - 'for the month of March there were a record number of admissions - 144. Census was 366 for the month which is up

16 from the previous month. We have admitted a number of individuals who have significant medical problems. This is a continuation, and in fact an acceleration of previously record high admissions for the last six months or so. We are extremely concerned about this trend; and although we expect a peak during the first quarter of the year, our current numbers are more than we would have anticipated. Over time AMHI's overtime has been quite high and growing rapidly and we are doing everything we can to maintain it at a reasonable level. At the same time we're dealing with significant increases in numbers and high levels of acuity. As an example, we're having difficulty finding patients for our Alternative Living program in our inpatient population.' Alternative Living is the half-way house setting.

'Medicare. We received notice that our provider agreement with Medicare would be terminated as of - this is April 1 - as of April 22 and that a notice would appear in the Kennebec Journal on April 8 indicating the same. This was expected. What was unexpected was the fact they did not mention any possibility of corrective action in their letter and only referred to a hearing before an administrative law judge.' So, this was a surprise. We sort of expected to see 'if you disagree with this, send us a plan of correction'. 'A subsequent call has yielded a visit with HICFA Regional Office in Boston to attempt to remedy the situation. We have made great strides in terms of record-keeping, but there are still some areas that are troublesome and they're not easily corrected by changes in procedure and

closer monitoring. They cite what they consider to be serious manpower shortages in the area of psychiatric - in the psychiatric area and in activities. We have addressed that area of psychiatry through a 20-hour contract with Dr. Veragay* which will begin April 12 and we have revised the activity schedule effective April 18, '88, to provide for weekend coverage and evening coverage. There are, however, no additional resources directed to that area and we will attempt to make the case that our current staffing is adequate.'

April 8 - 'census is 370. Older adult unit is over its census. A large number of patients require ADL support and basic nursing care. A number of incontinent patients among this group. Preparation for oral review. Much work has gone into preparing for HICFA meeting in Boston on April 12. Each deficiency has been analyzed and we are colating the efforts which have been made towards a plan of correction for each of those deficiencies. Meetings have been held between AMHI personnel department and unions regarding the impact of changes resulting from reconfiguring the therapeutic activities department. Much work has gone into revising the therapeutic activity schedule to allow for evening and weekend coverage. And, some of the staff has been quite upset over these changes. Every effort has been made to minimize the impact of what we feel are necessary changes.'

What this is saying is basically the option for additional staff was not there; and it was suggested.

---

* spelled phonically

Q. Why don't you elaborate. You say the option for additional staff was not there. What do you mean by that?

A. Well, what I'm saying is we were cited by HICFA for inadequate psychiatric staff, inadequate activity staff and my view was clerical staff was a problem. Those specific areas were recommended for additional staffing by me and the decision was to not go for staffing.

EXAMINATION BY REPRESENTATIVE MANNING

Q. Excuse me. Is that - what you just said - in that weekly report?

A. Well, you have to understand that this is a weekly report that goes to the Commissioner and the Governor's Office. It's not a real good -

Q. In other words you feel intimidated asking the Governor's office -

A. You just don't paint a person in the corner. It's just not good form to - I mean, this is - my work goes to the Commissioner, okay, and to communicate too directly to the Governor would not be proper - proper protocol.

Q. Call it teamwork.

A. Yeah, I guess that's what you'd call it.

EXAMINATION BY SENATOR GAUVREAU

Q. Outside of the context of that so-called Friday Report, you were involved in devising a plan of correction to submit to the Boston office.

A. Yes.

Q. And, is it your statement that you were recommending augmenting staffing patterns in the psychiatric, social and clerical?

A. Yes, those three areas. It would have probably been less than what originally came out. I think we were looking at it would probably take five additional people to run the evening/weekend schedule. And - in terms of activity staff. The request after the May survey was, I believe, 15. So, it was a slightly smaller - in looking at what do think you need, it would be like 5 for the weekend coverage and some clerical help and physician coverage. There's some real problems - even if given a physician, there's the recruitment problem. So I mean there were some issues in terms of what you could do how fast.

Q. My recollection was that we had added some 18 people in July. The Governor used discretionary funds for that purpose. I'm not clear on what you're saying. You had recommended five weekend individuals and then adding a psychiatric component and clerical?

A. Five people would be sufficient to cover evenings and weekends. That would cover that section of programming. They cited us for insufficient staff and they cited us for not having any program on evenings and weekends. The number of people it would take to put a program in for evenings and weekends only would be five; then we did make some internal reallocations to beef up from other areas.

Q. Dr. Buck was transferred to AMHI.

A. Yes. That was - actually that suggestion was made before Medicare. That was part of the plan of correction as written.

Q. Are you saying you were gonna recommend five new staff positions as of going to HICFA for the April 12th meeting? You were recommending five new positions?

A. Yeah.

Q. And that wasn't acceptable?

A. Right.

Q. So now you're at the April 12th meeting. And, what did your plan of correction consist of?

A. I think you may have copies of this. A training effort - a substantial training effort which did - you have the material and I think you've discussed it somewhat. I believe I personally wrote every word on this, but I may have had some help from Rick Hanley. This was my writing. I thought we - you know, I think we made a pretty good attempt to do with - gave the best shot that we had. That was the task - take the best shot we could with what we had.

Q. This is the six-prong plan which we should have on page 2 of our Medicare narrative.

A. Yes. So, basically, it's the training effort, extensive work that Dr. Rohm did with his staff in beefing up the supervision of physician extenders and tightening up various aspects of medical documentation. Dr. Buck - taking him off the Maine State Prison so that he could supervise physician extenders better. The addition of a 20-hour contract with a physician, the revision and some work with the social work department and their documentation, and revising the therapeutic activities schedule to include evenings

and weekends.

Q. And, did you believe that that plan had a reasonable chance of securing approval from the Boston HICFA?

A. Well, I think we were giving it our best shot. I guess we - you know, it was like a 50/50 at that time. That's about what I was thinking. Maybe, maybe not. Maybe 60/40. We were working very hard and we tried to put together the best thing we could. We did make some progress. In fact, when you come to the May survey you see substantial improvements in the area of documentation and there were many things that were cleared up; but there were still many things that were left.

Q. Now, as I understand Commissioner Parker's presentation, it was shortly after the April 12th meeting in Boston that the Department received correspondence to the effect that the State of Maine had proferred a plan which deserved consideration. That, in fact, would prompt the followup survey in May. Is that your understanding?

A. Yes. The term 'credible allegation' is basically what moves HICFA to do something. If they receive a complaint against a facility, they call - and they get what they call a credible allegation, that means they'll go and inspect the facility. They'll do - the other thing is if there's a credible allegation that we were in compliance, that they could come out and look at it. My view is that given the circumstances it would have been very foolish for them not to give us another look see. That we did prepare a nice presentation for them. And, it would put them in

a position of appearing to be unfair if they didn't do it. So, I was - they didn't give us any assurances that they'd come up, but I think we were all pretty confident that they would come out again.

Q. So what's the next significant development, then, in this story the May survey itself?

A. Yes, I think so.

Q. And when did that occur?

A. May 27. Well, there are some other significant things, I guess. The census - the April 15th Friday Report - census was 375. And we didn't have a lot of luck with our census and admissions and the kinds of things that were going on during the survey. It was not the best of circumstances that we were working with. We were working with a heavy workload prior to going into a very significant survey. So, the conditions were there for getting knocked off. 'Census was high on April 15. ARC episodes were a concern last month and remain a concern. It seems clear that SRC usage is related to the hospital census, number of admissions, staffing levels and patient acuity.' I mention that HICFA did not indicate one way or another whether they would be resurveying us, but it's our opinion that they will. Stanton Collins indicated that the follow-up survey would be unannounced and that if they did survey us, Dr. Fong who did us the first time would come back and do it again for continuity.

