Division of Licensing and Regulatory Services

Annual Report
State Fiscal Year (SFY) 2011
July 1, 2010 to June 30, 2011

SFY 2011 Annual Report
Licensing And Regulatory Services

Division of Licensing And Regulatory Services

Annual Report
SFY 2011

TABLE OF CONTENTS

SFY 2011 Annual Report
Licensing And Regulatory Services

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."

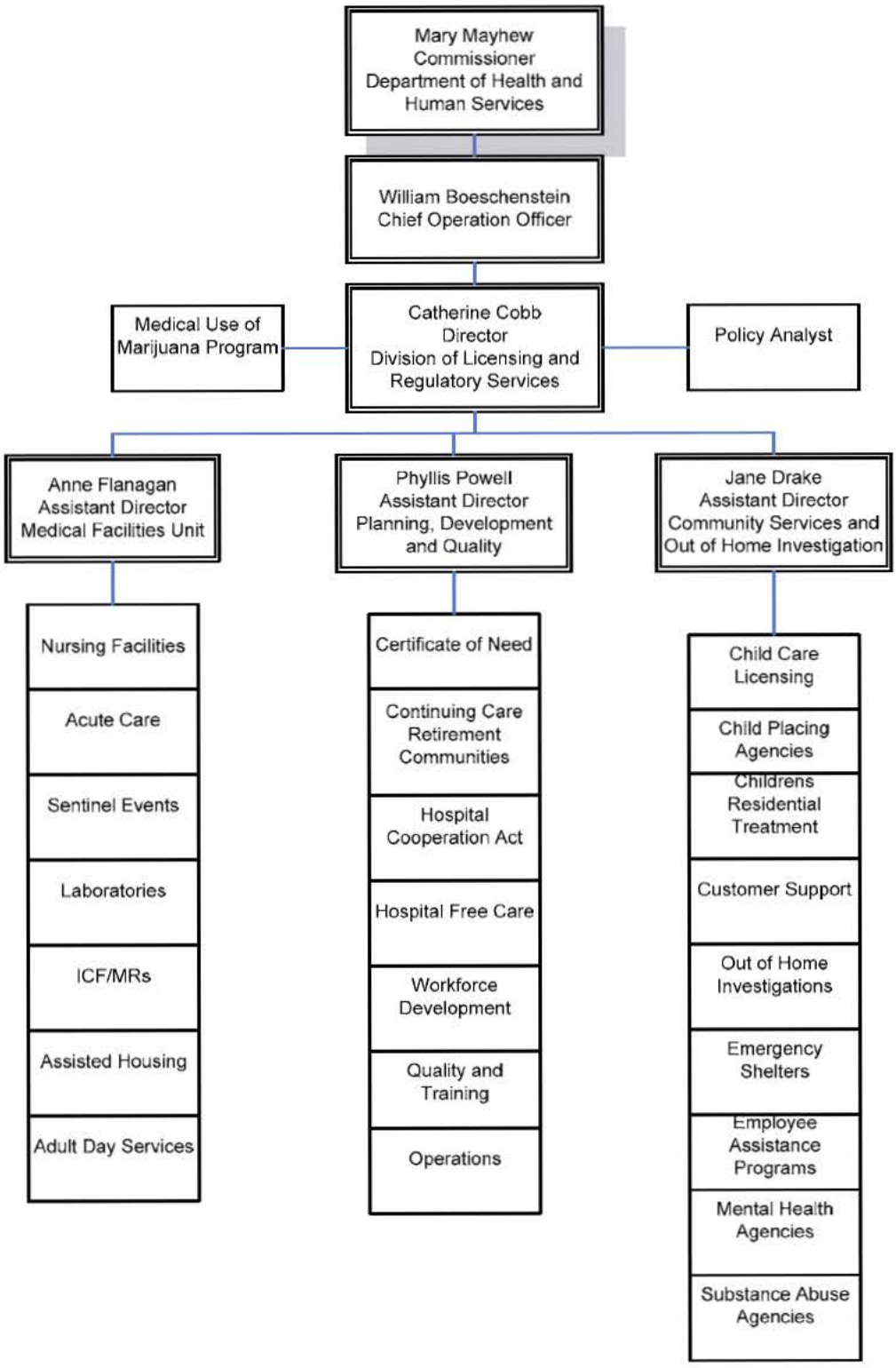
"We will focus on process improvement; we will cultivate provider partnerships; services to stakeholders will reflect the complexity of needs; and the administration of programs will be efficient and effective. There will be measurable performance objectives by program; performance indicators and staff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

In 2010, the Division was assigned responsibility for implementing the Maine Medical Use of Marijuana Act. Also, additional duties for long term care workforce development were transferred from the Department of Education.

In 2011, there were no new programs implemented in the Division.

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
Sentinel Events Hotline: 1 (207) 287-5813

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	1037 Forest Avenue Suite 11 Portland, ME 04103	Toll Free: 1-800-482-7520 Main Line: 1-207-797-2892 Fax: 1-207-797-2801
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

IV. 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

Administration Staff Table SFY 2010		
Staff	**Positions**	**Duties**
Division Director	1	Division-wide/department-wide
Policy Analyst	1	Legislative policy, rules and regulatory changes.
Paralegal	1	FOA requests, Hearings, 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
Clerk IV	2	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.

Receptionist Telephone Calls SFY 2011	
Calls Received	**Number of Calls Received 2011**
1. Child Care (includes requests for application packets/questions for licensor's/questions for support staff)	2,983
2. Miscellaneous calls (includes scheduling conference rooms, picking up mail & escorting visitors from Lobby, giving e-mail/website information, etc.)	2,161
3. CNA Registry	4,003
4. CRMA	1,337
5. Assisted Living	942
6. Acute (Non Long Term) Care	1,019
7. Mental Health/Substance Abuse	701
8. Complaint calls	599
8. Long Term Care	620
10. Community Services Director's Office	215
11. Division Director's Office	313
12. ICF/MR	261
13. Medical Facilities Office Manager	220
14. CLIA	258
15. Paralegal	84
16. Healthcare Oversight/PDQ	132
17. CSL Office Manager	195
18. Medical Facilities Director	53
19. Sentinel Event calls	80
20. Workforce Development Manager	150
20. Medical Marijuana Program	3,976
TOTAL	**20,302**

* Medical Marijuana Program not tracked until 4th qtr. sfy10

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, certificate of public advantage and the certified nursing assistant registry. The policy analyst ensures compliance with the Maine Administrative Procedure Act during the rulemaking process. The Division is responsible for over 35 sets of rules. In addition, the analyst assists the senior leadership team with the drafting and monitoring of legislation

Rulemaking Activity

The following table identifies the regulatory work done by DLRS during the fiscal year. Regulatory work included [1] meetings with a number of work groups to collaborate on rules that are in development to be amended, combined, or repealed and replaced; [2] drafting proposed amendments to rules in response to public laws enacted by the Maine Legislature, and to update rules to include best practices and changes in federal regulations; and [3] completing the regulatory process to adopt rules in compliance with the Maine Administrative Procedure Act and Executive Orders.

RULEMAKING ACTIVITY
SFY 2011 (July 1, 2010 – June 30, 2011)

Rules	Action
(NEW) Rules Governing the Maine Medical Use of Marijuana Program, 10-144 CMR Chapter 122 *Effective August 4, 2010.*	**ADOPTED** rules to implement the *Maine Medical Marijuana Act*. In November 2009, voters approved an initiated bill that changed Maine's medical use of marijuana laws. The initiated bill replaced the informal system that protected patients who grew and used marijuana for medical conditions. The 124th Maine Legislature made additional changes to the law (Public Law 2009, Ch 631)
Rules Governing the Maine Certification of Healthcare Cooperative Agreements, 10-144 C.M.R. Ch. 500 Effective September 1, 2010	**ADOPTED** rules to repeal and replace the "Hospital Cooperation Act Program Manual." They are promulgated pursuant to the Hospital and Health Care Provider Cooperation Act. They establish a voluntary procedure for state review and continuing supervision of cooperative agreements through the issuance of a certificate of public advantage (COPA).

Licensing Rules for Behavioral Health Programs	**DEVELOPMENT** of a rule for the licensing of behavioral health programs that will combine the elements of 3 current licensing rules: substance abuse treatment, mental health treatment, and children's residential treatment programs. A **STAKEHOLDER WORK GROUP** that includes staff from multiple DHHS departments is preparing this draft rule. This is a work-in-progress.
Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities, 10-144 C.M.R. Ch Chapter 110.	**STAKEHOLDER WORK GROUP** convened to update of the current nursing facility licensing rules. This is a work-in-progress.

Legislative Policy Initiatives

The Division developed draft legislation for consideration and monitored relevant legislation. A number of legislative bills pertaining to Division programs became Public Law.

