MAINE STATE LEGISLATURE

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JOINT STANDING COMMITTEE
ON
HEALTH AND HUMAN SERVICES

117th Maine Legislature

Majority And Minority Reports
On
REVIEW OF
THE MAINE MENTAL HEALTH SYSTEM

November 22, 1996

Appendix 1

NOV 28 1996

Augusta Mental Health Institute

Nursing Service

Policy & Procedure

SUBJECT: Staff Assignment to the Dining Room During Meal Times

Effective Date: 1/96
Committee Revise/Review Date: 1/96

Authorization: Katherine Guilbault RN MSN
Katherine Guilbault, RN, MSN
Director Of Nursing

I. PURPOSE:

To assure the safety of patient's during meal time.

II. POLICY:

There will be a Registered Nurse, Licensed Practical Nurse, or Mental Health Worker who holds current CPR certification in the dining room during each meal time.

III. QUALIFICATIONS:

Registered Nurses, Licensed Practical Nurses, and Mental Health Workers who hold a current CPR card.

IV. PROCEDURE:

At least one staff person that is presently CPR certified will be assigned on the Shift Assignment Sheet to the dining room during meal times.

V. PERFORMANCE IMPROVEMENT:

Monitoring of Incident Reports.

Augusta Mental Health Institute

Nursing Service

Policy & Procedure

SUBJECT: Cardiopulmonary Resuscitation Certification (CPR) Policy

Effective Date: November 1990
Committee Revise/Review Date: September 1991
November 1994

Authorization: [signature]
Katherine Guilbault, RN, MSN
Director of Nursing

I. PURPOSE:

To facilitate CPR certification of nursing staff involved in direct patient care.

II. POLICY:

All direct care nursing staff will attend mandatory CPR training, utilizing the American Heart Association Guidelines. Members of the Emergency Response Team must be CPR certified on a bi-annual basis.

III. QUALIFICATIONS:

Registered Nurses, Licensed Practical Nurses and Mental Health Workers

IV. PROCEDURE:

1. Nurse Managers or Administrative Coordinators will schedule staff for CPR and Emergency Response reviews.
2. Mock codes will be held quarterly on patient care areas.

V. PERFORMANCE IMPROVEMENT:

Criteria for this standard can be monitored by reviewing the following:

CPR Certification Card

Attached: American Heart Association Guidelines for CPR

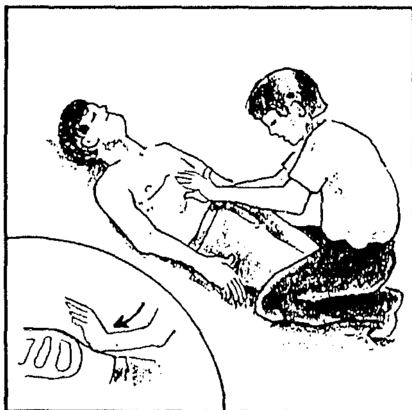
If your attempt to ventilate is not successful, you learned on page 15 that you must consider the possibility of an obstructed airway. Have you failed to provide an open airway, or is there a foreign body obstruction?

Reposition the head, repeating the head-tilt/chin-lift to open the airway, pinch the nose and seal the mouth with yours and attempt again to ventilate. If you are still unable to ventilate, you may assume that you have correctly opened the airway and that another type obstruction exists.

HEIMLICH MANEUVER

If a foreign body is obstructing the airway the Heimlich maneuver is used to attempt to relieve the obstruction.

In the assessment step the unconscious victim was positioned on his back. Kneel straddling his thighs. With one hand directly over the other, place the heel of your hand in the middle of the victim's abdomen a little above the navel. Be sure your hands are not placed too high where pressure might be applied on the tip of the xiphoid or the ribs.



Press quickly into the abdomen and upward toward the head. The force of the thrust should be along the midline of the body, not off to either side. The thrusts use the air in the lungs to force the object out of the airway. Perform each thrust with the intent of removing the obstruction from the airway. If necessary, a series of up to 5 thrusts may be performed in rapid succession.

FOREIGN BODY CHECK

The tongue/jaw lift is the preferred method of checking for a foreign object in the mouth or throat of an unconscious victim. With the head up, grasp the lower jaw, placing your thumb on the tongue and wrapping your fingers around the chin. Lift the jaw to open the mouth. Holding the victim's tongue down against the lower jaw with your thumb may offer better access to sweep an object from the throat, and may even help to relieve the obstruction.

Once the mouth is opened, sweep it for debris. Run your index finger down inside of the cheek towards the base of the tongue. Scrape across the back of the throat, and clear the debris out the other side of the mouth with a sweeping motion of the fingers. It may be necessary to remove dentures.

BREATHING ATTEMPT

Open the airway and attempt to ventilate. If unsuccessful, reposition and try again. **If the victim is still obstructed, repeat the above maneuvers in rapid sequence.** As his muscles relax your efforts may be effective in dislodging the obstruction.

If the obstruction has been relieved, you will see the chest rise when you ventilate. Give two slow breaths; you are now ready to check the pulse to determine if the heart

has stopped from lack of oxygen during the obstruction. If pulse is absent, begin single rescuer CPR with compression/ventilation cycles.

If pulse is present, open the airway and check breathing. Proceed with rescue breathing if indicated (page 16). If both pulse and breathing are present, maintain an open airway if the victim is unconscious. You must continue to monitor and may place him on his side to maintain an airway. A person who has experienced an obstruction should receive medical attention even if he appears to recover fully.

OBSTRUCTED AIRWAY - CONSCIOUS ADULT

The overview section Conscious Victim with an Airway Obstruction covered possible causes of airway obstruction as well as recognition of good air exchange, poor air exchange and complete obstruction. Review this on page 17 before proceeding with performance skills.

If the individual becomes obstructed because of swelling in the airway from an illness or a severe allergic reaction, you must gain access immediately to a facility with advanced life support capability. This obstructed airway procedure would be at the least ineffective and could be harmful.

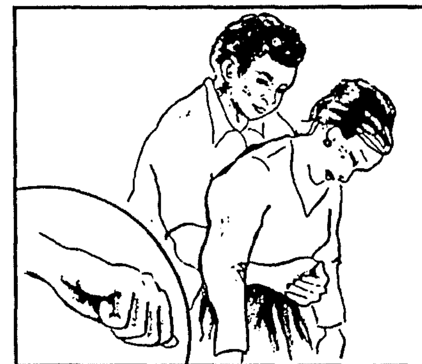
ASSESSMENT

Assessment begins with, "Are you choking?" If the victim can reply or is coughing forcefully, he still has good air exchange. Encourage his coughing but do not interfere.

HEIMLICH MANEUVER

If he is unable to reply to your question, or if the coughing becomes ineffective and he shows other signs of poor air exchange (page 18), you must proceed with abdominal thrusts. Perform the Heimlich on the conscious victim before activating EMS.

The obstructed victim may be either sitting or standing. If he is standing, the rescuer stands with one foot beside and the other foot behind the victim. This braces you to support the victim and positions you for performing abdominal thrusts.



Wrap your arms around the victim's waist. Make a fist, place the thumb side of your fist against the victim's abdomen, slightly above the navel and below the xiphoid. Grasp your fist with the other hand. Press your fist into the victim's abdomen with a quick inward and upward thrust. Each individual thrust has the potential of relieving the obstruction. The chance of rib damage or internal injury can be minimized by careful hand placement.

When you perform manual thrusts, the chair back or your body must support the victim. The action is with the hands; the arms do not press on the ribs. If the obstruction is not removed after 5 thrusts, reassess your hand position and repeat the thrusts until the obstruction is cleared or the victim becomes unconscious from the lack of oxygen.

VICTIM WITH OBSTRUCTED AIRWAY BECOMES UNCONSCIOUS

If the victim becomes unconscious, slide him down your leg onto the floor, and call for help. Activate the EMS system.

Position the victim on his back. Position changes combined with muscle relaxation, may have dislodged the obstruction. Use the tongue/jaw lift to open the mouth and the finger sweep for adults to try to remove the object from the airway. Open the airway and attempt to ventilate. If the airway is still obstructed use the Heimlich maneuver, foreign body check and breathing attempt steps which you learned earlier for the unconscious, obstructed victim. (See page 28).

If you are the victim and alone, perform the maneuver on yourself. Press your fist into your upper abdomen as in conscious victim or lean forward and press your abdomen quickly over any firm object.

Caution: Do not thrust with force in practice.

INFANTS AND CHILDREN

The "Basic Life Support Overview" (pages 10 - 19) explains the CPR steps common to all ages. This section presents the specifics for infants and children. Infant procedures are used until approximately one year of age and child from one to about eight years of age. *Italics will clearly indicate where child procedures differ from the infant sequence.*

Infants and children are subject to accidents which may be lessened or prevented by thoughtful planning. Automobile related injuries are a major cause of death in children. The Family Safety Action Survey on pages 54 - 56 presents accident prevention suggestions on automobile safety and other areas such as burns, drowning, poisonous substances, and choking.

Airway management and breathing problems are major concerns with infants and children. Respiratory problems are far more likely to occur initially than cardiac problems at this age. Rapid recognition and intervention before cardiac arrest is very important. Any child who is struggling to breathe should receive life support assistance as rapidly as possible.

ONE RESCUER CPR - INFANT AND CHILD

AIRWAY "A"

Assess consciousness by gently tapping the shoulder, then call loudly for help. The loud noise will startle a conscious infant. *A child may respond to your asking, "Are you OK?"* If someone is available send him to activate EMS. If you are alone do one minute of CPR before calling 911.

If the victim is unresponsive, he must be placed on his back on a firm, hard surface. If a fall, for example from a crib, high chair, tree, or bicycle may have caused neck injury it is essential to prevent movement of the head and neck when positioning the victim. The infant should be moved as a unit supporting the back of his head with your hand and his neck and back on your wrist and forearm. His legs will straddle your elbow. With the baby in this position you can also move to a phone to activate EMS while starting CPR. *Position a larger child as you would an adult.*

Children are not simply little adults. The infant has a very small flexible airway, and his head is large in proportion to the rest of his body. The head-tilt/chin-lift is used to open the airway. The head is tilted back by pressing gently on the forehead with the palm of your hand which is closer to the head. The finger tips of the other hand are placed only on the bony part of the jaw near the chin and are used to lift upward (Adult illustration page 13). Be careful not to completely close the mouth or press on the soft area under the chin. Unless neck injury is suspected tilt the baby's head so the center back of the head is on the same surface (plane) as his back, as if he is sleeping on his back. *Children may require a slight backward tilt.* **Do not hyperextend as this may actually pinch off the airway.**

BREATHING "B"

First determine if the victim is breathing. Place your ear near his mouth; face the chest. Remember, you must maintain the open airway as you look, listen and feel for signs of breathing and continue to maintain it, if you have to breathe for him. If breathing is present continue to monitor an unconscious victim and activate EMS.

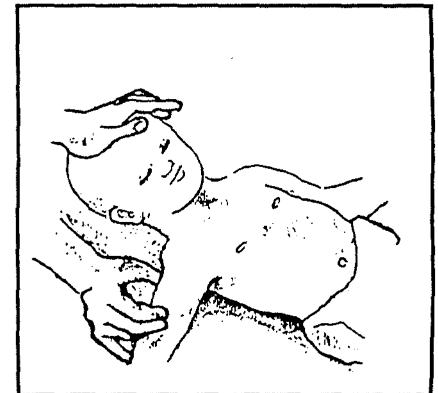
If the victim is breathless you will give two slow breaths (1 - 1.5 seconds/inspiration). Make a seal by opening your mouth just enough to cover both the mouth and nose to breathe an infant. *In children, seal only the mouth with yours and pinch the nose.* Inflate the lungs slowly. An infant's or child's airway is much smaller than an adult's; blow hard enough to overcome the resistance. **The volume of your breath should be adjusted to the size of the victim. Watch for a normal chest rise with each breath and allow the chest to fall as the infant or the child exhales between breaths.** Review pages 14 - 15 of the Overview for a discussion of breathing and possible airway obstruction.

The problem of gastric distention can be reduced by maintaining an open airway and adjusting the volume of your slow breaths for the small lung size of the infant or child.

CIRCULATION "C"

After two successful slow ventilations, you are ready to check the pulse. The carotid pulse which is checked in children and adults is very difficult to find on an infant's short, fat neck. The brachial pulse in the upper arm is recommended for infants.

The brachial artery is found in the groove between the two muscles on the side of the upper arm that touches the body. Gently pull the arm away from the body and turn it palm up. Place your thumb on the outside of the arm just above the elbow and your first two fingers on the inside and press gently to feel the pulse.

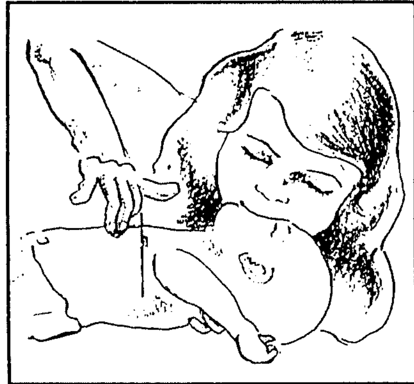


While assessing the pulse, maintain the open airway with your hand on the forehead in case the baby should be able to breathe spontaneously. ***Circulation "C"*** *(page 22) describes how to find the carotid pulse in a child.*

If you find that the pulse is present, remember you should breathe once every 3

seconds (20 times per minute) as long as necessary. Monitor the pulse until you gain EMS access.

If pulse is absent you must begin circulating blood artificially with chest compressions. It is difficult to find the pulse in infants and children. If you are uncertain of a pulse, it is better to begin chest compressions than to omit them when respiratory arrest is present. You know that a victim must be on a firm surface for compressions to be effective. When you opened the airway to the neutral, sleeping position the infant may have assumed a "sniffing" position. The head would be extended opening the airway, but the shoulders would still be supported by the firm surface. (If someone were to hold a rose up for you to smell, the natural reaction is to stick your nose out to sniff the flower - thus "sniffing" position.) In some infants the head-tilt lifts the shoulders. You may then provide a firm surface for compressions and maintain the open airway by using the hand which has been on the forehead to slip under the baby's shoulders.



The proper position for infant chest compressions is on the midline of the chest, slightly below the nipples on the lower third of the sternum. Imagine a line connecting the nipples. Measure one finger width from this line toward the feet and place the tips of two or three fingers on the sternum. *The compression position for children is found by running the fingers of your hand (the hand not maintaining the head-tilt) along the rib cage until your middle finger fits into the notch where the ribs and sternum meet. Place your index finger beside it on the lower end of the sternum. Visually mark your finger position on the sternum. Pick up your hand and place the heel of that hand along the sternum next to your "visualized" finger location. Be sure you do not press on the xiphoid.*

The chest of an infant or child is smaller and more flexible than an adult, so much less pressure is required. Compression and release time are equal. Press straight down, not to the side, to a depth of 0.5 - 1 inch for infants *or 1 - 1.5 inches for children.* When pressure is released allow the chest to expand fully. Keep your fingers, *or the heel of your hand for children,* in contact with the sternum to maintain proper position. *The compression rate for children is 100 per minute* and at **least** 100 per minute for infants and both may be counted one, two, three, four, five.

You know how to move a baby as a unit supporting his head and back with your hand and forearm. If you need to carry an infant while performing CPR, your arm provides the firm surface for compressions. **It is essential that you keep your arm positioned so the baby's head is not above his feet.** When possible put the infant on a firm stationary surface.

COMPRESSION/VENTILATION CYCLES

A breath is delivered after each five compressions (5:1 ratio). When you complete the fifth compression, pause to deliver a slow breath. Watch for a normal chest rise.

To achieve a rate of *100 compressions per minute for children* and at least 100 compressions per minute for infants, you will need to do 5 compressions in about 3 seconds. The breath requires 1 - 1.5 seconds inspiration time for both infants and children. Repeat the cycles in rapid sequence.

It may be necessary to use both hands to open the child's airway. It is very important to observe the position of your hand on the child's chest when you have properly located the landmark. There is insufficient time to relocate the landmark each time when administering CPR to a child, with a ratio of 5:1. After the slow breath, return your hand to the visualized area to resume compressions.

REASSESSMENT

After you have completed about 1 minute of compressions and ventilations, or 20 cycles which may take somewhat longer than 1 minute, stop for 5 seconds to recheck the pulse. **If EMS has not been activated, call 911 now.** If pulse is present, open the airway and check breathing. Rescue breathe, if indicated, and monitor. If you must leave, turn an unconscious victim to his side unless neck or back injury is suspected.

CONTINUE CPR

If pulse is absent, resume 5:1 cycles of compressions and ventilations. Repeat the pulse check every few minutes, continuing CPR as indicated.

OBSTRUCTED AIRWAY: UNCONSCIOUS INFANT OR CHILD

Before continuing, please review the obstructed airway material on pages 17 - 18.

AIRWAY/ASSESSMENT

You have come upon a victim who appears to be unconscious. You will begin by assessing unresponsiveness. If he is unconscious, yell for help; as soon as help is available access EMS. Properly position him and open the airway, then look, listen and feel for signs of breathing. Perform this airway step and breathing assessment just as you learned in infant and child CPR, pages 30 - 31.

ATTEMPT BREATHING

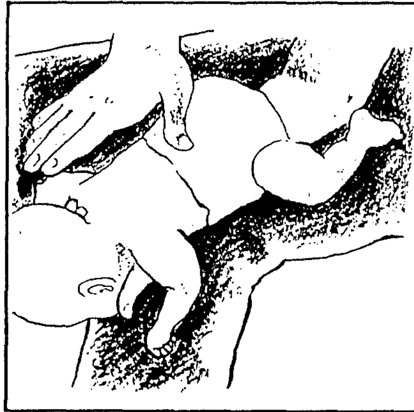
If you found that the victim is breathless, you must begin rescue breathing. Remember, unless you maintain an open airway, the victim cannot breathe spontaneously nor can you breathe for him.

Seal the mouth and nose as appropriate for the age of the victim. Ventilate slowly. If you feel a resistance to your breath and the victim's chest does not rise, you may assume an obstruction. It is necessary to determine if your inability to ventilate is caused by an improperly opened airway. Reposition the head, tightly seal the mouth and nose, and breathe again. If this attempt is successful, go to Circulation "**C**" step of Infant and Child CPR; assess pulse and continue as indicated.

BACK BLOWS AND MANUAL THRUSTS

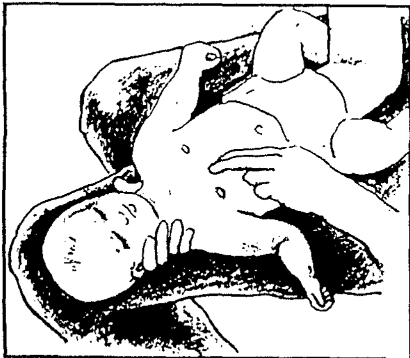
If repositioning did not provide an open airway, you may assume a foreign body is causing the obstruction. A combination of back blows and chest thrusts is used for infants and *abdominal thrusts are used for children.*

To deliver back blows, place the infant face down on your forearm, legs straddling your elbow; head and neck support are provided by resting the infant's chin in the curve between your thumb and index finger. The victim's head should be lower than the chest but should not be straight down. You can gain additional stability by resting your arm against your bent leg. **Use the heel of your hand to deliver up to five forceful blows to the infant's back between the shoulder blades.**



Head and neck support must be maintained while positioning the infant on his back for chest thrusts. Place the hand which you just used for back blows behind the infant's head and neck, with your wrist and arm extending down the back. Turn the victim and rest your arm on your thigh with the infant slightly head down.

Abdominal thrusts are not recommended for infants. **Use two or three fingers on the lower third of the sternum to apply up to five quick chest thrusts.** These are similar to chest compressions but are at the rate of approximately one per second. *The "Heimlich Maneuver" is used for children as well as adults. However, the thrusts in small children are done with less force than on adults. Refer to page 28 for this technique.*



FOREIGN BODY CHECK

Grasp the infant's or child's lower jaw placing your thumb over the tongue and your fingers around the outside of the jaw. Lift the jaw away from the back of the throat while depressing the tongue with your thumb. If you are able to see a foreign object, remove it. **Do not sweep the mouth unless an object is visible, since the object may easily be pushed deeper in the airway.**

BREATHING ATTEMPT

The obstruction may have been dislodged, even if you did not visualize and manually remove it. Try again to ventilate, open the airway, seal the mouth and nose with your mouth and blow slowly. *For children, seal the mouth and pinch the nose.* If ventilation is unsuccessful, reposition the head; try again. If you are unable to produce a chest rise, repeat the appropriate maneuvers to relieve the obstruction. If you are still alone after several times through the series of steps (about one minute), stop long enough to access EMS. Continue your efforts to relieve the obstruction. When you are able to ventilate, check the pulse and proceed as indicated; the top of page 29 reviews the possibilities.

OBSTRUCTED AIRWAY - CONSCIOUS INFANT OR CHILD

It is especially important with infants and children to be aware of the probable cause of airway obstruction. Two conditions should exist before manual thrusts are used on a conscious victim. You should actually see him become obstructed from food or a foreign object or find him in a situation where it is apparent, for example a toddler playing with a toy with small pieces. You must also have evidence of poor air exchange such as an ineffective cough and increasing difficulty breathing.

If the victim has an illness such as croup, an obstruction may occur because of swelling in the airway. You must immediately access EMS; use of the obstructed airway procedure would be ineffective and cause loss of valuable time.

ASSESSMENT

Since an infant cannot indicate that he is obstructed, the rescuer must determine it by observing the baby's ability to breathe. Remember signs of poor air exchange include an ineffective cough, high pitched crowing sounds, increasing breathing difficulty and blueness around the lips. *When a child is old enough to respond ask, "Are you choking?"*

BACK BLOWS AND MANUAL THRUSTS

If the infant or child is in respiratory distress and a foreign body is suspected, you must quickly try to relieve the obstruction. For infants up to five back blows are delivered between the shoulder blades. If the baby is still obstructed, turn him over and deliver up to five chest thrusts. Each should have the potential of relieving the obstruction. These maneuvers use the same techniques you learned on the preceding page for unconscious obstruction.

If the victim is a child and he is standing or sitting, abdominal thrusts are performed with the rescuer standing behind the victim. The Heimlich maneuver is the same as adult; see page 29 for the details. Use an amount of pressure appropriate to the child's size. If the victim is lying down abdominal thrusts are the same for the conscious and unconscious child.

Alternate the series of back blows and chest thrusts until the airway is cleared or the infant becomes unconscious. *If the victim is a child repeat the series of five abdominal thrusts; be sure your hand positon is correct each time.*

OBSTUCTED AIRWAY - VICTIM BECOMES UNCONSCIOUS

The victim is now unconscious. Yell for help; send the responder to activate the EMS system. If you are alone after several times through the series of steps (about one minute), access EMS.

FOREIGN BODY CHECK

Even if the obstruction has not been expelled from the victim's mouth, it may be in a position where you can see and remove it. Use the tongue/jaw lift as you did earlier for an unconscious choking infant or child. **If you can see a foreign object, remove it with your fingers. Do not blindly sweep the mouth.**

BREATHING ATTEMPT

Open the airway, seal the mouth and nose and attempt to ventilate. If unsuccessful, reposition and try again. If you are unable to get a chest rise, the victim is still obstructed.

Review from Back Blows through Breathing Attempt on pages 33 - 34 and repeat these steps until the airway is cleared. After a successful ventilation, check the pulse and proceed on the basis of your assessment. You may need to maintain an airway and monitor, or rescue breathe, or do chest compressions and ventilations.

PROFESSIONAL RESCUERS

TWO RESCUER CPR

Two rescuer CPR is taught primarily to professionals associated with health care and emergency services. Since it is rare that two lay rescuers are on the scene together, perfection of their single rescuer skills is generally more important. This sequence is written for an adult victim with two professionals arriving together when CPR is not in progress. It presumes mastery of basic CPR skills. If additional medical help is needed, the second rescuer should call before he begins compressions.

Rescuer "**A**," positioned at the victim's head, will be responsible for airway, breathing and monitoring. The other rescuer, "**B**," kneeling by the chest, will do compressions. Rescuers work best on opposite sides of the victim, but two-person CPR is possible on the same side.

Rescuer "**A**" will assess unresponsiveness, position the victim and open the airway using the appropriate method. He will then assess breathing and if indicated, continue by ventilating twice slowly (1.5 - 2 seconds/inspiration). He should observe the chest rise and allow exhalation between breaths. Use of a mask is recommended, see page 38.

While "**A**" checks for a pulse, "**B**" locates his landmark to begin chest compressions. If a pulse is not found rescuer "**B**" performs five compressions at a rate of 80 - 100 per minute. He should pause after the fifth compression for "**A**" to give one slow breath (1.5 - 2 seconds/inspiration). Counting "one and two and three and four and five and breathe" will help the compressor maintain a smooth, equal rhythm and allow a pause for "**A**" to ventilate. Ten cycles of five compressions and one ventilation should take 40-53 seconds. After about one minute, stop compressions for 5 seconds to check for a spontaneous pulse.

It is also important for the ventilator to maintain an open airway and to check frequently for a pulse to assure that compressions are adequate. It may be necessary to tell the compressor to check his hand position or to press harder, if the pulse is not felt with each compression.

When the compressor becomes tired, he indicates a desire to change. The switch should be made as quickly as possible. It is convenient to change at the end of a cycle and to check for return of spontaneous pulse before continuing CPR. If indicated compressions and ventilations are resumed. Remember to stop every few minutes to check the pulse. If the victim is an infant or child, adjust ventilation times and compression rates as appropriate.

Rescuers will continue CPR as they move the victim, pausing only if essential for such things as stairs, movement in and out of the vehicle and intubation.

DIVISION OF RESPONSIBILITY

Rescuer "A"	Rescuer "B"
Determine Unresponsiveness Position victim Open airway Determine breathlessness	Call for assistance, if needed
Give 2 slow breaths Determine pulselessness	Position self at chest Locate landmark
Maintain airway Monitor pulse for compression effectiveness Give slow breath	Begin chest compressions Proper rate and a 5:1 ratio Pause for breath after 5th compression
After 1 min check for spontaneous pulse	Call for switch when tired
Rescuers switch as quickly as possible. Check spontaneous pulse at switch and/or every few minutes.	

Two professional rescuers may easily relieve a lay rescuer at the end of any 15:2 cycle. They assume the roles of rescuers "**A**" and "**B**," check pulse and continue CPR. If two professionals do not begin together, the second one may begin compressions at the end of any cycle.

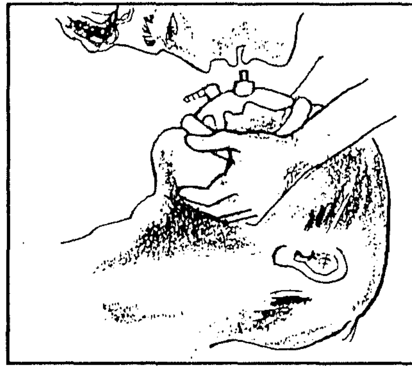
OTHER PROFESSIONAL RESCUE SKILLS

JAW THRUST WITH HEAD-TILT

If the head-tilt/chin-lift does not open the airway, the jaw thrust will provide additional forward movement of the jaw. It is also the method used when applying a mask. If two rescuers are present, one is usually at the top of the head and the other at the chest. The rescuer opening the airway places one hand on each side of the head. The fingers grasp below the angle of the lower jaw just in front of the ear lobe. The base of the thumb rests on the cheek bone. With elbows resting on the same surface as the victim, lift the jaw forward and tilt the head back. The lips can be opened with the ends of the thumbs, if necessary to ventilate. The victim's nose is sealed with your cheek as you breathe.

If the rescuer is alone, the jaw thrust can also be performed from the side of the victim. The rescuer can then provide breathing and compressions. This is illustrated without head-tilt in the Special Situations section.

MOUTH-TO-MASK VENTILATION

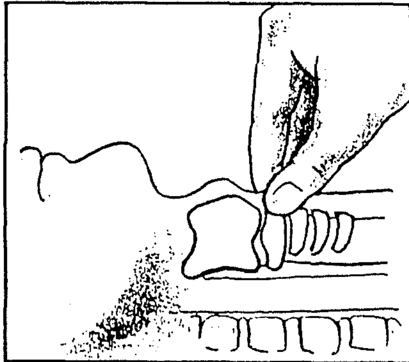


When two professional rescuers are providing CPR, the ventilator may use mouth-to-mask ventilation instead of mouth-to-mouth. A mask makes oxygen administration possible. As it avoids direct mouth-to-mouth contact with the victim, it may be aesthetically more pleasing and may decrease communication of disease.

The mask should be transparent; you must be sure the mouth remains open under the mask. It should also be equipped with a one way breathing valve and a fitting for administration of oxygen.

The mask is placed over the victim's mouth and nose with the lower edge under the lip and above the chin. The thumbs on either side of the mask press it to the face as the fingers lift up on the jaw and tilt the head to open the airway. You must maintain a tight seal between the mask and the victim's face to prevent air leakage around the mask when you blow through the inhalation port. Training is essential to proper mask use. Face shields are also available but obtaining a tight seal may be difficult.

CRICOID PRESSURE



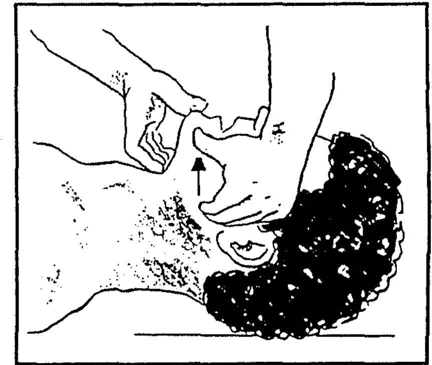
Pressure is applied on the esophagus by applying external pressure on the cricoid cartilage. The technique should be used only by trained health care professionals. Locate the Adam's apple, place your thumb and index finger on the ridge just below the Adam's apple and press down gently. The windpipe is protected by the ring of cricoid cartilage and the pressure is transferred back to the esophagus. This reduces problems of gastric distention and regurgitation during both ventilation and intubation. Care should be taken not to press below the cricoid cartilage as this lower area is unstable, and you may obstruct the trachea (windpipe).

Special Situations

The material covered in this section deals with special conditions and would not be necessary in many rescue situations.

SUSPECTED NECK INJURY

In accident cases, if there is a possibility of a neck fracture, caution must be used when positioning the victim and opening the airway. Neck injury should be suspected in near drowning or automobile accidents, especially if the victim has facial cuts and



bruises. In this case, all possible movement should be avoided. Your first approach to opening the airway should be the jaw thrust without head-tilt. The fingers are placed behind the angle of the lower jaw to displace it forward without tilting the head back or moving it to either side. This allows the head to be stabilized in a neutral position without extending the neck. Your thumbs hold the mouth open and the nose is sealed with your cheek as you breathe. If this is unsuccessful, the head should be tilted back very slightly, and another attempt made to ventilate. The airway may also be opened with chin-lift without head-tilt though the head is not as stable as when held between the hands. If there are two rescuers, the ventilator may be positioned at the top of the victim's head so his elbows can rest on the working surface for even greater stability.

RESCUE BREATHING — MOUTH-TO-NOSE METHOD

Mouth-to-nose ventilation may be used instead of mouth-to-mouth when there is extensive mouth injury, it is difficult to get a good seal, the mouth cannot be opened, or the rescuer simply prefers it.

When performing mouth-to-nose ventilations, one hand is left on the forehead to maintain the airway with the head-tilt. The other hand lifts the lower jaw to close the mouth. The thumb can be used to seal the lips. The rescuer takes a deep breath, seals his mouth around the victim's nose and breathes slowly while watching for a chest rise. He removes his mouth and watches the chest fall when the victim exhales. Open the victim's lips or mouth to allow the air to escape during exhalation because the soft palate may block the nasal passage.

MOUTH TO STOMA VENTILATION

If the victim has had his voice box removed (laryngectomy) he breathes through an opening (stoma) which connects the airway to the skin at the front of the neck just above the notch in the collarbone. This small opening may be hidden by a scarf or high neck shirt, but it can easily be detected by running your finger inside the neckline. The rescuer breathes directly through the stoma. Exhalation occurs when the rescuer removes his mouth to breathe.

AIRWAY MANEUVERS

The Heimlich maneuver is as safe and effective as any other single method of relieving airway obstruction and is easy to learn. However, the chest thrust is still suggested in cases of advanced pregnancy or gross obesity.

If a conscious victim is standing, stand behind him to perform chest thrusts. Slide your arms just under his armpits and around the chest. Place the thumb side of your fist on the middle of the sternum. Grasp it with the other hand and press with quick backward thrusts. If the victim is down, place him on his back. Your body and hand positions for chest thrusts are the same as for chest compressions. Deliver each thrust

slowly and distinctly instead of rapidly like chest compressions.

PREGNANCY

In pregnant women the increased weight of the uterus may reduce blood flow during CPR. Circulation can be improved by placing a pillow under the right hip or by a second person shifting the uterine weight to the left.

ELECTRIC SHOCK

Electric shock, including lightning, may disrupt heart rhythm. The shock may also affect the respiratory control center of the brain or may produce prolonged muscular contractions or paralysis of the muscles of respiration. This inability to breathe prevents air exchange leading to oxygen depletion and cardiac arrest.

The rescuer should exert great care not to touch a victim still in contact with an electrical source as he may also be shocked. Be careful when you are told, "The power is off." Did the person really know how to disconnect the power? After properly clearing a victim from an energized object, begin to assess his status immediately. If spontaneous respiration or circulation is absent, the techniques of cardiopulmonary resuscitation should be initiated. Injuries from a fall or burns may occur with a shock and must be considered when you start CPR. Use appropriate positioning and airway procedures. If help is available, remove clothing which shows signs of burning.

NEAR DROWNING

The rescuer should reach the victim as quickly as possible, preferably with the assistance of some flotation device. **The rescuer must exercise care to protect his own life when assisting a near drowning victim.**

Rescue breathing should be started as soon as possible. It may be performed when the rescuer can stand in shallow water or with flotation for support in deep water. You must be able to support the face above water. Do not be concerned about draining water from the lungs.

Suspect neck injury in a diving accident. Open the airway using the jaw thrust or chin-lift without extending the neck. Float the victim onto a back support, carefully moving him as a unit, to remove him from the water.

If you believe a foreign object is blocking the airway or if rescue breathing is unsuccessful, perform the Heimlich maneuver with the victim on his back and his head turned to the side.

The pulse of a near drowning victim may be difficult to find because of slowdown of body functions. If a pulse is not found, begin chest compressions.

Victims of cold water drowning have been successfully resuscitated after relatively long periods of submersion; give them a chance by initiating CPR. Every submersion victim should be promptly transported to an advanced life support facility.

HYPOTHERMIA

Exposure to extreme cold air or near drowning in cold water are examples where hypothermia may affect resuscitation. Prolonged exposure to cold causes a depression of cardiac functions and of oxygen needs. It may be necessary to allow as much

1. b 2. d 3. d 4. d 5. a 6. c 7. c 8. a 9. b 10. b 11. d

as 45 seconds to assess pulse. Access EMS rapidly and CPR should be performed as assessments indicate. Remove wet clothing; insulate the victim in blankets, apply warmth to the neck, arm pits, and groin and administer warm moist oxygen to help prevent heat loss during transport.

TRAUMATIC INJURY

Transport to a trauma center is of the utmost importance. If a victim is pinned in a car, do not try to move him without professional help unless he is in additional danger. Direct manual pressure may be applied over a wound to control severe bleeding. If CPR is required, all precautions must be taken to protect the cervical spine.

COMMUNICABLE DISEASES

Since CPR requires close contact with training manikins and with individuals, transmission of communicable diseases must be considered. Tuberculosis, hepatitis B, HIV, and herpes simplex are diseases of concern to the rescuer.

While there is no record of transmission of these diseases through manikin practice, it is still important to take precautions. These include: instructor cleaning of manikins after a class according to the manufacturer's directions, vigorously wiping the manikin's face for at least 30 seconds with bleach or alcohol after use by each student, possible use of a face shield for each student, simulation of the finger sweep in obstructed airway practice and simulation of breaths by the second rescuer in two-person rescue training. If you have a cold, sore throat, cold sore or a similar infection, postpone training until you recover.

Performance of CPR should not endanger the life of the rescuer. A lay rescuer will most likely perform CPR in the home environment. Professional rescuers should be trained in the use of, and use protective equipment such as masks and gloves.

BLS Performance Sheet

Adult FBAO Management: Conscious

Name ______________________ Date ______________

Step	Objective	Critical Performance	S	U
1. Assessment	Determine airway obstruction.	Ask "Are you choking?"		
		Determine if victim can cough or speak.		
2. Heimlich Maneuver	Perform abdominal thrusts.	Stand behind the victim.		
		Wrap arms around victim's waist.		
		Make a fist with one hand and place the thumb side against victim's abdomen in the midline slightly above the navel and well below the tip of the xiphoid.		
		Grasp fist with the other hand.		
		Press into the victim's abdomen with quick upward thrusts.		
		Each thrust should be distinct and delivered with the intent of relieving the airway obstruction.		
		Repeat thrusts until either the foreign body is expelled or the victim becomes unconscious (see below).		

Victim with Obstructed Airway Becomes Unconscious (Optional Testing Sequence)

Step	Objective	Critical Performance	S	U
3. Positioning	Position the victim.	Turn on back as unit.		
		Place face up, arms by side.		
	Call for help.	Call out "Help!" or, if others respond, activate EMS system.		
4. Foreign Body Check	Perform finger sweep.*	Keep victim's face up.		
		Use tongue–jaw lift to open mouth.		
		Sweep deeply into mouth to remove foreign body.		
5. Breathing Attempt	Ventilate.	Open airway with head-tilt/chin-lift.		
		Seal mouth and nose properly.		
		Attempt to ventilate.		
6. Heimlich Maneuver	(Airway is obstructed.) Perform abdominal thrusts.	Straddle victim's thighs.		
		Place heel of one hand against victim's abdomen, in the midline slightly above the navel and well below the tip of the xiphoid.		
		Place second hand directly on top of first hand.		
		Press into the abdomen with quick upward thrusts.		
		Perform 6–10 abdominal thrusts.		
7. Foreign Body Check	(Airway remains obstructed.) Perform finger sweep.*	Keep victim's face up.		
		Use tongue–jaw lift to open mouth.		
		Sweep deeply into mouth to remove foreign body.		
8. Breathing Attempt	Ventilate.	Open airway with head-tilt/chin-lift.		
		Seal mouth and nose properly.		
		Attempt to ventilate.		
9. Sequencing	(Airway remains obstructed.) Repeat sequence.	Repeat Steps 6–8 until successful.†		

* During practice and testing, simulate finger sweeps.

† After airway obstruction is cleared, ventilate twice and proceed with CPR as indicated.

Instructor ______________________ Check: Satisfactory ______ Unsatisfactory ______

BLS Performance Sheet

Adult FBAO Management: Unconscious

Name ______________________________ Date ______________

Step	Objective	Critical Performance	S	U
1. Assessment	Determine unresponsiveness.	Tap or gently shake shoulder. Shout "Are you OK?"		
	Call for help.	Call out "Help!"		
	Position the victim.	Turn on back as unit, if necessary, supporting head and neck (4–10 sec).		
	Open the airway.	Use head-tilt/chin-lift maneuver.		
	Determine breathlessness.	Maintain open airway.		
		Ear over mouth, observe chest: look, listen, feel for breathing (3–5 sec).		
2. Breathing Attempt	Ventilate.	Maintain open airway.		
		Seal mouth and nose properly.		
		Attempt to ventilate.		
	(Airway is obstructed.) Ventilate.	Reposition victim's head.		
		Seal mouth and nose properly.		
		Reattempt to ventilate.		
	(Airway remains obstructed.) Activate EMS system.	If someone responded to call for help, send him/her to activate EMS system.		
3. Heimlich Maneuver	Perform abdominal thrusts.	Straddle victim's thighs.		
		Place heel of one hand against victim's abdomen in the midline slightly above the navel and well below the tip of the xiphoid.		
		Place second hand directly on top of first hand.		
		Press into the abdomen with quick upward thrusts.		
		Each thrust should be distinct and delivered with the intent of relieving the airway obstruction.		
		Perform 6–10 abdominal thrusts.		
4. Foreign Body Check	Perform finger sweep.*	Keep victim's face up.		
		Use tongue–jaw lift to open mouth.		
		Sweep deeply into mouth to remove foreign body.		
5. Breathing Attempt	Ventilate.	Open airway with head-tilt/chin-lift maneuver.		
		Seal mouth and nose properly.		
		Reattempt to ventilate.		
6. Sequencing	Repeat sequence.	Repeat Steps 3–5 until successful.†		

* During practice and testing simulate finger sweeps.

† After airway obstruction is cleared, ventilate twice and proceed with CPR as indicated.

Instructor ______________________________ Check: Satisfactory ______ Unsatisfactory ______

Augusta Mental Health Institute
Minutes of:
Medical Executive Committee Meeting
Wednesday, June 26, 1996

MEMBERS PRESENT (x):	x Jose Castellanos, MD x Roger Wilson, MD Gerald Veregge, MD	x Ulrich Jacobsohn, MD x George Davis, MD x Douglas Gowler, MD	x Manuel Hermida, MD x John Szala, D.O.
AFFILIATES PRESENT (x):	x Lorraine Spiller, PA	x Julie Barrett, PA	
GUESTS PRESENT (x):	x John Arness, MD x Brian Gottlieb, MD x Don Weston, MD x Bill Lajousky, Admin Asst. to Dr. Clark x Roger Coleman	Jason Kirkpatrick, MD Boris Konnikow, MD x Linda Clark (Recorder)	Robert Spitzer, MD x Milton Hirshberg, MD x Rod Bouffard, Supt. x Richard Michaud

MINUTES: Minutes of 06/19/96 and 06/21/96 were reviewed and accepted as presented.

ANNOUNCEMENTS AND F.Y.I.:

DR. JOEL D'BOSKIN There will be a 2-day consult on safety and security next Tuesday and Wednesday. It will be in the form of an assessment of AMHI's current safety and security.

ISSUE	DISCUSSION	RECOMMENDATIONS / ACTION	RESPONSIBLE PERSON
SAFETY AND QUALITY OF CARE:	Despite a formidable agenda, the President of the Medical Staff recommended that the issues of safety and quality of care be dealt with firmly, and that resolution be made on the motion of 02/08 (tabled on 03/06 pending Ms. Peet's visit.) A lively discussion ensued, highlights are as follows: It is questioned whether the medical staff can deliver the quality of care that will ensure the safety of our patients - that question must be answered by this body.		
	Mr. Bouffard indicated that staffing issues have been addressed by Dr. Lowell and Kathy in response to acuity and the higher number of admissions. Dr. Clark was to assess the adequacy of physician staffing. Dr. Davis indicated that it's not just the number of staff, but several issues combined: • morale (a healthy staff is better at healing) • who's in charge? • permanence / security of jobs • number of permanent psychiatrists • Consent Decree issues - rumored that a medical physician will be cut	Recommended that staffing levels be reported to Medical Executive Committee on a regular basis.	

ISSUE	DISCUSSION	RECOMMENDATIONS / ACTION	RESPONS. PERSON
SAFETY AND QUALITY OF CARE (continued):	Mr. Bouffard responded that a number of actions have been initiated to raise morale and provide quality of care:	• 60 positions will be moving to the community; • Ricki Celentano has been on contract to work with staff • Bill Doughty has been brought in to work with displaced staff, providing training, writing resumes, finding alternate employment in the state system, etc.; • other suggestions are welcome; • the future of AMHI should be determined by the Task Force by October 1; • unit staffing is currently higher than the Consent Decree requires - AMHI is being staffed for acuity (at least nurses & MHWs) ; • if a physician position is being targeted for elimination, and if it is felt that that cut is dangerous, the position can be manipulated and perhaps saved; • there's a meeting tomorrow around the issue of recruitment of permanent physicians (first order of business is to recruit a full-time Medical Director.)	
	Motion of 02/28/96 was read, as was the tabling motion of 03/06/96.		
	Continued discussion on the size and lack of permanence of the psychiatric staff. Several comments made such as: • minimum size staff needed, whether a 30- or a 100-bed hospital to cover vacations and stats calls (need "depth on the bench") ; • political decisions are being made far distant from clinical wisdom and with disregard for clinical input; • the quality of care rendered depends on the adequacy of the medical staff;	Suggestion made that medical staff's perception of danger be put into the hands of administration daily, hourly, if necessary. Suggestion made by a *locum tenens* physician that *locum tenens* physicians be given a voice and allowed to vote in Medical Executive Committee meetings.	
	• we are in danger of having a catastrophe; • we are not covered as we need to be; • we are not practicing psychiatry - we are being deprived of our integrity by the administration . . . and by the patient advocates; • new policies and procedures are taking away the ability to exercise clinical judgment; • everytime something else happens, more rules and paperwork result; • treatment teams are demoralized, they have no control over the care of the patient; • physician licenses to practice are on the line;	Suggested by Mr. Bouffard that someone from Medical Executive Committee work ***with*** administration, instead of making this a media event. The President of the Medical Staff proclaimed that Dr. Wilson, as acting Medical Director will be given a voice and vote in this meeting.	
	• high overtime and frequent double shifts have an effect on quality of care offered • staffing ratios are based on a model, not based on real patients' needs.	Suggested that Mr. Bouffard present overtime data at a future meeting.	Rod Bouffard

ISSUE	DISCUSSION	RECOMMENDATIONS / ACTION	RESPONS. PERSON
SAFETY AND QUALITY OF CARE (continued):		Suggested that the 02/28 motion be removed and a new motion was offered . . . "The clinical staff has determined that the quality of care has deteriorated to the point where this body is submitting this issue to administration with the responsibility to make it right . . ."	
	Countered that quality of care is the responsibility of ***this body***, and that ***this body*** will be held accountable. Lively discussion ensued regarding whether our patients ***are*** or ***are not*** safe today. • Dr. Jacobsohn gave a historical overview of previous attempts to alert administration to the medical staff's predictions of danger, and how the warnings went unheeded . . . (1986 letter...1988 catastrophe; Feb. 1996 verbal warning...April 6 murder) • Noted that Commissioner Peet doesn't understand (or apparently care to hear) these concerns - as evidenced by her repeated failure to appear here, failure to attend Governing Body meetings, etc. • " . . . I've never seen it this bad in 38 years at AMHI." • Reported that the Maine State Board of Medicine has expressed its concern regarding the high use of *locum tenens* psychiatrists all over the state (not just at AMHI.)	Committee appointed today of Dr. Wilson, Dr. Szala, Dr. Davis and Dr. Jacobsohn. This committee will write a letter stating the concerns of the medical staff to the Commissioner (and to the Governor). A draft will be presented here next week.	Dr. Wilson Dr. Szala Dr. Davis Dr. Jacobsohn

José Castellanos MD

Jose Castellanos, MD, President of the Medical Staff

Position count at Augusta Mental Health Institute, 1995-97

PL 368, page 466,467	Part I Budget position count		4 general fund 550 other revenue

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PL 368	Part I Budget pages 556, 567	-225
PL 395	Supplemental Budget page 680	+11
PL 395	Supplemental Budget pages 680, 681	- .5
PL 560	Productivity Realization Task Force bill pages 1435, 1436	-24
PL 665	Supplemental Budget page 1829	+31.5

Position count when delayed actions occur at AMHI during fiscal year 1996-97 — 342.5

KEY SURVEY NEW ENGLAND AREA PSYCHIATRIC HOSPITALS

NAME OF HOSPITAL	NEW ENGLAND STATE.	CAN EMPLOYEES TAKE KEYS HOME?	KEY SYSTEM ON A DATABASE?	NUMBER TO LINK KEYS TO EMPLOYEE?	LOST PASSKEYS PER YEAR	CHARGE FOR LOST KEYS?	NUMBER OF STAFF WORKING AT HOSPITAL	SECURITY FORCE
Acadia Hospital	Maine	Yes	Yes	No	None	Yes $10.00	100+	No
Augusta Mental Health Inst.	Maine	Yes	~~No~~ yes	Yes	3 to 4	No	450+	No
Bangor Mental Health Inst.	Maine	Yes	No	Partly	2	Yes $1.00	450+	No
Brattleboro Retreat	Vermont	Yes	Yes	No	6 to 7	No	600	Yes
Butler Hospital	Rhode Island	Yes	No	No	Unknown	Yes $2.00	800+	Yes
Jackson Brook Institute	Maine	Yes	No	No	15	Yes $15.00	400+	Unknown
McLean Hospital	Massachusetts	Yes	Yes	Yes	1 or 2	Yes $3.00	1,500	Yes
Vermont State Hospital	Vermont	Yes	No	No	Unknown	No	200+	No
Veterans Admin. Hospital	Maine	Yes	Yes	No	1 to 12	Unknown	1,100	Yes
Worcester State Hospital	Massachusetts	Yes	No	Yes	20 to 30	Yes $3.00	350+	Yes

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

July 8, 1996

Senator Joan Pendexter, Co-Chair
Representative Michael Fitzpatrick, Co-Chair
Members, Joint Standing Committee on Health and Human Services
115 State House Station
Augusta, ME 04333

Dear Senator Pendexter, Representative Fitzpatrick & Committee Members:

I am writing to advise that Dr. William McFarlane, Chief of Psychiatry at Maine Medical Center, has agreed to Chair the Clinical Review Panel looking at policy and practices at Augusta Mental Health Institute as they pertain to the operations of the hospital.

Should you have questions or require additional information, please feel free to contact me.

Sincerely,

Melodie J. Peet
Commissioner

MJP/ss

AMHI INVESTIGATION TEAM
Interview List

Melodie Peet

Wayne Douglas

Rod Bouffard

Don Williams

Gordon Clark, M.D.

Catherine Guibault

Walter Lowell

M. Hermida, M.D.

D. McFarland, R.N.

A. DuFresne, M.S.W.

L. Graves

D. Woods, R.N.

L. Randall, M.H.W.

L. Hunt, R.N.

C. Steen, S.W.

J. Whelan, Psy. D.

J. Whalen, Psych.

O. Buck, M.D.

R. Brandt, R.N.

P. Albert, Custodian

S. Poulin, L.P.N.

B. Coffin, R.N.

E. Potter, R.N.

J. Santulli, R.N.

J. Marks, M.H.W.

DISTRIBUTED 10/7/96

MANDATORY REPORTING PROTOCOL

Dept. of Human Svs / Adult & Children Emergency Svs.
624-8060 or 1-800-452-1999

Bureau of Mental Retardation
287-3861 or 287-3078
This is the Pineland Center switchboard. Ask that the Administrator on Call be contacted immediately and return your call. Indicate that this is a report of alleged patient abuse, neglect, exploitation, or injury.

Patient Injuries
Patient to Patient Incidents
Patient Sexual Behavior
Staff to Patient Incidents
Allegations of Abuse, Neglect, Exploitation

Patient to patient incidents (includes patient to patient sexual behavior) and staff to patient incidents, including allegations of physical/sexual abuse/neglect and exploitation, made by patients and/or observed by staff or patients must be taken at face value despite clinical/administrative judgments to the contrary and therefore be **reported immediately** to the Department of Human Services. Disclosures made by patients of incidents occurring in the community (prior to admission) are also reportable. Allegations or complaints of abuse, neglect or exploitation made by patients within grievances are to be reported to the Department of Human Services. All AMHI staff, including contract employees, are required to report according to the following protocol:

EXCEPTION: All injuries, UAL's, or AWOL's occurring with DHS wards shall be reported to DHS. For non-DHS patients, clearly unintentional injuries, UAL's, or AWOL's shall not be reported to DHS.

PROTOCOL: If a reportable event occurs, the first order of priority is to protect the alleged victim from further harm (real or imagined) and, secondly, to assure that the alleged perpetrator/aggressor is also protected or supervised to prevent exposing the ward population to further abuse and to assure proper treatment interventions are carried out. Once these items are carried out, the reporting process is then initiated.

Ward Nurse Responsibilities:

a. Assures appropriate care is given to the victim and to the alleged perpetrator.
b. Assures that verbal reports are made to the Department of Human Services, to the Physician, Assistant Director of Nursing or Director of Nursing. The verbal report shall include:
   (1) Name of the patient(s) involved

(2) Nature and extent of the alleged Abuse/Neglect/Exploitation or detail regarding the patient accident or patient to patient incident/staff to patient incident
(3) Names of witnesses or of people with additional information
(4) Action taken or to be taken in the care of the victim and alleged perpetrator

c. Assure that an incident report is completed and sent to Director of Nursing
d. Progress note written of the facts noting the time and, if appropriate, names of staff involved, and that verbal notification has been made to DHS. Be sure to include the names(s) of staff who may have taken photos of the patient's injury for the record. Consistent with AMHI policy, do not reference the existence of an incident report in the chart.

Reporting Process:

a. Report received by Ward Nurse (if unavailable, report to NOD or ADN or DON).
b. Prevent further abuse/neglect/exploitation and/or exposure to further injury.
c. Ward Nurse notifies: (See Ward Nurse responsibilities).
   (1) DHS (Adult Protective or Child Protective Services when appropriate)
   (2) Physician
   (3) NOD/ADN
   (4) Family/guardian/patient representative
   (5) Person who made initial report that report has been made to DHS
d. NOD or ADN notifies:
   (1) Superintendent or Administrator on Call
   (2) Director of Nursing (8 AM to 4:30 PM Mon-Fri)
   (3) Law Enforcement (if appropriate to situation)
   (4) Patient Advocate

   and sees to proper follow up care in collaboration with the physician:
   (1) Medical Care
   (2) Evidence preservation
   (3) Emotional support
   (4) Increased supervision
   (5) Medical Exam in cases of alleged physical/sexual abuse (send patient to emergency room with change of clothing).

For allegations of sexual misconduct: Make every attempt to preserve evidence which may assist Law Enforcement in a criminal investigation until the investigation is completed or unless directed to stop by your supervisor. The patient needs support during this time. Be sure no washing is done of patient's body, clothes, bedding, or the scene (where appropriate).

Patient Injuries
Patient to Patient Incidents
Patient Sexual Behavior
Staff to Patient Incidents
Allegations of Abuse, Neglect, Exploitation

The Nurse must notify the following people/agency and they, in turn, must report as indicated by the graphic display below.

Observed By and/or Reported to Ward Nurse

WARD NURSE - - - - - - - - - - - Files incident report to Director of Nrsg.

Physician

ADN or NOD

D.H.S. / B.E.A.S. and/or B.M.R.

Family/Guardian and/or Pt. Rep.

Notifies complainant or witness of report to Dept. Human Svs.

Law Enforcement When Appropriate

Director of Nursing or Designee

Superintendent or designee

Patient Advocate

Observed By and/or Reported to Director of Nursing

DIRECTOR OF NURSING

Ward Nurse

D.H.S / B.E.A.S. and/or B.M.R.

Patient Advocate

Law Enforcement if appropriate

Superintendent or Designee

Notifies the complainant or witness of report to DHS

Physician

A.D.N. (NOD)

Family / Guardian and / or Patient Representative

Patient Injuries
Patient to Patient Incidents
Patient Sexual Behavior
Staff to Patient Incidents
Allegations of Abuse, Neglect, Exploitation

Observed By and/or Reported to Patient Advocate

PATIENT ADVOCATE

Superintendent

D.H.S.

DIRECTOR OF NURSING

LAW ENFORCEMENT

Notifies complainant or witness of report to DHS

(N.O.D.)
Ward Nurse

D. H. S.
(If Advocate Non-Report)

Physician

Family and/or
Private Guardian

A.D.N. or Nurse Mgr.

Observed By and/or Reported to Dept. of Human Services

D. H. S.

Director of Nursing
(A.D.N. or N.O.D.)

Law Enforcement
if appropriate

Superintendent
or Designee

Patient
Advocate

N.O.D. or
Ward Nurse

Physician

Family Guardian and/or
Patient Representative

Patient Injuries
Patient to Patient Incidents
Patient Sexual Behavior
Staff to Patient Incidents
Allegations of Abuse, Neglect, Exploitation

Observed By AMHI Employees Who Are Not Part of a Team / Ward

AMHI Employee Reports to:

D.O.N. or A.D.N. E I T H E R O R D.H.S./B.E.A.S./B.M.R.