Again, April 22, 'census was 377. Stone North Middle, our older adult program - that's one of the units we're trying to

get certified - which is a Medicare distinct part, is ten beds over census and episodes of single care usage were up dramatically during the last reporting period. Physical assaults were also at a high during March and for the last nine months. Going into the weekend we have 28 patients on our 30-bed Admission Unit with only one transfer out. Only one possible transfer out. Admissions is a three-day period and the Admission Unit tends to build up and after Monday they're transferred to the other treatment units. Admissions, again - April 29 - census remains uncomfortably high at 373. Acuity levels remain fairly constant, although constant these days means high. The adult and older adult program continue to be overcrowded having 57 patients on a 45-bed unit.' That's the one we're trying to get certified. 'And, 53 patients on a 40-bed unit. Respectively the rest of the hospital is at or near census. It is increasingly difficult to find appropriate patients for minimal levels of supervision - in terms of crowding, Stone North Upper with only 12 staff has a patient population of 24 patients. We've been running this unit as an overflow area and as an extension of the alternative living program. It is increasingly difficult to find appropriate patients for the minimal levels of supervision in these two areas, however.' So, there was some physical space up there. You could put 40 patients on Stone North Upper, but that's the staff that was deleted - limited period - back in September.

'Preparation for Medicare survey. We continue in our preparation for Medicare survey and we've made substantial improve-

ments in our medical records. Our certification will probably boil down to the adequacy of psychiatric staff, adequacy of activity staff. We now have seven day a week schedule and evening schedule and active treatment.'

May - 366 census, 130 a month was the pace of admissons. We received a new deadline from Medicare. They moved it back. I think it's because they couldn't get the physicians to come in.

May 20 - 'admissions are running at a pace of 130. Census is 367.'

May 27 - 'as of May 26 census is 377. Nine people on short leave. Admissions are on a pace of approximately 130 a month. Patient areas are crowded once again and overtime will no doubt be unusually high this month as will incidents and usage of single room care. Dr. Fong and Dr. McCann, doctor of nursing, arrived Tuesday and will be conducting an exit interview - exit conference at one today. They have been reasonably tight-lipped as to outcome. However, they have also been honing in on admissions, acuity level, and weekend coverage. Conditions are perfect for non-certification as they have a recent suicide, some patient deaths, higher levels of incidents and overcrowding are distinct parts to point to. Our record-keeping has improved greatly. However, there will be plenty of gaps found as these surveyors are quite meticulous and very competent. Regardless of the outcome I think our staff has put forth extraordinary effort and have made massive changes in a short period of time. For this they should be commended.' And, that takes us thorugh Medicare's May survey.

Q. It sort of seems that based on that last note, you were not too optimistic as far as the prospects for reattaining -

A. Well, you have to remember that note's written on the 27th. That's the day they're gonna leave us. So, we had some signals - non-verbal cues - comments to go by. So it would be unfair to say my crystal ball was on that report. But, I think the general problem is if HICFA's coming in telling you you're short on - you have staffing problems. Staffing is a problem at your facility. And, in activities we didn't add anything. We did some reorganization and so forth, but they were suspicious of us in that area. In nursing on the first go-round they suggested that sometimes we were doing - our nurse staffing was smoke and mirrors. And, I'm not quite - I honestly don't know what they meant by that and we were all kind of wondering what that meant. It just sounded like they didn't trust us and we were trying to pull something over on them. I didn't feel we were doing that. So, I really didn't know what the heck they were referring to. I personally feel that sometimes they don't give you enough credit for the assignments that - and the people they consider indirect care, they don't always give you any credit for those type of nurses. So, that's a minor point.

Q. When did we finally get confirmation from HICFA that - May 27th?

A. Yeah, because they had already given us notice that we were decertified. So, that was it. When we didn't pass that day - now they may have followed up with a - they did follow up with an official written report. I don't know if I have the cover letter

on that or not. I don't have the date that it came to us.

Q. I recall reviewing that. It just said they did note some significant improvements. I believe there were improvements in record - in documentation I believe it said. But, ultimately, they felt we would not pass muster.

A. Right.

Q. Now, the next significant action I can recall occurring is that in approximately June of last summer the Governor recommended I believe an additional 18 people work at AMHI. Now, I guess I'd ask you what was your response after you had been confirmed - we knew that we would not attain recertification. What was your next step after that?

A. Well, there were - June 3 - on June 3rd, just for your information, we're at 379 in terms of census. Admissions for the month of May is 125. That's fairly substantial when you get that level of admissions. Twenty people on 15-minute checks, five in constant observation, eight receiving one-to-one. What that tells you is if you have a bunch of people on 15-minute checks and you have a bunch of people on one-to-ones, then you have a bunch of people on COR, which those are all overtimes. So, if you have ten or 15 of those going on at one time - let's say you had 10 - and two shifts probably for sure, that's 20 people and whatever you had to carry through the evening shift. You might have up to 30 people needing to be called in for overtime to take care of that type of acuity. So, we were having that type of acuity in the summer period.

Medicare. 'Obviously the major projects for this week and coming months will be dealing with Medicare decertification issues. We will of course be working with the Department to formulate a reinstatement plan; and given the current census and unrelenting admission load, this should be a challenge.'

So, June 7, we prepare a - there are numerous meetings and conversations and I can't tell you - either my calendar doesn't have all the entries in because there was significant back and forth on this primarily with Ron Welch and the Commissioner and somewhat, I guess, with Ron Martel. But, what I did is I believe it was June 7 - I prepared a packet of material for presentation which included a table of contents, which I am reading from; a general narrative, and this is the outline of my presentation; setting and what happened - explaining what happened. Census didn't follow the trend, admissions were extremely high - no let up, acuity very high, staff working high overtime, Medicare/Medicaid survey more stringent, preparing for JCH, new standards, more stringent, more medical, patient rights rules, compliance and pull string, having documentation. So, what's the problem - the crisis, census and admissions, loss of Medicare/Medicaid for 65 and over - so they were tied together. The thread of Medicaid loss in the adolescent unit. That is kind of a side issue, but there was some work needing to be done over there and trying to gear up for JCH. Problem definition, quality of care and reimbursement, approach. So, the approach I'm suggesting is aim for the

114th as the major fix. Keep AMHI afloat for another two years to get any significant community impact. Maintain reimbursement and deal with some of the crowding issues. So, in the packet, in addition to this, is admission and census charts which show the admission and census, the cost sheets for what I'm recommending, and then the narratives for psychiatry, the psychiatric place - ment sheets with - Dr. Rohm and I have worked on, by the way - does have input into the staffing and development of budget, particularly the medical staff. The activities narrative and activities placement sheets which were put together with Carol Donnally and Rick Hanley who's her boss. And, a narrative on clerical services. Attached was basically a request from me which had the 18 positions in it; but there is also another request attached to deal with what I felt was even more severe which was the problem of overcrowding. We call it overcrowding all the time but it's really a matter of overcrowding equals understaffing. So, the true word in reality probably should have been understaffing. Crowding was easy. Everybody understood what that meant. So, deal with the crowding issues. And, that was a significant proposal - between the three of them would be about 60 staff which -

Q. This was made in one month?

A. I'm sorry?

Q. What time period are you in now?

A. This was all together. My suggestion for the 18 staff and the overcrowding was at the same time. It didn't come afterwards.

It was the same time.

Q. So, what time - this is 1988?

A. 1988 - June 7 - and there were numerous meetings on this.

Q. Okay. Well, we know that ultimately 18 new positions were funded on a temporary basis to get us through until the special session in the fall.