LEGISLATIVE ACTIVITY
SFY 2011 (July 1, 2010 – June 30, 2011)

LD#	Public Law or Resolve	DLRS was DHHS lead for 27 of the following bills (indicated by **)	
Note: No committee action taken on the *draft legislation* in the "CNA Employment Restriction Report" [Resolve 68 Workgroup]			
TOPICS with multiple bills: **CERTIFICATE OF NEED: 5 bills, and bill to repeal CIF** **FINGERPRINTING: 3 bills** **MARIJUANA: 10 bills**		**Status of 51 bills** **Enacted: 21 bills** **Carried over: 2 bills** **DEAD: 28 bills**	
1	PL 11, Ch 304 (emergency) Effective 6/13/11	An Act To Ensure Regulatory Fairness and Reform	Some changes to the rulemaking process: 3 authorities for each proposed rule; legislature may request agency to review a rule; cost-benefit analysis expanded; definition of 'rule' expanded.
29	DEAD	An Act To Limit Salaries of Hospital Administrators	
65**	Resolve 11, Ch 28 (emergency) Effective 4/28/11	Resolve, To Require Dementia Care Training in Long-term Care Facilities, Adult Day Care Programs, Certain Residential Care Facilities and Supported Living Arrangements	Office of Elder Services WORK GROUP convened to review dementia care training.
127**	DEAD	Resolve, To Align Child-to-staff Ratios in Child Care Facilities	

157**	DEAD	An Act To Encourage Access to Health Care in Maine	
267	DEAD	An Act to Strengthen the Laws on Methicillin-resistant Staphylococcus Aureus and to Improve Health Care	CDC lead.
282	DEAD	An Act To Limit Charges for Fingerprinting Performed for Certain Criminal History Background Checks	It wanted state to pay the fingerprint fee for foster parents after they paid for the first set.
296	Veto Sustained DEAD	An Act to Find Cost Savings and Efficiencies in the Fingerprinting System for Criminal Background Checks (changed to resolve)	
303**	DEAD	An Act To Improve Hospital Transparency	
352**	**PL 11 Ch 52 (emergency) Effective 7/1/11**	**An Act To Amend the Laws Governing Criminal History Record Information**	This new law allows DLRS to access police reports for use in the investigation of suspected abuse, neglect or exploitation in licensed, certified and registered facilities and programs that provide care to children and adults.
360**	PL 11, Ch 424 Effective 2/15/12	~~An Act To Repeal the Maine Certificate of Need Act of 2002~~ *new title*: "An Act to Amend the Maine Certificate of Need Act of 2002"	CON work group: Convene by October 1, 2011 AMEND RULES: permit CON filing at any time of year and allow CON applicants to waive the technical assistance meeting, no later than January 1, 2012.
398**	Veto Sustained DEAD	An Act To Require Criminal History Record Information for Licensure of Nurses	
466	DEAD	An Act To Require Hospitals To Adopt Employee Illness and Injury Prevention Programs and To Provide Lift Teams and To Require Reduced Workers' Compensation Insurance Rates for those Hospitals	
472	PL 11, Ch 254	An Act To Enhance the Security of Hospital Patients, Visitors and Employees	
499	DEAD	An Act to Protect Persons in Residential Care who are Under Limited Guardianship	OES lead.

509	PL 11, Ch 385	An Act To Establish Host Homes in Maine as Alternative Emergency Shelters for Homeless Youth	A licensed emergency shelter that operates an emergency shelter family home must be licensed as a child placing agency by the department under rules adopted pursuant to sections 7801 and 8202.
537	Resolve 11, Ch 35	~~An Act To Expand Recertification Options for Certified Nursing Assistants~~ *new title*: *"Resolve To Design and Implement a Demonstration Project on Recertification of Certified Nursing Assistants."*	OES, DLRS and stakeholders shall work together on a project that provides a mechanism for UAPs to work or serve as a trainee in a licensed home health agency or nursing facility under required supervision in order to qualify for certification on the Direct Care Worker Registry.
543	Carried-over	An Act To Protect Legislative Intent in Rulemaking	
581**	PL 11, Ch 213	An Act To Repeal the Laws Governing the Capital Investment Fund	CIF law repealed.
582**	DEAD	An Act To Amend the Maine Certificate of Need Act of 2002	
624	PL 11, Ch 423	An Act To Require a Person Who Commits a Sex Offense against a Dependent or Incapacitated Adult To Register under the Sex Offender Registration and Notification Act of 1999	
636	DEAD	An Act To Ensure Proper Health Information Management	
639	DEAD	An Act To Protect Medical Care Providers and Hospital Staff	OAMH lead.
674**	DEAD	An Act To Authorize the Department of Health and Human Services To Administratively Suspend or Revoke Facility Licenses	
750**	DEAD	An Act To Decriminalize Possession of 6 or Fewer Marijuana Plants	
754**	DEAD	An Act To Remove Criminal Penalties for Possession of up to 5 Ounces of Marijuana	

759**	PL 11 Ch 145	An Act To Increase Efficiency and Effectiveness in the Licensing of Certain Health and Human Services Providers	This law removes licensing redundancies when a provider receives and maintains accreditation from a national accrediting body approved by the department.
806**	Carried Over	An Act To Provide Public Access to Price Lists of Hospitals and Ambulatory Surgical Facilities	
818	DEAD	Resolve, To Improve the Training and Retention of Maine's Professional Direct Care and Personal Supports Workforce	
825**	DEAD	An Act To Amend the Maine Certificate of Need Act of 2002 for Nursing Facility Projects To Provide Alternative Means To Satisfy MaineCare Neutrality	
828**	DEAD	An Act To Amend the Maine Certificate of Need Act of 2002 for Nursing Facility Projects	
837**	Resolve 11, Ch 59	~~An Act To Protect Children's Health and Promote Safe Schools and Child Care Centers by Limiting the Use of Pesticides~~ *Changed to a Resolve*: "*Resolve, To Enhance the Use of Integrated Pest Management on School Grounds.*"	**Note:** The law, unlike the LD, *does not* require DHHS to amend its Child Care licensing rules to include language similar to the rules for school pesticide use.
873	PL 11, Ch 444	An Act To Promote the Establishment of an Adult Day Health Care Program for Veterans in Lewiston	
887	DEAD	An Act To Include Medicinal Marijuana Patients in the Controlled Substances Prescription Monitoring Program	OSA lead.
914	PL 11, Ch 428	An Act To Make Certain Synthetic Cannabinoids Illegal	OSA lead.
1106**	DEAD	An Act To Lower the Cost of Health Care through Improved Energy Efficiency	
1118	DEAD	An Act To Provide a Tax Credit for High-quality Child Care Sites	

1159**	**PL 11, Ch 383**	**An Act To Amend the Identification Requirements under the Maine Medical Use of Marijuana Act**	Marijuana bill. Forfeiture of excess marijuana; changes to required information on registry identification card; concurrent expiration date for patient and caregiver cards; a state-issued photo-ID and a registry identification card are needed to establish authorized participation in the MMMP; department records submitted to court are admissible in evidence to prove the content of the records; prorate caregiver fee for new patient when replacing individual that was a patient for less than 12 months
1192	DEAD	An Act To Require That Marijuana Seized by Law Enforcement Officers Be Tested and Made Available for Use by Authorized Medical Marijuana Dispensaries	CDC lead.
1241	PL 11, Ch 196	An Act To Remove the Requirement That Employers Offer Substance Abuse Services to Employees Who Fail Drug Tests	
1270**	DEAD	Resolve, To Convene a Task Force To Study Staffing Ratios and Issues for Nursing Homes and Residential Care Facilities	
1296**	PL 11, Ch 407	An Act To Amend the Maine Medical Use of Marijuana Act To Protect Patient Privacy	MARIJUANA BILL. Changes include: patient registration is voluntary; new definitions; exceptions to registration requirement for a few primary caregivers who cultivate marijuana for a patient; the qualification of a minor patient is made by the treating physician after review by a consulting physician; forfeiture of excess marijuana; a qualifying patient may assert the medical purpose for using marijuana as a defense to any prosecution involving marijuana possession; the public may petition the department to add medical conditions to the list of debilitating conditions; patient may have information expunged from department records.
1302**	PL 11, Ch 398	An Act To Extend Fire Code Rules to Single-family Dwellings Used as Nursing Homes for 3 or Fewer Patients	
1393**	DEAD	An Act To Require Estimates of Patient Costs in Any Plan of Care prior to Treatment	

1399	PL 11, Ch 464	An Act To Implement the Recommendations of the Criminal Law Advisory Commission Relative to the Maine Criminal Code and Related Statutes	MARIJUANA BILL – PART OF CLAC bill. **Note:** DLRS interest is the section dealing with **MMMP and paraphernalia:** Section 21 states that the use of paraphernalia under the Maine Medical Marijuana Act is an 'exception' to the law instead of an 'exclusion'.
1406**	DEAD	An Act Regarding the Scope of Services That May Be Provided by Pharmacies Owned by Hospitals	
1453	DEAD	An Act To Legalize and Tax Marijuana	OSA lead.
1480**	PL 11, Ch 420	An Act To Correct Errors and Inconsistencies in the Laws of Maine	Marijuana Bill – Part of corrections bill. Repeals definitions in Ch. 558 because they are replaced by Chapter 558-C, *The Maine Medical Marijuana Act*.
1531**	PL 11, Ch 322	An Act To Amend the Maine Human Rights Act Regarding Accessible Building Standards	Applies to health care facilities.
1537**	**PL 11, Ch 257**	**An Act To Amend Licensing and Certification Laws Administered by the Department of Health and Human Services**	Unlicensed assistive persons laws amended. End stage renal disease facilities laws amended.

V. 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 Maine Care 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 characteristic 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 & Adult Day Program Unit Accomplishments for 2011:

In SFY 2010, the Unit adopted the "California Model" to investigate licensing complaints. This model continued to be implemented through 2011. The model brings structure to the complaint investigation process leading field staff to only focus on allegations that might be considered a licensing violation. Since the process is more focused, there is a clearer understanding prior to staff arriving at the facility, of what needs to be accomplished while on site. The model also relieves staff from having to write detailed narratives that describe how they arrived at their findings. It only requires staff to highlight and reference their supporting evidence. This model is designed to reduce the amount of time needed to investigate complaints and complete the related paperwork. The division obtained computer tablets for all staff so that more onsite work at the facility can be achieved.

Another major accomplishment of the Unit was completing the transition of all Level IV Residential Care Facilities, from a Microsoft Access database to a more sophisticated Oracle database (ASPEN). The system has allowed our Unit to work more collaboratively with the State Fire Marshal's Office, allowing for more timely inspections. Transitioning into a database like ASPEN has allowed the division to collect information/data more uniformly and allows for better monitoring of work practices/trends.

Assisted Housing - Provider Table SFY						
	Provider Counts			Beds/ Capacity if Applicable		
Provider Types	**2009**	**2010**	**2011**	**2009**	**2010**	**2011**
Assisted Living	32	36	39	1,467	1,653	1,785
Level I Residential Care	59	52	51	106	97	96
Level II Residential Care	54	48	46	201	179	170
Level III Residential Care	342	340	356	1,444	1,440	1,494
[1]Level IV Residential Care	191	198	205	5,340	5,829	5,884
Adult Day Care	34	33	34	595	579	585
TOTAL	**712**	**707**	**731**	**9,153**	**9,777**	**10,014**

[1] Multi-level, (meaning part of a nursing facility and part Level IV Residential Care), providers are reported under the level IV section in this table.