Ward Nurse

DHS/BEAS/BMR

Superintendent or Designee

Notifies witness or complainant of report to D.H.S.

Patient Advocate

Physician

Family/Guardian/ Representative

Observed By a Patient

Patient Notifies...

* Care Worker -----

Ward Nurse

Ward Nurse

If Careworker is not part of Treatment Unit, see above

Physician

ADN or NOD

D.H.S. / B.E.A.S and/or B.M.R.

Family Guardian and/or Patient Representative

Notify Witness or Complainant of report to DHS / BMR

Law Enforcement when appropriate

DON or Designee

Superintendent or Designee (Serious Incidents and Allegations of Abuse, Neglect and Exploitation)

Patient Advocate

* A "Careworker" is any employee of a treatment unit. In a situation where the employee is not a member of a treatment unit (see top graphic).

RAPE, PROCEDURE FOR TREATMENT OF

Rape is understood to be the act or attempted act of having sexual relations with a person of either sex who is unwilling or does not voluntarily consent to such relations.

This policy assures that all rape victims are treated promptly and appropriately and that all physical evidence of rape is protected until properly trained personnel can evaluate it.

a. As soon as a rape, attempted rape or an alleged rape has been discovered or reported, remove the victim to a quiet, secluded area, making sure to cover the patient with a sheet/blanket if the clothing is torn or bloodied. Assign a staff member of the same sex to stay with the patient. (This assures privacy for the patient, allows the patient to be given needed support and protects any physical evidence.)

b. Make every effort to preserve evidence which may assist law enforcement in a criminal investigation. Be sure no washing is done of a patient's body, clothes, bedding or the scene (where appropriate).

c. **DO NOT** attempt to question the patient regarding the incident at this time unless he/she offers to do so. **DO NOT** touch the patient without first asking permission. (This allows the patient time to regain composure. Asking permission before touching the patient helps him/her regain a sense of control.)

d. If the incident took place on the ward, secure the area by removing all patients, locking the door or assigning a staff member to remain in the area until released by the Nurse Manager, NOD or physician on duty. (This assures that any physical evidence that might be in the area will be undisturbed until evaluated.)

e. If another patient is known or alleged to be involved in the incident, remove him/her to a quiet, secluded area and assign a staff member of the same sex to stay with the patient until evaluated by the physician on duty. **DO NOT** attempt to question the patient about the incident at this time. (This allows the patient privacy as well as protecting physical evidence.)

f. Be sure to keep victim and alleged perpetrator separated. Transfer to another unit should be considered.

g. If the incident takes place during the day shift, notify the clinic at once. If the incident takes place during other shifts, weekends or holidays, notify the NOD at once. (The clinic or NOD will notify the physician on duty, the patient advocate, nurse manager, superintendent and any other appropriate people).

h. Under ALL circumstances, the victim and any other involved patients are to be kept as they are found. Under NO circumstances is any patient to be bathed, or their clothing changed, or otherwise have the condition they are found in altered in any way until they have been examined by KVMGER physician. (Altering thephysical condition of the patient can destroy any physical evidence present.)

i. All victims or alleged victims are to be transported to KVMGER as soon as possible, accompanied by at least one staff member of the same sex, who will remain with the patient during the time they are at the emergency room. (The ER has appropriate facilities for treating the patient. Having a staff member with the patient will provide both emotional and

(1) Staff may assist, but not physically force, a voluntary patient to return.
(2) A voluntary patient may be considered Absent Without Leave until such time as the patient is contacted and indicates refusal to return or until the responsible clinician determines that continued absence is indicative of refusal to return. At this time the patient must be discharged.

d. Law Enforcement Agencies should not be notified unless the patient is a danger to self or others as determined by the Director of Nursing or Nurse O.D. If this be the case, the patient shall be placed on unauthorized leave status and the procedures regarding such status then apply. The Unauthorized Leave Report must be completed prior to notification of Law Enforcement Agencies.

SEARCH - MISSING PATIENTS

The search for a missing patient is seen as a matter of the highest urgency. All AMHI staff must expect to be active participants in the search for a missing patient and the identification of a missing patient will be treated as a potentially life threatening emergency.

Special Precautions
A thorough assessment of elopement risk shall be part of any evaluation pertaining to increase in level for all patients. Under some circumstances, however, the treatment team should consider the need for additional precautions before the patient leaves the unit. These situations include when a patient has already eloped more than once, when elopement poses special risks (as in the disoriented or potentially suicidal patient), or when a patient is progressing to a new level of independence. Possible precautions could include taking a thorough description or photo to show what the patient is wearing, photographing the soles of the patients shoes, arranging for a call-in at a certain time. Treatment plan interventions should be designed for patients who have difficulty returning on time or for whom elopement is a particular risk.

Patient Description/Notification
At the time of admission, a Patient Description/Notification sheet, including a color photo will be completed by the treatment team and filed in a Description/Notification log that will be kept in the chart room. When a full search is called, staff assigned to the search team from the missing patient's unit will immediately make 12 copies of the Description/Notification sheet and bring them when reporting for the search.

Search Initiation
As soon as a patient fails to report on time or is reported missing from a supervised activity, a search of the patient's treatment unit will be initiated **immediately.** If the patient is not found on the unit and has not returned in 10 minutes, a search will be called by the Program Services Director or the NOD. The Program Services Director or Charge Nurse will call the switchboard to notify the operator of the search, requesting that the patient be paged over the Public Address System and asked to report to the

switchboard. The switchboard operator will make this announcement twice within five minutes.

The Program Services Director or Charge Nurse will then report **immediately** to the NOD office with the patient's chart, accompanied by members of the Search Team from that unit, and any other staff who have information to contribute. If the missing patient is known to regularly frequent certain areas of the hospital, the Program Services Director or Charge Nurse may assign search staff from the unit to check those areas and then report **immediately** to the NOD office.

Search Coordinator
During the day shift, the Superintendent will coordinate the search from the NOD conference room. During the second and third shifts, the NOD will serve as search coordinator from the NOD conference room until the Administrator on Call arrives and takes over the Search coordinator tasks. The Superintendent or the Administrator on Call will be notified **immediately** by the charge nurse from the patient's unit or the NOD as soon as a patient is designated missing.

Log Person
The Search Coordinator will identify a Log Person to record all information pertinent to the search, such as time of initiation, quadrant assignments, notifications and reports. The Log Person will also coordinate and document all communications with search parties.

Search Team
As soon as a search is called, the Charge Nurse for each treatment unit will **immediately** identify at least two staff persons from that unit to report for the search.

In addition, the following departments with staff not assigned to units will send staff members to participate in search teams when they are on duty:

- Maintenance and Engineering (4 staff persons during 1st shift, M-F)
- Housekeeping
- Psychology
- Nursing
- Dietary
- Medical Records
- Vocational Incentive Program
- Rehabilitation Services
- MIS
- Chaplaincy
- Business Office
- UR,QA

When a change of shift occurs during a search, no staff will go off duty unless discharged by the Search Coordinator, regardless of job description. No change in Search Coordinator will occur until the new Search Coordinator is thoroughly briefed and familiar with ongoing search procedures. Discharge of staff of change in Search Coordinator must be approved by the Superintendent.

Additional Staff
It is understood that in the event of a search, unit staffing will be tightened. During an extended search, when additional help is needed on the unit or in the search, additional staff may be called in according to the Disaster Call-In plan.

Search Procedures
The Search Coordinator will request the switchboard operator to announce "Search Team, please report to the NOD conference room." All staff assigned to the search team will report immediately.

Search procedures will proceed from as described below at the discretion of the Search Coordinator, depending on the severity and type of risk involved.

The Search Coordinator will ensure that all search assignments are recorded by the Log Person in order to facilitate identification of areas searched, and notification of search team members when the patient is found.

The Search Coordinator and other staff involved with the search are expected to make decisions regarding courses of action based on each specific situation and individual patient. This will include the order and level of search procedures, timing of notifications and initiation of any other needed procedures.

Level 1: Preliminary Search
Missing patient is voluntary, not evaluated as dangerous or unable to care for self, with no other dangerous circumstances, i.e., cold weather.

Staff will search common areas (such as the canteen, library, ARC) and any other places, such as Rite-Aid that the patient is known to frequent. A search of the grounds will be conducted by car. If the patient is not found, all necessary notifications and reports will be completed.

This level of search is appropriate only for patients who will be declared AMA if they do not return within 4 hours.

Level 2: Quadrant Search
Conducted for all other patients.
Notify the Superintendent and Capitol Security

a. Initiate Quadrant Search by assigning staff to quadrants according to forms available at the switchboard. Staff will complete the search of each quadrant and report back to Search Coordinator by radio when search is complete or patient is located. Radios are available at the switchboard.

b. Place APB by calling Forensic Treatment Unit, Section III (7-7547 or 7-7467)

c. Initiate search of roads leading from AMHI, especially those that lead to any known destination for the missing patient.

d. Complete all needed notifications and reports.

Level 3: State Game Warden Service Search
This search condition is set by the Superintendent to locate any missing patient suspected of having eloped and is most likely to be found in an uninhabited off road, open or wooded area. The search is performed by the State Game Warden Service.

a. Upon request from the Superintendent the Search Coordinator will obtain a copy of the APB from FTU Section III and will contact the State Game Warden Service and ask for their assistance in locating the missing patient.
b. The Search Coordinator will assign the charge nurse or other appropriate clinical staff to brief the State Game Warden Service on the patient's background and condition.

Level 4: Patients missing from off-ground activities:
Each off-grounds activity shall have a designated charge person. This individual is responsible for assuring that an initial search of the immediate area is begun. Care should be taken that other patients on the activity continue to be adequately supervised.

If after a preliminary search the patient is still missing, responsible staff are to notify the appropriate Program Service Director (weekdays/day shift) or the NOD (weekends and evening/night shifts). The Program Service Director or NOD will notify the Superintendent.

In order to determine the necessary search level, at a minimum the following information should be processed with the hospital contact:
a. the current mental status of the missing patient, including assessment of dangerousness,
b. any known prior elopement history and pattern,
c. perceived need for higher level search that would involve additional support (e.g. Warden Service, local authorities), and
d. need for additional AMHI staff to assist with search and eventual transport.

A staff member is to remain at the site of the activity to coordinate on-site search arrangements. Provisions will be made to either relieve or otherwise pick up this staff member as soon as the situation permits (i.e. patient found or search called off).

Search for a patient missing from an off-grounds activity can be extremely challenging. Prompt notification of law enforcement agencies should occur when needed.

Apprehension and Return
Recognizing that AMHI is the one with the custody issue and that law enforcement agencies are often busy and short staffed, they often are not able to provide transportation for return of the patient that has eloped unless it is absolutely essential. Providing safety and security of the patient and transportation back to AMHI is primarily the responsibility of AMHI. In most cases staff should be sent to visually assess the

appropriateness of returning a patient without law enforcement assistance when a patient has been apprehended and reported in control. Appropriate assignment of staff to perform this function is done by the Search Coordinator in consultation with the OD after assessing reports of patients condition, level of dangerousness and cooperation.

a. Institute personnel may assist, but not physically force, a voluntary patient who wishes to return.
b. Institute personnel may take an involuntary or legal hold patient into custody only when found in a public place and it can be accomplished without the use of an unreasonable degree of force.
c. A missing patient located in a non-public place such as private homes, stores, etc., may only be taken into custody by law enforcement officials.
d. AMHI personnel's assessment as to the level of dangerousness of a missing voluntary patient is helpful, but it is important to remember that when law enforcement agencies or Capitol Security locates a missing voluntary patient who is not a legal hold, they cannot keep the patient detained unless they believe from their own observations that the individual is mentally ill and a danger to self or others. If the patient is not willing to return to the hospital voluntarily, the patient can only be returned to the hospital after having been evaluated and Emergency Involuntary papers instituted.
e. In cases where the patient is a legal hold or considered too dangerous for Institute personnel to safely transport, law enforcement should be asked for direct assistance in transporting the patient.

Radios/ Communication
Search team members from FTU will bring all available FTU radios when reporting to search. In addition, six (6) radios, and flashlights will be available at the switchboard. The switchboard operator is responsible for inspecting these radios and flashlights daily and for ensuring that they are in working order. In addition, 6 radios will be available from the Night Engineer during the evening hours. All staff who may be assigned to a search team will be trained as needed in the proper use of radios and portable phones. Such training will be coordinated by the Director of Hospital Services.

The Log Person will serve as a backup operator to assist with communications by telephone and radio, both internal and external, for all levels of search.

At the end of a search, all members of the public notified during the search will be notified by the Search Coordinator that the search is concluded and thanked for their help.

If contacted by the media, members of the search team will refer all questions to the Superintendent or to the Assistant to the Commissioner.

Search Review
A review of the search will be conducted by the Superintendent within 24 hours, or on the next business day. All participants in the search will attend.

CRITICAL EVENT NOTIFICATION OF FAMILIES OR GUARDIANS

In the event of an unexpected death or the life threatening injury or illness of a patient, the Clinical Director will be notified immediately by the Attending Physician, the Physician on Duty or the Physician Extender. The Clinical Director will designate who is to notify the patient's family, next of kin, and/or guardian of the circumstances of the event. In addition, the the Clinical Director will ensure that the Superintendent is notified. If the Clinical Director cannot be reached, the Administrator on Call will be notified, and will call the Superintendent. The Superintendent or the Administrator on Call will then consult with the Attending Physician, Physician on Duty or Physician Extender to decide how the family will be notified. Notification will be done as soon after the event as is reasonably possible, but not before the circumstances of the critical event are accurately reported and understood.

When necessary, the Attending Physician, Superintendent or Clinical Director will coordinate follow-up contacts with the family or guardian. The Superintendent will ensure that all initial and follow-up contacts are made.

A record of all personal or telephone contacts with the patient's family and/or guardian will be made in the progress notes section of the patient's chart. Within two weeks of each event, the notification procedures followed will be reviewed by the Quality Operations Committee.

DEATH NOTIFICATION

It is policy at AMHI to maintain a uniform process to report deaths of consumers under our care, including:

a. AMHI patients transferred to other facilities for medical reasons;
b. unauthorized leaves (AWOL, UAL);
c. short leaves; and/or
d. convalescent status.

The AMHI Death Notification form 690 shall be completed within 24 hours to include a concise statement about the death, other basic information and any unusual circumstances about the death. **The Nurse Manager/Ward Nurse is responsible for seeing that this form is completed (in consultation with the MD/OD) and its subsequent mailing.** The sequence of reporting is as follows (with some concurrently):

Death Notification Chart

Ward Nurse/Charge Nurse

Physician, Physician Assistant or O. D.	Nurse on Duty, Director of Nursing or Assistant Director of Nursing
Clinical Director	Supt. or Chief Operating Officer
Dept. Med. Director--Jacobsohn	Commissioner
Medical Examiner's Office (after consulting with Dept's Medical Director)	Patient Advocate
Family or Guardian	Chaplaincy as Appropriate
	Attorney General's Office

REVIEW OF ASSESSMENT PLAN

By Decision and Order of March 8, 1996, the Court ordered that Defendants file a comprehensive plan by March 25, 1996 for completing the individual assessments of class members (Paragraph 2, page 37). Defendants filed the Assessment Plan ("Plan for Completing Class Members Assessments") and Plaintiffs responded ("Plaintiffs' Objections and Comments to Defendants' Plan for Completing Class Members Assessments", referred to below as "Comments") within the timeframes established by the Court's Order.

Plaintiffs requested that I reject the plan based on several concerns raised in their comments. During the period established for my review of the plan pursuant to the Court's Order, Defendants amended the original submission. While I find that the original submission would not have been approvable, I approve the Amended Plan for the reasons discussed below. The Amended Plan (Plan for Completing Class Member Assessments, 4/11/96) is attached to this Review.

The Amended Plan outlines a program for locating class members at Section II. Its proposal for assessing class members is Section III (with attachments).

Regarding locating class members, Plaintiffs raised concerns with respect to the details of the field search, staff available for the field search, and the existence of a protocol for contacting class members. The Department has amended its initial plan outlining the specifics of its field search activities (Amended Plan, pages 3, 4). The Amended Plan notes that there are 10 staff with varying levels of involvement in the location process. Two staff work fulltime. Their respective responsibilities are outlined in the Amended Plan at page 4. All telephone contacts with class members are made pursuant to a

protocol (written script). The Department reports a high degree of success in making positive contacts with class members, only one individual has reacted in a reportedly negative manner. (See Amended Plan, pages 3, 4.)

Regarding the assessment process, Plaintiffs raised several concerns. Generally, among other things, these include: how the Consent Decree Coordinators are to function, who performs assessments, how the assessments are structured, and what is their relationship to the ISP process and to service delivery.

Plaintiffs' concerns regarding the relationship of the Consent Decree Coordinator to the overall process of conducting the assessments include: the specific functions to be performed by the Consent Decree Coordinators (CDCs) (Comments, pages 1, 5), staffing available to CDCs (Comments, page 5), funding available to CDCs (Comments, page 1), the authority of CDCs (Comments, page 8), and the distribution and numerical efficiency of CDCs (Comments, pages 1, 5, 6). It appears that many of these concerns stem from the failure of the initial plan to identify the relationship of Consent Decree Coordinators to the Behavioral Health Network of Maine (BHNM). The Amended Plan notes that the Behavioral Health Network of Maine is a corporate entity which represents the majority of provider agencies which provide case management and service planning for class members (Amended Plan, page 6). CDCs are DMHMR employees whose relationship to the Behavioral Health Network is to be guided by the terms of the proposed contract between the Department and BHNM.

Under this arrangement, BHNM carries the principal responsibility for class member assessment, with the CDCs providing, for the most part, coordinative, quality assurance and back-up roles. The Amended Plan notes that CDCs will be deployed in relative proportion to the number of class members in the given region (Plan, page 5). Pursuant to the contract, CDCs will be

authorized to monitor and make necessary adjustments regarding the quality of assessments. Resolution of problems will be accomplished through negotiation with the local BHNM project representative, and if that fails, the CDC will arrange for an alternative assessment through the use of Departmental staff. This is outlined in the "Contingency Plan" section of the Amended Plan. (See Amended Plan, page 7.)

I find that the Amended Plan is reasonably clear with regard to the role of the CDCs and their intended authority under the operation of the proposed contract with BHNM. Largely because their role is limited, i.e., not having primary responsibility for assessment of class members, I do not find fault with the total number of CDCs (8) selected to perform the identified functions.[1]

Plaintiffs also raised a number of concerns regarding the assessment process, these included training for assessors (Comments, page 1), the need for a protocol for assessments (Comments, pages 1, 7), that assessments be conducted in a manner which integrated them with the ISP process (Comments, pages 1, 7, 8, 9), that they be performed by qualified people (Comments, page 6), and that prior assessments, which may be stale or inadequate, not be relied upon (Comments, page 4).

The attachment to the Amended Plan entitled "Assessment Process" contains a list of domains to be accounted for in the assessment process. This is not, in and of itself, an assessment tool. A specific assessment tool, however, will be developed which utilizes these domains and, in accordance with the terms of the

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[1] The Amended Plan allows for DMHMRs' Regional Directors to make reassignments of personnel needed to supplement the functions of the CDCs if necessary (Amended Plan, page 5). I note also that the utilization of BHNM in combination with the Contingency Plan (Amended Plan, page 7) will provide a wide pool of potential assessors.

Amended Plan, will be submitted for approval (Amended Plan, page 7). Training will be made available to all people conducting assessments, as well as those who may be utilized for that purpose under the Contingency Plan (Amended Plan, page 7). Also, the Amended Plan notes that assessments will be available to all class members and that reliance is not placed upon prior assessments (Amended Plan, page 5). Additionally, specific consideration is given in the Amended Plan to integrating the ISP process with the assessment process. This will result in case management services and an ISP for all class members who want them, whether or not they are currently in service. For individuals with service needs who do not wish case management services or a formal ISP, the CDC will be responsible for securing services (Amended Plan, pages 7, 8). The Amended Plan establishes that all people performing assessments must have minimum certification as a Mental Health Rehabilitation Technician II (MHRT II). In order to assure that all clinical issues are addressed, each assessment which is completed by a non-clinician will be review by a licensed individual. (See Amended Plan, page 6).

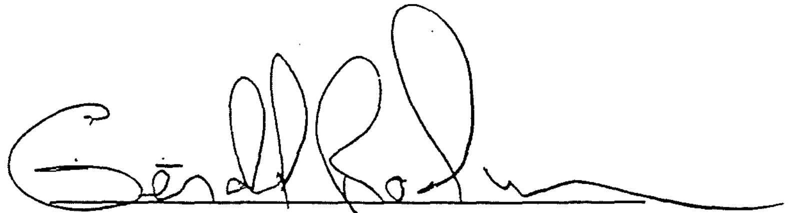
In addition to the concerns noted above, Plaintiffs are concerned that the Assessment Plan (as well as Consolidated Final Plan of 3/18/96) fails to identify how the new regional structures will operate (Comments, page 8), that there is no costing out or specific resource allocation for implementing the Assessment Plan (Comments, page 8), and that the plan includes a method by which class members may seek to opt out of participation in the Consent Decree (Comments, page 3).

I agree that Defendants' new regional structure is not adequately described vis-a-vis many of their obligations under the Consent Decree. With respect to Defendants' obligation to perform class members assessments, however, I do not find this flaw to be fatal. I find that the Amended Plan demonstrates that it can result in the comprehensive clinical assessment of class members by

October 30, 1996.

Regarding budgeting, it is clear that the cost of class members' assessments has not been definitively determined. Most likely, this will not fully occur until the assessment process has been completed due to a number of variables involved, including the number of assessments performed and the time utilized per assessment. The Department, however, has identified a variety of plausible funding sources including its MIS/QA budget line, Medicaid funds, and its reinvestment account. (See Amended Plan, page 8.) I am confident that the Department will be able to cover the cost associated with this project without having to resort to any fiscally induced limitations upon the conduct of the assessments. Lastly, the provisions in the initial plan regarding class members potentially opting out of class membership have been eliminated in the amended plan.

April 11, 1996
Date



Gerald Rodman, Master

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April 11, 1996

Gerald Rodman, Court Master
P. O. Box 724
Augusta, ME 04332

re: Assessment Planning

Dear Mr. Rodman:

Enclosed is a plan for completing class member assessments, submitted in response to paragraph 2 of the Decision and Order dated March 8, 1996, in Bates v. Peet. This revised plan is intended to address your concerns and those expressed by the plaintiffs in their written comments, and replaces the plan previously submitted on March 25.

Thank you.

Sincerely,

Katherine Greason
Katherine Greason
Assistant Attorney General

cc: Helen Bailey, Esq.
Peter Darvin, Esq.
Richard Goldman, Esq.
Neville Woodruff, Esq.
Wayne Douglas, Associate Commissioner
Andrea Blanch, Associate Commissioner
Carmen Coulombe, AAG
Terri Laurie, Consent Decree Coordinator, DMHMR

PLAN FOR COMPLETING CLASS MEMBERS ASSESSMENTS

I. Introduction

The Department of Mental Health and Mental Retardation (the "Department") submits this plan in accordance with paragraph 2, page 37, of the March 8, 1996 Decision and Order of the Court in Bates v. Peet, Docket No. CV-89-88 (the "March 8 Order"). This plan details the process which the Department proposes in order to complete individual assessments of class members.

As a necessary first step, the Department must locate class members in order to assess them. The Court's March 8 Order requires the Department to submit a list of class members with verified addresses by June 30, 1996. Section II of the plan describes the process now in place for verifying addresses and locating class members whose present whereabouts are unknown. Section III of this plan describes the assessment process which the Department will employ. Consent Decree Coordinators, new positions the Department is proposing to establish in the regional service networks, will play a key role in the assessment process.

The Department has initiated negotiations with the Behavioral Health Network of Maine to provide case finding and clinical assessments of members. It is expected that clinical assessments of members will begin by May 15, 996 and be completed by October 30, 1996.

II. Location of Class Members

A. Summary of Actions through March, 1996

The Department has undertaken a number of steps to locate class members and verify addresses to date including:

1. Placing 3,400 posters in places likely to be frequented by class members, informing them of their rights and soliciting their input in plan development.

2. Broadcasting public service announcements on radio and television with information regarding rights and services.

3. Utilizing social clubs and similar consumer networks to contact class members.

4. Working directly with other agencies (DHS, OSA, Department of Corrections, DMR, mental health agencies, etc) to identify and locate class members.

5. Conducting mass mailings (based on available addresses) with self-addressed, stamped return envelopes to contact class members. When forwarding addresses are learned, another letter is sent to the new address.

6. Reviewing records at Augusta Mental Health Institute and the DMHMR Reimbursement Office to find additional information which assists in locating class members.

7. Reviewing death records in the Bureau of Vital Statistics.

As class members are located, their addresses are verified by the member, an agency or other reliable source.

The chart in Exhibit 1 displays the Department's progress in locating class members and verifying addresses.

By 12/95, about 2,150 class members had been accounted for by either verified address or death records.

B. Actions in Progress to Locate Class Members

These further steps have been initiated to locate class members as of 3/11/96:

1. Cross-referencing Data Sources. The table below describes other databases that have been used to locate class members, and the current status for each.

Source of Information	Acquisition of Cross-referencing Data Target Date	Integration of Data into our MIS Target Date	Status
State of Maine			
Corrections	03/18/96	03/29/96	Data received; integration in progress.
Labor	03/25/96	03/29/96	In progress.
DHS	03/29/96	04/04/96	In progress.
Taxation	04/05/96	04/11/96	Meeting with taxation for tech. specifications.
Inland Fisheries	04/10/96	04/12/96	Feasibility of electronic transfer of data being research; manual review will be undertaken if electronic process is not possible
State Police	04/15/96	04/22/96	Manual search underway.
Court Admin.	04/01/96	04/05/96	Feasibility being assessed.
Nat'l Credit Bureau	03/01/96	03/29/96	Data received, being converted to database
MHMR			
AMHI & BMHI Med. Records	04/01/96	04/07/96	List of unknown cases produced. Review in process as of 3/21/96.

2. Field Search. Department staff are checking last known addresses of about 800 class members who have not yet been located and verified. We project 6/30/96 to be the completion date for this set of activities, but the process will not be terminated until all class members have been accounted for.

Action	Target	Status
Modify MIS to accommodate verification process	03/29/96	In process
Maintain active lists of unverified cases	03/21/96	Complete
Cross-reference DMR, BCSN and crisis site data to verify addresses	03/29/96	In progress
Conduct field searches	06/30/96	
Update Consent Decree MIS	Ongoing	As replies from field efforts come in, the MIS will be updated to indicate that addresses have been verified or supplied addresses are invalid.
Prepare complete list of verified addresses for court	06/30/96	Waiting for data.

Field search activities are seen as a progression of the following steps:

A. Developing class member case files based on current database cross-referencing with the unverified/unknown class members totalling about 1,300 people.

B. Cross-referencing all listed addresses to find potential phone numbers for contact.

C. Contacting by phone all potential class members for verification of address/location. A script is used for all phone contacts to ensure consistent presentation of entitlement to services.

D. Contact with local police/sheriff's departments and local post offices for information on missing class members.

E. Contact with identified known relatives, next of kin, or significant others for potential location and verification of class members.

F. Visit last known addressees to seek any forwarding information about remaining unknown/unverified class members.

Thus far, phone contacts have been well received. Class members have been cooperative and seemed to welcome the opportunity for continued/future services. An unverified class member made it known that he did not want any future contact from the Department and he called 3-4 different Departmental staff to make his wish clear. This was the only negative response received from the numerous phone contacts made. To date, seventy (70) class members have been verified through phone contacts.

To date, field search activities have included steps A-C. As many as 3 additional contact persons have been identified from recent medical records and billing reviews at AMHI to be used for step E. The following data has been collected from cross-referencing data sources and field search activities A-C:

Class members verified in database = 1,941
Class members potentially out of state with unverified addresses = 363
Class members unknown (no current info) ≈ 60
Deaths = 314

All remaining class members have case files for potential addresses but they have not yet been verified. Phone contacts will be attempted with the remaining unverified class members before any other contacts are attempted.

Once activities A-E have been exhausted utilizing the current staff assigned that responsibility, a determination will be made as to who is best trained/qualified to do the door-to-door type canvassing associated with step F. It is anticipated that the last step (F) may be a combined location and assessment activity process completed by professionals with appropriate training/experience. Ultimately, the Consent Decree Monitors will be responsible for the coordination of step F. At this time, approximately 60 class members remain unknown with no current information.

There are currently ten (10) staff who have varying levels of involvement in the class member location process. Two staff are working full time developing case files from incoming data, referencing potential phone numbers, and then making phone contacts for actual verification of addresses. Four staff are ultimately responsible for data entry and MIS system maintenance. Two of those four staff spend considerable time with the process (1 about 70% of his time and the other 50% of his time). Four additional staff have provided ongoing supports as liaisons to other departments, divisions or services (i.e., MH, MR, Crisis). The remaining two staff include the person responsible for the overview of location efforts and the secretary who provides the clerical support necessary for the process.

3. Implementation of System to Maintain Active Addresses of Class Members. The Department will maintain current addresses for all class members.

III. Assessment of Class Members

A. Background

- Approximately nine hundred twenty-five(925) initial assessments were completed by January, 1995.
- A self-assessment tool was developed in May, 1995. It was distributed to class members identified through CHS, DMV and DOC collaboration. 363 responses have been reviewed to date.
- For the purpose of this plan, the Department intends to complete an assessment on all class members, whether or not they had done previously an assessment of self-assessment referred to above.

B. Assessment Completion

The Department will complete clinical assessments and documentation of needs for all class members by October 30, 1996 in accordance with the March 8 Order.

Consent Decree Coordinators

The Department has received funding and is recruiting 8 clinical consent decree coordinators. The intent is to have those positions filled by May 15, 1996. These eight positions will be deployed in the three departmental regions. They will oversee and coordinate the assessment process at the local level.

Region I, Cumberland and York Counties, will have three CDC's to serve the 1193 class members that are estimated to live there.

Region II, Oxford, Franklin, Androscoggin, Kennebec, Somerset, Waldo, Knox, Lincoln, and Sagadahoc Counties will have four CDC's to serve the estimated 1,636 class members who live there.

Region III, Piscataquis, Penobscot, Hancock, Washington, and Aroostook Counties will have one CDC to serve the estimated 181 class members who live there.

New class members that are admitted to AMHI will be assigned to a CDC from the region of admission.

Consent Decree Coordinators will report to the Regional System Manager and, with the Mental Health Team Leader, comprise the locus of responsibility for compliance with the terms of the Settlement Agreement on behalf of individual class members.

The Department believes that eight CDC's will provide adequate capacity to perform the described functions for all class members. If it determines that this is in fact not the case, the Regional Director(s) will make necessary reassignments or other arrangements to assure that the terms of this agreement are met.

CDC's will represent the needs of class members both individually and collectively in the resource allocation process at the regional level. This will take place both through agency contracts for services and in the

development of individual service agreements for class members. Each region will have within its budget funds set aside for specialized services through wraparound funds and funds targeted for transportation.

Support for these positions will be provided in the regional offices.

Assessment Process

The Department has negotiated with the Behavioral Health Network of Maine, a corporate entity with 15 member organization which provide community based mental health services to adults and children throughout the state. BHNM represents the majority of the provider agencies who provide case management and service planning for class members, and who will be available to provide services to class members not currently receiving services who may want and need them. It will improve the linkage and continuity between assessment and service planning and delivery if the assessments are done in conjunction with the agency which is likely to provide services planning.

The Department will develop a contract with BHNM to provide comprehensive clinical assessment to all the members of the class. This will be accomplished using the qualified staff resources of the member agencies, and subcontracts with other licensed mental health service provider agencies as necessary (an example of this category of agency is Holy Innocents which is not a member of BHNM) and will be coordinated at the local level under the auspices of the Consent Decree Coordinators. Each CDC will assure that the class members for whom she/he is responsible have access to and complete an assessment which meets the standards set out by the Department.

The contract which the Department will develop and execute with BHNM will be very clear as to the roles and responsibilities of the parties and include a frequent feedback loop to assure that that the timeframes and quality of assessment and follow up are being met.

The contract with BHNM will detail that The CDC will be responsible to monitor the quality of assessments, ar if a problem with quality is identified, the CDC will attempt to rectify the problem with the local BHNM projec representative. If this is not quickly possible, the CDC will arrange an alternative assessment through the proce described in "Contingency Plan" below.

The BHNM has agreed that the cadre of individuals completing the assessments will be made up of communit support workers certified by this Department at the Mental Health Rehabilitation Technician II level, as well a licensed masters level social workers, psychologists, psychiatrists and psychiatric nurses.

To be approved by BHNM to perform assessments with class members not currently in service, an MHRT II must be in good standing with a licensed agency, must be fully certified and have documented competency in psychosocial rehabilitation. All non-licensed staff performing assessments will be supervised by a licensed professional and the ratio of supervisor to MHRT II will not exceed 1 to 5.

Each assessment completed by a nonlicensed staff person will be reviewed by a licensed person for assuranc clinical areas are adequate and appropriate before the assessment will be considered completed.

The Department and BHNM are in the process of developing a work plan that will specifically define the project tasks, timeframes and responsibilities. A draft of that work plan is included with the understanding that it is still subject to refinement as the parties finalize the contract, which is dependent on approval of this plan.

Tasks in the project work plan included here constitute minimal performance obligations. Additional obligations reflecting all aspects of this plan narrative will be included in the final project work plan for contractual purposes. This will include language to assure that all class members are offered a complete range of alternatives for completion of the assessment. The contract incorporating this work plan will be completed no later than April 26, 1996.

Also attached is a summary of the areas that will comprise the assessment process and lead to a uniform assessment tool. This assessment tool will be submitted to the Court Master and Plaintiffs for approval prior to implementation, as will the letter of invitation and all protocols specific to contracting class members. These will be developed through a joint process between the Department and BNHM.

A graph is included which is a representation by local service area of estimated staffing capacity to complete the assessments.

Contingency Plan

If irresolvable difficulties are identified in all or in part of the BHNM 's ability to carry out the terms of this contract, the Department will be prepared to deploy departmental staff who have been identified as qualified to complete the assessments, and it is developing a list of qualified individuals with whom it can contract directly to complete the remaining assessments. This pool of qualified individuals can also be used for those class members who choose not to have an assessment through the BHNM process. This will be an option for all class members, and if elected the CDC will arrange for the assessment from this trained pool of individuals.

Stephen Rose, Ph.D. at the University of New England School of Social Work will be part of the design team for the assessment tool and is working with the Department to review case management practice and design training for the intensive case managers that will be hired by the Department. He has agreed coordinate this aspect of the assessment process. The Department, with Dr. Rose will identify 10-15 individuals who will be trained at the same time as the BHNM staff are trained in the assessment tool and process. Departmental staff who are prepared to do assessments will have the flexibility within their current responsibilities to perform assessments on an as needed basis. They will either be licensed mental health professionals or other individuals who have been specifically trained in psychosocial rehabilitation assessments.

C. ISP Development

Assessments of class members currently in service will be used by the class member and his/her case manager to update or refine individualized service plan. Whether or not it takes the form of a formal ISP, the service plan will derive from the class members own identified needs as identified through the assessment.

For class members who are not currently in service and for whom the assessment identifies a need for case management and/or other services and supports, the assessment will serve as the basis of the service plan. If a new case manager is assigned , the assessment will be made available to that person through the BHNM local

coordinator when that linkage is made. If the class member chooses an alternate route to services and supports, the CDC will assure that the assessment is the basis of whatever plan is developed.

Unmet needs that are identified through this process will be addressed in the service plan and data about those needs will be collected through the BHNM process and the CDC where appropriate.

BHNM will develop a data collection and reporting system as described in the project plan which will be consistent with the Department's data requirements.

D. Consent Decree Coordinator Responsibilities

See attached FJA.

E. Budget

The Department has identified funds to be used for this project under the MIS/QA section of the March 18, 1996 Comprehensive Plan, and those funds were appropriated by the legislature. Additionally, for those class members who are Medicaid eligible, the assessments are Medicaid reimbursable under Community Support Services. The Department will assure that funding will be available to complete the assessments. If additional funds are necessary, the reinvestment account will be used for this purpose.

BHNM Behavioral Health Network of Maine
99 Western Avenue Augusta, Maine 04330 tel 207-621-6214 fax 207-626-3453.

The Maine Resource for Maine People

Gordon H. Clark, Jr., M.D., M.Div., F.A.P.A.
Medical Director

Aroostook Mental Health Center *Caribou*
Community Counseling Center *Portland*
Community Health and Counseling Services *Bangor*
Counseling Services, Inc. *Saco*
Crisis and Counseling Center, Inc. *Augusta*
Day One for Youth and Families *Cape Elizabeth*
HealthReach Network *Waterville*
Ingraham *Portland*
Kennebec Valley Mental Health Center *Waterville*
Mid Coast Mental Health Center *Rockland*
Shalom House, Inc. *Portland*
Shoreline Community Mental Health *Brunswick*
Sweetser Children's Services *Saco*
Tri-County Mental Health Services *Lewiston*
Youth and Family Services, Inc. *Skowhegan*

MEMORANDUM

TO: Susan Wygal - Program Services Director
Division of Mental Health

FROM: Wesley R. Davidson - Executive Director

DATE: April 9, 1996

RE: CONSENT DECREE PLAN - CLASS MEMBER ASSESSMENTS

Susan, I'm writing as a follow-up to our meeting yesterday in which we discussed a variety of approaches to the actual development and implementation of a protocol for offering and providing assessments to Class Members. As a result of our meeting, I accepted responsibility for developing an outline of a developmental and implementation task that BHNM would assume responsibility for in partnership with DMH.

The outline format that I have chosen defines: 1) the developmental task; 2) the projected timeframe for its completion; and, 3) identification of BHNM and/or DMH resources that will be allocated to each. I hope this approach responds to your needs as you develop a final response for submission to the Court Master.

Please note that this outline is offered as a refinement to BHNM's original proposal as submitted to DMH on April 4, 1996. This outline reflects our collaboration in an attempt to refine the Department's plan in a manner that will be acceptable to the plaintiffs and the court. The outline represents our best thinking to date. However, it is understood that the specifics of the tasks, timeframes, and resource allocations are subject to revision pending further review and alteration as needed to win acceptance by the court. Given this and recognizing the fluid and uncertain nature of this process at present, it is understood that the specifics of what BHNM will be charged with in the way of responsibility for and the related compensation for its work will be finalized as a part of actual contract negotiation once a plan is finalized and approved by the court.

Please feel free to contact me today in the event that you require any additional information or clarification about the content of the outline presented below:

SAMPLE DRAFT

Project Task	Projected Timeframe	BHNM/DMH Resources
1. Hire Project Coordinator	1-to-2 weeks after signing of DMH contract.	BHNM Board of Directors.
2. Assessment Protocol Development -- A uniform assessment process and supporting documentation forms based on a Psychosocial Rehab-focused model of assessment will be developed. The assessment will include the clinical intake data elements presented in Attachment "A" and an initial assessment of the Class Members' current goals and interests, and related service needs. The development and implementation of the assessment protocols will allow for the assessments to be integrated into the normal service delivery system of the region.	April 30, 1996 Completion	BHNM Design Team comprised of: DMH's Director of Community Clinical Services, Dr. Kalanowski and one additional DMH representative and BHNM's Medical Director, Dr. Clark; and staff drawn from BHNM member agencies such as AMHC - Greg Disy; CHCS - Kay Carter; SCMHC - Leslie Eastman; SH - Ed Blanchard; etc.. Individuals and agencies listed are resource examples and are subject to change. Additionally, a BHNM Information System Committee member(s) will be included on the Team.
3. An electronic relational database system will be designed by BHNM to support development of electronic and hard copy reports on clinical assessments, met and unmet service needs, and related service resource development or reallocation or development needs. This data base will allow for reporting on an individualized Class Member basis, as well as in the aggregate for a system-wide use.	Initial design and start-up capability completed by May 15, 1996.	BHNM - Information Systems Committee in consultation with the BHNM Assessment Protocol Design Team and DMH Information System staff (? Stan Fabisiak ?)

SAMPLE DRAFT

Project Task	Projected Timeframe	BHNM/DMH Resources
4. Class Member contact protocol consisting of:	April 30, 1996	BHNM Assessment Design Team

A. Letter of introduction, outlining that BHNM on behalf of DMH wishes to meet with Class Members and offer them an opportunity to participate in an assessment process. (Class Member initiated phone contact will be encouraged in the letter, reflecting a desire to respect the individual Class Member. When the Class Member self-initiates contact with BHN or the subcontracted assessment agency provider, an appointment to meet with the Class Member at his or her home or an alternative location acceptable to the Class Member and regarded as safe for both the Class Member and the assessment personnel will be scheduled.

B. Letter followed up a telephone call and personal contact by BHNM project staff and/or subcontracted assessment provider agency, depending on Class Member classification as follows:

1) A complete new assessment;

2) An updated assessment from an assessment resource of his or her choosing with the following options by Class Member status:

a) Class Members not presently in service;

SAMPLE DRAFT

Project Task	Projected Timeframe	BHNM/DMH Resources
(1) BHNM sub-contracted assessment provider from a listing of agency-based alternatives available within the region in which the Class Member lives.		
b) Consumers currently in service;		BHNM Subcontracted Assessment Provider Agency
(1) Assessment with their current provider;		
(2) Assessment by an alternative provider from a listing of such within the region in which the Class Member lives to include DMH Consent Decree Coordinator, as necessary to win Class Member participation in the process.		
(3) Assessment by a trained and supervised consumer and/or family member when all other alternatives for the provicion of assessment have been refused.		
C. Class Members who do not initiate a call will be called directly by BHNM or sub-contracted assessment provider agencies and/or contacted in person by an actual visit to the		

SAMPLE DRAFT

Project Task	Projected Timeframe	BHNM/DMH Resources
known and/or verified address as provided to BHN by DMH.		
5. Recruitment and identification of agency-based assessment coordinators.	April 30, 1996	Agency-based coordinators from BHNM subcontracted assessment contract agency (see partial listing Attachment B of those already identified by agency).
6. Orientation and Training of agency-based coordinators and DMH Consent Decree Coordinators.	May 8, 1996	BHNM assessment protocol design team and DMH staff representatives
7. Recruitment and selection of designated assessment providers (to be drawn from staff resource pool of the subcontracted provider agencies - see Attachment C for example specific to BHNM member agencies).	May 10, 1996	BHNM agency-based Coordinators
8. Training of the selected assessment providers	May 15, 1996	BHNM agency-based coordinator and DMH Consent Decree Coordinators
9. First-round of 200 letters mailed (weekly for 15 weeks) to Class Members based on a categorized and prioritized listing of Class Members:		
a. Class Members not currently in service	May 8, 1996 onward for duration of the project	BHNM central project staff.

SAMPLE DRAFT

Project Task	Projected Timeframe	BHNM/DMH Resources
b. Class Members currently in service that have been identified by the Office of Advocacy to receive letters of introduction and initial contact through BHN central project staff.	May 8, 1996 onward for duration of the project	BHNM central project staff
c. Class Members currently in service.	May 8, 1996	Agency-based coordinators and selected assessment providers.
10. Subcontracting with BHN member assessment provider agencies and other community-based provider resources.	April 30, 1996	BHN Project Coordinator.
11. Telephone and personal face-to-face follow-up contact with and scheduling of assessments and documentation of Class Member declining participation as experienced.	May 22, 1996	BHN central project staff and subcontracted agency-based providers (200 mailings per week for a period of 15 weeks)
12. Class Member assessments scheduled and completed with supporting documentation forwarded from the assessor to BHN for data entry and processing as they are system completed.	October 15, 1996	Agency-based assessment providers and BHN central project staff and information personnel
13. On a bi-weekly basis, BHNM will submit status reports on the number of Class Members contacted, schedule for assessment, and the number of completed assessments.	Beginning June 1, 1996, onward for the duration of the project.	BHNM Project Coordinator and Information System Resource.
14. Class documentation of class members declining participation in the assessment process forwarded to BHN central project staff.	Weekly as experienced.	BHN agency-based assessment coordinators as needed.

SAMPLE DRAFT

Project Task	Projected Timeframe	BDS/DMH Resources
15. Contingency planning team will review all situations in which Class Members decline participation to develop and offer an alternative to assessment processes tailored to the individual Class Member's needs, interest, or situation,	Weekly throughout the duration of the contract period as the Class Members decline participation.	Agency-based coordinator, DMH Consent Decree Coordinator, and BHN project staff as needed.
16. Class Member complaints and grievances with assessment process to be documented and forwarded to BHN project staff and the DMH Consent Decree Coordinators.	As they occur throughout the duration of the project.	Agency-based assessment providers and coordinators.

Assessment Process

Current Mental Health Concerns

Risk Assessment

Psychiatric History

- Diagnoses
- Hospitalization
- Medication History
    - Current
    - Past
    - Adverse Responses
    - Preferred Medications

Medical History

- Medical Illness
- Drug Allergy
- Alcohol Use
- Drug Use
- Caffeine Use
- Tobacco Use
- Medical/Dental Follow-up
    - Most recent exams:
        - Medical:
        - Dental:

Eye:

Gyn/Reproductive:

Family Psychiatric and Medical History

Abuse/Survivorship History and Needs

Physical

Sexual

Emotional

Cultural and Gender Considerations

Housing History

Financial History

mployment-History

Education History

Legal History

Current Status

Advanced Directive/Power of Attorney for Health Care

Past History

Family and Social Supports

Family History

Significant Relationships/Marital History

Other Sources of Support

Spiritual History

.ecreational Interests

Transportation Needs

Mental Status Examination

Class Member Goals

Mental Health:

Medical:

Substance Abuse:

Recovery from Trauma:

Housing:

Financial:

Employment:

Education:

Legal:

Family/Social:

Spiritual:

Recreational:

Transportation:

Other Identified Needs:

Support Plan:

Follow-Up Plan:

SAMPLE DRAFT

ATTACHMENT B

DMH - AMHI CONSENT DECREE

BHHM MEMBER AGENCY
ASSESSMENT PROCESS COORDINATORS

(Incomplete List -- Still in Process of Developing)

MEMBER AGENCY	COORDINATOR	POSITION
Aroostook Mental Health Center (AMHC)	Greg Disy	Director of Community Support
Community Counseling Center (CCC)		
Community Health and Counseling Services (CH&CS)	Kay Carter	Director of Community Support
Counseling Services Incorporated (CSI)		
Crisis and Counseling Services (CCS)	Gail Miller	
HealthReach Network (HRN)	Caroline Feely	
Ingraham	Jon Bradley	
Kennebec Valley Mental Health Center (KVHC)		
Midcoast Mental Health Center (MCMHC)		
Shalom House (SH)	Ed Blanched	Clinical Director
Shoreline Community Mental Health Center (SCMHC)		
Tri-County Mental Health Center (TCMHC)	Joan Datel	Community Support Unit Manager
Youth and Family Service (YFS)	Laura Wilfred	Clinical Director

ATTACHM..NT C

BHNM

Estimated Assessment and Capacity
(FTE Needs by Region Slatewdo)

SAMPLE
DRAFT

Geographic Region (1)	Class Members (1)		Estimated Staff Hours (2)			Staff Resources (3)					
						Number of Staff Available			FTE's Needed (4)		
	Percentage	Number	2	5	8	Total (+)	Total	CSP	FTE	FTE	FTE
Aroostook	1.20%	37	74	[illegible]	208	55	55	27	0.09	[illegible]	0.38
Northeast	4.50%	144	288	720	1152	94	94	61	0.37	[illegible]	1.46
Ken-Som (5)	24.30%	777	1554	[illegible]	6210	187	·38	97	1.97	[illegible]	7.89
Tri-County (5)	16.60%	531	1002	[illegible]	4248	177	81	29	1.35	[illegible]	6.39
Shoreline (5)	10.30%	328	656	[illegible]	2624	90	90	42	0.83	[illegible]	3.33
Cumberland (5)	27.00%	864	1728	[illegible]	6912	114	69	29	2.19	[illegible]	8.78
York (5)	10.30%	329	658	[illegible]	2632	106	104	7	0.84	[illegible]	3.34
Statewide	**94.20%**	**3010**	**6020**	[illegible]	**24080**	**822**	**630**	**292**	**7.64**	[illegible]	**30.58**
Out of State	5.80%	186									
Total	**100.00%**	**3196**	A	B	C				A	B	C

(1) Final Consolidated Plan For Implementing Settlement Agreement to AMHC Consent Decree, March 18, 1996, Department of Mental Health & Mental Retardation.
(2) Includes only direct contact time with class member.
(3) BHNM staff resouces available by region.
(4) One FTE based on 105 working days * 7.5 hours = 787.5 hours. This computation is for the period from May 15 through October 15, 1996 and excludes 4 holidays that occur during the period.
(5) Additional staff resources from other BHNM members and/or other qualified community based service providers agencies (estimated @ 60) can be brought to accessed to assist in these regions as necessary

State of Maine
Division of Human Resources

ADMINISTRATIVE REPORT OF WORK CONTENT

FTA / Consent Decree Coordinator

Position (LEAVE BLANK)

TO BE COMPLETED BY AUTHORIZED AGENCY PERSONNEL UNIT

TYPE OF REQUEST	TYPE OF POSITION
[X] ALLOCATION	[X] CLASSIFIED
[ ] REALLOCATION	[ ] UNCLASSIFIED (Attach copy of statutory authority for making this position unclassified)
[ ] REEVALUATION	

EMPLOYEE NAME		LOCATION OF POSITION	TELEPHONE NO.
N/A		Statewide	N/A
PRESENT TITLE Proposed- MH&MR Casework Supvr.	RANGE 25	NAME OF SUPERVISOR	TELEPHONE NO.
DEPARTMENT Mental Health & Mental Retardation		BUREAU/DIVISION Regional Operations - DMHMR	

I certify that this is an accurate statement of the major duties and responsibilities of this position and its organizational relationships, and that the position is necessary to carry out government functions. This certification is made with the knowledge that this information is to be used for statutory purposes relating to appointment and payment of public funds, and that false or misleading statements may constitute violation of such statutes or their implementing regulations.

SIGNATURE OF INCUMBENT	DATE
SIGNATURE OF IMMEDIATE SUPERVISOR	DATE
SIGNATURE OF AGENCY PERSONNEL DESIGNATE	DATE
SIGNATURE OF AGENCY COMMISSIONER	DATE

TO BE COMPLETED BY COMMISSIONER OF PERSONNEL

TYPE OF POSITION	ASSIGNED CLASS TITLE	ASSIGNED RANGE
[ ] CLASSIFIED [ ] UNCLASSIFIED		

SIGNATURE OF COMMISSIONER OF PERSONNEL	DATE

APPEAL

COMPENSATION — DATE

FROM ______________
TO ______________ COMMISSIONER OF PERSONNEL

CLASSIFICATION

FROM ______________
TO ______________ CHAIRPERSON OF PERSONNEL BOARD

TO BE COMPLETED BY AGENCY PERSONNEL UNIT

1. Primary purpose of unit, division, agency (Why does it exist?)

The Department of Mental Health & Mental Retrdation's mission is to promote the health, aspirations and growth of adults and children who have mental illness, mental retardation and other serious developmental disabilities; to help meet their needs for personal, social, educational, vocational economic development; to enable them to function at maximum levels of potential; and to support optimal choices and equal opportunities to be part of their communities. To these ends, the Department operates and provides for abroad spectrum of programs, facilities, services and advocacy.

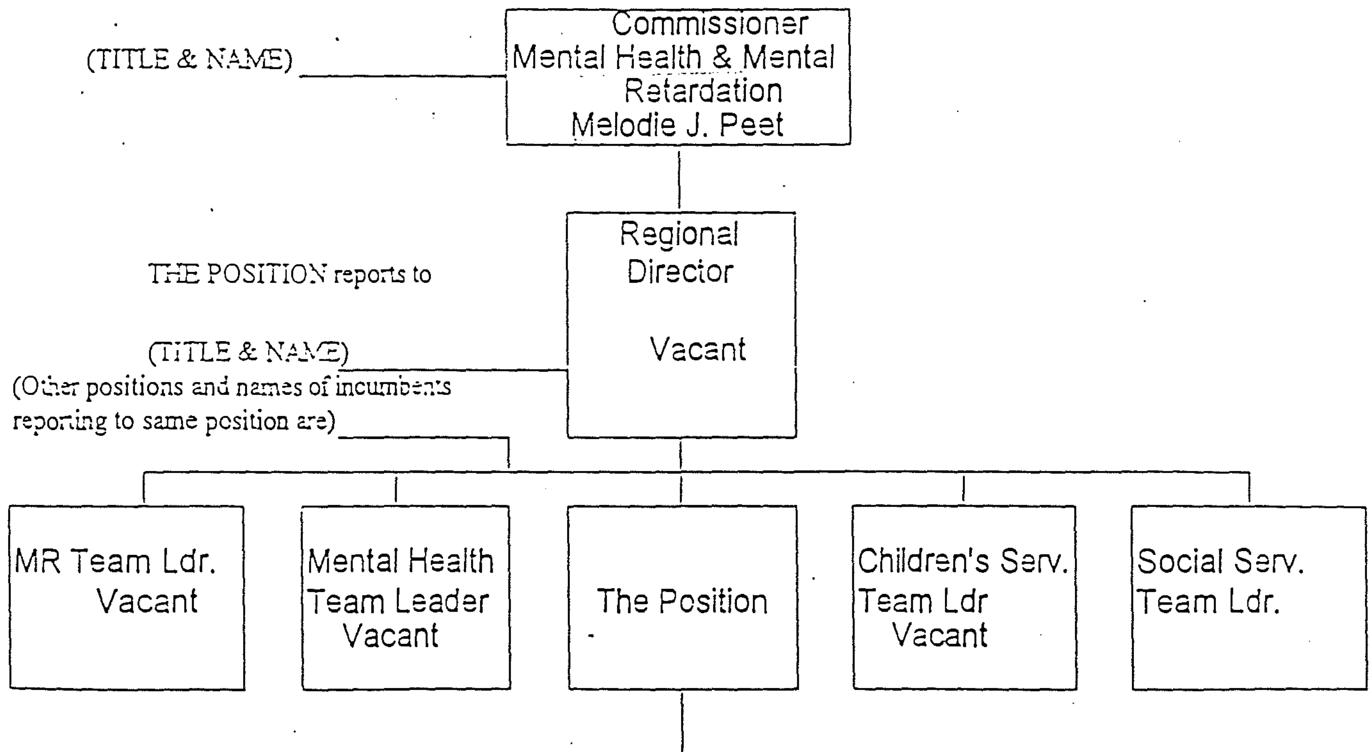
2. Primary purpose of position (Why does it exist?)

This position will be responsible for monitoring consent decree implementation for individual class members in the local network service areas. It will oversee location, assessment and service development efforts, to assure quality services, documentation and reporting data on unmet needs.

3. List titles of positions which provide functional direction to the incumbent (Sources of assignment)

Mental Health Team Leader
Regional Director
Director, Consent Decree Compliance
Assoc. Commissioner Programs
Facilities Operations Manager

4. In the space provided complete the wire diagram to show the position within the organizational structure



List title and number of positions supervised by THE POSITION with names of present incumbents

Not applicable

5. Give extent and examples of decision making authority.

This position will have extensive decision making authority developing and implementing strategies overseeing the compliance with consent decree on behald of class members, accessing and monitorin effectiveness of service delivery creating and maintaining systems of data collection and reporting

Position will have access to flexible funding to use in a discretionary fashion as determined within the regional office. The amount and specific use will be based on clas member needs.

6. Describe in narrative form those activities which this position will accomplish through delegation to others and to whom they are delegated. (Supervisors only)

N/A

7. List all position titles, units, departments and others with which there is working relation and its nature.

All employees of the central office Program Division, Regional Office, Insitituions, plaintiffs, counsel fo the Department, community provider networks, class members and families - Identification of service availability and program development needs.