A. Yes.

Q. Is it your commentary or testimony today that you were recommending some 60 positions of which 18 ultimately were approved?

A. I had a couple of things sectioned out. One was 18 positions for the Medicare. The other was an overcrowding piece which was basically restaff the Stone North Upper. It's like going back in time to '87 with a little additional augmentation and putting the professional staff on there. Then a float pool, so there'd be a 13-person float pool. And, my comment was if you can't do this, at least do the float pool because of - I was hoping that they'd want to go for the whole package.

Q. So what ultimately got approved though was not the staffing on Stone North of the float pool, but the positions to help us regain certification for Medicare.

A. Yes. Now, I am very clear about the level of enthusiasm I had for that proposal - the overcrowding. And, that one was one that was vigorously supported by myself. And, right up until the end that there was a refusal to bring that about.

Q. Now as it turns out, the 18 additional people that were added in the summertime of '88, where were they assigned?

A. I'm sorry?

Q. What were their duties?

A. The 18?

Q. Yes.

A. Okay. The 18 staff consisted of ten people in the therapeutic activities department.

Q. I beg your pardon?

A. Ten people for the therapeutic activities department, two recreational therapists and four OTAs and four RTAs, which are somewhat like mental health workers. They're not licensed or certified, but may have special training.

Q. Let me just focus in a bit here. We know that we've been decertified due to concerns about our admissions unit, recreational programming, our physician contact with clientele and - I guess that was it. Now, those positions, did you support those 18 positions?

A. Yes.

Q. Did you believe at the time that was a meaningful and appropriate response to the certification?

A. Yes. In hindsight I underestimated, but at that time, yes.

Q. Was there another overture by the State of Maine in the summer of '88 to HICFA to again come back in and survey us to look at our certification?

A. Not to my knowledge, no.

Q. When did we next ask HICFA to come in and take a look at us?

A. We haven't. We have not.

Q. So why did we wait from - if you felt in June of '88 we had added 18 new people and you felt that was a meaningful response to the certification problems, why between June and January when you left the institute, why wasn't there an effort made to again approach HICFA and regain certification for Medicare?

A. Well, we were not ready to do it. There was a number of things - continuing high census and admissions and remember my comments earlier about the admission unit becoming a resource drain and a bottleneck. That's part of the backdrop here. And, the other part is just the stabilization of medical staff was not accomplished until October and then that isn't particularly stable even yet. There are still two - basically two unfilled psychiatry positions at AMHI. While the Medicare - all the positions for Medicare were filled fairly rapidly, the backfilling wasn't necessarily done in the other areas. So, for example, the recreational aides and all that, they were mostly taken from inside. So, while we hired all those people, then we had to rehire mental health workers to backfill the people that were promoted to -

Q. Let me ask you this. When you left the institute in January of 88 - 89, did you believe we were then in a situation to go back to Boston and have recertification considered?

A. No.

Q. Well, then the question of the day, I guess, is what still must be done so we can approach HICFA and try to get recertification for our Medicare loss?

A. In my view it can be best done in one of two ways - I hate to keep going back to it. I don't think the Admission Unit is really able to handle the number of admissions that it's getting. It's a small unit. It's got 30 people. It's just not a very good place. It's jammed up. It's crowded. And, when someone's sick or off, like Dr. Arness who's on the admission unit. He had a surgery and he was out for awhile. The new doctor that's here from the rental firm - she's working extremely hard and very well and probably - her documentations probably would rate as outstanding. But, she was working 12-hour days, too, to keep up - to do that. So, I think the workload, the pace and quite frankly the events of the summer. You had - in my opinion you have HICFA coming in and citing quality of care. You have the patient deaths in the summer. You have Joint Commission coming in in December and saying some of the very same things that HICFA's saying and some of the advocates are saying and saying that we have large resource needs. The Joint Commission was telling us we had resource defecits.

Q. In layman's parlance, you mention that the Admission Unit you feel is overcrowded and a real impediment to regain the certification.

A. With the staff that exists there now, the best shot in my opinion, although it might cause some problems in the area of nurse staffing would be to split off and have two geographic units basically. So, you would split your admissions in half and the treatment teams would release the patient to another unit, so you'd have continuity of care, you'd have one doctor and one professional team working

with a patient through their hospitalization. Right now you have roughly 1,200 people come into the Admission Unit. Guess what - 600 or 500 more go to the treatment units and they hand them off. Let's say somewhere between three and ten days - somewhere in that time period. So, you got one treatment team that greets the patient and admits them and then if they're going to stay they're handed off to another treatment team who has to learn what the patient's about and either operate on a treatment plan that someone else has devised and they hadn't devised; or, develop their own treatment plan very quickly because the time frames for developing treatment plans are fairly rigid. So in ten days you have to have a comprehensive treatment plan.

Now, if you divide the thing into two areas so you got three doctors on the majority - the three major treatment units. You've got three doctors on admissions, okay, so that means roughly 400. It doesn't work out that way but it's even numbers for simplicity. 400 admissions per doctor. You take six doctors and 1,200 patients, that's 200 admissions per doctor. You've got six social workers for 1,200 admissions, that's 200 for them. You've got 13 social workers the other way, that would be about like a hundred. So, in my opinion, you would get a lot better mileage out of your professionals if you cut out that because it's such a short-term thing. Cut out that triage unit and develop the two geographic units.

Q. Now, if we did that, are you saying that that in tandem with the additional staffing that we added over the summer as well as

with the special session reforms, would that be enough in your judgement for us to go back to HICFA and ask for recertification?

A. You might have to do something with nursing staff.

Q. Specifically what?

A. Well, you have to have - you need at least one nurse on each distinct part; and to have an admission unit you'd have to have a little heavier admission - little better nursing coverage than you might have on a unit where the stay was longer. So, there could be some options. We did not go forward with looking at that. That was something that we were expected not to do simply because there was emphasis on getting the admission unit certified. So, we put aside what I think might have been the longer range positive option - a more positive option for the short-term need to acquire Medicare rapidly.

Q. But, if I'm not mistaken, we've failed in that nothing is certified at this point.

A. That's true.

Q. My problem is having sat here for two and a helf days - I don't have a real good idea on what we're doing at this moment to advance to our goal to reattain certification.

A. Well, you have - a lot is being done, but I think the problem is that it may or may not be a high probability shot to try to certify the Admission Unit given the bottleneck that I mentioned earlier. That that unit, the way it's configured, does not particularly lend itself for accreditation because it gives - built into that unit are a number of continuity of care problems

given the rapid turnover. And, the need for having timely records kept.

Q. Can you just summarize what else has happened between the June or July of '87 and the time you left the institute - I'm sorry. June or July of '88 and the time you left the institute, what action was taken to your knowledge to work towards the recertification? I know you didn't agree with the admissions unit. But, what action was taken?

A. Well, we hired the staff. We assigned an individual to the Admission Unit for training and teaching of documentation - review charts and to provide training for staff on the Admission Unit. A lot of work was done by the medical staff in terms of their documentation. We attempted - in the summer between June and the special session we were running into some substantial problems, so what we did there is we took three of our positions and deleted them and turned them into 12 intermittent personnel to form a float pool. Basically, 12 people. So what we did is we took three positions, divided them into 12 people and burned them up in a three-year, four month period essentially to create a float pool to get us through the summer months, because we were running out of - we were essentially running out of staff. That's - one of the things that's happening in the summertime is things were really out of sight - out of synch. On July 18th there's a note from the NOD - the NOD is like the administrative nurse in charge and so forth. This is a note to Vera Gillis. "By now you will have heard from many about the crazy weekend of understaffing.