Licensure Surveys SFY			
Assisted Housing/ Adult Day Services	**2009**	**2010**	**2011**
TOTAL	**246**	**328**	**224**

Note: The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size.

Assisted Housing Program Complaints Investigated SFY			
Assisted Housing and Adult Day Services	2009	2010	*2011
TOTAL	**84**	**70**	***See Table Below**

*New data format and reporting started 7/1/10 SFY11

Assisted Housing - Complaints State Fiscal Year 2011		
Provider Type	**Complaints Received**	**Complaints Investigated**
Adult Day	1	0
Assisted Living	23	7
Level 1	0	0
Level 2	1	0
Level 3	35	18
Level 4	115	46
TOTAL	**175**	**71**

*New data format and reporting started 7/1/10 SFY11 by Provider Type

Assisted Housing Staff Table SFY			
Staff	**2009**	**2010**	**2011**
Assisted Housing Supervisor/Manager	1	1	1
RN Consultant	.5	.5	0
Program Licensor	7	7	7
Facilities Licensor	2	2	2
Support Staff	1	1	1
TOTAL	**11.5**	**11.5**	**11**

VI. Behavioral Health

Behavioral Health encompasses all behavioral health programs except hospital in-patient units. The unit's licensors survey and license behavioral health programs as well as investigate complaints. Because of the necessity to align service delivery with policies and contracts of other Offices, the Unit meets regularly with Offices such as the Office of Adult Mental Health, the Office of Substance Abuse, and the Office of Child and Family Services.

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

Children's Residential Care Facilities
Children's Residential Care Facilities are residences maintained for board and care of one or more children under the age of 21; often for behavioral services and mental health treatment.

Mental Health Agencies
Mental Health Agencies provide outpatient and/or residential services. The behavioral health unit also reviews agency compliance with the Consent Decree.

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
Agencies, organizations, and corporations often have Employee Assistance Programs for employees who are having emotional distress, substance abuse problems, or other issues, that interfere with work performance.

Shelters for Homeless Youth and Emergency Shelters for Children
Shelters provide homeless youth a place to stay while a more long term housing plan is developed. Mental health and substance abuse treatment is not normally provided; referrals for such treatment are made if there is a need.

Behavioral Health Provider Table SFY						
Provider Types	**Provider Counts 2009**	**Provider Counts 2010**	**Provider Counts 2011**	**License Surveys 2009**	**License Surveys 2010**	**License Surveys 2011**
Children's Residential	149	117	109	48	70	55
Substance Abuse	87	89	90	54	45	43
Mental Health	121	129	135	77	59	72
** Employment Assistance Programs	80	88	88	18	25	26
Children's Placement Agencies	21	22	23	13	18	24
Shelters for Homeless Youth	3	3	3	3	1	2
Emergency Shelters for Children	2	2	2	1	1	2
TOTAL	**461**	**450**	**450**	**214**	**219**	**224**

Behavioral Health SFY 2011	
Provider Types	**Capacity**
Children's Residential	1,767 beds
Substance Abuse	33,066 consumers
Mental Health	100,489 consumers
Employment Assistance Programs	39,778 consumers
Children's Placement Agencies	5,299 consumers
Shelters for Homeless Youth	32 beds
Emergency Shelters for Children	22 beds
TOTAL CAPACITY	**180,453**

Behavioral Health Complaints Investigated SFY			
Provider Types	**2009**	**2010**	***2011 SEE NEW TABLE BELOW**
Children's Residential	23	23	
Substance Abuse	8	4	
Mental Health	14	23	
Employment Assistance Programs	0	1	
Children's Placement Agencies	2	0	
Shelters for Homeless Youth	1	0	
Emergency Shelters for Children	0	2	
TOTAL	**48**	**53**	

Note: The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size.

*New data format and reporting started 7/1/10 SFY11 by Provider Type

Behavioral Health - Complaints Investigated State Fiscal Year 2011		
Provider Types	**Complaints Received**	**Complaints Investigated**
Mental Health	55	50
Substance Abuse	11	14
Children's Placement Agencies	2	2
Children's Residential	26	23
TOTAL	**94**	**89**

*New data format and reporting started 7/1/10 SFY11 by Provider Type

Behavioral Health Staff Table SFY			
Staff	**2009**	**2010**	**2011**
Supervisor Behavioral Health	1	1	1
Program Licensor	6	6	5
Support	1	1	1
TOTAL	**8**	**8**	**7**

VII. 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.

There are two types of Child Care Facilities:

- *Child Care Center is a facility for 13 or more children under 13*
- *Small Child Care Facility is a facility that is not at the provider's residence and serves 12 or fewer children..*

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 SFY						
Provider Types	**Provider Counts 2009**	**Provider Counts 2010**	**Provider Counts 2011**	**Capacity 2009**	**Capacity 2010**	**Capacity 2011**
Family Child Care Provider	1,519	1,537	1,317	15,755	15,194	13,832
Child Care Facility	726	783	669	33,463	31,789	28,416
Nursery School	131	139	90	2,315	2,282	1,563
TOTAL	**2,376**	**2,459**	**2,076**	**51,533**	**49,265**	**43,811**

Child Care Licensing Complaints and Survey Table SFY			
	2009	**2010***	**2011** **SEE NEW TABLES BELOW**
Complaints	268	207	
Surveys	2,583	1,946	
TOTAL	**2,851**	**2,153**	

*In SFY2010, there was a change in methodology that resulted in a decrease in the data for that year.

Note: The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size.

** New data format and reporting started 7/1/10 SFY11 by Provider Type

Child Care Licensing - Surveys State Fiscal Year 2011	
Family Child Care Provider	1,416
Child Care Facility	688
Nursery School	93
Total	**2,197**

Child Care Licensing - Complaints State Fiscal Year 2011			
Complaints*	**Complaints Received**	**Complaints Due to be Investigated**	**Complaints Investigated**
Child Care Facility	44	51	57
Family Child Care	54	66	78
Nursery School	0	0	1
TOTAL	**98**	**117**	**136**

New data process started 7/1/10. 1st Qtr. data not tracked accurately between complaints Rec'd to Due to be investigated and investigated

Child Care Licensing Staff Table SFY			
	2009	**2010**	**2011**
Supervisors Child Care Licensing	2	2	2
Program Licensors	14	14	14
Support	2	2	2
TOTAL	**18**	**18**	**18**

STATE SANCTIONS SFY 2010				
Denials (New Applications & Non-renewals	**Conditional Licenses**	**Consent Agreements**	**License Modifications**	**# of Hearings**
27	**12**	**0**	**0**	**14**

VIII. 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. This unit of social workers specializes in interviewing children and has extensive experience and training in investigating child abuse complaints. The routing of the complaint will be based on the substance of the allegations and the probable need to interview a child or children as a result of the allegation. Any allegations regarding possible licensing violations are assessed by the respective licensing worker for that resource. Some of the licensed facilities and institutions that are investigated include child cares, foster homes, and children's residential facilities. 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.

Calendar Year 2010 Statistics*

CHILD CARE INVESTIGATED: 79
Unsubstantiated Assessments: **24**
Unsubstantiated Assessments with Licensing Violations: **44**
Indicated Assessments: **10**
Substantiated Assessments: **1**
Reports Referred to Licensing: **197**

FOSTER HOMES INVESTIGATED: 57
Unsubstantiated Assessments: **26**
Unsubstantiated Assessments with Licensing Violations: **22**
Indicated Assessments: **7**
Substantiated Assessments: **2**
Reports Referred to Licensing: **56**

RESIDENTIAL INVESTIGATED: 40
Unsubstantiated Assessments: **17**
Unsubstantiated Assessments with Licensing Violations: **18**
Indicated Assessments: **4**
Substantiated Assessments: **1**
Reports Referred to Licensing: **45**

MENTAL HEALTH INVESTIGATED: 1
Unsubstantiated Assessments: **0**
Unsubstantiated Assessments with Licensing Violations: **1**
Indicated Assessments: **0**
Substantiated Assessments: **0**
Reports Referred to Licensing:**35**

*** Information based on calendar year 2010**

Out of Home Investigations Complaints *SFY 2010			
Provider Type	**Complaints Received**	**Complaints Closed**	**Complaints Referred**
Child Care	282	85	220
Foster Homes	114	60	56
Residential	86	38	50
MH/SA	81	3	80
Dept. ED	65	-	64
Total	**628**	**186**	**470**

*Change in methodology from prior year reporting. Data is not compatible with previous years. **Note: The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size.**

Out of Home Investigations - Complaints SFY 2011			
Provider Types	**Complaints Received**	**Complaints Investigated**	**Complaints Received and Referred**
Child Care	75	69	**N/A
Foster Homes	118	53	57
Residential	38	35	*N/A
MH/SA	0	0	**N/A
Dept. ED	87	0	83
Corrections	2	0	3
Total	**320**	**157**	**143**

** **Data reported under respective Programs**

Out of Home Investigations Staff Table SFY			
	2009	**2010**	**2011**
Staff	**Positions**	**Positions**	**Positions**
Manager/ Supervisor*	0	0	0
Investigators	5	5	5
TOTAL	**5**	**5**	**5**

* **Assistant Director manages this program**

IX. 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.

The CON Unit has several review types according to the project. Below are tables illustrating the review types and facility types that were reviewed during calendar year (CY) 2009.

Capital Expenditure for Calendar Year (CY) 2010		
Review Type	**Number**	**Amount**
Complete Review	5	$454,222,684
Emergency Review	0	$0
Expired	0	$0
Not Subject to Review	30	$36,657,804
Subsequent Review	1	$0
Suspended	1	$5,269,000
Withdrawn	3	$103,396,299
		$599,545,787

Projects by Facility Type CY 2010		
Facility Type	**Number**	**Amount**
Hospital	24	$570,746,732
Nursing Facility	16	$19,661,577
Other	11	$9,137,478
		$599,545,787

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

Thresholds		
Category		**Amount**
Major Medical Equipment		$1,600,000
Capital Expenditures		$3,100,000
New Technology		$1,600,000
Nursing Facility Capital Expenditures		$1,000,000
New Health Service		
	Capital Expenditure	$140,098
	3rd Year Incremental Operating Costs	$509,449

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 Maine Care costs must have an equal decrease in Maine Care costs elsewhere. This maintains budget neutrality while allowing some projects above the nursing facility thresholds to proceed. For 2010-2012 a three year Capital Investment fund was established.

