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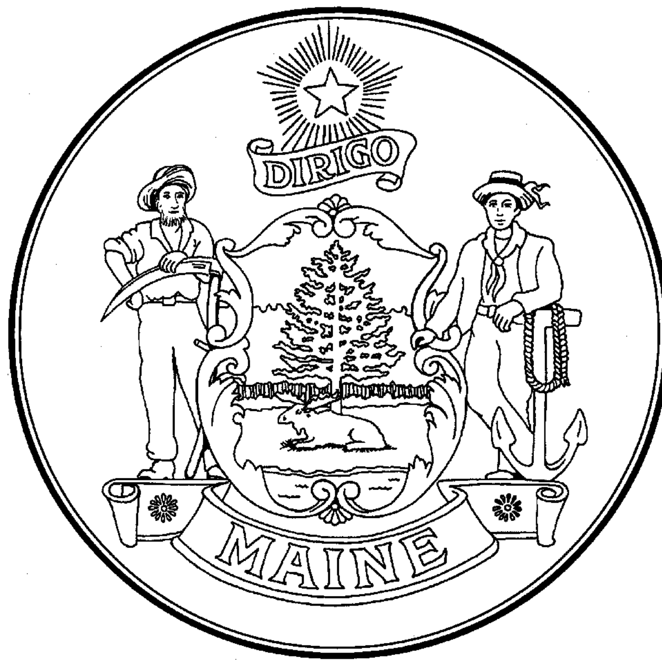

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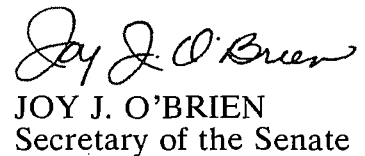
114th MAINE LEGISLATURE

FIRST REGULAR SESSION - 1989

Legislative Document **No. 1141**

S.P. 430 In Senate, April 11, 1989

Reference to the Committee on Human Resources suggested and ordered printed.



JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator BUSTIN of Kennebec.
Cosponsored by Representative BURKE of Vassalboro, Representative MELENDY of Rockland and Senator TITCOMB of Cumberland.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-NINE

An Act to Improve Individualized Treatment and Planning Procedures for Long-term Care Clients.

1 **Be it enacted by the People of the State of Maine as follows:**

3 **22 MRSA c. 1627** is enacted to read:

5 CHAPTER 1627

7 **TREATMENT AND PLANNING PROCEDURES**

9 FOR LONG-TERM CARE CLIENTS

11

§7361. Definitions.

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As used in this chapter, unless the context otherwise
15 indicates, the following terms have the following meanings.

17 **1. Applicable state agency.** "Applicable state agency" means:

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A. The Bureau of Maine's Elderly for clients who are being
21 discharged from a hospital or who are receiving or in need of community-based services; and

23

B. The Bureau of Medical Services for clients needing or
25 receiving care in an institutional setting.

27 **2. Appropriately constituted.** "Appropriately constituted," when referring to an interdisciplinary team, means
29 membership which includes the client's physician, primary nurse, relevant therapists, social worker, homemaker, service
31 coordinator, involved family members and others as applicable. The client or a designated client representative shall be a
33 member of the team. The makeup of the team shall be sufficiently broad to address each significant need of the
35 client and in no event may consist of fewer than 3 members.

37 **3. Client service coordinator.** "Client service coordinator" means the member of the interdisciplinary team
39 responsible for convening meetings of the team, assuring that records of meetings are kept and conducting reviews of the
41 prescriptive program plan.

43 **4. Community-based** services. "Community-based services" means those services needed or provided in the client's home,
45 the private home of another person, a foster, group or congregate housing site or in some other community-based setting.

47

5. Critical juncture. "Critical juncture" means the point
49 at which a long-term care provider or agency observes that a client is in need of initial long-term care, a significant
51 change in long-term care or the cessation of long-term care. A critical juncture shall be deemed to occur prior to discharge

1 from a hospital, admission to a nursing or boarding home, the receipt of community-based services, the termination of nursing 3 or boarding home care or the termination of community-based services. "Critical juncture" includes a significant change in 5 the client's condition, a planned significant change in the method or place of service delivery and the termination of 7 services by a significant service provider.

9 **6. Deficit list.** "Deficit list" means a list of services recommended for a client's care or treatment which are currently 11 unavailable to the client. When an appropriate service exists but a barrier prevents the client from receiving that service, 13 that barrier shall be described in the deficit list.

