Division of Licensing and Regulatory Services

Biennial Report
SFY 2008 - 2009
September 1, 2009

Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

John E. Baldacci, Governor

Brenda M. Harvey, Commissioner

This report was prepared by
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I. Background

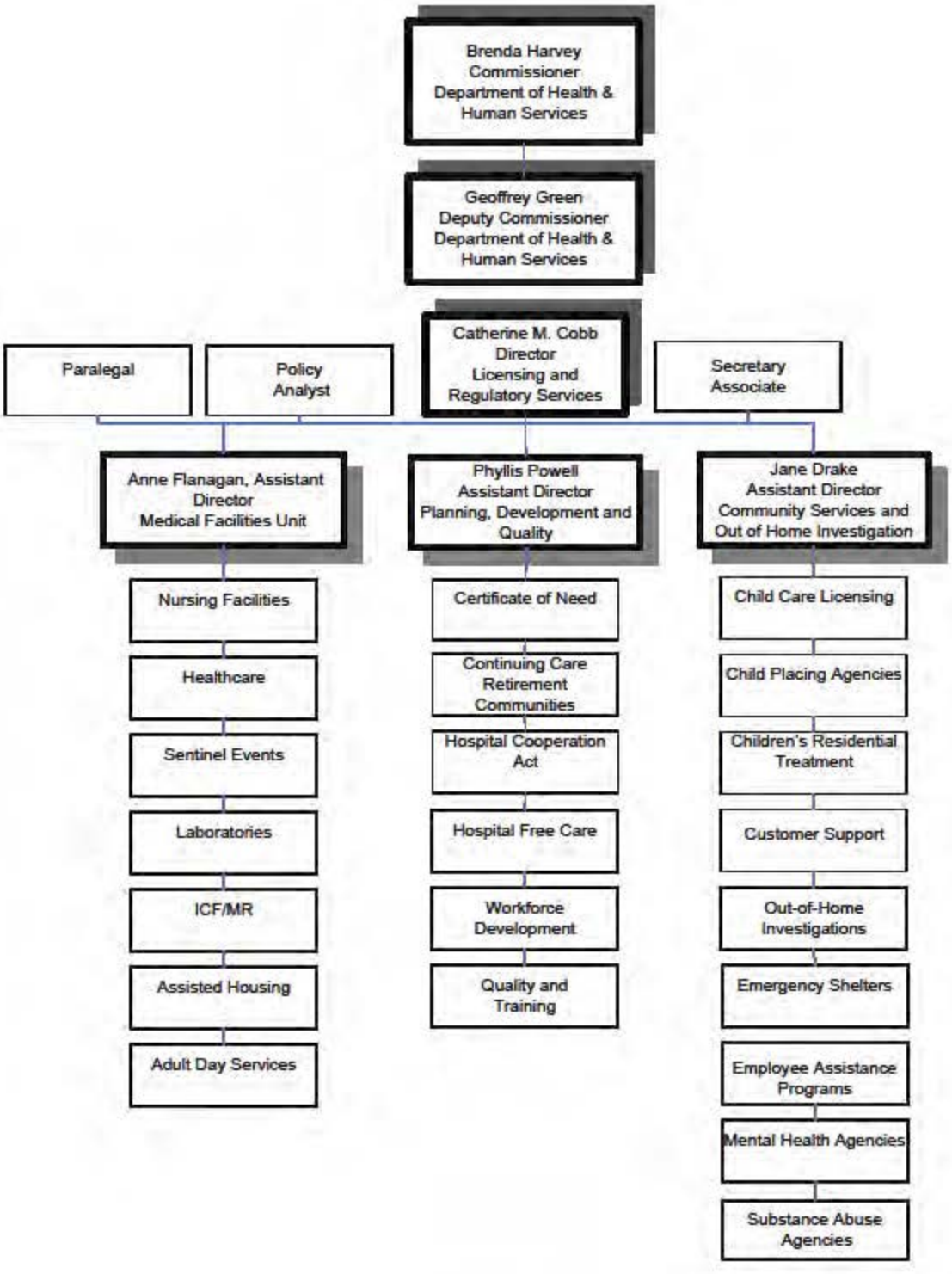
The Division of Licensing and Regulatory Services was created in 2005 from various licensing units in the legacy Department of Human Services and Department of Behavioral and Developmental Services. The merger of the two departments was guided by the efforts of many advisory groups. Shortly upon creation of the Department of Health and Human Services, an Administrative Processes Oversight Committee was formed. Among its recommendations concerning the department were several pertaining to regulatory oversight activities involving licensing. Chief among those recommendations were:

"Assure the consistent application of licensing requirements within and across programs, appropriately balancing the Department's enforcement responsibility with its responsibility to improve provider quality by providing technical assistance; define clear boundaries between other department functions and ensure that the approach and standards are consistent and mutually consistent and mutually supportive across those functions."

"We will focus on process improvement; we will cultivate provider partnerships; services to stakeholders will reflect the complexity of needs; and the administration of programs will be efficient and effective. There will be measurable performance objectives by program; performance indicators and staff performance expectations will reflect the Division's core values and be implemented throughout the Division."

In 2006, additional regulatory oversight functions were integrated into the Division. These included Certificate of Need regulation, health care antitrust oversight under the Certificate of Public Advantage Act, management of free care guidelines and oversight of continuing care retirement communities.

II. Organization Chart



III. Contact Information

Phone List:

Division Central Number: 1 (800) 791-4080 and 1 (207) 287-9300
Medical, Nursing, and Residential Care Facilities, C.N.A. Registry, and Customer Support: 1 (800) 383-2441
Home Healthcare Agency (HHA) Hotline: 1 (800) 621-8222
Child Protective Intake Emergency Number: 1 (800) 452-1999
Adult Protective Intake Emergency Number: 1 (800) 452-1999

Address:

SHS #11
41 Anthony Avenue
Augusta, ME 04333-0011

Website:

http://www.maine.gov/dhhs/dlrs/index.shtml

District Offices:

Augusta	41 Anthony Ave Augusta, ME 04330	Toll free: 1-800-791-4080 Mainline: 1-207-287-9300 FAX: 1-207-287-9307
Bangor	396 Griffin Road Bangor, ME 04401	Toll Free: 1-800-432-7825 Main Line: 1-207-561-4100 Fax: 1-207-561-4298
Biddeford	208 Graham Street Biddeford, ME 04005	Toll Free: 1-800-322-1919 Main Line: 1-207-286-2400 Fax: 1-207-286-2527
Ellsworth	17 Eastward Lane Ellsworth, ME 04605	Toll Free: 1-800-432-7823 Main Line: 1-207-667-1600 Fax: 1-207-667-8692
Houlton	11 High Street Houlton, ME 04730	Toll Free: 1-800-432-7338 Main Line: 1-207-834-7700 Fax: 1-207-834-7701
Lewiston	200 Main Street Lewiston, ME 04240	Toll Free: 1-800-482-7517 Main Line: 1-207-795-4300 Fax: 1-207-795-4651
Portland	161 Marginal Way Portland, ME 04101	Toll Free: 1-800-482-7520 Main Line: 1-207-822-2000 Fax: 1-207-822-2226
Sanford	890 Main Street, Suite 208 Sanford, ME 04073	Toll Free: 1-800-482-0790 Main Line: 1-207-490-5400 Fax: 1-207-490-5463
Skowhegan	98 North Avenue, Suite 10 Skowhegan, ME 04976	Toll Free: 1-800-452-4602 Main Line: 1-207-474-4873 Fax: 1-207-474-4800

i. Administration

Background

Administration oversees the broad functions of survey and certification of health and long term care facilities, certification and licensing of child care programs, licensing of behavioral health providers, operation of the Registry of Certified Nursing Assistants, other work force development programs, and the regulatory oversight functions described herein.

The Director, Assistant Directors for Planning, Development and Quality, Community Services and Medical Facilities, guide the day to day operation of the Division and lead planning activities. Senior leaders are also responsible for developing and implementing performance metrics for their areas of function to assure that the Division is accountable and continually striving to improve performance.

Program Responsibilities

Division-wide responsibilities.

Administration Staff Table		
Staff	**Positions**	**Duties**
Division Director	1	Division-wide/department-wide
Policy Analyst	1	Legislative policy, rules and regulatory changes.
Paralegal	1	FOA requests, Hearings and Informal Dispute Resolution, CNA actions and support to the CNA Registry.
Secretary Associate	1	Supports the Director and administrative activities, building control, and web master.
Assistant Directors	3	Planning, Development and Quality; Community Services; and Medical Facilities
Reception	1	Division-wide
Customer Service Intake	1	Division-wide

Projects/ Collaborations

The Director represents the Division at the Legislature, and is a member of the Department's Integrated Management Team. The Assistant Directors are responsible for policy, planning, management, and stakeholder involvement for their respective programs. Each leads specific strategic plan initiatives.

Policy Analysis, Legislation and Rules

The policy analyst prepares the annual regulatory agenda and works with other Division staff when drafting proposed amendments to licensing, certification, and registration rules as well as rules governing sentinel events reporting, certificate of need and the Certified Nursing Assistant registry. The Division is responsible for over 35 sets of rules. In addition, the analyst assists the senior leadership team to draft and monitor legislation.

Rulemaking Initiatives

In addition to several 90-day emergency rules, to ensure the safe use of swimming pools and activities at lakes and ponds by licensed child care facilities and certified family child care programs, the following table identifies rules that were amended during this biennium.

RULES AMENDED DURING 2008	
Rules	**Action**
Hospital Licensing Rules, 10-144 C.M.R. Ch. 112. Amended February 20, 2008.	Implement legislation that required hospitals to give registered nurses information about the Whistleblowers' Protection Act, and to require hospitals to notify consumers before destroying patient imaging records using x-rays, magnetic resonance imaging or computerized tomography.
Child Care Facility Licensing Rules, 10-148 C.M.R. Ch. 32. Amended January 31, 2008 and August 27, 2008.	Implement legislation concerning: operating without a license; limitation on reapplication after denial or revocation of a license; amendment of the definition of child care facility to exclude programs such as karate, dance, or basketball; increase licensing fees; increase term of a license to 2 years; conduct at least one unannounced inspection of a child care facility between 6 and 18 months after the issuance of a license; swimming pool safety; and activities at lakes and ponds.
Assisted Housing Licensing Rules, 10-144 C.M.R. Ch. 113. Amended August 20, 2008.	Implement legislation concerning operating without a license, right of entry, confidential information, and financial penalty provisions.
Substance Abuse Treatment Licensing Rules, 14-118 C.M.R. Ch. 5. Amended February 29, 2009.	Implement a regulatory framework to support universal, co-occurring competent practice statewide by: adding co-occurring disorder-related definitions; personnel record-keeping and staff credentialing requirements; clarification of requirements relating to coordination of client care and collaboration among a client's different treatment providers; and clarification of criteria for granting waivers for opiate treatment programs.