CY 2010-2012 Capital Investment Fund			
	Small	**Large**	**Total**
Non-Hospital	$943,392	$5,345,886	$6,289,278
Hospital	$6,603,741	$37,421,200	$44,024,941
			$50,314,219

CON applicants are required to pay a nonrefundable fee for the review of each project. The CON Unit also collects fees for copies of documents requested under the Freedom of Information Act (FOIA).

Revenue CY 2010	
FOIA	$667.50
CON Applications	$122,,000.00
Total	**$122,667.50**

Office of Program Evaluation and Government Accountability Report

In March 2011, the Government Oversight Committee asked OPEGA to initiate a limited review of the Certificate of Need (CON) Program. The focus was on the process used, and factors considered, in making determinations on CON applications.

OPEGA reviewed the CON statute and related rules, the annual reports produced on the CON program, and the procedures used by the DHHS Certificate of Need Unit in processing CON applications. OPEGA also reviewed a sample of files for CON applications processed in 2008 – 2010 to assess consistency and adherence to the Certification of Need statutory purpose in making CON determinations.

This Information Brief describes the purpose of the CON program, the processes followed and factors considered in assessing CON applications. OPEGA's limited review found there to be clarity, consistency and transparency in the process as prescribed in the existing statute. Consequently, OPEGA does not recommend any further detailed review of the process itself at this time.

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 Maine Care 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

DLRS is responsible for administrating the annual Hospital and Health Care Provider Act Assessments. Except for state-operated mental health facilities, any hospital licensed by the Department of Health and Human Services is subject to an annual assessment under Chapter 405-A, Para. 1850. Assessments for all hospitals that were collected in CY 2009 totaled $200,000.00

A hospital may apply for a Certificate of Public Advantage (COPA) pursuant to the Hospital and Health Care Provider Act of 2005. The approval of a COPA would authorize the hospital(s) 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). During CY 2009, only one application for a COPA was received. This application was also withdrawn by the applicant 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.

In addition to collecting the data, DLRS also ensures compliance with the Charity Care guidelines and compliance with the notification statutes. DLRS serves as an information resource for hospital staff responsible for Free Care determinations as well as conducting compliance audits.

Calendar Year 2010 Free Care

Hospital	Mandated Free Care Amount	# of Patient Records Reported	Additional Uncompensated Care Amount	# of Patient Records Uncompensated Care
Acadia Health Care	$3,542,025.00	633	$10,035,655.00	1,900
Blue Hill Memorial Hospital	$1,108,077.00	413	$39,406.00	61
Bridgton Hospital	$475,764.43	1,019	$403,769.40	696
Calais Regional Hospital	$262,113.10	88	$10,054.04	24
Cary Hospital	$591,717.00	291	$111,344.00	65
Central Maine Medical Center	$6,119,202.62	4,706	$3,075,141.97	4,074
Charles A. Dean Memorial Hospital	$243,678.00	99	$119,947.00	73
Down East Community Hospital	$1,209,624.32	201		219
Eastern Maine Medical Center	$11,898,452.00	1713	$6,634,482.00	3,646
Franklin Memorial Hospital	$3,643,298.00	1,124	$493,885.00	213
Goodall Hospital	$13,544,004.00	1,232	**	**
Houlton Regional Hospital	$1,196,794.00	425	$5,478.00	41
Inland Hospital	$26,579.49	27	$863,669.77	343
Maine Coast Memorial Hospital	$1,706,631.00	509	$224,325.00	240
Maine General Medical Center	$5,488,989.32	2,125	$231,591.29	286
Maine Medical Center	$21,275,826.00	29,293	$4,360,748.00	2,822
Mayo Regional Hospital	$1,654,360.00	588	$250,815.00	123
Mercy Hospital	$5,341,599.00	4,901	$2,365,728.00	3,867
Mid Coast Hospital	$1,942,430.00			
Miles Memorial Hospital	$1,416,098.33	710		
Millinocket Regional Hospital	$521,097.45		$278,701.73	
Mount Desert Island Hospital	$135,901.04		$362,519.59	
New England Rehabilitation Hospital of Portland	$285,670.00	106		
Northern Maine Medical Center	$388,385.97	116	$202,456.14	54
Parkview Adventist Medical Center	$737,448.00	399	**	**
Penobscot Bay Medical Center	$1,121,049.31	674	$1,362,762.16	1,378
Penobscot Valley Hospital	$712,227.61	810	$13,808.81	60
Redington-Fairview General Hospital	$648,648.66	234	$563,125.27	204
Rumford Hospital	$315,605.83	512	$206,956.61	332
Sebasticook Valley Hospital	$1,148,002.00		$545,930.00	
Southern Maine Medical Center	$2,804,221.00	1,097	$193,697.00	229
Spring Harbor Hospital	$5,271,481.00	1,567	$485,060.00	143
St. Andrew's Hospital and Healthcare Center	$169,957.63			
St. Joseph Hospital	$1,027,197.25	674	$60,182.82	114
St. Mary's Regional Medical Center	$7,260,600.49	4,751	$2,052,494.18	2,581

Hospital	Mandated Free Care Amount	# of Patient Records Reported	Additional Uncompensated Care Amount	# of Patient Records Uncompensated Care
Stephens Memorial Hospital	$1,065,905.00	1,443	$391,788.00	808
The Aroostook Medical Center	$1,126,809.00	254	$581,528.00	181
Waldo County General Hospital	$1,496,724.42	2,509	$89,563.65	969
York Hospital	$4,410,049.62	6,922	**	**
Totals	**$113,334,243.89**	**72,165.00**	**$36,616,613.43**	**25,746.00**

**** Hospitals are required to report the two categories of Free Care (required and not required) separately. However, some hospitals included the non-required Free Care amounts as part of the required total.**

The CON Annual Report may be found at the following website:
http://www.maine.gov/dhhs/dlrs/con/index.shtml#report2009

Healthcare Oversight – Staff Table By Calendar Year			
Staff	**2008**	**2009**	**2010**
Healthcare Financial Analysts	2	3	3
Support	.5	.5	.5
TOTALS	**2.5**	**3.5**	**3.5**

X. Sentinel Events

In 2002, Maine established a mandatory Sentinel Event reporting system. Sentinel Events are defined as unanticipated deaths and other serious adverse events that are most often preventable. 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.

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 further requires the reporting of the following events:

- 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.

On September 12, 2009 Legislature approved LD 1435, an Amendment to the previous law. Subsequent Rules were effective April 19, 2010.

Key statutory changes include:

- Sentinel Event definition added the National Quality Forum, 28 Serious Reportable Events;
- Addition of inter-facility transfer patients. Patients suffering a Sentinel Event and are subsequently transferred to another facility are reportable events;
- Facilities must report events upon discovery within one business day;
- Confidentiality protections added for all communications and reports of suspected sentinel events;
- Voluntary submission of 'near miss' events;
- Requirements for facilities to adopt standardized procedures for identifying and reporting sentinel event;
- Penalty for failure to report Sentinel Events increased to maximum of $10,000;
- Facility requirements for submitting Root Cause Analysis specified.
- Stage 3 and 4 pressure ulcers

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. By December 31, 2010 at total of 342 Sentinel Events have been reported and reviewed since the inception of the program in 2004. The overwhelming majority are unanticipated patient deaths.

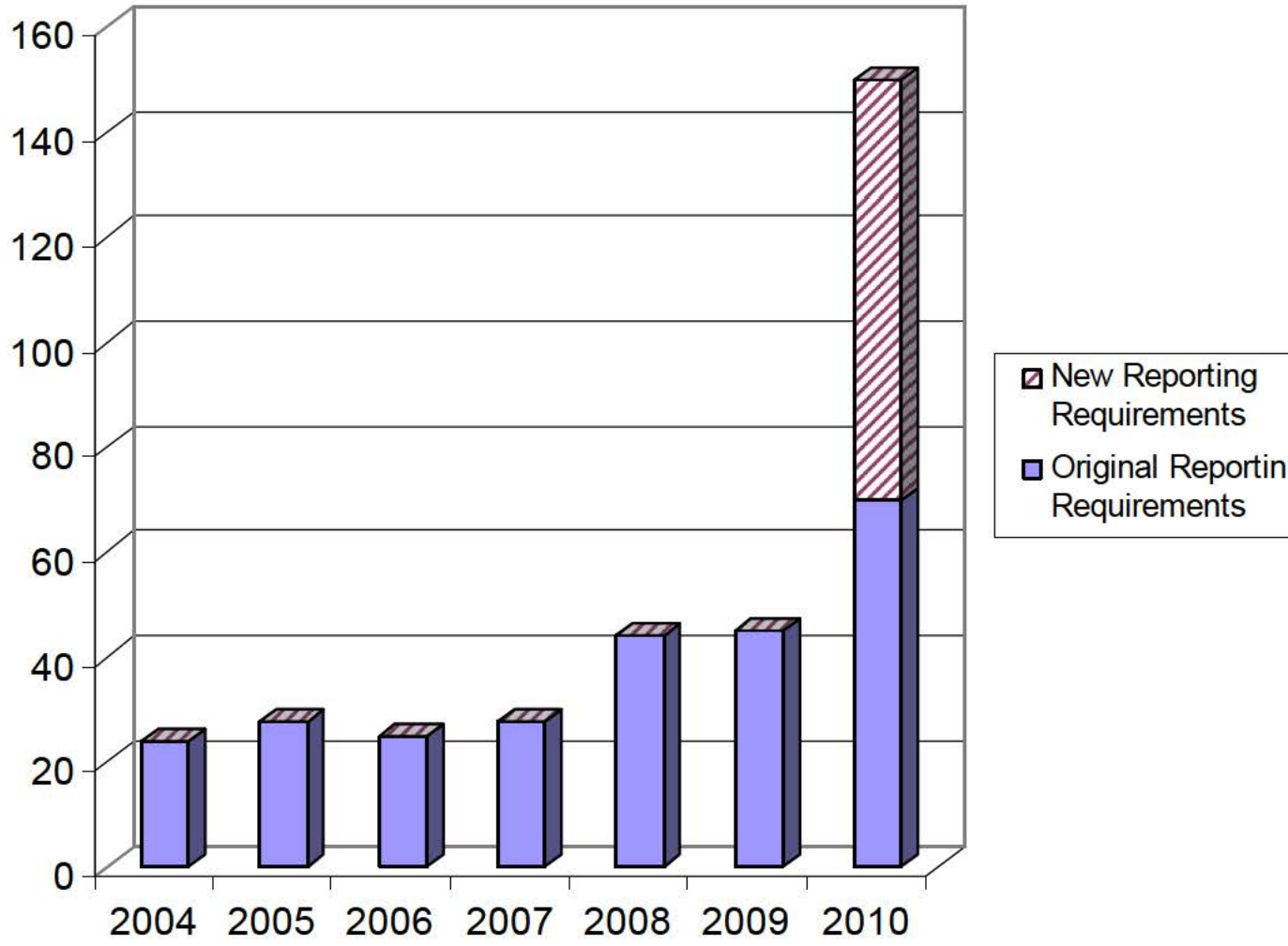
Maintaining a commitment to a collaborative approach among all stakeholders for identifying, reporting, and sharing aggregate data for all Sentinel Events offers the best opportunity for preventing recurrences.