Something needs to be done immediately or something terrible could happen. Some are exhausted and discouraged. We're killing them with overtime and freezing. We cannot wait for a special session of Legislature or it will be too late. I will be calling you as I really need to talk with you about it. I had volunteered to work three weekends this month. Now I wonder if I can really do it. This weekend has taken quite a toll on me and the sadness I feel for the staff hurts me very deeply. I've almost cried several times as I had to tell staff they were frozen. I feel helpless. I'm hoping the administration can ask for emergency help. What else can be done? More CORs in place of one to one. Most likely not as the one to ones are problems and peers need to be separated. Anyway, she's basically saying she ran out of options. She ran out of people to draft for overtime. So what we did is this intermittent personnel business, so we had to delete three of our mental health worker positions and to create essentially intermittent mental health worker positions. That was a quick way of getting a float pool together, although it did cost us three positions.

Q. Let me ask you, when we came back in session - special session in the fall - in September of '88, and I think many members of the Legislature felt that by infusing some 6½ million dollars into the mental health system we were doing two goals: We were long-range planning; but we also were addressing what was referred to as AMHI overcrowding and I think many of us felt that the bottom line would be that we would be in a position to go back to HICFA

and ask to get recertified for Medicare. Now, were there recommendations which you had made prior to the special session over and above what you've told us which you felt were reasonable or you felt were related to us getting Medicare certification? My question is, we had the package available to us in the special session in September of '88 and many of the legislators, myself included, felt that this was a reasonable effort to work toward, among other things, recertification. Were there - had you made requests for other items in that package which were not accepted which you felt were related to regaining recertification?

A. No. The one thing that I did talk about as a strategy is what about the proposition of having our - basically having our arms twisted and somehow allowing the union proposal to go through as a hedge against the possibility that the deinstitutionalization, the depopulation or the workload relief wouldn't come on line. And, so that was not acceptable. We were gonna go with the administration's proposal. And, I guess I was right in there pitching as well as everybody else because I do believe if - I think it was a good package. So, the only part - where I found myself, you know in the paper I sometimes felt guilty because I wasn't maybe telling the whole truth is when in selling the package I found myself sometimes arguing aginst the position that I would have easily bought into like well wouldn't it make sense to have additional mental health workers and then when - the union was proposing this and I was talking to the union rep. They said well, if you look at it, the deinstitutionalization or the work-

load reduction equals your staffing request, which it would. And, in the preparation of the briefing paper for the Commission, I think that's one of the things that I could live with myself by emphasizing that point, is that the solution in that package was one of balance. And, there was an infusion of staff to deal with workload and a reduction of workload. And, that workload reduction hasn't occurred. Not only has it not occurred, the workload has increased; and not only has the workload increased, everything that transpired over the summer happened and makes it less likely for a body who is going to come in and give you a stamp of approval made it much less likely of certifying or accrediting body to give you a stamp of approval under those conditions. I mean, they - when you have negative patient outcome they're going to be extremely picky. So, all of this leads up to not a very good picture for regaining accreditation.

Q. Let me just - one final question here. As of January, '89, when you left the institute, how far away do you think we are now from regaining certification with Medicare?

A. Well, I gave my best guess - when was it, October - and I might have to go back and modify that; but, it's a function of - in my opinion it's a function of workload. In other words, if we're running 1,200 admissions lickety-split and we're sitting there with doctors who are here on short term which could leave here or there - if everything's in place, we could probably get accredited in three or four months I would say - get Medicare - maybe. If it can be gotten at all.

Q. If everything's in place, maybe, if it can be gotten at all. I'd like a little more precision there.

A. Wouldn't we all. Everybody wants precision. Everybody wants to know when it is. Give me a date. What I've been saying all along is it's a function of staffing and workload. And, if the workload isn't going to change and the staffing isn't going to increase, you're gonna have to be a little lucky to get it. Now, you reduce the workload, you're gonna get Medicare. If you increase the staffing the way it's organized now, you might get Medicare. You might have to reorganize just to spread things out. I do think that that 30-bed unit makes it difficult. There might be some easier ways to -

Q. What you're saying basically is the model we have now you don't think is a very logical model in terms of delivering services and if we reorganize we might - that's a more logical way to go about our task.

A. Drop the total admissions of the hospital down to about a thousand, then I think that 30-bed unit can do its job. It may make more sense to split them off even under those conditions. What I'm saying is if you drop the admission load on the admission unit, it probably wouldn't be overwhelmed.

Q. And to do that we would have to bring to bear the southern Maine inpatient beds.

A. That's your most immediate way of doing it.

Q. So, would it be fair to say your advice to us as far as working recertification would be to make sure that we brought those inpatient

beds on line as soon as possible.

A. I think that gives you the best shot. Just in terms of Medicare only it gives you a better shot than even maybe adding some staff to the Admission Unit as currently constructed. Some of the people at AMHI may or may not agree with that, but I think that's fair to say. But, the other thing is if you get all swept up in worrying about Medicare, then you're in danger of forgetting all the other patients who are at AMHI and there are a hell of a lot more patients on those other units than there are on the 30-bed unit that's still in crisis stabilization triage essentially. And, if you look at where the problems are coming from, there are some problems that come from the Admission Unit. It's a lot of the other units. You could have maybe longer term patients and patients who have care needs that don't pop right out at you. I think the staff do a real good job trying to triage problems as they come to them. But, what happens in that kind of setting is you deal with what's hot and what's acvtive at the time. You may not fully implement a treatment plan for someone who is less of a problem on a unit. A person could - I think in some of the reports use psychiatric wallflower is a term that's used occasionally. But if a person isn't causing trouble, they may not get much attention. And, I don't think that's a matter of the staff not wanting to do it. I think it's having to attend to what's the most immediate. And that's how your treatment plans occasionally break down is that people are dealing with what's immediate and right in front of them and they may not get to the more sophisticated or less

immediate aspects of treatment plans.

Q. Thank you. Are there other questions by the Committee? Representative Rolde?

EXAMINATION BY REPRESENTATIVE ROLDE

Q. Mr. Daumueller, I'd like to get back to this 20-bed unit in Southern Maine.

A. Yes.

Q. Now, where does that stand? During the special session we gave six million dollars approximately, of which three million was to go for community programming. Was this one of the community programs that we were funding at that time?

A. Yes.

Q. Where is it to be located? Has the planning gone that far ahead?

A. There were a number of options that were being worked on. The last update - the last official update I had on this was probably the - something like the 9th of January - and the plan at that point was to - because there was no provider available at that point in time, to give case managers pots of money that could be distributed and utilized by those case managers for inpatient care in a fairly distributed fashion. That is much a much less acceptable solution than having an inpatient program in one place in terms of diversion and deflection in my opinion. If there are recent developments beyond that -

Q. What was the original plan? Was it to establish a new inpatient unit? Was it to use existing inpatient units and have them expanded somehow? It all seems pretty amorphous at this point.

A. Well, I think it was written to give flexibility so that it wouldn't be necessarily pinned down; but my understanding was to develop an inpatient unit in a general hospital, first choice; or -

Q. Another P-6 in a sense?

A. Yeah, only this facility would take inpatients who are involuntary. The only other - the places that take involuntary are the State hospitals, Togus and some at Jackson Brooke, although it's a small percentage of their business.

Q. All right. Now, were they in touch with other hospitals? Were they talking about Southern Maine Medical? Was there anything that specific or was it just kind of a fuzzy -

A. Well, there were two hospitals that were mentioned as potentials.

Q. Can you name them or is this all confidential?

A. I just - well -

Q. What I'm trying to get at is was there a plan? Is there something - you said it was stalled.

A. It was - in the fall it looked pretty good. It looked like something was going to happen fairly shortly. So, we were a lot more enthusiastic at that time. Then, I'm not sure when things went downhill.

