MAINE COMMISSION ON MENTAL HEALTH

FIRST ANNUAL REPORT
FEBRUARY 1990

Maine Commission on

Mental Health

First Annual Report

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EXECUTIVE SUMMARY

During the past year, the Commission has identified several ongoing problems at the State's mental health institutes. These include problems caused by professional staff shortages, physical plant limitations, and others identified in the body of the report. The Commission believes that resolution can only be achieved by further decreasing the institutional population. Due to Maine's egregious lack of crisis, residential, vocational and other supportive services in the community, a major expansion of our community system is needed to accomplish this in a way that is humane and appropriately supportive of persons with severe and prolonged mental illness. Therefore, the Maine Commission on Mental Health makes the following recommendations:

- that, as a step toward promoting a community based system, Maine's contracts with community providers designate a community provider to have coordinating clinical responsibility for persons with mental illness in its area, wherever they are in the system; that the coordinating agency be responsible for following the person through the system, including attending treatment team conferences at the institutes; that the coordinating agency control access to in-patient psychiatric services for these persons and that the Bureau of Mental Health explore, as other states have done, establishing fiscal incentives to discourage inappropriate admissions to the institutes, as mutually defined and agreed upon by the Department and agencies, within the limits of available services;

- that the Department establish as a priority the development of a sufficient number of crisis stabilization beds throughout the state for those individuals who can be served in that setting in their communities (in contrast to Maine, New Hampshire has 650 crisis beds and only 140 adult state psychiatric beds);

- that the Department work with community hospitals to establish more involuntary beds around the state and work with the Department of Human Services and the Maine Health Care Finance Commission to establish fiscal incentives, as well as explore possible changes in the certificate of need process to leverage this development;

- that the Administration and Legislature establish as a priority the development of residential and vocational alternatives to enable persons with mental illness to be productive members of their communities; that respite care services be developed to assist the families of these individuals, who are responsible for the greatest portion of their care; that the problems at the Bureau of Rehabilitation be resolved, to enable supported employment programs to continue to grow.

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This is the annual report of the Maine Commission on Mental Health, presented pursuant to 34-B M.R.S.A. 3903, which reads:

By February 1, 1990 and each year thereafter, the commission shall present a report to the Legislature and the commissioner assessing the State's implementation of and compliance with the community and institutional standards and evaluating the state mental health institutes. The report shall set out the standards, the degree of compliance with the standards, identify any areas of noncompliance and suggest a plan of correction.

Due to the fact that the State has not yet completed the processes of development and implementation of standards for the mental health system, this report will focus upon the following areas:

A description of the STANDARDS DEVELOPMENT PROCESS to date, as well as the current plans and schedule for completion of this process.

An assessment of the Department of Mental Health and Mental Retardation's enforcement of and COMMUNITY PROVIDERS' compliance with the existing Regulations for Licensing Mental Health Facilities.

An assessment of the compliance of the STATE MENTAL HEALTH INSTITUTES with existing standards (state licensing, Medicare and Joint Commission on Accreditation of Healthcare Organization) as well as the current assessment and recommendations of the subcommittee on institutes of the Commission.

The Commission wishes to point out that, while this report is mostly concerned with adult mental health services, it very strongly supports the goals of the Bureau of Children With Special Needs, as reflected in Maine's Plan for Children's Mental Health Services.

STANDARDS DEVELOPMENT PROCESS

The process of development of standards of care for the mental health system is now in its second year, having undergone significant changes in the fall of 1989. This section will provide an overview of the original process, the changes in that process and the current plans and schedule for development and implementation of standards.

The development of standards began in late 1988, led by a consultant hired by the Department of Mental Health and Mental Retardation. The original concept was that there would be three levels of standards. The Level 1 standards would delineate the values, conceptual underpinnings and requirements of a mental health system. The Level 2 standards begin to define a system of services and supports that meets the requirements set out in Level 1 standards. The Level 3 standards would be program and service standards, based upon the goals set forth in Levels 1 and 2.