Sentinel Events Reported in 2010

A total of 150 sentinel events were reported to the Division of Licensing and Regulatory Services in 2010, compared to 45 in 2009. This represents more than a 300% increase in reporting.
During the 7 years of reporting sentinel events, hospitals have steadily increased participation in the program. By 2006, only 61% of all Maine hospitals had reported a sentinel event. By the end of 2010, 100% of the 41 acute care hospitals in Maine had reported at least one sentinel event. Other states experience reflects 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).

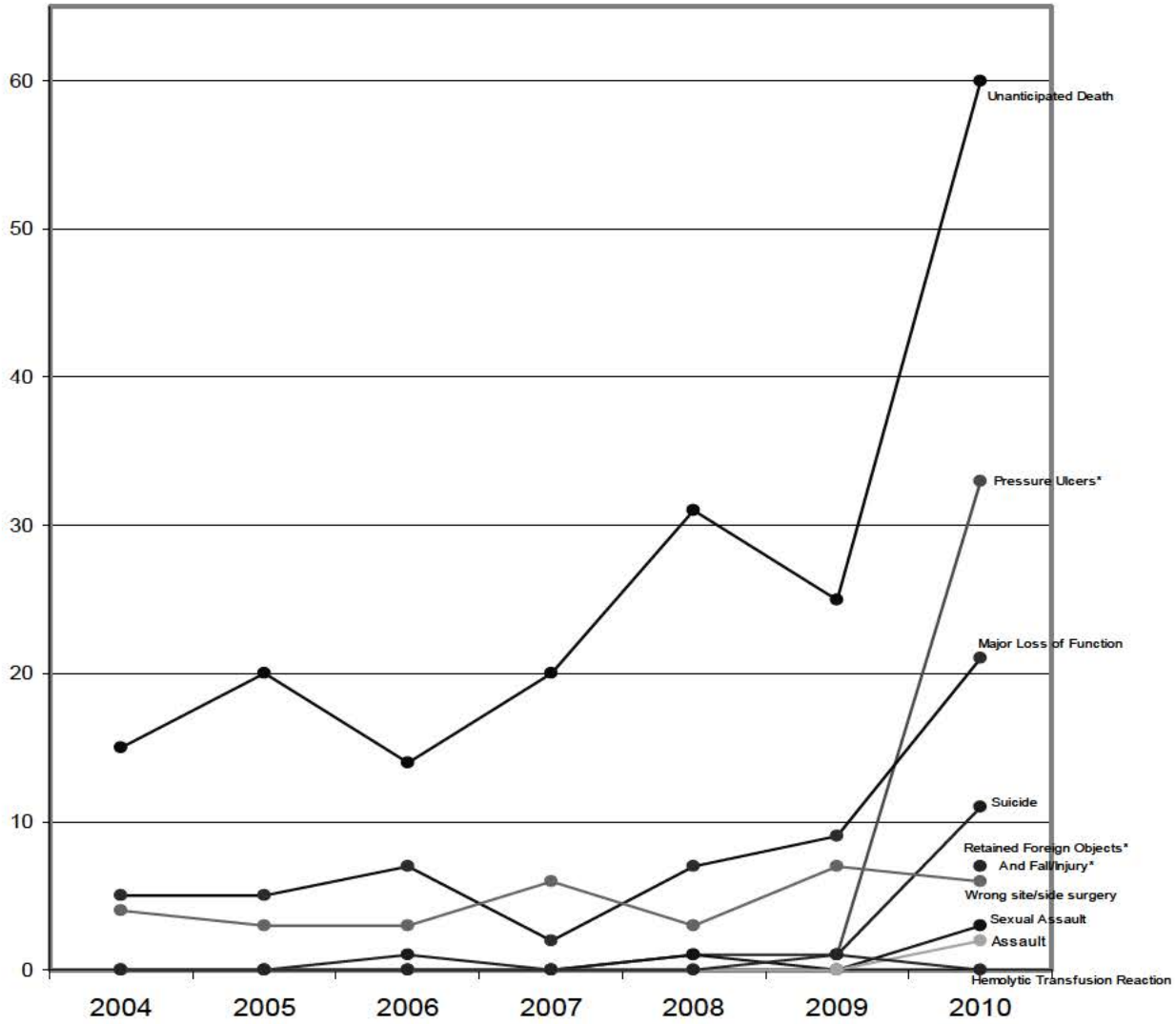
Maine is the only state that reviews each Sentinel Event and conducts on site facility visits. Modifications to the case review process have been made to ensure that Sentinel Event Team visits take place within the 45 day period following the report of an event and prior to the submission of the Root Cause Analysis. Findings from medical record case reviews are shared with the facility leaders to enhance their Root Cause Analysis process and contribute to the lessons learned. This collaborative approach is unique to Maine, and provides an independent assessment that augments the facility's review.

Sentinel Events Reported, by Year, 2004-2010



The trends by type of sentinel event have remained fairly constant throughout the history of the sentinel event program. Unanticipated deaths have been the most prevalent type of event reported in every year. This is followed by major loss of function, and wrong site surgery. In 2010, new reporting requirements added specific categories which appear for the first time in Table 2. They include: stage III pressure ulcers, retained foreign objects following surgery, and staff assault.

Sentinel Events Reported, by Category, 2004-2010

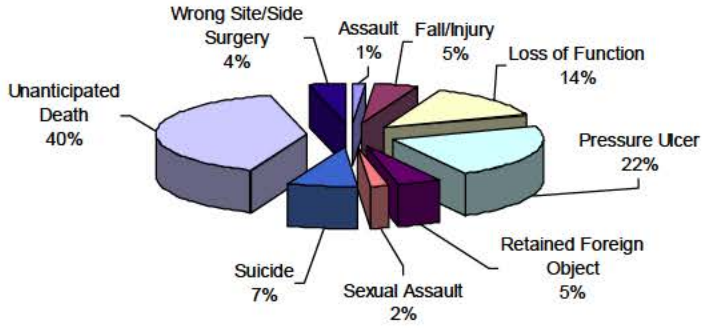


	2004	2005	2006	2007	2008	2009	2010
Unanticipated Death	15	20	14	20	31	25	60
Pressure Ulcers*	0	0	0	0	0	1	33
Major Loss of Function	5	5	7	2	7	9	21
Suicide	0	0	1	0	1	1	11
Fall/Injury *	0	0	0	0	0	0	7
Retained Foreign Objects*	0	0	0	0	0	0	7
Wrong site/side surgery	4	3	3	6	3	7	6
Sexual Assault	0	0	0	0	1	0	3
Assault	0	0	0	0	0	0	2
Hemolytic Transfusion Reaction	0	0	0	0	0	1	0

* New Reporting Requirements in 2010

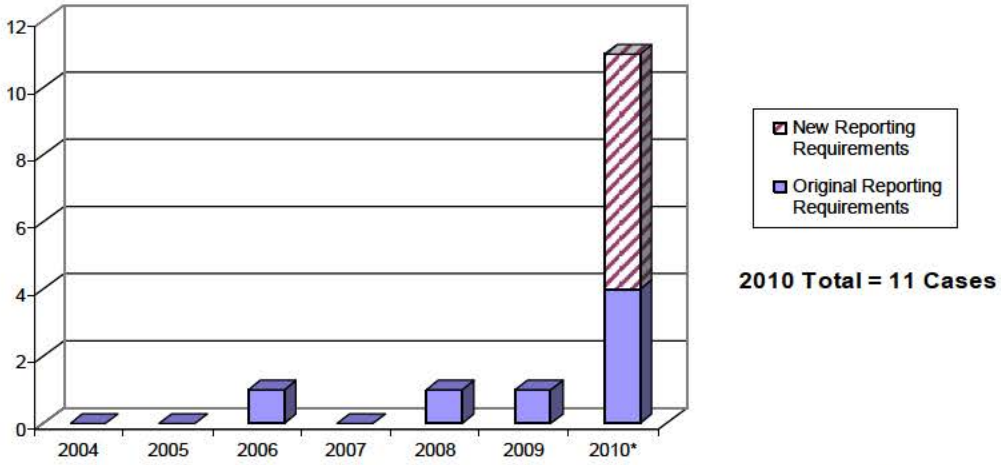
The table below indicates sentinel events by type in 2010. Unanticipated death was reported in the majority of cases at 60 (40%). Pressure ulcer reporting is a new requirement and represents 33 (22%) of all reported cases in 2010.