15 **7. Designated client representative.** "Designated client representative" means a person designated by the client for the 17 purpose of participation on the interdisciplinary team or, if the client is unable to designate a representative, the client's 19 attorney-in-fact or guardian or, if there is no attorney-in-fact or guardian, an attorney, paralegal or advocate designated by 21 the applicable state agency to represent the client.

23 **8. Institution-based service.** "Institution-based service" means a service provided in a hospital or a nursing or boarding 25 home.

27 **9. Interdisciplinary team.** "Interdisciplinary team" means a team of persons established under this chapter whose meetings 29 are conducted in accordance with professionally accepted standards and whose purpose is to evaluate a client's needs for 31 long-term care services and to develop an individual prescriptive program plan to meet the client's needs for those 33 services.

35 **10. Least restrictive alternative.** "Least restrictive alternative" means a guiding principle in the interdisciplinary 37 team's design and implementation of a prescriptive program plan to meet a client's long-term care needs. According to this 39 principle, a prescriptive program plan shall be designed to permit the client to function at a maximum level in the setting 41 which imposes the least restrictions on the client's personal autonomy, individual choice, mobility and freedom of 43 association. It is presumed that this principle is best met in or near the client's own home and that institutional placement 45 is most restrictive.

47 **11. Licensed long-term care service provider.** "Licensed long-term care service provider" means a hospital, nursing home, 49 boarding home, home health agency or community home health agency or any other facility or agency which provides long-term 51 care under a license issued by the State.

12. Long-term care. "Long-term care" includes all medical, nursing, social, psychosocial, rehabilitative, therapeutic, supportive and other services required to maintain or improve the functioning of a person over an indefinite future.

13. Long-term care client. A "long-term care client" means a recipient or intended recipient of long-term care.

14. Maximum feasible restoration of functional capacity. "Maximum feasible restoration of functional capacity" means a guiding principle in the interdisciplinary team's design and implementation of a prescriptive program plan for a long-term care client. This principle requires that the prescriptive program plan be designed and implemented with the explicit purpose of restoring the long-term care client to maximum functional capacity. By way of example, a client who has lost mobility, speech, bowel or bladder control or the ability to participate in the planning of the client's own program plan will receive those services best calculated to restore the maximum feasible level of mobility, speech, bowel or bladder control or ability to participate in the planning of that program plan.

15. Normalization. "Normalization" means a guiding principle in the interdisciplinary team's design and implementation of a prescriptive program plan for a long-term care client. This principle requires that, to the extent feasible, a client's care be provided in a homelike setting and the client be allowed a variety of personal choices. To the extent possible, the client shall be allowed to maintain associations in the community, make choices necessary for daily living and select the routines and rhythms of life which the client prefers.

16. Prescriptive program plan. "Prescriptive program plan" means a written plan prepared by an interdisciplinary team in sufficient detail to provide all treatment providers and care givers the guidance necessary to carry out the plan as intended. The plan shall be designed to meet the long-term care client's needs in the least restrictive, most normal setting and manner and with the goal of maximum feasible restoration of functional capacity.

17. Private agency which receives public funding. "Private agency which receives public funding" means a private agency which receives public financing or publicly financed in-kind services. An agency does not receive public funding solely on account of its receipt of reimbursement for services to individual clients through Medicare, Medicaid or other state or federal programs.

1 **18. Publicly assisted client.** "Publicly assisted client" means a client whose care is subsidized or paid for by Medicare, 3 Medicaid, home-based care funding, local general assistance or support from a private agency which makes funding available to 5 private individuals based on their specific needs or place of residence.

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§7362. Rules of construction

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11 If any requirement of this chapter is less specific or less stringent than any requirement of any state or federal law, rule, regulation or policy, then the more specific or stringent 13 requirement shall control.

15 **§7363. Applicability**

17 **1. Prescriptive plan; interdisciplinary team.** Each publicly assisted client receiving long-term care shall receive 19 care based upon a prescriptive program plan developed in accordance with the requirements of this chapter by an 21 appropriately constituted interdisciplinary team.

23 **2. Licensed long-term care provider.** Each licensed long-term care provider shall provide its services based upon a 25 prescriptive program plan developed by an appropriately constituted interdisciplinary team in accordance with the 27 requirements of this chapter.

29 **3. Agency.** Each agency which receives public funding to plan for, coordinate and deliver long-term care shall provide 31 its services based upon a prescriptive program plan developed by an appropriately constituted interdisciplinary team in 33 accordance with the requirements of this chapter.