Q. What happened? Why did it go downhill?

A. I think people said they didn't want to do it. They weren't interested. Other options were exercised in the facilities that were under consideration.

Q. Why didn't they want to do it? Did they have to go through

Certificate of Need? Was this a problem with the Maine Health Care Finance Commission?

A. Okay. I can only relay those negotiations were not - I was not at all involved in them.

Q. Was that being done through the administration?

A. Yes.

Q. So, at this point we don't know where that program is. But, you say it's critical to our getting recertification.

A. I'd say that would be a real boone, yes.

Q. All right. Let me ask an obvious question. The fact that we have lost Medicare certification, how was the difference of monies made up? Presumably that was money coming in to pay for patients under Medicare. What happens now that we don't get that $4,000 a day? Who picks that up?

A. Well, I think the Department has increased the revenues in other areas, first off.

Q. Increased revenues?

A. Yes. Primarily, I believe it's Title 19.

Q. I don't understand.

A. In other areas of - I think the Department as a whole has increased its acquiring of Title 19 revenues.

Q. From the federal government?

A. Yes. Not at AMHI, but in other ways.

Q. So you're saying that federal money that we're losing is being made up with federal money?

A. You're losing the money that you should be getting at AMHI

but there have been improvements in other areas of the Department's programs. That's my understanding. That they offset those dollars that are being lost at AMHI. And, at AMHI one of the things that has been done is - as a response to a number of things. We've had a lot of problems wiht medical illness and people being physically ill at AMHI. We also have had problems with patient to patient assaults. One of the things is you have frail elderly and medically ill people housed with people who are quite ambulatory and able to take care of themselves. We created - coexistent with the infirmary - added 20 beds, what is now known as the senior rehab unit and those 20 beds are designed to care for frail elderly and medically ill patients. To put them in a more protective - protected environment. So, I think that's one way of meeting a lot of the things that were being identified. In addition to that, if that area is certified as a SNF-ICF dual license nursing home - the infirmary and that area - that should bring in a significant revenue by itself. So, there should be a significant monetary increase when that comes on line as a nursing home.

By the way, you asked me a question about did I ask for anything - make any additional requests. Were you talking about before the special session or after?

REPRESENTATIVE MANNING - I think what I asked was back when you stated that the roof was falling in back in February and the census was going up. I think at that - I think maybe during your - going through your chronological order of events - I think that's what I was referring to. Whether or not at that time you - inaudible

phrase - knowing fully well that the previous year we had - it seems that every - that at that time of the year we always had a high increase of census and we - the previous year the administration gave you additional staff on a short-term basis. You're still getting the same increases the next year around. They seem to die down in the summer but back up. And, at that time did you ask for additional dollars?

A. In the February period?

Q. The February period.

A. Yeah.

Q. And the answer was there wasn't any money available.

A. There would not be any additional staff for AMHI.

Q. But that wasn't in the weekly report. You didn't ask anything in the weekly report because you - you wouldn't ask that because knowing fully well that would go to the Governor's office.

A. Yeah. That's not the kind of thing you would put in there because it would paint someone into a corner.

Q. It's called teamwork. I think we heard it yesterday.

A. Right. There was - it's something, though, you shouldn't - there was a discusison on September 22nd regarding Part 2 for the coming year.

Q. This coming year?

A. Yeah. So it would be for the session right now, where I did make some requests of the Department.

Q. And that was denied?

A. Yes. I'd asked for training funds, a subsidy for the

grow workshop, air conditioning, covering of exposed pipes, a person - call it, for lack of better term, standards, patient rights and environmental monitoring control as a position. Money for the budget shortfall and workers' comp, which we didn't even need to talk about because that's already covered. Then there were three other items in that package. One was a $90,000 item to I call it maximize head count. Basically it's taking positions - part-time positions and building them up to full-time positions which would not require the adding of head count. The reason being to minimize the appearance at least of asking for more staff. In addition to that, for the senior rehab program that I was describing, I had asked for about 15 positions to put that thing up and running so that it wouldn't take away from some of the other areas and it would also strengthen us in some of the areas we were weak in, particularly in the area of physical illnesses not being detected and so forth. One of the positions that was asked for was a Physician III, which is - would be a medical doctor that would primarily be assigned to that particular area. And, in addition to that, I gave her what basically amounted to almost like a position paper which outlined the - it's the concept of staff need versus workload reductions. In terms of staffing needs. And, what it is it's a memo that's designed to frame the context for discussing - for concerning staff needs. I go through and say that there's no definition - no exact definition of staffing need. A number of things play into it - admissions and so forth. I also say it's in my opinion it's

virtually impossible to try to keep pace with rising admission pressures and census by continually adding staff. It is clear that census reduction through augmenting community programs is in AMHI's best interests. Therefore, I am also pleased with the passage of the Department's emergency package, especially with the apparent receptivity of the Legislature to look at further system development during the next biennium. So that kind of anticipates additional requests. Our hospital's annual average population last year was 361 with a potential of driving the population down to 319 with the September package, and somewhere in the 275 to 300 area with the next biennium. This rapid depopulation will make a tremendous difference in what our staffing need will be. As you are aware, the Joint Commission has indicated that Bangor Mental Health Institute is significantly understaffed in many areas. If this is the case at BMHI it will be even more the case at AMHI until such time as admission and census pressures are reduced. Let me assume for the moment that the Legislature didn't pass the 6½ million dollar package and we're not interested in further population reduction through the enhancement of community resources. AMHI would be expected to be staffed for approximately 383 patients. Past JCH show cleanly be Medicare certified and provide high quality active and temporary treatment services. In order to do all these things in the way that they should be done I have prepared the number of staff that would be needed which is attached to this memo. As you can see, the number is quite substantial; the dollar cost staggering. These

potential costs, of course, need not concern us if we can successfully implement the plans already funded by the Legislature in a timely manner.

So, what I'm saying is I'm all in favor of deinstitutionalization and reducing the workload. If that doesn't occur there may be some - we want to do everything the way we're supposed to do it. But there may be a heavy impact in terms of staffing. And, I gave her some off the top of my head estimates; and they were off the top of my head estimates and they were not distributed because this was just between us. I had 206 staff to do everything just right for 383 patients. That would yield an overall staff to patient ratio of 2.35, which as a matter of fact is less than in Pineland, as I understand it, and it just seemd to me that that's not a bad benchmark and not an overinflated view of what a staff/patient ratio might be in a contemporary hospital using contemporary standards and with all the expectations as currently coming on line.

Q. I just want to - quickly - you had indicated one of the ways we were gonna make up the money was to take a portion of the rehabilitation and make it into ICF.

A. Yes. That would increase revenues. That was one of the - most of the patients there would come from the older adult program which was currently a Medicare distinct part.

Q. And the way you did that it would shift people from one part of the hospital to another part?

A. Right.

Q. So that if that's the case, to make up for additional dollars

that we're losing because of Medicare, then other parts of the hospital are now gonna be suffering.

A. No. No. This would be - this is a good move. We did it already. I mean, we've already established that unit - November 28th.

Q. But, do we need to increase the staff to supplement those who went into that new area?

A. Well, I think it would make sense to do so. There are some inefficiencies in creating another area and that's why I asked for 15 people. Two things: one is it very much looks like a new program even though there are additional staff and it is a new program. And, it's one that makes sense and would bring in revenue and would increase the quality of care and provide a safer environment. So I just thought there was good reason to fund that. And, it was a reasonably modest request - 16 people.