RULES AMENDED DURING 2009	
Rules	**Action**
Rules Governing the Reporting of Sentinel Events 10-144 CMR Chapter 114 Effective Date January 1, 2009	Adopt a free-standing rule that replaced sentinel event reporting provisions in four licensing rules (Intermediate Care Facilities for Persons with Mental Retardation, End Stage Renal Disease, Ambulatory Surgery Facility, and Hospitals).
Rules for the Licensing of Hospitals 10-144 C.M.R. Ch. 112 Effective January 1, 2009	Replace the hospital licensing rules to implement Public Law 2007, Ch 314 and streamline the hospital survey process. Hospitals are exempt from state inspection requirements if they are federally certified by the Centers for Medicare and Medicaid Services [CMS] for participation in the federal Medicare program and hold full accreditation status by a health care facility accrediting organization recognized by CMS. Certified hospitals that are not accredited are subject to state inspection every 3 years. All hospitals remain subject to a state inspection in response to a complaint, suspected violation of hospital licensing laws and rules or suspected violation of the CMS conditions of participation. All hospitals remain subject to state inspection to determine compliance with building codes, fire codes, life safety codes and for other similar purposes. At the hospital's request, the Department may review a hospital's architectural plans and a fee may be charged. Pursuant to Public Law 2007, Ch 324 hospital licenses may be renewed for up to 24 months.
Rules for the Certification of Family Child Care Providers 10-148 CMR Chapter 33, Effective July 1, 2009	Final adoption of major substantive portions of Chapter 33 by the Maine Legislature (Resolve 2009, chapter 8) The Certification of Family Child Care Providers Rules include the following amendments: adds "operating without a certificate" provisions; adds a limitation on reapplication after denial or revocation of a certificate; the application fee for a provisional or temporary certificate is $80.00; the term of a full certificate is increased to 2 years; a $160 renewal fee will be assessed biennially for a full or a conditional certificate; and at least one unannounced inspection will take place between 6 and 18 months after the issuance of a full certificate.

Legislative Policy Initiatives

The Division submitted several pieces of proposed legislation for consideration. A number of legislative bills pertaining to Division programs became Public Law or a Resolve .

Legislative Summary -123rd Legislature - 2nd Regular & 2nd Special Sessions January - April 2008		
LD #	**Public Law Or Resolve**	**Title and Comment**
2105	PL, Ch 631	**An Act To Change the Timing of the Health Care Occupations Report and To Add and Clarify Definitions Relating to Swimming Pools and Spas** Family child care program pools are residential swimming pools and not subject to Maine Center for Disease Control and Prevention registration rules. Child care facility pools are public pools. DLRS will amend certification rules to comply with this legislation.
2301	PL, Ch 681	**[Emergency] An Act To Amend the Maine Certificate of Need Act of 2002.** Effective when signed by Governor on 4/23/2008, this bill deals with threshold amount for review, and emergency and necessary renovations.
2033	Resolve, Ch 199	**[Emergency] Resolve, Directing the Department of Health and Human Services To Adopt Rules Governing Water Activities Offered by Licensed Child Care Facilities** DLRS promulgated emergency rules that took effect June 1, 2008 in response to this Resolve.
2108	Resolve, Ch 172	**Resolve, To Adopt Respectful Language in Programs Affecting Developmental Services** DLRS shall amend its rules to comply with this Resolve.

124th Legislature – 1st Regular Session January – June 2009		
LD #	**Public Law Or Resolve 2009**	**Title and Comment**
80	Resolve, Ch 8	**Resolve, Regarding Legislative Review of Portions of Chapter 33: Rules for the Certification of Family Child Care Providers, a Major Substantive Rule of the Department of Health and Human Services, Division of Licensing and Regulatory Services** Portions of the DLRS Rule for the Certification of Family Child Care Providers were reviewed and authorized by the legislature as a prerequisite for final adoption and implementation.
877	Resolve, Ch 68	**Resolve, To Review the Maine Registry of Certified Nursing Assistants** DLRS will convene a working group to examine and make recommendations for changes to the current law prohibiting an individual from employment as a CNA in certain settings if the individual has been convicted of a crime involving abuse, neglect or misappropriation of property in a health care setting.
1395	PL, Ch 383	**An Act To Amend the Maine Certificate of Need Act of 2002 (emergency)** Changed thresholds used to calculate whether a project is subject to CON review. Removed indexing provisions. Record opens when department receives a CON application. Neither a public information meeting nor a public hearing is required for the simplified review and approval process. The department may impose a fine of up to $10,000 and a hearing to contest the fine is available to the person subject to the fine.
1417	PL, Ch 215	**An Act To Add Unlicensed Assistive Persons with Notations to the Maine Registry of Certified Nursing Assistants** DLRS is authorized to investigate complaints against unlicensed assistive persons of abuse, neglect or misappropriation of property of a client, patient or resident in a home or health care setting. It requires the Maine CNA Registry to list and include a notation to the unlicensed assistive person's listing when a complaint is substantiated. It requires the Registry to notify an individual of the right to request a hearing to contest a finding that a complaint was substantiated and gives the individual the right to petition the department to have a finding of neglect removed from the registry if the finding of neglect is a one-time occurrence and there is no pattern of neglect. This bill identifies unlicensed assistive persons who may not be employed or placed by a licensed, certified or registered agency or facility.
1435	PL, Ch 358	**An Act To Amend Sentinel Events Reporting Laws To Reduce Medical Errors and Improve Patient Safety** Added definitions of 'immediate jeopardy', 'near miss' and 'root cause analysis.' Providers must have a written standardized procedure to identify sentinel events. DLRS shall develop standardized reporting and notification procedures. The SE team may conduct on-site visits to health care facilities to determine compliance with laws and rules. The SE team reports to the DLRS licensing section incidences of immediate jeopardy. Health care facilities may voluntarily notify DLRS of the occurrence of a near miss. When a suspected sentinel event is reported, DLRS shall determine whether the event constitutes a sentinel event. DLRS may impose a fine of up to $10,000 and a hearing to contest the fine is available to the person subject to the fine.

ii. Assisted Housing and Adult Day Services

Assisted Housing

"Assisted Housing" is an umbrella term describing many types of residential programs for adults, where they receive personal care services, medication assistance, and many other therapeutic services. The Unit works closely with the Long Term Care Ombudsman Program to resolve issues brought forward by the public.

"Private Non-Medical Institutions (PNMI)" and "Residential Care Facilities (RCF)" provide the same services and type of housing. The distinguishing difference is that a PNMI receives MaineCare funds and complies with additional requirements as specified in various sections of the Regulations Governing the Licensing and Functioning of Assisted Housing Programs. Both are described as a house or other place that, for consideration, is maintained wholly or partly for the purpose of providing residents with assisted living services". Residents live in either private or semi-private bedrooms with common living areas and dining areas. The characteristics of persons served varies and are identified in the facility's admissions policy.

There are four levels of PNMIs: Levels I, II, III and IV. Each has its own regulatory requirements and is distinguished by the number of residents served and/or type of staff. Each facility is reviewed for regulatory compliance during a complaint investigation and on an annual or bi-annual survey.

Adult Day Services

An Adult Day Health Services Program provides health monitoring and personal care services in addition to a group program of care, therapeutic activities and supervision. A Social Adult Day Services Program is designed to meet the social and supervisory needs of participating adults.

Assisted Living Programs

An Assisted Living Program provides assisted living services to consumers in private apartments in buildings that include a common dining area, either directly or indirectly through contracts. There are two types of programs. Type I provides personal care and medication administration and Type II provides those services and nursing services.

Assisted Housing - Provider Table State Fiscal Year						
	Provider Counts			Beds/ Capacity if Applicable		
Provider Types	**2007**	**2008**	**2009**	**2007**	**2008**	**2009**
Assisted Living	33	32	32	1474	1465	1467
Level I Residential Care	74	59	59	125	104	106
Level II Residential Care	70	55	54	273	208	201
Level III Residential Care	335	339	342	1433	1446	1444
Level IV Residential Care	184	190	191	5273	5367	5340
Level IV Residential Care (ML[1]) included on LTC section	n/a	n/a	n/a	n/a	n/a	n/a
Adult Day Care	39	39	34	655	668	595
TOTAL	**735**	**714**	**712**	**9233**	**9258**	**9153**

*2007 data is from report dated January 2007
**2008 data is from report dated January 2009
***2009 data is from report dated June 2009
[1] Multi-level; meaning part of a nursing facility

Licensure Surveys			
Assisted Housing/ Adult Day Services	**2007**	**2008**	**2009**
TOTAL	**317**	**331**	**246**

Assisted Housing Program Complaints Investigated State Fiscal Years			
Assisted Housing and Adult Day Services	2007	2008	2009
TOTAL	**191**	**136**	**84**

Assisted Housing Staff Table			
Staff	**2007**	**2008**	**2009**
Assisted Housing Supervisor/Manager	2	1	1
RN Consultant	1	2	.5
Program Licensor	9	8	7
Facilities Licensor	2	2	2
Support Staff	2.5	2	1
TOTAL	**16.5**	**15**	**13.5**

iii. Behavioral Health

Behavioral Health encompasses all behavioral health programs except hospital in-patient units. The Unit surveys and licenses programs, regardless of the age of the consumer. Given the necessity to align service delivery with policies and contracts of major Offices within the Department, alignment with those internal customers is part of the mission. Unit staff meets regularly with representatives of the Offices of Child and Family Services, Adult Mental Health and Substance Abuse. Any complaints against the agencies are also investigated, unless triaged as abuse or neglect involving a child, in which case it is referred to the Out of Home Investigations Unit.

Child Placing Agencies with and without Adoption Programs
Child Placing Agencies find or otherwise place children under the age of 18 into homes where care will be provided on a 24-hour a day basis. Placements include children in the foster care system.

Children's Residential Care Facilities
A Children's Residential Care Facility is any residence maintained exclusively for board and care of one or more children under the age of 21 (not solely for recreational and educational or just educational purposes), often for behavioral services and mental health treatment.

Mental Health Agencies
A Mental Health Agency or facility provides outpatient and/or residential services. The Unit also determines compliance with the "Consent Decree". The Unit deems for accreditation where standards are equal to or exceed, Maine rules.

Substance Abuse Agencies
Substance Abuse Agencies provide outpatient care, residential programs, driver education and evaluations programs, inpatient care, methadone treatment, halfway houses and shelters.

Employee Assistance Programs
These programs assist people within an organization who are dealing with emotional distress or suspected of substance abuse that interferes with work performance.

Shelters for Homeless Youth and Emergency Shelters for Children
These programs assist homeless youth with shelter for short stays to stabilize and assist with a more long term housing plan. No mental health or substance abuse treatment is provided. Referrals for such treatment may be made.

Behavioral Health Provider Table						
Provider Types	**Provider Counts 2007**	**Provider Counts 2008 ***	**Provider Counts 2009**	**License Surveys 2007**	**License Surveys 2008**	**License Surveys 2009**
Children's Residential	153	153	149	130	71	48
Substance Abuse	95	90	87	45	48	54
Mental Health	118	120	121	63	32	77
** Employment Assistance Programs	65	n/a	80	34	44	18
Children's Placement Agencies	20	20	21	20	10	13
Shelters for Homeless Youth	3	3	3	3	3	3
Emergency Shelters for Children	2	2	2	2	1	1
TOTAL	**456**	**388**	**463**	**297 *****	**209 *****	**214 *****

*Provider counts for 2008 are as of 10/1/2008
**data not available
***2 year surveys

Behavioral Health Capacity Table Year End SFY 2009	
Provider Types	
Children's Residential	1,050 beds
Substance Abuse	27,573 consumers*
Mental Health	85,184 consumers*
Employment Assistance Programs	22,403 consumers*
Children's Placement Agencies	4,937 consumers*
Shelters for Homeless Youth	48 beds
Emergency Shelters for Children	22 beds
***TOTAL CAPACITY**	**141,217**

*duplicated count

Behavioral Health Complaints Investigated			
Provider Types	**2007**	**2008**	**2009**
Children's Residential	45	22	23
Substance Abuse	0	8	8
Mental Health	4	14	14
Employment Assistance Programs	0	0	0
Children's Placement Agencies	0	2	2
Shelters for Homeless Youth	3	1	1
Emergency Shelters for Children	0	0	0
TOTAL	**52**	**47**	**48**

Behavioral Health Staff Table			
Staff	**2009**	**2008**	**2009**
Supervisor Behavioral Health	1	1	1
Program Licensor	7	6	6
Support	1	1	1
TOTAL	**9**	**8**	**8**

iv. Child Care

Community Care Workers complete inspections annually to determine compliance. Licenses are issued for up to two years. Inspections include a tour of the physical plant, review of records and interviews with staff/providers and others. Community Care Workers are also a resource to providers and provide technical assistance as well as participate in new provider trainings.