8. Amount and nature of other moneys directly affected by position (Contact agency business office for specifics)

DOLLAR IMPACT

$

9. Describe in Task Statement form those activities performed directly

% of TIME	
	EXAMPLE: Develops/formulates/writes marine resource research project proposals using knowledge of Federal proposal guidelines, technical writing skills, marine resource research techniques and agency policy in order to obtain State/Federal/private agency funding.
	Coordinate/Assure assessment of each class member in local service network in compliance with consent decree mandate.
	Oversee/completion of mandated individual service planning for each class member in a manner consistent with the client-directed approach, and assure regular updating of plans.
	Develop/Implement a process to locate and establish ongoing contact with class members in net work area.
	Coordinate/Oversee access to case management services for all class members requesting the within local service network area, in a manner consistent with the requirements of the consent decree,
	Prepare/Complete reports, plans, summaries, analyzes and recommendations based on identified needs of individual class members and experience with the service network in order to come into compliance with the consent decree and its provisions.
	Coordinate/ Provide quality assurance for individual class member services and collaborate with Departmental CQI activities with service entities.
	Provide/Document followup with all class members who refuse case management and other mental health services as required for compliance with the consent decree.
	Coordinate and assure assistance to class members as needed to pursue grievances, mediate disputes, and secure advocacy services to exercise rights as defined by the Department and in the consent decree.

10. Justification for request (List additional duties assigned to this position)

N/A - New position

11. Give purpose of assigning these duties to this position (Reorganization, combination of positions, Legislative mandate, etc.)

N/A - New position

12. Give name and title of person assigning these duties

N/A - New position

13. Give name and title of person previously performing these duties

N/A - New position

14. List knowledge and abilities essential to the position

Knowledge of consent decree settlement agreement , subsequent agreements, and other relevant documents
Knowledge of departmental, institutional and regional operations
Knowledge of local service systems and funding mechanisms
Knowledge of individualized service planning, assessment for services and supports and goal development.
Knowledge of current values/trends/directions/practices in the field of services and supports to persons with mental illness.
Knowledge of basic data collection and reporting
Ability to effectively communicate with persons with mental illness and others.
Ability to work independently
Ability to prepare written reports and other communications.

15. List the type of equipment used in performance of duties and the frequency use

TYPE OF EQUIPMENT	FREQUENCY

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

July 26, 1996

Senator Joan Pendexter, Chair
Representative Michael Fitzpatrick, Chair
Members, Joint Standing Committee on
Health and Human Services
State House
Augusta, Maine 04333

Dear Senator Pendexter, Representative Fitzpatrick and Members of the Committee:

Enclosed please find three documents that were requested by the Committee at the July 19th hearing. If you have any questions or concerns about these documents, please feel free to contact my office.

Sincerely,

Melodie J. Peet
Commissioner

MJP/jw
Attachments

PRINTED ON RECYCLED PAPER

PHONE: (207) 287-4223 (Voice) (207) 287-2000 (TTY) FAX: (207) 287-4268

AMHI PSYCHIATRIC RECORD ORDER (July 11, 1994)

DEMOGRAPHIC & SUMMARY SECTION

I. Admission Data Sheet
II. Photocopy of admission cards with movement card attached.
III Priority Patient Tracking Sheet
IV. DRG Validation Sheet (Infirmary patients)
V. Diagnostic Page
VI. Clinical Resume (copies placed loosely in chart folder)
VII. Consolidated aftercare plan and referral
VIII Diagnostic Sheets/Global Rating 103-103B (Closed record)
IX Patient Photograph
X. Death Certificate (also death notification #690).
Permission for autopsy (144)
Deceased Patient Release Form (638)

ORDERS AND MED SHEETS

I. Admission Treatment Orders (F506)
II. Physicians' Orders (F195).
III. Doctors' Orders (F217)
IV. Nursing Home Transfer (F84)
V. Psychotropic Medication Flow Sheet (F9-9B)
VI. Anticonvulsant Medical Flow Sheet (F101)
VII. Epileptic Record (F71)
VIII Lithium Flow Sheet (F107)
IX Lithium Assessment (F249)
X... Lithium Follow Up (F249B)
XI... Medication Records (F28)
XII Standard PRN Medication Orders (F69) White

ASSESSMENTS

I. Admission Note
II. Psychiatric Assessment
III. Movement Disorder Rating (Tardive Dyskinesia) (F301)
Initial and then secondary
IV. Nursing Assessment (F100)
V. Social Service Assessment/History of interval
VI. Psychological Assessment
VII. Rehabilitation Assessment
VIII. Chaplaincy Assessment
IX. Dual Diagnosis Intake (F626)
Assessment typed on white
X. Sexual Abuse Assessment
XI. Others
Vocational Evaluations
Legal Assessment
Nutritional screening (197-197B)
Self medication educational assessment

TREATMENT PLAN SECTION

I. Community-based ISP
II. Master Problem List
III. Individual Treatment and Discharge Plan
IV. Nursing Care Plan (3A and 3B)
V. Patient Daily Treatment Schedule

ontinued

5. PROGRESS NOTES

- I. Progress notes (Pink after white) Save yellow copies for coder
- II. Rehab Services Progress Notes
- III. Substance Abuse Treatment Monthly Summary (F625)

6. CHECK SHEET SECTION

- I. Health Monitor Sheet (F58)
- II. As Needed: Insulin Record (F312)
- III. As Needed: Neuro Observation Check Sheet (F251)
- IV. COR 1 to 1 Patient Activity Documentation Form
- V. COR/Seclusion/Restraint Monitor Sheet
- VI. Totals of Intake and Output (F258)
- VII. Legal Hold Hourly CHecks (F149)
- VIII. Flow Sheet/Patient Care (F650)
- IX. Personal Items Iventory (F545)
- X. Protective Restraint Flow Chart (F127B) (ICF)
- XI. Graphic Chart (ICF)
- XII. CNA Daily Care Record (ICF)

7. PATIENT RIGHTS

- I. Patient Rights Status (PR-1)
- II. Psychiatric Emergency (PR-1B)
- III Guardian/Correspondent/Representative Instructions (PR-2)
- IV. Change of Representative (PR-2A)
- V.. Mailroom Notification (PR-3)
- VI.. Informed Consent for Treatment (PR-4)
- VII.. Capacity for Informed Consent - Second Opinion (PR-5)
- VIII Patient's Agreement to Administrative Due Process (PR-6)
- IX. Request for Administrative Due Process Hearing Patient (PR-6A)
- X.. Request for Administrative Due Process Hearing MHW (PR-6B)
- XI.. Medication Proposal/Due Process Hearing (PR-6C)
- XII.. Refusal for Treatment -Second Opinion (PR-7)
- XIII Patient Medication Consent Form (PR-8
- XIV Patient/Guardian Medication Consent Form (PR-8A)
- XV Patient Privilege Agreement (PR-9)
- XVI. Request to Treat Compliant Incapacitated Patient (PR-11)
- XVII Capacity Guardianship and advance Directives
- XVIII Treatment Information: Clozaril Author. Form
- XIX Living Will Revocation notice (PR-14)
- XX.. Durable Power of Attorney Revocation Notice (PR=15)

8. LEGAL SECTION

I. Admission Office Contact Sheet (F297)
II. Status Change Sheets (F290)
III. Emergency Involuntary Application (MH 100)
IV. Certification of Need for Psychiatric Hospitalization (F23)
V. Certification of Need Psychiatric Inpatient (F158)
VI. Certification of Need Psychiatric ICF (F163)
VII. Certification of Need Infirmary Patient (F164)
VIII. Application for Court Commitment (MH108
IX. Hearing Preparation (MH104)
X. Order to Examine (MH103)
XI. Order to Hospitalize (DC 108) plus two reports from outside
XII. Order to Dismiss (MH110)
XIII. Notice of Elopement (Forms Kept in FTU)
XIV. AMA Statement of Patient leaving against Medical Advice
XV. Communications for Dept of MHMR
XVI. Commissioner's Permission to Treat

9. SUPPORT DOCUMENTS

I. Information from other Agencies/Hospitals
II. Release of Information Forms (F150/81)
III. CMHC-AMHI Transfer Data Base
IV. Continuing Contact Forms
V. Correspondence
VI. UR Form F70
VII. UR Denial Letter
VIII. Charges for Care and Treatment (F303)
IX. Medicare Certification and Utilization Review
X. Financial and Banking Papers

10. MEDICAL SECTION

I. Physicial/Neurological Examination (F75)
Health Assessment (F222) (See Adm/Annual Med HX and Nutrit Scr)
Immunizations (F72)
Medical Clearance For GYN (F664)
Consent to HIV Testing Form

II. Medical Problem List (F233B)
Blue Medical Summary/90 day note (CS/Discharge)

III. Clinical Progress Notes (F647)

IV Inter-Hospital Consults Request (F148-2)
Consultation Request (F148-5)
Dental Examinations
Physical Therapy Evaluations
Audiograms
EKGs
Dietary Consults

V. Laboratory Reports

INCIDENT REPORTING

An incident is any happening that is not consistent with the normal or usual operation of the Hospital or any department therein; injury does not have to occur. The potential for injury, property damage, or legal liability is considered an incident. An incident report is completed to:

a. provide a record of the incident and to document the facts.
b. provide a base from which hospital staff can further investigate to determine and evaluate:

   (1) deviations from the standard of care, policies, procedures, etc.
   (2) corrective measures needed to prevent recurrence.

c. provide means of refreshing the memory of those having direct knowledge of the incident.
d. alert Hospital risk manager to a possible claim situation and to respond immediately for complete investigation and documentation.
e. fulfill a regulatory requirement.
f. collect data for statistical analysis and computer input.

In order to further the goals of our Risk Management Program, maximize management responsiveness and excellence of patient care, and to maintain a high level of managerial awareness, incidents will be reported out in a single system administered by the Safety Officer.

The incident report is confidential and no reference to incident reports shall be in the progress notes of the medical record. All staff members shall have equal responsibility for filing reports. Hospital staff shall document and report all unusual incidents on AMHI Incident Forms and shall channel the report to the risk manager for necessary follow-up.

Employees shall be cautioned against committing the Hospital to liability through their acts or statements in the presence of patients, visitors, or others at any time. No employee shall be disciplined for an unintentional, nonmalicious incident if it is reported. However, failure to report an incident may be grounds for disciplinary action.

All incidents involving patients shall be immediately reported to the Nurse Manager or the N.O.D. All incidents must be reported with the Incident Report Form (Rev. 9/94). This form must be completeted by the person that observed or discovered the incident. The completed form MUST be delivered to the Risk Manager within twenty-four hours or the next work day.

CRITICAL EVENT NOTIFICATION

All events listed in this summary require that an Incident Report be completed and handled according to established policy. This summary is in addition to special requirements stated in the Death Notification policy, Guardianship Notification policy and the Mandatory Reporting policy.

The following events are to be reported (where appropriate) to the Charge Nurse/Nurse Manager/Department Head, who is then responsible for reporting to the NOD, who in turn reports to the AOC:

KEY

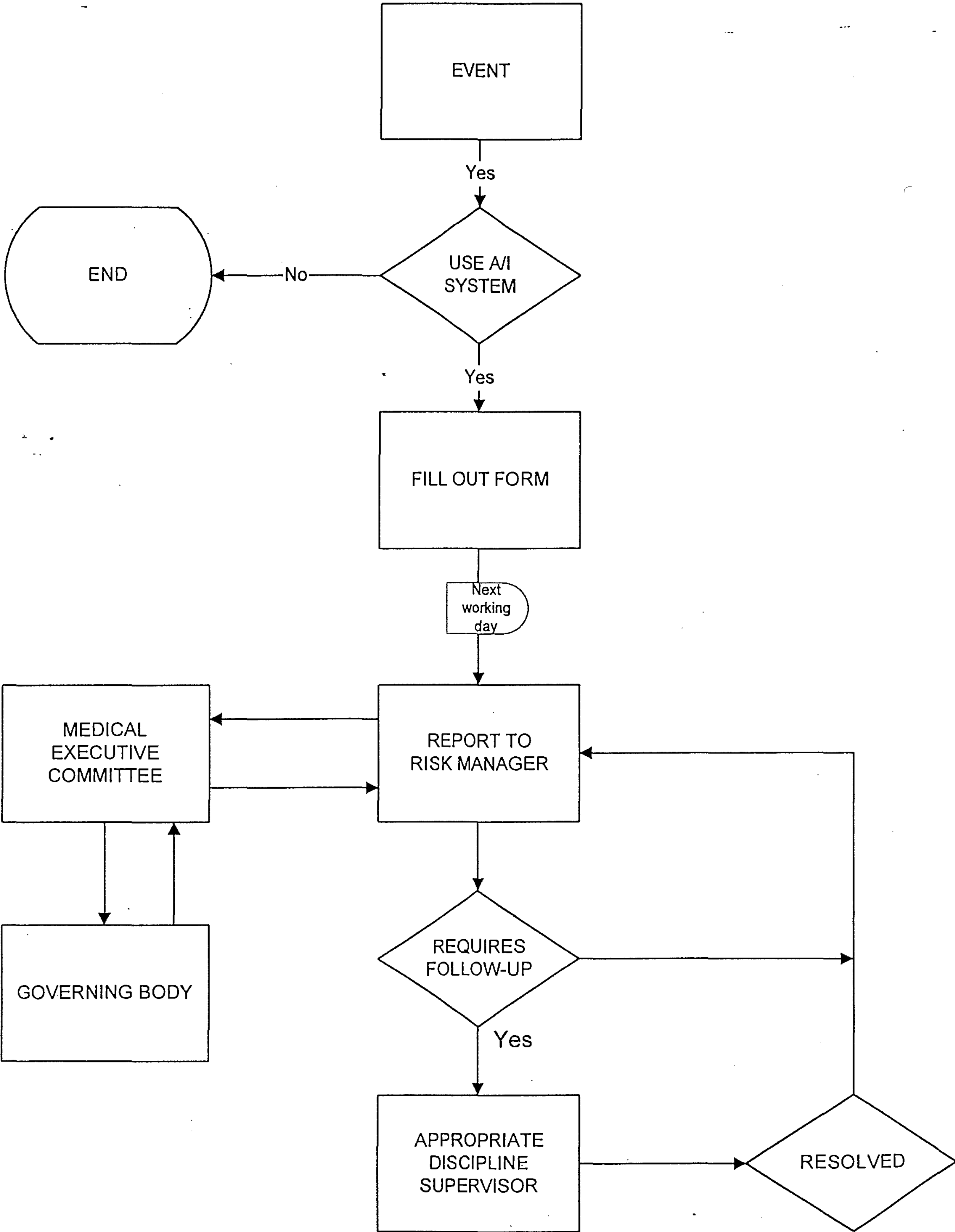
1 = Report immediately to Superintendent/Designee (AOC - Administrator on Call and Risk Manager). The AOC then reports to the Superintendent and the Commissioner. Also to be written in the Morning Report.

#3

Documents Separate from Medical Record

- Unit Shift Report
- Patient/Staff Assignments
- Individualized Shift Work Sheets
- "Critical Incident Report"
- "OD" Book
- McDowell Report
- Bouffard, Estabrook, Williams Report
- Peer Review
- Memos
- Individual Patient Report

FLOW CHART ACCIDENT/ INCIDENT REPORTING PROCESS



STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

September 13, 1996

Honorable Joan Pendexter, Chair
Honorable Michael Fitzpatrick, Chair
Health and Human Services Committee
State House
Augusta, Maine 04333

Dear Senator Pendexter and Representative Fitzpatrick:

As you have requested, the following is a description of the non-patient chart documents previously identified for the Committee.

1. Unit Shift Report: This document is completed by the Charge Nurse on each unit for each patient. It records, on an abbreviated basis, critical information that is planned to occur or actually did occur for the patient during that shift. It is a communication tool between staff on all shifts. It serves as the basis for the change of shift report that occurs at 6:45 am; 2:45 pm and 10:45 pm each day. It is written so that it may be referred to as needed from day-to-day. It is maintained in the unit Nursing Office. (This form is labeled: Patient Profile/Pertinent Patient Data)

2. Patient/staff assignments: These forms are completed on each unit by the Charge Nurse or designee. The forms list each patient's name and the staff member primarily responsible for care of that patient during that shift of duty. It also lists other tasks and the staff assigned to complete them each shift. (This form is labeled: Assignments, and includes a shift designation)

3. Individualized shift work sheets: These are notes developed by the Charge Nurse that summarize the information the nurse received from the off-going charge nurse. This is not a designated AMHI form. Most Charge Nurses have approached this information gathering in different ways and usually these notes are not retained by the facility but are the personal notes of the charge nurse.

4. "Critical incident report": This report is completed by the Nursing Supervisor on duty on evenings, nights, weekends and holidays. It provides a "thumbnail" sketch of critical events, such

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as: fires, high profile incidents, security issues, that may occur which involve patients, staff or visitors. It is maintained in the Nursing Supervisor's Office.

5. "OD" book: This "Officer of the Day" notebook is maintained by the PA (Physician's Assistant) on evenings and nights and is left at the AMHI switchboard during week days. It is used as a communication tool among the three PA's who work during that time each week. Examples of information that might be recorded are information received by telephone on pending admissions and calls received by the PA regarding inpatient needs.

6. Administrator on Call Book: There are designated department heads who act in the absence of the Superintendent on evenings and weekends. A composition type notebook serves as the recording document for calls received and actions taken during that time. Administrators on call follow-up the next working day to assure issues are addressed. It is maintained in the superintendent's office.

7. McDowell Report: The Commissioner appointed an independent review team, chaired by Don McDowell, to examine the issues related to the death of Wrendy Hayne. This report is the result of their review.

8. Bouffard, Estabrook and Williams Report: Following issuance of the McDowell Report, the Commissioner directed Rod Bouffard, Richard Estabrook, and Don Williams, employees of the Department of MH, MR and SAS to review the issues related to the care and treatment by AMHI staff of Wrendy Hayne and Harold Pulsifer. This report is the result of their investigation.

9. Peer Review: Three members of AMHI Medical Staff reviewed the issues related to the death of Wrendy Hayne and specifically the performance of Dr. Hermida and Dr. Renshaw. There is a peer review undertaken whenever a significant issue of medical care is raised. Peer reviews are maintained in the Medical Director's Office.

10. Miscellaneous Memos: These are memoranda related to the care and treatment of Harold "Pete" Pulsifer and to the care, treatment and death of Wrendy Hayne. These memoranda are documents of internal communication between staff at AMHI.

11. Individualized Patient report: This is the same as #1.

12. Death review report: This is a report completed under an arrangement with the Maine Medical Association. A subcommittee designated by that group completed a review of the care and treatment and death of Wrendy Hayne. This group reviews every patient death at AMHI.

Initial review by the Attorney General's Office suggests that the following confidentiality laws may limit the availability of the documents for review.

1. 34 - B M.R.S.A. Section 1207
2. 34 - B M.R.S.A. Section 1207
3. 34 - B M.R.S.A. Section 1207

4. 34 - B M.R.S.A. Section 1207, 24 M.R.S.A. Section 2510
5. 34 - B M.R.S.A. Section 1207
6. 34 - B M.R.S.A. Section 1207
7. Confidentiality issues concerning this report have already been addressed by District Court.
8. 34 - B M.R.S.A. Section 1207, 5 M.R.S.A. Section 7070; 24 M.R.S.A. Section 2510
9. 34 - B M.R.S.A. Section 1207, 5 M.R.S.A. Section 7070; 24 M.R.S.A. Section 2510
10. 34 - B M.R.S.A. Section 1207, 24 M.R.S.A. Section 2510
11. 34 - B M.R.S.A. Section 1207
12. Confidentiality issues concerning this report have already been addressed by District Court.

I hope this information is responsive to your request.

Sincerely,

Melodie J. Peet
Commissioner

MJP/dg

Orbeton, Jane

From: Waterbury, Jamie A.
To: Orbeton, Jane
Cc: Peet, Melodie; Spencer, Sandra C.; Douglas, Wayne R.
Subject: Top Clinical Staff at AMHI in April
Date: Tuesday, September 17, 1996 2:12PM

The following information is provided as requested:

Top clinical staff at AMHI in April:

Director of Nursing	Kathy Guilbault	- Still at AMHI
Clinical Director	Dr. Gordon Clark	- No longer at AMHI/or Dept.
Superintendent	Walter Lowell	- No longer at AMHI (but still employed by DMHMRSAS in different capacity)

If you need further information, please let me know. Thanks.

AUGUSTA MENTAL HEALTH INSTITUTE

GOVERNING BODY BYLAWS

ARTICLE I
DEFINITIONS

For the purposes of these Bylaws, the following terms shall have the following meanings:

Commissioner: Commissioner of the Department of Mental Health and Mental Retardation

Associate Commissioner, Programs: Associate Commissioner for Programs of the Department of Mental Health and Mental Retardation

Associate Commissioner, Administration: Associate Commissioner for Administration of the Department of Mental Health and Mental Retardation

Medical Director: Medical Director for the Department of Mental Health and Mental Retardation.

Superintendent: Superintendent of Augusta Mental Health Institute

Clinical Director: Director of Clinical Services, Augusta Mental Health Institute.

Director of Nursing: Director of Nursing of Augusta Mental Health Institute.

Institute: Augusta Mental Health Institute

Department: Department of Mental Health and Mental Retardation

ARTICLE II
PURPOSE AND SCOPE

The Governing Body of Augusta Mental Health Institute, owned and operated by the State of Maine, is composed of the Commissioner, the Associate Commissioner for Programs, the Associate Commissioner for Administration, the Superintendent, the Director of Clinical Services, an elected member of the Medical Staff, and the Director of Nursing. The Chief Operating Officer serves as the Secretary to the Governing Body, and is also a voting member.

The Governing Body has the overall responsibility for the operation of Augusta Mental Health Institute, establishing policy, maintaining quality patient care,

providing for institutional management, as well as planning and reviewing its own performance.

The Commissioner of the Department of Mental Health and Mental Retardation serves as chair of the Governing Body.

The Governing Body, via the Commissioner, is responsible to the Governor of the State of Maine and to the Legislature. The Legislature has statutory responsibility for approving the operating budget, capital improvements and numbers of positions at the Augusta Mental Health Institute.

The Governing Body, through these bylaws, establishes a committee structure to carry out the purposes of the Augusta Mental Health Institute.

The Governing Body shall formally meet at least quarterly and shall keep minutes of these meetings. These minutes shall include at least:

1. Date of the meeting;

2. Names of the members who attended;

3. Approval of minutes and interim actions;

4. Topics discussed;

5. Decisions reached and actions taken;

6. Parties responsible for implementation of recommendations;

7. Review of committee minutes: Management, Medical Staff, Safety Committee, Quality Policy Review; and

8. Reports of the Superintendent.

Informal or ad hoc meetings may be held, as necessary, at the Institute or the Department. Actions taken will be formalized at the next regular meeting.

A quorum shall consist of two thirds of the membership of the Governing body. All new Governing Body members shall receive an orientation to Augusta Mental Health Institute. Meetings will be conducted informally using consensus decision making to advise the Commissioner, whose decision will be final. The Governing Body shall ensure that all members participate in continuing education and remain up to date on current trends and legal and ethical standards in the field.

Bylaws shall be reviewed by the Governing Body at least every 3 years, or more frequently as necessary, signed by the Governing Body members and dated.

ARTICLE III
MEMBERSHIP, AUTHORITY, AND RESPONSIBILITY OF THE GOVERNING BODY

The Governing Body members have both individual and corporate responsibilities on behalf of the Institute. Individual responsibilities result from the members' duties and responsibilities inherent in their respective positions within the Department. All members should understand and FULFILL their roles and responsibilities.

Commissioner: The Department of Mental Health and Mental Retardation is under the direction and supervision of the Commissioner. The Commissioner has the responsibility for the supervision, management and control of research and planning, grounds, buildings and property, offices, employees and patients of Augusta Mental Health Institute. The Department is charged with the enforcement of all laws concerning the Institute, except in those cases where specific duties are given elsewhere.

The Department is authorized and empowered to accept for the State any Federal funds appropriated under Federal laws related to mental health and mental illness, and to do those acts which are necessary for the purpose of carrying out those Federal laws; and to accept from any other agency of government, individual group or corporation any funds which may be available in carrying out the provisions contained in the laws of the State of Maine.

As Chair of the Governing Body, the Commissioner is responsible for approving the agenda, conducting the meeting, focusing discussion and speaking for the Governing Body.

Associate Commissioner for Administration: The Associate Commissioner for Administration is responsible for fiscal administrative management of the Department. This role involves oversight of the business personnel and support areas of the Institute, and provides coordination and communication among the three major institutions within the Department. The Associate Commissioner also serves as the intermediary and advocate for the Institute with the Bureau of Budget, the Department of Human Resources, and the Bureau of General Services.

Superintendent of the Augusta Mental Health Institute: The Superintendent by statute has general superintendence of the Institute under the direction of the Department. The Superintendent reports to the Commissioner, acting for the Governing Body on a day to day basis. Under current statute, the Superintendent also serves as Director of the Division of Mental Health with broad responsibility for both State mental

health institutes, and planning for adult community mental health services.

The Superintendent directs the Institute within established statutory provisions and incorporates the Department and Bureau policies to assure the orderly operation of this facility and is designated as the appointing authority for all Institute staff.

The Superintendent is responsible for the quality of care given at Augusta Mental Health Institute, and all aspects related to that function.

The Superintendent is responsible for the financial affairs of the Institute, assuring that audit recommendations are implemented and that policies and procedures of the Department of Finance and Administration are followed.

The Superintendent has the authority and responsibility to organize and direct the resources of the Institute in order to fulfill its assigned Mission which is:

> To provide for a continuum of the highest quality mental health services to individuals who require inpatient psychiatric care and treatment. Services are designed to contribute to maximum self-management of illness, and self-advocacy in obtaining critical resources. Services are provided in an environment that affirms the dignity and worth of those receiving treatment. In the interest of continuously improving services and reducing the stigma frequently attached to mental illness, Augusta Mental Health Institute supports comprehensive staff development, as well as research activities designed to increase knowledge about individuals with severe and persistent mental illness. Support staff participate in these functions and are viewed as critical members of the hospital team.
>
> Skilled staff support patients and families by assessing and building upon existing individual and family system strengths, and by treating all individuals with dignity and respect.
>
> Staff function as healing agents, recognizing the importance of human relationships on health, and the disruption that is created by illness and hospitalization. Whole person care addresses the relationships among mind, body and spirit.
>
> Patients and families are acknowledged as essential members of the healthcare team, and are actively involved in treatment planning. Treatment promotes continuity between hospital and outpatient services, relying on a working partnership with

community services providers to assist patient in realizing their goals.

The Superintendent is responsible for long-term and short-term planning for the facility. This occurs within the context of Department of Mental Health and Mental Retardation planning including the State Mental Health Plan, the state budget, cooperative planning with community providers and advisory groups, and internal planning for the development and allocation of resources.

In addition, the Superintendent mandates and directs a comprehensive quality improvement system, operating under a plan that assures that the most important aspects of patient care are continuously monitored and evaluated, problems corrected and results monitored, and opportunities for improvement identified utilizing the administrative and professional committee structure.

The Superintendent is responsible for policy and procedure development and review in a manner which meets the standards of the JCAHO, and of federal and state certifying agencies.

The Superintendent also strives, through the State budget process, to assure the availability of sufficient physical and financial resources to adequately serve the Institute population. The Superintendent reviews institutional activities and services and supervises and participates in the preparation of the Institute's budget.

The Superintendent is responsible for establishing a chain of supervision for the operation of the facility in his/her absence.

This shall be in order, (1) the Chief Operating Officer; (2) Director of Clinical Services; (3) Director of Hospital Services; and (4) the Director of Nursing. and (5) Assistant to the Superintendent. These persons shall have the authority to serve as chief administrative officer for all statutory obligations. The N. O. D. is delegated the authority to make day to day operational decisions when specific authorization of the Superintendent is not needed or when contact with the Superintendent is unsuccessful and a decision cannot wait. During evening and nighttime hours, an Administrator-on-Call rotation is established to provide support to the NOD function.

The Superintendent's performance is evaluated annually by the Commissioner and the Governing Body. The Superintendent is responsible for assuring that the agenda is properly prepared for approval of the Commissioner and that accurate minutes are taken with regard to topics discussed, action taken, and members present, absent and excused.

Clinical Director of the Augusta Mental Health Institute: The Director of Clinical Services functions as the chair of the Medical Executive Committee and ensures that controls are in place to ensure each member of the professional staff observe the standards of the profession and assume and carry out functions in accordance with federal, state, and local laws, rules and regulations. The Director of Clinical Services is responsible to the Superintendent for the diagnosis and treatment of patients served at the Institute and for the quality of that treatment.

Elected Member of the Medical Staff: In addition to the Clinical Director, one additional member, selected by the Medical Staff, will attend the Governing body. This individual will attend all meetings and speak for the Medical Staff.

Corporate responsibilities occur consonant with the Governing Body's duty to establish policies, maintain quality patient care, provide for institutional management and planning and to assist the hospital in meeting its mission.

The Governing Body Shall:

a) Authorize the establishment of a Medical Staff.
b) Review and approve Medical Staff Bylaws, including membership, credentials review, clinical privileges and mechanisms for fair hearing procedures and membership termination.
c) Authorize the Superintendent to review and approve, if appropriate, specific clinical privileges for each eligible individual which are in turn approved by the Governing Body.
d) Review and approve the operating budget and capital improvement requests to be forwarded to the Department for further review and inclusion in the Department's overall budget submission to the Bureau of the Budget.
e) Support and participate in long range planning for the Institute.
f) Review and approve the Institute's Quality Improvement Plan.
g) Annually review the performance of the Governing Body.
h) Receive reports from an elected member of the Medical Staff concerning discussions and recommendations, if any, from Medical Staff and Clinical Executive Committee.
i) Approve Governing Body Bylaws which meet the criteria of JCAHO.
j) Appoint and evaluate the Chief Executive Officer.
k) Delineate authority and responsibility of the Governing Body, the Medical Staff, and the Executive Staff and to see that there is a clearly defined Table of Organization which defines lines of authority and accountability.
l) Establish and maintain systematic and effective communication mechanisms between the Governing Body and the Chief Executive Officer, Director of Clinical Services and Medical Staff.

m) Maintain a record of Governing Body proceedings and insist that similar records exist for other important committees.

n) Require that only members of the Medical Staff with privileges may admit and insist that patient care is under the direction of a physician on staff.

o) Establish and maintain a mechanism to assure that all individuals who provide patient care are competent to provide such care.

p) Require mechanisms to insure the provision of one level of care, insuring that patients with the same problems get the same level of care.

q) Require summary reporting on quality of patient care and quality assurance system.

r) Approve an institutional budget and monitor the implementation of that budget.

s) Approve Committee Structure.

t) Avoid conflict of interest.

ARTICLE IV
QUALIFICATIONS AND APPOINTMENT PROCESS TO THE GOVERNING BODY

I. Commissioner

A. The Commissioner shall be a person experienced in Human Services Administration or who has had other satisfactory experience in the direction of work of a comparable nature.

B. The Governor of the State of Maine shall appoint the Commissioner with the advice and consent of the Joint Standing Committee on Human Resources and the Maine Senate for as long as he shall so behave at the pleasure of the Governor, subject to removal for cause by the Governor.

C. The Commissioner may appoint, subject to the Personnel Law and except as may otherwise be provided, any employees who may be necessary.

II. Associate Commissioner of Programs

A. The Associate Commissioner for Programs shall be a person experienced in Human Services Administration or who has had other satisfactory experience in the direction of work of a comparable nature.

B. The Commissioner of the Department of Mental Health and Mental Retardation shall appoint the Associate Commissioner. The appointment shall be at the pleasure of the Commissioner for an indeterminate term and until a successor is appointed and qualified.

C. It shall be the duty of the Associate Commissioner to carry out the purposes of the Department.

III. Associate Commissioner of Administration

A. The Associate Commissioner for Administration shall be a person experienced in Human Services Administration or who has had other satisfactory experience in the direction of work of a comparable nature.

B. The Commissioner of the Department of Mental Health and Mental Retardation shall appoint the Associate Commissioner. The appointment shall be at the pleasure of the Commissioner for an indeterminate term and until a successor is appointed and qualified.

C. It shall be the duty of the Associate Commissioner to carry out the purposes of the Department.

IV. Medical Director

A. The Medical Director shall be a psychiatrist who, in addition to appropriate licensure and certification, has at least 8 years of progressively responsible clinical and administrative experience in community and institutional settings providing care, treatment, and habilitation for persons with psychiatric and developmental disabilities.

B. The Medical Director is appointed by the Commissioner and has major responsibilities in the areas of quality assurance, staff development, clinical supervision, consultation, research and evaluation.

C. The Medical Director is responsible to the Commissioner for the development, implementation, and periodic evaluation of a planned and systematic process for assuring quality and appropriate patient care.

IV. Superintendent

A. The Superintendent, if s/he is a psychiatrist, shall have the following qualifications: certification in psychiatry by the American Board of Psychiatry and Neurology, or similar

qualification; certification of eligibility for certification, in administration by the American Psychiatric Association Committee on certification in Administrative Psychiatry and at least 2 years experience in administration, or have completed a 2-semester course in hospital administration, with emphasis on psychiatric hospital administration. When a non-psychiatrist is the Superintendent, s/he shall have the following qualifications: a masters degree in hospital administration or its equivalent, and 5 year's experience in administration of a psychiatric facility or in the psychiatric field, or have the equivalent of such education and experience.

B. The Superintendent is appointed by the Commissioner in consultation with the Mental Health Advisory Council to act in their behalf in the overall management of the Institute for an indeterminate term at the pleasure of the Commissioner.

V. Director of Clinical Services

A. The Director of Clinical Services shall be a psychiatrist who is licensed to practice medicine in the State of Maine and is certified in psychiatry by the American Board of Psychiatry and Neurology.

B. The Director of Clinical Services is appointed by the Superintendent and the Governing Body and serves in accordance with the Professional Clinical Staff Bylaws and in accordance with the Personnel Rules and Regulations for Maine State Employees. The clinical administrative responsibility for the diagnosis and treatment of patients shall rest with the Clinical Director who is accountable therefore to the Governing Body.

VI. Director of Nursing

A. The Director of Nursing Services shall be a Registered Nurse, prepared on the Master's level, licensed to practices nursing by the Board of Nursing in Maine, and have 10 years experience in nursing, with clinical experience in psychiatric nursing and progressive experience in nursing administration.

B. The Director of Nursing is appointed by the Superintendent. The clinical and administrative responsibilities for meeting professional standards of nursing practice rests with the Director of Nursing.

ARTICLE V
COMMITTEES

The Superintendent shall establish a committee structure in order to fulfill the responsibilities of the Governing Body, to assess the results of the facility's activities, to meet standards requirements, legal mandates, and to assist in the effective management of the facility. The Superintendent shall be an ex-officio member of all Institute committees. The Superintendent will review the purpose of each standing committee at least annually in order to assure that the facility's goals and objectives are being met. At a minimum, there shall be constituted, a Medical Executive Committee and a Safety Committee. However, the Superintendent shall establish additional standing and ad hoc committees as needed to ensure the purposes of the Institute are being met.

The Governing Body, through the authority of the Superintendent, authorizes the Medical Staff to establish committees in order to fulfill its functions. A current list of committees established will be maintained by the Superintendent and can be found in Chapter 6 of the Hospital's Policy Manual.

ARTICLE VI
PROFESSIONAL MEDICAL STAFF

The Governing Body recognizes the authority and responsibility of the Medical Staff of the hospital. The Medical Staff's role and functions are established through its bylaws which are approved by the Governing Body.

The Medical Staff must work with, and is subject to, the ultimate authority of the Governing Body; however, full cooperation is necessary between the Medical Staff and the Governing Body in order to provide quality care to patients in the hospital.

The Medical Staff shall account to the Governing Body for the quality and appropriateness of patient care rendered by all its members and other health professionals through a program of credentials review and privileging, a comprehensive quality assurance program, and an organized method of taking corrective action with respect to professionals as provided in the Medical Staff Bylaws.

A. **Medical Staff Appointments**: The Governing Body has the authority and responsibility for appointing Medical Staff members. The Medical Staff shall establish, review and revise at least annually, bylaws, rules, and, as necessary, procedures for processing and evaluating applications for Medical Staff membership and for granting of clinical privileges. The Governing Body shall approve all clinical privileges upon recommendation of the Clinical Executive Committee and approval of the Director of

Clinical Services and the Superintendent.

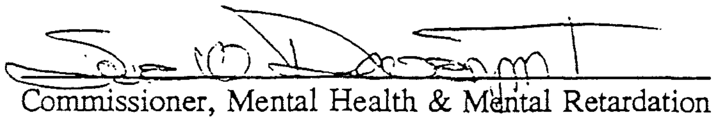
No applicant shall be denied Medical Staff membership or clinical privileges on the basis of sex, race, creed, color, or national origin.

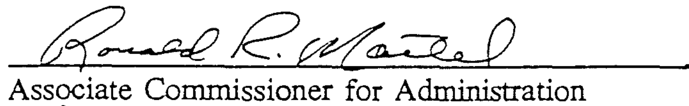
B. <u>Corrective Action</u>: Whenever the activities or professional conduct of any professional with clinical privileges are detrimental to patient safety or to the delivery of quality patient care, violate policies adopted by the Governing Body, violate Medical Staff Bylaws or the rules and regulations of the Medical Staff, or are disruptive to hospital operations, or whenever a professional fails to meet and satisfy the qualifications for staff status provided in the Medical Staff Bylaws, corrective action against such professional may be initiated by any member of the Medical Staff, by the Superintendent, or by the Governing Body. Determinations and actions shall be based on the foregoing criteria. All deliberations relative to corrective actions will occur in accordance with the Medical Staff Bylaws.

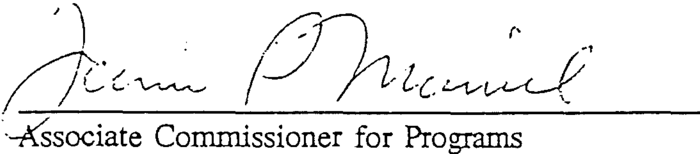
C. <u>Medical Staff Duties in Relation to Governing Body</u>: The Medical Staff/Clinical Executive Committee, make recommendations directly to the Governing Body for its approval in, at least, the following areas:

(1) Structure of the medical staff;
(2) The mechanism used to review credentials and to delineate individual clinical privileges;
(3) Individual medical staff membership;
(4) Specific individual privileges for each eligible member;
(5) The organization of the quality assurance activities of the Medical Staff as well as the mechanism used to conduct, evaluate and revise such activities;
(6) Mechanism by which membership on the medical staff may be terminated; and
(7) Mechanism for fair hearing procedures.

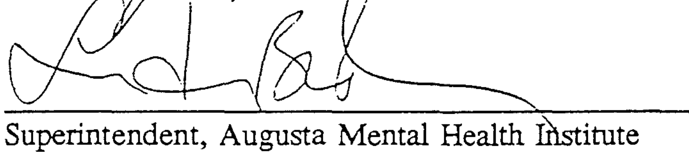
The undersigned Governing Body members have reviewed and approved the written Governing Body Bylaws:


Commissioner, Mental Health & Mental Retardation

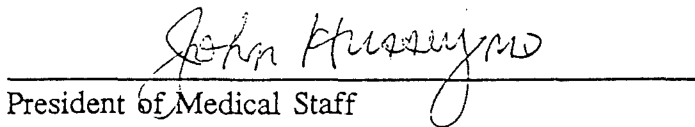

Associate Commissioner for Administration


Associate Commissioner for Programs

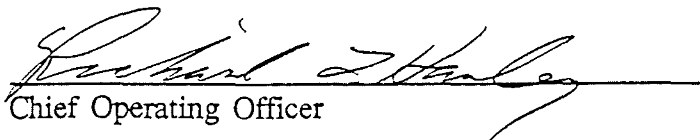
Medical Director, DMHMR


Superintendent, Augusta Mental Health Institute

Director of Clinical Services


President of Medical Staff

Director of Nursing Services


Chief Operating Officer

Reviewed 7/94

 DISTRIBUTED 10/7/96

Doc. Total = $9,000.00

STATE OF MAINE
CONTRACT FOR SPECIAL SERVICES 14B 6960157

Vendor Code	DOC TOTAL	FND	AGY	ORG	Sub Org	APPR	Activity	OBJ	Sub Org	Job No.
01-0216933	$3,334.00	010	14B	5401		102		4099		
	$5,666.00	014	14B	2401		202		4099		

Termination Date: June 30, 1997 Date Received: ____________

THIS AGREEMENT, made this 20th day of May, 1996, is by and between the State of Maine, Department of Mental Health and Mental Retardation, hereinafter called "Department," and Maine Medical Association hereinafter called "Contractor."

The type of organization of the Contractor is (complete appropriate statement):
- ☐ 1. An individual doing business as ____________.
- ☐ 2. A partnership.
- X 3. A corporation of the State of Maine.
- ☐ 4. Other: ____________.

The principal office of the Contractor is located at (street, city, state, zip):
P.O. Box 190, Association Drive, Manchester, Maine 04351.
The Employer Identification Number of the Contractor is: 01-0216933.
IRS or Social Security Number

WITNESSETH, that for and in consideration of the payments and agreements hereinafter mentioned, to be made and performed by the Department, the Contractor hereby agrees with the Department to furnish all qualified personnel, facilities, materials and services and in consultation with the Department, to perform the services, study or projects described in Rider A. The following riders are hereby incorporated into this contract by reference:

Rider A - Specifications of Work to be Performed
Rider B - Payment and Other Provisions

ENCUMBERED
JUN 14 1996
STATE CONTROLLER

IN WITNESS WHEREOF, the Department and the Contractor, by their representatives duly authorized, have executed this agreement in 5 originals as of the day and year first above written.

Cathy Morrison

APPROVED AS TO FORM:

Date: ____________ 19__

By: ____________
Attorney General

DEPARTMENT:

Augusta Mental Health Institute
Mental Health & Mental Retardation
Department Name

By: Walter E. Lowell
Authorized Signature

APPROVED, CONTRACT REVIEW COMMITTEE:

Date: JUN 12 1996 19__

By: Richard B. Thompson
Chairman

CONTRACTOR:

Maine Medical Association
Contractor Name

By: [signature]
Authorized Signature

____
Typed Name and Title

*By Bureau of Accounts and Control — TINTED FIELDS ARE REQUIRED ON MFASIS — BP54 (883) (Rev. 9/89)

RIDER A
SPECIFICATIONS OF WORK TO BE PERFORMED

The Department may request that a review be done of a single clinical service or may request a series of reviews of two or more specialties.

2. If the Department requests a series of reviews, there will be two reviews conducted each year at approximately six month intervals. The staff of AMHI will identify the sequence in which the reviews are to occur: i.e. which clinical service is to be done first, second, etc.

3. The number of peer reviews to be done by Maine Medical Association are as follows:

AMHI staff physicians:

10 = Family Practice Physicians (10 charts each)
2 = Psychiatrists (10 charts each)

Contract Physicians

10 = Psychiatrists (5 charts each)

15 = Total Reviews

A random sampling process using the skip interval technique to identify the cases. The sampline universe will include all cases admitted to that particular clinical service during the preceeding 1 month period. An additional 5 cases may be specifically selected on recommendation of member of the staff through the Chief of Staff. It is encouraged that physicians being reviewed provide office records on the cases selected. X-rays should be available to the review team.

It is encouraged that physicians being reviewed provide office records on the cases selected. X-rays should be available to the review team.

4. The Chairman of the Peer Review Committee of the Maine Medical Association will appoint a sub- committee of three specialists to conduct the review. The Chairman of the subcommittee will be responsible for coordinating the timing of the review in conjunction with the Administrative staff of AMHI.

5. The Medical Records department at AMHI will assume responsibility for identifying and pulling the appropriate medical records and x-rays so that they will be available at the time of the review.

6. The specialist consultants will meet at 10:00 a.m. and a preliminary discussion will be held among them and the chief of staff and doctor or doctors being reviewed to assure that appropriate waivers and confidentiality statements have been signed and to organize the review process. It is anticipated service to be reviewed will be available during the course of the day for questions and discussion if the reviewers so desire.

7. The chart review itself will last from approximately 10:30 a.m. to mid-afternoon. A checklist of quality elements will be identified for which all charts will be reviewed. It is suggested that the draft review criteria formulated by the AMA be used as a checklist as a way of assessing basic levels of acceptable quality of care.

However, it is to be understood that the major thrust of the review process is to focus on aspects of appropriateness of procedures and judgment in decision making. Each consultant will prepare a brief written outline of his findings and conclusions for each case at the time of review.

8. If they wish, the consultants will meet with the clinical service to be reviewed singly at the end of their review. Otherwise, they will meet with the Clinical Director and the President of Medical Staff at the end of the afternoon. During this time a presentation will be made by the Chairman of the Specialists Review Group outlining in general the findings reached during the review process. It is anticipated that a dialogue will occur regarding management of cases. Appropriate minutes will be kept of this meeting to document the discussion and to clearly outline the issues which are raised. Working documents and notes will not be preserved.

9. The Chairman of the Specialist Review Committee will prepare a draft written report summarizing the findings of the process and making any recommendations. This draft report will be sent to the Clinical Director and President of Medical Staff. The Clinical Director at AMHI will be asked to respond to this report in writing and will be specifically requested to indicate any aspects of the findings with which he or other members of the clinical department take issue or question. If necessary, the supervising members of the Peer Review Committee of the MMA will clarify questions or resolve disagreements. Once accomplished, a final report will be prepared and submitted to the Peer Review Committee of the MMA for review by the chairman and filing.

10. The final report will be sent to the Clinical Director for transmittal to the staff, Executive Committee and hospital administration.

RIDER B
PAYMENT AND OTHER PROVISIONS

1. **CONTRACT PRICE.** **$9,000.00**

2. **INVOICES AND PAYMENTS.** Payment shall be made by the Department within 15 days after receipt of an approved itemized invoice submitted by the Contractor upon his usual billing forms or business letterhead.

3. **BENEFITS AND DEDUCTIONS.** If the Contractor is an individual, the Contractor understands and agrees that he is an Independent Contractor for whom no Federal or State Income Tax will be deducted by the Department, and for whom no retirement benefits, survivor benefit insurance, group life insurance, vacation and sick leave, and similar benefits available to State employees will accrue. The Contractor further understands that annual information returns as required by the Internal Revenue Code or State of Maine Income Tax Law will be filed by the State Controller with the Internal Revenue Service and the State of Maine Bureau of Taxation, copies of which will be furnished to the Contractor for his Income Tax records.

4. **INDEPENDENT CAPACITY.** The parties hereto agree that the Contractor, and any agents and employees of the Contractor, in the performance of this agreement, shall act in an independent capacity and not as officers or employees or agents of the State.

5. **CONTRACT ADMINISTRATOR.** All invoices, progress reports, correspondence and related submissions from the Contractor shall be directed to:

   Name: Gordon Clark, M.D.

   Title: Clinical Director

   Address: P.O. Box 724, Augusta, Maine 04330

   who is designated as the Contract Administrator on behalf of the Department for this contract.

DEPARTMENT"S REPRESENTATIVE. The Contract Administrator shall be the Department's representative during the period of this agreement. He has authority to stop the work if necessary to insure its proper execution. He shall certify to the Department when payments under the contract are due and the amounts to be paid. He shall make decisions on all claims of the Contractor, subject to the approval of the Head of the Department.

7. **CHANGES IN THE WORK.** The Department may order changes in the work, the contract sum being adjusted accordingly. All such orders and adjustments shall be in writing. Claims by the Contractor for extra cost must be made in writing and signed by the Contract Administrator before executive the work involved.

8. **PERIOD OF PERFORMANCE.** The Contractor shall (check one as applicable):

   X A. Work when called by the Department. (Quarterly)

   ☐ B. Use due diligence to complete the work within a reasonable time.

   ☐ C. Complete the work no later than ______________________.

   ☐ D. If the work is not completed by ______________________, Contractor shall pay Department as follows: ____ ______________________

9. **SUBCONTRACTS.** Unless provided for in this contract, no contract shall be made by the Contractor with any other party for furnishing any of the work or services herein contracted for without the consent, guidance and approval of the Contract Administrator. Any subcontract hereunder entered into subsequent to the execution of the contract must be annotated "Approved" by the Contract Administrator before it is reimbursable hereunder. This provision will not be taken as requiring the approval of contracts of employment between the Contractor and his employees assigned for services thereunder.

10. **SUBLETTING, ASSIGNMENT OR TRANSFER.** The Contractor shall not sublet, sell, transfer, assign, or otherwise dispose of this agreement or any portion thereof, or of his right, title or interest therein, without written request to and written consent of the Contract Administrator, except to a bank. No subcontracts or transfer of agreement shall in any case release the Contractor of his liability under this agreement.

EQUAL EMPLOYMENT OPPORTUNITY. During the performance of this contract, the Contractor agrees as follows:

a. The Contractor will not discriminate against any employee or applicant for employment relating to this agreement because of race, color, religious creed, sex, national origin, ancestry, age or physical handicap, unless related to a bona fide occupational qualification. The Contractor will take affirmative action to insure that applicants are employed and employees are treated during employment, without regard to their race, color, religion, sex, age or national origin. Such action shall include but not be limited to the following: employment, upgrading, demotions, or transfers; recruitment or recruitment advertising; layoffs or terminations; rates of pay or other forms of compensation; and selection for training including apprenticeship. The Contractor agrees to pose in conspicuous places available to employees and applicants for employment notices setting forth the provisions of this nondiscrimination clause.

b. The Contractor will, in all solicitations or advertising for employees placed by or on behalf of the Contractor relating to this agreement, state that all qualified applicants will receive consideration for employment without regard to race, color, religious creed, sex, national origin, ancestry, age or physical handicap.

c. The Contractor will send to each labor union or representative of the workers with which he has a collective or bargaining agreement, or other contract or understanding, whereby he is furnished with labor for the performance of this contract, a notice, to be provided by the contracting department or agency, advising the said labor union or workers' representative of the Contractor's commitment under this section and shall post copies of the notice in conspicuous places available to employees and to applicants for employment.

d. The Contractor will cause the foregoing provisions to be inserted in any subcontracts for any work covered by this agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials. The Contractor, or any subcontractor holding a contract directly under the Contractor, shall, to the maximum feasible, list all suitable employment openings with the Maine Employment Security Commission. This provision shall not apply to employment openings which the Contractor, or any subcontractor holding a contract under the Contractor, proposes to fill from within its own organization. Listing of such openings with the Employment Service Division of the Maine Employment Security Commission shall involve only the normal obligations which attach to such listings.

12. **EMPLOYMENT AND PERSONNEL.** The Contractor shall not engage on a full-time, part-time or other basis during the period of this agreement, any professional or technical personnel who are or have been at any time during the period of this agreement in the employ of any State Department or Agency, except regularly retired employees, without the written consent of the public employer of such person. Further, the Contractor shall not engage on this project on a full-time, part-time or other basis during the period of this agreement any retired employee of the Department who has not been retired for at least one year, without the written consent of the Contract Review Committee.

13. **STATE EMPLOYEES NOT TO BENEFIT.** No individual employed by the State at the time this contract is executed or any time thereafter shall be admitted to any share or part of this contract or to any benefit that may arise therefrom directly or indirectly due to his employment by or financial interest in the Contractor or any affiliate of the Contractor. This provision shall not be construed to extend to this contract if made with a corporation for its general benefit.

14. **WARRANTY.** the contractor warrants that it has not employed or written any company or person, other than a bonafide employee working solely for the contractor to solicit or secure this agreement, and that it has not paid, or agreed to pay any company or person, other than a bonafide employee working solely for the Contractor any fee, commission, percentage, brokerage fee, gifts, or any other consideration, contingent upon, or resulting from the award for making this agreement. For breach or violation of this warranty, the Department shall have the right to annul this agreement without liability or, in its discretion, to deduct from the contract price or consideration, or otherwise recover the full amount of such fee, commission, percentage, brokerage fee, gifts, or contingent fee.

1 **ACCESS TO RECORDS.** The Contractor shall maintain all books, documents, payrolls, papers, accounting records and other evidence pertaining to cost incurred under this agreement and to make such materials available to their offices at all reasonable times during he period of this agreement and for three years from the date of the expiration of this agreement, for inspection by the Department or any authorized representative of the State of Maine and copies thereof shall be furnished, if requested.

16. **TERMINATION.** The performance of work under the contract may be terminated by the Department in whole, or, from time to time, in part whenever for any reason the Contract Administrator shall determine that such termination is in the best interest of the Department. Any such termination shall be effected by delivery to the Contractor of a Notice of Termination specifying the extent to which performance of the work under the contract is terminated and the date on which such termination becomes effective. The contract shall be equitably adjusted to compensate for such termination and the contract modified accordingly. In any event, this contract shall terminate on June 30, 1997.

7. **GOVERNMENTAL REQUIREMENTS.** The Contractor warrants and represents that all governmental ordinances, laws and regulations shall be complied with.

18. **INTERPRETATION AND PERFORMANCE.** This agreement shall be governed by the laws of the State of Maine as to interpretation and performance.

19. **OWNERSHIP.** ~~All notebooks, plans, working papers, or other work produced in the performance of this contract are the property of the Department and upon request shall be turned over to the Department.~~

20. **STATE HELD HARMLESS.** The contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work, services, materials or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of this contract and against any liability, including costs and expenses for violation of proprietary rights, copyrights, or rights of privacy, arising out of publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this contract or based on any libelous or other unlawful matter contained in such data.

21. **APPROVAL.** This contract is subject to the approval of the Maine Attorney General's Office, the Contract Review Committee and the State Controller before it can be considered as a valid, executable document.

22. **ENTIRE AGREEMENT.** This contract contains the entire agreement of the parties, and neither party shall be bound by any statement or representation not contained herein.

EXTERNAL REVIEW PROGRAM - PROTOCOL

_______________ Hospital
and Peer Review Committee of the
Maine Medical Association

Introduction:

The Medical Staff of the _______________ Hospital has endorsed the concept of an external review panel. This program is recommended because of the problems inherent in peer review and quality control in a small community hospital.

The Peer Review Committee of the Maine Medical Association has agreed to supervise and generally coordinate the conduct of such review. This document contains a suggested prodecure for the review process.

Goals:

The goals of the review process will be to:

1. Review individual practices within the hospital to ensure that the type and quality of care provided is current and appropriate.

2. Provide an education forum for the staff through the review mechanism.

3. Provide documentation of the quality of care at _______________ to the Medical Staff and Board of Directors.

Procedures:

1. A hospital may request that a review be done of a single clinical service or may request a series of reviews of two or more specialties.

2. For a hospital requesting a series of reviews, there will be two reviews conducted each year at approximately six month intervals. The Staff of the _______________ Hospital will identify the sequence in which the reviews are to occur: i.e. which clinical service is to be done first, second, etc.

3. Each review will consist of a total of 20-25 cases. Of this total, 20 cases will be selected by a random sampling process using the skip interval technique to identify the cases. The sampling universe will include all cases admitted to that particular clinical service during the preceding 12 month period. An additional 5 cases may be specifically selected on recommendation of members of the Staff through the Chief of Staff.

   It is encouraged that physicians being reviewed provide office records on the cases selected. X-rays should be available to the review team.

4. The Chairman of the Peer Review Committee of the Maine Medical Association will appoint a subcommittee of three Specialists to conduct the review. The Chairman of the Subcommittee will be responsible for coordinating the timing of the review in conjunction with the Administrative Staff of the ________________ Hospital.

5. The Medical Records Department at ________________ will assume responsibility for identifying and pulling the appropriate medical records and x-rays so that they will be available at the time of the review.

6. The Specialist Consultants will meet at 10:00 a.m. at the ________________ and a preliminary discussion will be held among them and the Chief of Staff and doctor or doctors being reviewed to assure that appropriate waivers and confidentiality statements have been signed and to organize the review process. It is anticipated that the service to be reviewed will be available during the course of the day for questions and discussion if the reviewers so desire.

7. The chart review itself will last from approximately 10:30 a.m. to mid-afternoon. A checklist of quality elements will be identified for which all charts will be reviewed. It is suggested that the draft review criteria formulated by the AMA be used as a checklist as a way of assessing basic levels of acceptable quality of care.

   However, it is to be understood that the major thrust of the review process is to focus on aspects of appropriateness of procedures, judgment in decision making, technical aspects of surgery, post-operative complications, etc. Each consultant will prepare a brief written outline of his findings and conclusions for each case at the time of review.