After the Level 1 standards were published by the Department, two meetings were held on March 10 and 17 with the goal of developing the Level 2 standards. This stage of the process was completed with a series of approximately eight all day meetings held in June to develop the Level 3 standards, attended by a small number of departmental staff and individuals with interest in the specific program areas under discussion. This culminated in the published Draft 2.2 of the Mental Health Standards, submitted to the Commission and the Human Resources Committee of the Legislature in July, 1989.

The Commission, in a response forwarded to the Department in October, expressed several serious concerns regarding the draft standards. Among them were the following:

- that the ideal system defined in the draft would create several questions in an underfunded community system, among them how service priorities would be established and whether or not the agencies would be punished for failing to meet standards due to a lack of resources.

- that the standards were immeasurable and inexact, with frequent use of terms subject to individual judgement, such as "appropriate".

- that the standards appeared to be more driven by system and agency concerns than by consumer self-determination, creating possible infringements of individual rights.

- that the two state mental health institutes were only marginally addressed by the standards.

Partially as a result of this response and the concerns of others both in and out of the Department, the departmental leadership of the process was changed in November and a new process instituted. The development of the standards would now be driven by a steering committee, composed of the quality assurance committee of the Commission and several Department staff. This process would be led by Chris Bliersbach, director of the Department's Division of Quality Assurance.

The first phase of this effort involves a massive revision of Draft 2.2 of the standards. The only section of the draft retained was the standards themselves, with the indicators, monitors and controls replaced with new, more measureable indicators, licensing standards and quality assurance standards. The intent is to establish minimum performance standards for the providers to meet, develop higher standards to measure performance against and drive ongoing improvement in the system and, in the process, incorporate the existing licensing standards. To date, the committee has agreed upon the deletion of approximately 60% of the original standards and is in the process of a major revision of those that were retained. Once this is complete and the "generic" standards, which apply to all programs, are agreed upon, several work groups will be developed to establish program specific standards. Among the programs to be addressed will be outpatient, in-patient, rehabilitation, medication management, residential, case management, home-based and crisis/emergency services.

The proposed schedule for this process is as follows:

November - March 1990: Complete the initial revisions of the draft standards and identify and recruit the work groups.

March - August 1990: Work groups complete drafts of program standards and protocols for implementation are developed.

September - January 1991: Field review is conducted, responses reviewed, revisions made based upon responses and appropriate documents prepared for public hearing.

February - June 1991: Hearings held and preparations made for implementation.

July 1991: Implementation of standards.

The date of implementations is the same as that originally proposed by the Department in Draft 2.2. It is anticipated that, through quality assurance and licensing reviews as well as other forms of feedback, the standards will undergo intermittent revisions to insure maximum effectiveness.

COMMUNITY PROVIDERS

Community providers are currently held accountable to the Regulations for Licensing Mental Health Facilities. These are limited, general regulations, aimed at providing guarantees to consumers of services by establishing baselines to be met in the areas of organization and administration, physical plant, location, safety and health, personnel management, including supervision, training and development, client management, including medications and client records, client rights and professional qualifications. These regulations are rather basic and do not address the issues of quality of care and practice that are being dealt with in the development of standards.

In review of this process, the Commission has identified several issues that it feels need to be addressed. The most pressing problems involve the Department of Mental Health and Mental Retardation's enforcement of the licensure regulations. 34-B M.S.R.A. 3606.5. reads:

Monitoring for compliance. Regardless of the term of the license, the commissioner shall monitor the licensee, at least once a year, for continued compliance with applicable laws and rules.

Due to the fact that the Director of Licensing is the only individual in the Department responsible for licensing activities, licensure surveys are currently being conducted on an approximately biennial basis. As a result, the Department is meeting neither the letter nor the intent of this statutory requirement.

This lack of staff inhibits the Department's enforcement of the licensure regulations in other ways. After completion of a survey, the Department issues a report of the findings of the survey including, if applicable, deficiencies identified and conditions for continued licensure. However, a plan of correction is not requested from the provider, nor are follow-up visits conducted, due to the personnel that would be needed to perform these additional activities. These are usual functions of a licensure agency, which would also include evaluation of the plan of correction and possible return of the plan to the provider for clarification and changes, provision of assistance to the provider in meeting regulatory requirements and ongoing post-survey visits, as needed, to insure that compliance is achieved. The purpose of all of these functions is for the licensing body to be able to provide assurances to the public that certain performance and management standards are being met.