When a complaint is received it is assigned to a licensor or an Out of Home Investigator. This determination is based on the nature of the complaint. Complaints alleging non-compliance with licensing rules are assigned to licensors.

Family Child Care is provided in a person's home for 3-12 children under 13.

Child Care Center is a facility for 13 or more children under 13.

Nursery School is a facility providing for 3 or more children 33 months or older and under age 8, with no sessions longer than 3 ½ hours.

Child Care Providers						
Provider Types	**Provider Counts 2007**	**Provider Counts 2008**	**Provider Counts 2009**	**Capacity 2007**	**Capacity 2008**	**Capacity 2009**
Family Child Care Provider	Not Available	1,491	1,519	Not Available	16,010	15,755
Child Care Facility	Not Available	625	726	Not Available	30,990	33,463
Nursery School	Not Available	121	131	Not Available	2,643	2,315
TOTAL	**2,530**	**2,237**	**2,376**	Not Available	**49,643**	**51,533**

08 provider counts are as of 10/1/2008 and capacity as of 11/08

Child Care Licensing Complaints and Survey Table			
	2007	**2008**	**2009**
Complaints	421	302	268
Surveys	1,965	2,604	2,583
TOTAL	**2,386**	**2,906**	**2,851**

Child Care Licensing Staff Table			
Staff	**2006**	**2008**	**2009**
Supervisors Child Care Licensing	2	2	2
Program Licensors	15	15	14
Support	3	2	2
TOTAL	**20**	**19**	**18**

v. Out of Home Investigations

All allegations of abuse and/or neglect involving children in facilities and institutions that are licensed are triaged and investigated by the Out of Home Investigations Unit. The routing of the report will be based on the substance of the allegations and the probable need to interview a child or children as a result of the allegations. This Unit of social workers specializes in interviewing children and has experience in investigating child abuse complaints. Out of Home Investigations and Child Protective Services will team an investigation of injury of unknown origin.

The final assessment may have a finding of abuse or neglect and may cite licensing violations. Any licensing violations identified during an assessment of an incident are shared/referred to the appropriate licensing authority for follow-up.

Out of Home Investigations
Workload Information by State Fiscal Year

Provider Types	Received 2007	Closed 2007	Referred 2007*	Received 2008	Closed 2008	Referred 2008*	Received 2009	Closed 2009	Referred 2009*
Child Care	95	---	---	313	---	---	230	---	---
Foster Homes	57	---	---	59	---	---	62	---	---
Residential	48	---	---	68	---	---	87	---	---
Total	**200**	**203**	**581**	**470**	**213**	**451**	**379**	**184**	**489**

*referred to licensing for investigation

Out of Home Investigations
Staff Table

	2007	2008	2009
Staff	**Positions**	**Positions**	**Positions**
Manager/ Supervisor	1	0	0
Investigators	6	6	5
TOTAL	**7**	**6**	**5**

vi. Healthcare Oversight

Certificate of Need

The Certificate of Need (CON) Act provides the framework for review of proposals by or on behalf of certain health care facilities and nursing facilities involving expansion of plant and equipment, the provision of new services, transfers of ownership and control and other initiatives requiring a CON.

The process is integrated with the priorities of the State Health Plan (SHP) and operates within constraints established by the Capital Investment Fund (CIF). The CIF acts as a limit on annual investment subject to review under the CON statute. Investment is measured based on the third year incremental costs associated with an approved project. Both the SHP priorities and the CIF are determined independently by the Governor's Office of Health Policy and Finance.

Several process improvements were instituted in 2008. These include standardized financial templates and joint technical assistance meetings. These changes were designed to streamline dialogue between an applicant and the CON Unit that was often necessary to obtain all relevant information regarding the impact of a project. Combined technical assistance meetings resulted in increased transparency between the CON Unit and applicants.

Capital Expenditure by CY		
	CY 2007	**CY 2008**
Not Subject to Review	10	13
Capital Expenditure	$33,516,864.00	$13,789,745.00
3rd Operating Year	$3,557,475.00	$3,592,476.00
Reviews Completed	17	16
Capital Expenditure	$490,985,244.00	$611,100,302.00
3rd Operating Year	$49,161,805.00	$57,169,983.00
Subsequent Reviews Completed		2
Capital Expenditure		$5,500,000.00
3rd Operating Year		
Expired Letters of Intent	1	
Capital Expenditure	$13,500,000.00	
3rd Operating Year	$9,964,500.00	
Withdrawn	4	2
Capital Expenditure	$128,785,344.00	$6,003,280.00
3rd Operating Year	$8,048,283.00	$450,000.00

The CON Act establishes a number of thresholds that trigger review.

Expenditures	Base Year	Base Amount	Frequency	CPI	2006	CPI	2007	CPI	2008
Major Medical Equipment	9/30/2003	$1,200,000	annually	5.36	1,333,099	4.63	1,394,821	4.74	1,460,936
Capital Expenditures	9/30/2003	$2,400,000	annually	5.36	2,666,198	4.63	2,789,643	4.74	2,921,872
New Technology	9/30/2003	$1,200,000	annually	5.36	1,333,099	4.63	1,394,821	4.74	1,460,936
NF Capital Expenditures	9/30/2001	$510,000	biannually	22.64	625,464			9.37	684,070
New Health Service	9/30/2003	$110,000	biannually	10.8	121,880			9.37	133,300
	9/30/2003	$400,000	biannually	10.8	443,200			9.37	484,728
Large Project[1]	9/30/2004	$500,000	N/A						

*NF means nursing facility.

The CIF established by the Dirigo Health Act, created several categories of projects to enable hospital and non-hospital projects, small and large, to be competitive in their own categories. The Dirigo Health Act did not establish a CIF for nursing facility projects. Instead, the CON Act of 2002 established a nursing home funding pool. In other words, a project increasing MaineCare costs must have an equal decrease in MaineCare costs elsewhere. This maintains budget neutrality while allowing some projects above the nursing facility thresholds to proceed.

CIF 2007	Small	Large	Total
Non-Hospital	$138,560	$1,247,043	$1,385,603
Hospital	$969,922	$9,633,797	$10,603,719
Total			**$11,989,322**

CIF 2008	Small	Large	Total
Non-Hospital	$138,560	$1,247,043	$1,385,603
Hospital	$969,922	$3,399,458	$4,369,380
Total			**$5,754,983**

Projects		Total Capital Expenditure with Contingency	3rd Year Incremental Operating Costs
CY 2007			
Hospital	**Approved**	$96,151,720.00	$16,298,672.00
Hospital	**LOIs**	$392,480,244.00	$32,863,133.00
Nursing Facility	**LOIs**	$850,000.00	0
Nursing Facility	**In Review**	$1,503,280.00	0
NSTR	**Other Healthcare**	$1,510,000.00	$47,000.00
NSTR	**Hospital**	$31,329,752.00	$3,510,475.00
NSTR	**Nursing Facility**	$677,112.00	0
		$524,502,118.00	**$52,719,280.00**
Withdrew	**Other Healthcare**	$1,732,344.00	$942,952.00
Withdrew	**Hospital**	$127,053,000.00	$7,105,331.00
Expired	**Hospital**	$13,500.00	$99,645.00
CY 2008			
Hospital	**Approved**	$431,621,817.00	$31,533,308.00
Hospital	**LOIs**	$5,000,000.00	$333,000.00
Nursing Facility	**Approved**	$3,240,593.00	0
Nursing Facility	**LOIs**	$50,000.00	0
Other Facility	**LOIs**	$500,000.00	$300,000.00
NSTR	**Hospitals**	$10,872,937.00	$3,342,371.00
NSTR	**Nursing Facility**	$677,112.00	0
NSTR	**Other Healthcare**	$2,239,696.00	$250,105.00
Subsequent Review	**Hospital**	$5,500,000.00	0
		$459,702,155.00	**$32,909,157.00**
Withdrew	**Hospital**	$4,500,000.00	$450,000.00
Withdrew	**Nursing Facility**	$1,503,280.00	0
Hospital	**In Review**	$68,250,656	$24,983,675
COPA	**Approved**	$101,837,236	0
Nursing Facility	**In Review**	$600,000.00	0

*COPA means Certificate of Public Advantage
**LOI means Letter of Intent
***NSTR means Not Subject To Review.

Revenues		
	CYR 2007	**CYR 2008**
COPA	$190,742.00	$409,287.00
FOIA	$485.75	$1,710.00
CON Application Fees	$347,000.00	$69,000.00
TOTAL	**$538,227.75**	**$479,997.00**

Continuing Care Retirement Communities

To operate a Continuing Care Retirement Community (CCRC), a person must submit an application to the Bureau of Insurance (BOI) for a preliminary Certificate of Authority to operate a CCRC. The CON Unit provides certain assurances to the BOI in order for a certificate to be granted. CCRCs are allowed to accept private pay non-CCRC residents with approval from the Bureau of Insurance upon successful licensure from DLRS and review from the Healthcare Oversight staff. These facilities may have MaineCare and Medicare patients, subject to Bureau of Insurance restrictions, if they complete the CON process. There are only two CCRCs in Maine.

Hospital Cooperation Act

Pursuant to the Hospital and Health Care Provider Act of 2005, a hospital may apply for a Certificate of Public Advantage (COPA) which authorizes the hospital to enter into a cooperative agreement with another hospital if the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that might result from the agreement. This is a voluntary process that includes participation from the Office of the Attorney General and the Governor's Office of Health Care Policy and Finance (GOHPF). No notices to file an application were received in CY 2007. A notice to file an application was received in 2008 and an application was received in the fourth quarter. As of the end of CY 2008 a review was in process for a project involving $101,837,236. The project was completed in CY 2009

Hospital Free Care Guidelines

DLRS collects data on the free care policies of hospitals, including minimum income guidelines to be used in determining whether individuals are unable to pay for hospital services. It sets forth procedures for notifying patients of the availability of free care, determining who is qualified for such care, and annually reporting the quantity of free care provided.