35 **§7364. Procedures**

37 **1. Convening of team.** Within 3 business days after a critical juncture in a client's need for long-term care or the 39 cessation of such need, an interdisciplinary team meeting shall be convened for the purpose of formulating a prescriptive 41 program plan for the client. The team shall be appropriately constituted to assure that all significant care and treatment 43 needs of the client can be professionally assessed and remedial recommendations made.

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2. Meeting procedure. At the onset of an 47 interdisciplinary team meeting a team member shall be made responsible for taking minutes of the meeting. The team shall 49 review all information which is available to it and solicit the views of each participant. The team shall choose a client 51 service coordinator and detail a prescriptive program plan in

accordance with the requirements of this chapter. The client or client's representative must assent to the plan before it may be implemented.

§7365. Contents of prescriptive program plan

1. Plan components. Each prescriptive program plan shall be individually tailored to the actual needs of the client, describe the nature of the client's specific needs and capabilities, including the need for further evaluation, specify treatment needs for further evaluation and specify treatment needs with short-range and long-range objectives and timetables for the attainment of these objectives. The prescriptive program plan shall in all cases:

A. Define the client's need for all relevant services without regard to the availability of those services;

B. Identify all services available to meet the client's needs;

C. Recommend a course of action to meet as many needs of the client as possible; and

D. Include plans for continued exploration of suitable program services within specified time frames and by specified persons.

2. Available services. The client service coordinator shall obtain assurances that all services identified under subection 1, paragraph B, are provided at the earliest possible date. The respective responsibilities of each team member for implementing the client's prescriptive program plan shall be specified.

3. Deficits. The client service coordinator shall prepare a detailed deficit list describing all relevant services under subsection 1, paragraph A, which are not currently available. The deficit list shall be updated at the conclusion of the time allowed for completion under subsection 1, paragraph D, and provided immediately to a designated agent within the applicable state agency.

4. Reconvening. The client service coordinator shall review the client's progress toward attainment of planned treatment objectives at least quarterly and shall reconvene the interdisciplinary team, in all cases, within one year of the last interdisciplinary team meeting held for a client. Any member of the interdisciplinary team, including the client or client's representative, may reconvene the team at an earlier date whenever any significant change in the client's condition requires a change in the plan for the client's care and treatment. The team, with appropriate changes in membership,

shall be reconvened at each critical juncture in the client's care and treatment.

§7366. State agency responsibilities

The applicable state agencies shall coordinate their activities in a manner calculated to assure that long-term care is provided to clients throughout the State, to the extent feasible given limited public and private resources, in accordance with prescriptive program plans developed pursuant to this chapter. Without limiting their responsibilities to assure the implementation of a comprehensive, coordinated long-term care system, the applicable state agencies shall:

1. Rules; forms. Adopt such rules and develop such forms as may be required by long-term care providers to fully carry out the purposes of this chapter;

2. Training. Provide coordinated training activities to assure that long-term care providers develop and implement long-term care services in accordance with this chapter;

3. Deficit lists. Designate persons within their agencies to record deficit lists of currently unavailable services needed by long-term care clients and descriptions of barriers to the receipt of existing services by clients;

4. Develop services. Utilize the information obtained pursuant to subsection 3 to plan for and develop services and to overcome existing barriers to the receipt of those services; and

5. List client representatives. Develop and maintain a list of designated client representatives throughout the State to assist clients who are unable to designate their own representatives.

§7367. Compliance with other laws

Affected state and private agencies involved in the planning for and delivery of long-term care services shall conform to the various requirements of state and federal law deriving, without limitation, from the hospital discharge planning requirements of the United States Medicare Catastrophic Coverage Act of 1988; the nursing home reform requirements of the United States Omnibus Budget Reconciliation Act of 1987; and the various state law requirements for in-home and community support services for adults with long-term care needs, Title 22, sections 7301 to 7306; in-home and community support services for the elderly, Title 22, sections 7321 to 7323; personal care assistance services for severely physically disabled adults, Title 22, sections 7341 to 7343; placement and therapeutic services for dependent and incapacitated adults, Title 22,

1 sections 3488 to 3492; boarding care facilities, Title 22, sections 7901-A to 7913; licensing of hospitals and
3 institutions, Title 22, sections 1811 to 1827; and rules, regulations and policies adopted pursuant to these laws.

5

STATEMENT OF FACT

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This bill will make uniform throughout Maine's system of
9 long-term care the procedures for assessing the needs of individual clients and tailoring programs to meet their needs.
11 It will also provide the individualized treatment planning process with a set of articulated and maximum feasible
13 restoration of functional capacity. Finally, the bill addresses the need of Maine's long-term care system to have available to
15 it a "snapshot" of needed services which are currently unavailable to long-term care clients.