8. If they wish, the consultants will meet with the clinical service to be reviewed singly at the end of their review. Otherwise, they will meet with the entire Staff of the ________________ at the end of the afternoon. During this time a presentation will be made by the Chairman of the Specialists Review Group outlining in general the findings reached during the review process. It is anticipated that a dialogue will occur regarding management of cases. Appropriate minutes will be kept of this meeting to document the discussion and to clearly outline the issues which are raised. Working documents and notes will not be preserved.

9. The Chairman of the Specialist Review Committee will prepare a draft written report summarizing the findings of the process and making any recommendations. This draft report will be sent to the Staff of the ________________ Hospital. The Chief of Staff at the ________________ will be asked to respond to this report in writing and will be specifically requested to indicate any aspects of the findings with which he or other members of the Clinical Department take issue or question. If necessary, the Supervising members of the Peer Review Committee of the MMA will clarify questions or resolve disagreements. Once accomplished, a final report will be prepared and submitted to the Peer Review Committee of the MMA for review by the Chairman and filing.

10. The final report will be sent to the Chief of Staff for transmittal to the Staff, Executive Committee, Hospital Administration and Board of Directors.

11. The Survey Fee of $2150 payable to Maine Medical Association at the time release forms are returned, includes a stipend for the Consultants. In addition, Consultants will be reimbursed for their travel expenses and other incidental expenses by the Hospital.

Adopted 8/7/90

Release Form

EXTERNAL MEDICAL/SURGICAL REVIEW PROGRAM

______________________________ Hospital

WHEREAS, the ____________________ Hospital wishes for Dr. __________ __________ to participate in the External Medical/Surgical Review Program conducted by the Peer Review Committee of the Maine Medical Association for the ____________________ Hospital and,

WHEREAS, Dr. ____________________ has agreed to participate in these review activities but wishes to be released from any potential liability for acts, omissions, opinions, decisions, judgments or other conclusions or statements (written or oral) he/she may perform, reach or make as a part of the results of these review activities and,

WHEREAS, both parties wish to have assurance that the review will be conducted in a responsible and professional manner,

THEREFORE, the undersigned agree as follows:

The Board of Trustees of the ________________________ Hospital, the Medical Staff of the ____________________ Hospital and the physicians of the department being reviewed, hereby release Dr. ____________ and the Maine Medical Association, its employees and agents from any liability for any acts, omissions, statements (written or oral), opinions, judgments, or other conclusions he/she may perform, reach or make during the conduct of the External Medical/Surgical Quality Review at __________________________ Hospital so long as Dr. ________ _________ performs or expresses such acts, omissions, statements (written or oral), opinions or judgments only during specific meetings held during the conduct of the review or established with the Medical Staff of the ____________________ Hospital for this purpose or in written reports generated as a result of this review process and formally endorsed by the Peer Review Committee of the Maine Medical Association. Furthermore, the ____________________ Hospital agrees to provide Dr. _________________ with access to any and all medical records, committee minutes, members of the nursing and Medical Staff and any other material he/she may require for the purpose of conducting a complete review.

Dr. ____________________ hereby agrees to confine the scope of his review to issues directly related to the quality and appropriateness of medical and surgical care rendered at the ______________________ Hospital by Medical Staff members who are subject to the review being conducted and to comment on elements of care which fall only within the scope of his professional training and skills. Furthermore, he agrees not to release or disclose any information collected during the conduct of the review without the express written permission of both the _________________________ Hospital and the physician who rendered the care under review, other than as may be

required by law. Any requests for release of information generated during the course of this review will be referred to the ____________ ____________ Hospital and release of this information may be made only by that organization through its duly appointed representatives.

______________________________ (signature)
Reviewing Physician

______________________________ (signature)
Administrator

______________________ Hospital

______________________________ (signature)
Chief of Staff

______________________ Hospital

Physician(s) in Department being reviewed
(signature)

______________________________ ______________________________

______________________________ ______________________________

____
Date

Community hospital release forms should accompany check for Survey Fee and be mailed to Peer Review Committee, Maine Medical Association, P.O. Box 190, Manchester, Maine 04351.

State institution release forms should be mailed to Peer Review Committee, Maine Medical Association, P.O. Box 190, Manchester, Maine 04351. Billing will be done through the Department of Mental Health and Mental Retardation.

Adopted 3/14/89

Maine Medical Association
External Review Program

RESOURCE MATERIALS FROM HOSPITAL AVAILABLE FOR TEAM PRIOR TO ARRIVAL OR UPON ARRIVAL

1. List of doctor's surgical cases (if surgeon) in past year or his medical cases (if non surgeon) for doctor being reviewed

2. List of privileges from Credentials Committee of hospital for doctor being reviewed

3. C.V.

4. Photocopy of validated credentials and CME experiences for past two years [If grandfathered, include recent CME experiences only]

5. Departmental or sectional minutes pertinent to this service for the past twelve months

6. Quality Assurance Committee minutes pertinent to this service for the past twelve months

7. Tissue Committee reports pertinent to this service for the past twelve months

OTHER REQUESTS TO HOSPITAL

A. Ask hospital to include five ambulatory surgery cases in charts to be pulled for review of surgical services

B. Ask Chief of Staff to document to review team chairman any indication that the doctor's health status is a factor in his delivery of care

Adopted 3/14/89

Maine Medical Association
External Review Program

PROCEDURE FOR REVIEW TEAM LEADER AND COLLEAGUES

1. Prior to day of review, team leader orchestrates meeting of team, confirmation of date and time of review with hospital administration and transportation arrangements, if any, with other team members

2. On day of review, make presence in hospital known to hospital administrator immediately upon arrival

3. Confirm luncheon plans and opportunity to talk with administrator and Chief of Staff. If pathologist and operating room supervisors are to be interviewed, arrange it with administrator at this time

4. Organize work space in private area assigned by hospital

5. Review records with concern for decision making processes; are records legible; do progress notes make sense, etc.

6. Lunch - with adminstrator (or representative) and Chief of Staff

7. Review team completes and summarizes record review; formulates questions (if any) for physician being reviewed

8. If necessary, meet with physician(s) being reviewed in private to obtain physician responses to questions (opportunity for reviewee to meet reviewers). Team not to make summary remarks but discuss specific items of interest only

9. Team reconvenes in private to confirm with team leader the major points to be made in his report; resolve any differences of opinion

10. Team meets with service or entire staff as described in #8 of the Protocol.

11. Take leave of institution by returning records, minutes, and reports to administrator; indicate to administrator that you are leaving the premises

12. Each reviewer submits expenses directly to hospital; reviewer's stipend to be paid by Medical Association

13. Submit written report directly to hospital adminstrator and Chief of Staff

14. Submit copy of report to Chairman of Peer Review Committee care of MMA, P.O. Box 190, Manchester, Maine 04351

Adopted 3/14/89

PEER REVIEW GUIDELINES FOR
EXAMINATION OF MEDICAL RECORDS

1. The physician provides adequate information in the records to support the diagnosis(es).
    a. The history and physical findings support the diagnosis.
    b. There is evidence that appropriate differential diagnoses were considered.
    c. There is no suggestion that the information in the records was "tailored" to fit the diagnosis.
2. The physician orders appropriate tests and the results support the final diagnosis.
3. Treatment measures are documented and appropriate for the diagnosis.
4. Minor and major complications are documented.
    a. They are acceptable/unacceptable.
    b. They are avoidable/unavoidable.
    c. They were recognized and treated on a timely basis.
    d. They were treated appropriately.
5. Appropriate consults were obtained. Inappropriate consults were not requested.
    a. The record shows that the physician acknowledged recommendations of the consultant.
    b. The record shows that the physician followed the consultant's recommendations.
6. When surgery is performed:
    a. The record documents proper indications for surgery and that options to surgery were considered.
    b. The surgical report adequately describes the operative findings and procedures.
    c. Surgical findings are consistent with the diagnosis.

d. The procedure fits the problem and is appropriate.

e. The patient was adequately prepared for surgery (proper pre-op workup, proper consents, medically stable).

f. The surgical technique and results are acceptable and within standard of care limits.

g. Surgical complications are documented and unavoidable/avoidable (acceptable/unacceptable).

h. Complications were recognized on a timely basis and treated properly.

i. Proper prophylactic measures were used (e.g. antibiotics, prophylaxis against deep vein thrombosis).

j. Transfusions were used properly and blood loss was not excessive.

k. There is satisfactory evidence that the surgery was necessary.

l. If the surgery was performed on an emergency basis, there is satisfactory documentation of the need for emergency surgery.

m. There is no evidence that the information and documentation is "tailored" to fit the diagnosis and surgery.

n. The pathology report is consistent with the surgical impression and final diagnosis.

o. Anesthesia records are complete.

7. The physician maintains satisfactory medical records.

   a. Overall records appear satisfactory.

   b. Medical records department has assessed the physician's performance as satisfactory.

   c. The physician completes his records on a timely basis.

8. There is evidence that the patient was properly informed of his diagnosis, the reasons for his treatment and treatment alternatives.

9. Admission or non-admission to the hospital was appropriate.

10. Length of hospitalization was appropriate.

    a. Was it too long or too short?

    b. Records document the patient's readiness for discharge or reason for extended stay.

    c. The record shows that the patient was given proper discharge instructions and a follow-up appointment.

CHART #

ATTENDING PHYSICIAN:

DISCHARGE DIAGNOSIS:

BRIEF SYNOPSIS:

***QUALITY OF CARE: EXCELLENT CARE
APPROPRIATE CARE
INADEQUATE CARE
SEVERITY LEVEL I
SEVERITY LEVEL II
SEVERITY LEVEL III

COMMENTS: (Criticisms, "Teachable Point")

***SEVERITY LEVEL I: Confirmed quality problem without the potential for significant adverse effect on the patient.

SEVERITY LEVEL II: Confirmed quality problem with potential for significant adverse effects on the patient.

SEVERITY LEVEL III: Confirmed quality problem with significant adverse effects on the patient. The definition of an adverse effect being: 1. Unnecessarily prolonged treatment complications of readmission. 2. Patient management which results in anatomical or physiologic impairment, disability, or death.

HIGHLIGHTS OF REPORT OF COUNCIL ON MEDICAL SERVICE
AMERICAN MEDICAL ASSOCIATION

QUALITY OF CARE

Definition of care of high quality: "Care which consistently contributes to improvements or maintenance of the quality and/or duration of life."

"This definition essentially characterizes such care as that which is consistently related to favorable patient outcomes. It recognizes that, when other variables which could effect outcome (eg. patient age, sex, living environment, attitude towards illness, health history, severity of illness, natural history of the disease, etc.) are adequately measured and accounted for, patient outcome reflects the degree of effectiveness with which health professionals combine their own skill and compassion with the use of technology for the patient's benefit."

ELEMENTS OF HIGH QUALITY CARE

OUTCOME:

1) Produce the optimal possible improvement in the patient's physiologic status, physical function, emotional and intellectual performance and comfort at the earliest time possible consistent with the best interests of the patient.

PROCESS:

1) Be provided in a timely manner without either undue delay in initiation of care, inappropriate curtailment or discontinuity, or unnecessary prolongation of such care.

2) Be based on accepted principles of medical science and the proficient use of appropriate technologic and professional resources.

3) Make efficient use of the technology in other health system resources as needed to achieve the desired goal.

EDUCATION:

1) Emphasize the promotion of health, the prevention of disease or disability, and the early detection and treatment of such conditions.

2) Seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning that process.

COMMUNICATION:

1) Be provided with sensitivity to the stress and anxiety that illness can generate and with concern for the patient's overall welfare.

DOCUMENTATION:

1) Be sufficiently documented in the patient's medical record to enable continuity of care and peer evaluation. (Ledgible.)

FOR BACKGROUND USE ONLY

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Report: C
(I-87)

Subject: Guidelines for Quality Assurance

Presented by: Donald K. Crandall, M.D., Chairman

Referred to: Reference Committee G
(Hugh E. Stephenson, Jr., M.D., Chairman)

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1 At the 1986 Annual Meeting, the House of Delegates adopted Coun-
2 cil on Medical Service Report A on "Quality of Care." That report
3 identified eight essential elements which characterize care of high
4 quality, and presented a series of nine "Guidelines" for the conduct
5 of quality assessment, the process by which the quality of medical
6 care delivered is monitored and measured. At the 1987 Annual Meet-
7 ing, the Council's Report A described the operation of five specific
8 quality assessment systems underway or planned, and discussed how
9 specific features of these systems illustrated the quality assess-
10 ment guidelines in an operational way.
11
12 The integral complement to any program of medical quality assess-
13 ment is a system for medical quality assurance, or physician-
14 directed activity designed to assist practitioners in modifying
15 practice behavior found deficient by quality assessment, and for the
16 protection of the public against incompetent practitioners. Quality
17 assessment and quality assurance activities may be combined under
18 one program, or may be conducted separately.
19
20 To supplement the quality assessment guidelines and to further
21 assist in the development of effective peer review programs, the
22 Council has prepared the following guidelines for the conduct of
23 medical quality assurance activities. These guidelines are based on
24 the Council's continuing study of this subject and ongoing discus-
25 sions with other groups concerned with improving the quality assur-
26 ance process. The Council believes that they should be utilized in
27 any medical peer review system, whether voluntary or government man-
28 dated, and whether conducted by medical societies, medical groups or
29 foundations, hospital medical staffs, payors, corporate review pro-
30 grams or federal agencies.

Past House Action: A-87:255-259; A-86:268-272

1 1. The general policies and processes to be utilized in
2 any quality assurance system should be developed and
3 concurred with by the professionals whose perform-
4 ance will be scrutinized, and should be objectively
5 and impartially administered. Such initial involve-
6 ment and commitment with ongoing objectivity is
7 critical to assuring continued participation and
8 cooperation with the system.
9
10 2. Any remedial quality assurance activity related to
11 an individual practitioner should be triggered by
12 concern for that individual's overall practice pat-
13 terns, rather than by deviation from specified cri-
14 teria in single cases. Because of the inherent var-
15 iability of patients and biological systems, judg-
16 ment as to the competence of specific practitioners
17 should be based on an assessment of their perform-
18 ance with a number of patients and not on the exam-
19 ination of single, isolated cases, except in extra-
20 ordinary circumstances.
21
22 3. The institution of any remedial activity should be
23 preceded by discussion with the practitioner
24 involved. There should be ample opportunity for the
25 practitioner to explain observed deviations from
26 accepted practice patterns to professional peers,
27 before any remedial or corrective action is decided
28 upon.
29
30 4. Emphasis should be placed on education and modifica-
31 tion of unacceptable practice patterns rather than
32 on sanctions. The initial thrust of any quality
33 assurance activity should be toward helping the
34 practitioner to correct deficiencies in knowledge,
35 skills or technique, with practice restrictions or
36 disciplinary action considered only for those not
37 responsive to remedial activities.
38
39 5. The quality assurance system should make available
40 the appropriate educational resources needed to
41 effect desired practice modifications. Consistent
42 with the emphasis on assistance rather than punitive
43 activity, any quality assurance program should have
44 the capability of offering or directing the practi-
45 tioner to the educational activities needed to
46 correct any deficiencies, whether they be peer con-
47 sultation, continuing education, or self-learning
48 and self-assessment programs.

1 6. Feedback mechanisms should be established to moni-
2 tor and document needed changes in practice pat-
3 terns. Whether conducted under the same auspices
4 or separately, linkages between quality assurance
5 activity and a quality assessment system should
6 allow assessment of the effectiveness of any reme-
7 dial activities instituted by or for a practitioner.
8
9 7. Restrictions or disciplinary actions should be
10 imposed on those practitioners not responsive to
11 remedial activities, whenever the appropriate pro-
12 fessional peers deem such action necessary to pro-
13 tect the public. Depending on the severity of the
14 deficiency, such restrictions may include loss of
15 medical and medical specialty society membership,
16 loss or revocation of specialty board certifica-
17 tion, restriction or rescission of hospital staff
18 privileges, third-party payment denials, or suspen-
19 sion or revocation of licensure.
20
21 8. The imposition of restrictions or discipline
22 should be timely, consistent with due process.
23 Before a restriction or disciplinary action is
24 imposed, the practitioner affected should have full
25 understanding of the basis for the action, ample
26 opportunity to request reconsideration and to sub-
27 mit any documentation relevant to that request, and
28 the right to meet with those considering its imposi-
29 tion. However, in cases where those considering
30 the imposition deem the practitioner to pose an
31 imminent hazard to the health of patients, such
32 restrictions or disciplinary actions may be imposed
33 immediately. In such instances, the due process
34 rights noted above should be provided on an expe-
35 dited basis.
36
37 9. Quality assurance systems should be structured and
38 operated so as to assure immunity for practitioners
39 conducting or applying such systems who are acting
40 in good faith. As indicated in Board of Trustees
41 Report Z, filed at the 1987 Annual Meeting, the AMA
42 Committee on Medicolegal Problems is reviewing
43 state and federal legislation as well as pertinent
44 court decisions as the basis for developing compre-
45 hensive guidelines on immunity in peer review
46 activities for both members and nonmembers.

1 10. To the degree possible, quality assurance systems
2 should be structured to recognize care of high
3 quality as well as correcting instances of defi-
4 cient practice. The vast majority of practicing
5 physicians provide care of high quality. Quality
6 assurance systems should explore methods to iden-
7 tify and recognize those treatment methodologies or
8 protocols which consistently contribute to improved
9 patient outcomes. Information on such results
10 should be communicated to the professional
11 community.
12
13 Recommendation
14
15 The Council on Medical Service recommends that the House of Dele-
16 gates endorse these quidelines for quality assurance and encourage
17 their incorporation and use in any system designed to assure the
18 quality of medical care.
19
20 The Council will continue its study of quality assurance activ-
21 ity as it relates to these guidelines and, as appropriate, will
22 submit further reports to the House of Delegates regarding applica-
23 tion of the guidelines in specific quality assurance programs.

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

DEPARTMENT RESPONDS TO RECOMMENDATIONS

For immediate release
Wednesday, June 12, 1996

Contact: Wayne Douglas, Associate Commissioner
Telephone: (207) 287-4290

Augusta -- Melodie Peet, Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, announces the following measures that are being taken in response to the Augusta Mental Health Institute (AMHI) review team's report on their investigation into the death of Wrendy Hayne.

"First, let me assure the public that the Department is committed to the safety and high quality of care for the patients at AMHI, and I have been personally assured by AMHI administration that appropriate steps have been taken to ensure that patients at AMHI continue to receive the quality care that the hospital has historically provided. In addition, AMHI has undergone two Health Care Finance Authority and one Joint Commission of the Accreditation of Hospitals reviews since the April 6 incident, and all have concluded that the hospital is operating safely and continuing to provide quality care and treatment to its patients."

"I would also like to take this opportunity to publicly thank Don McDowell and the entire Review Team for the excellent job that they did investigating the tragic death of Wrendy Hayne. I have read the report, and I am taking the Team's recommendations very seriously. The Department is committed to addressing each recommendation in a timely way."

The Department has taken the following steps to address each recommendation:

Security:

- As an interim measure, all locks have been changed at AMHI, and a new key policy has been implemented.
- All staff have been trained in the new key policy.
- The Department has engaged a national security and treatment expert to review hospital security policies at the beginning of July.

PRINTED ON RECYCLED PAPER

PHONE: (207) 287-4223 (Voice) (207) 287-2000 (TTY) FAX: (207) 287-4268

Treatment Issues:

1. Develop Stability in Psychiatric Staffing

- The Department has been conducting a campaign to recruit full-time physicians.
- The Department is creating additional community-based psychiatric positions to supplement AMHI staffing.
- AMHI has implemented an expanded training program for locum tenens physicians that includes an extensive review of hospital policies.
- Locum tenens physicians will be required to stay for minimum tenures.

2. Provide training for treatment staff in the recognition and required interventions in abusive relationships.

- The Department has met with experts in the field of domestic violence, and will be contracting to provide domestic violence training to the treatment staffs of AMHI and BMHI, as well as community workers within the 7 regions of the state.

3. Respond to criminal behaviors through the police and criminal justice system.

- AMHI administrative staff is meeting with the Attorney General and District Attorney to establish appropriate working protocols between those departments.
- AMHI staff will undergo training to better understand appropriate actions in response to criminal or threatening behavior.

4. Clarify policy and procedures regarding the notification of guardians when there is a change of patient status.

- A new policy has been implemented requiring that the AMHI superintendent, clinical director and director of clinical operations review and approve of all patient level changes.

- Staff will undergo training to clarify hospital policy for guardian notification. Hospital policy requires that guardians be notified prior to any change in patient treatment.

5. Empower treatment teams to take extraordinary steps to protect patients in their charge and bring issues to the highest level of administration as necessary.

- Hospital administration will develop a policy for reporting and addressing any situation where patient or staff safety is in jeopardy.

- In the interim, the Superintendent has issued an order directing any member of a treatment team to immediately report any incidences that jeopardize patient or staff safety.

6. Develop more effective ways for treatment teams to collaborate when there are patient treatment issues that involve more than one patient or treatment team.

- New protocols will be developed to require patient treatment teams to collaborate whenever treatment issues involve more than one patient.
- The AMHI quality assurance coordinator will track all patients who require multi-team interventions.

7. Comply with consent decree requirements regarding the assessment of voluntary patients and the appropriateness for continued hospitalization.

- The hospital is implementing a policy to comply with the Consent Decree, and will confer with Plaintiffs and the Court Master.

8. Clarify the policy on treatment and discharge planning when the individual will not participate in planning.

- A protocol has been implemented to respond to the issue of patients who refuse to participate in treatment and/or discharge planning.

9. Develop policies to provide support to family members post critical events.

- Understanding the needs of families during difficult situations, the Ethics Committee is rewriting the policy and procedures to be taken following any critical incident. Every effort will be made to ensure that families are treated with respect and care by AMHI staff.

10. Decide on the future of AMHI as soon as possible.

The Department understands the significance of this recommendation and agrees that a resolution regarding the future of AMHI needs to be made carefully and expeditiously.

- The Governor's Maine Task Force on Mental Health will be looking at the appropriate role of state hospitals in our changing mental health environment, and the Legislature will address the issue of allocating resources.
- AMHI administration will work with staff to allay fears and concerns that they may have.
- AMHI staff will work with patients to assure them of their safety, both now and in the future.

In addition to specifically addressing the recommendations above, the Department is taking the following actions:

- Through the Productivity Realization Task Force Plan, the Department created the position of Director of Facilities Management to oversee the institutions. Rod Bouffard, who has been appointed to that position, will bring a team to AMHI to support management and operations of the hospital.

- The Department is reviewing all situations identified in the report which resulted in the potential failures of staff to comply with hospital policies. Any failure to comply with policies will result in appropriate action.

MCDOWELL REPORT

SECURITY:

As an interim measure, all locks have been changed at AMHI, and a new key policy has been implemented.

All critical locks are changed with most of patient room locks changed. 90% complete.

The new key policy is implemented.

All staff hve been trained in the new key policy.

All staff have been trained in new key policy.

The Department has engaged a national security and treatment expert, Joel Dvoskin, to review hospital security policies at the beginning of July. *Any recommended changes to be implemented by August 1, 1996.*

Joel Dvoskin completed his consultation on 7/12/96 - awaiting written recommendations.

APPOINTMENT OF NEW HOSPITAL LEADERSHIP:

Rod Bouffard, Director of Facilities Management, will serve as Acting Superintendent of AMHI.

This is completed.

Bill Thompson, former Acting Superintendent of AMHI and nationally known hospital administrator, will serve as consultant to hospital administration regarding the management and operations of the hospital.

This is completed.

Dr. Roger Wilson, Clinical Director at the Bangor Mental Health Institute, will serve as Acting Clinical Director at AMHI.

This is completed.

A team of senior-level psychiatrists who are external to the Department will conduct a comprehensive review of all clinical policies and procedures.

Dr. William McFarland has agreed to chair this review - awaiting confirmation on start date.

Richard Michaud will move into the newly-created Chief of Hospital Operations position. Richard, who is currently employed by the Department, has a Master's Degree in Hospital Administration and extensive experience working in psychiatric hospitals.

This is completed.

DEPARTMENT OF UPGRADED POLICES, PROCEDURES AND PROTOCOLS

DEVELOP STABILITY IN PSYCHIATRIC STAFFING.

The Department is creating the additional community-based psychiatric positions to supplement AMHI staffing. *July 15, 1996.*

Financial order submitted 7/5/96 to Bureau of Budget then to the Governor's office for review on 7/19/96 - if the Governor signs it becomes effective. This order is for 4 psychiatrists - 3 community and 1 AMHI.

AMHI has implemented an expanded training program for locum tenens physicians that includes an extensive review of hospital policies. *Completed.*

A training program for locum tenens physicians that reviews hospital policies is in effect. 7/1/96.

Locum Tenens physicians will be required to stay for at least 3 months. *Effective with expiration of each current locum tenens term.*

Locum Tenens are required to stay with AMHI 3 months.

Create additional full time inpatient psychiatric position at AMHI. *July 15, 1996.*

This position has been requested through the Bureau of Budget to the Governor's office on 7/19/96 for approval.

Convert one locum tenens position to full time contract position. *July 31, 1996.*

Provide training for treatment staff in the recognition and required interventions in abusive relationships.

The Department is contracting with the Maine Coalition for Family Crisis Services to provide domestic violence training to the treatment staffs of AMHI and BMHI, as well as community workers within the 7 regions of the state. *To be completed by August 31, 1996.*

AMHI management staff met with Maine Coalition for Family Crisis Services last week. Domestic Violence training for management staff is slated for 7/24/96, train the trainer training is scheduled for August 21-22 with a plan for all staff to be trained by September 30, 1996. The delay is a result of the contractors scheduling problem.

Respond to criminal behaviors through the police and criminal justice system.

AMHI administrative staff is meeting with the Attorney General and District Attorney to establish appropriate working protocols between those departments. *June 28, 1996.*

AMHI administrative staff met with the Attorney General and District Attorney on 6/28/96.

Policy to be developed in response to meeting. *August 1, 1996.*

A draft policy of working protocols has been forwarded to Kathy Greason, AAG for approval (to address criminal behaviors).

AMHI staff will undergo training in new policy. *August 31, 1996.*

As soon as approved policy returns - AMHI staff will undergo training.

Clarify policy and procedures regarding the notification of guardians when there is a change of patient status.

A new policy has been implemented requiring that the AMHI superintendent, clinical director and director of clinical operations review and approve of all patient level changes. *Completed.*

This policy is completed.

Staff will undergo training to clarify hospital policy for guardian notification. Hospital policy requires that guardians be notified prior to any change in patient treatment. *Documented training to be completed by July 1, 1996.*

All staff have undergone training to clarify hospital policy for guardian notification.

Empower treatment teams to take extraordinary steps to protect patients in their charge and bring issues to the highest level of administration as necessary.

Hospital administration will develop a policy for reporting and addressing any situation where patient or staff safety is in jeopardy. *July 12, 1996.*

A policy to address any situation where patient or staff safety is pending.

In the interim, the Superintendent has issued an order directing any member of a treatment team to immediately report any incidences that jeopardize patient or staff safety. *Completed.*

See attached order from Superintendent dated June 12, 1996.

Develop more effective ways for treatment teams to collaborate when there are patient treatment issues that involve more than one patient or treatment team.

Notify all treatment staff to assess all patients to determine whether there are treatment issues involving more that one patient, and, if so, to collaborate with other appropriate treatment teams and/or staff. *Completed.*

On 7/10/96 - AMHI Medical Executive Committee approved a policy concerning collaboration of treatment teams.

Formal protocols will be developed to require patient treatment teams to collaborate whenever treatment issues involve more than one patient. *July 12, 1996.*

Formal protocols were approved by Medical Executive Committee on 7/10/96. All new policies will be pulled together and staff training will be done by July 19, 1996.

The AMHI quality assurance coordinator will track all patients who require multi-team interventions. *Completed.*

Nursing Service will track all patients who require multi-team intervention. Nursing Service will report this to Quality Assurance who will do a quarterly summary for Medical Executive Committee and Quality Operations Committee.

Comply with consent decree requirements regarding the assessment of voluntary patients and the appropriateness for continued hospitalization.

The hospital is implementing a policy to comply with the Consent Decree, and will confer with Plaintiffs and the Court Master. *New draft policy has been presented, follow-up meeting on July 3, 1996.*

A new policy regarding assessments was approved on July 3, 1996. Procedures to do on-going assessments are in place.

Clarify the policy on treatment and discharge planning when the individual will not participate in planning.

A protocol has been implemented to respond to the issue of patient who refuse to participate in treatment and/or discharge planning. *Completed.*

A new policy was implemented to respond to patients who refuse to participate in treatment/discharge planning. This was passed by Medical Executive Committee on 7/10/96.

Develop policies to provide support to family members post critical events.

Superintendent to be personally responsible for making or coordinating appropriate contact with families. *Completed.*

A policy making family notification a responsibility of the Superintendent was passed 7/10/96.

Review and revise policy and procedures. *July 15, 1996.*

Decide on the future of AMHI as soon as possible.

The Governor's Maine Task Force on Mental Health will be looking at the appropriate role of state hospitals in our changing mental health environment, and the Legislature will address the issue of allocating resources. *October 1, 1996.*

Provide staff support concerning issues regarding the uncertainty of the hospital's status pending a decision on the future of the institution. *Ongoing.*

The following are some means being used to support AMHI staff:

A. A psychologist is contracted to work with staff.
B. Bill Doughty is on grounds to assist with job placement.
C. Governor King and Commissioner Peet visited on 7/2/96.
D. Staff meetings are held on a regular basis to keep staff informed of any issues.

DISCIPLINARY ACTION

In response to the McDowell report, an internal personnel investigation has been completed and disciplinary action will be taken against 5 individuals.

Disciplinary action has been taken against 5 individuals.

STATE OF MAINE

M E M O R A N D U M

TO: ALL STAFF

FROM: WALTER E. LOWELL, ED.D., ACT. SUPT.

DATE: June 12, 1996

SUBJECT: REPORTING SAFETY CONCERNS

****

DEPARTMENT HEADS/PROGRAM DIRECTORS SHARE WITH YOUR STAFF A.S.A.P.

As a consequence of one of the recommendations in the McDowell Commission's report, I am reminding staff to report any situation that jeopardizes patient and staff safety directly to their supervisor. At all times, staff should feel free to contact either the Director of Clinical Operations, Medical Director or the Superintendent, directly, if safety concerns are not resolved.

b

STATE OF MAINE

M E M O R A N D U M

TO: ALL STAFF

FROM: WALTER E. LOWELL, ED.D., ACT. SUPT.

DATE: June 12, 1996

SUBJECT: FOLLOW-UP OF MCDOWELL COMMISSION REPORT
****

DEPARTMENT HEADS/PROGRAM DIRECTORS SHARE WITH YOUR STAFF A.S.A.P.

As a follow-up to the McDowell Commission report, I am asking staff who become aware of close personal and emotional relationship between patients to notify your supervisor, Program Director or Director of Clinical Operations. This is to assure that proactive steps are taken to do joint treatment planning concerning respective patients.

b

S T A T E   O F   M A I N E

Inter-Departmental Memorandum Date June 20, 1996

To Joint Standing Committee on Health & Human Services

Fm N. Lawrence Ventura, Supt. Dept BMHI

Subject Recommendations Concerning Treatment

As per your request, I have responded to the following recommendations put forth by the Independent Team reviewing the recent death of an AMHI patient.

1. <u>Develop stability in staffing, especially psychiatrists</u>.

   BMHI has made it a priority to recruit and retain a stable psychiatrist work force. In the past three years there has been normal turnover. The hospital also contracts yearly with a locum tenens firm to supply us with psychiatrists on a short and long-term basis.

2. <u>Train treatment staff in recognizing and intervening in abusive relationships</u>.

   When a patient arrives at BMHI a regular admission screening process identifies current and past abusive relationships. BMHI has also appointed an ad hoc committee to study workplace violence. This committee is also looking at other various types of abuse, or violence.

3. <u>Respond to criminal behaviors through police and the criminal justice system</u>.

   There is a mechanism in place to assure that incidents are reported to the Clinical Director and Superintendent. The Clinical Director and Superintendent review and report any incidents that they determine are necessary to go through the criminal justice system. Based on past experience, this has been beneficial to both the patient and community at large.

4. <u>Clarify policies and procedures concerning notification of guardian about changes in status</u>:

   Guardians are invited to attend Rolling Treatment Team meetings on a monthly basis and are contacted between meetings by the physician if there is a medication change. Other issues involving the Guardian are handled by the Social Worker.

5. <u>Empower treatment teams to take extraordinary steps to protect patients in their charge</u>.

   It is BMHI's philosophy that all staff are encouraged and expected to bring safety concerns to the appropriate Treatment Team and to Administration.

6. **Develop more effective ways for treatment teams to collaborate.**

Patients at BMHI move from one unit to another as a function of their clinical status. Treatment teams at BMHI are quite familiar with each other based on the interaction between them that occurs during these transfers.

Patients receive many clinical services in programs off their residential units. This exposes patients and staff from different units to each other on a regular basis.

The Clinical Executive Committee exercises oversight on all inpatient units. Its members consist of all Clinical Department Directors, the Clinical Director, the Program Services Director and the Superintendent. Its Chair rotates quarterly. Members of this Committee are assigned to two inpatient units or programs as clinical/administrative consultants and meet on a regular basis with their assigned treatment teams. Four days a week, the Committee meets at 3:30 p.m. to flag any emergent issues.

The Clinical Executive Committee meets bi-weekly with the entire professional clinical staff to review and discuss emergent issues.

The Clinical Director does rounds daily.

7. **Comply with the Consent Decree requirement for assessment of voluntary patients in order to determine the appropriateness of continued hospitalization.**

N/A

8. **Clarify policies for treatment and discharge planning when the individual will not participate in planning.**

Since 1989 and the establishment of the Rolling Treatment Plan procedure, non-compliance of treatment becomes a focus of the Treatment Plan.

9. **Develop policies for providing information and support to family members following critical incidents involving patients.**

At BMHI, when critical incidents take place, whoever has the closest relationship with the guardian and/or family member, advises them of relevant information.

Dist. Commissioner Peet
Wayne Douglas, Assoc. Comm.
Rod Bouffard, Dir. Facility Mgt.

To: Members of the Health and Human Services Committee
Fr: Commissioner Melodie Peet
Re: Changes taking place at the Augusta Mental Health Institute

June 21, 1996

Security:

- As an interim measure, all locks have been changed at AMHI, and a new key policy has been implemented.
- All staff have been trained in the new key policy.
- The Department has engaged a national security and treatment expert, Joel Dvoskin, to review hospital security policies at the beginning of July. *Any recommended changes to by implemented by August 1, 1996.*

Appointment of New Hospital Leadership

- Rod Bouffard, Director of Facilities Management, will serve as Acting Superintendent of AMHI.
- Bill Thompson, former Acting Superintendent of AMHI and nationally known hospital administrator, will serve as consultant to hospital administration regarding the managment and operations of the hospital.
- Dr. Roger Wilson, Clinical Director at the Bangor Mental Health Institute, will serve as Acting Clinical Director at AMHI.
- A team of senior-level psychiatrists who are external to the Department will conduct a comprehensive review of of all clinical policies and procedures.
- Richard Michaud will move into the newly-created Chief of Hospital Operations position. Richard, who is currently employed by the Department, has a Master's Degree in Hospital Administration and extensive experience working in psychiatric hospitals.

Development of Upgraded Policies, Procedures and Protocols

Develop Stability in Psychiatric Staffing

- The Department is creating three additional community-based psychiatric positions to supplement AMHI staffing. *July 15, 1996.*
- AMHI has implemented an expanded training program for locum tenens physicians that includes an extensive review of hospital policies. *Completed.*
- Locum tenens physicians will be required to stay for a at least 3 months. *Effective with expiration of each current locum tenens term.*
- Create additional fulltime inpatient psychiatric position at AMHI. *July 15, 1996.*
- Convert one locum tenens position to full time contract position. *July 31, 1996.*

Provide training for treatment staff in the recognition and required interventions in abusive relationships.

- The Department is contracting with the Maine Coalition for Family Crisis Services to provide domestic violence training to the treatment staffs of AMHI and BMHI, as well as community workers within the 7 regions of the state. *To be completed by August 31, 1996.*

Respond to criminal behaviors through the police and criminal justice system.

- AMHI administrative staff is meeting with the Attorney General and District Attorney to establish appropriate working protocols between those departments. *June 28, 1996.*
- Policy to be developed in response to meeting. *August 1, 1996*
- AMHI staff will undergo training in new policy. *August 31, 1996.*

Clarify policy and procedures regarding the notification of guardians when there is a change of patient status.

- A new policy has been implemented requiring that the AMHI superintendent, clinical director and director of clinical operations review and approve of all patient level changes. *Completed.*

- Staff will undergo training to clarify hospital policy for guardian notification. Hospital policy requires that guardians be notified prior to any change in patient treatment. *Documented training to be completed by July 1, 1996.*

Empower treatment teams to take extraordinary steps to protect patients in their charge and bring issues to the highest level of administration as necessary.

- Hospital administration will develop a policy for reporting and addressing any situation where patient or staff safety is in jeopardy. *July 12, 1996.*

- In the interim, the Superintendent has issued an order directing any member of a treatment team to immediately report any incidences that jeopardize patient or staff safety. *Completed.*

Develop more effective ways for treatment teams to collaborate when there are patient treatment issues that involve more than one patient or treatment team.

- Notify all treatment staff to assess all patients to determine whether there are treatment issues involving more than one patient, and, if so, to collaborate with other appropriate treatment teams and/or staff. *Completed.*

- Formal protocols will be developed to require patient treatment teams to collaborate whenever treatment issues involve more than one patient. *July 12, 1996.*

- The AMHI quality assurance coordinator will track all patients who require multi-team interventions. *Completed.*

Comply with consent decree requirements regarding the assessment of voluntary patients and the appropriateness for continued hospitalization.

- The hospital is implementing a policy to comply with the Consent Decree, and will confer with Plaintiffs and the Court Master. *New draft policy has been presented, follow-up meeting on July 3, 1996.*

Clarify the policy on treatment and discharge planning when the individual will not participate in planning.

- A protocol has been implemented to respond to the issue of patients who refuse to participate in treatment and/or discharge planning. *Completed.*

Develop policies to provide support to family members post critical events.

- Superintendent to be personally responsible for making or coordinating appropriate contact with families. *Completed.*
- Review and revise policy and procedures. *July 15, 1996.*

Decide on the future of AMHI as soon as possible.

- The Governor's Maine Task Force on Mental Health will be looking at the appropriate role of state hospitals in our changing mental health environment, and the Legislature will address the issue of allocating resources. *October 1, 1996.*
- Provide staff support concerning issues regarding the uncertainty of the hospital's status pending a decision on the future of the institution. *Ongoing.*

Disciplinary Action

- In reponse to the McDowell report, an internal personnel investigation has been completed and disciplinary action will be taken against 5 individuals.

New

4/24/96

Key Security Policy

General Guidelines: In order to maintain proper safety and security for patients and staff, both within and around our buildings, is necessary to adhere to the following:

a. All keys are the property of the Augusta Mental Health Institute and are to be considered "on loan" during the period of employment only.
b. The individual receiving keys is fully responsible and accountable for the security of the keys at *ALL* times.
c. The exchange of keys between employees is not allowed.
d. Any keys not being used *MUST* be returned to the Engineer's Office. This will reduce the needless reproduction of keys as well as your liability.
e. Good judgement must be used at all times in the use and care of keys.
f. Keys will not be issued to anyone without proper authorization.
g. All keys are to be returned upon termination of employment. Keys that are not returned will be considered theft of State property and will be referred to the State Attorney General's Department for possible prosecution.
h. Forensic services key guidelines are outlined in chapter 15.

Key Issuing & Authorization: The procedure for issuing, authorizing, and recording of keys will be as follows:

a. Keys will be issued by the completion of a pre-printed key requisition which must be completed and signed by the department head or designee at least one working day prior to the actual date the key wiill be needed. The requisition will then be turned to the Engineer's Office for final approval and issue. Exceptions to this rule should be rare. A record of all keys issued will be prepared and kept in the Engineer's Office and updated as necessary.
b. Standard key issue for AMHI staff will consist of the following keys:
    1. PKA (Pass Key AMHI)
    2. 157c (Fire extinguisher key)
    3. Fire Key (self explanatory)

c. Other agency issue for non-AMHI staff will consist of the following keys:
    1. PKC (Pass Key Central)
    2. 157c (Fire extinguisher Key)
    3. Fire Key (self explanatory)

d. Key issue will be for only your own area of responsibility. Requests for areas other than your own area of responsibility requires the approval of the responsible department head prior to final approval of the request.
e. All employees will be required to sign for all keys personally and this signature will certify the receipt of same.
f. The Superintendent or Director of Hospital Services are the only persons authorized to approve the issue of a grand master or master key. Appeals will be made to Superintendent. Approval will be obtained in the order listed below:

    1. Superintendent
    2. Director of Hospital Services
    3. Director of Clinical Operations
    4. NOD (evenings, nights, weekends and holidays) with AOC notification

g. The pass key may be loaned to surveying agencies with approval as indicated in g. above.
h. Non-AMHI staff may be issued or loaned keys only with the approval of the Superintendent or Director of Hospital Services. T Nurse on Duty may authorize temporary issuance during evenings, nights, week-ends and holidays.
i. Final approval and issue of all keys will be given by the Locksmith or designee. The designee will be appointed by the Director of Hospital Services. Final approval will be based on this policy and added guidelines as needed to assure the maintenance of security.

Key Replacement: The procedure for issuing replacement keys that are lost, stolen or worn out will be as follows:

a. Worn out keys will be turned in to the Locksmith for replacement in kind. The locksmith will then render the returned key unusable by breaking the key in half.
b. Replacement keys for lost or stolen keys can only be authorized by the Superintendent or designee.
c. Once the incident of lost or stolen keys has been audited, the Superintendent or his designee will approve a replacement set of keys, if appropriate.
d. Loan of keys through the switchboard for keys left at home will be allowed for one day only (standard set only). A request for a second day's loan of keys will be judged as lost and must be reported according to current policy. If the employees must go home for keys it will be on their own time and will be use vacation time or compensation time for pay purposes.

Key Turn In: The procedure to turn in keys will be as follows:

a. Upon termination of employment, employees are required to return *ALL* keys issued to Human Resources for further processing. Maintenance personnel will make the necessary notations when keys are returned.
b. It is the responsibility of persons on Leave Of Absence (LOA) or Industrial Accident (IA) to turn keys in as soon as the LOA or IA is approved.
c. Persons under suspension must also turn in all keys until they return to work provided the suspension exceeds five days.
d. Staff are expected to return all keys that are no longer required to perform their jobs, to the Locksmith for inventory and storage

Procedures to be followed for missing keys:

a. A concentrated effort will be made to immediately find the missing keys. In any situation where keys are lost it is of the utmost importance to find the keys as soon as possible and establish that patients do not have access to the keys. The extent of a search will depend on the circumstance of the missing key.
b. The Director of Clinical Operations and Director of Hospital Services will meet to immediately determine the impact of the missing keys on the safety of patients and unit milieu. If deemed appropriate, a search to include unit, staff and patient areas will be implemented. Patients will be requested to assist in the search by voluntarily permitting search of room and person. If a patient refuses to participate voluntarily in the search and is deemed likely to be harboring a missing key, thereby posing a safety risk to self and or others, a physician order may be obtained to conduct a patient room and person search.
c. An Incident Report summarizing the missing key(s) will be prepared by the staff member to whom the keys belong prior to leaving work for the day. The written report will provide an accurate description of the keys, where they may have been lost or stolen and when they were noted as missing. Also include an indication of security problems associated with the specific set of keys. Any addition information that could assist in the recovery or immediate actions necessary to prevent further breaches of security will be included in the report. A verbal report must be made to the immediate supervisor for further reporting. The immediate supervisor is responsible for notifying the following

   1. Director of Hospital Services
   2. Director of Clinical Operations and Nursing
   3. Switchboard - Will notify the Locksmith
   4. Mail Room
   5. Chief Engineer
   6. Building Maintenance Superintendent
   7. Program Services Director of the affected treatment unit (if applicable)
   8. Department head of affected area (if applicable)
   9. Clinical Risk Manger

d. Upon receipt of the written incident report the Clinical Risk Manager will notify the above individual or department head by written memo of the missing keys. The Clinical Risk Manger, Building Maintenance Superintendent, Chief Engineer and Director of Hospital Services will make recommendations to the Safety Committee for changes to locks based on the incident. In the event a key is missing that is used in an extremely sensitive area, the key will be replaced as soon as reasonable to maintain proper security.

e. Reporting of missing key on Week-Ends, Evenings, Nights and Holidays will by a verbal report to their immediate supervisor fo further reporting. The immediate supervisor is responsible for notifying the following for action as required. The written incident report will be filed through normal channels.

1. Nurse on Duty (NOD)
2. Administrator on Call (AOC) - will carry on function outlined in b.
3. Night Engineer
4. Switchboard - Will notify the Locksmith on the next normal work day.

f. Annually, as part of ongoing staff safety training, in the Occupational Health and Safety Class, this key procedure will be reinforced.

g. All missing keys that are found must be given to the Switchboard for identification and return to the owner. The Switchboard will notify the Locksmith when keys are returned for identification of the owner and securing of the keys at the lock shop until the keys are returned to the owner.

h. Any staff not properly accounting for and securing any key that will allow general access to patient areas will be subject to disciplinary action.

APPROVED: ______________________

Walter Lowell, Ed. D., Act. Superintendent, AMHI

April 24, 1996

AUGUSTA MENTAL HEALTH INSTITUTE
KEY SECURITY
POLICY ADDENDUM
April 8, 1996

Procedures to be followed for missing keys:

a. A concentrated effort will be made to immediately find the missing keys. Additional staff will assist in the search when keys are believed missing on a patient treatment unit or in areas that patients have access. In any situation where keys are lost it is of the utmost importance to find the keys as soon as possible and establish that patients do not have access to the keys. The extent of a search will depend on the circumstance of the missing key.

c. An Incident Report summarizing the missing key(s) will be prepared by the staff member to whom the keys belong prior to leaving work for the day. The written report will provide an accurate description of the keys, where they may have been lost or stolen and when they were noted as missing. Also include an indication of security problems associated with the specific set of keys. Any addition information that could assist in the recovery or immediate actions necessary to prevent further breaches of security will be included in the report. A verbal report must be made to the immediate supervisor for further reporting. The immediate supervisor is responsible for notifying the following

1. Director of Hospital Services
2. Director of Nursing
3. Switchboard - Will notify the Locksmith
4. Mail Room
5. Chief Engineer
6. Building Maintenance Superintendent
7. Program Services Director of the affected treatment unit.(if applicable)
8. Department head of affected area.(if applicable)
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d. Upon receipt of the written incident report the Clinical Risk Manager will notify the above individual or department head by written memo of the missing keys. The Clinical Risk Manger, Building Maintenance Superintendent, Chief Engineer and Director of Hospital Services will make recommendations to the Safety Committee for changes to locks based on the incident. In the event a key is missing that is used in an extremely sensitive area, the key will be replace as soon as reasonable to maintain proper security.

e. Reporting of missing key on Week-Ends, Evenings, Nights and Holidays will by a verbal report to their immediate supervisor for further reporting. The immediate supervisor is responsible for notifying the following for action as required. The written incident report will be filed through normal channels.

1. Nurse on Duty (NOD)
2. Administrator on Call (AOC)
3. Night Engineer
4. Switchboard - Will notify the Locksmith on the next normal work day.

g. Annually, staff will be reminded of the importance associated with the keys during the Occupational Health and Safety Class.

h. All missing keys that are found must be given to the Switchboard for identification and return to the owner. The Switchboard will notify the Locksmith when keys are returned for identification of the owner and securing of the keys at the lock shop until the keys are returned to the owner.

I. Any staff not properly accounting for and securing any key that will allow general access to patient areas will be subject to disciplinary action.

APPROVED: ______________________

Walter Lowell, Ed. D., Act. Superintendent, AMHI April 10, 1996

AUGUSTA MENTAL HEALTH INSTITUTE
Key Policy
Addendum #2

May 7, 1996

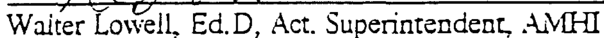
ADD:

Employee Transfer Out: When an employee transfers from one unit to another it is the responsibility of the current supervisor or department head to assure keys that are no longer needed get returned to Maintenance. The Employee's record will be brought up to date by the Locksmith when the keys are returned.

Employee Transfer In: When an employee transfers from one unit to another it is the responsibility of the new supervisor or department head to assure keys necessary for the employee to do their job are available. If additional keys are required it is the responsibility of the new supervisor to complete a key issue slip and process it through proper channel to the Locksmith. The Employee's record will be brought up to date by the Locksmith when the keys are issued.

Employee Termination: When an employee terminated employment at Augusta Mental Health all keys will be turned in to Human Resources. The keys being returned will be listed on a prepared form to be used as a receipt for keys from employees. A copy of the form and keys will be returned to the Locksmith for record changes an filing.

Approved:



Walter Lowell, Ed.D, Act. Superintendent, AMHI

May 14, 1996

AUGUSTA MENTAL HEALTH INSTITUTE
Key Policy Addendum 3
June 17, 1996

FIRE KEY:

Your, Fire Key must be properly attached to your set of Augusta Mental Health Institute keys at all times. This is necessary to allow identification of all keys if lost, misplaced or other wise not in your possession. This policy applies to ALL personnel issued keys, without regard to employer. It is your responsibility to properly secure and take proper care for property belonging to Augusta Mental Health Institute. Violation of this policy will result in Disciplinary or Legal actions at the discretion of the Superintendent of the Augusta Mental Health Institute. All supervisors are responsible for monitoring their immediate staff to ensure Fire Keys are properly attached and will take immediate action to correct all violations.

KEYS ISSUED TO NON AUGUSTA MENTAL HEALTH INSTITUTE EMPLOYEES:

Non Augusta Mental Health Institute emplyees will be issued keys only if one of the following conditions apply:

1. Employee of the Department of Mental Health, Mental Retardation and Substance Abuse, plus demonstrate a need related to patient care.

2. Work at Augusta Mental Health Institute for more then thirty hours per week, plus demonstrate a need related to patient care.

All exceptions must be approved by the Superintendent or his/her designee. It is expected that there will be very few exceptions because of the importance of security in our environment. If the Designee disapproves a request for key the applicant may file an appeal for consideration by the superintendent. The Superintendent's decision will be final and no additional appeals will be accepted.

Approved
QOPS
6/18/96

MEMORANDUM

DATE: May 8, 1996

TO: Physicians and Program Service Managers

FROM: Walter Lowell, Ed.D., Superintendent
Douglas Gowler, MD, Acting Medical Director
Katherine Guilbault, RN, MS. Director of Clinical Operations

RE: **SPECIAL DIRECTIVE** : Patient Levels

This directive is effective immediately and until further notice:

Patients who are under Emergency Involuntary Committment (blue papers) and patients for whom an Application for District Court (white paper) has been submitted will be permitted off the Unit only with 1:1 supervision by AMHI staff. Such patients will be permitted off grounds only for scheduled appointments , and then only when escorted by AMHI staff.

Any new decision to increase the level (that is, any decrease in supervision) of a patient who is committed to AMHI must be approved by the Superintendent, the Medical Director and the Director of Clinical Operations prior to implementation. Committed patients for whom re-application (application for re-committment) has been made will be treated like any other committed patient.

cc: N. Bouchard
A. LeBlanc
J. Champine
L. Diket
B. Gagne

MEMORANDUM

DATE: May 28, 1996

TO: Levels Revision Reviewers

FROM: Ann LeBlanc, Ph.D.

RE: Revision # 3

I have taken your ideas and come up with a NEW, IMPROVED, **SIMPLIFIED** version of the revision of the revision of the levels system change. Please note that the difference between 1:1 and "shadowing" is not included - this will need a change in other procedures first. At this point, there is also no change in the restriction of patients on blue papers or awaiting a hearing. Please remember that this does not apply to re-application to court, only new applications.

I made the whole thing into a diagram that I hope is self-explanatory, with thanks to Dr. Harter, who originally did it this way. Please notice that we have gone from 6 levels to 4, with fewer and more general clinical descriptors. I'm not sure, but I think that this would make it easier for patients who have been here a long time to get off the unit and/or off grounds - there's more wiggle room.

Take a look at this and send me comments -

Thanks!

Revision # 3 - Proposed Levels System

Purpose:

The level system is intended to assure that all patients have access to exercise and fresh air, as well as activities on and off grounds, at a level of participation that is consistent with their clinical condition. The levels system is designed to encourage patient functioning at a maximum level of autonomy within sensible limits according to clinical capacity. The patient's clinical condition will be repeatedly assessed by the treatment team in order to ensure safety and maximum participation in therapeutic activities. Clinical observations of behavior that justify each level will be clearly documented when assigning a patient level.

General Levels Procedures:

Each patient level will be reviewed at least daily by the psychiatrist in consultation with other members of the treatment team. This may be done in routine staffing meetings. Changes in levels are made by the psychiatrist in consultation with the clinical team. When making a change in level, the psychiatrist will document those clinical observations pertinent to the change.

Each patient's clinical team should try to anticipate increases in level that might become appropriate over the week-end, with special attention to holiday week-ends. Detailed descriptions of patient changes that would support or fail to support an increase in level should be included in a progress note to assist the physician on duty. In general, increases in patient level will not be made over the week-end without such advance planning on the part of the treatment team.

At the time of admission, a patient is generally placed on Level 0 until assessed by the unit staff. Any special observations, such as checks, Constant Observation or 1:1 supervision must be ordered by the physician or physician extender at the time of admission. No patient will be restricted to the unit for more than 72 hours without a review by the full clinical team.

All patients under Emergency Involuntary Commitment (blue papers) and all patients for whom an Application for District Court Commitment has been filed will be Level O. All decisions to increase the level of District Court committed patient must be approved in advance by the Superintendent, the Medical Director and the Director of Clinical Operations.

Patients may make request for a change in level at any time, although such request will be most expeditiously managed at Morning Meeting. Such requests will be reviewed by the psychiatrist daily. The decision to change a patient's level, and the rationale for the decision will be shared directly with the patient. Patients will be assisted to plan requests for level changes in advance in order to minimize delays required in order to provide thoughtful clinical review.

A physician's order is required for all level changes. In an emergency situation, however, the RN may reduce a patient's level to a more restrictive level with immediate follow-up by telephone to obtain a physician or physician extender's order. A medical assessment and written order for the change must then be obtained within two hours. such a restriction will be effective fro a maximum of 24 hours. at which time a re-evaluation of the level by a psychiatrist must occur.

NOTE: Specific procedures and documentation requirements must be followed whenever special observations, seclusion or restraint are needed.

Each Program Services Manager will maintain a daily unit census sheet listing the current level for each patient on the unit using the Clinical Services Patient Status Levels Form.

AMHI Activities Levels

Level	Level 0	Level 1	Level 2	Level 3
Clinical Observations	Dangerous to self or others Behavior cannot be managed off unit	Not dangerous to self or others May need help to care for self, follow daily schedule	Not dangerous May need reminders to care for self, follow schedule Can maintain personal safety	Can maintain personal safety Cares for self, follows schedule independently
On Unit Options	Seclusion/restraint COR 1:1 on unit 15' - 60' checks on unit Independent on unit	15' - 60' checks on unit Independent on unit	Independent	Independent
On Grounds Options	None	1:1 off unit supervised groups 15'-60' blocks, 1-4 X daily	Unlimited	Unlimited
Off Grounds Options	None	Supervised groups	With non-AMHI staff $\geq$ 2 hours pass Overnight short leave (1 night)	Overnight passes ($\geq$ 1 night) Takes bus to activities TCS

b. Off-ward levels may not be used to punish, coerce, encourage or otherwise require patients to attend activities or treatment. Treatment is voluntary, subject only to psychiatric emergencies, treatment allowed by an Administrative Hearing or treatment allowed by a guardian.

c. Any restriction must be individual, structured to the patient's clinical needs and supported in the patient's chart.

Off-ward levels are based upon clinical assessment of issues surrounding individual care needs. No one may be denied off-ward access solely because of status of "pending District Court." At a minimum, levels must be reviewed at each treatment planning conference. Patients' requests for level advancement must be reviewed as soon as possible.

Off-Ward Level Definitions: Off-Ward levels require a medical order.