Hospital	# of Patient Records Reported	Mandated Free Care Amount	# of Patient Records Uncompensated Care	Additional Uncompensated Care Amount
The Aroostook Medical Center	254	$ 1,126,809	181	$ 381,528
Blue Hill Memorial Hospital[7]				
Bridgton Hospital	1,019	$ 475,765	696	$ 403,769
Calais Regional Hospital[6]				
Charles A. Dean Memorial Hospital	51	$ 164,135	63	$ 129,862
Cary Medical	291	$ 591,717	65	$ 711,344
Central Maine Medical Center	4,706	$ 6,119,202	4,074	$ 3,075,147
Down East Community Hospital[1]	201	$ 1,209,624	219	
Eastern Maine Medical Center	1,048	$ 6,226,669	41,775	$ 8,788,027
Franklin Memorial Hospital[2]	-	$ 815,982	-	$ 1,126,832
Goodall Hospital[3]	1,232	$ 1,354,404		
Houlton Regional Hospital	377	$ 973,659	43	$ 3,569
Inland Hospital	27	$ 26,579	343	$ 863,670
Maine Coast Memorial Hospital	509	$ 1,706,631	240	$ 224,325
MaineGeneral Health & Medical Center[3]	2,411	$ 5,720,581		
Maine Medical Center	21,358	$17,586,993	1,922	$ 2,225,708
Mayo Regional Hospital	449	$ 1,290,696	121	$ 322,674
Mercy Hospital	4,904	$ 5,341,599	3,867	$ 2,365,728
Mid Coast Hospital[4]	-	$ 1,942,430		
Miles Memorial Hospital[5]	710	$ 1,416,098		$ 230,000
Millinocket Regional Hospital[5]	618	$ 463,627	-	$ 252,451
Mount Desert Island Hospital[2]		$ 135,901		$ 362,520
New England Rehab Hospital	106	$ 285,670	-	$ -
Northern Maine Medical Center[7]				
Parkview Adventist Medical Center[7]				
Penobscot Bay Medical Center	882	$ 2,140,332	1,440	$ 1,206,401
Penobscot Valley Hospital	886	$ 650,379	664	$ 292,267
Redington-Fairview General Hospital	234	$ 648,649	204	$ 563,125
Rumford Hospital	512	$ 315,506	332	$ 206,957
Sebasticook Valley Hospital[7]				
Southern Maine Medical Center[7]				
Stephens Memorial Hospital	1,443	$ 1,065,905	808	$ 391,788
St. Andrews Hospital and Healthcare Center	100	$ 169,957		$ 71,517
St. Joseph Hospital	674	$ 1,027,197	114	$ 60,182
St. Mary's Regional Medical Center	1,870	$ 2,983,060	3,072	$ 2,657,148
Waldo County General Hospital	1,260	$ 865,039	263	$ 265,372
York Hospital[7]				

# of Respondent(s)	# of Patient Records Reported	Mandated Free Care Amount	# of Patient Records Uncompensated Care	Additional Uncompensated Care Amount
30	48,132	$64,840,795	60,506	$27,181,910
			All Patients	All Uncompensated Care
			108,638	$92,022,705
Footnotes:				

[1]Hospital was able to report on number of patients but did not break out specific values for both categories.
[2]Hospital was not able to provide number of patients.
[3]Hospital did not delineate between mandated and voluntary free care.
[4]Hospital did not delineate between mandated and voluntary free care, did not provide number of patient records.
[5]Hospital delineate amounts of care but could not delineate number of patient records.
[6]Hospital provided policy but did not provide patients or free care charges.
[7]As of Reporting date no data received.

The CON Annual Report may be found at the following website:
http://www.maine.gov/dhhs/dlrs/c_o_n/index.shtml#report2008

Healthcare Oversight – Staff Table By Calendar Year		
Staff	**2007**	**2008**
Healthcare Financial Analysts	2	2
Support	0	.5
TOTALS	**2**	**2.5**

vii. Sentinel Events

In 2002, Maine established a mandatory sentinel event reporting system. The law applies to all licensed General and Specialty Hospitals, Ambulatory Surgical Centers, End-Stage Renal Disease Facilities/Units, and Intermediate Care Facilities for Persons with Mental Retardation. The law further requires an annual report to the Legislature and public. Maine continues to significantly under-report sentinel events based on estimates from national studies. Maintaining a commitment to a collaborative approach among all stakeholders for identifying, reporting, and sharing aggregate data for all sentinel events offers the best opportunity for preventing recurrences. A total of 147 Sentinel Events have been reported and reviewed since the inception of the program in 2004. The overwhelming majority are unanticipated patient deaths.

Definition of Sentinel Event

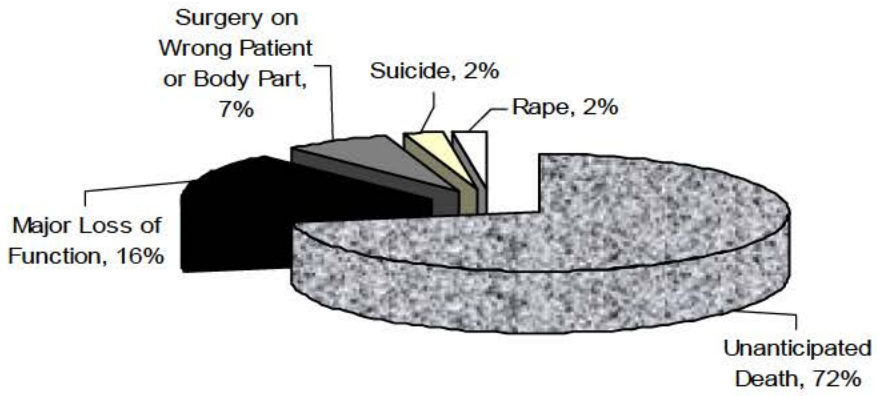
Sentinel events are outcomes determined to be unrelated to the natural course of the patient's illness or underlying condition, or proper treatment of that illness or underlying condition. The law, during the time of this report, characterized sentinel events as:

- Unanticipated death;
- A major permanent loss of function that is not present when the patient is admitted to the health-care facility;
- Surgery on the wrong patient or wrong body part;
- Hemolytic transfusion reaction involving administration of blood or blood products having blood group incompatibilities;
- Suicide of a patient in a healthcare facility where the patient receives inpatient care;
- Infant abduction or discharge to the wrong family; and
- Rape of a patient.

Sentinel Events Reported in 2008

Only forty-three sentinel events were reported in 2008. Thirty nine were reported by licensed hospitals, two by Intermediate Care Facilities for persons with Mental Retardation (ICFMR), two by Ambulatory Surgery Centers and none from End Stage Renal Disease Centers (ESRD). This number represents a 50% increase over events reported in 2007; however, only 80% of Maine hospitals have reported at least one sentinel event since the inception of the program. Eight hospitals have never reported a single event.

A breakdown of the 2008 sentinel events is as follows:



Projects/Collaborations

The Sentinel Event Program, in partnership with Maine Medical Center, was selected to participate in the National Patient Safety Improvement Corps (PSIC). Co-sponsored by the Agency for Health Care Quality (AHRQ) and the Veterans Administration (VA), the PSIC is a unique collaborative of public and private entities dedicated to reduce medical errors and improve patient safety.

The effort was culminated with two statewide Patient Safety Conferences for all 41 Maine hospitals, including Maine's state-owned psychiatric hospitals.. These full day programs were co-sponsored by DLRS and Maine Medical Center and were offered to senior leaders from each hospital. More than 150 attendees participated. Dr. Allan Frankel, a nationally recognized expert in the field of safety in healthcare delivery was the featured faculty. The outcome of this effort was a unanimous agreement to form a statewide coalition to continue the team training techniques to reduce communication and handoff errors across the state.

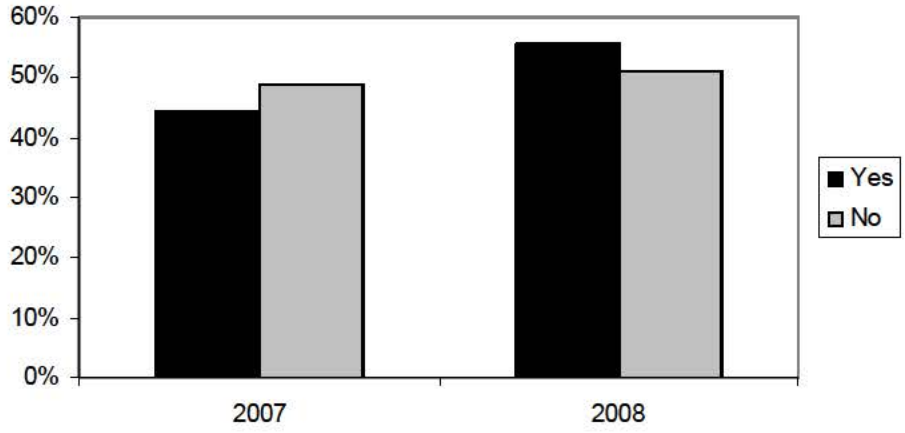
A culture of patient safety is necessary to improve reporting. The patient safety conference was a collaborative approach to this issue. Other states report that the number of reporting hospitals generally increases when facilities see the relevance of reporting to improving patient safety within their own institutions and the state (Rosenthal et al, 2001).

Changes have been made in the case review process to ensure that visits are scheduled soon after an event. Findings case reviews are shared with the facility leaders to enhance their root cause analysis process and lessons learned. This approach at collaboration may be unique to Maine, and provides an independent assessment that augments the facility's review.

	2004	2005	2006	2007	2008
	No. %	No. %	No. %	No. %	No. %
Reporting hospitals	11 27%	20 49%	25 61%	32 78%	33 80%
Non-reporting hospitals	30 73%	21 51%	16 39%	9 22%	8 20%
Total	41 100%	41 100%	41 100%	41 100%	41 100%

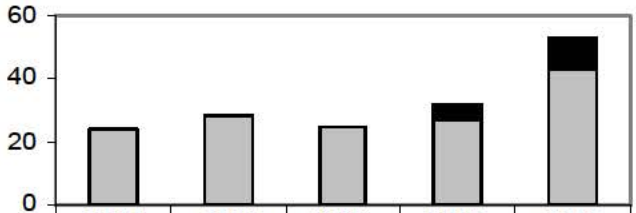
2007 to 2008 Sentinel Events with evidence of a delay in treatment

DLRS began to study cases for signs of delay in treatment preceding the sentinel event and contributing to the root cause in 2007. The number and rate grew to over 50% for sentinel event cases reported in 2008



12 cases had evidence of a delay versus 15 without in 2007
21 cases had evidence of a delay versus 22 without in 2008

In 2007 and 2008, onsite compliance audits were conducted by the Sentinel Event Team for the purpose of education and discovery. During that process a total of 15 unreported Sentinel Events were identified.



	2004	2005	2006	2007	2008
Discovered Through Audit	0	0	0	5	10
Self Reported	24	28	25	27	43

All sentinel event information submitted to DLRS is privileged and confidential. No information about individual facilities is discoverable or made public. A firewall is maintained between the Sentinel Event Team and the survey unit that regulates facility licensure. Many states have moved to make reporting publicly transparent.

Sentinel Events by Calendar Year Staff Table			
Staff	**2007**	**2008**	**2009**
Supervisor	1	1	1
Health Services Consultants	1	2	2
TOTALS	**2**	**3**	**3**

viii. Long Term Care

The Long Term Care Unit is responsible for federal certification and state survey of nursing facilities and intermediate care facilities for persons with mental retardation. Certification functions are performed under contract with the Centers for Medicare and Medicaid Services (CMS). The functions are authorized under Section 1864 of the Social Security Act (the Act) and are referred to collectively as the certification process. In addition, Maine law requires facilities to be licensed under state rules every two years. The surveyors accept the federal requirements as meeting state requirements for more than 90% of the standards.

Facilities are certified every nine to fifteen months using federal regulations and every two years using state licensure rules. Multidisciplinary teams must be federally qualified to participate in long term care surveys and complaint investigations. Complaint and entity-reported incidents are triaged and investigated by 4 centrally managed complaint nurses and district office staff.

Skilled Nursing Facility
Skilled nursing facilities provide specialized medical and nursing services and employ a variety of therapy and skilled nursing personnel. The emphasis on restorative services is oriented toward providing services for residents who require and can benefit from skilled nursing and one or more types of skilled restorative services, e.g., physical, occupational or speech therapy.

Nursing Facility
A nursing facility primarily engages in providing long term nursing care and related services to residents who require medical or nursing care; rehabilitation services, health-related care and services.