Sentinel Events Reported, by Type of Event, 2010



From 2004 to 2009 there were 3 reports of inpatient suicide. In 2010 there were 4 reports of inpatient suicide in hospitals. Expanded reporting requirements put into effect in 2010 captured an additional 7 cases of either completed suicide within 48 hours following treatment, or attempted suicide with significant injury. Of note there are 3 additional cases of unanticipated death reported in 2010 in general hospitals under unusual and unexplained circumstances.

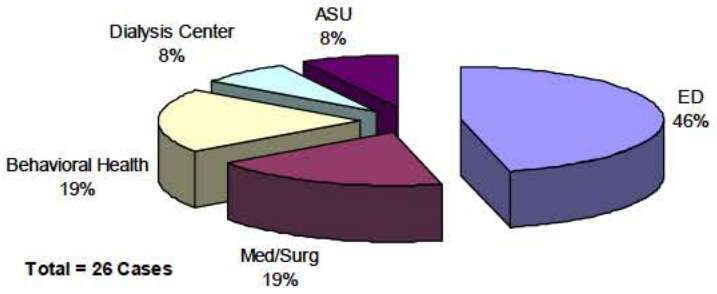
Table 10. Sentinel Event Reports of Suicide and Attempted Suicide, 2004-2010



*Includes attempted suicides resulting in serious disability and completed suicides within 48 hours of treatment.

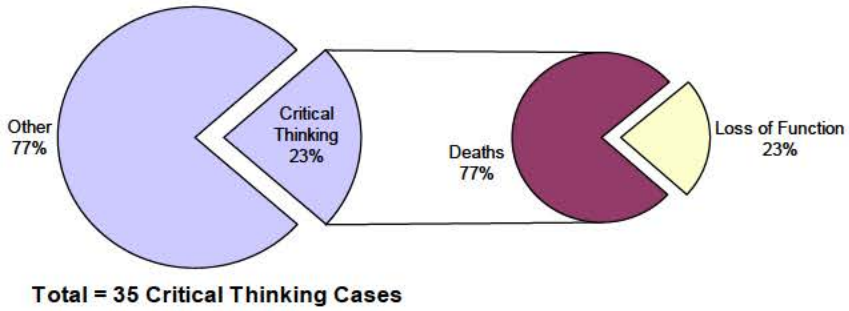
In 2010, there were reports of 26 cases of patients whose deaths were within 48 hours of treatment. Of the 26 events, a majority of the cases, 12 (46%), were patients discharged from the Emergency Department.

Table 23. Sentinel Event Reports of Deaths within 48 hours of Treatment, by Department, 2010



Of the 150 reported sentinel event cases, 35 (23%) had evidence of critical thinking errors. Critical thinking or the decision making process errors resulted in death in 27 (77%) of the events and loss of function in 8 (23%) of the cases.

Sentinel Events with Critical Thinking Issues, 2010



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	**2009**	**2010**
Supervisor	1	1
Health Services Consultants	2	2
TOTALS	**3**	**3**

XI. 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. Long Term Care Facilities are certified, every nine to fifteen months in a Federal fiscal year with an expected average of 12 months, using Federal regulations. Intermediate Care Facilities for Mental Retardation (ICF-MR) must be surveyed every twelve months. For both long term care and ICF-MR, the surveyors must be federally qualified to complete the recertification process and to investigate complaints.

In the late spring of Federal Fiscal Year (FFY) 2009, Maine began implementing the new Quality Indicator Survey (QIS) process and was fully implemented (all seasoned long term care surveys were trained) by December of FFY 2010. The QIS survey process utilizes a Federal computerized data system (Aspen Survey Explorer-Q) to assist in identifying residents and families to be interviewed, resident observations and to identify potential problem areas. The QIS survey is conducted in two Stages. Stage I includes a "Census" sample of 40 residents who reside in the facility. The surveyors must screen for interview and interview up to 40 residents in the sample, interview three families, briefly review all 40 records and complete staff interviews on all 40 residents. In addition, to the Census sample, 30 residents' medical records are reviewed to complete the "Admission Sample". The data from these two samples is compiled in the team leaders' computer and triggered areas (areas of possible concern) are identified for the surveyors to investigate during the Stage II portion of the survey. The "triggered areas" are identified by the QIS data system through the data from Stage I, Minimum Data Set, Version 3.0 (MDS) assessment information and outstanding complaint investigations. The Stage II triggered areas are then investigated using the "investigative protocols" developed by the Centers for Medicare and Medicaid Services (CMS). Over the next 5 years, CMS has a schedule for each State, nationwide to begin using this process. In order to participate in this process, a newly hired surveyor must complete a week long Federal basic long term care training, must pass the Surveyor Minimum Qualification Test (SMQT) and become a QIS qualified surveyor (one week of classroom, one week mock survey and two compliance surveys). The State of Maine currently has two certified QIS trainers.

Additionally, during SFY 2011, Maine participated in a number of projects. Maine was involved in efforts to reduce the number of pressure ulcers in Long Term Care facilities. This federally-supported Pressure Ulcer Prevention initiative was led by Maine Quality Counts and involved many public and private partnerships from across the state. Maine has also been involved in the Culture Change initiative for Long Term Care residents. This ongoing initiative represents a drive to make the facilities more of a home environment for their residents.

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 and reported under Assisted Housing program. Multi-level facilities are a distinct part of a nursing facility. The Long Term Care Program is responsible for licensure surveys and complaints at these facilities.

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 does 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 2009**	**Provider Counts 2010**	**Provider Counts 2011**	**Beds/ Capacity 2009**	**Beds/ Capacity 2010**	**Beds/ Capacity 2011**	**Licensed or Certified**
Nursing Facilities	109	109	108	6,894	7,043	7,017	Both
ICF/MR	17	17	17	199	193	193	Both
ML - Level IV Residential Care	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL	**126**	**126**	**125**	**7,093**	**7,236**	**7,210**	

Note: ML- Level IV are reported in Assisted Housing as "Level IV Res Care".

Long Term Care Surveys – Workload Table SFY						
Provider Types	**Annual Surveys 2009**	**Annual Surveys 2010**	**Annual Surveys 2011**	**Other Surveys 2009**	**Other Surveys 2010**	**Other Surveys 2011**
Nursing Facilities	112	119**	99**	182	157	138
ICF/MR	20	17**	16**	1	1	0
ML - Level IV Residential Care	46	20*	74*	0	3	0
TOTAL	**178**	**156**	**189**	**183**	**161**	**138**

*As of 2010, Residential Care ML surveys were significantly reduced due to the implementation of QIS.

** Also due to the implementation of QIS, nursing home facilities were surveyed solely under Federal regulations .

Note: The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size. (QIS survey teams average 4 surveyors per survey and may be more or less >100 beds or < 40 beds).

Long Term Care - Complaint Table SFY						
Provider Types	**Received 2009**	**Received 2010**	**Received 2011**	**Investigated 2009**	**Investigated 2010**	**Investigated 2011**
Nursing Facilities	877	880	839	805	780	774
ICF/MR	70	37	31	39	27	16
ML - Level IV Residential Care	122	137	110	137	111	64
TOTAL	**1,069**	**1,054**	**980**	**981**	**918**	**854**

Nursing Home Complaints Number of Days from Survey Start to Complaint Closure	
SFY	**Days**
2009	136
2010	126
2011	174

***Changed Process**

Nursing Home Complaint Allegations Investigated By **SFY**					
	SFY	Allegations Investigated	Substantiated	Unknown	% Substantiated
Nursing Homes	2009	1,790	266	206	16.8%
	2010	1,702	253	124	16.0%
	2011	1,698	180	312	13.0%

Long Term Care Staff Table			
Staff	**Positions 2009**	**Positions 2010**	**Positions 2011**
Managers	.5	1	1
Health Services Supervisor	4	4	3
Health Services Consultants	24	24	24*
Health Facility Surveyors (HFS)	3	3	1
Support	4.5	4	4
TOTAL	**36**	**36**	**33**

* 8 Vacancies under (health services consultant , lost 2 Social Workers & 2 Health Facility Surveyors that had also been vacant.

Nursing Home Informal Dispute Resolution (IDR) Report Federal Tags Only SFY										
SFY	**Requested**	**Withdrawn**	**Number Held**	**Number of Tags Reviewed**	**Tags with No Change**	**No Change Percentage**	**Tags Revised**	**Revised Percentage**	**Tags Deleted**	**Deleted Percentage**
2008	33	7	33	129	43	33%	29	23%	39	30%
2009	28	1	27	97	27	28%	1	1%	39	40%
2010	18	0	17	63	11	18%	1	2%	36	57%
2011	27	3	21	54	13	24%	15	28%	26	48%

XII. Acute (Non Long Term) Care

Background

The Acute Care Team 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. The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size. Teams may include licensed social workers, nurses, laboratory specialists, health facility specialists and consultants, including physicians and pharmacists. The volume of both certification surveys and complaint surveys, continue to increase both nationally and in Maine.

General Hospitals

General Hospitals must be both State licensed and certified in Maine. There are 21 General Hospitals 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 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 four 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. 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. There are fifteen CAH's in Maine. Only one of these is 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 surveys are not required annually. The Unit inspects between nine and eleven HHAs each year.

Home Health Care Service Providers

Home Health Care Service Providers (HHCS) 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 six and eight 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 three and five 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 dialysis centers and 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 eighteen each year.

In Federal Fiscal Year 2009, Maine was one of twelve states to participate in a national initiative from the Centers of Medicare and Medicaid Services called **ARRA (American Recovery and Reinvestment Act of 2009). This initiative was aimed at reducing healthcare acquired infections in ASC's.** In Federal Fiscal Years 2010 and 2011, Maine continued participation in this initiative utilizing new federal survey processes and infection control tools. Additionally, Maine intends to utilize this funding to provide education on prevention of healthcare acquired infections for ASC providers and the Acute Care Team during SFY2012.

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 centers 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.

Federally Qualified Health Centers

Federally Qualified Health Center (FQHC's) 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 conducts complaint surveys for these suppliers.