Restricted to ward for 72 hours (may be renewed with clinical justification).

- **Level 1:** Off-ward with staffonly (specify if 1:1 or special conditions)
- **Level 2:** Limited off-ward unsupervised (for example, for specific blocks of time or to certain destinations)
- **Level 3:** Off-ward unsupervised, ad lib
- **Level 4:** Off-ward and off-grounds, unsupervised

All patients, regardless of level, are expected to be on the unit for meal times and for change of shift. However, staff in the various treatment areas (ARC or the Gym) may call the treatment unit on behalf of a patient in order that the patient can be accounted for at meal times or at change of shift. Wards may set reasonable hours after which a patient may go out in the morning and by which they must return in the evening.

OFF/ON GROUNDS ACCESS

The Institute shall grant on and off-ground access, within statutory limitations, in keeping with the need for participation in and interaction with the community and its resources. Such access is granted to patients on an individual basis, who, as determined by the professional staff, and authorized by physician's order have the ability to comprehend the extent of the access and the capability of responding appropriately.

It is the responsibility of the staff to be knowledgeable of the patient's status, needs, and any restrictions which may apply. The Institute recognizes that patients whose legal status requires them to be supervised during off-ward access are entitled to frequent exercise and activity off the ward relative to the custody and therapeutic requirements of the Institute as a whole.

The Treatment Team is responsible and accountable for, as part of the individual treatment program, the appropriateness of on and off grounds access. Specific concerns which must be considered are:

a. ability to care for oneself;
b. indications of dangerousness to self/others
c. high probability community disruption based on demonstrated past history;
d. past and potential compliance with restrictions or access; and
e. statutory limitations.

The Treatment Team may determine, as part of the individual's treatment program, that it is inappropriate for a voluntarily admitted patient to have on or off grounds access. Those voluntary patients who are not willing to comply with restrictions imposed by their treatment program and request leave, may be discharged. If, however, the patient is found, upon evaluation by a qualified mental health professional, to be appropriate for commitment under the criteria established by law, emergency involuntary admission papers should be initiated and the patient retained involuntarily.

Before on-grounds access is granted, responsibilities associated with this access shall be discussed with the patient and a signed agreement shall be filed in the patient's record.

Patients may be granted access in pairs when clinically indicated and this procedure will be monitored by the case manager/primary therapist.

Whenever a pass permitting off grounds visits is issued, there must be documentation that the patient has been informed of the conditions attached to the pass and of the circumstances under which the pass would be cancelled. The conditions must be documented in the patient's record. The pass should be issued only after assuring documentation that the patient has signed an agreement understanding and abiding to these conditions.

Whenever necessary, a monitoring system will be implemented by the unit staff to ensure that patient checks are made as appropriate. The frequency and method of such checks is to be determined on an individual basis. Access levels for Legal Hold patients will be monitored by the Forensic Treatment Unit.

Emergency Involuntary Status

Decisions about off/on grounds access for patients who are on emergency involuntary status (blue papers) or for whom an Application for District Court Commitment (white papers) have been filed are made on the same individualized, clinical basis as described above. When such patients have off-grounds access, however, they will be accompanied by AMHI staff. Patients who are already Court Committed and are awaiting re-hearing may be assigned off-grounds access without AMHI staff when their condition warrants, according to the off-ward levels policy*(12/95)*

f. If a reporter or other individual is found on a ward without permission of the Superintendent/designee, that individual shall leave the area until such approval is received.

CORRESPONDENCE

In order that each patient has a reasonable opportunity to communicate with relatives and others in the community, the Institute will provide writing materials and postage adequate to mail at least one letter per day for each inpatient who is unable to procure such items.

Exceptions:

a. If staff believe that mail contains contraband, such mail may, upon the written order of a physician and Superintendent, be subjected to physical examination in the patient's presence.

b. Any illegal items found during such an examination may be confiscated by the facility.

c. Any other contraband shall bee held in safekeeping, and returned to the patient upon discharge, except that no medication shall be released without the authorization of a physician.

d. Any exception to the right to communicate by mail must be explained to the patient. The justification for any such exception, and an itemized list of any materials confiscated must be documented in the patient's permanent treatment record.

e. Additional procedures will be developed to assure security in the cases of forensic patients.

f. If staff believe there is a therapeutic justification for any patient without funds to conduct correspondence in excess of one letter per day, special arrangements can be made with the Assistant to the Superintendent to provide necessary funds for postage.

OFF-WARD LEVELS

The Rights of Recipients of Mental Health Services provide that all inpatients are entitled to be treated in the least restrictive appropriate setting to meet their needs. It also provides that all inpatients are entitled to a reasonable opportunity for physical exercise and recreation, including access to outdoor activities. At no time shall access to recreate outdoors, or to be off the ward, be treated as a privilege which the patient must earn by meeting certain standards of behavior (see Consent Decree Paragraph 159).

a. Going off the ward is a right, not a privilege. Patients may be restricted only for clinical safety reasons, (danger to self, danger to others, elopement risk, physical illness, refusal to dress properly for the weather or significant and ongoing problems with refusal of nutrition or personal hygiene).

SEXUAL BEHAVIOR

During hospitalization the patient's primary responsibility is to make choices which promote health. In general, sexual involvement while hospitalized may not contribute to this goal. Nevertheless, AMHI recognizes sexuality as an inherent part of every individual's being. The purpose of these guidelines is to assist staff to:

a. ensure respect for patients rights;
b. ensure safety of vulnerable individuals; and
c. ensure the best possible provision of effective treatment.

This policy is also intended to ensure that individuals are actively supported in developing and expressing their own sexuality in accordance with their own values. AMHI recognizes the right of capacitated patients to engage in mutually consensual sexual activity within the bounds of conventionally accepted expectations of privacy. Furthermore, when making decisions about sexual activity, a central consideration must be that such behavior affects more than just the two people involved. AMHI rejects the view that all patients are presumptively incapacitated and

unable to engage in sexual decision-making. Decisions pertaining to capacity shall be made on an individualized basis by appropriately credentialed professional staff as follows:

a. the initial evaluation of capacity made at time of admission will be considered an assessment of the patient's ability to make decisions, sexual and otherwise, until such time as additional evaluation is warranted;
b. assessments of capacity for sexual decision-making will be undertaken as frequently as needed to ensure that patients are not unduly restricted;
c. patients will not be restricted from sexual activity based solely on length of stay, residential location within the hospital or other non-individualized criteria; and
d. when potentially dangerous or exploitative sexual behavior is observed between patients, a specialized assessment of capacity pertaining to sexual decision-making will be completed by appropriately credentialed professional staff.

Depending upon results of the individualized assessment, any one of the following actions may be pursued:

a. if the patient is found to lack capacity to make informed sexual decisions, the treatment team will meet to devise a plan for the protection and education of the patient and may impose restrictions in conformity with patients' rights regulations; or
b. if the patient is found to have the capacity to make informed decisions, the team may still make individualized recommendations for safe and non-exploitative sexual behavior; or
c. if a patient, capacitated or not, is engaging in unsafe or exploitative behaviors, the treatment team recognizes its obligation to protect and educate that patient to the extent necessary to prevent physical/emotional harm to that patient or another patient.

When a patient who is under **FULL GUARDIANSHIP** expresses a desire for a sexual relationship, AMHI staff will consult with the guardian recognizing the principles set out above:

a. if the guardian does not object, AMHI will not interfere with the relationship;
b. if the guardian objects to the relationship, the patient may request a clinical evalation of his/her ability to make sexual decisions. Should the patient be found to have the ability to make informed sexual decisions in his/her best interest, a meeting with the patient, guardian and AMHI staff will be arranged to attempt to negotiate an acceptable solution; and
c. if the patient is found to have the ability to make sexual decisions and, after an attempt at a negotiated solution, the guardian continues to reject the patient's ability to make such decisions, the patient may be assisted to petition the probate court to resolve the issue.

Individualized recommendations for safe and nonexploitative sexual behavior will be provided for every patient who either wants such guidance or is seen by the treatment team as needing such counseling.

SEXUAL ACTIVITY BETWEEN STAFF AND PATIENTS IS STRICTLY PROHIBITED UNDER ANY CIRCUMSTANCES.

STATE OF MAINE

M E M O R A N D U M

TO: ALL STAFF

FROM: WALTER E. LOWELL, ED.D., ACT. SUPT.

DATE: June 12, 1996

SUBJECT: REPORTING SAFETY CONCERNS
****

DEPARTMENT HEADS/PROGRAM DIRECTORS SHARE WITH YOUR STAFF A.S.A.P.

As a consequence of one of the recommendations in the McDowell Commission's report, I am reminding staff to report any situation that jeopardizes patient and staff safety directly to their supervisor. At all times, staff should feel free to contact either the Director of Clinical Operations, Medical Director or the Superintendent, directly, if safety concerns are not resolved.

b

STATE OF MAINE

M E M O R A N D U M

TO: ALL STAFF

FROM: WALTER E. LOWELL, ED.D., ACT. SUPT.

DATE: June 12, 1996

SUBJECT: FOLLOW-UP OF MCDOWELL COMMISSION REPORT

****

DEPARTMENT HEADS/PROGRAM DIRECTORS SHARE WITH YOUR STAFF A.S.A.P.

As a follow-up to the McDowell Commission report, I am asking staff who become aware of close personal and emotional relationship between patients to notify your supervisor, Program Director or Director of Clinical Operations. This is to assure that proactive steps are taken to do joint treatment planning concerning respective patients.

b

b. advise the provider as to what is needed (whether its an admission interview, team conference, or other matters);

c. for billing purposes AMHI pays the provider from the time they leave their home to the time they return home, referred to as a "portal to portal fee". The amount charged by hour to AMHI is determined by the interpreter or by the agency that assigned the interpreter. Cost for services are higher for nights, weekends and holidays; and

d. the provider must present a bill for payment which is sent to the Chief of Hospital Services. billing should include the following details:

(1) name of provider
(2) name of patient
(3) hours of service
(4) date(s) of service
(5) signature of a ward nurse/nurse manager indicating these services were provided, as detailed in the billing.

The time when an interpreter comes in is an excellent time to plan ahead for other needs (interviews by various disciplines, treatment activities, etc.). Each patient presents different needs, however. One could contract with the interpreter to return daily for a specified length of time to provide services for a client. Its more effective to plan ahead then to try to find this kind of service on short notice.

GUARDIAN/PATIENT REPRESENTATIVE, NOTIFICATION OF

It shall be the policy of the Augusta Mental Health Institute to notify guardians, public or private, in any issue of informed consent and or in any of the following circumstances**In cases of pending guardianship, DHS, BMR or the pending private guardian is to be considered the patient's representative and must be kept informed relative to the following:**

When notifying DHS, BMR and the assigned case worker is unavailable and a decision is needed, the caller should speak with the supervisor or manager. When contacting a private guardian and the guardian is unavailable, the physician will make a decision and document whether they hold treatment until guardian is reached or whether the value to the patient mandates treatment in the absence of consent. In the absence of consent and treatment is ordered the guardian will be notified as soon as possible.

MD/PA notifies the guardian/patient representative about the following:

a. Informed consent regarding voluntary admissions.
b. Consent for treatment.
c. Any change in treatment provider(s), i.e. M.D.

d. Medication and other treatment changes, including cessation of medication. (Do not need to notify DHS of PRN medication usage, provided the general order has been approved, includes both P.O. and I.M. situations. Also use of over the counter medications on the back of form PR-8 or PR-8A if the guardian has signed the form.
e. Changes in patient's condition.
f. Any physical problems requiring evaluation and/or treatment at medical hospital.

RN/LPN notifies the guardian/patient representative about the following: (as soon as practicable, but no more than one hour post occurrence)

a. Any S.R.C. or restraint episode (does not include use of protective devices providing general order has been approved by D.H.S. within one hour of occurrence).
b. Patient transfer to other units and/or KVMC before the fact (regardless of the reason). In cases of medical emergencies, notification may occur as soon as possible after the transfer to the medical center.
c. Injuries or incidents (includes patient to patient sexual behavior, staff to patient incidents) including suspected patient abuse, neglect or exploitation, as soon as practical after the event, but no more than one hour post occurrence.
d. Guardian's ward being placed on S.L./C.S. (before the fact), U.A.L., A.W.O.L.
e. Any change in treatment provider, i.e., R.N. or L.P.N.
f. Any change is privilege level, before the fact.

Social Workers notify guardians/patient representative (with sufficient notice so that they may attend or address patient needs) about the following:

a. Meetings regarding the guardian's ward, i.e. treatment planning, team conferences, etc.
b. Pending District Court commitment hearings or other court related issues.
c. Plans of discharge and of discharge, before the fact.
d. Any changes in treatment provider, i.e., Social Worker

Guardians, whether they be from theDepartment of Human Services, Child or Adult Protective Services Divisions, Bureau of Mental Retardation, guardians shall have the same access to patient records as is outlined in other parts of this policy manual. They shall have the right to file grievances and to make informed consent decisions regarding treatment. Treatment decisions shall be made with the guardian's consent, except in the case of an emergency. In cases of emergency where the guardian cannot be reached for consent, treatment shall proceed; however, the guardian must be contacted at the earliest possible moment.

The procedures for establishing guardianship can be found under Social Services Procedures Relating to Guardianship. Other references to guardianship can be found in policies in this manual relating to the establishment of informed consent and other patient rights policies.

Do not notify D.H.S. or B.M.R. for:

a. the finding of the examining physicians or licensed psychologists;
b. the specific process of the protective proceedings recommended; and
c. the available options for review of such findings, including the option of additional professional opinions, involvement of an additional party of the patient's choosing in any subsequent discussions of the issues of capacity and treatment, or other appropriate measures.

Where, in the absence of a recommendation for a hearing, it is indicated that an adult patient lacks the necessary capacity to give informed consent, protective proceedings in accordance with law shall be initiated. Where possible, consideration shall be given that guardianship or conservatorship be limited in regard to specific areas of incapacity, and reviewed periodically.

REFUSAL OF TREATMENT: Patients whether voluntary, involuntary, or emergency involuntary with unimpaired capacity have the right to refuse any specific treatment. When a patient refuses a specific form of treatment the Assistant to the Superintendent will be informed immediately, where upon a physician or licensed psychologist not having direct responsibility for the patient's treatment shall examine the patient regarding the need for the treatment. When any such patient refuses a specific treatment, the proposed treatment and a range of appropriate alternatives shall be explored with the patient by the treating physician and representative of the treatment team. This process shall include but is not limited to:

a. the presentation in a treatment team meeting of the treatment information already provided;
b. the adequate provision to solicit the patients's opinion and suggestions in the development of treatment alternatives; and
c. documentation, which shall include, but is no limited to:

(1) the refusal of treatment including the patient's reason for refusal;
(2) the recommendations made by the treatment team and/or the examiner;
(3) the alternative treatment methods considered; and,
(4) the result of attempts to formulate alternative treatment plans, including documentation of maximum patient participation in discussion and formulation of plans.

Discharge of Treatment-Refusing voluntary Patients from Inpatient Facilities: Discharge of voluntary patients from the hospital may only be considered after the steps above have been taken and it is found that no alternative treatment plan can be developed. In this event, discharge may occur after:

a. notification of patient;
b. attempts to involve the patient in the formulation of a discharge plan
c. at least one day prior notification of a designated family member, if feasible and expressly permitted by the patient.

will be expanded (writing in progress)

ADVANCED DIRECTIVES (Medical)

NOTE: Advanced Directives include Living Will Declarations and Durable Powers of Attorney.

The purpose of this policy is to:

a. provide for the distribution of written information to patients concerning their right to make decisions about care; and
b. establish procedures to support effective administration of patients' Advanced Directives (AD) at AMHI, ensuring compliance with the Federal 1990 Patient Self-Determination Act (OBRA, Section 4206) Statutes Annotated. Title 18-A, Article V, Part 7.

IN NO INSTANCE WILL ANY MEMBER OF THE TREATMENT TEAM OFFER RECOMMENDATIONS REGARDING ANY ASPECT OF AN A.D. OR ACT AS A WITNESS TO ONE.

Upon admission, if the patient is able to give informed consent, or at the time the patient is able to give informed consent: AMHI will provide written information (Healthcare: Your Right to Choose Brochure) to patients concerning their right to make decisions about care.

AMHI will accept all written A.D.'s, if available, and ensure incorporation in the patient's medical record. The attending physician and/or any employee who receives an original or copy of a patient's A.D. is responsible for ensuring that such is added to the patient's medical record.

Admission: Within one working day of the patient's admission process, A clerk will determine whether or not an A.D. (Living Will or Durable Power of Attorney) exists.

a. If an A.D. exists prior to this admission, a copy should be obtained. The Clerk will notify the Social Worker, who will document the location of form in the Progress Notes, e.g. home, medical record, etc.
b. If an A.D. does not exist, then the Clerk will provide a copy of the brochure and inquire if the patient seek to make A.D. If yes, the Clerk will:

    (1) notify the Ward Clerk to contact Notary and witness patient's completion of forms; and
    (2) file in the Medical Record (legal documents).

    If no, clerk will document on Advance Directive Summary form on the front of the chart.

c. If the patient was admitted within the last thirty days and declined interest in declaring A.D. that decision will be honored.

Medical Record: Any A.D. received by mail will be directed to Medical Records. The A.D. will immediately be made part of the patient's existing medical record:

Personnel File

WRITTEN REPRIMAND

Employee's Name: Kathleen Whitzell   Date: June 25, 1996

Classification: Program Services Director

Department: Mental Health, Mental Retardation & Substance Abuse Services   Work Location: Augusta Mental Health Institute

DESCRIBE IN DETAIL THE REASON FOR THIS REPRIMAND:

(Continue on back or second sheet if necessary.)

The review team has considered your involvement in the [redacted] incident and has concluded the following:

1) As Program Director for the Social Learning Program, it is your ultimate responsibility to manage the care of patients entrusted to you. A policy infraction concerning notification of [redacted] guardian occurred when the guardian was not notified of a change in her privilege level by a member of your team.

2) Your responsibility as Program Director requires that you work cooperatively with other Program Directors and other executive management team members in resolving intra-program issues. The team believes that you did not fulfill this leadership responsibility by becoming more active in the resolution of this matter.

WHAT MUST BE DONE TO AVOID FURTHER DISCIPLINARY ACTION:

(Steps needed to improve and timetable if appropriate.)

The Team has considered the short time you were in this new role as a mitigating circumstance in determining the level of discipline imposed. However, assuring that accurate and complete information is communicated throughout treatment teams is critical to the role of Program Director.

Therefore, in the future, you must take an active and assertive role in intra-unit issues whether they concern patient treatment or other management topics.

PREVIOUS ORAL REPRIMAND(s) OR OTHER DISCIPLINARY ACTIONS(s) RELATED TO THIS SPECIFIC PROBLEM, IF ANY:

(Give dates.)

None

Parties at Disciplinary Interview:

[signature] Williams

Kathy. Whitzell [signature]

Supervisor's Signature

Employee's Signature

EMPLOYEE:

Your signature means only that you have seen and read this Written Reprimand. This record will be placed in your personnel file.

Personnel File

WRITTEN REPRIMAND

Employee's Name:	Diane Gilbert	Date:	June 25, 1996
Classification:	Program Services Director		
Department:	Mental Health, Mental Retardation & Substance Abuse Services	Work Location:	Augusta Mental Health Institute

DESCRIBE IN DETAIL THE REASON FOR THIS REPRIMAND:

(Continue on back or second sheet if necessary.)

The review team has examined your involvement as Program Director in the [redacted] [redacted] Based on this examination the team has concluded the following:

The urgency of the April 3rd meeting was not communicated clearly to the other treatment team. This failure on the part of your team is your ultimate responsibility.

WHAT MUST BE DONE TO AVOID FURTHER DISCIPLINARY ACTION:

(Steps needed to improve and timetable if appropriate.)

The Team has considered the short time you were in this new role as a mitigating circumstance in determining the level of discipline imposed. However, assuring that accurate and complete information is communicated throughout treatment teams is critical to the role of Program Director.

Therefore, in the future, you must take an active and assertive role in intra-unit issues whether they concern patient treatment or other management topics.

PREVIOUS ORAL REPRIMAND(s) OR OTHER DISCIPLINARY ACTIONS(s) RELATED TO THIS SPECIFIC PROBLEM, IF ANY:

(Give dates.)

None

Parties at Disciplinary Interview: Lori Williams

Rodney Bouffard
Supervisor's Signature

Diane Gilbert
Employee's Signature

EMPLOYEE:

Your signature means only that you have seen and read this Written Reprimand. This record will be placed in your personnel file.

cc: Employee

Senator Beverly Miner Bustin
Assistant Democratic Leader
State House Station 3
Augusta, Maine 04333

THE MAINE SENATE
117th Legislature

165 Cony Street
Augusta, Maine 04330
(207) 622-3009

July 26, 1996

Joint Standing Standing Committee On
Health & Human services
State House Station 3
Augusta, Maine 04333

Dear Sen. Pendexter, Rep. Fitzpatrick, Committee Members,

I am aware of the interpretation of MRSA 5, section 7070, paragraph E, regarding disciplinary actions. I was the sponsor of the original legislation. I can tell you the interpretation given to you at your last meeting by Julie Armstrong is incorrect and not the intent of the original legislation.

The intent of the legislation was to have the "clock start ticking" for the 120 days on the date the arbitration was filed. To have it any other way would create chaos in the process and prejudice the decision makers. The legislation I sponsored was intended to expedite the process when the case reached the arbitration level. Currently, an arbitrator in most instances, has to render a decision within 30 days of the hearing. It behooves the parties then to reach a decision before the 120 days have passed. To release the employee disciplinary information at step one of the process is unreasonable and not practical in many instances.

If you have further questions or concerns, please do not hesitate to contact me.

Sincerely,

Beverly Miner Bustin

Senator Beverly Miner Bustin
District 15

cc: Commissioner Melodie Peet
Linda Pistner, Chief Deputy Attorney General
Julie Armstrong, Bureau of Employee Relations

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

August 1, 1996

Jane Orbeton
Legal Analyst
Office of Policy and Legal Analysis
State House Station 13
Augusta, Maine 04333

RE: Your request for disciplinary documents

Dear Jane:

I have received your request for copies of disciplinary actions taken as a result of the death of Wrendy Hayne and subsequent investigation done as a consequence of the death. In addition, my staff have reviewed this matter with the Bureau of Employee Relations, Chief Counsel Julie Armstrong. You can be assured that this Department will comply with the committee's request to the full extent permitted by law.

As you are already aware, it is only the final written disciplinary decision which ultimately becomes public. In other words, any underlying investigatory reports or documents relating to employee misconduct or allegations of misconduct remain confidential. Accordingly, it is only the final written disciplinary decision that we will be permitted to provide you with when it is no longer confidential.

You are correct that pursuant to 5 MRSA S7070, a final written decision that is appealed to arbitration is no longer confidential 120 days after a written request for the decision, assuming the decision of the neutral arbitrator is not issued and released before the expiration of the 120 days. While some of the discipline has been grieved pursuant to the applicable collective bargaining agreements, none has yet been appealed to

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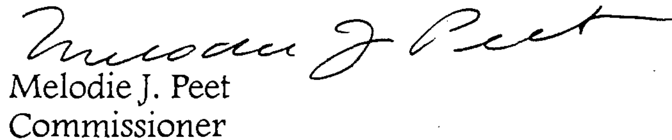
PHONE: (207) 287-4223 (Voice) (207) 287-2000 (TTY) FAX: (207) 287-4268

arbitration. For any disciplinary actions which have been appealed to arbitration within 120 days of your request, we will be able to provide you with the final written decisions at the expiration of the 120 days or November 19, 1996. Any action which has not been appealed to arbitration by that date, however, would remain confidential, and we would be unable to release them until they are actually appealed.

I think that the Committee should know that the Maine State Employees Association, which represents the employees in question, disagrees with the State's interpretation. It takes the position that the 120 day period begins with the filing for arbitration regardless of the time necessary to receive the Step 3 written decision from the Bureau of Employee Relations.

I hope this clarifies our position on this matter and assure you that we will cooperate with the Committee in every way allowed by law.

Sincerely



Melodie J. Peet
Commissioner

MJP/dlw

cc: Julie Armstrong
Don Williams

Maine State Employees Association ■ Service Employees International Union
Ray Dzialo, President Carl Leinonen, Executive Director

HAND DELIVERED

August 21, 1996

Julie M. Armstrong, Esq.
Chief Counsel
Bureau of Employee Relations
State House Station 79
Augusta, ME 04333

Re: AMHI Personnel Investigation Records

Dear Julie:

On July 24, the Joint Standing Committee on Health and Human Services requested copies of all disciplinary records relating to the death of Wendy Hayne, or to any subsequent investigation. I understand that your office advised the Department to release all of the requested documents, including records that are not final written decisions, on the 121st day following that request. No Demand for Arbitration has yet been filed in any of these cases.

As you know, we are prepared to ask the Courts to enjoin the release of any documents except the final decision, which may be released 120 days after arbitration is demanded, consistent with 5 M.R.S.A. § 7070. We believe the courts will enforce the legislature's intent to protect employees from public disclosure of disciplinary allegations prior to review by an independent arbitrator.

This Union proposes an alternative that should meet the needs of the Joint Standing Committee, the employees, and the parties to the collective bargaining agreement. By expediting the arbitration process, we can get a final written decision by an arbitrator on or before November 25.

Specifically, we propose asking the American Arbitration Association to schedule two of three dates in September or October with one of the following arbitrators commonly used by the State and MSEA: Timothy Bornstein, Timothy Buckalew, Bruce Fraser, Sarah Kerr Garraty, Mark Irvings, Lawrence Katz, James Litton, Elizabeth Neumeier, Robert O'Brien, Michael Ryan, Harvey Shrage, and Arnold Zack. We would then arbitrate all pending grievances together, and either close orally or submit briefs before October 25.

Please understand that this letter is not a Demand for Arbitration, but merely a proposal aimed at resolving this dispute. In the event this proposal is rejected, we will process these grievances consistent with the collective bargaining agreement, and will ask the court to enjoin any release until 120 days following the Demand for Arbitration.

Sincerely,

Arb. schedule Oct 1 and 3

Timothy L. Belcher, Esq.
Chief Counsel

cc: Melodie Peet

P.O. Box 1072, 65 State Street, Augusta, ME 04332-1072 ■ 207-622-3151 ■ Fax 207-623-4916

SENATE

JOAN M. PENDEXTER, DISTRICT 31, CHAIR
JOHN W. BENOIT, DISTRICT 17
ROCHELLE M. PINGREE, DISTRICT 12

JANE ORBETON, LEGISLATIVE ANALYST
BETSY REINHEIMER, COMMITTEE CLERK

HOUSE

MICHAEL J. FITZPATRICK, DURHAM, CHAIR
BIRGER T. JOHNSON, SOUTH PORTLAND
DAVID ETNIER, HARPSWELL
J. ELIZABETH MITCHELL, PORTLAND
DAVID C. SHIAH, BOWDOINHAM
KYLE W. JONES, BAR HARBOR
GLENYS P. LOVETT, SCARBOROUGH
JEFFERY JOYNER, HOLLIS
JEAN GINN MARVIN, CAPE ELIZABETH
ROBERT J. WINGLASS, AUBURN

STATE OF MAINE

ONE HUNDRED AND SEVENTEENTH LEGISLATURE

COMMITTEE ON HUMAN RESOURCES

April 25, 1996

Commissioner Melodie Peet
Department of Mental Health, Mental Retardation and Substance Abuse Services
State House Station 40
Augusta, ME 04333-0040

Dear Commissioner Peet,

On behalf of the Joint Standing Committee on Health and Human Services, I am writing to request that you provide certain information to the committee. Specifically we are interested in reviewing correspondence between the Department of Mental Health, Mental Retardation and Substance Abuse Services and the federal Health Care Financing Administration and between the department and the Department of Human Services Division of Licensure and Certification pertaining to recent inspections and compliance with federal and state certification standards at the Augusta Mental Health Institute. Since the Department of Human Services is involved in this issue, I will send a copy of this letter along to Commissioner Kevin Concannon to inform him of the interest of the committee.

I would appreciate it if you could forward this information by May 1 to Jane Orbeton, who will send it along to all committee members. If we were in session we could maintain close contact with you through less formal briefing sessions. I regret that this is not possible at this time of year.

Sincerely,

Mike

Michael J. Fitzpatrick
House Chair

cc: committee members
Commissioner Kevin Concannon

SENATE

JOAN M. PENDEXTER, DISTRICT 31, CHAIR
JOHN W. BENOIT, DISTRICT 17
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BETSY REINHEIMER, COMMITTEE CLERK

STATE OF MAINE

HOUSE

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JEAN GINN MARVIN, CAPE ELIZABETH
ROBERT J. WINGLASS, AUBURN

ONE HUNDRED AND SEVENTEENTH LEGISLATURE

COMMITTEE ON HUMAN RESOURCES

TO: Members, Joint Standing Committee on Human Resources

FROM: Michael J. Fitzpatrick, House Chair

DATE: May 31, 1996

SUBJ: Report on AMHI

You will recall that on April 25th I wrote to Commissioner Peet asking for correspondence between the Department of Mental Health, Mental Retardation and Substance Abuse Services and the federal Health Care Financing Administration on inspections and compliance at the Augusta Mental Health Institute. I received from the commissioner this week a report, a copy of which I am sending along to all committee members. Thank you for your patience.

STATE HOUSE STATION 115, AUGUSTA, MAINE 04333 TELEPHONE: 207-287-1317

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

May 23, 1996

The Honorable Michael Fitzpatrick
House Chair, Health and Human Services Committee
State House Station #115
Augusta, ME 04333

Dear ~~Representative~~ Mike Fitzpatrick,

I am following up to your letter of April 25, 1996 requesting copies of correspondence between the Department of Mental Health, Mental Retardation and Substance Abuse and the federal Health Care Financing Authority pertaining to recent inspections and compliance with federal and state certification standards at the Augusta Mental Health Institute. I am enclosing a copy of the Health Care Financing Authority's report of deficiencies found by the Department of Human Services during its substantial allegation survey. The Department's plan of correction for each deficiency is included on the report, as well.

Please feel free to contact me if you have questions or concerns.

Sincerely,

Melodie

Melodie J. Peet, Commissioner

PHONE: (207) 287-4223 (Voice) (207) 287-2000 (TTY) FAX: (207) 287-4268

DEPARTMENT OF HEALTH & HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

Division of
Health Standards and Quality

Region 1
J.F.K. Federal Building
Government Center
Boston, MA 02203

MAY 17 1996

Walter Lowell, Ed.D.
Administrator
Augusta Mental Health Institute
Arsenal Street, P.O. Box 724
Augusta, Maine 04330

Provider No: 20-4007

Dear Dr. Lowell:

Section 1865 of the Social Security Act and pursuant regulations provide that a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will be "deemed" to meet all Medicare health and safety requirements with the exception of those relating to utilization review. Section 1864 of the Social Security Act authorizes the Secretary of Health and Human Services to conduct a survey of an accredited hospital participating in the Medicare program if there is a substantial allegation of a serious deficiency or deficiencies which would, if found to be present, adversely affect the health and safety of patients. If, in the course of such a survey, a hospital is found to have significant deficiencies with respect to compliance with the Conditions of Participation, we are required, following timely notification of the accrediting body, to keep the hospital under Medicare State Agency survey jurisdiction until the hospital is in compliance with all the Conditions of Participation.

We have received a report of deficiencies found by the Maine Department of Human Services (State Agency) during its substantial allegation survey completed on April 23, 1996. Based on this report, we find that Augusta Mental Health Institute is not in compliance with all the Conditions of Participation for hospitals. A complete listing of all deficiencies found by the State Agency is enclosed.

These deficiencies have been determined to be of such serious nature as to substantially limit your hospital's capacity to render adequate care and prevent it from being in compliance with the Condition of Participation at 42 CFR 482.21 (Quality Assurance).

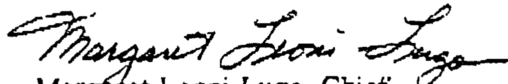
In accordance with section 1865(b) of the Social Security Act, the State Agency will shortly conduct a complete Medicare survey of your facility to assess compliance with the other Conditions of Participation which were not surveyed during the recent survey. They will also furnish you with a complete listing of any other deficiencies noted during the full survey.

After the completion of the Medicare survey, Augusta Mental Health Institute will be asked to submit to the State Agency a plan with acceptable completion dates for correction of all its cited deficiencies.

The requirement that Augusta Mental Health Institute must submit a plan to correct its Medicare deficiencies does not affect its accreditation, its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. When Augusta Mental Health Institute's plan of correction has been implemented and it has been found to meet all the Medicare Conditions of Participation for hospitals, the State Agency will discontinue its survey jurisdiction.

Copies of this letter are being forwarded to the Maine State Agency and to the JCAHO. If you have any questions on this matter, please contact Gail Stryde at (617) 565-3309.

Sincerely yours,



Margaret Leoni-Lugo, Chief
Survey and Certification Branch

Enclosure

cc: Maine State Agency
JCAHO

05/20/96 15:33 AMHI-SUPT-OFFICE → 207 287 4268

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0391

ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	204007	A. BUILDING______ B. WING______	04/23/96

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA MENTAL HEALTH INSTITUT	PO BOX 724, ARSENAL STREET AUGUSTA, MAINE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	MEMO TAG: INITIAL COMMENTS	A 000		
A 050	482.21 CONDITION: QUALITY ASSURANCE 42 CFR 482.21 CONDITION OF PARTICIPATION QUALITY ASSURANCE ------------------------------------ The governing body must ensure that there is an effective, hospital-wide, quality assurance program to evaluate the provision of patient care. This CONDITION is not met as evidenced by: Based on review, it was determined that, although the Governing Body had approved a facility wide Performance Improvement Plan, there was no documentation that the facility had implemented this Plan to evaluate the provision of patient care and to document appropriate remedial actions and their outcomes to address deficiencies found through the Quality Assurance program.	A 050	The Governing Body Minutes will more adequately reflect implementation of the Performance Improvement Plan. This will be accomplished by: 1) revising agenda to more adequately reflect evaluation of patient care and; 2) Minutes will reflect care that has been given and remedial actions and outcomes taken.	6/18/96

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. The findings above are discloseable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUGUSTA MENTAL HEALTH INSTITUT	PO BOX 724, ARSENAL STREET AUGUSTA, MAINE

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A 050	(Continued From Page 1)			
	See Tag A51--The hospital did not document compliance with its Plan.		Plan as noted on page 1	
	See Tag A58--The hospital did not document remedial actions and their outcomes to address deficiencies found through the Quality Assurance program.		Plan as noted on page 1	
A 051	482.21(a) STANDARD: CLINICAL PLAN 42 CFR 482.21(a) Clinical plan ---------- The organized, hospital-wide quality assurance program must be ongoing and have a written plan of implementation. This STANDARD is not met as evidenced by: Based on review of the Performance Improvement Plan, Governing Body minutes, reporting schedules, minutes of the Medical Executive Committee and Quality Operations Committee and conversations with several facility employees, including the Superintendent, Clinical Medical Director and Director of Quality Assurance/Quality Improvement, it was determined that, although the facility had a Plan, there was no documentation that it was implemented as defined. See Tag A52--There was no documentation that the facility departments/disciplines	A 051	The minutes of Governing Body, Medical Executive Committee and Quality Operations Committee will more adequately document implementation of the QI/QA plan. The Outpatient Clinic opened in January, 1996 and aggregate information is now available for quarterly reporting to the Medical Executive Committee. Social Learning Program indicators will be reported to the Quality Operations Committee on a quarterly basis.	5/31/96

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUGUSTA MENTAL HEALTH INSTITUT	PO BOX 724, ARSENAL STREET AUGUSTA, MAINE

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A 052	(Continued From Page 3) although the facility had a plan for evaluating services, there was no documentation that the facility was following its plan.			
	Findings include:			
	_ There was no documentation that the Governing Board received any department/discipline annual reports, which were due in July, 1995. The document entitled Quality Assurance Annual Report FY 1994-1995, that was attached to the Governing Body minutes, was incomplete and did not include any department/division annual reports. There was documentation that provided evidence of the Governing Board receiving an annual report of safety at a later time.		The Hospital wide QI/QA Annual Report will be updated to include previously done reports that were omitted.	6/16/96
	_ The document entitled Quality Assurance Annual Report FY 1994-1995 provided to surveyors did contain several more annual reports than the copy which was attached to the Governing Body Minutes. However, it still did not include several other department/division annual reports. Surveyors requested the missing reports and were provided with two others. However, by the end of the survey they still did not have documentation of the following several departmental annual reports: Forensics Treatment Unit, Medical Information System, Medical Records and Pharmacy. There was no documentation provided to indicate		The Hospital wide QI/QA Annual Report will include annual reports from Forensic Treatment Unit, Medical Information Systems, Medical Records, and Pharmacy.	6/16/96

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 052	(Continued From Page 4) on annual report from the Governing Body.			
	Based on a review of nine months of FY 1995-1996 Quality Operations Committee meeting minutes (July'95-April'96) and a review of the quarterly departmental reporting schedule, it was determined that there was no documentation that any department/discipline met its required reporting schedule. Examples include: The Social Service Department was scheduled to report in July, October, and January, there was no documentation in the minutes that it had reported at all; the Nursing department was scheduled to report in July, October and January, there was documentation that it reported in October and February; the Medical Staff was scheduled to report in August, November and February, there was documentation that it reported in September and December; the Ethics Committee was scheduled to report in August, November and February, there was no documentation in the minutes that it had reported at all; Dietary and Support Services were scheduled to report in September, December and March, there was documentation that it reported in July and September; Rehabilitation was scheduled to report in September, December and March, there was documentation that it reported in September only.		All Departments and units will report as scheduled.	5/14/96

DEPARTMENT OF HEALTH AND HUMAN SERVICES
[illegible]TH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 053	(Continued From Page 6) disciplines to the Quality Operations Committee and minutes of the Quality Operations Committee from July, 1995 to April, 1996 it was determined that, although there were indicators developed for Infection Control and Pharmacy, there was no documentation that these Departments followed the facility Plan.		The minutes of the Quality Operations Committee will document that Infection Control and Pharmacy processes and objectives are carried out.	5/21/96
	Findings include:			
	— Infection Control was scheduled to report to the Quality Operations Committee in July, October and January. There was documentation of only one report from infection control in October.		The minutes will reflect that Infection Control will report out as indicated in the QI/QA Plan.	5/21/96
	— The facility Plan included seven Pharmacy indicators. This Department was not included on the quarterly reporting schedule. A review of the minutes did not reveal any quarterly reports from the Pharmacy Department.		The minutes will reflect that Pharmacy indicators will report out as indicated in the QI/QA Plan.	5/21/96
	— A review of Medical Staff indicators revealed two indicators related to medications. Medical Executive Committee meeting minutes of 06/07/95 documented questions regarding polypharmacy. This polypharmacy indicator was to be followed up at Quality Review. The Quality Review of 12/06/95 documented plans for this indicator to be further reviewed and approved in two weeks. There was no documentation that this occurred. The minutes of 01/03/96		The Medical Staff will expedite the contract with Maine Medical Association for peer review including high dose and polypharmacy. In addition, we will review the hospital's high dose and polypharmacy trends and benchmark against national standards.	6/18/96

AH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	204007	A. BUILDING ____ B. WING ____	04/23/96

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA MENTAL HEALTH INSTITUT	PO BOX 724, ARSENAL STREET AUGUSTA,MAINE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 053	(Continued From Page 7) documented the issue of polypharmacy indicator again the the decision was made to seek peer review through the Maine Medical Association. As of the date of the survey, this peer review had not begun.			
A 054	482.21(a) ELEMENT of STANDARD: CLINICAL PLAN All medical and surgical services performed in the hospital must be evaluated as they relate to appropriateness of diagnosis and treatment. This ELEMENT is not met as evidenced by: Based on review of the facility's Performance Improvement Plan 1995-1996 reporting schedule and Medical Executive Committee meeting minutes for a period of twelve months, it was determined that there was minimal documentation that the facility evaluated Medical services as they related to appropriateness of diagnosis and treatment.	A 054	The Medical Executive Committee (MEC) minutes will reflect the evaluation of Medical Services as they relate to appropriateness of diagnosis and treatment.	5/22/96
	Findings include: __ The Medical Staff was scheduled to report to the Quality Operations Committee in August, November and February. There was documentation of reports only in September and December. Additionally, these reports did not document substantive review of medical services as they related to		The Quality Operations Committee will document substantive review of medical services as they relate to appropriateness of diagnosis and treatment.	5/22/96

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
...TH CARE FINANCING ADMINISTRATION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 204007	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 04/23/96

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A 054	(Continued From Page 8) appropriateness of diagnoses and treatment.			
	_ A review of Medical Staff indicators revealed two indicators related to medications. Medical Executive Committee meeting minutes of 06/07/95 documented questions regarding polypharmacy. This polypharmacy indicator was to be followed-up at Quality Review. The Quality Review of 12/06/95 documented plans for this indicator to be further reviewed and approved in two weeks. There was no documentation that this occurred. The minutes of 01/03/96 documented the issue of polypharmacy indicator again and the decision was made to seek peer review through the Maine Medical Association. As of the date of the survey, this peer review had not begun.		The Medical Staff will contract and expedite the contract with Maine Medical Association for peer review including high dose and polypharmacy. In addition, we will review the hospital's high dose and polypharmacy trends and benchmarked against national standards.	6/18/96
	_ The Medical Executive Committee was sent memos on at least two different occasions which were compiled from review of patient specific incident reports and related to restraint use and inappropriate behavior. The purpose of this analysis was to relate these findings to treatment options for these individual patients. A review of the minutes revealed no discussion of these and, thus, no documentation of any actions. In fact, a meeting (07/05/95) following the receipt of one memo regarding restraint use		The minutes of the Medical Executive Committee will reflect follow up on all treatment and care related issues.	5/22/96

DEPARTMENT OF HEALTH AND HUMAN SERVICES
[illegible]TH CARE FINANCING ADMINISTRATION

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	204007	A. BUILDING________ B. WING________	04/23/96

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A 054	(Continued From Page 9) documented "No problems regarding Single Room Care and Restraint."			
	_ The Medical Executive Committee minutes of 06/07/95 documented that the indicator "Hypertension" was to be discontinued and "orthostatic hypotension recognition and management" was to be instituted and reviewed at Quality Review. No further documentation of this indicator was noted.		The Medical Executive Committee will make a determination as to whether this continues to be a valued indicator at this time.	5/22/96
	_ The Medical Executive Committee minutes of 01/10/96 documented a QA report of a serious illness due to Clozaril use. There was no documentation of substantive discussion of this case. The action documented was "No Action."		The minutes of the Medical Executive Committee will reflect the review of all care and treatment issues and document in the minutes.	5/22/96
	_ Resperidol use was to be discussed at the next meeting. There was no documented evidence of further discussion of this drug use.		Resperidol will be assigned to a Drug Use Evaluation and reported back to Medical Executive Committee as to findings.	7/1/96
A 058	482.21(c) STANDARD: IMPLEMENTATION 42 CFR 482.21(c) Implementation ------------------------------------ The hospital must take and document appropriate remedial action to address deficiencies found through the quality assurance program. The hospital must document the outcome of the remedial action.	A 058		

FORM HCFA-2567(09-92)

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
[illegible]TH CARE FINANCING ADMINISTRATION

FORM APPROVED
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A 058	(Continued From Page 10)			
	This STANDARD is not met as evidenced by:			
	Based on review of the Quality Improvement Plan 1995-1996, the minutes of the Medical Executive Committee for one year, the minutes of the Quality Operations Committee for FY 1995 - 1996, and the minutes of the Governing Body January, 1995 through March, 1996, it was determined that there was minimal documentation that the hospital took appropriate remedial action to address deficiencies found through the Quality Assurance program and minimal documentation of the outcome of remedial action.		The minutes of the Governing Body, Medical Executive Committee and Quality Operations Committee will more thoroughly document QA/QI activities including remedial actions identified in the QA/QI program.	5/22/96
	Findings include:			
	— There was no documentation that the Governing Board received any department/discipline annual reports, except safety, which were due July, 1995. The document entitled Quality Assurance Report FY 1994-1995, that was attached to the Governing Body minutes, was incomplete and did not include any department/discipline annual reports.		Plan of correction as noted on page 4 (052).	5/31/96
	— The Quality Improvement Plan indicates that Quality information will be forwarded from the Medical Executive Committee and the Quality Operations Committee to the Governing Body. A review of Governing Body minutes from January		The minutes of the Governing Body meeting will more thoroughly document discussion and evaluation of Medical Staff indicators.	6/18/96

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A 058	(Continued From Page 11) 1995 to March 1996 revealed that there was no discussion of Medical Staff departmental or divisional indicators which included a review of the results of the monitoring, with the exception of one case reviewed in March 1995.			
	— A review of Medical Staff indicators revealed two indictors related to medications. Medical Executive Committee meeting minutes of 06/07/95 documented questions regarding polypharmacy. This polypharmacy indicator was to be followed-up at Quality Review. The Quality Review of 12/06/95 documented plans for this indicator to be further reviewed and approved in two weeks. There was no documentation that this occurred. The minutes of 01/03/96 documented the issue of polypharmacy indicator again and the decision was made to seek peer review through the Maine Medical Association. As of the date of the survey this peer review had not begun.		The Plan of Correction is noted above under A054.	
	— The Medical Executive Committee was sent memos on at least two occasions which were compiled from review of patient specific incident reports and related to restraint use and inappropriate behaviors. The purpose of this analysis was to relate these findings to treatment options for these individual patients. A review of the minutes revealed no discussion of these		The minutes of the Medical Executive Committee will reflect follow up on all treatment and care related issues.	5/22/96

DEPARTMENT OF HEALTH AND HUMAN SERVICES — FORM APPROVED
HEALTH CARE FINANCING ADMINISTRATION — OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 204007	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 04/23/96

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A 058	(Continued From Page 12) and, thus, no documentation of any action. In fact, a meeting (07/05/95) following the receipt of one memo regarding restraint documented "No problems regarding Single Room Care and Restraint."			
	Based on review of the Medical Staff Quarterly Reports presented in September and December, 1995 to Quality Operations Committee, there was no documentation of several problematic issues and, thus, no subsequent resolution. The September minutes documented only a problem with closing Medical Records within fifteen days. The action documented "staff working on obtaining signatures in a more timely fashion." The December meeting minutes documented only "Data presented by L.M." There was no documentation of other indicators which did not meet established thresholds such as treatment plans being established within three days, completion of annual psychiatric evaluations, case review and episodes of restraint and inappropriate behavior.		The Medical Executive Committee minutes will document all patient care issues brought to the committee including recommendations and actions.	5/22/96
	— The 04/10/96 Medical Executive Committee meeting minutes document six x-ray requests without appropriate clinical information. There were no actions or recommendations related to this.		The minutes of the Medical Executive Committee will document all recommendations and actions related to care and treatment.	5/22/96
	•• The 04/10/96 Medical Executive Committee meeting minutes			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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A 058	(Continued From Page 13) documented that seven of ten annual psychiatric assessments were not done. There were no Medical Staff specific recommendations related to this.		As noted above.	5/22/96
	The Quality Operations Committee meeting minutes document discussion of the problem with developing treatment plans within three days of admission. The 07/25/95 minutes document that 21% were developed in a timely manner. This matter was referred to the September meeting. The 09/12/95 meeting minutes document that the treatment plan issue be referred to Clinical Operations. The 10/03/95 meeting minutes document that a report on treatment planning is due in three weeks. The issue is not discussed again until 11/14/95. At this time the minutes document that the compliance is down and the issue is to be studied. The 02/03/96 meeting minutes document that the group studying this issue is to meet next week. There is no further discussion of this issue at this committee. The 04/10/96 Medical Executive Committee meeting minutes document that for the quarter ending January, 1996, there is a 30% compliance rate with the indicator that treatment plans be developed within three days of admission. The meeting minutes do not document any actions or recommendations related to this.		The minutes of the Quality Operations Committee will document and follow up all care and treatment issues. Treatment planning timeliness is now assigned to Program Managers to improve compliance rate. Treatment plan timeliness will be monitored by the Quality Operations Committee.	5/21/96

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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A 227	482.41(a) STANDARD: BUILDINGS	A 227		
	42 CFR 482.41(a) Buildings ------------------------------- The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.		All AMI locks and keys are in the process of being changed. A new policy has been implemented and reviewed by all staff. A Security Process Action Team has been established.	5/31/96
	This STANDARD is not met as evidenced by:			
	Based on a tour of the entire physical plant and conversations with several facility employees, including the Director of Hospital Services and the Chief Engineer, it was determined that the current key lock and security system could not ensure the safety and well being of patients.		Plan of correction as noted above.	
	Findings include the following:			
	The key and lock security system at A.M.H.I. was installed approximately thirty years ago. The surveyor was told that an average of three sets of keys issued to staff were lost or misplaced annually. Included in this set is the A.M.I. building pass key, which accesses all patient buildings and common areas.		As noted above.	
	At approximately 0720 hours on 04/23/96 an audible visual fire alarm sounded at the facility's gymnasium. As staff responded to		The lock on the mechanical room door will be inspected to ensure that it functions appropriately and if found to be a problem, will be replaced.	5/21/96

DEPARTMENT OF HEALTH AND HUMAN SERVICES
[HEA]LTH CARE FINANCING ADMINISTRATION

FORM APPROVED
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A 227	(Continued From Page 15) the area it was noted by the surveyor that the lock on the mechanical room door did not function correctly; several levels of keys were used before the lock released.			

SENATE

JOAN M. PENDEXTER, DISTRICT 31, CHAIR
JOHN W. BENOIT, DISTRICT 17
ROCHELLE M. PINGREE, DISTRICT 12

JANE ORBETON, LEGISLATIVE ANALYST
BETSY REINHEIMER, COMMITTEE CLERK

HOUSE

MICHAEL J. FITZPATRICK, DURHAM, CHAIR
BIRGER T. JOHNSON, SOUTH PORTLAND
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GLENYS P. LOVETT, SCARBOROUGH
JEFFERY JOYNER, HOLLIS
JEAN GINN MARVIN, CAPE ELIZABETH
ROBERT J. WINGLASS, AUBURN

STATE OF MAINE

ONE HUNDRED AND SEVENTEENTH LEGISLATURE

COMMITTEE ON HUMAN RESOURCES

June 13, 1996

Commissioner Kevin W. Concannon
Department of Human Services
11 State House Station
Augusta, Me 03443

Dear Commissioner Concannon,

The Health and Human Services Committee has received copies of the correspondence between the Department of Mental Health, Mental Retardation and Substance Abuse Services and the federal Health Care Finance Administration pertaining to recent inspections and compliance with federal and state certification standards at the Augusta Mental Health Institute. The Health and Human Services Committee was the Human Resources Committee during most of the 117th Legislature, being renamed by a change in Joint Rule 13 adopted late in the Second Regular Session.

The committee has heard that there has been communication or correspondence regarding this issue from the Health Care Finance Administration since the letter from Margaret Leoni-Lugo to Dr. Lowell that was forwarded to the committee date stamped May 17, 1996. The committee would appreciate copies of all correspondence on this issue among any of the participating agencies: your department, the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Health Care Finance Administration. On behalf of the committee we are also making this request of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Thank you for your assistance.

Sincerely,

Joan
Mike

Senator Joan M. Pendexter
Representative Michael J. Fitzpatrick
Chairs

cc: Commissioner Melodie J. Peet

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

July 1, 1996

The Honorable Joan Pendexter
The Honorable Michael Fitzpatrick
State House Station #115
Augusta, ME 04333

Dear Senator Pendexter and Representative Fitzpatrick:

I wanted to give you advanced notice of the results of a survey of AMHI which was recently completed by the Department of Human Services. As the enclosed letter indicates, the Department found several deficiencies at AMHI, and has placed a condition upon the hospital. My team is in the process of reviewing the deficiencies cited by DHS, and putting together a plan of correction to address the problems. I am taking this "condition" very seriously, and I will forward to you the plan of correction upon its completion.

In the meantime, please know that I remain committed to ensuring the safety and well-being of patients at AMHI. As you know, I recently made several major changes in hospital administration to address problems that had arisen at the hospital, and I am confident that the new Acting Superintendent and Acting Clinical Director will provide the hospital with the leadership that it so clearly needs.

I will keep you apprised of all further developments. In the meantime, please feel free to contact me with questions or concerns.

Sincerely,

Melodie J. Peet
Commissioner

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PHONE: (207) 287-4223 (Voice) (207) 287-2000 (TTY) FAX: (207) 287-4268

Angus S. King, Jr.
Governor

Kevin W. Concannon
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

June 27, 1996

Rodney Bouffard, Acting Superintendent
Augusta Mental Health Institute
P.O. Box 724
Augusta, Maine 04332-0724

Dear Mr. Bouffard:

Pursuant to its authority under Section 1811 and 1813, as amended by P.L. 1967, c.231, Section I, Augusta Mental Health Institute (hereinafter, "AMHI") is now required to be licensed by the state and pursuant to its authority under 22 MRSA 1817, the Department of Human Services (hereinafter the "Department") is issuing to AMHI a conditional license to operate a hospital. This action is taken because the Department has determined that the interests of the patients at AMHI and the general public would be best served by offering the opportunity to correct conditions which resulted in the serious and substantial failure of AMHI to comply with the provisions of the *Regulations for the Licensure of General and Specialty Hospitals in the State of Maine* (July 1972, with amendments through July 1, 1994), hereinafter the "Regulations".

The Department's proposed action results from observations and staff interviews conducted by staff of the Division of Licensing and Certification during Federal/State surveys and complaint investigations conducted at AMHI on June 4-6, 1996 and June 20-21, 1996. In addition to the information provided by the surveys on June 4-6, 1996 and June 20-21, 1996, it is also significant to note that a survey and complaint investigation were conducted on April 22-23, 1996, in which a Federal Condition of Participation, specifically Quality Assurance, was found to be out of compliance in addition to other deficiencies and a plan of correction was submitted by the hospital to the Health Care Financing Administration and the Department. A follow-up survey conducted by the Department on June 4-6, 1996 documented that systems were in place to comply with the Federal Condition of Participation, however it was also noted that the systems would need to be maintained and reevaluated for continued compliance by the Department. The survey also provided documented evidence of deficiencies related to the Medical Staff, specifically with regard to credentialing, organization, significant number of locum tenens, quality improvement and compliance with Bylaws. The recent

appointment of an Acting Medical Director, in view of the medical staff deficiencies, provides the need for ongoing monitoring by the Department to ensure compliance with the Regulations.

As proposed by the Department, the conditional license to be issued to AMHI would be subject to the following conditions, which must be met within the specified timeframes and are deemed necessary for the protection of the health and safety of the patients of the facility:

I. Condition Pertaining to Medical Staff

Within fifteen (15) days of the effective date of the conditional license, AMHI will:

1. Submit a written plan for the provision of continuity of care and leadership, while addressing the complexity of Medical Staff deficiencies with an Acting Medical Director.

Within thirty (30) days of the effective date of the conditional license, AMHI will ensure that:

2. The Medical Staff will institute a policy and procedure to include Medical Staff's performance improvement activities in the process of reappointment and reappraisal.

3. The Medical Staff will develop and utilize a system for translating monitoring of appropriateness of diagnosis and treatment into evaluative and interventional activities to confirm variances in performance or breaches in quality of care. The evaluative data will then be utilized to develop interventions to improve diagnosis and treatment.

4. Locum tenens physicians' credential files will contain primary verification of those required credentials, in accordance with the Medical Staff Bylaws (Article 5.2.1.).

5. The Medical Staff physicians will be reappointed in accordance with the AMHI Medical Staff Bylaws (Article 5). The four (4) physicians who were not reappointed in 1995 or 1996 will be reappointed if they are continuing to practice at AMHI.

Within sixty (60) days of the effective date of the conditional license, AMHI will ensure that:

6. The Medical Staff develops a procedure regarding the utilization and documentation of Quality Improvement data relative to a plan for follow-up and remedial action.

7. The Medical Staff Department Meeting minutes, as well as the Medical Executive Committee Meeting minutes, will document remedial actions taken to address poor outcomes, discrepancies in outcomes of therapy with individual physicians, and interpretation and documentation of the Drug Utilization Evaluation as it impacts on quality of care.