Multi-Level Residential Care Facility
These facilities are licensed under Assisted Housing rules. See page 11. Multi-level facilities are a distinct part of a nursing facility.

Intermediate Care Facility for Mental Retardation (ICF-MR-G or Nsg)
Maine is the only state to differentiate between group and nursing level of care. This differentiation ensures clients with high level medical needs receive quality care and clients with similar needs together to better serve and support them in a homelike environment. The number of facilities is on the decline. They are surveyed every 12-months using federal recertification regulations (annual survey), and state licensure rules.

Once a year, during the annual survey visits, the Utilization Review-Inspection of Care Process (UR-IOC) is conducted following Medicare requirements. This process involves a review of the services provided to all clients within the facility, review of the appropriate placement of clients and verification that an individual client actually resides within the facility. When this process is completed the individual is certified as needing either group or nursing services for a 6-month period. In 6-months, the facilities submit a form (BMS-85) that updates each client's medical and social needs. The clients are then reclassified through a desk audit for an additional 6-months.

ICF-MR-G:
Consumers are generally medically stable and staff do not need to be licensed nurses or CNAs. The primary focus is to provide training and education to each client on how to become more independent in activities of daily living. This training can range from teaching clients to bathe, dress, communicate and eat to managing money and learning to cook.

ICF-MR-NSG:
Individuals have high medical needs, such as gastric tubes, active seizure disorders or medically unstable disease processes. They are required to have licensed nursing staff and CNAs 24-hours, seven days a week. They have two primary focuses: to meet the medical needs of clients while providing education and training toward teaching clients to become more independent in activities of daily living.

RN surveyors must also quality as a Qualified Mental Retardation Professional (QMRP) in order to conduct surveys. They participate in a 4-6 month training program and complete 1 week of federally required training prior to conducting annual health surveys and investigating complaints independently.

Long Term Care – Provider Table
SFY

Provider Types	Provider Counts 2007	Provider Counts 2008	Provider Counts 2009	Beds/ Capacity 2007	Beds/ Capacity 2008	Beds/ Capacity 2009	Licensed or Certified
Nursing Facilities	112	109	109	7126	6902	6894	Both
ICF/MR	20	20	17	216	214	199	Both
ML - Level IV Residential Care	69	65	67	1780	1922	1950	Licensed
TOTAL	**201**	**194**	**193**	**9122**	**9038**	**9043**	

Long Term Care Surveys – Workload Table SFY						
Provider Types	**Annual Surveys 2007**	**Annual Surveys 2008**	**Annual Surveys 2009**	**Other Surveys 2007**	**Other Surveys 2008**	**Other Surveys 2009**
Nursing Facilities	115	99	112	245	182	182
ICF/MR	20	15	20	0	1	1
ML - Level IV Residential Care	46	38	46	0	1	0
TOTAL	**181**	**152**	**178**	**245**	**184**	**183**

Long Term Care - Complaint Table SFY						
Provider Types	**Received 2007**	**Received 2008**	**Received 2009**	**Investigated 2007**	**Investigated 2008**	**Investigated 2009**
Nursing Facilities	1207	888	877	1174	898	805
ICF/MR	86	117	70	84	96	39
ML - Level IV Residential Care	210	128	122	138	175	137
TOTAL	**1503**	**1133**	**1069**	**1396**	**1169**	**981**

Nursing Home Complaints Number of Days from Survey Start to Complaint Closure	
SFY	**Days**
2007	140
2008	149
2009	136

Nursing Home Informal Dispute Resolution (IDR) Report Federal Tags Only											
SFY	**Requested**	**Withdrawn**	**Withdrawn Percentage**	**Number Held**	**Number of Tags ID Red**	**No Change**	**No Change Percentage**	**Revised**	**Revised Percentage**	**Deleted**	**Deleted Percentage**
2007	39	1	2%	26	109	42	39%	35	32%	32	29%
2008	33	7	5%	33	129	43	33%	29	23%	39	30%
2009	28	1	4%	27	97	27	28%	1	1%	39	40%

Long Term Care Staff Table			
Staff	**Positions 2007**	**Positions 2008**	**Positions 2009**
Managers	1	.5	.5
Supervisor	4	4	4
Health Surveyor	23	23	24
Facilities Surveyors	3	3	3
Support	4.5	4.5	4.5
TOTAL	**35**	**35**	**36**

ix. Healthcare

Background

The Non Long Term Care (NLTC) Unit is responsible for federal certification and state surveys. Federal certification is done under contract with CMS. The functions are authorized under Section 1864 of the Social Security Act (the Act) and are referred to collectively as the certification process. In addition, Maine law requires most facilities to be licensed. Multidisciplinary teams must be federally trained to participate in surveys and complaint investigations. Teams may include licensed social workers, nurses, laboratory specialists, health facility specialists and consultants, including physicians and pharmacists.

General Hospitals
General Hospitals must be both State licensed and certified in Maine.

Psychiatric Hospitals and Units
Psychiatric Hospitals are specialty hospitals which provide inpatient psychiatric care to mentally ill patients. Psychiatric Hospitals must meet additional Federal requirements. All four are accredited by the Joint Commission. Some psychiatric units are contained within General or Critical Access Hospitals and are designated to provide inpatient psychiatric care. Some have a special payment designation from CMS and are called Prospective Payment Excluded (PPE) Units. There are five PPE psychiatric units.

Rehabilitation Hospitals and Units
Rehabilitation Hospitals are specialty hospitals that provide inpatient rehabilitation services. The single rehabilitation hospital in Maine is accredited. Rehabilitation units have a special payment designation from CMS as PPE units. There are four PPE rehabilitation units.

Critical Access Hospitals
Critical Access Hospitals (CAHs) have 25 or fewer beds which can be utilized as either acute care or swing beds. The CAH designation falls under a special Medicare grant program. This designation as a rural limited service hospital may apply when the hospital is in either a designated Health Professional Shortage Area or a designated Medically Underserved Area. Swing beds allow the CAH to provide skilled nursing services. Only two of these are accredited.

Home Health Agencies
Home Health Agencies (HHAs) are state licensed and federally certified and furnish services to patients under the care of a physician, and under a plan established and periodically reviewed by the physician, on a visiting basis in the patient's place of residence. Services may include part-time or intermittent nursing care; physical or occupational therapy or speech-language pathology services; medical social services, and to the extent permitted in regulations, part-time or intermittent services of a home health aide. HHA surveyors are not required annually. The Unit inspects between ten and twelve HHAs each year.

Home Health Care Service Providers
Home Health Care Service Providers (HHCSP) offer acute, restorative, rehabilitative, maintenance, preventive or health promotion services through professional nursing or another therapeutic service,

such as physical therapy, home health aides, nurse assistants, medical social work, nutritionist services, or personal care services, either directly or through contractual agreement, in a patient's/client's place of residence. These providers are State licensed, but not certified for participation in federal reimbursement programs.

Medicare-Certified Hospices

Hospice delivers a range of interdisciplinary services provided 24 hours a day, 7 days a week to the person who is terminally ill and that person's family. Hospice services are delivered in accordance with hospice philosophy which is a philosophy of palliative care for individuals and families during the process of dying and bereavement. It is life affirming and strengthens the client's role in making informed decisions about care. Providers are required to be both state licensed and CMS certified. Between eight and ten hospices are inspected each year.

Volunteer Hospices

Volunteer hospices provide care at no charge. They often work closely with Medicare-certified hospices providers to provide care and support to patients and families and are state licensed. Under state regulations, between four and six Volunteer Hospices are surveyed each year.

End Stage Renal Disease Facilities

End Stage Renal Disease (ESRD) facilities are state licensed and federally certified, and serve patients with renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life. Facilities include renal transplantation centers, renal dialysis centers or renal dialysis facilities. Maine inspects all 17 each year.

Ambulatory Surgical Centers

Ambulatory Surgical Centers (ASC's) are state licensed and federally certified providers "that operate exclusively for the purpose of providing surgical services to patients not requiring hospitalization." ASC's perform surgical procedures "that generally do not exceed 90 minutes in length and do not require more than four hours recovery or convalescent time". Maine inspects all 17 each year.

Rural Health Centers

Rural Health Centers (RHCs) are federally certified providers of primary care services within certain areas of the state that meet the criteria of rural area location, federally designated shortage area, and/or medically underserved area. Under federal regulations, Maine inspects these every six years.

Outpatient Physical Therapy Providers

Three types of organizations may qualify as federally certified Outpatient Physical Therapy/ Outpatient Speech Pathology (OPT/OSP) providers. They are rehabilitation agencies, clinics and public health agencies. Almost all OPT/OSP providers are rehabilitation agencies. A rehabilitation agency provides "an integrated, multidisciplinary program designed to upgrade the physical functions of handicapped, disabled individuals by bringing together, as a team, specialized rehabilitation personnel." Maine certifies them every six years.

Comprehensive Outpatient Rehabilitation Facilities

Comprehensive Outpatient Rehabilitation Facilities (CORF) are "established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician." There are no CORF in Maine.

Portable X-Ray Providers

Portable X-Ray providers offer "diagnostic x-ray tests furnished in a place of residence." The mobile unit can neither be fixed at any one location nor permanently located in a SNF or a hospital." Under Federal regulations, Maine certifies them every six years.

Transplant Centers

Transplant Centers are organ-specific transplant programs that furnish organ transplants, and other medical and surgical specialty services required for the care of transplant patients. There is one Transplant Center in Maine. CMS contracted surveyors inspect this facility approximately every three years.

Healthcare – Provider Table SFY							
Provider Types	**Provider Counts 2007**	**Provider Counts 2008**	**Provider Counts 2009**	**Licensed or Certified**	**Beds/ Capacity if Applicable 2007**	**Beds/ Capacity if Applicable 2008**	**Beds/ Capacity if Applicable 2009**
Ambulatory Surgical Center	17	18	18	Both	N/A	N/A	N/A
End Stage Renal Disease	17	17	17	Both	N/A	N/A	N/A
Federally Qualified Health Center	46	57	59	Certified	N/A	N/A	N/A
Laboratories CLIA	952	985	987	Certified	N/A	N/A	N/A
Home Health Agencies	58	59	53	Some of each	N/A	N/A	N/A
Hospice	27	30	28	Some of each	N/A	14*	14*
Hospital	41	41	41	Both	3,825	3,988	4,038
Occupational Physical and Speech Therapy	15	16	16	Certified	N/A	N/A	N/A
Portable X-Ray	4	4	4	Certified	N/A	N/A	N/A
Rural Health Center	41	44	44	Certified	N/A	N/A	N/A
TOTALS	**1,218**	**1,271**	**1,267**	**N/A**	**3,825**	**4,002**	**4,052**

* One Hospice has actual licensed bed capacity.

Healthcare – Workload Table SFY						
Provider Types	**Licensure Surveys 2007**	**Licensure Surveys 2008**	**Licensure Surveys 2009**	**Certification Surveys 2007**	**Certification Surveys 2008**	**Certification Surveys 2009**
Ambulatory Surgical Center	11	7	15	1	5	5
End Stage Renal Disease	7	6	6	10	10	5
*Federally Qualified Health Center	0	0	0	0	0	0
Laboratories CLIA	0	0	0	35	48	33
Home Health Agencies	14	11	13	10	9	12
Hospice	8	15	7	1	6	2
**Hospital	10	2	0	8	10	9
Occupational Physical and Speech Therapy	0	0	0	2	4	3
Portable X-Ray	0	0	0	4	1	0
Rural Health Center	0	0	0	3	11	4
TOTALS	**50**	**41**	**41**	**74**	**104**	**73**

*Federally Qualified Health Centers are not subject to State licensure or certification.
**Number of surveys impacted by changes in State statute.