Although the issuance of a license implies this assurance, the Department cannot, in reality, offer it. A recent review of the status of those agencies licensed by the Department found over 25% on either a conditional or provisional license. While the violations identified during the survey were serious enough to result in a modification of the provider's license, the Division to Licensing was placed in a position in which performing appropriate and needed monitoring of these providers would have reduced time for other licensure activities and dramatically lowered the number of providers surveyed.

An issue that relates to this is the section of the regulations that applies them either upon the basis of the agency's functions or upon the receipt of funds from the Department. Especially with the prospect of the promulgation of standards that will be applied to the entire system, the issue of who exactly will be subject to Departmental standards or regulations is one that will have to be resolved before long.

In the absence of effective oversight, the last line of protection for the public is the provider's quality assurance program. While the Joint Commission on Accreditation of Healthcare Organizations recommends devoting 1-3% of an agency's operating budget to quality assurance, a recent survey of 31 licensed mental health agencies found that 16, or 52%, spend less than 1% on quality assurance, raising serious questions about their abilities to insure quality care. Additionally, the Department of Mental Health and Mental Retardation spends .24%, or less than one quarter of one percent on quality assurance activities.

Unless these problems are resolved, the development of standards could prove to be an exercise in futility, as the Department lacks the capacity to enforce them according to their design. As a result, the Commission recommends the following:

- that the Division of Quality Assurance be provided with sufficient quality assurance and licensing staff to perform the activities necessary to insure quality of care to the public and that the staff needs be reviewed once the standards are in place to insure the capacity for implementation.

- that the budgets of providers contracting with the Department be supplemented to allow for quality assurance activities to be ade quately performed both to provide necessary assurances to the public and to allow them to meet the additional requirements which will result from the promulgation of standards of care.

STATE MENTAL HEALTH INSTITUTES

The Augusta and Bangor Mental Health Institutes are currently held accountable to three sets of standards: the two Medicare special conditions for psychiatric hospitals, the Joint Commission on Accreditation of Healthcare Organizations standards and, as of 1989, state hospital licensure standards.

AUGUSTA MENTAL HEALTH INSTITUTE

The Augusta Mental Health Institute (AMHI) was decertified for Medicare reimbursement by the Health Care Financing Administration in May, 1988 and remains decertified. In order to be recertified, AMHI will have to complete a survey without deficiencies and remain in compliance for 90 days. Thus, AMHI is likely to remain decertified until at least mid-1990.

AMHI was surveyed by the Department of Human Services in October, 1989 under state hospital licensure regulations and granted a conditional license due to a "serious and substantial failure to comply with the provisions of the regulations."

Among the 30 conditions attached to AMHI's license are:

- development of a complete admissions policy within 90 days;
- adherence to established unit bed capacities for the Stone building which total 208 beds;
- several conditions relating to physical environment upgrading, waste disposal and plant maintenance;
- provision of adequate security for staff, patients and visitors;
- several conditions requiring correction of nursing staffing deficiencies, including inappropriate usage of licensed staff, lack of professional nurse availability on a 24 hour basis, insufficient ratio of RN's to patients and other nursing staff to insure proper supervision and a therapeutic milieu and lack of RN coverage on 120 of 378 shifts during a two week period;
- development of orientation and inservice education programs addressing the therapeutic milieu for direct care personnel;
- filling of physician vacancies within one year and reassessment of physician to patient ratios;

- correction of medical record deficiencies, including unqualified supervisors and lack of functional systems to abstract data and identify deficiencies and

- insuring that all needed social work interventions are carried out and documented.

An appropriate plan of correction has been submitted, but staffing deficiencies will be extremely difficult to correct, with an RN vacancy rate running upwards of 50% and the ongoing problems in recruiting physicians.

