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State of Maine

Human Resources Committee

AMHI HEARINGS

Room 228 Jan. 26th, 1989

State House

Good morning, welcome to the morning session Committee Meeting on Human Resources, my name is Paul Gauvreau and I serve as Senate chair and on my left is Senator Peter Manning who serves as House chair of the committee. The purpose of hearings today is an educational one to afford the committee members an opportunity to learn the (command) nature of the problems that beset our mental health system in general with particular focus on the system at the Augusta Mental Health Institute and at the sister Bangor, Bangor Mental Health Institute. The purpose of the hearings today is for the committee to gain a better understanding of the problems which are present in our mental health system so that we can fashion appropriate (appropriations) to the legislature as far as any plan of correction for any particular __________ we might feel appropriate. We have for todays session requested that three individuals, Susan Parker, AMHI Superintendent Deutmiller and the present acting administrator of that facility, Dr. Walter Rohm. The committee will determine whether or not additional individuals will be asked to make presentations to the committee at the close of this afternoon today's proceedings. I would like to introduce the members of the committee starting at my far right. Representative Mary Cathcart of Orono. Seated to her left would be Rep. Christine Burke of Vassalboro and then Rep. Peggy Pendleton of Scarborough and to her left is Jean Dellert of Gardiner, Senator Ed Randall to my right is Senator Bonnie Titcomb of Cumberland County and Portland and Rep. Edward ________ Bangor to his left and Rep. Michael ________ is seated to his left.

At this point the Committee is please to welcome Commissioner Susan Parker, whom I understand will make a prepared statement

to the committee. At the close of her presentation you will be invited to ask questions.

SP: Thank you very much Sen. Gauvreau. Good morning Sen. Gauvreau, Rep. Manning and members of the committee. I am Susan Parker, Commissioner of Mental Health and Mental Retardation. I am very pleased to meet with you this morning to discuss the situation at AMHI. Alot of things have happened at AMHI since my arrival in July of 1987. These events have painted a grim picture of a very troubled mental health insitution. First there was an investigation by the Commission on Overcrowding between Sept. and Dec. of 1987, which did in fact reveal serious problems of patient care as a result of a chronic overcrowding or understaffing. Then there was the failed effort to retain Medicare certification between Feb. and May of last year. There were patient deaths during the summer of 1988 and then a follow-up investigation into patient care practices within the institution and lastely an on-going assessment of patient care by the department of Human Services for 47 of their wards under the care of adult protective services. The fact is that history has finally caught up with us. We are here this morning to discuss with you how we got into this serious situation but we're also here to discuss with you how we intend to get out of it. The following is an anecdote which illustrates to me a grim but a very real solution to the sad situation. When I came back to Maine in July of 1987 to take this job I was told that in 1984 the mental safety net that was constructed over the bridge that connects the two parts of Augusta, separated by the Kennebec River, was constructed at least in part because AMHI patients were jumping to their deaths. That was a real indicator to me that something was exceedingly wrong. The census had been cut

in half at AMHI since 1973 under the social policy that swept the country called deinstitutionalization. This happened despite the fact that communities resources were very inadequate for people with mental illness not to mention their families. Problems became worse during the late 70's and the 1980 because a comprehensive plan for the delivery of comprehensive services had never been developed. When you look at it, people with mental health and mental illness problems haven't had much choice all these years except to return to the institutions and it doesn't surprise me one whit that many were desperate enough to jump off the bridge. Think about their families. But obviously the metal safety net can't be the only solution.

Nancy, could we have the first chart.

The chart that will immediately rest on the easel here will illustrate the actually the staff to patient ratio at AMHI and it will show what has happened since fiscal year 1980. This will illustrate quite clearly that the lack of planned community services has had it's impact on AMHI. Since 1984 AMHI has been adding nearly 2 patients per month to it's base population. At the close of fiscal year 1988 the facility admitted an all time record number of people, that of 1477. Between 1980 and the spring of 1987 despite the influx of patients to AMHI a total of 17 staff were added to the facility. Quite obviously the staff/patient ratio has fallen steadily over a 5 year period. My arrival here in July of 1987 coincided with the 8th Medicare visit in 4 1/2 years in which officials either warned the administration that AMHI problems needed to be fixed or the facility would fail in its certification until corrective action was taken. I would also

+96 people

+17 staff

like to point out that at the same time the sister institution up in Bangor was also experiencing its problems. The resources at BMHI have been severly strained. Among other problems a month prior to my arrival long standing management difficulties erupted into extreme employee dissatisfaction that was about to result in an employee who was about to suffer a reprimand. Diciplinary action I think it was called. The protest that occurred at BMHI needed to have immediate attention from the central office the department. We provided that. Fortunately we have succeeded in making some high level management changes in March of 1988 which have helped to eleviate the strain on the Bangor Mental Health Institute.

And now I would like to move on to another topic. Specifically the State Mental Helath Plan and the investigation into the overcrowding situation. Alot has been said over the last couple of weeks about the administration not providing information to the legislature. I am really disturbed by that. I would like to describe what we've been doing over the last year and a half and I think once you have heard what I've had to say you will agree that we have, in fact, collaborated with the legislature regarding the situation at AMHI. The 113th legislature understood that there was no comprehensive plan in Maine nor was there adequate understanding of the conditions at AMHI and BMHI. Two pieces of legislation were passed. The first mandated that the State Department of Mental Health and Mental Retardation should put together a state plan. Secondly, the 113th legislature established a commission to study overcrowding. These two events occured just prior to my arrival. When I took office I knew that we had serious problems in the Mental Health field and that the both the planning effort and the study of the institutions required