Healthcare Complaint Table SFY						
Provider Type	**Received 2007**	**Received 2008**	**Received 2009**	**Investigated 2007**	**Investigated 2008**	**Investigated 2009**
Ambulatory Surgical Center	1	0	0	2	0	1
End Stage Renal Disease	1	1	2	3	1	2
Federally Qualified Health Ctr.	0	0	4	0	0	4
Laboratories CLIA	3	2	0	1	0	0
Home Health Agencies	29	20	23	13	11	48
Hospice	8	4	7	4	5	8
Hospital	221	191	360	110	138	184
Occupational Physical & Speech Therapy	0	1	0	0	1	0
Portable X-ray	0	0	0	0	0	0
Rural Health Center	2	4	3	0	5	3
TOTALS	**262**	**221**	**399**	**132**	**161**	**250**

Healthcare – Staff Table SFY			
Staff	**Positions 2007**	**Positions 2008**	**Positions 2009**
Managers	1	.5	.5
Supervisor	1	1	1
Health Surveyor	8	6	6
Quality Assurance Surveyor (Labs)	1	1	1
Support	1.5	1.5	1.5
TOTAL	**12.5**	**10**	**10**

x. Clinical Laboratory Improvement Amendments (CLIA)

The Clinical Laboratory Improvement Amendments (CLIA) was enacted by Congress in 1988, establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test is performed. A laboratory is any facility which performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease or impairment of, or assessment of health. Regulations are based on the complexity of the test method; thus, the more complicated the test, the more stringent the requirements. Three categories of tests have been established: waived complexity, moderate complexity (including the subcategory of provider-performed microscopy (PPM)), and high complexity. Based on test complexity, the following five types of CLIA certificates are issued:

Certificate of Waiver
This certificate is issued to approximately 500 laboratories to perform only waived tests.

Certificate of Provider-Performed Microscopy (PPM)
This certificate is issued to 340 laboratories in which a physician, midlevel practitioner or dentist performs the microscopy procedures. This certificate permits the laboratory to also perform waived tests.

Certificate of Registration
This certificate is issued to 75 laboratories that enables the entity to conduct moderate or high complexity laboratory testing or both until the entity is determined by survey to be in compliance with the CLIA regulations.

Certificate of Compliance
This certificate is issued to a laboratory after an inspection by the CLIA program that finds the laboratory to be in compliance with all applicable CLIA requirements. Laboratories holding this type of certificate are inspected biennially by DLRS under the CLIA Program.

Certificate of Accreditation
This is a certificate that is issued to 70 laboratories on the basis of the laboratory's accreditation by an accreditation organization approved by CLIA. Laboratories holding this type of certificate are inspected biennially by their accrediting organization.

Using the Federal CLIA regulations, Maine inspects between 40 and 50 laboratories performing moderate and/or high complexity testing each year.

The CLIA program surveys two percent (2%) of laboratories performing only waived tests. The purpose of these surveys is to gather information for the CLIA Program and to provide an educational component regarding good laboratory practices to the entities performing waived complexity laboratory tests. Maine performs 10-12 Certificate of Waiver surveys each year. The laboratories are randomly selected.

Maine Medical Laboratory Act

Laboratories as required by the Maine Medical Laboratory Act to have a license. There are 12 laboratories holding Maine Medical Laboratory licenses and 38 entities holding Health Screening Laboratory permits. The Maine Medical Laboratory licenses are issued for a three year period. Health Screening Laboratory permits must be renewed annually.

*CLIA data contained in Non-long Term Care Section ix.

xi. Quality/Training/Data

Background

Data generation and quality assurance functions are internally and externally driven. For example, the grant with CMS, which funds federal survey and certification activities, includes various state performance expectations. Quality and performance metrics for the Division are centrally managed. The Quality Unit works under the Planning, Development and Quality umbrella in DLRS.

Program Responsibilities

The Quality Unit supports the Division's overall activities by monitoring compliance with state performance expectations, assisting in the preparation of responses to compliance issues, budgeting and report generation.

The Unit ensures staff performing survey and certification meet DLRS and federal training standards. The federally-required Training Coordinator position is in this Unit.

The Unit shares responsibility with the Office of MaineCare Services for coordination with regard to M.D.S. 2.0, the federal resident assessment instrument used in nursing facilities. The Unit is also responsible for OASIS, which is the assessment instrument used by certified home health agencies.

Division quality initiatives are supported by the Quality Unit. These include migration of various state licensing programs to the federal ASPEN data platform; GPRA goals, preparation of data in support of required annual reports, CON Report, Sentinel Events Report, publishing top deficiencies by facility type and improving access to data.

Quality/Training/Data				
Initiatives	**2007**	**2008**	**2009**	**Details**
Assisted Housing Licensure Interface Development		X	X	Coordinated with manager of Assisted Housing and Muskie to develop an interface with ASPEN to improve tracking specific licensure data.
Time Management Code Development		X	X	Provided program information and perspective in partnership with Financial Services and Payroll to develop task codes that cover each program's functional activities.
Financial Management and Code Development		X	X	Provided the Program information and perspective in partnership with Financial Services for a coding system for expenditures by program.
CMS Survey and Certification Grant Reporting and Budgeting- Training Coordinator, QIES Coordinator	X	X	X	Quarterly, annual and specialty reports on budget, expenditures, workload, surveys, training, surveyor qualifications. Monitor performance standards and research outliers. Conduct ad hoc reports for CMS regarding funding allocation, disaster preparedness, computer usage, etc.
Complaint Pilot Initiation and Development		X	X	Coordinated with California for materials and advice. Developed Maine specific forms and procedures. Provided training for the implementation of the pilot. This is now instituted in all programs except Child Care Licensing and Behavioral Health Licensing.
QIS Preparatory Research and Planning			X	Coordinated with other States, Federal contractor, CMS and internal workgroups. Developed detailed schedule of surveys for the six month implementation phase and coordinated OIT activities and support.
Creation of Incident Reporting Form and Procedures		X		Created a new form fill incident reporting form and procedures to standardize data gathering/reporting and move the intake of incidents from central location to regional offices.
Legislative Database support for Division			X	Maintenance of the Legislative database for the Division
OASIS Coordinator		X	X	The Unit is responsible for OASIS, which is the assessment instrument used by certified home health agencies. The OASIS and MDS Coordinator is responsible for providing technical assistance to providers and for coordination of new information/ training when it occurs. Responsible for providing technical assistance and coordination of training for providers.
MDS/RAI Coordinator	X	X	X	The Unit shares responsibility with the Office of MaineCare Services for coordination with regard to implementation of M.D.S. 2.0, the federal resident assessment instrument. Responsible for providing technical assistance and coordination of training for providers

Complaint Pilot/Quality Initiative

A significant achievement in SFY 2009 is a reduction in the amount of time required to process complaint investigations. The material and process developed in California was revised to fit Maine's needs and a pilot was initiated using the materials. The pilot was successful and all but two units in DLRS are now following the new complaint initiative. In LTC and NLTC, the number of complaints has increased.

Outstanding Complaints w/o Surveys			
	SFY 07	SFY 08	SFY 09 (To Date)
Augusta District Office	0	1	60
Bangor District Office	0	0	0
Intermediate Care Facility	1	1	3
Portland District Office	1	1	20
Non Long Term Care	107	140	186
Total	**109**	**143**	**269**

The Unit ensures staff performance meets DLRS and federal training requirements. Additionally, it facilitates internal staff development and collaborates with stakeholders to provide best practice workshops and training. See Appendix C for details.

Trainings by Type by SFY			
	2007	**2008**	**2009**
CMS mandatory trainings	12	15	18
Division-wide trainings	0	3	4
Provider trainings	4	5	2
Other	1	2	1
Total	**17**	**25**	**25**

Collaboration for Quality Initiatives – External Partners

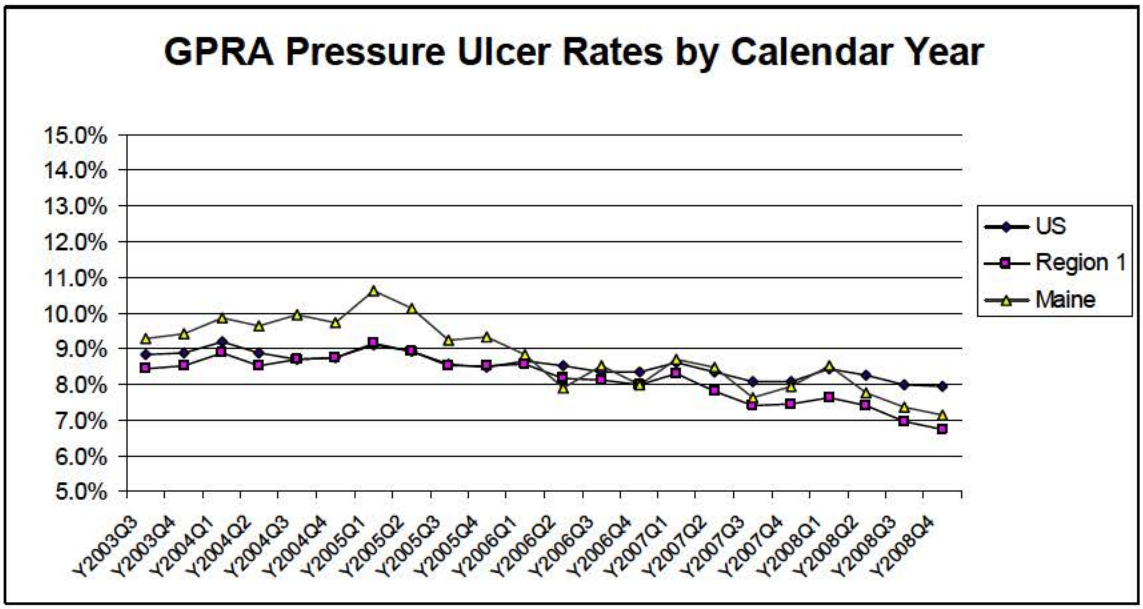
A major function of this Unit is to coordinate the Division's collaboration with stakeholders from various healthcare areas to improve the quality of care and life of Maine residents living in various settings. This includes coordination of meetings, workgroups, provider training, and the dissemination of information from Federal, State and other sources. Listserves are a primary means of disseminating timely information to providers.