EXAMINATION BY REPRESENTATIVE BOUTILIER

Q. First of all, can we gat a copy of that memo?

A. Actually, if you want, you can have everything that's in here.

Q. What's the date of that particular memo?

A. September 22.

Q. Okay. I'll come back to that in a bit. First thing, I think you reading through your Friday memos was helpful, but I'm curious as to what the real purpose of the Friday memo is if it isn't a true understanding of what some of the problems are about what the solutions should be. If you send a memo that isn't truly respective of not only what the pulse of the facility is in terms of

census and admissions, but also ways to deal with that, what's the purpose?

A. I think those Friday memos are a pretty good pulsebeat. What isn't put in a memo like that is that I'm recommending 'X' number of staff or just simply because that should go through the department and not straight to the Governor's office and then to the Department. So, what you would see in a memo is that I'm working closely with the Department on matters of resource allocation and then I would be talking to them about what the numbers might be or should be.

Q. Obviously there are other communications, either verbal -

A. Oh yes. Most - actually, paper, contrary to this book, is probably the least of the communication that goes on. I don't write a lot of memos to tell you the truth. It just may look like it because you're seeing a whole bunch of them together; but I'm not a very paper-memo-oriented person. I think that'd be quite clear. A stack of memos for the year is probably that thick.

Q. Well, the Legislature is not the best mind readers either, and if we don't have it documented it's difficult for us to understand what you need to survive let alone be certified and provide proper patient care. So if your Friday memos to the Commissioner and to the Governor do not appropriately cite things that need to be done in reaction to what is census and admissions, but you do it through verbal communication, how strong is the verbal communi-

cation? It seems to me when you went through the Friday memos something that struck me was at the end of the Friday memo always seemed to be well, we're coping and the staff is doing well and we set up this plan and we're implementing it. So, if the Commissioner wanted to - didn't have any other communication, had no verbal communication whatsoever and went strictly by the Friday memo, he or she, whoever the Commissioner was - in this case Susan Parker - could say at the end well, he seems to be coping and I won't step in at this point because things seem to be happening over there and they're trying to deal with the problem.

A. I think what you saw was the January meeting of the Governing Body and then the special meeting to deal with staffing issues in February - on February 11th - where those issues were communicated directly and verbally.

Q. Did you also have - and those primarily had to do with the fact that Medicare was gonna be close to being decertified if not imminent, correct? As well as trying to deal with the overall long-term problem of high admissions, high census.

A. Well, Medicare is in the background, of course, but this was - the primary focus of the January and February communications were crowding and staffing and patient care issues.

Q. Obviously, though, the Medicare funding issue is important.

A. Yes. Yes.

Q. We received copies of some letters that you received. One was dated March 23rd which talked about HICFA's feeling about

the Medicare funding and that they were very concerned about the medical records requirement, the special staffing requirement and we're going to decertify. And that was prior to them receiving a plan of correction. I guess I was more interested in the second letter as far as after we received a copy of it; but you basically inferred it was more of a formality than anything that was - truly could be cited as being HICFA's approval of a correction plan. It was more of just them not wanting to do the wrong thing and giving you the shot; but not truly corresponding to an excellent corrective plan. Did I understand you correctly?

A. Yes. I think - I'm just trying to put myself in their position. I think the last thing they want to do is be accused of being unfair because I don't think they felt they needed to be.

Q. Obviously, there was a meeting on April 12th in which you gave the Medicare narrative concerning some of the problems as you saw them. And in the second paragraph you cited that there were growing pains and it was clear that the Medicare certification - we're convinced that many state facilities such as ours are having to make difficult adjustments required of continued participation in the Medicare program, as Medicare standards need to be more and more rigidly interpreted. Difficulties in the certification process are common and to be expected as multidisciplinary treatment teams orient the psychiatric facilities and attempt to integrate themselves in the more traditional medical model. So, it's obvious to me, and at least in written documentation, you

probably knew and you admitted you knew prior to this, but at least in written documentation you stated clearly there was a difference in interpretation and that was going to affect your facility. This memo - did you discuss and present this memo to the Commissioner and to other sources?

A. Yeah. We had a meeting prior to going down to Boston.

Q. What date was that?

A. To prepare for the meeting. What day was the meeting? I think it was the day before. Let's see - one o'clock, Monday, April 11th, I believe. Yeah, with Dr. Rohm. Dr. Rohm, myself, Linda Crawford, Susan Parker.

Q. This says the meeting agenda for April 12th.

A. Yeah. That was in Boston.

Q. So, April 12th was in Boston.

A. Yeah.

Q. And the day prior to you having this cover letter and the narrative printed you had probably had some copies and you handed it out at a meeting on the 11th.

A. I'm not sure if I handed it out then or if it was already over there.

Q. You discussed the Medicare narrative.

A. Yeah, and we discussed what we were going to say.

Q. One of the confusions I had in the testimony we've heard so far is that there was a feeling that although decertification might be imminent, there was a lack of understanding as to why decertification was imminent and that the Commissioner felt although

it was possible they would be decertified, that when it happened she was not aware as to why they were gonna be decertified and she later learned that it wasn't because stndards had changed but because the standards were interpreted differently. Now in this memo you're saying very early on, actually the day before even in written communications, that standards were interpreted differently and that you were gonna have a tough time transitioning to that.

A. When you look - the actual standards I don't think have changed very much at all over the years. The interpretation yes has changed. The aggressiveness of the survey and maybe even to some extent the purposes of the survey has changed. It used to be more of a consultation and they would never really pull your chain. They'd just keep telling you that this is wrong and this is wrong and, you know, keep either improving or not improving or whatever the case may be and they'd keep taking a consultive role. With HICFA doing the surveys, and they've always supervised the surveys, with them doing it there's much more of a stick and carrot approach. In other words, if you don't meet the standards they're going to put you into the decertification mode, okay. That doesn't mean they're going to decertify you right away. They'll treat someone else just like they would treat us. State hospitals generally have had some transition and growing pain problems and because of the way they provide care and because of the role of the physician being one of a head of a large group and working more as a consultant amongst a treatment team and not having as much direct treatment involvement.

Q. Above and beyond your written communications - you obviously were there in a private meeting to discuss the next day's meeting with HICFA - did you at that time say they're really being much more strict in the interpretation of the regulations and these are the things we have to do and name specific things?

A. I think we just discussed the - how we would present ourselves and familiarize ourself with a plan of correction to give it our best shot. This was not the time we would argue about anything other than getting the survey.

Q. So pretty much you left it to the Commissioner to make judgement calls on monies and types of priorities and you, although you had your personal feelings about what the staffing level should be and what the reduction of workload should be and what things should be done to do that, you presented them - you had always had to come back with contingency plans when faced with the reality that that's not gonna happen.

A. Well, any plan of correction we did would be within the - let's say the guidelines that would be established in terms of resources.

Q. Again, I get back to the Legislature can't read minds. I think in the special session the temperment of the Legislature was they really wanted to deal with the problem and it's tough when we're given a scenario that this is how to deal with the problem and then you do that. I think I'm echoing what the Senator said before that the Legislature's feeling was that was going to deal with the problem. It's obvious that by the time it got to the

Legislature, it had already been changed many times. The changes were not appropriate. And, you stated that you didn't feel that you thought the chances were 50/50 or 60/40 that those changes would be appropriate, correct? In terms of the program that you mentioned, you talked about community based services and supplementing those and dealing with it. I brought up something the other day in terms of the current census. Not in terms of admissions. In terms of the current census, if we fund properly community based services, and that's not in the hypothetical saying there's gonna be two admission units. Under the current situation, how much could you reduce the current census in terms of people currently in the census if you had properly funded community based services?