8. A consistent monitoring, trending and evaluation of nosocomial infection data to determine potential patient care ramifications, trends or areas needing improvement will be developed.

Written progress reports will be submitted to the Division of Licensing and Certification on a monthly basis to determine compliance with this condition.

II. Condition Pertaining to Governing Board

Within forty-five (45) days of the effective date of the conditional license, AMHI will:

10. Ensure that all hospital physicians have current appointments and reappointments.

III. Condition Pertaining to Dietary

Within sixty (60) days of the effective date of the conditional license, AMHI will:

11. Provide adequate dietary staff to facilitate patient nutritional assessments, teaching and participation in treatment planning.

General Conditions

All deficiencies noted in the Statement of Deficiencies (enclosed herewith as Attachment A) shall be corrected in accordance with a plan acceptable to the Division of Licensing and Certification, and provided to the Department no later than fifteen (15) days after the effective date of the conditional license. Corrections to any and all deficiencies noted on Attachment A shall be verified by staff of the Division of Licensing and Certification. AMHI shall remain in compliance with all Department regulations applicable to hospitals.

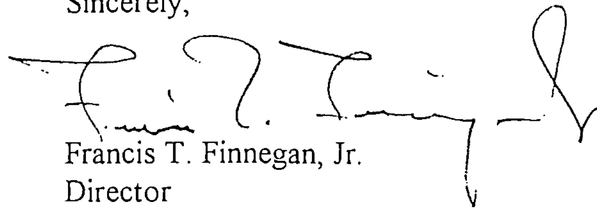
Subject to the opportunity for a hearing before an impartial hearing officer, explained below, the Department intends to issue a conditional license to AMHI immediately after receipt of this letter. During the period of conditional licensure, the Department will closely monitor and evaluate AMHI for compliance with the conditions imposed, as well as all Department regulations, in the hope of being able to issue to the facility a full licensure status at the end of the conditional licensure period. Should AMHI fail to fulfill any of the conditions imposed upon its license, the Department may immediately terminate the hospital's license upon written notification. The Department is authorized to take further steps to assure compliance, including those authorized by 4 MRSA §1151(2) and §1156, MRSA §10051, 22 MRSA §47 and §1817 (and/or other remedies available at law).

If you believe that the licensing action proposed is incorrect, you may request a hearing for the purpose of refuting the basis of the Department's action. Such a hearing would be held before an impartial hearing officer. AMHI would have the right to be represented at the hearing by an attorney or other representative of its choice. It would have the right to call witnesses to present documentary evidence, to cross-examine witnesses, and to a written decision based upon the evidence presented. A request for a hearing must state in

detail your reasons for believing the Department's action to be incorrect. A request for a hearing must be mailed to the following address and received within twenty (20) days of receipt of this letter:

Louis T. Dorogi, Director
Division of Licensing & Certification
35 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011

Sincerely,



Francis T. Finnegan, Jr.
Director
Bureau of Medical Services

FTF:el

cc: Kevin W. Concannon, Commissioner, Department of Human Services
Andrew M. Gattine, Assistant Attorney General
Louis T. Dorogi, Director, Division of Licensing and Certification
Sandra Bethanis, R.N., Assistant Director

JUN-28-'96 11:44 R

Angus S. King, Jr.
Governor

Kevin W. Concannon
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

July 1, 1996

Senator Joan M. Pendexter, Chair
Committee on Human Resources
#3 State House Station
Augusta, Maine 04333

Representative Michael J. Fitzpatrick, Chair
Committee on Human Resources
#2 State House Station
Augusta, Maine 04333

Dear Senator Pendexter and Representative Fitzpatrick:

A copy of your letter to Commissioner Peet regarding copies of correspondence related to the recent inspections at the Augusta Mental Health Institute has been sent to me. Please be assured that we are in the process of gathering the appropriate documents and will forward them to you most expeditiously.

If you have any questions, please feel free to contact me directly at 287-2093. Thank you.

Sincerely,

Francis T. Finnegan, Jr.
Director
Bureau of Medical Services

FTF:el

Post-it® Fax Note 7671	Date 6-28-96 # of pages ▶ 1
To Jane Orbeton	From Fran Finnegan
Co./Dept.	Co.
Phone #	Phone #
Fax #	Fax #

Name of Facility: Augusta Mental Health Institute

Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
This regulation was not met as evidenced by the following findings:		
• It was determined through a review of credentials files for locum tenens physicians that although the medical staff qualifies members, in part, through primary verification of credentials as required in the medical staff by-laws (Article 5.2.1), locum tenens physician credentials files did not contain primary verification of those required credentials.	A procedure has been developed to procure primary verification of Locum Tenens physicians. As of this date a query has been made to verify the licensure of all Locum Tenens physicians. The National Practitioner Data Bank is being queried and was completed on 7/11/96 with no issues noted.	7/10/96 7/11/96
<u>Chapter IX.F.1.</u>		
Regardless of any other categories having privileges in the hospital, there is an active staff, properly organized, which performs all the organizational duties pertaining to the medical staff. These include:		
1. Maintenance of the proper quality of all medical care and treatment in the hospital.		
This regulation was not met as evidenced by the following findings:		
• It was determined through a review of the Medical Staff Executive Committee meeting and QI minutes for nine (9) months prior to survey and confirmed through interviews with the Medical Director, that the medical staff lacks a		

Signature of Person Completing Plan of Correction:

Date:

Name of Facility: Augusta Mental Health Institute		Date of Survey: 6/6/96 & 6/21/96
SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
mechanism for evaluating all medical care and treatment in the hospital as evidenced, specifically by the following findings:	The quality of care provided by the Locum Tenens physicians is monitored as part of the hospital QA program with follow up and correction of problems.	
1. Assessment of medical care and appropriateness is significantly hampered by an inordinate reliance on short term locum tenens physicians whose provision of care has not been amenable to quality monitoring, identification, follow up and correction of problems;	(1) The hospital is actively seeking permanent physicians i.e. the Liberty Group has reviewed the hospital's needs. Employment agencies have been contacted along with national level mental health professionals. We will interview in the next 3 weeks for the position of Medical Director.	7/09/96 8/15/96
2. Patient care problems or serious incidents identified in 10/95; 1/96; and 4/96 and referenced in the minutes were not correlated with documentation of determination of causes of problems, corrective action, or follow up;	(2) The Director of QA will track the incident reporting system and monitor responses from Medical Executive Committee. The Medical Executive Committee's actions will be reported to Governing Body.	
3. It was determined from the above, plus a review of data relative to Drug Utilization Evaluation (DUE) for polypharmacy and polypharmacy with Clozaril, that although these DUE are an integral part of the medical staff's quality assurance program, there was no documented cumulation, trending, or interpretation of the DUE data, nor was there documentation of the impact on quality of care of the DUE findings;	(3) The D.U.E. for polypharmacy and polypharmacy with Clozaril quality data will be documented in Medical Executive Committee minutes for discrepancies in data, interpretation and documentation. Polyphatmacy and polypharmacy with Clozaril data will be presented in 30 days to Medical Executive Committee for review, evaluation, and approriate action. In the future pharmacy QA will be reviewing all drug usage.	
4. It was determined from the above, plus a review of nosocomial infection data, that although records of infections are maintained, data collection techniques were inconsistent and interpretations of data by the medical staff to determine potential patient care ramifications, trends, or potential for improvement was not documented and nosocomial rates and thresholds were not definitative;	(4) The infection control nurse will maintain consistant data collection techniques. Medical staff will define data and thresholds for nosocomial rates using National Standards. Medical Exeuctive Committee minutes will reflect interpretation of infection control data to detect patient care ramifications, trends or potential for improvement. Consistant data collection techniques have been established and will be followed by the infection control nurse.	

Signature of Person Completing Plan of Correction: Date:

DIVISION OF LICENSING AND CERTIFICATION - STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION - Continuation Sheet

Name of Facility: Augusta Mental Health Institute | Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
5. Although quality monitoring through indicator screening, revealed performance below threshold on indicators which was documented in the minutes, there was no documented discussion, analysis, or effective remedial action taken by the medical staff to address deficiencies.	(5) The Medical Executive Committee minutes will document discussion, analysis, or effective remedial action upon quality monitoring. This is consistant with bylaws - a copy of Medical Executive Committee minutes will be sent to Governing Body.	7/10/96
<u>Chapter IX.I.1.</u> Requires that "The by-laws of the medical staff are a precise and clear statement of the policies under which the medical staff regulates itself." **This regulation was not met as evidenced by the following findings:**		
1. The medical staff by-laws (Article 7.1) requires that the Medical Executive Committee shall be a committee of the whole of the voting members of the medical staff; however, it was determined that a physician participating as a member of the Medical Executive Committee was not a voting member of the medical staff during the period surveyed;	In accordance with Medical staff bylaws (Article 7.1) this physician's status was changed to a non-voting, honorary member.	6/19/96
2. The medical staff by-laws (Articles 7.2 and 8.3) requires that the Medical Executive Committee utilize quality assurance sessions to review QA data, formulate recommendations and actions in response to QA findings, evaluate quality monitoring data regularly, evaluate and take actions in response to problematic situations, and	The Medical staff has been given the responsibility to develop, in coordination with the quality manager, a system to utilize QA sessions to review data, formulate recommendations and actions in response to QA findings. An annual review of the QA program will be completed at the end of each year. QA will be a standing agenda item for all Medical Executive Committee meetings as of 7/17/96. The Medical Executive Committee minutes will reflect discussion and action.	7/17/96

Signature of Person Completing Plan of Correction: | Date:

Name of Facility: Augusta Mental Health Institute

Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
annually review the quality assurance program. It was determined that the Medical Executive Committee did not consistently document that it performed these activities in the period surveyed;		
3. Although the medical staff by-laws (Article 8.10) requires that the medical staff identify and analyze the incidence and causes of infection and review results of antimicrobial susceptibility, it was determined that the Medical Executive Committee did not perform these functions in the period surveyed;	The infection control nurse will report infection control data and actions taken monthly to Medical Executive Committee, who in turn will identify and analyze the incidence and causes of infection and review results of antimicrobial susceptibility. Quarterly this information is reported to Infection Control Committee.	7/31/96
4. Although the medical staff by-laws (Article 8.8) requires that the medical staff conduct ongoing monitoring and evaluation of drug use and appropriateness and record findings, conclusions, and recommendations on a quarterly basis, it was determined that evaluation of findings, conclusions, and recommendations resulting from analysis and discussion of the findings were not performed;	As data is collected it will be presented to Medical Executive Committee, then it will be discussed and reviewed for appropriate action.	7/31/96
5. Although the medical staff by-laws (Article 9.6) specifies a procedure for summary suspension, it was determined that two (2) summary suspensions in August, 1995 were not in accordance with the specified procedure.	In the future Medical staff bylaws will be followed. All disciplinary actions will be reported to Governing Body.	9/11/96
Chapter IX.P Requires that the evaluation of clinical practice be met by: "Monthly meetings of the medical staff...at which the quality of medical work is adequately appraised...action is taken by		

Signature of Person Completing Plan of Correction:

Date:

Name of Facility: Augusta Mental Health Institute

Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
the executive committee, and reports are made to the active staff...Minutes of such meetings give evidence of....A review of the clinical work done by the staff on at least a monthly basis; Minutes of such meetings give evidence that....this includes consideration of selected deaths, unimproved cases, infections, complications, errors in diagnosis, results of treatment...[and include a]...short synopsis of each case discussed...".		
These regulations were not met as evidenced by the following findings:		
• It was determined through a review of Medical Staff Executive Committee meeting minutes for nine (9) months prior to survey, and confirmed through interview with the Medical Director, that although the committee met on at least a monthly basis, clinical quality discussions meeting these requirements were not documented.	The Medical Executive Committee will discuss, review and document quality improvement data, serious injuries, sentinel events, infections, complications, and other clinical issues. Procedures will be developed for each remedial action.	7/01/96
<u>Chapter XI.A.5</u>		
The number of administrative and technical personnel, such as bakers, cooks, dishwashers, dietary assistants, etc. is adequate to perform effectively all defined functions and to cover all hours of departmental operations.		

Signature of Person Completing Plan of Correction:

Date:

Name of Facility: Augusta Mental Health Institute

Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
s regulation is not met as evidenced by:		
Through a review of the dietary policy and procedure manual, an interview with the Dietician, review of the Dietary Quality Improvement plan and monitoring reports and record review, provided documented evidence of inadequate staffing to enable the patient nutritional assessment, teaching and participation in treatment planning.	Active efforts are being made to recruit a clinical dietitian. We're exploring the alternative in contracting for these services. An advertisement for a clinical dietitian was run in newspapers with poor results. Another advertisement will run in the newspapers on July 21, 1996 to continue the attempt to recruit.	8/01/96
pter XXI.B.		
re shall be a hospital-wide written plan describing the inization, scope, objectives and procedures for ementing these activities to include: A description of the methods of monitoring, documenting, evaluating and reporting of QA/QI activities for all clinical departments of the hospital, as well as for all support service departments and contracted servioces which impact, in any manner, upon the care and treatment of patients.		
s regulation is not met as evidenced by:		
A review of the Dietary Quality Improvement plan and monitoring reports and confirmed an interview with the Dietician, provided documented evidence that the trends and data collected through the Dietary Quality	Quality Operations will actively discuss, review and document the Dietary Quality Improvement data and recommend remedial action if necessary.	6/27/96

Signature of Person Completing Plan of Correction:

Date:

Name of Facility: Augusta Mental Health Institute | Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
Improvement Program were not being utilized in the evaluation process.		

Signature of Person Completing Plan of Correction: | Date:

fenay —

AUGUSTA MENTAL HEALTH INSTITUTE
P.O. Box 724
Augusta, Maine 04332

July 9, 1996

Louis T. Dorogi, Director
Division of Licensing & Certification
35 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011

Dear Mr. Dorogi:

This letter is in response to the Department of Human Services, Division of Licensing's letter dated June 27, 1996 and the requirement that the Augusta Mental Health Institute submit a written plan of corrective action for the deficiencies cited. That plan is attached herewith.

Item 1. Commissioner Peet has appointed me Acting Superintendent of the Augusta Mental Health Institute. You may be aware that I have extensive experience working with organizations in transition to institute active treatment and other important clinical interventions needed to come into compliance with state and national standards. Consistent, quality care was, and is my expectation for patients by all staff.

Katherine Guilbault, RN, MSN, continues to provide a stabilizing effect in her capacity as Director of Clinical Operations. She provides valued nursing perspective to the senior administrative staff and Medical Executive Committee.

William Thompson, FAAMA, a noted hospital administrator has been retained as a management consultant. He is presently working two days per week with senior management to evaluate the entire spectrum of management operations. Due to his previous experience as interim Superintendent of the Augusta Mental Health Institute and as CEO of acute care hospitals, he has unique experience and expertise on which to base management recommendations.

Roger Wilson, M.D., with seventeen years of experience as Director of BMHI, is presently serving as Medical Director at the Augusta Mental Health Institute. In addition to providing Medical Staff leadership, he is reviewing the entire system for delivery of care. Dr. Wilson is recognized state wide as an advocate for high quality care both within the institutions and in the community.

Active efforts are underway to recruit a permanent Medical Director, as described below:

- 7/9/96 - The Liberty Health Care Corporation has been asked to identify a Medical Director with significant experience in Medical Administration & Clinical Management.
- 7/9/96 - Dr. Robert Glover, former Commissioner of Mental Health/Mental Retardation in Maine, Executive Director National Association of State Mental Health Program Directors, has been contacted to assist in identifying a qualified psychiatrist to fill the position of Medical Director.
- Comp Health has been asked to identify a qualified psychiatrist to serve as Medical Director.
- Preliminary discussions are taking place with a psychiatrist due to begin employment in August as to his qualifications for and interest in the position of Medical Director.
- Additional contacts have been made with various organizations to identify qualified psychiatrists.
- An advertisement has been submitted for placement in appropriate professional journals in accordance with their publication schedule. This advertisement will be for the position as Medical Director as well as staff psychiatrists.

Following the appointment of a new Medical Director, Dr. Wilson will provide consultation one day a week on-site, as well as by telephone.

Item 2. The Medical Director receives data related to individual physician performance. This data is an element of ongoing supervision and the reappointment process.

Item 3. In conjunction with the Director of Quality Assurance, the Medical Staff will develop a system to evaluate and translate diagnosis and treatment issues into interventions for improving performance and quality of care.

Item 4. A procedure has been developed to procure and utilize primary verification of Locum Tenens physicians as of 7/10/96.

Item 5. All future appointments and reappointments will comply with Article (5) of Medical Staff Bylaws. Four physicians have been recommended for reappointment by the Medical Executive Committee on 6/4/96 pending National Practitioner Data Bank query, which was completed on 7/10/96. Satisfactory results of this query were reviewed at Medical Executive Committee's on 7/10/96 and will be presented to the Governing Body at their July meeting.

Item 6. The Medical Executive Committee will discuss and review quality improvement data as presented and will develop a plan for each remedial action where appropriate. In addition, Quality Assurance will be a standing agenda for the Medical Executive Committee.

Item 7. The Medical Staff Minutes will document discrepancies in data, interpretation and documentation of the DUE.

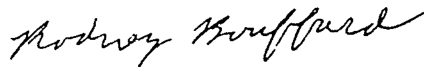
Item 8. A consistent method for monitoring, evaluating, and trending nosocomial infections to determine potential patient care ramifications has been established. After taking any appropriate actions, the infection control nurse will report monthly to the Medical Executive Committee. The Infection Control Committee will monitor actions and data quarterly.

Item 10. A policy and procedure has been developed by hospital administration to ensure that appointments of all physicians and clinicians are done on a timely basis and are current.

Item 11. Active recruiting is underway for a full time clinical dietitian. If this is unsuccessful, a contract will be obtained for clinical dietitian services.

Having carefully assessed the current transitional needs, Mr. Thompson, Dr. Wilson and I are confident that active efforts are underway to ensure that we will be able to meet or exceed the standards established by your department. I look forward to working with you to demonstrate that we have made and will continue to make progress in the future.

Yours truly,



Rodney E. Bouffard
Acting Superintendent

/s
Letlic.lwp

For Licensing and Certification Us
POC Accepted ____ Date ____
Not Accepted ____ Date ____
Returned For:
Revision ____ Date ____

DIVISION OF LICENSING AND CERTIFICATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Surveyors: Linda Ayer, R.N., Mary Dufort, R.N., Beth Patterson, R.N., Sandy Brown, R.N.
Francine Blattner, M.D., Steve Blattner, M.D., Jim Nickerson, HFS

Date Survey Completed:
June 6, 1996 and June 21, 1996

Name of Facility:
Augusta Mental Health Institute

Address:
Arsenal Street, Augusta, ME 04330

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
AMHI June 4-6, 1996 and June 20-21, 1996 State Survey **Chapter VII.J.2.** The procedure related to the submission and processing of applications involves the administrator, credentials committee of the Medical Staff or its counterpart, and the governing board, all functioning on a regular basis. **This regulation was not met as evidenced by the following findings:** A review of Credentials files and meeting minutes of the Board of Trustees provided docuemtned evidence that four (4) of four (4) physicians due for reappointment in 1995 and 1996 were not reapponted in accordance with the medical staff by-laws (Article 5).	The four physicians have been recommended for reappointment by Medical Executive Committee on 6/4/96 pending National Practitioner Data Bank query. All were approved. Governing Body met on 6/18/96 and approved all four appointments pending National Data Bank findings. National Data Bank query was completed on 7/10/96 with no negative findings. The Medical Executive Committee received these results on 7/10/96.	7/10/96
Chapter IX.D.2. Reappointments are made periodically, and recorded in the minutes of the governing board. Reappointment policies provide for a periodic appraisal of each member of the staff,		

Signature of Person Completing Plan of Correction: Date:

Name of Facility: Augusta Mental Health Institute

Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
including consideration of his physical and mental capabilities. Recommendations for reappointments are noted either in the credential committee or medical staff meetings' minutes.		
This regulation was not met as evidenced by the following findings:		
• A review of Credentials files and meeting minutes of the Board of Trustees provided documented evidence that four (4) of four (4) physicians due for reappointment in 1995 and 1996 were not reappointed in accordance with the Medical Staff By-Laws. (Article 5)	Governing Body met on 6/18/96. Privileges for the four physicians were approved pending National Practitioners Data Bank query. A written procedure has been developed for appointment/reappointment process. This has been assigned to the Medical Director. The Governing Body will meet monthly until all significant issues are resolved.	6/18/96
• It was determined through a review of credentials files and meeting minutes of the Medical Executive Committee for nine (9) months prior to survey, and confirmed through interview with the Medical Director, that four (4) of four (4) physicians due for reappraisal and reappointment in 1995 and 1996 did not undergo reappraisal or reappointment as required in the Medical Staff By-laws (Article 5).		
<u>Chapter IX.D.3.</u>		
Temporary staff privileges (for example, locum tenens) are granted for a limited period if the physician is otherwise properly qualified for such.		

Signature of Person Completing Plan of Correction: Date:

AUGUSTA MENTAL HEALTH INSTITUTE
PLAN OF CORRECTION

JCAHO 5/23/96 TYPE I DEFICIENCY

STANDARD: IM.7.6

The hospital defines, captures, analyzes, transforms, transmits and reports specific data and information related to care process and outcomes (IM.7) medical record data and information are managed in a timely manner. (IM.7.6)

DEFICIENCY:

Delinquencies average 51% to 75% of the average monthly discharges. The hospital noted the medical record delinquencies were due to Medical Record Coder. This individual was disciplined and dismissed from the hospital. The hospital is currently working to replace this individual and achieve compliance with this standard.

ACTION - RESPONSIBLE PERSON & Date Due Completion:

Hire contracted coder. -- Linda Moulton -- 6/96

Change record closure from 15 to 30 days as allowed by Hospital Licensing Regulations and JCAHO Standards. -- Medical Executive Committee -- 6/1/96

Aggressively reach all staff to sign off on records. - Linda Moulton -- ongoing

JCAHO - 5/26/96 - SUPPLEMENTAL RECOMMENDATIONS

STANDARD: IM.7.8

The hospital defines, captures, analyzes, transforms, transmits and reports patient specific data and information related to care processes and outcomes. (IM.7)
All medical record entries are dated and authenticated and their authors are identified. (IM.7.8)

DEFICIENCY:

All verbal order entries in the medical record were dated, 17 of 20 records reviewed. Authentication was present.

ACTION - RESPONSIBLE PERSON & DATE DUE COMPLETION:

No action.
Responsible Person - Medical Director

JCAHO 5/23/96 -- SUPPLEMENTAL RECOMMENDATIONS

STANDARD: MS.5.15

The organization establishes mechanisms for hospital specific appointment of medical staff members for granting and renewing or revising hospital specific clinical privileges. (MS.5)

Whatever mechanism for granting and renewal or revision of clinical privileges is used, evidence indicates that the clinical privileges are hospital specific and based on the individual's demonstrated current competence. (MS.5.15)

DEFICIENCY:

Nine of the ten clinical privileges of each licensed independent practitioner were hospital-specific. One privilege list permitted treatment of adolescents and children which are no longer treated at the hospital.

Department of Mental Health, Mental Retardation & Substance Abuse Services

Response/Action Taken by Augusta Mental Health Institute for Recent Deficiencies Cited by:
JCAHO, McDowell Investigation Report, HCFS, and DHS Licensing

JCAHO

	Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
Type I Recommendation	Medical Record Deficiencies	Approximately 51%-75% of medical records lacking closure	Hired "coder"	Director, Q.I.	6/15/96	Completed
			Updated record closure process to comply with standards/regulators		6/1/96	Completed
Supplemental Recommendations	Date and authenticate medical record entries.	Approximately 15% of verbal orders in records lacked date.	Medical staff instructed to date all entries at MEC	Clinical Director	6/96	Completed

Clinical privileging for medical staff are hospital specific.	Privileges not applicable when hospital services changed.	New policy developed/implemented to credential medical staff	Medical Director	7/16/96	Completed

Department of Mental Health, Mental Retardation & Substance Abuse Services

Response/Action Taken by Augusta Mental Health Institute for Recent Deficiencies Cited by:
JCAHO, McDowell Investigation Report, HCFS, and DHS Licensing

Health Care Finance Administration (HCFA)

	Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
42-CFR482.21 Quality Assurance A050	Governing Body must ensure the hospital-wide QA program.	**No documentation reflecting evidence of implementation of hospital-wide QA plan to assess active treatment/patient care.**	**Revise Governing Body agenda to reflect evaluation of patient cases, minutes will reflect care that is given, and actions and outcomes.**	Superintendent, Secretary to Governing Body	6/18/96	Ongoing

	Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
42-CFR 482.21(a) Clinical Plan A051 A058	Hospital must have ongoing QA plan with written plan of implementation.	There is no documentation that QA plan was implemented as defined in the areas of social learning, outpatient clinic, infection control, pharmacy and medical staff to demonstrate appropriate treatment.	Governing body, Medical Executive Committee, Quality Operations Committee document/reflect the QA/QI Plan. The minutes of Quality Operations, Medical Executive Committee and the Governing Body will reflect Infection Control Monitoring, Pharmacy indicators, evaluation of medical services which reflects and demonstrates appropriate treatment for identified diagnosis.	Superintendent Medical Director QI Director	5/31/96	Ongoing

Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
All organized services, including contractor services, must be evaluated.	There was no documentation that the facility was following its plan: - no annual reports received by Governing Body in July, 1995; - documentation provided to Governing Body was incomplete; - no annual report for Forensic Treatment Unit, Medical Information System, Medical Records, Pharmacy; - There was no documentation provided to indicate an annual report from the Governing Report.	QI/QA Annual Reports will include all required reports (from each discipline).	QI Director	6/16/96	Ongoing

	Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
		There was no documentation that any department/discipline met its required reporting schedule.	All departments and units will report as scheduled.	QI Director	5/14/96	Ongoing
42-CFR-482 A053	Nosocomial infections and medication therapy must be evaluated.	Although there are indicators developed for Infection Control and Pharmacy, there is no documentation that departments followed facility plan.	Members of Quality Operations Committee will document Infection Control and Pharmacy processes and objectives are carried out.	QI Director	5/21/96	Ongoing

	Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
	Medical staff indicator re: polypharmacy not assessed -- no documentation.		Contract completed with Maine Medical Association for peer review -- in addition, we will review the hospital's high dose and polypharmacy trends and benchmark against national standards.	Medical Director	061896	Ongoing
A054 A058	Medical services must be evaluated for appropriateness of diagnosis and treatment.	Insufficient reporting and documentation regarding evaluation of diagnosis and treatment regarding polypharmacy, restraint use, clinical indicators (hypertension), medication reaction, and drug use evaluation.	Medical Executive Committee minutes will reflect review of medical services as it relates to appropriateness of diagnosis and treatment.	Medical Director	5/22/96	Completed Ongoing

	Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
			Drug usage evaluation will be done.	Director of Pharmacy Clinical Director	7/1/96	To be completed 7/30/96
A058	Hospital must take and document all actions to address deficiencies.	Lack of medical record completion. Lack of psychiatric assessments	Minutes of MEC will reflect correction of deficiencies. QA Dept. will notify psychiatrists when assessments need to be done and will do follow-up to assure they are done.	Medical Director	5/22/96	Completed, Ongoing
		Treatment planning not completed per policy and lack of reporting/documentation for implementing plan of corrections.	Responsibility and accountability for treatment planning assigned to Program Services Manager.	Program Services Manager	5/21/96	Completed, Ongoing
		Other deficiencies identified under A051 and A054.				

	Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
A027	Development and condition of site/physical plant must assure patient safety and well being.	Insufficient key and lock security.	Replace locks and implement new key policy.	Director of Hospital Services	6/26/96	Completed in all patient related areas.
					9/30/96 (in all non-patient related areas)	
		Malfunctioning lock on mechanical room door.	Inspect and repair lock.		5/21/96	Completed

Department of Mental Health, Mental Retardation & Substance Abuse Services

Response/Action Taken by Augusta Mental Health Institute for Recent Deficiencies Cited by:
JCAHO, McDowell Investigation Report, HCFS, and DHS Licensing

McDowell Report

	Recommendation	Action	Responsible Person	Date Due Completion	Status
Security	Change lock	All locks changed on patient-related areas.	Director of Hospital Services	6/26/96	Completed
		All locks changed on non-patient related areas.		9/30/96	
	Train staff on new key policy	Train	Department Heads/Supervisors/ Program Directors		Completed
	Preview hospital security policies	Receive consult from Dvoskin	Superintendent	7/2/96	Completed
		Respond to recommendations with an action plan		8/1/96	

	Recommendation	Action	Responsible Person	Date Due Completion	Status
Appointment of New Hospital Leadership	Appoint new administrative leadership	Positions established and reassigned	Commissioner	6/24/96	Completed
		Recruitment for permanent medical director; acting capacity assigned	Superintendent		
	Enhance psycyiatric capacity of AMHI via community positions	Submit financial order to Governor for 4 positions; 3 community-based psychiatrists and 1 AMHI.	Superintendent	7/5/96	Completed
		Hire 4 new positions (if financial order approved)	Director of Human Resources / Medical Director	9/30/96	
	Expand training programs for locum tenens physicians	Training manual developed/implemented.	Medical Director	7/1/96	Completed and Ongoing
		Implemented locum tenens terms for 3 month minimum.	Medical Director		Completed

Recommendation	Action	Responsible Person	Date Due Completion	Status
Create full time psychiatrist position at AMHI	Convert locum tenen positions to full time position.	Director of Human Resources / Medi-cal Director	7/1/96	Completed
	Submitted financial order (above)	Superintendent	7/5/96	Completed
	Train all direct service staff at AMHI in domestic violence.	Clinical Nurse Specialist/Staff Development	9/30/96	
Establish protocol for responding to criminal behaviors	AMHI administration meet with Attorney General and District Attorney.	Superintendent/ Medical Director	6/28/96	Completed
	Draft policy/protocol for addressing criminal behaviors.	Medical Director / Chair of Policy & Procedure Committee	7/15/96	Completed
	Implement new policy and train staff on policy.	Program Service Directors / Supersors	7/15/96	Completed

McDowell Report, cont'd

Recommendation	Action	Responsible Person	Date Due Completion	Status
Clarify policy/procedure for notification of guardians when change is patient status.	Establish new policy for administrative/clinical review of status change.	Medical Director / Chair of Policy & Procedure Committee	6/96	Completed
	Train staff and implement new policy.	Program Service Directors / Supervisors / Department Heads	7/1/96	Completed
Empower treatment teams to use means necessary to protect patients in their charge.	Develop/implement policy for addressing patient or staff safety issues.	Superintendent	7/2/96	Completed

McDowell Report, cont'd

Recommendation	Action	Responsible Person	Date Due Completion	Status
Develop/impleme nmt ways for impoved treatment teams collaboration for issues involving more than 1 patient or team.	Assess all AMHI patients whose treatment requires teams collaboration.	Medical Director	7/10/96	Completed
	Establish/implement protocol for team collaboration.	Program Director, Medical Director	7/10/96	Completed
	Train staff in new protocol	Program Directors	7/19/96	
	Track patients needing multi-team interventions	QI	Ongoing	
Comply with Consent Decree assessment requirement	Establish/implement policy for ongoing assessments	Director of Psychology / Medical Director	7/3/96	Completed, Ongoing
Clarify policy/prcedure for treatment/discharge planning for patients resistant to participating.	Establish/implement policy for treatment/discharge planning for patients resistant to participataing.	Medical Director	7/10/96	Completed, Ongoing

Recommendation	Action	Responsible Person	Date Due Completion	Status
Develop policy to provide family support.	Establish/implement policy identifying Superintendent responsibility for family notification of critical events.	Superintendent	7/10/96	Completed
Decide future of AMIII.	Establish task force to recommend resource allocations.	Governor	10/1/96	
	Support AMIII staff in addressing issues of uncertainty.	Superintendent		Ongoing
Respond to internal personnel investigation.	Disciplinary action taken against 5 individuals.	Superintendent	6/26/96	Completed

Department of Mental Health, Mental Retardation & Substance Abuse Services

Response/Action Taken by Augusta Mental Health Institute for Recent Deficiencies Cited by:
JCAHO, McDowell Investigation Report, HCFS, and DHS Licensing

Division of Licensing & Certification

	Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
Chap VII J.2.	Governing Body & Medical staff recommendations for appointment are completed on a regular basis.	**(4) physician were not reappointed in accordance with bylaws**	**. Governing body 6/18/96 approved the (4) appointments pending national practitioner date bank finding.**	Medical Director	7/14/96	Completed
			. Query completed		7/10/96	
			. All 4 recommended by MEC to Governing Body		"	Pending Governing Body mtg. 7/13/96
Chap. IX D.2.	Recommendations for reappointments are noted for the credential committee or med staff minutes	**4 physicians due for reappointment 1995-1996 were not reappointed**	**. Written procedure developed for appointment and reappointment in process.**	Medical Director	6/18/96	Completed

	Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
		Meeting minutes did not document reappointment	**. Gov. Body monthly meeting scheduled to address key policies & procedures dealing with family notification of critical events, managements of patients refusing treatment/discharge planning and to assure compliance with hospital Q.I plan.**	Superintendent	7/31/96	Ongoing - monthly
Chap. IX D.3.	Locum tenens are granted privileges for a limited period of time.	**Locum Tenens credentials files did not contain primary verification of those required credentials.**	**. Procedure was developed to procure primary verification of licensure and to query national practitioner data bank for all locum tenens.**	Medical Director	7/11/96	Completed Ongoing
Chap. IX E.I.	Active staff performs all organizational duties pertaining to the medical staff.	**Medical staff lack a mechanism for evaluating all medical care and treatment as evidenced by the following:**		Superintendent		

Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
	1. Assessment of medical care and appropriateness is hampered by short term locum tenens whose provision of care has not been followed up for quality monitoring and correction of problems.	1. The hospital is seeking permanent physicians, i.e. the Liberty Group has reviewed the hospital needs. Employment agencies have been contacted. Interview in next 3 weeks for Medical Director.	Superintendent Medical Director		
	2. Patient care problems or serious incidents identified were not followed up.	2. CQI Plan/flow chart show QA Director will track reporting system and monitor Medical Executive Committee responses. If necessary QA Director will go to Governing Body	Medical Director Q.I.	7/31/96	
	3. Drug usage not evaluated or documented	3. The Medical Executive Committee will evaluate. Due within 30 days.	Medical Director	7/31/96	Ccmpleted
	4. Infection Control nosocomial rates and thresholds were not definitive.	4. Use correct formula for calculating incident rate.	Infection Control Nurse	8/4/96	

	Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
		5. Medical staff did not document, analyze nor take action on Q.I.	5. Medical Executive committee minutes will document discussion, analysis or effect of remedial action or quality monitoring; a copy of Medical Executive Committee minutes will go to Governing Body.	Medical Director	7/10/96	Ongoing
Chap. IX. 1.1.	The by-laws of Medical Staff are concise/clear statements of policies.	1. A non-member of Medical Staff was participating in Medical Executive Committee.	1. This physician's status was change to non-voting honorary member.	Medical Executive Committee	6/19/96	Completed
		2. Evaluate and respond to Q.A funding.	2. Q.A. Director will present all QA data to Medical Executive Committee which will reflect discussion and actions.	Medical Director QA Director	7/17/96	Ongoing
		3. Non-compliant with by-laws regarding review analysis of infection and causes.	3. Incorporate by-laws into CQI plan with monthly monitoring and quarterly report documentation.	Medical Director	7/31/96 Ongoing	

	Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
		4. Non-compliance with by-laws regarding drug use evaluations, analysis and recommendations.	4. Incorporate by-laws into CQI plan with monthly monitoring, and quarterly report documentation.	Medical Director QI Director	7/31/96 Ongoing	
		5. Non-compliance with by-laws regarding summary suspension.	5. Assure staff familiarity with by-laws. Document that all appropriate staff are knowledgeable and have received in-service on policy. Review, the Summary Suspension policy with Chairperson of the Governing Body.	Medical Director	9/11/96	
Chap. IX. p	Monthly medical staff meetings minutes reflect medical work is adequately appraised; a review of the clinical work done by the staff includes consideration of deaths, unimproved cases, infections, complications -- short synopsis of each case discussed.	Clinical quality discussions to meet these requirements were not documented.	Medical Executive Committee will discuss review QI data, serious injuries, sensitive events, infections and other clinical issues. Action plan will be developed for each issue as appropriate. QI component of Medical Executive meeting is now a standing agenda.	Medical Director QI Director	7/1/96 Ongoing	

Standard	Deficiency	Action	Responsible Person	Date Due Completion	Status
Adequate administrative and technical personnel to effectively perform defined functions.	**Inadequate staffing to enable nutritional assessment, teaching and participation in treatment planning.**	**Recruit and hire Clinical Dietician via hospital position or contract service.**	Director of Hospital Services	10/1/96	
Comply with hospital-wide plan.	**Non-compliance with Dietary Improvement Plan.**	**Assure monitoring documenting, evaluating and reporting of QA/QI activities for support services.**	Director of Hospital Services	6/27/96	Completed

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*ALSO ADMITTED IN CONNECTICUT
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***ALSO ADMITTED IN NEW HAMPSHIRE

July 11, 1996

Wayne Douglas, Esq.
Associate Commissioner
Department of Mental Health &
Mental Retardation & Substance Abuse Services
State House Station 40
Augusta, ME 04330

Re: Behavioral Health Network of Maine

Dear Wayne:

I have been informed, in my capacity as counsel for Behavioral Health Network of Maine ("BHNM"), of the review by the Office of the Attorney General regarding the contract procured by BHNM with the State of Maine's Department of Mental Health. Apparently, a question has been raised whether a conflict of interest may have existed on the part of Dr. Gordon Clark, who served as the Medical Director of the Augusta Mental Health Institute and the Associate Medical Director of the Department of Mental Health for the State of Maine during the period of contract negotiations. At the same time, Dr. Clark also served as the Medical Director of Behavioral Health Network of Maine. The concern which has been raised with respect to Dr. Clark's role involves whether Dr. Clark received a personal benefit as a result of Behavioral Health Network's procurement of the contract with the State.

The purpose of the submission of this letter is twofold. First, Behavioral Health Network categorically and emphatically denies any wrongdoing or improper conduct on its part with respect to the procurement of the contract with the State. Hopefully, there is no question in this regard. As I believe you are aware, the State was required, within a very short time period (too short to allow for the issuance of an RFP), to retain the services of a network of mental health practitioners capable of providing mental health services in accordance with the terms and conditions of the State's Consent Decree in the Bates v. Peet matter. Behavioral Health Network not only met the size, location and quality criteria

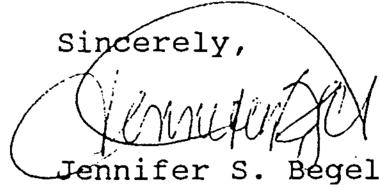
required by the State, but they were able to respond within the very short time frame imposed by the consent decree. This aspect of the contracting process had absolutely nothing to do with Dr. Gordon Clark.

The second purpose for the submission of this letter is to assure you of Behavioral Health Network's willingness to cooperate in dispelling whatever perception of impropriety might exist as a result of Dr. Gordon Clark's position as Medical Director of the Network. Dr. Clark had absolutely no involvement in the negotiations process for this contract. He is paid by Behavioral Health Network a monthly stipend for the provision of specific services in his role as Medical Director. During the pertinent period of time while the Network was negotiating with the State, Dr. Clark was involved, in addition to his other BHNM responsibilities, with one project related to the State contract. This involved the creation of an assessment tool intended for use by the Network in evaluating the needs of the patient population covered by the State's Consent Decree. Dr. Clark was not, however, paid any additional sums of money for this task, over and above his monthly stipend. Moreover, whether negotiations between Behavioral Health Network and the State were ultimately successful was entirely unrelated to Dr. Clark's work on the assessment tool. The bottom line is that the procurement by Behavioral Health Network of the State contract had and has no impact on Dr. Clark's compensation.

It is the understanding of Behavioral Health Network that one means of resolving the perception of any impropriety on Dr. Clark's part as an employee of the State would be for him to return to Behavioral Health Network any monies paid to him as compensation for his assistance in the creation of the assessment tool intended for use by Behavioral Health Network in conjunction with the State contract. The Network would be willing to attempt to calculate the amount of Dr. Clark's compensation, if any, related to this particular project, and to accept the return of that compensation from Dr. Clark. Please note, however, that Dr. Clark did provide other services in May of 1996 in his role as Medical Director, other than assisting with the creation of the patient assessment tool. Again, none of these other services were in any way related to either the Network's efforts to procure the contract with the State or to any other State activities.

Please do not hesitate to call if you have any questions regarding the above or wish to discuss these issues further.

Sincerely,



Jennifer S. Begel

JSB/mlc
cc Linda Pistner, Chief Deputy

jsb\1751-1\douglas.ltr

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RECEIVED
ATTORNEY GENERAL
JUL 16 1996

July 15, 1996

Linda Pistner, Esq.
Maine Attorney General's Office
State House Station 6
Augusta, ME 04333

RE: Dr. Gordon Clark/Behavioral Health Network

Dear Linda:

You have asked for documentation supporting the amount of compensation, if any, paid to Dr. Clark as a result of his contributions to the patient assessment form developed for use by BHNM in conjunction with the State (Consent Decree) Contract. I am enclosing a summary of work performed by Dr. Gordon Clark in the months of April and May of 1996 in his capacity as Medical Director of Behavioral Health Network of Maine. The summary is based upon information gathered from documentation kept by Dr. Clark, as well as by the Network, including calendars and memos.

The following facts and assumptions underlying this summary are noteworthy:

1. Behavioral Health Network first became involved with negotiations with the Department of Mental Health for the contract for patient assessments in mid to late April. As you know, the Department of Mental Health's plan with respect to the contract for the provision of assessments of Augusta Mental Health Institute patients covered by the consent decree was not approved by the Court until April 11, 1996. On May 7, 1996, Behavioral Health Network and the Department of Mental Health signed an agreement in principle with respect to the contract. I am enclosing a copy of that one-page letter agreement for your review.

2. Dr. Clark did not have any participation or involvement in the contract discussions between the Department of Mental Health and Behavioral Health Network.

3. Dr. Clark was not apprised of the need to prepare or create the patient assessment form until late April. His first direct involvement was on April 29, 1996, when he attended an assessment team meeting. (See enclosed summary.)

4. Dr. Clark spent the majority of his time in fulfilling his obligations as Consulting Medical Director of Behavioral Health Network of Maine on projects other than the patient assessment form. As you can see from the summary, he plays a significant role in the development of practice standards and protocols, in the development of crisis response standards and procedures, and in the development of level of care criteria for patients within the Behavioral Health Network.

5. Dr. Clark completed the draft of the patient assessment form on May 21, 1996. By memo of that same date, he forwarded the draft to all of the members of the design team of Behavioral Health Network, and requested a response to the draft by May 23, 1996 at 10 a.m.

6. By May 23, 1996, the form was finalized.

7. On May 24, 1996, Behavioral Health Network held a training session with its members with respect to the patient assessment form. Dr. Clark had no participation in this training session.

8. As of May 24, 1996, Dr. Clark had no further involvement with the patient assessment form or with any other aspect of the contract between the Department of Mental Health and Behavioral Health Network.

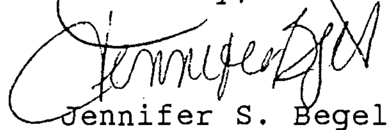
9. On June 4, 1996, the acting program manager for Mental health services sent a faxed request to Grete Chandler of Behavioral Health Network seeking the addition of questions regarding potential disabilities or limitations, including language and hearing, to the patient assessment form.

10. In response to the request from the Department of Mental Health, revisions were made to the patient assessment form. Dr. Clark did not participate in any of the changes to the form. Again, Dr. Clark's last involvement was on May 23, 1996.

Based on all of the above, and upon the information reflected in the attached summary, on behalf of Behavioral Health Network, we have calculated the amount of compensation which may be deemed attributable to Dr. Clark's contributions with respect to the patient assessment form. The total compensation is $811.65.

Please give me a call if you have any questions regarding this letter or the enclosed materials, or if you wish to discuss any aspect of this matter further.

Sincerely,



Jennifer S. Begel

JSB/mlc
Enclosures

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Services Provided by Dr. Gordon Clark
in his capacity as Medical Director of
Behavioral Health Network of Maine

April, 1996:

Date	Service	Hours
4/4	Meeting with Secretary of BHNM re General issues and Clinical Advisory Committee of BHN	1.5 hrs
4/5	BHN Board Conference Call re general issues including Clinical Advisory Committee	1.0 hrs
4/11	Meeting with Grete Chandler (BHNM) re Supervising Dr. Clark's projects ("supervision meeting")	1.5 hrs
4/12	BHN Board Meeting: general	4.0 hrs
4/15	Meeting with J. Morrison, C. Fagan and Dr. McFarlane re Cumberland County Crisis Services	1.5 hrs
4/18	Supervision Meeting with Grete Chandler	1.5 hrs
4/19	BHN Board Conference Call - general	1.0 hr
4/22	Meeting with Jane & Maine Medical Center re Cumberland County Crisis Services	1.0 hr
4/22	Clinical Advisory Committee ("CAC") of BHNM re development of practice guidelines and re co-existing disorders and dual diagnoses issues and training (including prep, travel and meeting time)	9.0 hrs
4/25	Supervision Meeting with Grete Chandler	1.5 hrs
4/29	Crisis Response Services Reception (for York County)	2.0 hrs
4/29	Team Meeting for Discussion regarding development of Patient Assessment Form for use with State Contract	1.5 hrs
	Total April	27.0 hrs

Additional work in April, including preparation for all above meetings, and gathering materials and pertinent information, involved the following projects:

- -- LOCUS project- (level of care and utilization of service). This relates to all patients within the Network — 4.0 hrs
- -- Coexisting Disorders (dual diagnosis) project — 8.0 hrs
- -- Crisis Sub Committee (developing appropriate and uniform crisis responses across the state) — 2.0 hrs

Summary of April:

Total Preparation time for projects unrelated to the Patient Assessment Form	14.0 hrs
Total time spent on projects (excluding prep time) other than the Patient Assessment Form	27.0 hrs
Total Preparation time (including meetings) for assistance with the Patient Assessment Form	2.5 hrs
Total April hours for all BHNM work, including the Patient Assessment Form	43.5 hrs

May 1996:

5/2	Supervision Meeting with Grete Chandler	1.5 hrs
5/3	Telephone with Grete Chandler re General BHN	.5 hrs
5/3	Telephone Discussion with Grete Chandler Re Patient Assessment Tool for use in connection with State Contract	1.0 hr
5/10	BHN Board Meeting - general BHN (excluding time re patient asessment form)	2.0 hrs
5/10	Discussion at Board meeting regarding Patient Assessment Form status	1.0 hrs
5/16	Supervision Meeting with Grete Chandler	1.5 hrs
5/20	CAC meeting (prep, travel, mtg)	9.0 hrs
5/23	Supervision Meeting with Grete	1.5 hrs
5/24	BHN Board Conference Call	1.0 hr
5/30	Supervision Meeting with Grete Chandler	1.5 hrs
5/31	BHN Board Conference Call	1.0 hr
	Total	21.5 hrs

Additional work in May, including preparation for all above meetings, and gathering materials and pertinent information, involved the following projects:

--	LOCUS project- (level of care and utilization of service).	4.0 hrs
--	Coexisting Disorders (dual diagnosis) project	8.0 hrs
--	Crisis Sub Committee (developing appropriate and uniform crisis responses across the state)	2.0 hrs

Summary of May:

Total Preparation time for projects unrelated to the Patient Assessment Form	14 hrs
Total time spent on projects (excluding prep time) other than the Patient Assessment Form	21.5
Total Preparation time in May (including meetings) for assistance with the Patient Assessment Form	7.5 hrs
Total May hours for all BHNM work, including the Patient Assessment Form	43.0 hrs

CALCULATION OF COMPENSATION

April, 1996

Total Compensation	$3500.00
Total hours worked	43.5
Hours attributable to Patient Assessment Form	2.5
calculated hourly rate	$80.46
compensation attributable to Patient Assessment Form	$201.15

May, 1996

Total Compensation	$3500.00
Total hours worked	43
Hours attributable to Patient Assessment Form	7.5
calculated hourly rate	$81.40
compensation attributable to Patient Assessment Form	$610.50

Total compensation paid to Dr. Gordon Clark in April and May of 1996 which may be attributed to work by Dr. Clark on the Patient Assessment Form for the BHNM contract with the State:

$811.65

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July 11, 1996

Wayne Douglas, Esq.
Associate Commissioner
Department of Mental Health &
Mental Retardation & Substance Abuse Services
State House Station 40
Augusta, ME 04330

Re: Behavioral Health Network of Maine

Dear Wayne:

I have been informed, in my capacity as counsel for Behavioral Health Network of Maine ("BHNM"), of the review by the Office of the Attorney General regarding the contract procured by BHNM with the State of Maine's Department of Mental Health. Apparently, a question has been raised whether a conflict of interest may have existed on the part of Dr. Gordon Clark, who served as the Medical Director of the Augusta Mental Health Institute and the Associate Medical Director of the Department of Mental Health for the State of Maine during the period of contract negotiations. At the same time, Dr. Clark also served as the Medical Director of Behavioral Health Network of Maine. The concern which has been raised with respect to Dr. Clark's role involves whether Dr. Clark received a personal benefit as a result of Behavioral Health Network's procurement of the contract with the State.

The purpose of the submission of this letter is twofold. First, Behavioral Health Network categorically and emphatically denies any wrongdoing or improper conduct on its part with respect to the procurement of the contract with the State. Hopefully, there is no question in this regard. As I believe you are aware, the State was required, within a very short time period (too short to allow for the issuance of an RFP), to retain the services of a network of mental health practitioners capable of providing mental health services in accordance with the terms and conditions of the State's Consent Decree in the Bates v. Peet matter. Behavioral Health Network not only met the size, location and quality criteria

REVIEW OF ASSESSMENT PLAN

By Decision and Order of March 8, 1996, the Court ordered that Defendants file a comprehensive plan by March 25, 1996 for completing the individual assessments of class members (Paragraph 2, page 37). Defendants filed the Assessment Plan ("Plan for Completing Class Members Assessments") and Plaintiffs responded ("Plaintiffs' Objections and Comments to Defendants' Plan for Completing Class Members Assessments", referred to below as "Comments") within the timeframes established by the Court's Order.

Plaintiffs requested that I reject the plan based on several concerns raised in their comments. During the period established for my review of the plan pursuant to the Court's Order, Defendants amended the original submission. While I find that the original submission would not have been approvable, I approve the Amended Plan for the reasons discussed below. The Amended Plan (Plan for Completing Class Member Assessments, 4/11/96) is attached to this Review.

The Amended Plan outlines a program for locating class members at Section II. Its proposal for assessing class members is Section III (with attachments).

Regarding locating class members, Plaintiffs raised concerns with respect to the details of the field search, staff available for the field search, and the existence of a protocol for contacting class members. The Department has amended its initial plan outlining the specifics of its field search activities (Amended Plan, pages 3, 4). The Amended Plan notes that there are 10 staff with varying levels of involvement in the location process. Two staff work fulltime. Their respective responsibilities are outlined in the Amended Plan at page 4. All telephone contacts with class members are made pursuant to a

14A G596201

STATE OF MAINE

Standard Agreement Summary Page

Department Mental Health & Mental Retardation Bureau Mental Health

Community Agency Name Behavioral Health Network of Maine

Address 99 Western Avenue, Augusta, Maine 04330

Employer ID# 01-0489615

Project# MHC-6-001 CFDA# ______ Agency Fiscal Year July-June

	VENDOR CODE	AMOUNT	MFASIS ACCOUNT CODING
1.	01-0489615	$440,097	010 14A 1101 022 1003 6401
2.			
3.			

TYPE OF COMMUNITY AGENCY

(Complete Appropriate Statement)

1. A partnership: ______
2. A corporation of the State of: Maine
3. Other: ______

(Check One)

1. Non-Profit: X
2. For Profit: __
3. Government: __

AGREEMENT PERIOD

Effective Date: May 1, 1996

Termination Date: October 31, 1996

Amended Effective Date: ______

Amended Termination Date: ______

TYPE OF AGREEMENT

X New

__ Renewal

__ Amendment

__ Supplement

NAME OF LEAD AGENCY: ______

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

July 17, 1996

Senator Joan Pendexter
Representative Michael Fitzpatrick
Health and Human Services Committee
State House
Augusta, Maine 04330

Dear Senator Pendexter and Representative Fitzpatrick:

Recently, concern has been expressed over a contract entered into between the Department and the Behavioral Health Network to complete individual clinical assessments of the Augusta Mental Health Institute consent decree class members. Two specific issues have been raised: (1) The Department should have put our an RFP for the services reflected in the contract; and (2) There was a conflict of interest arising out of the fact that Dr. Gordon Clark, then Clinical Director at Augusta Mental Health Institute and Associate Medical Director for the Department, was also a contracted consultant to the Behavioral Health Network. I believe the Attorney General has reviewed the matter and is offering some analysis; the purpose of this letter is simply to provide you with background information about the contract and the context in which it arose.

The contract came about as a result of the Superior Court's March 8th Order. As you know, the order required the Department to file a comprehensive, final plan for implementing the terms of the Augusta Mental Health Institute consent decree/settlement agreement within 10 days, by March 18, 1996. The order also required the Department to file a comprehensive plan for completing individual class member assessments by the following Monday, March 25, 1996, and to actually complete all assessments by October 30, 1996.

The Department filed its plan for completing assessments on time, on March 25, 1996 and immediately entered into discussions with the Court Master and Plaintiffs' counsel to review and revise the assessment plan and make it acceptable to the Court. During the two and one-half weeks that followed, the Department was required to articulate in detail the method by which assessments were to be completed, including describing in specific, concrete terms who would do the assessments, how many clinicians would be deployed, what their professional training and qualifications would be, when assessments would be undertaken and completed, what resources would be available to carry out this process, etc.

An amended plan was submitted to and approved by the Court Master on April 11, 1996. The amended plan itself has as an appendix a copy of an early draft of the assessment work plan, which later became a part of the contract.

PRINTED ON RECYCLED PAPER

PHONE: (207) 287-4223 (Voice) (207) 287-2000 (TTY) FAX: (207) 287-4268

In our view, we could not have prepared an acceptable amended plan in the time required and at the level of specificity required without having identified a particular entity to undertake the job. At the time this plan was being prepared, the RFP statute had a minimum waiting period of 180 days. Even under the new RFP Statute with a 60 day waiting period, the Department would not have been able, realistically, to design a concrete assessment plan, negotiate a contract, and implement that plan to accomplish the formidable task of assessing all class members by the court imposed deadline.

Moreover, the Behavioral Health Network was, in our view, uniquely situated, to undertake this task. It is an organization whose members consist of a statewide network of community mental health providers who were already providing direct services to class members on an ongoing basis and whose clinical staff had the specific training and credentials required by the assessment plan. No other entity, including the new Spurwink/JBI apparently know as Eagle Health Care, was in that position. In addition, it is my understanding the Eagle Health Care was not even in existence at the time the Department was preparing and negotiating its assessment plan.

With respect to the alleged conflict of interest, it is important to stress that Dr. Clark played no role in soliciting the Behavioral Health Network contract, nor did he participate in any way in the negotiation or award of the contract. He was not a signatory to the contract, and, I understand, not even aware that negotiations had begun. Dr. Clark played a limited role with respect to contract work. His sole responsibility was to assist in the development of the assessment instrument to be used by clinical staff in evaluating class members. Dr. Clark received no additional compensation for performing the design work, but rather did that work in addition to his other Behavioral Health Network duties and was paid his normal monthly stipend. As you know, Dr. Clark is no longer employed by the department in any capacity. The Department has discussed with Behavioral Health Network the possibility of recouping the pro-rata portion of the monthly stipend attributable to this contract work, if any, and Behavioral Health Network has expressed a willingness to calculate and recoup that amount if it would help to alleviate any appearance of conflict.

The Department regrets that anyone feels that this process was unfair or has the appearance of a conflict of interest. If I can provide any additional information about this matter, please do not hesitate to let me know.

Thank you.