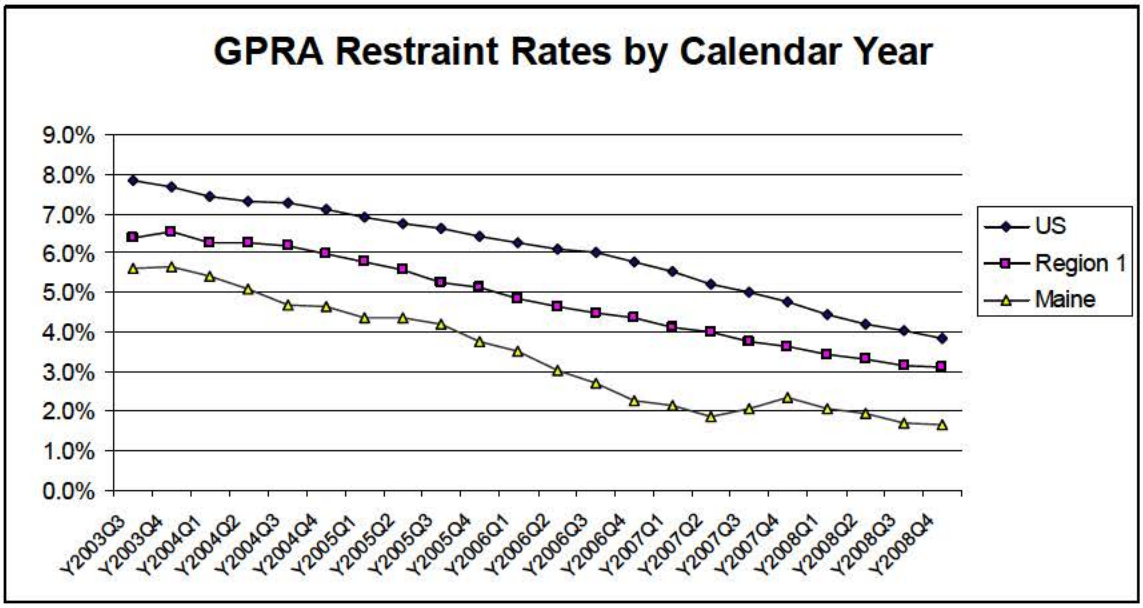
Quality Initiative				
Partners	**2007**	**2008**	**2009**	**Details**
Best Practice Committee – support best practice in quality of care/life for nursing home residents	X	X	X	Coordinated monthly meetings, provider training seminars, participation in work groups for special projects such as the Geriatric Mental Health Curriculum, PASSR changes, development of Mental Health Curriculum. Provided data reports and project updates.
Pressure Ulcer Taskforce – multi disciplinary stakeholder group formed for the purpose of reducing the incidence of pressure ulcers across the continuum of care in Maine	X	X	X	Coordinated meetings, provided research coordinated a presentation by a Vermont nursing home involved in a quality initiative with a related hospital regarding pressure ulcer reduction project, coordinated a presentation by the New Jersey Hospital Assn. regarding their multidisciplinary approach to the reduction of pressure ulcer rates, coordinated the Maine Quality Forum's presentation of hospital pressure ulcer rates in Maine. The group provided support for a pilot program initiated in Maine. Provided data updates on pressure ulcer rates in Maine.
LANE Committee – to improve the quality of care of nursing home residents		X	X	Represented DLRS on this committee with Maine Health Care as lead.
Survey and Certification and Case Mix Group	X	X	X	DLRS and OMS provided technical assistance to nursing homes regarding MDS 2.0 coding and reporting. This group met to increase the consistency and accuracy of the messages being provided to the nursing home providers.
MDS 3.0 Preparation Group		X	X	Preparation for the implementation of the MDS 3.0 Resident Assessment and Minimum Data Set System. This will impact training needs, case mix calculations, survey process and quality initiatives.
Town Meetings for Nursing Home providers		X	X	Planned and prepared for multiple town meeting sessions across the state over the last two years. Provided and presented resources and data in first round of meetings.
MUSKIE	X	X	X	Create reports PRU/DEP.
AIT/RFA Training	X	X	X	Educating administrators about the licensing and complaint process.

The Government Performance and Results Act (GPRA), part of the Federal Office of Management and Budget, set a goal to reduce nursing home pressure ulcer and restraint rates nationally in the summer of 2006. CMS in turn set goals for each individual state. Because of Maine's pressure ulcer rate being above the

national average, a multidisciplinary taskforce mentioned above was formed to focus pressure ulcer prevention across the continuum of care.

Because of the success of the initiative, DLRS was asked to present on its project at the 2008 meeting with CMS, New England state agencies, and hospital and nursing home association leaders. The following pressure ulcer and restraint rates show a major reduction in both restraints and pressure ulcers since the initiation of this goal for Region 1, the nation and Maine in particular.





Data Reports

Division quality initiatives include migration of various state licensing programs to the federal ASPEN data platform; GPRA goals; preparation of data in support of required annual reports, CON Report, Sentinel Events Report; publishing top deficiencies by facility type; and improving access to data.

Data Related	2007	2008	2009	Details
Routine ASPEN Reports on Complaints, enforcement, workload, survey			X	Standard reports are being run and distributed daily, weekly, monthly or quarterly depending on specific criteria.
Integrate CLIA and Assisted Housing Level IV survey functions into ASPEN		X	X	CLIA migrated to ASPEN. Assisted Housing Level IV provider and survey specific data is now being tracked in ASPEN.
Provide OSCAR 3 and 4 Reports to Providers		X	X	Every 6 months OSCAR 3/4s are distributed to those providers requesting the report
Data on Hospital Complaints and Citations to the Hospital Review Board	X	X	X	Reports include top 10 deficiencies and complaint allegation details.
Management reports for LTC	X	X	X	Management reports for LTC regarding complaints/ surveys/citations and other workload reports.
Workload Form revised and distributed for division-wide implementation			X	Database design in process.
Satisfaction Survey Database	For MFU only	For MFU only	X	Survey was revised and standardized. A database was developed and training conducted for all but one user.
Data entry and analysis for Sentinel Events Annual Report			X	Data included 2008 calendar year and all preceding data
Database development for Sentinel Events program		X	X	The data schema is 90 % complete. All programming needs to be done.
Process Miscellaneous Requests for Data	X	X	X	Provide reports on request.
ASPEN Quality Assurance and Data Scrubbing	X	X	X	Training was conducted. Staff run quality reports and correct erroneous or incomplete data.
QIES Coordination	X	X	X	Monthly meetings to coordinate activities related to ASPEN and other data projects involving DLRS internal partners, Muskie and QIES Automation Coordinator
Coordination with OIT regarding business needs	X	X	X	Projects: CNA web-portal, facilities web-portal, Division-wide equipment needs, QIS implementation plan, program specific needs for data programming, develop a business plan for DLRS

Nursing Home and Hospital Complaint Allegations Investigated By State Fiscal Year					
	SFY	**Allegations Investigated**	**Substantiated**	**Unknown**	**% Substantiated**
Nursing Homes	**2007**	1812	261	2	14.4%
	2008	1991	271	2	13.6%
	2009	1790	266	206	16.8%
Hospitals	**2007**	192	37	8	20.1%
	2008	386	68	17	18.4%
	2009	847	130	95	17.3%
Note: Denominator for % substantiated is determined by Number Investigated minus the number unknown.					

Staff	2007	2008	2009
Comprehensive Health Planner	1	1	1
Nurse Education Consultant	1	1	1
Management Analyst I	1	.825	.825
Support	0	0	.5
TOTAL	**3**	**2.835**	**3.325**

xii. Workforce Development

Background

A quality workforce is essential to quality healthcare. DLRS is responsible for developing curricula and training for Personal Support Specialists (PSS), Certified Residential Medication Assistants (CRMA), certifying trainers, registering temporary staffing and personal care agencies, and maintaining the CNA Registry. The CNA Registry responds to inquiries from the public, health care providers, individual CNAs and other state CNA Registries; enhances public safety by annotating information related to known criminal convictions as required by Maine law and substantiated complaints as required by Federal law; and provide information to CNAs on state or federally mandated employment restrictions, eligibility for placement on the Registry, and the appeals process.

Personal Support Specialist (PSS)

A PSS is an unlicensed entry-level worker. Successful completion of a DLRS approved course satisfies training requirements for direct care workers for certain home care programs and residential facilities.

Certified Residential Medication Aide (CRMA)

The CRMA departmental standardized curriculum is designed for unlicensed workers. Successful completion of this course satisfies training requirements for workers who pass medications in certain assisted housing programs as part of their employment.

DLRS supports the PSS and CRMA workforce development programs in the following ways:

- Convenes stakeholders to periodically update the curriculum.
- Provides web-based information on upcoming trainings.
- Maintains a list of approved trainers. New instructors must qualify for and successfully complete a 3-day Train-the-Trainer program.
- Performs quality improvement by monitoring course delivery and course evaluations and makes suggestions/recommendations to trainers.
- Maintains data about students who complete training and is available online. Participant data is stored and duplicate/replacement certificates can be provided on request, as needed by employers.

Sum of # County	Training Type CRMA 3 Day	CRMA Bridge	CRMA Re-cert.	CRMA Training	Feeding	PSS Family Only	PSS Test Out	PSS Training	Grand Total
ANDROSCOGGIN	65	20	324	250		5	2	121	787
AROOSTOOK	24	20	158	144	5		6	51	408
CUMBERLAND	116	32	353	330		4	11	113	959
FRANKLIN	30		39	31				22	122
HANCOCK	13	1	45	69				24	152
KENNEBEC	54	18	412	340			10	141	975
KNOX	22	2	65	48				21	158
LINCOLN	7		87	83				35	212
OXFORD	36	6	106	76			2	37	263
PENOBSCOT	96	4	245	271			11	129	756
PISCATAQUIS	25	1	26	23				10	85
SAGADAHOC	36	13	68	66			6	28	217
SOMERSET	24	4	137	82			2	37	286
WALDO	19	4	48	37			2	11	121
WASHINGTON	3		59	78				19	159
YORK	85	18	295	241		1	10	135	785
Grand Total	**655**	**143**	**2467**	**2169**	**5**	**10**	**62**	**934**	**6445**

Temporary Nurse Agency (TNA)

A business entity or subdivision that provides nurses within the state to another organization on a temporary basis. Businesses are required to register with DLRS.

Personal Care Agency (PCA)

"Personal Care Agency" means a business entity or subsidiary of a business entity that is not otherwise licensed by the DLRS, that hires and employs unlicensed assistive personnel to provide assistance with activities of daily living to individuals in the places in which they reside, either permanently or temporarily. An individual who hires and employs unlicensed assistive personnel to provide care for that individual is not a PCA agency.

Provider Count SFY 2009	
Temporary Nurse Agencies	65
Personal Care Agencies	116
TOTAL	**191**

Certified Nursing Assistant (CNA) Registry

DLRS operates Maine's CNA Registry, a requirement for every state. The Maine Registry is operated in accordance with the Omnibus Budget Reconciliation Act of 1987, state statutes and the Maine State Board of Nursing requirements.

Projects/ Collaborations

Geriatric curriculum development for seasoned CNAs and PSSs.
RCF training for new administrators of RCFs.
Revisions to PSS and CRMA Curricula.
Development of CNA Web-portal.

CNA Registry Telephone – Register of Calls Received - 2009

2009 Type of Call Received	Number of Calls - February -	Number of Calls - March -	Number of Calls - April -	Number of Calls - May -	Number of Calls - June -
1. Facility Registry Checks	530	818	757	615	752
2. Individual CNAs Checking Status	96	150	156	191	125
3. Testing Questions	119	153	133	74	93
4. Reciprocity Questions	10	10	8	9	22
6. Out of State CNA Questions	47	68	32	38	22
7. Other Calls	189	380	318	209	257
TOTAL	**991**	**1,579**	**1,404**	**1,136**	**1,271**

*Included in Misc. Calls data
**Data available on 12/08/2008 through 06/09/2009
***Data regarding the types of calls received by the CNA Registry was collected to determine the impact of an on-line web-portal for employers and CNAs that are required to verify that CNAs are active on this registry. The spike in calls in June is attributed to two factors: due to the economy, more CNAs are completing training and applying to be active, and as this web-portal has become operational, providers have called for technical assistance.