Acute (Non Long Term) Care – Provider Table SFY							
Provider Types	**Provider Counts 2009**	**Provider Counts 2010**	**Provider Counts 2011**	**Licensed or Certified**	**Beds/ Capacity if Applicable 2009**	**Beds/ Capacity if Applicable 2010**	**Beds/ Capacity if Applicable 2011**
Ambulatory Surgical Center	18	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	59	75	85	Certified	N/A	N/A	N/A
Laboratories CLIA	987	1,006	1,053	Certified	N/A	N/A	N/A
Home Health Agencies	53	55	55	Some of each	N/A	N/A	N/A
Hospice	28	27	29	Some of each	14*	30**	30
Hospital	41	41	41	Both	4,038	4,033	4033
Occupational Physical and Speech Therapy	16	15	15	Certified	N/A	N/A	N/A
Portable X-Ray	4	4	4	Certified	N/A	N/A	N/A
Rural Health Center	44	40	39	Certified	N/A	N/A	N/A
TOTALS	**1,267**	**1,298**	**1,356**	**N/A**	**4,052**	**4,063**	**4,063**

*One Hospice has actual licensed bed capacity.
**Two hospices have licensed inpatient hospice houses.

Acute (Non Long Term) Care – Workload Table SFY						
Provider Types	**Licensure Surveys 2009**	**Licensure Surveys 2010**	**Licensure Surveys 2011**	**Certification Surveys 2009**	**Certification Surveys 2010**	**Certification Surveys 2011**
Ambulatory Surgical Center	15	4	5	5	18	9
End Stage Renal Disease	6	10	4	5	6	9
*Federally Qualified Health Center	0	0	0	0	0	0
Laboratories CLIA	0	0	0	33	45	37
Home Health Agencies	13	14	11	12	14	12
Hospice	7	11	10	2	3	2
**Hospital	0	0	1	9	19	23
Occupational Physical and Speech Therapy	0	0	0	3	3	2
Portable X-Ray	0	0	0	0	2	1
Rural Health Center	0	0	0	4	7	10
TOTALS	**41**	**39**	**30**	**73**	**117**	**105**

*Federally Qualified Health Centers undergo federal complaint surveys.

**Number of surveys impacted by changes in State statute.

Note: The size and composition of the survey team, as well as the length of survey, are determined by the provider type and size

Hospital Complaint Allegations Investigated By **SFY**					
	SFY	Allegations Investigated	Substantiated	Unknown	% Substantiated
Hospitals	2007	192	37	8	20.1%
	2008	386	68	17	18.4%
	2009	847	130	95	17.3%
	2010	483	84	75	21.0%
	2011	437	100	7	23.3%
Note: Denominator for % substantiated is determined by the Number Investigated minus the number unknown.					

Acute (Non Long Term) Care Complaint Table SFY						
Provider Type	**Received 2009**	**Received 2010**	**Received 2011**	**Investigated 2009**	**Investigated 2010**	**Investigated 2011**
Ambulatory Surgical Center	0	5	2	1	3	2
End Stage Renal Disease	2	3	1	2	2	2
Federally Qualified Health Ctr.	4	3	14	4	4	12
Laboratories CLIA	0	0	0	0	0	0
Home Health Agencies	23	22	28	48	22	22
Hospice	7	2	6	8	1	2
Hospital	237	256	270	184	228	241
Occupational Physical & Speech Therapy	0	0	0	0	1	0
Portable X-ray	0	0	0	0	0	0
Rural Health Center	3	0	2	3	0	1
TOTALS	**276**	**291**	**323**	**250**	**261**	**282**

Acute (Non Long Term) Care – Staff Table SFY			
Staff	**Positions 2009**	**Positions 2010**	**Positions 2011**
Managers	.5	0	0
Supervisor	1	1	1
Health Surveyor	6	6	6
Quality Assurance Surveyor (Labs)	1	1	1
Support	1.5	1	1
TOTAL	**10**	**9.5**	**9.5**

XIII. 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 650 laboratories to perform only waived tests.

Certificate of Provider-Performed Microscopy (PPM)
This certificate is issued to 253 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 67 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 76 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 30 and 35 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 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 11 laboratories holding Maine Medical Laboratory licenses and 36 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 Acute (Non-long Term) Care Section IX.

XIV. 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 Maine Care Services for coordination with regard to M.D.S. 2.0 and the upcoming implementation of MDS 3.0, 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 or ALMS 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 SFY				
Initiatives	**2009**	**2010**	**2011**	**Details**
Time Management Code Development	X	X	X	Ongoing partnership with Financial Services and Payroll to essence task codes covering each program's functional activities.
Financial Management and Code Development	X	X	X	Continued partnership with Financial Services to perfect the coding system of 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.
QIS Implementation		X	X	Implementation of QIS survey in nursing home program.
Creation of Incident Reporting Form and Procedures	X	X	X	Continue to standardize data gathering/reporting and the intake of incidents from a central location to regional offices.
Legislative Database support for Division	X	X	X	Maintenance of the Legislative database for the Division
OASIS Coordinator	X	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 Maine Care Services for coordination with regard to implementation of M.D.S. 3.0, the federal resident assessment instrument. Responsible for providing technical assistance and coordination of training for providers.
ARRA Program	X	X	X	Provided financial tracking and end of Federal Fiscal Year reporting of all expenditures related to the number of Ambulatory Surgical Surveys that were designated in the "Recovery Act Funding Proposal", against the Federal

				funding that was provided to do those surveys.

Training

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.

Trainings by Type by SFY			
	2009	**2010**	**2011**
CMS Mandatory Trainings	18	21	19
QIS Training (a session consists of a 40 hour classroom, Mock survey and two compliance surveys)		4 Sessions	2
QIS Train the Trainer Session		1 Session	1
Division-wide Trainings	4	1	1
Provider Trainings	2	4	3
Other	1	7	3
Total	**25**	**33**	**29**

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.

GPRA, The Government Performance and Results Act

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.

Data and Reports

Division quality initiatives include migration of various state licensing programs to the federal ASPEN data platform or ALMS 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.

Staff	2009	2010	**SFY** 2011
Comprehensive Health Planner II	1	1	1
Nurse Education Consultant	1	1	1
Management Analyst I (changed to MA II)	.825	.825	1
Support	0	.5	.5
TOTAL	**2.835**	**3.325**	**3.5**

Quality Initiatives SFY				
Partners	**2009**	**2010**	**2011**	**Details**
Best Practice Committee – support best practice in quality of care/life for nursing home residents	X			Ongoing meetings, provider training seminars, participation in work groups for special projects such as Geriatric.
LANE Committee – to improve the quality of care of nursing home residents				Continue 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. Preparation for statewide training in August 2010.
Town Meetings for Nursing Home providers	X	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.
Routine ASPEN Reports on Complaints, enforcement, workload, survey	X	X	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	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			Every 6 months OSCAR 3/4s is distributed to those providers requesting the report. OSCAR Reports were retired in June 2009 and CASPER is the new reporting system.
CASPER Reports		X		New Federal Reporting system.
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	X		Database design and implementation.

Quality Initiatives SFY				
Partners	**2009**	**2010**	**2011**	**Details**
Data entry and analysis for Sentinel Events Annual Report	X	X	X	Data included 2008 calendar year and all preceding data. Data charts created for 2009 calendar year.
Database development for Sentinel Events program	X	X	X	The data schema is 90 % complete. Some programming still 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.
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.
Medical Use of Marijuana Program		X	X	Data system configured for new program in the ALMS data system. Provided monthly reporting of revenue and expenses and backup support.
QIES Coordination	X	X	X	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, UAP data inclusion into CNA database, equipment needs, QIS implementation plan, program specific needs for data programming, Medical Marijuana Use Program implementation into ALMS data system
DHHS Metrics Dashboard Workgroup		X	X	Inclusion into the workgroup to recommend revisions for a dashboard metrics system for DHHS.

Quality Initiatives SFY				
Partners	**2009**	**2010**	**2011**	**Details**
Quarterly & Annual Report for DLRS	X	X	X	Provided Quarterly and Annual reports for the division and coordinated the data collection with management for each program, making necessary updates and revisions as needed.
LMS Coordinator	X	X	X	LMS is a Center for Medicare/Medicaid Services data base used to manage federal training provided by CMS. CMS mandates that our surveyors receive basic training for the provider types that they survey. The surveyors are also required to update their skills with these trainings. This data base allows , the training coordinator and her back up to nominate (register) a surveyor for CMS classes. It also allows them to track a surveyor's progress in completing CMS basic trainings, satellite broadcasts and CMS updated classes.

XV. 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.

In State fiscal year 2010, Public Law Chapter 628 transferred oversight for the C.N.A. training from the Department of Education to the Division of Licensing and Regulatory Services. Also transferred by this legislation, is oversight for training for Activities Coordinators. DLRS will continue to collaborate with the Department of Education and the Maine State Board of Nursing.

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.

FY11 CRMA Training				
County	CRMA 3 Day	CRMA Bridge	CRMA Re-cert.	CRMA Training
ANDROSCOGGIN	47	14	375	217
AROOSTOOK	0	0	201	96
CUMBERLAND	129	17	435	256
FRANKLIN	34	1	59	22
HANCOCK	8	2	76	62
KENNEBEC	65	15	416	226
KNOX	19	3	81	39
LINCOLN	11	4	100	65
OXFORD	25	6	143	73
PENOBSCOT	104	11	383	207
PISCATAQUIS	18	2	49	32
SAGADAHOC	26	6	106	60
SOMERSET	33	7	147	76
WALDO	14	2	52	41
WASHINGTON	1	0	90	67
YORK	97	20	343	212
Grand Total	**631**	**110**	**3056**	**1751**

SFY11 PSS Training			
County	PSS Family Only	PSS Test Out	PSS Training
ANDROSCOGGIN	4	4	44
AROOSTOOK	0	37	54
CUMBERLAND	2	8	171
FRANKLIN	0	1	19
HANCOCK	0	1	30
KENNEBEC	0	14	113
KNOX	0	0	14
LINCOLN	0	0	31
OXFORD	1	8	27
PENOBSCOT	0	4	128
PISCATAQUIS	0	2	11
SAGADAHOC	0	3	29
SOMERSET	0	3	46
WALDO	0	4	12
WASHINGTON	0	0	16
YORK	0	8	127

Grand Total	7	97	872

Activities Coordinator and Feeding Assistant Training Approved Applications SFY11		
	Activities Coordinator	**Feeding Assistant**
ANDROSCOGGIN		
AROOSTOOK		1
CUMBERLAND		
FRANKLIN		
HANCOCK		
KENNEBEC		
KNOX		
LINCOLN		
OXFORD		
PENOBSCOT	1	1
PISCATAQUIS		
SAGADAHOC		
SOMERSET		
WALDO		
WASHINGTON		
YORK		
Grand Total	**1**	**2**

Program transferred from the Dept. of Education in Jan 2011

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.