Sincerely,

Melodie J. Peet
Commissioner

MJP/WD/dg

ANDREW KETTERER
ATTORNEY GENERAL

Telephone: (207) 626-8800
FAX: (207) 287-3145

STATE OF MAINE
DEPARTMENT OF THE ATTORNEY GENERAL
6 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0006

REGIONAL OFFICES:

84 HARLOW ST., 2ND FLOOR
BANGOR, MAINE 04401
TEL: (207) 941-3070
FAX: (207) 941-3075

59 PREBLE STREET
PORTLAND, MAINE 04101-3014
TEL: (207) 822-0260
FAX: (207) 822-0259

July 24, 1996

The Honorable Jeff Butland
Senate President
Office of the Senate President
Three State House Station
Augusta, Maine 04333-0003

Dear Senator Butland:

By letter dated July 3, 1996, you outline several concerns relating to the contract between the Department of Mental Health & Mental Retardation and Behavioral Health Network of Maine. At the request of the Department of Mental Health, this office has been reviewing these issues over the past several weeks. The attached memorandum to me from Chief Deputy Linda Pistner summarizes that review and advice given to the Department.

For the reasons outlined in the memorandum, we have concluded that this contract does not violate state laws governing conflicts of interest or those which set forth procedures for the award of contracts on a sole source bases. As we discussed, the questions you raise about the sole source contracting procedures are not issues of law, although the memorandum outlines the statutory approval procedure.

Sincerely,

ANDREW KETTERER
Attorney General

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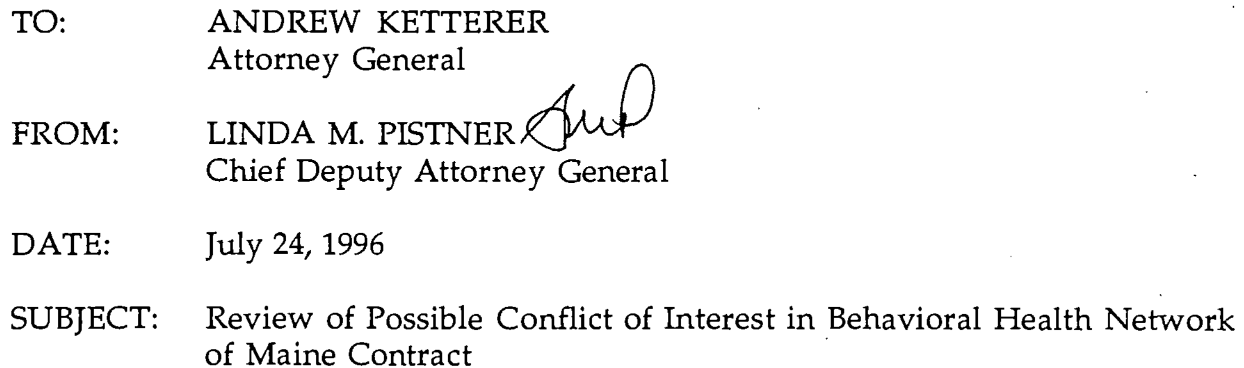
STATE OF MAINE
Department of the Attorney General



TO: ANDREW KETTERER
Attorney General

FROM: LINDA M. PISTNER
Chief Deputy Attorney General

DATE: July 24, 1996

SUBJECT: Review of Possible Conflict of Interest in Behavioral Health Network of Maine Contract

---

This memo will summarize the information I have gathered in reviewing the contract between the Department of Mental Health, Mental Retardation, and Substance Abuse Services (hereafter "DMH" for brevity) and Behavioral Health Network of Maine ("BHNM"), and the advice I have provided to DMH concerning the issue of whether a conflict of interest arises from the fact that Gordon Clark, M.D. served as Clinical Director at AMHI at the time the contract was awarded while simultaneously serving as Medical Director of BHNM. This information is relevant to the issues raised in Senate President Jeffrey Butland's letter to you of July 3, 1996.

BACKGROUND

As part of a Decision and Order issued by the Superior Court in Bates v. Peet on March 8, 1996, DMH was directed to file a comprehensive plan for completing individual assessments of class members with the Court Master by March 25, 1996. This plan was amended (in order to address concerns of the Master and comments submitted by the plaintiffs) through a filing made April 11, which included a draft statement of the tasks to be performed, projected timeframes, and identification of BHNM and DMH resources required to complete the tasks. This document provided the basis for the detailed Service Specifications in Rider A of the contract itself (Attachment A to this memo). DMH's amended plan was approved in a report issued by the Master dated April 11 (entitled "Review of Assessment Plan" and attached, together with the DMH amended plan filing, as Attachment B).

The contract basically requires BHNM to provide clinical assessments of all class members to be performed by qualified staff, either through its member agencies or through subcontracts with other providers, by September 15, 1996. Pursuant to the Superior Court's March 8th Order, DMH must complete its initial assessment of class members by October 30, 1996.

The contract was submitted to the Bureau of Purchases with a request for approval on a sole source basis rather than the standard bidding procedure, and was approved on that basis by the Director of the Bureau of Purchases, Richard B. Thompson, on May 31, 1996.

FACTS CONCERNING DR. CLARK'S ROLE [1]

Gordon Clark, M.D. served as the Clinical Director at AMHI on a part-time basis until he was replaced on June 20th. He also served as consulting Medical Director for BHNM under a contract dated June 1, 1995 covering the period from 2/6/95 to 8/6/95. In return for performing specified services described in that agreement, Dr. Clark was to receive $21,000 in eight monthly installments of $3500. While his written contract with BHNM expired in August 1995, the arrangement continued by mutual agreement thereafter with a monthly payment of $3500 for services.

Both Dr. Clark and Wayne Douglas (who was responsible for negotiating the contract for DMH) state that Dr. Clark had no involvement in either the selection of BHNM to provide the assessment services or in the negotiation of the contract. The only service provided under the DMH/BHNM contract in which Dr. Clark was involved was the development of the assessment protocol, and he is specifically mentioned in that regard in the contract (project task #5 on page 3 of Rider A). He received no compensation for this work above the previously established monthly stipend. In a conversation with A.A.G. Chris Leighton in late June, Dr. Clark estimated that he spent 30-40 hours in his work on the assessment protocol. BHNM subsequently sought to reconstruct the amount of time spent by Dr. Clark on this project, using documentation kept by Dr. Clark and by BHNM, producing a total of ten hours over April and May.

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[1]The facts recited in this memo were obtained from the following sources: DMH Associate Commissioner Wayne Douglas, who in turn got some of his information from Dr. Clark; Assistant Attorney General Chris Leighton, who contributed certain information based on a conversation with Dr. Clark; and counsel for BHNM, Jennifer Begel, Esq. (see her letter to Wayne Douglas dated July 11, and her letter to me dated July 15, which together form Attachment C).

ANALYSIS

Title 5, M.R.S.A. § 18. The central statute governing disqualification of executive employees from participation in specified matters, § 18(2) makes it a civil violation for an executive employee to personally and substantially participate in his official capacity in any proceeding in which, to his knowledge, he (or any of the specified related persons or entities) have a direct and substantial financial interest. The statute defines "executive employee" to include all compensated members of the classified or unclassified service employed by the executive branch, and would therefore apply to the AMHI Clinical Director. § 18(1)(B). Additionally, a "proceeding" is defined to include a contract. § 18(1)(D). However, given the facts as stated above, there is no violation of § 18 in the absence of any personal or substantial involvement by Dr. Clark in the award of the contract.

Title 17, M.R.S.A. § 3104. The application of this statute requires a closer review of the facts at hand. It provides:

> No trustee, superintendent, treasurer or other person holding a place of trust in any state office or public institution of the State shall be pecuniarily interested directly or indirectly in any contracts made in behalf of the State or of the institution in which he holds such place or trust, and any contract made in violation hereof is void. This section shall not apply to purchases of the State by the Governor under authority of Title 1, section 814.

In order for the contract at issue here to have violated this statute, therefore, Dr. Clark must be found to have held a "place of trust" within DMH, and he must have benefitted pecuniarily, either directly or indirectly from the contract in his position at BHNM.

The statute has been construed by only one reported case, Opinion of the Justices, 108 Me. 545 (1911), in which the Justices rendered an advisory opinion that the predecessor statute to § 3104 was violated by the award of a printing contract by the Governor and the Council to the Waterville Sentinel Publishing Company, in which the Secretary of State was both a shareholder and corporate treasurer. The Court concluded that an ability to influence the award of the contract was not required in order to establish a violation of the statute. However, the decision sheds little light on what is meant by "a place of trust in any state office or institution", for while it repeatedly refers to "State officers," state government was a much smaller entity in 1911. Giving a contemporary interpretation to this language, it certainly could be read to encompass the AMHI Clinical Director.

Predicting whether a court would conclude that Dr. Clark received either a direct or indirect pecuniary benefit from the DMH/BHNM contract depends on a full and detailed inquiry into the facts. The absence of any specific provision for

payment to Dr. Clark for services performed appears to eliminate a "direct" pecuniary benefit flowing to him under the contract. However, it is more difficult to rule out the possibility of an indirect pecuniary benefit.

In light of the fact that Dr. Clark had already been hired by BHNM at a fixed rate before it got the contract with DMH, the lack of any any additional compensation paid to Dr. Clark above his monthly stipend under his agreement with BHNM for the work he performed relative to the DMH contract, and the absence of any evidence that BHNM hired Dr. Clark for the purpose of obtaining the contract with DMH, it is my belief that a court would not conclude that Dr. Clark had a direct or indirect pecuniary interest in BHNM's contract with DMH, and thus there would be no violation of the statute. However, the fact that Dr. Clark performed a part of the services for which BHNM was paid under the contract during a time in which he in turn was paid pursuant to his consulting contract with BHNM creates at least an appearance problem.

Given the critical importance of concluding the class member assessments to compliance with the Court's March 8th order, even the appearance of a violation is a risk which DMH may wish to avoid. Accordingly, the prudent course would be to terminate Dr. Clark's relationship with either DMH or BHNM (which has been done) and to recoup an amount determined to represent the pro rata share of his stipend attributable to the contract work. These steps would eliminate any basis for concluding that Dr. Clark benefitted from the contract in question.

SOLE SOURCE ISSUES

In contrast to the above cited statutes which proscribe certain activities, the statutes governing the bid process and sole source contracts (5 M.R.S.A. §§ 1825-A to 1825-I) simply provide procedures which must be followed, and which apparently were followed in this matter. Under § 1825-B(2), competitive bidding may be waived by the Director of the Bureau of General Services under certain specified circumstances. An appeal procedure is provided by § 1825-E.

While one might inquire into the facts offered in support of the sole source justification[2] and the decision to approve the request to waive competitive bidding, these are questions of policy at this point. Since the required approval was obtained for a sole source contract, there is no issue of potential violation of statute.

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[2]State contracting forms refer to the agency's "justification" for a sole source contract. This appears to be what para. 2 of Senate President Butland's letter refers to as the "certification" process.

14A G5962O1

STATE OF MAINE

Standard Agreement Summary Page

Department Mental Health & Mental Retardation Bureau Mental Health

Community Agency Name Behavioral Health Network of Maine

Address 99 Western Avenue, Augusta, Maine 04330

Employer ID# 01-0489615

Project# MHC-6-001 CFDA# ____ Agency Fiscal Year July-June

	VENDOR CODE	AMOUNT	MFASIS ACCOUNT CODING
1.	01-0489615	$440,097	010 14A 1101 022 1003 6401
2.			
3.			

TYPE OF COMMUNITY AGENCY

(Complete Appropriate Statement) (Check One)

1. A partnership: ____ 1. Non-Profit: X
2. A corporation of the State of: Maine 2. For Profit: __
3. Other: ____ 3. Government: __

AGREEMENT PERIOD		TYPE OF AGREEMENT
Effective Date:	May 1, 1996	X New
Termination Date:	October 31, 1996	___ Renewal
Amended Effective Date:		___ Amendment
Amended Termination Date:		___ Supplement

NAME OF LEAD AGENCY: ____

STATE OF MAINE
REQUISITION FOR CONTRACT/GRANT AUTHORIZATION

Date: May 1, 1996
Department: Mental Health and Mental Retardation
Contact: Wayne Douglas
Contractor/Grantee: Behavioral Health Network of Maine
Tel #: 287-4222
Sum $ 440,097
Contract/Grant Services: Clinical Assessments of AMHI Class Member Needs
Approp: 010 14A 1101
Term: May 1, 96 - Oct 31, 96

SUBSTANTIATION OF NEED: This contract was awarded because of the Provider's unique position of having qualified staff available, statewide, to be able to start and complete the work within the short time-frames of the court ordered plan.

IMPACT OF CONTRACT ON CIVIL SERVICE SYSTEMS: NONE

[illegible]PLOYER/EMPLOYEE RELATIONSHIP BETWEEN STATE AND CONTRACTOR: NONE

EFFECT ON STATE AFFIRMATIVE ACTION EFFORTS: NONE

JUSTIFICATION FOR SOLE SOURCE: There was insufficient time between the development of the plan to be submitted to the court and the requirement to complete the work, for an RFP to be developed, published, bid on and awarded. This is a limited period, one time only job that had to be completed and submitted to the court by the end of October, this year.

( )MSEA REVIEW (contracts only) Date forwarded________( ) Info. request ( ) [illegible]nference__________( ) Date cleared__________
[illegible]le No.__________

BP37R REV1/95

Contract Number MHC-6-001

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION
AND SUBSTANCE ABUSE SERVICES

AGREEMENT TO PURCHASE COMMUNITY SERVICES

This agreement is made this 26th day of April, 1996, by and between the State of Maine, Department of Mental Health, Mental Retardation, and Substance Abuse Services, hereinafter called "Department," and Behavioral Health Network of Maine, located at 99 Western Avenue, Augusta, Maine 04330, telephone number 621-6214, hereinafter called "Provider," for the period of May 1, 1996 to October 31, 1996.

The employer identification number of the Provider is 01-0489615.

WITNESSETH, that for and in consideration of the payments and agreements hereinafter mentioned, to be made and furnished by the Department, the Provider hereby agrees with the Department to furnish all qualified personnel, facilities, materials, and services and, in consultation with the Department, perform the services, study or projects described in Rider A. The following Riders are hereby incorporated into this agreement by reference:

Rider A - Specifications of Services to be Provided.
Rider B - Method of Payment and Other Provisions.

IN WITNESS WHEREOF, the Department and Provider, by their duly authorized representatives, have executed this agreement in six originals as of the day and year first above written.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION
AND SUBSTANCE ABUSE SERVICES

By: Rodney Bouffard for Wayne Douglas
Wayne R. Douglas, Associate Commissioner, Systems Operations
(Typed Name and Title)

Approved as to Form
July 22, 1990
Attorney General

and

BEHAVIORAL HEALTH NETWORK OF MAINE

By: Grete Chandler
Grete L. Chandler, President
(Typed Name and Title)

Total Contract Amount: $440,097.00

MFASIS Account Code: 010 14A 1101 022 1003 6401

State Controller

Richard B. Thompson

MAY 31 1996

RIDER A

Specifications of Work to be Performed

I. CONTRACT SUMMARY

Funds are provided under this agreement for the provision of clinical assessments for all class members of the AMHI Consent Decree. The source of funds is the State General Fund. Use of funds shall be in accordance with requirements detailed in the DMHMRSAS Fiscal Accountability Rules and Exceptions to Federal OMB Circulars (CMR 14-191, Chapter 009); with the Maine Uniform Accounting and Auditing Practices for Community Agencies (CMR 08-114, Chapter 1); and with the terms of this agreement.

II. SERVICE GOALS

Goals of service to be provided under this Agreement shall conform to the Department's mission to develop a consumer driven system that is responsive to the wants and needs of the individual consumer.

III. SERVICE SPECIFICATIONS

The Department has agreed to fund the Provider up to $440,097 to provide case processing and clinical assessments of all class members. The Provider is responsible for furnishing adequate qualified staff, either through its member agencies or through subcontracts with other licensed, mental health service providers and/or agencies, to complete assessments of class members as provided herein. Provider, its subcontractors and the Department shall work cooperatively in the performance of this Agreement. The Department's Consent Decree Coordinators will be generally responsible for monitoring location and assessment efforts, the quality of assessments, making suitable arrangements for alternative assessments when necessary, resolving grievances, etc. consistent with the terms of this agreement.

The BHNM has agreed that all individuals completing the assessments will be made up of community support workers certified by this Department at the Mental Health Rehabilitation Technician II level, and/or licensed masters level social workers, psychologists, psychiatrists and psychiatric nurses. To be approved by BHNM to perform assessments with class members not currently in service, an MHRT II must be in good standing with a licensed agency, must be certified and have documented competency in psychosocial rehabilitation. All non-licensed staff performing assessments will be supervised by a licensed professional and the ratio of supervisor to MHRT II will not exceed 1 to 5. Each assessment completed by a nonlicensed staff person will be reviewed by a licensed person for assurance that clinical areas are adequate and appropriate before the assessment will be considered completed.

The Department and BHNM have developed a work plan that specifically defines the project tasks, timeframes and responsibilities. That work plan is included below as part of this agreement.

Project Task	**Projected Timeframe**	**BHNM/DMH Resources**
1. The Department will develop a contract with BHNM to provide comprehensive clinical assessment to all the members of the class.	April 26, 1996	DMH

2. Recruitment and identification of agency-based assessment coordinators.	May 3, 1996	Agency-based coordinators from BHNM sub-contracted agencies (see partial listing Attachment B of those already identified by agency).
3. The BHNM shall develop a draft assessment tool acceptable to the Department and [illegible] the [illegible] for approval prior to implementation. BHNM shall also develop an acceptable letter of invitation and all protocols specific to contracting Class Members.	May 8, 1996	BHNM Design Team
4. Hire Project Coordinator	May 17, 1996	BHNM Board of Directors.
5. Assessment Protocol Development. A uniform assessment process and supporting documentation forms based on a Psychosocial Rehab-focused model of assessment will be developed. The assessment will include the clinical intake data elements presented in Attachment A and an initial assessment of the Class Members' current goals and interests, and related service needs. The development and implementation of the assessment protocol will allow for the assessments to be integrated into the normal service delivery system of the region. Linkage will be made to ongoing case management services for those class members wanting but not receiving services.	May 17, 1996 Completion	BHNM Design Team comprised of: DMHMRSAS Director of Community Clinical Services, Dr. Kalinowski and one additional DMHMRSAS rep. (Stephen Rose, Ph.D. from the University of New England School of SocialWork);BHNM's Medical Director, Dr. Clark; and staff drawn from BHNM member agencies such as AMHC - Greg Disy; CHCS - Kay Carter; SCMHC - Leslie Eastman; SH - Ed Blanchard; etc.

Project Task	Projected Timeframe	BHNM/DMH Resources
		Individuals and agencies listed are resource examples and are subject to change. Additionally, a BHNM Information System Committee member(s) and/or the contracted Computer Consultant will be included on the Team.
6. Class Member contact protocol consisting of:	May 10, 1996	BHNM Design Team
A. Letter of introduction, outlining that BHNM on behalf of DMHMRSAS wishes to meet with Class Members and offer them an opportunity to participate in an assessment process. (Class Member initiated phone contact will be encouraged in the letter, reflecting a desire to respect the individual Class Member. When the Class Member self-initiates contact with BHNM or the sub-contracted assessment agency provider, an appointment to meet with the Class Member at his or her home or an alternative location acceptable to the Class Member and regarded as safe for both the Class Member and the assessment personnel will be scheduled).		
B. Letter followed up by a telephone call(s) and personal contact(s) by BHNM project staff and/or sub-contracted agency staff, depending on		BHNM project staff and/or designated agency based coordinator.

Project Task	Projected Timeframe	BHNM/DMH Resources
Class Member classification as follows:		
1) Class Members not presently in service;		BHNM project staff
a) A complete new assessment;		
b) An updated assessment from an assessment resource of his or her choosing by BHNM sub-contracted provider from a listing of agency-based resources available within the region in which the Class Member lives.		
c) Assessment by an alternative provider from a listing of resources within the region in which the Class Member lives to include DMHMRSAS Consent Decree Coordinator, as necessary to win Class Member participation in the process.		
d) Assessment by a trained and supervised consumer and/or family member when all other alternatives for the provision of assessment have been refused.		
2) Consumers currently in Sub-contracted service;		BHNM Agencies
a) Assessment with their current provider;		

Project Task	Projected Timeframe	BHNM/DMH Resources
b) Assessment by an alternative provider from a listing of resources within the region in which the Class Member lives to include DMHMRSAS Consent Decree Coordinator, as necessary to win Class Member participation in the process.		
C. For those Class Members who do not initiate a call, contracted BHNM or a sub-contracted provider agency will attempt to make contact via phone and/or an actual visit(s) to the known and/or verified address as provided by DMHMRSAS.		
7. Subcontracting with BHNM member agencies and other community-based provider resources.	May 15, 1996	BHNM Project Coordinator.
8. The Department will recruit and hire clinical consent decree coordinators.	May 15, 1996	DMHMRSAS
9. Orientation and Training of agency-based coordinators and DMHMRSAS Consent Decree Coordinators.	May 24, 1996	BHNM design team and DMHMRSAS staff representatives, CDCs.
10. Recruitment and selection of designated assessment providers (to be drawn from staff resource pool of the sub-contracted agencies - see Attachment C for example specific to BHNM member agencies).	May 17, 1996	BHNM, sub-contracted agency-based coordinators.
11. An electronic relational database system will be designed by BHNM to support development of an	Initial design and start-up capability completed by	BHNM - Information Systems Committee or contracted consultant in

Project Task	Projected Timeframe	BHNM/DMH Resources
electronic and hard copy reports on:	May 22, 1996;	consultation with the BHNM Design Team, and DMHMRSAS Information System staff (Stan Fabisiak).
a) Clinical assessments completed;		
b) Met and unmet service needs on an individual class member basis and on an aggregate network, region, and statewide basis; and		
c) Related service resource development or reallocation needs. This data base will allow for reporting on an individualized Class Member basis, as well as in the aggregate for system-wide use.		
12. First-round of 300 letters mailed (weekly for 10 weeks plus follow-up) to Class Members based on a categorized and prioritized listing of Class Members:	May 22, 1996 onward for duration of the project.	
a. Class Members not currently in service.		BHNM Central Project staff.
b. Class Members currently in service that have been identified by external sources, such as the Office of Advocacy, to receive letters of introduction and initial contact through BHNM central project staff.		BHNM Central Project staff.
c. Class Members currently in service.		Agency-based coordinators and other selected sub-contracted assessment providers.
13. Two training sessions for selected assessment providers	Between May 24-31, 1996	BHNM sub-contracted

Project Task	Projected Timeframe	BHNM/DMH Resources
		agency-based coordinators and DMHMRSAS Consent Decree Coordinators, and contingency planning team.
14. Telephone and personal face-to-face follow-up contact with Class Members to schedule assessments. Outcome of these contacts will be documented reflecting Class Member acceptance or declining participation in the assessment process as experienced.	May 31, 1996	BHNM central project staff and sub-contracted agency-based providers.
15. On a biweekly basis, BHNM will submit written status reports to the Department on the number of Class Members contacted, scheduled for assessment, declining participation, not able to locate, and the number of completed assessments. Back-up documentation shall also be made available upon request.	Beginning June 7, 1996, onward for the duration of the project.	BHNM Project Coordinator and Information System Resource.
16. Review and approval BHNM MIS System Reports.	May 17 through June 10, 1996	
17. Class Member assessments scheduled and completed with supporting documentation.	To be completed by September 15, 1996	Agency-based assessment providers and BHNM central project staff and information personnel.
18. Documentation of class members declining participation in the assessment process forwarded to BHNM central project staff.	Weekly as experienced.	BHNM agency-based assessment coordinators.
19. Contingency planning team will review all situations in which Class Members decline participation on a weekly basis, to develop and	Weekly throughout the duration of the contract period as Class	Agency-based coordinator, DMHMRSAS Consent Decree Coordinator, and

Project Task	Projected Timeframe	BHNM/DMH Resources
offer an alternative assessment processes tailored to the Individual Class Member's needs, interest, or situation.	Members decline participation.	BHNM central project staff as needed.
20. Class Member complaints and grievances with assessment process to be documented and forwarded to BHNM central project staff.	As they occur throughout the duration of the project.	Agency-based assessment providers and coordinators.

COMPLETED ASSESSMENTS AND PROCESSED CASES BHNM shall make reasonable, good faith efforts to contact and assess every class member and shall complete an assessment and/or process a case for such class members. A completed assessment always includes a face to face completion of the assessment protocol, and unmet needs data. An individual service plan for each class member assessed will be included provided that the class member consents. Some class members may accept an assessment but neither want nor need a service plan.

A processed case is one where an assessment was not completed but the following efforts were made to locate a class member, and documented accordingly, prior to referring the class member name to the Consent Decree Coordinator for further follow up.

(1) One letter will be sent inviting the class member to call to set up an appointment for an assessment.

(2) A sufficient number of telephone calls (up to 5, if necessary) to follow up on those who do not call, made over the course of four days, at different times of day, and on at least one weekend day, reasonably calculated to locate class members.

(3) A visit to the home address provided by the Department, and following that attempt, contact by planned visit with neighbor, family member or other similar person.

These efforts will take place over no less than a ten day period. If at the end of these steps, and at least this time period, the class member has not been located, the name and a record of efforts to contact will be forwarded to the CDC. If a CDC subsequently locates a class member, the CDC may refer the class member back to BHNM for assessment if the class member so requests.

Both completed assessments and processed cases as defined above are considered as successful closures for the purposes of meeting BHNM's performance targets. However, BHNM must complete assessments of cases referred back from CDCs before such cases are considered successful closures for purposes of the next payment percentage milestone as set forth in Rider B, paragraph 2.

Notwithstanding any other provision in this Agreement, Department personnel may directly engage and assess class members. Department will notify Provider of all assessments

completed and Provider may credit these as completed assessments for purposes of meeting percentage milestones listed in Rider B, Section 1.

The Consent Decree Coordinators employed by the Department shall oversee and monitor the location and assessment efforts as set forth in this agreement. BHNM, its subcontractors, and the CDC's shall fully cooperate with one another in the performance of this agreement. In the event of a disagreement between the CDC and the local project coordinator, the BHNM Project Coordinator/designee and the relevant Departmental Regional Director/designee shall be notified within 2 working days. The Project Coordinator/designee and Regional Director/designee shall resolve any dispute immediately. In the event that they cannot agree, the BHNM President/designee and the Contract Administrator/designee will make final determination.

Provider and subcontractor agencies shall be required to inform Department within ten (10) days of any change in class members address/phone number.

CONFIDENTIALITY In carrying out the terms of this contract, BHNM and any sub-contractor of BHNM, is assisting the Department in fulfilling its legal and statutory responsibilities. BHNM is authorized to collect, receive, and/or transmit confidential patient information to carry out these functions provided it shall take all reasonably necessary measures to protect against any unauthorized disclosure. BHNM shall include this same authorization and requirement in any subcontract awarded hereunder.

MIS The databases to be developed pursuant to this agreement shall be approved in advance by the Department and shall be fully compatible with and accessible to the Department's MIS system. All class member data collected, compiled, entered into and resident on any database established and maintained under this agreement shall be the property of the Department. Any software application jointly developed pursuant to this contract shall be the joint property of the parties.

IV. REPORTING AND FISCAL REQUIREMENTS

The Provider has submitted a budget for the services purchased under this Agreement and that budget has been approved by the contract administrator. Provider understands and agrees that the approved budget will be used by the Department on program audit to assess financial requirements and performance under this Agreement. The Provider agrees to be bound by the regulations and principles of the Department with regard to contract administration.

DELIVERABLES In addition to any other requirements set forth herein, BHNM shall furnish to the Department the following in accordance with the terms of this agreement:

a. Complete list of all class members, indicating (i) name, (ii) address, (iii) assessment status, (iv) date of completed assessment, (v) or, if not assessed, the reason for non-assessment and date(s) determined non-assessable.

b. For each individual class member not assessed, complete documentation of all efforts made to locate, contact, and assess such class members.

c. Complete copy of all assessments of all class members in all forms available (e.g. hard copy, electronic media).

d. Complete copy of individual service plan for each class member assessed.

e. A database consisting of all data collected in the assessment process, with such database in such format that is compatible with and immediately functional on and accessible by the Department's systems. The database shall be designed and constructed so as to enable reporting of unmet needs (i) on an individual class member basis for each class member assessed as well as (ii) in the aggregate on a network, region, and statewide basis.

f. A report indicating the aggregate unmet needs by network.

g. A final report detailing the process used to complete assessments, and a summary of results.

Items "a" and "b" described immediately above shall be delivered incrementally to coincide with case completion and payment dates described in Rider B. If case completion information is delivered early, payment will be made correspondingly early; if case completion information is delivered late, payment will be made correspondingly late. All seven local service network areas must meet the case completion target percentages for the percentages to be considered met and before payments are made.

With respect to assessments completed by Provider or its subcontracted agencies, BHNM may collect and furnish information in item (c) above in patient deidentified form provided (1) a coding system is used that is mutually acceptable to Provider and Department; (2) Provider furnishes to the Department a comprehensive, accurate master list of class member names/address by code number; (3) Department develops and maintains an appropriate system to assure the confidentiality of the master list so that individuals will have access thereto on a need to know basis. Agencies providing service to class members may retain that portion of the master code list that pertains to the class members in service at that agency. Consent Decree Coordinators, and other Department staff with a need to know, shall have access at all times to master code lists as well as all information collected, developed and maintained under this agreement on a class member specific basis.

Nothing herein shall limit any in way the Department's rights in and to information under this agreement, or interfere with (i) the ability Consent Decree Coordinator(s) or other appropriate Departmental personnel to have access to any such information; or (ii) the Department's right to access and use information as may be required to fulfill its legal obligations under the matter of Bates v. Peet, et al. Nothing in this paragraph shall limit Plaintiffs counsel from access to information necessary to represent any and all clients in Bates v. Peet et al.

All of the above shall be delivered to the Department on or before October 15, 1996.

The Provider has agreed with the Department that scheduled payments shall not be made until the required events and deliverables as described in this agreement are satisfied.

Notwithstanding, however, if the Department shall not withhold payment if its actions are the material cause of Provider 's inability to meet performance guidelines.

V. PERFORMANCE BY PROVIDER AND DEPARTMENT

The Provider and the Department each agree that it shall provide sufficient personnel to reasonably meet the requirements of this Agreement. If at any time either party believes that the other is not meeting any of its obligations under this Agreement either as to the pace of the completion of the work provided for herein, the quality of services being provided, or any other matter, the aggrieved party shall immediately give the other specific written notice of any such perceived deficiency and within three business days of the receipt of any such notice by the other party, it shall furnish to the aggrieved party either (a) a written plan by which it proposes to adjust its performance under the contract to meet the issues raised by the aggrieved party, or (b) a written statement of its reasons why it believes that the aggrieved party is incorrect in its perception that the other party is not meeting its obligations under the contract. Unless the aggrieved party shall notify the other party within three business days after the giving of such response, such response of the other party shall be deemed to have resolved the issue and, to the extent that response included a proposal for adjusting its performance under the contract, the responding party shall thereafter immediately implement such adjustments.

In the event that the aggrieved party does object in any respect to the response of the other party, the authorized representatives of the Provider and the Department shall meet immediately to attempt to resolve any such dispute.

RIDER B
METHOD OF PAYMENT AND OTHER PROVISIONS

1. **CONTRACT AMOUNT** $ 440,097.00

2. **INVOICES AND PAYMENTS**

The Department agrees to provide a total of up to $190,097 to the Provider in installments on or about the following dates in the following amounts:

Event	Date	Amount
Start-up	May 28, 1996	$66,040
39% Cases Completed	July 12, 1996	27,516
80% Cases Completed	August 12, 1996	27,516
100% Cases Completed	September 15, 1996	27,515
Project completion	October 15, 1996	16,510
Bonus Incentive if Project Completed by:		
	September 25, 1996	25,000
	or September 30, 1996	20,000

In order for payments to be made for % completed, provider shall complete the cases depicted in each local service network area as shown in Attachment D which is attached hereto. All of the seven local service networks involved must meet the required percentage before payment will be made. Payment will be made at the time of accomplishment with the % target, either prior to or after the completion date.

The remaining $250,000 of this contract is made available for payment of completed assessments at the rate of $150 per completed assessment. This payment schedule is subject to the Provider's compliance with all items set forth in this contract and subject to the availability of funds. Payments shall be made by the Department after receipt of an invoice on the Provider's usual billing forms or business letterhead. If there is a material discrepancy (7.5%) between the projected number of assessments (3,010) and those actually completed, the Department agrees to renegotiate the amount of the contract dollars available to reimburse provider, if necessary.

Assessments will be billed to Medicaid when a class member is/or can be made eligible for Medicaid. When a class member is not eligible for Medicaid and cannot become eligible in a reasonable manner, the Department will be billed for a completed assessment at the flat rate of $150 per assessment up to $250,000. Provider and subcontract may account for these payments in a discrete cost center distinct from any Provider agreement that Provider and subcontracting agencies may have with the Department. No seed with respect to the particular contract shall be withheld from General Fund allocation.. Revenue and expense associated with this contract will not, to the extent otherwise permissible by law, be factored into rate setting.

The Department represents that at current it has available sufficient funds to pay Provider up to total contract amount of this Agreement.

3. **BENEFITS AND DEDUCTIONS**

If the Provider is an individual, the Provider understands and agrees that he/she is an independent contractor for whom no Federal or State Income Tax will be deducted by the

Department, and for whom no retirement benefits, survivor benefit insurance, group life insurance, vacation and sick leave, and similar benefits available to State employees will accrue. The Provider further understands that annual information returns, as required by the Internal Revenue Code or State of Maine Income Tax Law, will be filed by the State Controller with the Internal Revenue Service and the State of Maine Bureau of Taxation, copies of which will be furnished to the Provider for his/her Income Tax records.

4. **INDEPENDENT CAPACITY**

The parties hereto agree that the Provider, and any agents and employees of the Provider, in the performance of this agreement, shall act in the capacity of an independent contractor and not as officers or employees or agents of the State.

5. **CONTRACT ADMINISTRATOR**

All progress reports, correspondence and related submissions from the Provider shall be submitted to:

Wayne R. Douglas, Associate Commissioner, Systems Operations
Department of Mental Health, Mental Retardation, and Substance Abuse Services
40 State House Station
Augusta, Maine 04333-0040

who is designated as the Contract Administrator on behalf of the Department for this agreement, except where specified otherwise in this agreement.

6. **DEPARTMENT'S REPRESENTATIVE**

The Contract Administrator shall be the Department's representative during the period of this Agreement. He/she has authority to curtail services if necessary to ensure proper execution. He/she shall certify to the Department when payments under the agreement are due and the amounts to be paid. He/she shall make decisions on all claims of the Provider, subject to the approval of the Commissioner of the Department.

7. **PROCEDURE FOR MODIFICATION**

By mutual written agreement of the parties, this agreement may be modified at any time, with or without new consideration. Any material modification to the approved budget by the Provider shall not be paid under this agreement without prior written approval from the Contract Administrator. If, in the Department's judgment, it appears at any point during the term of this agreement that the goal of completing class member assessments in a timely fashion may not be reached, the Department may require such modifications in this agreement as may be reasonably necessary to accomplish that goal. The Department will confer with BHNM about any such modifications.

8. **PERIOD OF PERFORMANCE**

A. Effective Date: April 26, 1996
B. Termination Date: October 31, 1996

9. **SUBCONTRACTS**

Unless provided for in this agreement, no arrangement shall be made by the Provider with any other party for furnishing any of the services herein contracted for without the consent,

guidance and approval of the Contract Administrator, which consent shall not be unreasonably withheld. Any subcontract hereunder entered into subsequent to the execution of this agreement must be annotated "approved" by the Contract Administrator before it is reimbursable hereunder. This provision will not be taken as requiring the approval of contracts of employment between the Provider and its employees assigned for services thereunder.

10. SUBLETTING, ASSIGNMENT OR TRANSFER

The Provider shall not sublet, sell, transfer, assign or otherwise dispose of this agreement or any portion thereof, or of its right, title or interest therein, without written request to and written consent of the Contract Administrator. No subcontracts or transfer of agreement shall in any case release the Provider of its liability under this agreement.

11. EQUAL EMPLOYMENT OPPORTUNITY

During the performance of this agreement, the Provider agrees as follows:

a. The Provider will not discriminate against any employee or applicant for employment relating to this agreement because of race, color, religious creed, sex, national origin, ancestry, age, physical or mental handicap, unless related to a bonafide occupational qualification. The Provider will take affirmative action to ensure that applicants are employed and employees are treated during employment, without regard to their race, color, religion, sex, age or national origin.

   Such action shall include but not be limited to the following: employment, upgrading, demotions, or transfers; recruitment or recruitment advertising; layoffs or terminations; rates of pay or other forms of compensation; and selection for training including apprenticeship. The Provider agrees to post in conspicuous places available to employees and applicants for employment notices setting forth the provisions of this nondiscrimination clause.

b. The Provider will, in all solicitations or advertising for employees placed by or on behalf of the Provider relating to this agreement, state that all qualified applicants will receive consideration for employment without regard to race, color, religious creed, sex, national origin, ancestry, age, physical or mental handicap.

c. The Provider will send to each labor union or representative of the workers with which it has a collective bargaining agreement, or other contract or understanding, whereby it is furnished with labor for the performance of this agreement a notice to be provided by the contracting agency, advising the said labor union or workers' representative of the Provider's commitment under this section and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Provider will cause the foregoing provisions to be inserted in any subcontract for any work covered by this agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

12. STATE EMPLOYEES NOT TO BENEFIT

The Provider shall not employ on any basis in the performance of this agreement any employee of the State who may participate in his/her official capacity in reaching a decision or recommendation in a governmental proceeding affecting the Provider.

13. **WARRANTY**

The Provider warrants that it has not employed or contracted with any company or person, other than a bonafide employee working solely for the Provider, to solicit or secure this agreement and that it has not paid, or agreed to pay, any company or person, other than a bonafide employee working solely for the Provider, any fee, commission, percentage, brokerage fee, gifts, or any other consideration, contingent upon, or resulting from the award for making this agreement. For breach or violation of this warranty, the Department shall have the right to annul this agreement without liability or, in its discretion to otherwise recover the full amount of such fee, commission, percentage brokerage fee, gift, or contingent fee.

14. **ACCESS TO RECORDS**

The Provider and any subcontractors(s) shall maintain all books, documents, payrolls, papers, accounting records and other evidence pertaining to this agreement and to make such materials available at its offices at all reasonable times during the period of this agreement and for such subsequent period as specified under Maine Uniform Accounting and Auditing Practices for Community Agencies (MAAP) rules. The Provider and any subcontractor(s) shall allow inspection of pertinent documents by the Department or any authorized representative of the State of Maine or Federal Government, and copies thereof shall be furnished, if requested.

15. **AUDIT**

Funds provided under this agreement are subject to the audit requirements contained in the MAAP rules, and may further be subject to audit by authorized representatives of the Federal Government.

16. **TERMINATION**

The performance of work under the agreement may be terminated by the Department in whole, or, from time to time, in part, whenever for any reason the Contract Administrator shall determine that such termination is in the best interest of the Department. Any such termination shall be effected by delivery to the Provider of a Notice of Termination specifying the extent to which performance of the work under the agreement is terminated and the date on which such termination becomes effective.

17. **GOVERNMENTAL REQUIREMENTS**

The Provider warrants and represents that all governmental ordinances, laws and regulations shall be complied with.

18. **INTERPRETATION AND PERFORMANCE**

This agreement shall be governed by the laws of the State of Maine as to interpretation and performance.

19. **STATE HELD HARMLESS**

The Provider agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work, services, materials or supplies in connection with the performance of this agreement, and from any and all claims and losses accruing or resulting to any person, firm or

corporation who may be injured or damaged by the Provider or in the performance of this agreement and against any liability, including costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy, arising out of publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished under this agreement or based on any libelous or other unlawful matter contained in such data.

20. **APPROVAL**

This agreement is subject to the approval of the State Controller before it can be considered as a valid, executable document.

21. **LIABILITY**

The Provider shall keep in force a liability insurance policy issued by a company fully licensed or designated as an eligible surplus line insurer to do business in this state by the Maine Department of Professional & Financial Regulation, Bureau of Insurance which policy includes the area to be covered by this agreement with adequate liability coverage to protect itself and the Department from injury or damage suits arising from any accident to any person occurring at the facility. Providers insured through a "risk retention group" insurer prior to July 1, 1991 may continue under that arrangement. Prior to or upon execution of this agreement, the Provider shall furnish the Department with written or photocopied verification of the existence of such liability insurance policy.

22. **BONDING**

The Provider shall obtain and maintain at all times during the contract period a fidelity bond covering the activities of all employees who handle Provider funds in an amount equal to at least 25% of the total amount of this contract.

23. **ACKNOWLEDGMENT**

The Provider agrees that any publication, presentation, or display of information regarding this project's activities, services, or funding will include, at minimum, a statement which indicates that the project is funded by the Maine Department of Mental Health and Mental Retardation.

24. **ENTIRE AGREEMENT**

This document contains the entire agreement of the parties, and neither party shall be bound by any statement or representation not contained herein.

BHNM Behavioral Health Network of Maine
99 Western Avenue Augusta, Maine 04330 tel 207-621-6214 fax 207-626-3453

The Maine Resource for Maine People

Gordon H. Clark, Jr., M.D., M.Div., F.A.P.A.
Medical Director

Aroostook Mental Health Center *Caribou*
Community Counseling Center *Portland*
Community Health and Counseling Services *Bangor*
Counseling Services, Inc. *Saco*
Crisis and Counseling Center, Inc. *Augusta*
Day One for Youth and Families *Cape Elizabeth*
HealthReach Network *Waterville*
Ingraham *Portland*
Kennebec Valley Mental Health Center *Waterville*
Mid Coast Mental Health Center *Rockland*
Shalom House, Inc. *Portland*
Shoreline Community Mental Health *Brunswick*
Sweetser Children's Services *Saco*
Tri-County Mental Health Services *Lewiston*
Youth and Family Services, Inc. *Skowhegan*

August 1, 1996

Sen. Joan M. Pendexter
Rep. Michael J. Fitzpatrick
Human Resources Committee
State House
Augusta, ME 04333

Dear Sen. Pendexter and Rep. Fitzpatrick:

In response to your call yesterday, I am providing information and materials about the Behavioral Health Network (BHN) to assist the Human Resources Committee in its review of the contracting process employed by the Department of Mental Health and Mental Retardation/ Substance Abuse.

Sincerely,

Grete Chandler
Grete Chandler 721-3177
President FAX 721-3181

Attachments

Behavioral Health Network
Letter to Sen. Joan M. Pendexter and Rep. Michael J. Fitzpatrick
August 1, 1996

BHN STRUCTURE

The Behavioral Health Network of Maine was incorporated in 1994 as a non-profit behavioral health care organization. Mental health and substance services are provided across Maine in over 70 locations.

MEMBERSHIP AND BOARD OF DIRECTORS

Members include the organizations listed below:

Aroostook Mental Health Center, Caribou
Community Counseling Center, Portland
Community Health and Counseling Services, Bangor
Counseling Services, Inc., Saco
Crisis and Counseling Center, Inc., Augusta
Day One for Youth and Families, Cape Elizabeth
HealthReach Network, Waterville
Ingraham, Portland
Kennebec Valley Mental Health Center, Waterville
Mid Coast Mental Health Center, Rockland
Shalom House, Inc., Portland
Shoreline Community Mental Health Services, Brunswick
Sweetser Children's Services, Saco
Tri-County Mental Health Services, Lewiston
Youth and Family Services, Inc., Skowhegan

Jackson Brook Institute and Spurwink School withdrew from membership in May and June, 1995, respectively.

Board members include:

Grete Chandler, President
Wes Davidson, Vice President
Emilie van Eeghen, Treasurer
Cindy Fagan, Secretary
Lynn Duby
Leyton Sewell

All Board members serve without reimbursement.

PAYMENT AND COSTS

BHN received a contract to 1) participate in the development of an assessment form, 2) assist in locating, and 3) assess approximately 3000 Consent Decree clients.

An agreement in principle was signed on May 7, 1996 for the period of May 1 to October 31. It is expected that 100% of the clients will have been assessed and their data submitted to the DMHMRSA by September 15, 1996.

BHN's contract of $190,097 is to cover costs including: an MSW Project Coordinator; printing, addressing and mailing 3,000+ letters; reproducing 3,000+ 21-page assessment forms; and location efforts.

To carry out this work, BHN contracted with the 16 organizations listed below, including three that are not members of BHN:

Aroostook MHC
Community Counseling Center
Community Health and Counseling Services
Counseling Services, Inc.
Crisis and Counseling Center, Inc.
HealthReach Network
Ingraham
Kennebec Valley MH Center
Mid Coast MHC
Shalom House, Inc.
Shoreline CMHS
Tri-County MHS
Youth and Family Services, Inc.
Catholic Charities of Maine
- in Portland, Holy Innocents
- in Fairfield, Catholic Charities, Fairfield

Motivational Services, Inc.
Maine Medical Center

Approximately one-third of the class members are, or were recently, in outpatient care with these organizations.

The organizations who conduct the assessment will bill Medicaid. The exception is when a class member is not or cannot become Medicaid reimbursable, in which case the Department will reimburse BHN $150 per assessment, and BHN will pass through that amount to the agency that conducted the assessment.

EMPLOYEES OF BHN

BHN has 2 FTE (full time equivalent) employees as well as several consultants who work as independent contractors. Their job responsibilities include projects related to the assessment, as well as projects entirely unrelated to this contract.

BUSINESS ACTIVITIES

BHN was formed to provide behavioral health services across the State. Toward that end, BHN contracts with managed care and similar entities to provide these services. These business relationships are entirely unrelated to the contract which BHN negotiated with the Department.

ASSESSMENT DATA

The assessment form, attached, was developed conjointly with the Department. This data, including hard copy of the forms and and the computer base, belongs to the Department. The database is an organized format of the information contained on the assessment form.

CONTRACT BETWEEN BHN and DMHMR/SA

I understand that the Committee will obtain a copy of the contract from the Department. The contract does not contain a profit line.

Attachment

Behavioral Health Network of Maine
Class Member Comprehensive Assessment

Introduction

The primary purpose of this assessment process is to reach out to class members in the Augusta Mental Health Institute consent decree. It is an opportunity to engage individuals and to explore with them their life goals and ways in which the service system can assist them in meeting those goals.

This assessment tool is intended as a guide and a way to record information that can be helpful in the process of identifying and meeting a person's real life goals. As you approach these assessments, it is essential not to lose sight of the fact that this is about what each person wants for his or her life, now and in the future. It is about achievable outcomes that reflect what she/he wants from services and supports. It is about strengths and working together to overcome obstacles.

We need this information for planning purposes and to help us comply with the settlement agreement, but most importantly we need to encourage the individuals who make up the class to take advantage of the supports that are available if they want and need them.

The assessment will be conducted in a highly individualized manner. As in any assessment interview, you must follow the client while working to cover all areas in the assessment instrument. It may take more than one meeting to complete this. If a consumer does not wish to answer a particular area, note this on the assessment.

The assessments may be handwritten in a legible manner. Information from the assessment instruments will form a database which will be utilized by the Department of Mental Health & Mental Retardation to plan system development and resource allocation. All instruments will be coded to maximize confidentiality. Where a consumer wants to utilize this document in his/her current work, they may receive a copy or have one sent to a service provider. If the consumer wishes to receive specific services, it is the responsibility of the interviewer to provide information or make a referral.

BEHAVIORAL HEALTH NETWORK OF MAINE

Class Member Comprehensive Assessment

Date of Assessment: ______________________ Clinical Record Number: ______________

Client Name: ____ D.O.B.: ________________

Source(s) of Information: ____

Agency & Clinician Completing Assessment: ______________________________________

Diagnosis for Billing Purposes (use DSM IV code, Axis I & II): Axis I: ___________
Axis II: ___________

I. **Client's Goals**: Identify the life goals and interests of the individual. This should be reflected in the language of the individual. Areas which should be discussed with the individual in formulating goals include: life direction; mental, medical, and dental health; substance use and abuse; housing (including furniture); financial, educational, vocational training, employment, and legal; recovery from trauma and/or abuse; family, social, spiritual, recreational:

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ____________________

II. **Client's Strengths** (include capacities, personal qualities, community participation & accomplishments that may be helpful in achieving his/her goals):

A. Interpersonal Strengths:

- health history & current situation
- functional capacity & limitations (physical)
- substance abuse history & current situation
- experience with psychotropic medication and perception of its meaning in their life

B. Interpersonal Strengths:

- family situation - history & current situation
- friendships/social network (history & current situation)
- more intimate relationships (history & current situation)

Client Name: ______________________ Clinical Record #: ______________________

Date of Birth: ______________________ Date of Assessment: ______________________

C. Situational Strengths:

- finances
- housing
- geographic location
- meaningful activity not limited to work

D. Community Participation - History & Current Situation:

- religious participation (interest-involvement)
- cultural involvement: ethnic, gender, sexual orientation, interests
- work or volunteer activity
- educational involvement
- legal involvement

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ____________________

E. Service Participation - History & Current Situation:

- Service Provider Involvement

III. **Current Mental Health Concerns:**

A. **Statement of concerns in client's words**:

1. Do you have concerns about the quality of your current mental health? ____ 1. Yes ____ 2. No

If yes, please specify: ____

____

____

2. Do the mental health providers you work with understand your concerns? ____ 1. Yes ____ 2. No

If no, please specify: ____

____

____

Client Name: ______________________ Clinical Record #: ______________________

Date of Birth: ______________________ Date of Assessment: ______________________

3. Have you ever felt you needed crisis services?
____ 1. Yes
____ 2. Sometimes
____ 3. No

If yes, please specify: ____

____

____

4. Were the crisis services appropriate to your needs?
____ 1. Yes
____ 2. No

If no, please specify: ____

____

____

B. **History of the development of the concerns** (including precipitating events/stressors, previous attempts at resolution, and what might have helped with this concern in the past.):

C. Are you having any **unusual experiences or behavioral difficulties that impede or interfere with your goals (symptoms and problems in functioning)**:
_____ 1. Yes
_____ 2. No

If yes, please specify: ____

____

____

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ___________________

D. Are you receiving any assistance to achieve your goals? _____ 1. Yes
_____ 2. No

If yes, please specify: ____

____

____

E. Do you feel that the services respond to your needs? _____ 1. Yes
_____ 2. No

If no, please specify: ____

____

____

IV. **Psychiatric/Mental Health History** (past treatment, including providers, medications, [including adverse reactions, preferred medications], hospitalizations, psychological testing; patient's understanding of past difficulties):

A. What psychotropic medication are you taking currently (names and dosages)?

____ Antianxiety medication
____ Antidepressant medication
____ Mood stabilizing medication (lithium, tegretol, depakote)
____ Antipsychotic medication
____ Anticholinergic medication (cogentin, artane, amantadine)

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ___________________

B. Do you have any concerns about your current medication?
____ 1. Yes
____ 2. No
____ 3. Not currently taking medications

C. Are you having any adverse reactions to your current medication?
____ 1. Yes
____ 2. No

If yes, what are they: ____

____

1. If yes, can you talk to your doctor about them? ____ 1. Yes ____ 2. No

2. Do you feel that your doctor understands your concerns? ____ 1. Yes ____ 2. No

D. What types of psychotropic medication have you taken in the past?

____ Antianxiety medication
____ Antidepressant medication
____ Mood stabilizing medication (lithium, tegretol, depakote)
____ Antipsychotic medication
____ Anticholinergic medication (cogentin, artane, amantadine)

E. Have you had any adverse reactions to drugs taken in the past?
____ 1. Yes
____ 2. No
____ 3. Don't remember

1. If yes, were you able to talk to your doctor about them? ____ 1. Yes ____ 2. No

2. Do you feel that your doctor understood your concerns? ____ 1. Yes ____ 2. No

F. Do you have a preferred medication? ____ 1. Yes Specify: ______________________
____ 2. No

If yes, does your doctor understand and discuss this with you? ____ 1. Yes ____ 2. No

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ____________________

V. **Substance Abuse History** (past and present use, physical/social consequences, past treatment):

	Yes	No
A. Do you currently use alcohol?		
B. Do you currently abuse alcohol?		
C. Have you abused alcohol in the past?		
D. Do you use more of your medications than your doctor prescribes?		
E. Do you currently abuse prescription drugs?		
F. Have you abused prescription drugs in the past?		
G. Do you currently abuse non-prescription drugs?		
H. Have you abused non-prescription drugs in the past?		
I. Are you currently attending AA or NA?		
J. Have you been to AA or NA in the past?		
K. Do you currently use caffeine?		
L. Do you currently use tobacco?		

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ____________________

M. Have you received any of the following substance abuse services in the past? (indicate type & times):

____ Individual Counseling # of Times: ____
____ Group Counseling # of Times: ____
____ Intensive Outpatient # of Times: ____
____ Partial Hospitalization # of Times: ____
____ Residential Treatment # of Times: ____
____ 1/4 or 1/2 Way House # of Times: ____
____ Detoxification # of Times: ____

VI. **Family Psychiatric/Substance Abuse History** (problems, treatment, medications, hospitalizations, suicides):

A. Is there a history of alcohol and/or substance abuse among your biological relatives?
____ 1. Yes
____ 2. No
____ 3. If yes, please tell us who they are (mother, father, etc.): ______________________

VII. **Medical History:**

A. Have you ever had any major illness or surgeries?

____ 1. Yes, please specify: ____
____
____

____ 2. No

____ 3. If yes, do you feel the treatment was appropriate? ____ 1. Yes ____ 2. No

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ____________________

B. Do you have any medical problems now?

____ 1. Yes, please specify: ____

____

____

____ 2. No

If you answered yes, are you receiving treatment for this problem now?

____ 1. Yes, please specify: ____

____

____

____ 2. No

C. Do you have any dental problems now?

____ 1. Yes, please specify: ____

____

____

____ 2. No

D. If you answered yes, are you receiving treatment for this problem now?

____ 1. Yes, please specify: ____

____

____

____ 2. No

E. Have you ever had an incident of head trauma, loss of consciousness, or seizures?

____ 1. Yes Specify: ____
____ 2. No

F. Do you have any drug allergies?

____ 1. Yes
____ 2. No

G. Do you have a primary health care provider?

____ 1. Yes Specify: ____
____ 2. No

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ____________________

H. When was your most recent medical exam?

____ 1. Within the last six months
____ 2. Between 6 months & one year
____ 3. Between 1 & 2 years
____ 4. Over 2 years ago

I. When was your most recent dental exam?

____ 1. Within the last six months
____ 2. Between 6 months & one year
____ 3. Between 1 & 2 years
____ 4. Over 2 years ago

H. When was your most recent eye exam?

____ 1. Within the last six months
____ 2. Between 6 months & one year
____ 3. Between 1 & 2 years
____ 4. Over 2 years ago

I. When was your most recent gynecological/reproductive exam?

____ 1. Within the last six months
____ 2. Between 6 months & one year
____ 3. Between 1 & 2 years
____ 4. Over 2 years ago

J. Are there particular obstacles preventing you from receiving good health care?

____ 1. Yes Specify: ____
____ 2. No

VIII. **Social History**:

A. **Family History** (major life events; quality of past and present family relationships; positive family events; significant relationships):

Client Name: ______________________________ Clinical Record #:______________________

Date of Birth: ____________________ Date of Assessment: ___________________

- Were the relationships in your family while you were growing up:
  - _____ 1. Generally Positive
  - _____ 2. Mixed
  - _____ 3. Not so positive

B. **Abuse & Survivorship History:**

- Were you ever physically abused?

_____ 1. Yes
_____ 2. No
_____ 3. If yes: a. How old were you? ________
b. Did this happen more than once? ____ 1. Yes If yes, how often? _____
____ 2. No

- Were you ever sexually abused?

_____ 1. Yes
_____ 2. No
_____ 3. If yes: a. How old were you? ________
b. Did this happen more than once? ____ 1. Yes If yes, how often? _____
____ 2. No

- If yes to any of the above, have you ever been offered assistance by mental health providers?

_____ 1. Yes
_____ 2. No

- If you answered yes to any of the above, would you like a referral for assistance with this?

_____ 1. Yes
_____ 2. No

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ____________________

C. **Educational History**:

- What is your highest level of education?