A. Well, given the - given unlimited resources you can take anybody out of an institution.

Q. Absent of setting up a new acute care setting.

A. What I'm saying is you can put services - you can surround a person with all the services they can get in a hospital. It might cost you five times the cost of a hospital stay to put them together. So, you can take virtually anybody out of an inpatient care; but if you put a limit on, let's say, at equal or better quality of life care and equal or better costs, I think you could take a substantial number out.

Q. What's substantial to you?

A. Oh, I would imagine - I think we were projecting bringing the census down to 300 or 275 and I think that's not an unreasonable estimate.

Q. That's at the most a hundred people.

A. Yeah. And I think - you can - it's just -

Q. That's projecting now. In the current census you think there's a hundred that could be served in the community for equal or better -

A. Now, in the community, no. I'm saying it's a long development process. There'd be a heck of a lot of time and effort that would have to go into getting a hundred people out. The inpatient adding to it would be fast; but to get - throw the inpatient out, it would take substantial time and effort. It would be a couple of years process before you could do anything like that.

Q. Also, I was very curious when you mentioned the memo you talked about some of the proposals that you had mentioned at the end. And, I was interested here you mentioned training as one of those. Something I brought up yesterday was the fact that the contract had not been extended for trainings at St. Joseph's and UMA. Are those two programs the monies that you were requesting in that training portion that you made in that memo?

A. No. That was a separate. What we were trying to do there was get a decision made on whether that nursing venture would come out of central office funding. We were going to do it out of our funds if they wouldn't do it out of theirs. The big hang-up there was basically getting an answer.

Q. You are aware of the St. Joseph's and UMA programs.

A. Yes. It's three-level funding. One is the individual, it's 5,000; one is the department which was 5,000; and there was another fundraising effort:

Q. Usually the student themselves.

A. Yeah.

Q. It would be the student, the State and AMHI - it would pick up 1/3, 1/3 and 1/3.

A. Well, a fundraiser - an independent fundraiser, the student and the Department were the three.

Q. The independent fundraiser being monies coming to AMHI to supplement the education of those people.

A. Yes.

Q. Do you feel confident that those programs in the past have been successful?

A. Well, they've been very well received and I think that's the kind of thing that should be encouraged. And, the flap, if you will, about this one was just getting a decision as to whether this was gonna be one of the Department's priorities for what was HRD funds or not.

Q. What was your recommendation?

A. My recommendation was that they pay for it, of course; because - also, because when that program went into existence it was designed to be a long-term commitment and there was the expectation there be a long-term commitment with the school. This wasn't gonna be a shot in the dark kind of thing.

Q. It's my understanding that the St. Joseph's program had ten slots that would be used. Every time there was an individual utilized one of those slots, 100% of them maintained their status at AMHI and eventually stayed even after the training occurred.

And, it also involved continuing ed courses and service training in the Augusta facility, correct?

A. Yeah.

Q. And that the UMA program was for mental health workers and for LPNs who wanted to increase their educational basis which again would assist AMHI and that 100% of the people involved in that program maintained their status at AMHI.

A. Yeah. There's a real advantage to home-grown - growing your own nurses from the facility out of the mental health worker/LPN ranks because you're finding people there who know AMHI and basically like to work there and I think there's a good chance of maintaining -

Q. I would reiterate that that's true of every health care facility. That health care facilities that participate in training and tuition reimbursement are successfully maintaining those nurses who participate. Is it also true that a substantial portion maybe 35, 40 nurses or mental health workers currently at AMHI that would have been in that program but are not able to do that because the contract has been defunded?

A. Vera did take a poll and that sound right. I can't give you a precise first-hand knowledge estimate. I think that's close.

Q. If your requests for staff - you mention 206 - and I tried to look into how many direct care staff - of that 206 are you including also housekeeping, dietary, physicians and so forth - of that 206, would you approximate that 100 are direct care staff that you would need in addition to what you have now, above and beyond the special session?

A. Yeah, um-hm.

Q. So, -

A. Mental health workers. Now that one would roughly give you a mental health worker staff to patient ratio overall of 1 to 4 - one staff for four patients on days, one for four on evenings and one for eight on nights. And that would be a 1 to 1 ratio. So, you got one patient, you'd have one mental health worker. That's how that works out in terms of staffing.

Q. Obviously, that's a - absent of any tremendous increases in community services and lack at least for now in any long-range very expensive and developing process for the community services you had mentioned when I first asked you the question, a hundred direct care staff is a huge increase. That's obviously substantially less than, say, 18 part-time equivalents that then become full-time equivalents or 64.5 that then becomes 33 full-time.

A. What that assumes is a single - what that kind of rhetoric or conversation - or the implication is you're gonna have a single level of care across the program and that there wouldn't be a difference - substantial difference between a Medicare unit and any other unit. So, basically, it's equivalent care.

Q. My last group of questions, and maybe I'll come back later after some other comments you make, but I'm concerned about the JCAHO accreditation. Have you participated in any meetings prior to your leave which put in your hands the feeling that that accreditation was in limbo?

A. My best judgement is that our accreditation would be granted with a substantial number of contingencies and I would expect many of the same contingencies which were cited at Bangor's facility. The one thing that did concern us is they were very concerned about the pipes and they were - one of the surveyors did mention - Dr. - I can't think of his name - anyway, one of the physicians - surveyors - did mention a potential for a tentative nonaccreditation decision. I think that's probably not in the style of JCH. I think what would happen is they would cite a number of contingencies and give us accreditation. But, the number of contingencies might be fairly substantial, and to meet all the contingencies, I think, you're looking at some resource areas that were cited. There may be some significant staff needs as a result of -

Q. Obviously you're dealing with the problem of exposed pipes - that's something that doesn't necessarily require emergency legislation or emergency funding from the legislature. Sometimes you can find funds in the Department and just allocate them temporarily and deal with that problem in the short term. In terms of one of JCHO's more strict requirements in the medical model is 24-hour coverage by RNs, correct?

A. Right. Yes.

Q. What is your estimation of how many RN's you would need in addition to what you have now to satisfy that crucial requirement in their new stricter interpretation of the regulation?

A. It's - I believe it's 50.

Q. So you would need 50 additional RNs in order to meet a very important criteria that JCAHO is now -

A. You might be able to massage that number downward slightly; but it's somewhere in that range - between 30 and 50. It would fall in that area.

Q. Wouldn't you say that if you are - and when did this feeling by JCAHO, though they've never given you formal determination as to date?

A. December 1st.

Q. So as of December 1st you could say you pretty much knew that you - let alone all the other criteria that they might give you - that you at least needed between 30 and 50 RNs to meet a very important quality of care issue that JCAHO was asking for, correct?

A. Yeah. The nurse - the HAP-nurse surveyor suggested we needed about twice as many nurses as we have. I think in looking at it it turned out to be somewhat less than that using a combination of full-time and 24-hour personnel. One of the things that we have going for nurses at AMHI is the number of weekends that they have to work. But that causes some drains and some needs on weekends. So, if you give people one in four or one in six off, then you have holes to fill on the weekend. So, when I say it's a combination of needs between full-time and part-time, some of those part-time are 24-hour positions are needed to backfill on weekends. But, 50 is not a bad guess. I don't know how we'd recruit 50 nurses and how long it would take to do that quite frankly.

Q. I asked the question the other day as to what seemed to be the length of time to recruit one RN and put them in that position. I was told between 30 days and six months, although they have had good results in filling some positions that were funded during the special session. Would you agree with that assessment?

A. Yeah. We've had fair results. I think it would take a while, but you might get there. There's different levels of confidence on that point. I'm a little bit pessimistic. I think Vera Gillis might be a little more optimistic in terms of filling them. I think enhancing the environment and the staffing levels would make people more willing to work at AMHI, 'cause one of the - in terms of turnover and exit conferences and word of mouth that goes through there, AMHI's not necessarily an easy place for people to work.