AMHI has received a three year reaccreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) with multiple contingencies, many of which will be reassessed for compliance in a focused survey to be conducted in the spring of 1990. The areas to be addressed in the focused survey will be nursing process, nursing direction and staffing, monitoring and evaluation of nursing services, infection control, monitoring and evaluation of dietetic services, monitoring and evaluation of social work services, clinical privileges, monitoring and evaluation of medical staff/department care, medical record review, pharmacy and therapeutics review, evidence of action taken in the quality assurance program, monitoring and evaluation of emergency services, monitoring and evaluation of radiology services, and use of quality assurance results in competence appraisal/clinical privileges.

The findings of the JCAHO survey were not dissimilar to the state licensure survey, again leaving AMHI in jeopardy regarding deficiencies resulting from staffing problems and vacancies. The pivotal nature of quality assurance to the JCAHO survey process creates another area of jeopardy to AMHI, due to the recent resignation of the institute's director of quality assurance. Finally, the instability and lack of leadership created by the frequent changes of superintendent result in poor environment in which to undertake actions of the magnitude required by the findings of the two surveys.

While there have been gains at AMHI in the past year, the Commission's subcommittee on institutes has identified serious continuing problems at the institute. The gains have come in several areas. AMHI has benefited from the work of Health Consortium, Inc., particularly the reorganization plan. What has been a byzantine and unworkable organizational structure has been replaced by a design that lends itself more readily to good management. The consortium also provided good blueprints for upgrading of several areas of patient care and hospital management. Additionally, improvement has been noted in basic, custodial patient care, due to the appropriation of funds for additional staff and the recent limitation of admissions. Finally, there have been physical plant improvements, most notably the provision of air conditioning in patient areas.

Problems continue to be noted in several areas. The very high nursing vacancy rate and difficulties in recruiting physicians create concerns about the quality of treatment provided. These staff shortages raise questions as to whether or not there are sufficient staff to appropriately identify and treat patients' medical and psychiatric problems and if, given staffing levels, appropriate supervision and support can be provided to direct care staff. The treatment planning process also has to be called into question in light of these staff shortages. With a 50% nursing vacancy rate it is doubtful that sufficient staff time is available to be devoted to the development and implementation of effective and appropriate treatment plans.

While the new organization plan has been implemented and top management of the institute has undergone changes, middle management remains essentially unchanged, as do the staff concerns about lack of communication and support identified in the subcommittee's May report on AMHI. Additionally, there appears to have been limited progress in the development and implementation of a system of clear expectations of and accountability for staff.

AMHI has implemented the Adult Patient Transfer Agreeement, effective January 8, 1990. While this appears to have had an immediate effect on patient census by limiting admissions to those people appropriate for admission to AMHI, the Commission believes that it is crucial that a tracking system be established for those patients denied admission under the protocol. As admissions have been curtailed without the development of new services, it is encumbent upon all concerned to be sure that these people are being appropriately treated and not simply being shifted to a setting in which they are being further underserved due to a lack of resources.

Finally, the issue of leadership at AMHI must be addressed. This has been constantly cited in the past year as a key to any significant improvements at the institute. Given that there are circumstances beyond the Department's control, such as William Meyer's recent departure, AMHI currently faces its sixth superintendent in slightly more than one year. Constantly being in the process of change has a negative impact on staff morale and sense of direction, as well as the faith of staff that an effective plan for the institute to repair itself can be developed and committed to. Establishment of leadership and direction has to be the highest priority for the Department in addressing the problems at AMHI.

BANGOR MENTAL HEALTH INSTITUTE

Bangor Mental Health Institute (BMHI) was surveyed in September, 1989, by the Department of Human Services under state hospital licensure regulations and granted a conditional license due to the "serious and substantial failure of BMHI to comply with the provisions of the regulations." Among the 12 conditions attached to BMHI's license are:

- definition of all of the components of the professional nursing organization structure, in accordance with state regulations, within 60 days;

- defining the distinct role of the professional nurse within one year;

- defining a ratio of licensed nursing personnel to mental health workers in order to insure that all patient medical and psychiatric needs are met, within 120 days;