CNA Website: http://www.maine.gov/dhhs/dlrs/cna/home.html
CNA Web-portal website: https://gateway.maine.gov/cnaregistry/

CNA Hearings Statistics Table			
Type	**2007**	**2008**	**2009**
Abuse	28	26	21
Neglect	12	12	13
Misappropriation of Property	2	1	3
Fraudulent Application	1	0	0
Total Hearings	**43**	**39**	**37**

CNA Registry Summary Report Statistics Table			
	Count 2007	**Count 2008**	**Count 2009**
CNA Status			
Active	14,603	14,056	15,112
Inactive	33,216	35,571	36,804
Total CNAs	**47,819**	**49,627**	**51,916**
Active and Annotated	631	641	676
Inactive and Annotated	1,175	1,203	1,182

Workforce Development Staff Table		
Position	**2008**	**2009**
Health Services Consultant	2	1
Health Services Supervisor	1	1
Office Associate	4	4
Total	**7**	**6**

APPENDIX A

Mission

The mission of the Division of Licensing and Regulatory Services is to support access to quality and effective health care and social services.

Vision

The Division will promote broadly accepted standards and integrated practices effective in helping people have safe and appropriate outcomes. Regulation will be a collaborative process. Enforcement will be appropriate to the scope and severity of the problem.

Values

Our core values describe the attitude and character of our Division. We will hold each other accountable and model these values. The words that describe these values were carefully chosen by us.

- **Integrity**
  i. We are conscientious stewards of the resources available to us.
  ii. These are our values.
  iii. We practice them daily.

- **Openness**
  i. The people we are working with will know/be informed of the information we have and what we need.
  ii. We make sure that everyone has access to information about the processes we are using.
  iii. We are all informed of our mission, vision and guiding principles.
  iv. We share current information. As a result, we speak with a unified voice.

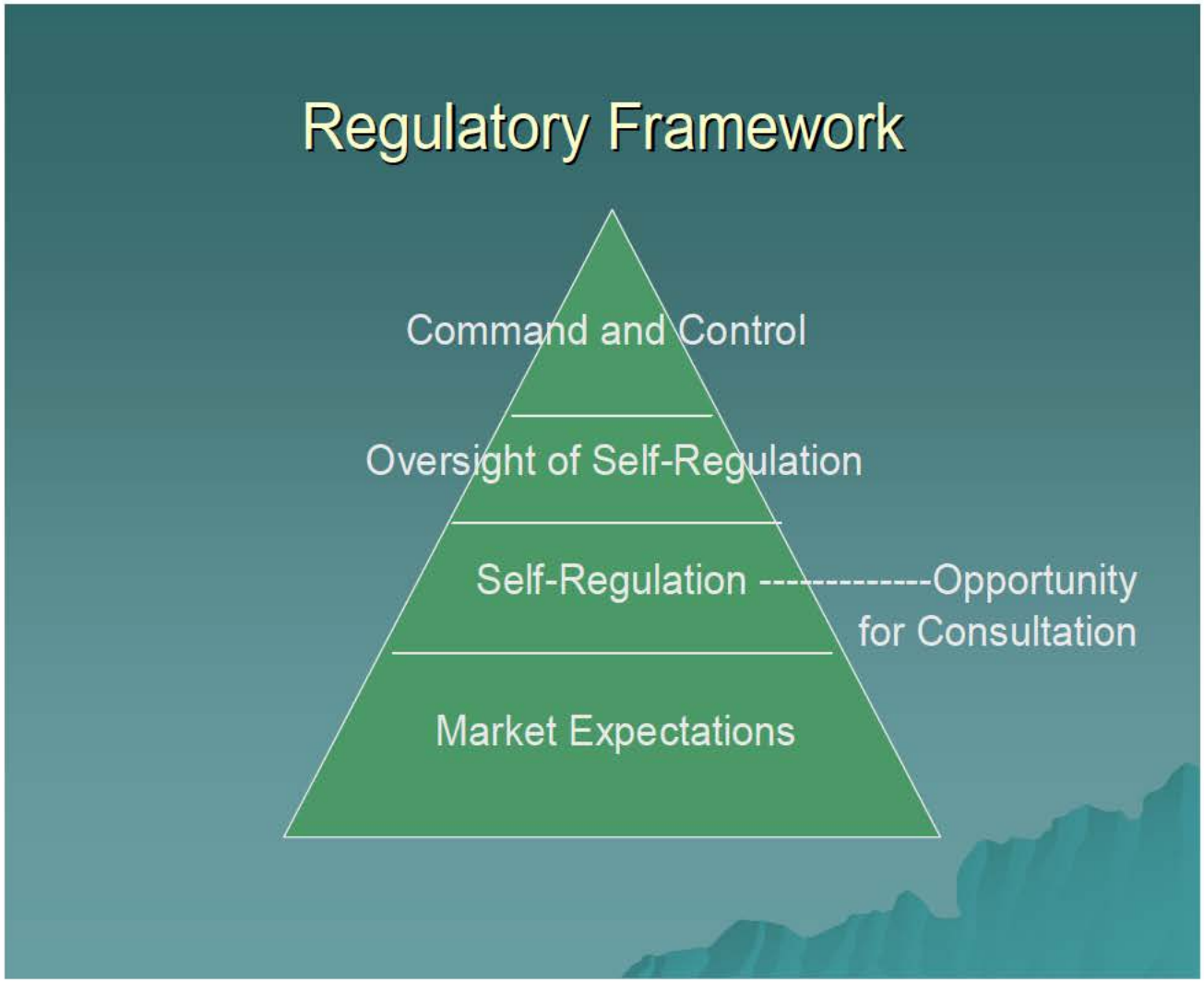
- **Quality**
  i. We have a structured orientation to assure that each new person knows his/her role and responsibilities and understands his/her position in the Division.
  ii. We receive the training we need in order to stay current with standards of best practice and we consistently implement the standards.
  iii. We invite your feedback, positive and constructive, to assure we always give our best.
  iv. We acknowledge verbally or in writing successes and areas needing improvement, large and small.

- **Safety**
  i. We prioritize the enforcement of regulations for a safe environment for our consumers.
  ii. We adhere to all employee safety and confidentiality policies.
  iii. We respect and support the decisions you make regarding your personal safety.
  iv. When we see a safety issue that needs attention, we advocate correcting it.

- **Trust**
    i. We tell you the truth.
    ii. If we don't know, we will say so, find the information, and get back to you.
    iii. We give you positive feedback along with constructive feedback.
    iv. When we have to give difficult feedback, we do so privately, openly, directly and clearly and in neither an intimidating nor a humiliating style.
    v. We do what we say we will do.
    vi. We assume your best intentions.

- **Validation**
    i. If we are responsible for a change, we will first seek your input. If we do not take your advice, we will share our reasons with you.
    ii. We recognize the work done and comment on it.
    iii. Our work makes a difference. When you struggle, we make ourselves available to you.

APPENDIX B


Regulatory Framework
Command and Control
Oversight of Self-Regulation
Self-Regulation ----------Opportunity for Consultation
Market Expectations

APPENDIX C

SFY 2007	DLRS Federal Training
07/24/06 (2 surveyors)	Basic Hospital
08/14/06 (2 surveyors)	Basic Nursing Home
08/24/06 (1 person)	ASPEN Advanced Technical Training
09/11/06 (2 surveyors)	CLIA Training
10/01/06	Facility Pressure Ulcer Reduction Project
10/31/06	Facility Restraint Reduction Project
11/06/06	Best Practice - Pressure Ulcer Conference - LTC providers
12/11/06 (1 surveyor)	Basic Nursing Home
02/05/07 (2 surveyors)	Basic Hospice
04/23/07 (1 surveyor)	ESRD Update
04/24/07 (2 managers)	CMS Leadership
05/07/07	New Jersey Presentation on Pressure Ulcer Reduction Project - PUTF
05/04/07	LTC Quarterly Training - Video Conference - FOSS/FMS
05/14/07 (1 surveyor)	Basic Nursing Home
05/14/07 (1 surveyor)	Basic ICF/MR
06/26/07 (1 person)	QIES Technical Conference
06/28/07	LTC Quarterly Training - "Almost Home" - Culture Change, Health Care Crimes Unit, Updates

SFY 2008	DLRS Federal Training
07/19/07 (2 people)	CLIA/QIES ASPEN training
07/23/07 (3 surveyors)	Basic Nursing Home
08/23/07 (1 person)	Basic ASPEN
09/01/07	Vermont on Pressure Ulcers - PUTF - Susan Kanae & Jim Ray
08/17/07	Town Meetings - LTC provider information - 4 Locations –-09/07/07
09/17/07 (1 person)	ASPEN Advanced
09/25/07 (1 person)	OASIS training
10/05/07	Outlook Calendar Training – Division-wide
10/22/07 (1 surveyor)	Basic Nursing Home
10/29/07 (1 person)	CLIA Update
11/01/07	Phone Intake Training – Division-wide
12/04/07 4 SFMO Insp	FSES Life Safety Code Training
01/2008	AIT training - Providers
01/04/08	LTC Quarterly Training - Infection Control
01/28/07 (1 surveyor)	Basic Hospital
02/11/08 (1 person)	Basic ICF/MR
03/04/08 (2 surveyors)	Basic Home Health
03/10/08	ASPEN Training
04/04/08	LTC Quarterly Training - Pharmacy Tag - Cliff Jackim - CMS & C. Diff - Kim Ware
04/15/08 (2 managers)	CMS Leadership
05/01/08	Best Practice - Incontinence Conference for LTC providers
05/12/08 (1 surveyor)	Basic Nursing Home
06/10/08 (1 person)	Training Coordinators Conference
06/24/08 (1 person)	QIES Technical Conference

SFY 2009	DLRS Federal Training
07/10/08	ASPEN Training
07/22/08 (1 surveyor)	ICF/MR Focused Training
08/05/08 (1 surveyor)	LMS Training
09/04/08	LTC Quarterly Training - Survey Process
09/08/08 (1 surveyor)	ESRD Update
09/08/08 (1 person)	Basic ASPEN Training
09/15/08 (1 person)	ASPEN Advanced Training
09/15/08 (2 surveyors)	Basic Nursing Home
09/23/08 (3 surveyors)	ESRD Update
09/25/08 (1 person)	ASPEN Advanced Training
10/06/08 (3 surveyors)	ESRD STARR Training
10/17-27/08	Town Meetings - LTC provider information - 3 Locations
11/01/08	Best Practice - Pharmacy & Culture Change Conference for LTC Providers
11/10/08	LTC Quarterly Training - Round Table, Flu
11/17/08	Complaint Report Training
11/18/08 (1 surveyor)	Basic Hospice
12/10/08	ICF/MR provider training - Paul Miller - CMS
02/05/09	LTC Quarterly Training - Human Resources - Lynn Hadyniak
02/10/09 (2 managers)	Hospital Update
02/23/09 (1 surveyor)	EMTALA Online Training
03/09/09 (2 surveyors)	Basic Hospital
04/20/09 (1 person)	QIES Workbench
04/20/09 (2 managers)	CMS Leadership
05/21/09	LTC Quarterly Training - Preparation for QIS training - computer, etc
6/19/09	LTC Tablet Training – Preparation for QIS Implementation Leadership/ Hospice training/CLIA/STARR/ESRD Update/

Appendix D

Listserve Addresses:

Assisted Living	beas-assisted@lists.maine.gov
Certificate of Need	dhhs-con-request@lists.maine.gov
Child Care Facilities	childcarefacilities@lists.maine.gov
Certified Residential Medication Aids	beas-crma@lists.maine.gov
Family Child Care	familychildcare@lists.maine.gov
Medical Facilities	dlrs-medicalfacilities@lists.maine.gov
Nursery Schools	nurseryschool@lists.maine.gov
Nursing Facilities	dlrs-nursingfacilities@lists.maine.gov
Personal Support Specialist	beas-pss@lists.maine.gov

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