____ 1. Less than Grade School
____ 2. Completed Grade School
____ 3. Attained a GED
____ 4. Post High School Vocational Training
____ 5. Bachelor Degree
____ 6. Masters Degree
____ 7. Doctorate Degree
____ 8. Post Doctorate Education

- Do you have any interest in pursuing or completing any further education?

____ 1. Yes Specify: ____
____ 2. No

- What could we do to help you with this?

____

____

D. **Cultural & Gender Considerations:**

- Do you feel you were ever discriminated against because of your family background or race?
____ 1. Yes
____ 2. No

- Do you feel you were ever discriminated against because of your sex?
____ 1. Yes
____ 2. No

Client Name: ______________________ Clinical Record #: ______________________

Date of Birth: ______________________ Date of Assessment: ______________________

- Do you feel you were ever discriminated against because of your sexual orientation?
  ____ 1. Yes
  ____ 2. No

E. **Housing History:**

- What is your current living arrangement?

  ____ 1. Live alone
  ____ 2. Live in a group situation
  ____ 3. Live with other in an intimate relationship
  ____ 4. Live with parents
  ____ 5. Live with roommate

- What is your current housing situation?

  ____ 1. Homeless
  ____ 2. Living in an apartment/home
  ____ 3. Living in a nursing/boarding home
  ____ 4. Living in a rooming house
  ____ 5. Living in an institution
  ____ 6. Other Specify: ______________________

- Is your housing safe and decent? ____ 1. Yes
  ____ 2. No

- Is your housing adequately furnished? ____ 1. Yes
  ____ 2. No

- What is your current monthly income? ______________

- How much do you pay monthly for rent? ______________

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ____________________

- Are there any services which you feel you need to maintain your independent living? (such as cooking, housekeeping, somebody to keep you company or to make you feel safe)

  ____ 1. Yes Specify: ______________________________________

  ____ 2. No

- Is your housing currently subsidized? ____ 1. Yes Specify: ____ Section 8
  ____ BRAP
  ____ Shelter+Care

  ____ 2. No

F. **Financial History:**

- What are your current means of support? (Check as they may apply)
  ____ 1. Self-supporting
  ____ 2. Family/Friends
  ____ 3. Social Security/SSI
  ____ 4. Unemployment
  ____ 5. Other Specify: ______________________________________

- Do you have a payee? ____ 1. Yes
  ____ 2. No

- If no, would you like a payee? ____ 1. Yes
  ____ 2. No

G. **Work Experience**:

- What kinds of employment opportunities are there in your community?

- Tell me something about your skills related to volunteer work, artistic efforts, job skills:

- What kinds of employment have you had in the past?

Client Name: ______________________ Clinical Record #: ______________________

Date of Birth: ______________________ Date of Assessment: ______________________

- Are you currently employed?
  - ____ 1. Yes
  - ____ 2. No
  - ____ 3. Not in the work force

- If no, how long has it been since you were employed?
  - ____ 1. Never employed
  - ____ 2. In the last 6 months
  - ____ 3. 6 months to 1 year
  - ____ 4. 1-2 years ago
  - ____ 5. 2-5 years ago
  - ____ 6. Over 5 years

- Would you like to work and if so, what type of work would you like to do?
  - ____ 1. Yes Specify: ______________________
  - ____ 2. No

H. **Legal History**:

	Yes	No
Have you ever been arrested?		
Have you ever been convicted of a felony?		
Have you ever been imprisoned?		
Are you currently involved in a lawsuit?		
Are you currently involved in a divorce or custody action?		
Is there any current legal action pending against you?		
Do you have a legal guardian?		
Is there currently an advance directive/power of attorney for your mental health care?		

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ____________________

I. Spiritual History:

- Do you belong to an organized religion?
  ____ 1. Yes
  ____ 2. No

- Have you ever belonged to an organized religion?
  ____ 1. Yes
  ____ 2. No

- Are you able to meet any spiritual needs that you may have?
  ____ 1. Yes
  ____ 2. No

- Is there any assistance you need to do so?

  ____ 1. Yes Specify: ____
  ____ 2. No

J. Recreational History:

- Do you participate in community activities?
  ____ 1. Yes, frequently
  ____ 2. Yes, infrequently
  ____ 3. No

- Do you have any hobbies?
  ____ 1. Yes
  ____ 2. No

- Do you participate in any sports?
  ____ 1. Yes
  ____ 2. No

- Would you like to participate in community activities?
  ____ 1. Yes Specify: ____
  ____ 2. No

- Are there any hobbies or recreational skills you would like to acquire?
  ____ 1. Yes Specify: ____
  ____ 2. No

Client Name: ______________________ Clinical Record #:______________________

Date of Birth: ______________________ Date of Assessment: ______________________

- Is there anything you need to help you participate in such activities?

  ____ 1. Yes Specify: ______________________________
  ____ 2. No

K. Transportation Needs:

- Do you own a car or have access to a car when you need one?
  ____ 1. Yes
  ____ 2. No

- Are you able to use mass transit, such as bus or train, to get where you need to go?
  ____ 1. Yes
  ____ 2. No

- Are there places you would like to go or things you would like to do that you cannot do now because of lack of transportation?
  ____ 1. Yes
  ____ 2. No

  If you answered yes, please tell us what they are?

  ____

  ____

L. **Family & Social Supports:**

- Are you currently married or have a significant other? ____ 1. Yes
  ____ 2. No

- Do you have a close relationship with at least one other family member?
  ____ 1. Yes
  ____ 2. No

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ___________________

- Do you have at least one person you consider a good friend?
  ____ 1. Yes
  ____ 2. No

- Is there any assistance you need that would help you develop social relationships?

  ____ 1. Yes Specify: ____

  ____ 2. No

IX. **Support & Follow-Up Plan including Treatment Recommendations:** Based on the goals the individual has articulated, identify supports, services, and follow-up which are required to help the individual achieve these goals and which are not currently available to the individual.

What would you like to see happen from here on?

Client Name: ______________________ Clinical Record #: ______________________

Date of Birth: ______________________ Date of Assessment: ______________________

A. Specific Needs & Areas Requiring Support & Follow Up

____ 1. Assistance with daily living skills (In-Home Support)
____ 2. Assistance with transportation
____ 3. Assistance with finding appropriate housing
____ 4. Assistance in finding a job
____ 5. Assistance with obtaining vocational training
____ 6. Assistance in obtaining therapy
____ 7. Assistance in obtaining a medical examination & care
____ 8. Assistance in obtaining a psychiatric evaluation & care
____ 9. Assistance in obtaining a pelvic exam
____ 10. Assistance in obtaining an eye exam
____ 11. Assistance in obtaining glasses
____ 12. Assistance in obtaining a dental exam
____ 13. Assistance in obtaining dentures
____ 14. Assistance in applying for state assistance
____ 15. Occupational Therapy
____ 16. Physical Therapy
____ 17. Expand social supports
____ 18. Expand recreational interests
____ 19. Specialized services for trauma survivor
____ 20. Culturally specific/competent services
____ 21. Spiritually-oriented services
____ 22. Alternative somatic therapies (e.g. acupuncture, massage, etc.)
____ 23. Other assistance (specify: ______________________________
____
______________________________)

X. Goal Areas Identified:

______ A. Health, Mental Health, Substance Abuse Services

_____ Mental Health Treatment
_____ Substance Abuse
_____ Medical Treatment

______ B. Living in the Community: safe, affordable housing.

______ C. Employment, Training, Education

______ D. Community Participation; Social Networks; Recreation

______ E. Legal Issues

______ F. Other: ______________________________

Client Name: ______________________________ Clinical Record #: ______________________

Date of Birth: ____________________ Date of Assessment: ___________________

Client Signature: _____________________________________ Date: __________________

Guardian Signature: ___________________________________ Date: ___________________

Clinician Signature: ___________________________________ Date: ___________________

Authorized Supervisor Signature: __________________________ Date: ___________________

Managed Care for Maine

- *Single Point of Entry for Children and Adults*
- *Crisis Intervention and Stabilization*
- *Assessment and Evaluation*
- *Case Management*
- *Outpatient Services*
- *Intensive Outpatient Services*
- *Supported Housing and Employment*
- *Day and Evening Programs*
- *Partial Hospitalization*
- *Residential Services*
- *Inpatient Services*

Managing Behavioral Health Services from Kittery to Fort Kent

Behavioral Health Network of Maine
99 Western Avenue
Augusta, Maine 04330
207-621-6214
207-626-3453 fax

The Behavioral Health Network of Maine was incorporated in 1994 as a non-profit, managed behavioral healthcare company.

BHNM

Behavioral Health Network of Maine

The Maine Resource for Maine People

Redefining Traditional Values for the Changing Health Care Marketplace

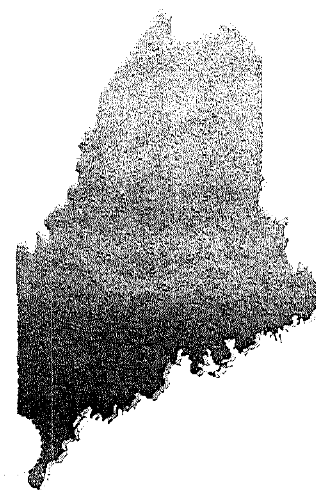
Local Providers

- *Experienced in providing care in Maine communities*
- *Experienced with the sources of stress and illness that affect Maine people*
- *Experienced in providing state-of-the-art mental health and substance abuse services*

BHNM is a non-profit, managed behavioral healthcare company developed by experienced Maine providers.

Service Orientation

- *Consumer Sensitive*
- *Easily Accessible*
- *Outcome Focused*
- *Cost Effective*
- *Individually Oriented*



Network Pledge

- *To design services to meet the individualized needs of our customers*
- *To encourage a partnership between BHNM and the individuals, families, employers, and payors who are the Network's clients*
- *To maintain a commitment to effectiveness and efficiency on behalf of those we serve*

BHNM is committed to helping Maine citizens acquire access to behavioral health services in their home communities.

Network Profile

The Behavioral Health Network of Maine was incorporated in 1994 as a non-profit behavioral health care organization in order to offer the best possible behavioral health care to the citizens of Maine. In 1994, more than 1500 member agency staff in over 70 locations throughout the state provided mental health and substance abuse care to nearly 30,000 Maine people, and over 20,000 crisis hot-line callers.

Licensed psychiatrists, psychologists, nurses, social workers, substance abuse counselors, and community support workers are the Network's front-line providers of high quality mental health and substance abuse services. Gordon H. Clark, Jr., M.D., M.Div., F.A.P.A., the Medical Director for BHNM, has written clinical practice standards which have been adopted network-wide.

When the Behavioral Health Network of Maine was formed, 15 non-profit agencies between Kittery and Fort Kent — all with IRS 501(C)(3) status — formalized their affiliation. As founding members, they are guided by the following mission:

To offer the people of Maine access to a comprehensive network of mental health and substance abuse services that meet the behavioral health needs of the community, yield positive outcomes, and are cost effective.

This mission statement is fundamental to developing a fully integrated and seamless delivery system. Using the mission statement as the underlying foundation, the following commitments are set forth in the Network's guiding principles:

- Providing an easily accessible, fully integrated, community-based system of care for clients.
- Working with clients — who may be individuals, families, employers, payors — as partners in a system that guarantees satisfaction.
- Using effective and resource sensitive methods that are both empirically based and consistent.
- Utilizing guidelines that are consumer-sensitive and outcome oriented.

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Founding Vision

Behavioral Health Network of Maine

The Behavioral Health Network of Maine is a non-profit organization charged with carrying out the common vision of its members:

- To join in a collaborative, Maine-based, behavioral health service delivery system
- To create a readily accessible, comprehensive, service delivery system tailored to meet the needs of both the public and private markets
- To meet the treatment needs of Maine citizens who experience mental health and chemical dependency problems

Incorporated in this vision is a consumer-centered, dynamic, and respectful system of services, which is essential to good outcomes in behavioral health care and is also a vehicle to compete effectively in today's managed care environment.

The Behavioral Health Network of Maine will work directly with insurers, including managed care companies. These strategies will promote the enhancement and development of a full continuum of cost- and outcome-effective prevention, intervention and treatment services.

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Service Locations

Behavioral Health Network of Maine

MADAWASKA
FORT KENT
VAN BUREN
LIMESTONE
CARIBOU
FORT FAIRFIELD
PRESQUE ISLE
HOULTON
MILLINOCKET
LINCOLN
DOVER FOXCROFT
BINGHAM
KINGFIELD
MADISON
HARTLAND
SKOWHEGAN
CALAIS
STRONG
BANGOR
MACHIAS
ORONO
FARMINGTON
WATERVILLE
ELLSWORTH
RUMFORD
SIDNEY
BELFAST
LIVERMORE FALLS
ALBION
BELGRADE
LEEDS
AUGUSTA
RANDOLPH
SOUTH PARIS
COOPERS MILLS
LEWISTON
AUBURN
RICHMOND
BRIDGTON
ROCKLAND
CASCO
DAMARISCOTTA
BRUNSWICK
DOVER
KEZAR FALLS
FREEPORT
BOOTHBAY HARBOR
BATH
WINDHAM
PORTLAND
SOUTH PORTLAND
HOLLIS
SACO
BIDDEFORD
SANFORD
KENNEBUNK
YORK

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Member Providers

Behavioral Health Network of Maine

GORDON H. CLARK, JR., M.D., M.DIV., F.A.P.A.
Medical Director
Portland

AROOSTOOK MENTAL HEALTH CENTER
Wesley R. Davidson, Executive Director
Caribou

COMMUNITY COUNSELING CENTER
Henry Nielsen, Executive Director
Portland

COMMUNITY HEALTH AND COUNSELING SERVICES
Joseph H. Pickering, Jr., Executive Director
Bangor

COUNSELING SERVICES, INC.
Sherry Sabo, Executive Director
Saco

CRISIS AND COUNSELING CENTER, INC.
Lynn Duby, Executive Director
Augusta

DAY ONE FOR YOUTH AND FAMILIES
David Faulkner, Executive Director
Cape Elizabeth

HEALTHREACH NETWORK
Emilie van Eeghen, Vice President
Waterville

INGRAHAM
Jane Morrison, Executive Director
Portland

KENNEBEC VALLEY MENTAL HEALTH CENTER
John Shaw, Executive Director
Waterville

MID COAST MENTAL HEALTH CENTER
Julianne Edmondson, Executive Director
Rockland

SHALOM HOUSE, INC.
Joseph C. Brannigan, Executive Director
Portland

SHORELINE COMMUNITY MENTAL HEALTH SERVICES
Grete Chandler, CEO
Brunswick

SWEETSER CHILDREN'S SERVICES
Cynthia P. B. Fagan, CPO
Saco

TRI-COUNTY MENTAL HEALTH SERVICES
J. Gregory Shea, Executive Director
Lewiston

YOUTH AND FAMILY SERVICES, INC.
Ron Hebert, Executive Director
Skowhegan

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Service Index

Behavioral Health Network of Maine

	Equity Member Agencies by Service Regions														
	I	I-II-III	III	III	III	III	III	III-IV	IV	III-V	IV-V	V	V	V	V
	AMHC	CHCS	Y&FS	C&CS	KVMHC	MCMHC	SCMHC	HRN	TCMHC	SWEETSER	CSI	DAY ONE	INGRAHAM	SHALOM	CCC
Case management services	●	●	■		●	●	●		●	●		4	●		●
Community support services	●	●					●						●		
Consultation and education	●		●	●	●	●	●	●	●	●	●	●	●		●
Crisis stabilization services	●	●		●		●	●		●	■	●		●		
EAP services	●							●	●		●				●
Emergency services	●	●		●	●	●	●		●				●		
In-home services	●	●	●	■	●	●	●		●	●		●			●
Inpatient care (access)	●	2		●	2	●	●		●		●				
Intensive outpatient treatment	●	●				●									●
Medication assessment and management	●	●	■		●		●		●	●	●				●
Outpatient treatment	●	●	●	●	●	●	●	●	●		●	●			●
Partial hospitalization/day treatment	●	1					3			■					●
Psycho-social rehabilitation services	●	●					●								
Psychological testing and assessment	●	●		●	●				●		●				
Residential treatment	●	●						●		■		4	2		
Respite care	●	■				■	●								
Self-help groups	●						●				●				
Sexual abuse treatment services	●	●	●		●	●	●		●		●				●
Single point of entry	●		●			●	●			●					●
Special educational services	●	■								■			●		●
Substance abuse services	●	●	●	●	●		●	●			●	●	●		
Supported housing	●						●						1		
Transitional housing	●												●		
Vocational services	●									■					
Wraparound services	●	●	2	■		●	●			■					

Legend: (gray) Adults, Adolescents, and Children; Adults Only; (■) Adolescents and Children Only

1 Adults and Children Only
2 Adults and Adolescents Only
3 Children Only
4 Adolescents Only

Service Regions
- I Aroostook
- II Piscataquis, Penobscot, Hancock, Washington
- III Somerset, Kennebec, Waldo, Knox, Sagadahoc, Lincoln
- IV Androscoggon, Oxford, Franklin
- V York, Cumberland

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Network Highlights

Behavioral Health Network of Maine

Quality

- Clinical services backed by proven track records of 15 behavioral health organizations, offering over 70 site locations from Kittery to Fort Kent.
- Long-standing relationships with and knowledge of the Maine behavioral health community, assuring the capacity to establish a seamless service system in Maine.

Pledge

- To design behavioral health services to meet the specific needs of our customers.
- To encourage partnerships between the Network and the individuals, families, employers, and payors whom we serve.
- To provide Maine citizens with access to behavioral health services in their own communities.
- To maintain a commitment to effectiveness and efficiency on behalf of those we serve.

Services

- Mental health and substance abuse counseling
- Medication clinics
- Supported housing services
- Child and family services
- Inpatient psychiatric and substance abuse services
- Case management

99 Western Avenue, Augusta, Maine 04330 207-621-6214 207-626-3453 FAX

BHNM Behavioral Health Network of Maine

99 Western Avenue Augusta, Maine 04330 tel 207-621-6214 fax 207-626-3453

The Maine Resource for Maine People

Gordon H. Clark, Jr., M.D., M.Div., F.A.P.A.
Medical Director

Aroostook Mental Health Center *Caribou*
Community Counseling Center *Portland*
Community Health and Counseling Services *Bangor*
Counseling Services, Inc. *Saco*
Crisis and Counseling Center, Inc. *Augusta*
Day One for Youth and Families *Cape Elizabeth*
HealthReach Network *Waterville*
Ingraham *Portland*
Kennebec Valley Mental Health Center *Waterville*
Mid Coast Mental Health Center *Rockland*
Shalom House, Inc. *Portland*
Shoreline Community Mental Health *Brunswick*
Sweetser Children's Services *Saco*
Tri-County Mental Health Services *Lewiston*
Youth and Family Services, Inc. *Skowhegan*

MEMORANDUM

TO: Susan Wygal - Program Services Director - Division of Mental Health

FROM: Wesley R. Davidson - Executive Director

DATE: April 9, 1996

RE: CONSENT DECREE PLAN - CLASS MEMBER ASSESSMENTS

Susan, I'm writing as a follow-up to our meeting yesterday in which we discussed a variety of approaches to the actual development and implementation of a protocol for offering and providing assessments to Class Members. As a result of our meeting, I accepted responsibility for developing an outline of a developmental and implementation task that BHNM would assume responsibility for in partnership with DMH.

The outline format that I have chosen defines: 1) the developmental task; 2) the projected timeframe for its completion; and, 3) identification of BHNM and/or DMH resources that will be allocated to each. I hope this approach responds to your needs as you develop a final response for submission to the Court Master.

Please note that this outline is offered as a refinement to BHNM's original proposal as submitted to DMH on April 4, 1996. This outline reflects our collaboration in an attempt to refine the Department's plan in a manner that will be acceptable to the plaintiffs and the court. The outline represents our best thinking to date. However, it is understood that the specifics of the tasks, timeframes, and resource allocations are subject to revision pending further review and alteration as needed to win acceptance by the court. Given this and recognizing the fluid and uncertain nature of this process at present, it is understood that the specifics of what BHNM will be charged with in the way of responsibility for and the related compensation for its work will be finalized as a part of actual contract negotiation once a plan is finalized and approved by the court.

Please feel free to contact me today in the event that you require any additional information or clarification about the content of the outline presented below:

OFFICE OF
THE GOVERNOR

NO. 7 FY 94/95
DATE January 5, 1995

AN ORDER CONCERNING THE STATE PURCHASES REVIEW COMMITTEE

WHEREAS, the economic condition of the region has significantly reduced State revenues; and

WHEREAS, it is the intention of the Administration to bring the State's budget into structural balance as rapidly as possible;

WHEREAS, it is necessary and prudent to reduce the authorized expenditures of State agencies in the purchase of goods and services, without unreasonably disrupting public services; and

WHEREAS, it is essential that all State agency purchases of goods and services be implemented in as efficient and cost-effective manner as possible, consistent with applicable State and Federal laws and guidelines; and

WHEREAS, administrative review by the expert State procurement agencies and the Governor's Office of all major purchases of goods and services by State agencies is necessary in order to ensure prudent financial and operations management;

NOW, THEREFORE, I, Angus S. King, Jr., Governor of the State of Maine, do hereby order that the State Purchases Review Committee is established for the administrative review and authorization of all major State agency purchases of goods and services, as follows:

The Contract Review Committee shall be composed of the Governor's Chief Operating Officer, or his designee, and the following members of the Department of Administrative and Financial Services: The Director of the Division of Purchases, or his designee, who shall serve as Committee Chairman; the State Budget Officer, or his designee; the State Controller, or his designee. The Director of the Bureau of Information Services, or his designee, shall advise the Committee with respect to contracts related to data processing subject to his authority under 5 M.R.S.A. Chapter 158, Subchapter II.

IT IS FURTHER ORDERED that the Committee shall act upon all State agency requests for proposals, contracts and contract renewals for special services valued at $100,000 or more, as well as any request for grant proposals or grant awards greater than $100,000. Grant awards and special services contracts of less than $100,000 in value may be approved solely by the Director of the Division of Purchases, who is authorized to require additional review by one or more additional Committee members, at the Director's discretion.

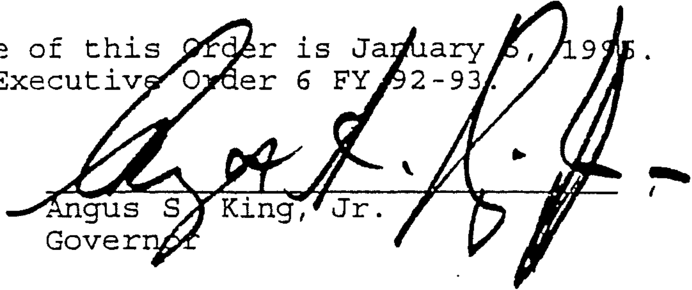
IT IS FURTHER ORDERED that the Committee and the Director of the Division of Purchases shall not approve the award of any grant or contract unless the Committee is satisfied that: (1) the service to be performed under the grant or contract cannot be economically provided by State Government; (2) that the award of the grant or contract is the most economical, effective and appropriate means of fulfilling a demonstrated need; and (3) that the award of the grant or contract will not impair the ability of the department or agency to meet its statutory duties and responsibilities under other State laws.

IT IS FURTHER ORDERED that single source special services contracts be awarded only when the Committee is satisfied that the service needed by the department or agency: (1) is available only from a sole source; (2) is of such narrow scope or ~~constraint~~ that the need can be met satisfactorily only by a single source; (3) is of such compelling urgency that government operations would be seriously impaired by delay inherent in following competitive procedures; or (4) otherwise is the most economical, effective and appropriate means of fulfilling a demonstrated need.

IT IS FURTHER ORDERED that prior to any State agency award of any special services contract or grant to an independent party, the awarding agency must receive the approval of the Purchases Review Committee or the Director of the Division of Purchases, as required by this Order. The awarding agency shall submit all requests for proposal, proposed contracts, contract amendments, related contract bid documents for special services, as well as any requests for grant proposals or grant awards to the Purchases Review Committee for certification of need as well as for documentation of compliance with applicable State and Federal law and financial guidelines. The Committee may, in its sole discretion, require additional information from the agency, reject the contract or grant, or require modification of the contract or grant in order to meet the requirements and objectives this Executive Order.

This Order is not intended to modify the ability of the heads of State agencies to make open market purchases for goods and services valued at less than $1,000 without prior approval, as recommended by the Total Quality Management Pilot Project.

The effective date of this Order is January 5, 1995. This Order supersedes Executive Order 6 FY 92-93.



Angus S. King, Jr.
Governor

DEPARTMENT OF ADMINISTRATIVE & FINANCIAL SERVICES

BUREAU OF GENERAL SERVICES

CHAPTER 120 RULES FOR APPEAL OF CONTRACT AND GRANT AWARDS

Summary: This chapter defines the procedures and criteria to be used in the appeal of contract or grant awards, outlines the appointment of an Appeal Committee, describes procedures to be used in hearing an appeal and how appellants will be notified of final agency action pursuant to 5 M.R.S.A. 1825-(C) (D) (E) (F).

Section 1. DEFINITIONS

1. REQUEST FOR PROPOSAL: Means a document listing the scope of work, requirements of the State and all evaluation criteria for a service needed by the State. This document is also known by the initials "RFP".

2. STATE PURCHASES REVIEW COMMITTEE: Means the committee established by Executive Order which reviews agency documents and actions related to contracts for special services.

3. CONTRACT: Means the agreement between a vendor/provider and the State of Maine, describing the service to be performed, the terms and conditions agreed to by the parties, the cost of the service and how payment will be made.

4. GRANT: Means an agreement between a group, organization or other recipient and the State which describes terms and conditions and scope of performance or action which is expected of the recipient.

5. STAY OF AWARD: Means an order issued by the Director of the Bureau of General Services which halts action on a contract or grant pending an appeal hearing.

6. APPEAL COMMITTEE: Means a committee of three (3) people, two members are appointed by the Commissioner of Administrative & Financial Services and must not have direct or indirect personal, professional or financial conflict of interest in the appeal and cannot be employees of the department affected by the contract. The third member is the Director of the Bureau of General Services or his designee.

7. <u>AGGRIEVED PERSON:</u> Means any person who bids on a contract and who is adversely affected financially, professionally or personally by that contract award decision.

Section 2. APPEALS PROCEDURE

1. STAY: The Director of the Bureau of General Services must insure that aggrieved persons have an opportunity to appeal a contract award decision. An aggrieved person may request a stay of contract award within ten (10) calendar days of notification of contract award by the contracting agency.

A. Requests for stay of contract award must be written and addressed to the Director of the Bureau of General Services and must state clearly the specific nature of the grievance, demonstrate irreparable injury to the petitioner, a reasonable likelihood of success on the merits of the appeal, and no substantial harm to adverse parties or to the general public.

B. The Director of the Bureau of General Services shall notify the petitioner in writing of the decision regarding the issuance of a stay within seven (7) days of receipt of request.

C. Failure of the petitioner, to obtain a stay does not affect the petitioner's right to a hearing of appeal as provided by statute and within these rules.

2. APPEAL: An aggrieved person may request a hearing of award decision from the Director of the Bureau of General Services in writing within fifteen (15) days of notification of contract award. A written request for appeal hearing must contain at a minimum the specific nature of the grievance, including the Appeal Criteria as defined in Section 3 Paragraph B of this rule and must demonstrate the conditions that make the petitioner an aggrieved person. The Director of the Bureau of General Services shall grant an appeal hearing unless it is determined that:

A. The petitioner is not an aggrieved person
B. A prior request by the same petitioner relating to the same contract award has been granted
C. The request was made more than fifteen (15) days after notification of award; or
D. The request is capricious, frivolous or without merit

A hearing will not be granted if the contract award is not approved by the State Purchases Review Committee.

1. NOTIFICATION: The Director of the Bureau of General Services shall notify the petitioner in writing of the decision regarding a request for a hearing of appeal

within fifteen (15) calendar days of receipt of the request. If a request for a hearing is granted, notification must be made at least ten (10) calendar days before the hearing date. The notification must include the date and location of the hearing and the names of the Appeal Committee members.

2. In the event the request for hearing is denied, the notification shall constitute final agency action. The notification shall include an explanation of the petitioners right to judicial review of final agency action under 5 M.R.S.A. 11001 et seq.

Section 3. APPEAL HEARINGS

1. APPEAL COMMITTEE: The Appeal Committee shall consist of three (3) people, two appointed by the Commissioner of Administrative & Financial Services. The third person is the Director of the Division of Purchases or other designee of the Director of the Bureau of General Services. This Committee shall appoint a person to serve as presiding officer over the hearing. This person may be one of the Committee members or any other person who has no direct or indirect personal, professional or financial conflict of interest in the appeal. This person cannot be an employee of any department affected by the contract. The presiding officer, if not from the ranks of the Appeal Committee shall have no vote in the decision but may provide advice, information or research at the request of the Committee.

The presiding officer shall control all aspects of the hearing, rule on points of order, rule on all objections and may question witnesses.

A recording secretary shall be furnished by the Division of Purchases to record by audio tape or other media the hearing of appeal. This person shall be responsible for scheduling additional hearing days and locations at the request of the Appeal Committee.

2. APPEAL CRITERIA: The burden of proof within the hearing of appeal lies with the petitioner. The evidence presented must specifically address and be limited to one or more of the following:

A. Violation of law;
B. Irregularities creating fundamental unfairness; or
C. Arbitrary or capricious award

Evidence of any type that cannot be related to this criteria may be ruled inadmissible by the presiding officer.

In the event multiple appeal hearing requests are granted on a single contract award, the Director of the Bureau of General

Services may assign the Appeal Committee to hear all petitioners within the same hearing as a combined appeal.

3. PARTICIPANTS: The petitioners may participate alone or be presented by Counsel or other agent. The State shall be represented by the contracting agency and/or its Counsel.

Other parties of interest may petition to intervene. Such petition shall be presented in writing to the Director of the Division of Purchases who shall determine and allow or disallow participation in writing within seven (7) calendar days of receipt of the request to intervene. Copies of this notification shall be sent to all Appeal Committee members, the presiding officer, the Appellant and the contracting State agency.

4. PRESENTATION OF EVIDENCE: The petitioner must present evidence to substantiate the specific grievances stated in the appeal. Brief opening statements directed to the Appeal Committee may be made by the petitioner, the contracting State agency and any intervenors, in that order.

A. The petitioner shall present evidence first, using witnesses and exhibits who may be cross examined by the State and the intervenors. Re-direct questioning related to issues raised during cross examination only may be done by the petitioner, followed by re-cross examination by the State and intervenors.

B. Witnesses may be called who can present factual information related directly to the appeal. All witnesses shall be sworn. To expedite the proceeding, testimony of any witness may be pre-filed in written form. If used, pre-filed testimony must be made available to the State, the Appeal Committee, presiding officer and all intervenors on the preceding work day, a minimum of twenty-four (24) hours prior to the hearing. Every such witness shall be subject to cross examination.

C. EXHIBITS: Exhibits relating to any issue of fact in the proceeding may be presented. Documentary evidence may be incorporated into the record by reference when the materials so incorporated are made available for examination by the parties before being received in evidence.

(1) COPIES: petitioner must furnish copies of all documentary evidence to the presiding officer, Appeal Committee, contracting State agency and all intervenors. Any costs associated with this subparagraph are the responsibility of the petitioner and shall not be recovered by any judgement of the Committee.

5. STATE/INTERVENOR EVIDENCE: The contracting State agency and all intervenors shall have the opportunity to submit evidence relevant to the appeal through witnesses and exhibits. The procedures for presenting this evidence are the same as those for the petitioner, substituting the words "contracting State agency" or "intervenor" for petitioner.

A. The order of examination and cross examination when the State presents evidence is state, all intervenors, and the petitioner.

B. The order of the examination and cross examination when an intervenor presents evidence shall be remaining intervenors (if any), the State and the petitioner.

6. SUBPOENA OF WITNESSES: In the event a witness is not willing to voluntarily testify, the Appeal Committee, subject to the approval of the Attorney General, shall issue a subpoena to require attendance, testimony and the production of any evidence relating to any issue of fact in the proceeding.

A. EXPENSES: Any expenses incurred by witnesses called by any party or intervenor shall be sole responsibility of the petitioner and shall not be recovered by any judgement of the Committee.

7. APPEAL COMMITTEE: The Appeal Committee may ask questions for clarification at any point throughout the direct and cross examinations. In addition, the Appeal Committee may ask questions after the direct and cross examination, may request additional witnesses, and may recall any witness for additional questioning.

8. RECORD: All evidence received or considered shall be part of the record. Evidence shall be admitted if it is the kind of evidence upon which reasonable persons are accustomed to rely in the conduct of serious affairs. The presiding officer may exclude irrelevant or unduly repetitious evidence. No sworn written evidence shall be admitted unless the author is available for cross examination or subject to subpoena, except for good cause shown.

Section 4. APPEAL DECISIONS AND ACTIONS

1. APPEAL COMMITTEE DECISION: The Appeal Committee shall consider all evidence entered into the record and shall look for clear and convincing evidence that one or more of the standards set forth in Section 3, subsection B, of these rules has been proven by the petitioner. The actions of the Committee are limited to one of the following:

A. Validate the contract award decision under appeal
B. Invalidate the contract award decision under appeal

A written decision and the reasons that support the decision must be submitted to the Director of the Bureau of General Services within fifteen (15) calendar days following the final day of the hearing of appeal.

2. NOTIFICATION OF FINAL AGENCY ACTION: The Director of the Bureau of General Services shall notify the petitioner, the contracting State agency, and all intervenors of this decision within ten (10) calendar days of receipt from the Appeal Committee. Such notification shall include the decision, an explanation of the reasons for the decision and an explanation of the petitioners right to judicial review of final agency action.

A. This notification is considered final agency action.
B. In the event the decision of the Appeal Committee is to invalidate the contract under these rules, the contract immediately becomes void and of no legal effect.

Effective Date: February 11, 1991

Amended: May 9, 1995

Filing -
FEB 06 1991

18-123 DEPARTMENT OF ADMINISTRATION
BUREAU OF PURCHASES

CHAPTER 110 RULES FOR THE PURCHASE OF SERVICES AND AWARDS

Summary: This chapter outlines the procedures to be used in the purchase of services and the awarding of grants and contracts pursuant to 5 M.R.S.A. 1825-C.

Section 1. DEFINITIONS

A. REQUEST FOR PROPOSAL: Means a document listing the scope of work, requirements of the state and all evaluation criteria for a service needed by the state. This document is also known by the initials "RFP".

B. CONTRACT REVIEW COMMITTEE: Means the committee established by Executive Order which reviews agency documents and actions related to contracts for special services.

C. CONTRACT: Means the agreement between a vendor and the State of Maine, describing the service to be performed, the terms and conditions agreed to by the parties, the cost of the service and how payment will be made.

D. GRANT: Means an agreement between a group organization or other recipient and the state which describes terms and conditions and scope of performance or action which is expected of the recipient.

Section 2. REQUEST FOR PROPOSAL PROCEDURE

A. All contracts issued under the review of the Contract Review Committee which do not qualify as sole source or emergency procurements must be competitively bid using the Request for Proposal.

i. The request for proposal must contain at a minimum a clear definition (scope) of the project, the evaluation criteria and relative scoring weights to be applied, the proposal opening date and time, and agency contact person.

aa. Cost of the contract must be included in the evaluation criteria and must receive a minimum of 25% of the total weight of all criteria.

bb. All proposals shall be opened publicly at the Bureau of Purchases, main office. Proposals received at the Bureau of Purchases main office after the advertised opening time

shall be rejected, unless the advertised opening date and time have been extended by the State Purchasing Agent due to circumstances requiring such an extension of time.

ii. Request for proposals must be submitted to the Contract Review Committee for review prior to release. Review includes, but is not limited to appropriateness of scope and clearly defined evaluation criteria with cost at a minimum of 25%. Agencies will be notified of approval.

iii. Request for proposals must be advertised for a minimum of three consecutive days in the Kennebec Journal of Augusta, allowing a minimum of fifteen (15) calendar days from the final day of advertising to the proposal opening date. This section does not limit advertising in any other publication, trade publication or other media.

aa. Advertisements must include at a minimum a brief description of the service requirements of the state, the name of the department and division issuing the RFP, the name of the contact person and address where copies of the RFP can be obtained, the opening date, the opening time and the opening location: Bureau of Purchases, Room 119 State Office Building, State House Station #9, Augusta, Maine 04333.

iv. Pre-Bidders conferences are allowed, but are not required. These conferences are used to be certain that all bidders have an equal understanding of the state requirements.

aa. Pre-Bidders conferences must be advertised within the RFP advertisement, including location, day and time. Conference must be scheduled a minimum of seven calendar days from the final day of advertising and a minimum of two weeks prior to proposal opening date. The State Purchasing Agent may authorize a pre-bidders conference on shorter notice that has not been advertised in the RFP. The contracting agency shall notify all prospective bidders who requested the RFP of the date and time of the conference under these circumstances.

bb. Conferences must be open to the public, questions raised must be documented in writing and responses must be written and

forwarded to each prospective bidder who received an RFP, whether in attendance or not.

cc. No alterations or changes to any requirement or specification within the original RFP can be made without notifying all bidders in writing a minimum of seven (7) calendar days before opening date.

v. Proposals shall be opened publicly at the Bureau of Purchases or a nearby appropriate facility at the discretion of the Bureau of Purchases. The opening of proposals shall be open to public attendance. The name of the respondent will be read aloud. No other information will be made available prior to evaluation and award notification. All proposals shall be sequestered from this time until notification of award by the contracting agency after which time they become public record.

Proposals received at the Bureau of Purchases later than the date and time specified will not be accepted and will be returned unopened or held at the Bureau to be picked up by the respondent. Late proposals not picked up within seven (7) calendar days will be destroyed.

vi. All opened proposals shall be turned over to the contracting agency's representative after the opening. A written record of the vendor names, date and time received, cost/price and agency representative shall be kept at the Bureau of Purchases.

Section 3. AWARD

a. The contracting agency is responsible for reviewing all RFP's based on the criteria established within the original Request for Proposal document. The agency shall document the scoring, substantive information that supports the scoring, and make the award decision which shall be subject to the Contract Review Committee approval.

i. Interviews/Presentations: Interviews and/or presentations may be considered within the review for information and scoring, if that provision was included within the original RFP documentation.

ii. Pricing/Negotiations: Pricing changes, alterations or negotiations are not allowed prior to the award decision and must not be used in

scoring. Minor negotiations after notice of award are allowed and if agreement cannot be reached, the proposal may be rejected and the award made to the next highest rated bidder who was in compliance with all terms, conditions and requirements.

iii. Documentation: Written records must be kept by each person reviewing or ranking proposals. These records must be made available upon request.

iv. Award: Award must be made to the highest rated proposal which conforms to the requirements of the state as contained in the RFP.

v. Proposed Award Decision Notification: Contracting agency must notify all bidders responding to an RFP of the award decision in writing, postmarked or delivered a minimum of fourteen (14) calendar days prior to contract effective date. This notice must include a statement that the award is conditional pending Contract Review Committee approval.

The award decision, a copy of the award notification to bidders, supporting justification of award, individual and summarized scoring and a minimum of four contracts with the state agency head and vendor authorized original signatures must be sent to the Contract Review Committee for final review and approval a minimum of fourteen (14) calendar days prior to contract effective date.

B: Upon final approval by the Contract Review Committee, the Chairman shall affix an original signature to the contracts, keep one copy, and forward to Accounts and Control for final approval of encumbrance, terms, and account coding. The Controller will keep one copy and the remaining copies shall be returned to the contracting agency for distribution to vendor.

i. Contracts are not considered fully executed and valid before completing final approval of encumbrance. No contract will be approved based on an RFP which has an effective date less than fourteen (14) calendar days after award notification to bidders.

ii. Attorney General approval is not required unless changes have been made to existing boilerplate or at the request of the Contract Review Committee. Nothing within this paragraph

prevents agency requests for Attorney General review of any contract.

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
& SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE J. PEET
COMMISSIONER

WAYNE R. DOUGLAS
ASSOCIATE COMMISSIONER
SYSTEMS OPERATIONS

August 19, 1996

Grete Chandler, President
Behavioral Health Network
Shoreline Community Mental Health Services
19 Middle Street
Brunswick, ME 04011

Dear Grete:

The Department of Mental Health, Mental Retardation and Substance Abuse Services hereby requests Behavioral Health Network recoup from Dr. Gordon Clark an amount of money representing the pro rata share of his monthly stipend attributable to his work in connection with the contract between the Department and Behavioral Health Network involving assessments of class members.

As you know, it is our position that the contract does not violate any conflict of interest laws. Although the Attorney General appears to concur with this view, he has recommended that, to avoid any appearance of a conflict, it may be advisable for Behavioral Health Network to seek recoupment from Dr. Clark.

Accordingly the Department is hereby making that request.

Sincerely,

Wayne R. Douglas
Assoc. Commissioner
Systems Operations

WRD/dg
cc: Melodie J. Peet, Commissioner

PHONE: (207) 287-4290 (Voice) TTY: (207) 287-2000 FAX: (207) 287-4268

9/13/96

Filing Fee $20.00

For Use By The Secretary of State
File No. ....
Fee Paid ....
C. B. ....
Date ....

File No. 19950183ND Pages 14
Fee Paid $ 20.00
DCN 1943321500013 ARTI
------------ FILED ------------
11/28/1994

Gary Cooper
Deputy Secretary of State

A True Copy When Attested By Signature

Deputy Secretary of State

NONPROFIT CORPORATION

STATE OF MAINE

ARTICLES OF INCORPORATION

(CHECK ONLY IF APPLICABLE)

☐ This is a Domestic Condominium Corporation.

Pursuant to 13-B MRSA §403, the undersigned, acting as incorporator(s) of a corporation, adopt(s) the following Articles of Incorporation:

FIRST: The name of the corporation is Behavioral Health Network of Maine, Inc.

SECOND: The corporation is organized for all purposes permitted under Title 13-B, MRSA, or, if not for all such purposes, then for the following purpose or purposes:

(See attached Exhibit A)

THIRD: The name of its Registered Agent and address of registered office (the registered agent must be a Maine resident, whose business office is identical with the registered office; or a corporation, domestic or foreign, profit or nonprofit, having an office identical with such registered office.)

Claudia D. Raessler
(name)

One Portland Square, P.O. Box 586, Portland, Maine 04112-0586
(street address (not P.O. Box), city, state and zip code)

(mailing address if different from above)

FOURTH: The number of directors (not less than 3) constituting the initial board of directors of the corporation, if they have been designated or elected, is n/a.

The minimum number of directors (not less than 3) shall be three (3) and the maximum number of directors shall be nine (9).

FIFTH: Members: ("X" one box only)

☐ There shall be no members.

☒ There shall be one or more classes of members, and the information required by §402 is as follows:

(See attached Exhibit B)

SIXTH: ☒ (Check if this article is to apply)

No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in or intervene in (including the publication or distribution of statements) any political campaign on behalf of any candidate for public office.

SEVENTH: ☐ (Check if this article is to apply. Then *fill in* reference number of *Section 501(c)(?)* in first paragraph below.)

Upon the dissolution of the Corporation or the termination of its activities, the assets of the Corporation remaining after the payment of all its liabilities shall be distributed exclusively to one or more organizations organized and operated exclusively for such purposes as shall then qualify as an exempt organization or organizations under Section 501(c)(______) of the Internal Revenue Code of 1986, as amended, and as a charitable, religious, eleemosynary, benevolent or educational corporation within the meaning of Title 13B, of the Maine Revised Statutes as amended.

No part of the net earnings of the Corporation shall inure to the benefit of any member, director, or officer of the Corporation, or any private individual (except that reasonable compensation may be paid for services rendered to or for the Corporation in carrying out one or more of its purposes), and no member, director, or officer of the Corporation, or any private individual, shall be entitled to share in the distribution of any of the corporate assets on dissolution of the Corporation.

EIGHTH: Other provisions of these articles, if any, including provisions for the regulation of the internal affairs of the corporation, and distribution of assets on dissolution or final liquidation:

(See attached Exhibit C)

Dated: 11-23, 1994

INCORPORATORS	ADDRESSES
ADDITIONAL INCORPORATORS IDENTIFIED IN EXHIBIT D	Shoreline Community Mental Health Services
Grete Chandler (signature)	Street 18 Pleasant Street
Grete Chandler (type or print name)	Brunswick, Maine 04011 (city, state and zip code)
(signature)	Street
(type or print name)	(city, state and zip code)
(signature)	Street
(type or print name)	(city, state and zip code)
(signature)	Street
(type or print name)	(city, state and zip code)
(signature)	Street
(type or print name)	(city, state and zip code)

EXHIBIT A

SECOND: The Corporation is organized and shall at all times be operated as a not for profit organization exclusively for the benefit of; to perform the functions of; or to carry out the purposes of those organizations providing behavioral health services in the State of Maine. The primary activities of the Corporation will be:

(a) to facilitate the provision of and access to a full complement of behavioral health services by qualified health care providers to persons in the community regardless of their ability to pay;

(b) to establish a network of behavioral health providers to provide and enhance the types of health care services available to communities;

(c) to establish uniform and consistent utilization review and quality assurance programs among behavioral health providers so as to eliminate unneeded duplication of services; improve the delivery of consistent and advanced behavioral health services; and facilitate the long range planning of participating providers;

(d) to operate for the support of members offering behavioral health services;

(e) to promote and encourage an informed understanding and utilization of behavioral health services among the general population and particularly among providers of health benefit programs; and

(f) to facilitate the efforts of Network providers so as to improve the educational resources available to members of the community.

In addition, the Corporation shall have such other purposes as are permitted to a corporation organized under Title 13-B of the Maine Revised Statutes Annotated, as amended.

EXHIBIT B

FIFTH: 1. MEMBERSHIP RIGHTS - The Corporation shall not have authority to issue capital stock, and the conditions of membership shall be fixed by the Bylaws and by action of the Board of Trustees.

The rights, powers and responsibilities of the members are as follows:

Each member shall be entitled to cast one vote at annual or special meetings of the members of the Corporation, for the election of the Trustees of the Corporation, and for such other purposes or such other matters as may be prescribed for consideration of the members by these Articles of Incorporation, the Bylaws of the Corporation, amendments thereto, and the laws and statutes of the State of Maine, as from time to time constituted. Members shall not have the right to cumulate their votes. Specifically, the Members shall have the following rights:

A. The establishment of the size of the Board of Trustees within the limits set forth in the Bylaws of this Corporation as they may be amended from time to time;

B. The election of Trustees, with the exception of filling of a vacant Board seat as provided in the Bylaws of this Corporation;

C. The removals of Trustees from the Board of Trustees;

D. The amendment, restatement, or modification of the Articles of Incorporation or the Bylaws of this Corporation;

E. The approval of the sale, lease, or other disposition (excluding by mortgage or pledge for purposes of security) of all, or substantially all, of the assets and property of this Corporation;

F. The dissolution of this Corporation or its merger with or consolidation with another corporation; and

G. Any other matter which a majority of the Board of Trustees voting on the matter votes to submit to the Members.

2. MEMBERSHIP QUALIFICATIONS - Members of this Corporation shall be limited to healthcare providers, which have as one of their functions, the provision of behavioral health services to individuals.

3. AMENDMENTS - These articles and the Corporation's Bylaws may be amended only by a majority vote of all of the members of the Corporation at a meeting called for such purpose or by unanimous written consent vote.

EXHIBIT C

EIGHTH: 1. CORPORATE POWERS - The Corporation shall have, among others, the following powers in furtherance of its corporate purposes:

(a) The Corporation may conduct the businesses and activities authorized to it in such place or places as it may by its Board of Trustees choose and determine, and in that regard to apply for, procure and execute such authorizations, forms, documents and writings, and to pay such fees or charges, as may be necessary under the applicable law of any jurisdiction to the conduct of the Corporation's business therein.

(b) The Corporation may purchase, receive or take by grant, gift, devise, bequest or otherwise, lease, or otherwise acquire, own, hold, improve, employ, use and otherwise deal in and with, real or personal property, or any interest therein, wherever situated, in an unlimited amount, but consistent with its charitable purposes.

(c) The Corporation may solicit and receive contributions from any and all sources and may receive and hold, in trust or otherwise, funds received by gift or bequest.

(d) The Corporation may sell, convey, lease, exchange, transfer or otherwise dispose of, or mortgage, pledge, encumber or create a security interest in, all or any of its real or personal property, or any interest therein, wherever situated.

EXHIBIT C

EIGHTH: 1. CORPORATE POWERS - The Corporation shall have, among others, the following powers in furtherance of its corporate purposes:

(a) The Corporation may conduct the businesses and activities authorized to it in such place or places as it may by its Board of Trustees choose and determine, and in that regard to apply for, procure and execute such authorizations, forms, documents and writings, and to pay such fees or charges, as may be necessary under the applicable law of any jurisdiction to the conduct of the Corporation's business therein.

(b) The Corporation may purchase, receive or take by grant, gift, devise, bequest or otherwise, lease, or otherwise acquire, own, hold, improve, employ, use and otherwise deal in and with, real or personal property, or any interest therein, wherever situated, in an unlimited amount, but consistent with its charitable purposes.

(c) The Corporation may solicit and receive contributions from any and all sources and may receive and hold, in trust or otherwise, funds received by gift or bequest.

(d) The Corporation may sell, convey, lease, exchange, transfer or otherwise dispose of, or mortgage, pledge, encumber or create a security interest in, all or any of its real or personal property, or any interest therein, wherever situated.

(e) The Corporation may purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise deal in and with, bonds and other obligations, shares, or other securities or interests issued by others, whether engaged in similar or different business, governmental, or other activities.

(f) The Corporation may make contracts, give guarantees and incur liabilities, borrow money at such rates of interest as the Corporation may determine, issue its notes, bonds and other obligations, and secure any of its obligations by mortgage, pledge or encumbrance of, or security interest in, all or any of its property or any interest therein, wherever situated.

(g) The Corporation may lend money, invest and reinvest its funds, and take and hold real and personal property as security for the payment of funds so loaned or invested.

(h) The Corporation may make donations in such amounts as the members or Trustees shall determine, irrespective of corporate benefit, for the public welfare or for community fund, hospital, charitable, religious, educational, scientific, civic, or similar purposes, and in time of war or other national emergency in aid thereof; provided that it shall make no contribution for other than religious, charitable, scientific, testing for public safety, literary or educational

purposes or for the prevention of cruelty to children and animals.

(i) The Corporation may pay pensions and establish and carry out pension, retirement and benefit plans, trusts and provisions for any or all of its employees, and may provide insurance for its benefit on the life of any of its employees.

(j) The Corporation may indemnify and reimburse officers, Trustees, employees and agents of the Corporation for such costs, expenses and liabilities, including reasonable attorneys' fees, as may be sustained by such indemnified parties as a consequence of their relationship with the Corporation; provided, however, that the person to be indemnified shall not have been finally adjudged by a court or agency of competent jurisdiction not to have acted in good faith and with the reasonable belief that his action or failure to act was in, or not opposed to, the best interests of the Corporation.

(k) No part of the assets of the Corporation and no part of any net earnings of the Corporation shall be divided among or inure to the benefit of any member, officer or Trustee of the Corporation or any private individual or be appropriated for any purposes other than the purposes of the Corporation as herein set forth; provided that such assets or earnings may be divided among or inure to the benefit of those nonprofit,

charitable organizations which are members of this Corporation, or their successor non-profit corporations, while such corporations remain exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code; and no substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation except to the extent that the Corporation makes expenditures for purposes of influencing legislation in conformity with the requirements of Section 501(h) of the Internal Revenue Code; and the Corporation shall not participate in, or intervene in (including the publishing or distributing of statements) any political campaign on behalf of any candidate for public office.

(1) The Corporation shall have and may exercise all powers necessary or convenient to effect any or all of the purposes for which the Corporation is formed; provided that no such power shall be exercised in a manner inconsistent with the laws of the State of Maine; and provided, further, that the Corporation shall not engage in any activity or exercise any power which would deprive it of any exemption from federal income tax which the Corporation has or may receive under the Internal Revenue Code.

2. DISTRIBUTION OF ASSETS - Upon the liquidation or dissolution of this Corporation, after payment of all of the

liabilities of the Corporation or due provision therefor, all of the assets of the Corporation shall be disposed of in such proportion as the Board of Trustees may designate to each member of the Corporation then exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code or if no member of the Corporation is then so exempt, to one or more organizations in the State of Maine exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code as the Board of Trustees may designate.

3. AMENDMENTS - These articles and the Corporation's Bylaws may be amended only by a majority vote of all of the members of the Corporation at a meeting called for such purpose or by unanimous written consent vote.

[ATY.DLG.D99990]BHN.EXH

ARTICLE IX - INCORPORATORS

Signatures and post office address of each of the persons associating together to form the corporation.

Signatures and Names	P.O. Address
Grete Chandler Signature	Shoreline Community Mental Health Services Street
GRETE CHANDLER Name	18 Pleasant St Brunswick Me Name
Signature	Street
HENRY NIELSEN ~~NEILSON~~ Name	Community Counseling Center Name
Henry Nielsen Signature	343 Forest Ave, Portland, Me 04101 Street
CARL PENDLETON Name	Sweetser Childrens Services Name
Carl Pendleton Signature	50 Moody St Saco, Me 04072 Street
Joseph C Brannigan Name	Shalom House Inc Name
Joseph C Brannigan Signature	One PostOffice Sq. Portland Me. 04112 Street
Jane Morrison Name	Ingraham Name

CDR.D99990JBHN.ME-ARTICLES-INCORP

Jane Morrison
Signature

247 Oxford St
Street Portland, ME 04104

Lynn F. Duby
Name

The Crisis and Counseling Centers
Name

Lynn F. Duby
Signature

99 Western Avenue, Augusta, Me. 04330
Street

Wesley R. Davidson
Name

Aroostook Mental Health Center
Name

Wesley R. Davidson
Signature

P.O. Box 1018, One Vaughn Place, Caribou, ME 04736
Street

[illegible signature]
Name

Signature

Jackson Brook Institute
Name

175 Running Hill Rd
So. Portland, ME 04106
Street

J. Gregory Shea
Name

Tri County Mental Health Services
Name

J. Gregory Shea
Signature

PO Box 2008, 1155 Lisbon St. Lewiston, ME 04241-2008
Street

Ronald P. Hebert
Name

Youth & Family Services, Inc
Name

[illegible signature]
Signature

Po Box 502, Rt 201, Skowhegan, Me 04976
Street

[illegible signature]
Name

Counseling Services, Inc., Saco
Name

[signature]
Signature

David J. Faulkner
Name

Julianne Edmondson
Signature

Name

Signature

Name

Signature

Name

Signature

Name

Signature

Name

PO Box 231, Cape Elizabeth, ME 04107
Street

Drug Rehabilitation, Inc.
Name

Mid Coast Mental Health Center
12 Union Street, Rockland, ME 04841
Street

Name

Street

Name

Street

Name

Street

Name

Street

Name

BEHAVIORAL HEALTH NETWORK OF MAINE
As of 9/6/96

Network	Total Number of Cases	Number of Contacts	Completed Assessments	Scheduled Assessments	Declined	Deceased	Out of State	Unable to Locate
Aroostook	31	31	12	0	6	0	2	11
Northeast	146	146	92	0	15	1	7	31
Ken-Som	607	585	302	33	118	11	17	104
Coastal	367	362	185	4	74	3	17	79
Tri-County	513	486	248	23	93	6	21	95
Cumberland	740	706	302	11	164	8	19	202
York	315	259	129	0	41	3	14	72
TOTALS	2,719	2,575	1,270	71	511	32	97	594

BEHAVIORAL HEALTH NETWORK OF MAINE
As of 9/13/96

Network	Total Number of Cases	Number of Contacts	Completed Assessments	Scheduled Assessments	Declined	Deceased	Out of State	Unable to Locate
Aroostook	31	31	12	0	6	0	2	11
Northeast	148	147	94	0	17	1	6	29
Ken-Som	610	602	325	16	124	12	17	108
Coastal	368	367	196	0	77	3	17	74
Tri-County	516	497	265	13	95	7	21	96
Cumberland	739	737	314	4	182	9	19	209
York	319	259	160	0	52	4	14	89
TOTALS	2,731	2,640	1,366	33	553	36	96	616