- ensuring that there are enough registered nurses to perform and document needed nursing functions and enough licensed nursing staff to meet the acuity of patient needs, within one year;

- ensuring that the orientation of all direct care workers focuses on psychiatric principles, therapeutic intervention, assessment and evaluation skills;

- ensuring that patients are only admitted on the recommendation of a physician;

- ensuring that, within one year, physician staffing is sufficient to provide for all medical and psychiatric needs of patients, full interdisciplinary team involvement and timely documentation;

- ensuring an adequate number of maintenance personnel to meet all health and safety need of patients, within one year and

- ensuring that safety, welfare and privacy of all patients is observed by providing a minimum floor space of 65 square feet per patient within 150 days.

An appropriate plan of correction has been submitted, but there will be several obstacles to its implementation, including approval of the 8 R.N. and 7 maintenance positions requested, as well as the ongoing difficulties in recruiting physicians to work at the state hospitals.

BMHI currently has a contingency on its accreditation status from JCAHO. A focused survey will be conducted, most likely in early spring, 1990, which, if substantial compliance is not found, could adversely affect BMHI's accreditation status. The areas to be addressed in the focused survey will be nursing direction and staffing, monitoring and evaluation of nursing services, appointment and reappointment of medical staff, clinical privileges, monitoring and evaluation of medical staff/department care, pharmacy and therapeutics review, and monitoring and evaluation of pathology and medical laboratory services and radiology services. Substantial compliance was noted in several areas, including infection control, nursing process, medical record review, patient rights, direction and staffing of clinical services and the rehabilitation services and program.

The findings were not dissimilar to the state licensure and obstacles to compliance are similar, primarily in the areas of staffing levels. Finally, BMHI was found to have sufficiently corrected deficiencies in the survey of D-1, the admissions unit, to merit medicare recertification.

The subcommittee on institutes held a series of meetings with BMHI staff in December, 1989. Almost 50 staff spoke with the subcommittee, including professional, supervisory and direct care staff, as well as housekeeping and maintenance personnel.

The predominant theme that ran through these meetings was that poor communication between management and supervisors and direct care staff is having an adverse effect on staff morale and patient care. The message was conveyed to the subcommittee that direct care staff do not believe that their concerns are taken into account when staffing and management decisions are made, nor are these decisions effectively communicated and explained. Staff from most units also felt that their knowledge of and efforts on behalf of patients are not taken into account nor given credence in the treatment planning process. It is felt that there is little positive feedback provided to direct care workers, with an inordinate emphasis on the finding and pointing out of errors. All persons with whom we spoke agreed that communication is poor and morale has been adversely affected. One result of this appears to be a high incidence of direct care workers calling in sick, which results in people being pulled to work on units with which they are neither familiar nor comfortable, inevitably affecting the quality of patient care.

One particular example of the effect of an administrative decision on staff was repeatedly pointed out to the subcommittee. Multiple nursing and housekeeping staff complained that, since housekeeping duties were changed from unit based to functional assignments, the level of cleanliness has fallen off and housekeeping staff have become increasingly unhappy.

The subcommittee was struck by the amount of energy being invested in staff complaining about each other, work assignments and the lack of cleanliness on units, apparently as a result of this decision. In every unit that we visited in the Pooler Pavilion, at least one staff member pointed out how the unit is no longer as clean as it once was. Irrespective of the level of correctness of the administrative decision, it has had a negative impact and appears to have had a negative outcome on the units.

The subcommittee believes that what is needed is an initiative by the management to open up communications with direct care and other line workers. Key to this would be greater visibility of management and supervisory staff on units, the discussion and consideration of line worker issues and greater explanation of managerial decisions, in order to increase the investment of line workers in carrying out these decisions. We wish to point out that we are not advocating that the administrative and medical staffs abdicate their appropriate and ultimate responsibilites, nor, for that matter, did the staff with which we spoke. Rather, the direct care and line staff need to feel that their concerns and opinions, which are often based upon the greatest amount of time spent with patients, are being considered and taken into account. For these staff members not to feel this adversely affects their morale and, ultimately patient care.