Q. I hate to say this 'cause I probably should know this exact date, but what's the exact date in January that you left?

A. The 11th.

Q. Between December 1st and January 11th did you approach the Commissioner and say our JCAHO accreditation might be in jeopardy and there are several things that we specifically have to do including but not exclusive to hiring a significant complement of RNs?

A. Yeah. December - I sent a memo on December 9 and then we talked about it another time somewhere around that time.

Q. Did you send it to anybody else besides the Commission?

A. I don't believe so.

Q. Did you receive a response by Commissioner?

A. We met and discussed it.

Q. And what was the response by the Commission and consequently what was your recommendation?

A. Well, basically it was what was the impact of the Joint Commission on our Medicare readiness and I did talk about what the HAP nurse had said in our - actually it was in the pre-exit conference. The Commissioner's opinion was that we didn't manage the Joint Commission's survey process properly and she mentioned the New York - where they had done this - and that we should have gotten a different kind of nurse surveyor had we been on the ball. And, I guess the assumption would be that that recommendation then wouldn't have been made.

Q. That comment says to me that there was more concern about the relationship between JCAHO to your Medicare certification rather than something that may be even more substantial and that is if you lose that accreditation you lose your Medicaid funding as well.

A. Yeah. Basically, what I was saying is that the short-term threat is Medicare. However, long-term the Joint Commission is a bigger threat in fact because if you look at Joint Commission, one of the things they want to ensure that there's a single level of care across all units and they're looking at the same kinds of things that Medicare is looking at. They're looking for to see

in the record the physician involvement on a regular basis; and, a lot of quality assurance on the part of medical staff and other departments. So, in - it was my opinion that while Medicare is the short-term threat, Joint Commission is a long-term threat although you'll have more time to correct the Joint Commission and Medicare you won't have any time to correct.

Q. But if you were - when in JCAHO - when do you anticipate them in rough terms. You can never say the exact date, I know.

A. Ballpark guess is that they would tell us that congratulations you get accreditation for three years provided you meet - correct the following contingencies. I would expect a substantial packet of material in a substantial number of areas and they would then put a survey team back - let's see - approximately nine months from the date of the survey which would be probably October - somewhere around October - maybe in the summer.

Q. So, October of this year you would anticipate getting some kind of notice in that regard.

A. Between six months and nine months.

Q. So, if the Legislature wants to read minds again, because there's no increase in this budget for those types of changes, we could expect to come back in for a special session to deal with an emergency money allocation for additional RNs, at least 40, and also deal with all the contingencies that they are probably gonna mention in October, but we already know about as of December 1st, correct?

A. You may get different opinions on that, but yes I would say

that's true.

Q. Thank you.

SENATOR GAUVREAU - Thank you. Just a note to the Committee. I was reminded by staff we have to vacate this room at noon because the Speaker of the House has scheduled a press conference at 12:15, so we will only have ten more minutes today to proceed with the hearing. So, we will invite Mr. Daumueller to return tomorrow morning for further testimony. I believe the order of questions is Representative Pederson, Representative Burke and Representative Dellert.

EXAMINATION BY REPRESENTATIVE PEDERSON

Q. Mr. Daumueller, the Governor was asking you to be able to return some money to the State Government. I believe one of the big items - one of the big ticket items was the land sale at BMHI and you also had a piece of land here and we had a building down in Portland. I think probably that was the big part of that amount of money that was gonna be involved.

A. Actually, I think it probably wasn't the biggest - well, there was a substantial portion, but it was one that got a lot of attention.

Q. Right. The other question - I want to make this as quickly as possible - is has the overtime changed any from over the past year? In other words, is the overtime higher now than it was in the summer and are we still demanding that the staff stay over when we can't find a replacement we demand them to continue to work?

A. Overtime is high. If you go back in time - this is total overtime - it was 1,700 hours in '85, 3,900 hours in '86, '87 3,300 hours,

and '88 5,700 hours.

Q. So, presently we probably have the same level of overtime.

A. Higher. Higher.

Q. Okay.

A. I think one of the - clearly one of the things that we're doing is making sure that we pay attention to needs that are identified. If a physician says I need a COR or a one-to-one, we're not arguing about it. We're providing it.

Q. So we're still putting a lot of stress on the staff.

A. Yes.

Q. The other thing that I was a little bit concerned about and wasn't clear was the capacity of the hospital. We have a design capacity of 250 and we have an optimal capacity of 350? How does this work. I want a little clarification there.

A. Well, I always feel like a babbling idiot when someone says how many beds do you have because we aren't licensed for any certain number of beds; and it's a matter of how many people you have and how many you want to call it on any given particular day. When you - if you say how many beds we have set up and staffed, you're - I think it's 367, but are we really staffed for 367 I don't think so. I think we're staffed for more like 300. So, I've always had - like I say, I've always felt like a babbling idiot when trying to explain to people how many beds we're set up for because I don't think - we've never been set up to handle the patients the way we wanted to handle them and provide the treatment that we felt we ought to provide, given the numbers that we've had.

Q. Would you say that we'll have a very difficult time solving the revolving door type of admissions - out and in again - unless we have community services?

A. Yes. That's critical. The linkage - the discharge planning from the hospital end, a good solid discharge planning on the hospital end and linkage with case management. So, I'm very much in support of what you've done for case management and as things go that case management will - as a person comes in - they'll have a case manager and as they exit they'll have a case manager, so more and more community input will be into the treatment planning. And, discharge planning.

Q. My last question is do you think we've utilized the advocates - the hospital advocates, the Maine advocates, the family advocates? Do you think we've utilized them in the role - in the problems that we've had?

A. Well, frankly I think probably the advocates are one of the reasons we're here today - and not in a negative sense - in a positive sense I think. They've been very faithful in pointing out what they feel are deficiencies. They, in many respects, drive me crazy but they're doing their job and they were pointing out all our flaws and our dirty laundry and that's their job. They were doing their job.

Q. Thank you.

SENATOR GAUVREAU - Unfortunately, we're going to have to break unless your question is very, very short. We have to vacate the premises.

REPRESENTATIVE BURKE - I'll try and keep my first question short. The next time we meet I can start again.

EXAMINATION BY REPRESENTATIVE BURKE

Q. Basically, you listed a number of times when you indicated to Commissioner Parker that there were serious deficiencies in staff situations. When did you realize you had lost or were in danger of losing Medicare assignment completely? What resources did - were you told that you had in order to pull yourself into compliance?

A. We could contract for psychiatry. We had a person in mind who we did contract with. Other than that we pretty much had to do with what we had.

Q. Who told you that?

A. That would be the Commissioner.

Q. That was right from Commissioner Parker that you could not hire more staff at that point in time - that you could contract with one psychiatrist?

A. Yes.

Q. Okay. So, that's basically at this point what I'd like to clear up. Commissioner Parker had a hands-on understanding of exactly what was happening and told you in so many words, or directly - not just in so many words - directly that you could not hire more staff. That that was not a resource that was open to you.

A. We also looked at some other options of would it be possible to maybe pull from another facility for a short time, too. I won't say that one contract was the only option that was ever discussed.

Q. Okay.

A. We were scrambling for other options in terms of contracting for psychiatry.

Q. Okay. I'll pick up again next time. Thanks.

SENATOR GAUVREAU - We now have to break. The Committee will reconvene in this room tomorrow morning at nine A.M. to continue the hearing and presentation of Mr. Daumueller. Thank you.

HEARING CONCLUDED AT 12:00 P.M.