PCA Provider Count SFY			
Provider	**2009**	**2010**	**2011**
Temporary Nurse Agencies	65	67	72
Personal Care Agencies	116	126	145
Family Provider Service Option	*	252	304
Placement Agencies	*	3	4
Total	**191**	**448**	**525**

* **no** data available for these providers in 2009

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.

NEW CNA Renewal Process (Started December 22, 2010) State Fiscal Year 2011	
CNA Renewal Status	**2011**
Renewals Processed	2,521
Renewals-Needing more information	692
Renewals- Undeliverable	1,253
Renewals- Returned for address correction	872
Renewals Received/had not worked 8 hrs. in the last 24 months-Unable to renew	732

CNA Training- Applications Approved State Fiscal Year 2011	
Type	**2011**
Adult Education	5
Secondary School	
Community College	
Private Programs	
Job Corp	
Total	**5**

CNA Training- Students Trained State Fiscal Year 2011	
Type	**2011**
Adult Education	533
Secondary School	526
Community College	0
Private Programs	18
Job Corp	55
Total	**1132**

CNA Hearings Statistics Table SFY			
Type	**2009**	**2010**	**2011**
Abuse	21	18	5
Neglect	13	32	13
Denial of Placement on Registry	0	0	1
Misappropriation of Property	3	5	1
Fraudulent Application	0	0	0
Total Hearings	**37**	**55**	**20**

CNA Registry Summary Report Statistics Table SFY			
	Count 2009	**Count 2010**	**Count 2011**
CNA Status			
Active	15,112	15,779	15,339
Inactive	36,804	38,510	41,065
Total CNAs	**51,916**	**54,289**	**56,404**
Active and Annotated	676	665	645
Inactive and Annotated	1,182	1,209	1,303

CNA Registry Telephone – Register of Calls Received

CNA Registry Telephone – Register of Calls Received State Fiscal Year 2011- Quarterly				
Type of Call Received	**SFY 2/2009-6/2009**	**2010**	**2011**	
1. Facility Registry Checks	3,472	5,342	6,991	
2. CNA's Checking Status/Placement	718	1,317	1,635	
3. Testing Questions	572	914	996	
4. Reciprocity Letter Questions	59	90	347	
5. Out of State CNA	207	261	331	
6. Renewal Questions	N/A	N/A	3,286	
7. Other Calls	1,353	2,508	980	
8. Website Prompted Checks	*N/A	*N/A	*2,665	
TOTAL	**6,381**	**10,432**	**17,231**	

*Information not previously tracked before 10/1/11

CNA Registry Web Portal Usage State Fiscal Year 2011				
Type of Call Received	**2010**	**2011**		
1. Page Views	20,569	43,417		

*data for web portal usage/Web portal created for utilization in SFY10

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

Workforce Development Staff Table SFY			
Position	**2009**	**2010**	**2011**
Health Services Consultant	1	.5	0
Nurse Educator	1	1	0
Office Associate	4	4	4
Workforce Development Manager			1
Total	**6**	**5.5**	**5**

XVI. Medical Marijuana

During SFY 2011 The Maine Medical Use of Marijuana Program (MMMP), which employs two individuals full time, spent the greatest amount of its time and energy on transitioning patients and caregivers to a registry identification card system under the new law. As of June 30, 2011 there were 1762 medical marijuana patients, of which 542 had caregivers registered with the MMMP. Besides issuing registration cards to patients and caregivers the program is also responsible for issuing registry identification card to participating hospice provider staff, nursing facility staff and board members as well as principal officers of dispensaries.

SFY 2011 also saw the MMMP issue Certificates of Registration to 5 Dispensaries using criteria delineated in rules that became effective on August 4, 2010. There are three more dispensaries preparing to meet the criteria provided in the rule governing the program.

A large part of MMMP employee time was spent in education and oversight during the last year. Each of the nearly 2000 applications filed by patients had to be checked to make sure they had conditions for which medical marijuana was authorized. Each caregiver application had a background check completed on the applicant to verify that they met caregiver requirements. Finally a public information program was created and educational lectures were offered several times during the year.

Medical Marijuana Applications
State Fiscal Year 2011

Patient Applications	2011	2012
Applications Received	1,560	
Patients Activated	1,571	
Pending Applications *	197	

***Total pending is based on pending applications at the end of the year**
Data not tracked prior to October 2010

APPENDIX A – Mission, Vision and Values

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.

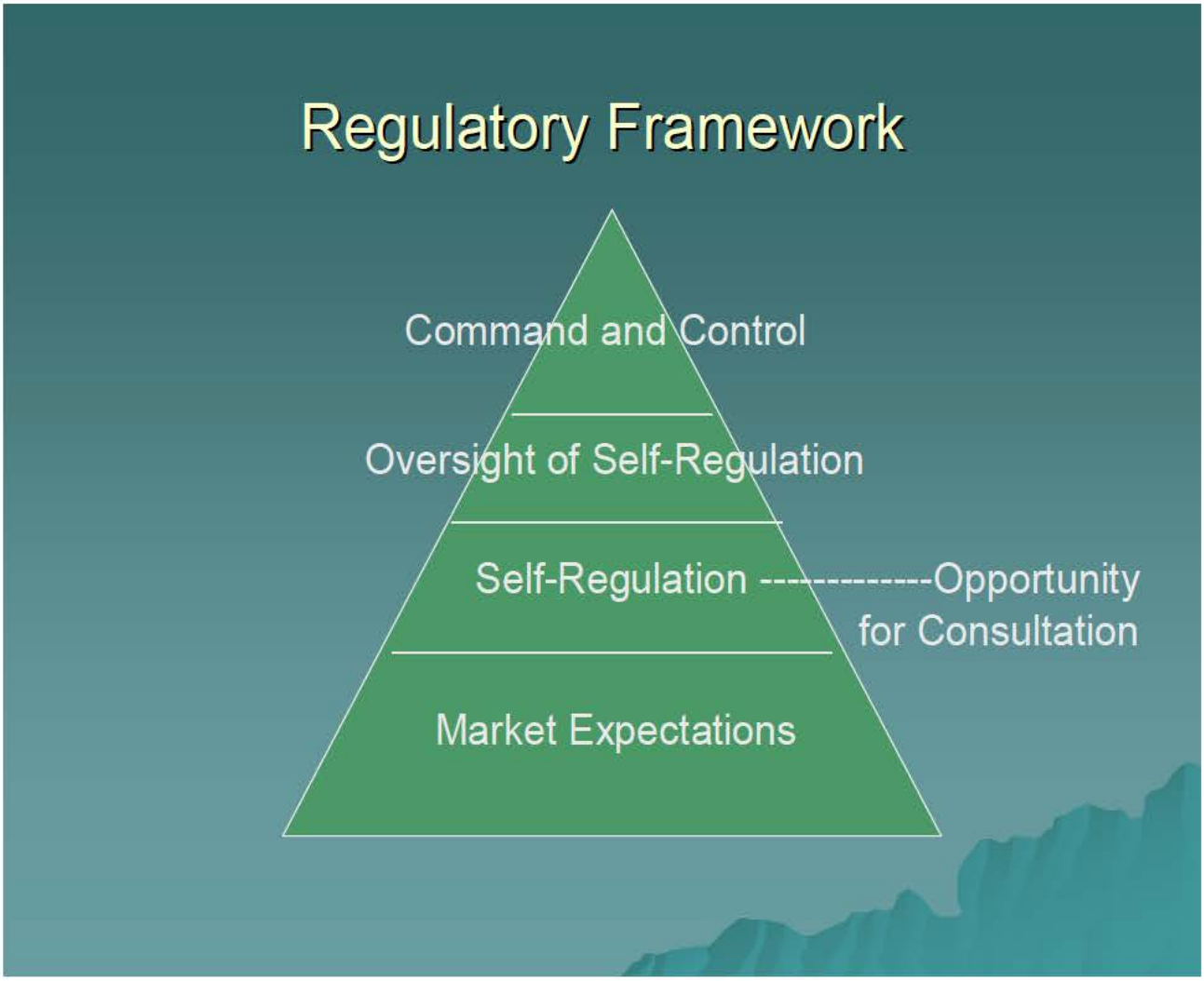
- **Quality**
  i. We have a structured orientation to assure that each new person knows his/her role and responsibilities and understands his/her position in the Division.
  ii. We receive the training we need in order to stay current with standards of best practice and we consistently implement the 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



APPENDIX C- * Listserv Addresses

Assisted Living
beas-assisted@lists.maine.gov

Certificate of Need
dhhs-con-request@lists.maine.gov

Child Care Facilities
childcarefacilities@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

Behavioral Health
BehavioralHealth-request@lists.maine.gov

* LISTSERV

An automatic mailing list server developed by Eric Thomas for BITNET in 1986. When e-mail is addressed to a LISTSERV mailing list, it is automatically broadcast to everyone on the list. The result is similar to a newsgroup or forum, except that the messages are transmitted as e-mail and are therefore available only to individuals on the list.

Non-Discrimination Notice

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to the DHHS ADA Compliance/EEO Coordinators, #11 State House Station, Augusta, Maine 04333, 207-287-4289 (V), or 287-3488 (V)1-888-577-6690 (TTY). Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to one of the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.

This report was prepared by
The Division of Licensing and Regulatory Services
Department of Health and Human Services
41 Anthony Avenue
11 State House Station
Augusta, ME 04333-0011

For further information please contact:

Catherine M. Cobb, Director.
(207)287-9300
Catherine.cobb@maine.gov

Revised: October 18, 2011