urgent attention. Just to give you an illustration of the degree to which these two items assumed priority status in my administration, let me also tell you that this department must oversee the Pineland down in Pownal, the Military and Navel Children's home in Bath, the Aroostook Residential Center up in the north, the Elizabeth Levinson Center in Bangor as well as BMHI. Those 6 institutions or facilities as we sometimes call them, combined with the community programs within the Bureau of Mental Retardation, Mental Health and Bureau of Children with Special Needs combine to give us alot of issues to deal with on a daily basis. Because mental health was such a priority in my administration some of these other situations have really assumed a, not a secondary status, but not the highest of the high priorities that we have with mental health. Nevertheless, senior staff, that is, 10 different individuals I call senior staff within the department were mobilized and I appointed several people to work with me to participate in the commission to study overcrowding. We committed significant time and resources to participate beginning Sept. of 1987. The members to the commission were the Commissioner, the Director of the Bureau of Mental Health and the Superintendents of AMHI and BMHI. From July through Dec. we prepared volumenous documentation. Much of it was on request, some of it was not and oral testimony on the physical plants of the institutes, the patient charecteristics, the admissions procedures and pressures and treatment issues. We also participated with Commission members in actual site visits to the institutions in which staff advocates, legislative members and citizens described in painful detail the impact of overcrowding and under staffing on patient care. During some instances, specific cases were cited, although the identity of the patients was not revealed. This was done in order to give

Committee members the more graphic sense of the reality of the institutes. During Jan. of 1988 the Commission devlivered it's interim report detailing the serious staffing problems at AMHI and BMHI and their impact on patient care. However, the Commission concluded that the response should be not to add more beds or staff to the institutes, rather the emphasis of the commission was to expand community resources.

Not so)

Secondly, we initiated the long over-due state wide planning process which is now the basis for our expanded Mental Health Service system initiated in the Sept. special session. Under the agess of the Governor's Mental Health Advisory Committee, specifically the Plan Development Committee, we agreed amongst ourselves that we would sponsor regional planning and to that end the Commission on overcrowding, and in its report, did express confidence in the design of our planning project as well as the anticipated outcome to that project. In the early months of 1988, in addition to our continued participation on the commission as it studied the community service needs, the department conducted 10 public forums in all reaches of the State and engaged over 1200 people in assessing needs and devising solutions in order to build a comprehensive Mental Health system in Maine. I, and top staff, attended each public forum. We presented the findings of the public forums as well as the planning efforts of the regional groups, directly to the Commission. Progress on the plan was reported on an ongoing basis and in July we actually distributed the results, not only to the Commission on Overcrowding but the Mental Health Sub-Committee on Appropriations and the Human Resources Committee as well as to individual legislatures ors who had interest in that. Although our original time table was to present a proposal to the 114th legislature for the 1990/1991

was there enough to fund this?

bienium the process was speeded up when we requested a $6.6 million dollar appropriation in the Special Session in Sept. to initiate plan activities this fiscal year. In our opinion people and patient care issues could not wait.

And now I will move on to conclusions about the State Mental Health Plan and the overcrowding conditions.

It seems to very clear to all of us, the Department, the Commission and other knowledgable people that the only permanent solution to severe overcrowding and understaffing is to provided badly needed community services to mentally ill persons and their families. Unfortunately, this approach, that is, the building of community services takes far more time than all of us would wish. Within weeks after the Commissions' conclusion that the answer was not to add beds or staff, Medicare indicated for the 9th time in 5 years the presence of serious problems in some of the units at AMHI.

NOT THE CASE;

And now to move on to a Medicare cronology.

The series of events regarding Medicare were as follows:

On Feb. 23rd Medicare actually decertified AMHI, which means that unless we succeed in addressing the problems in a follow-up survey we would loose funding. Medicare surveys do not have precise and quantifiable standards and it was, therefore, difficult to measure our deficiencies against a standard that was numerically something we could actually look at. It's a moving target. Nevertheless, in view of past Medicare survey results and in the context in a slight downward trend in average daily population - Ralph, may we have the

population chart please - we decided we could regain certification and the Superintendent of AMHI drew up a plan of correction. In March and April we reported our progress to the Mental Health Advisory Committee and Human Resource Committee members met with Commission on Overcrowding the day before we actually presented our plan of correction to the Federal Government and the Health Care Financing agency administrators in Boston. We were greatly encouraged when Medicare decided that the plan of correction was sufficient for them to believe that AMHI was in compliance with the conditions cited and they agreed to conduct a follow-up visit. The Health Care Financing Agency Officials could easily have said the Plan of Correction was inadequate. They chose not to do that. They believed that the detail and the plan of correction was sufficient to merit a follow-up survey, thus they would not be wasting their time. We thus proceeded, greatly encouraged by their response with the corrective actions. We were very optimistic. However, during the period when AMHI's staff were attempting to implement the plan of action and the patient population began increasing just when everyone expected it to decrease as it had in the past years and the chart to my right and to your left explains what I am talking about. If we look at the red line which is calendar year 1988 we need to look back at the difference between May and June. The follow-up survey was May 29. You will see that the census between April, May and June was going up slightly. That affected the units for which we were seeking full Medicare recertification. That unit including that unit included the Admissions Unit. At the end of the Medicare follow-up visit at the end of May we were informed that AMHI was decertified. Yes we were surprised. All indications were that preparations were going well. Still unable to precisely measure how far short we were of

certification, we called in a consultant who was familiar with Medicare who confirmed that, in fact, the standards had become were being more strictly interpreted and helped us to evaluate our position. I publically said that we would re-apply for certification within the minimum 90 day time limit and asked the Superintendent to prepare a staffing plan that would permit AMHI to both regain Medicare certification and retain accredidation status with the Joint Commission on the Accreditation of Health Organizations. In fact, I sent Ron Welch, the Associate Commissioner for Programs to AMHI to work with Superintendent Daumueller on building the solution. At foremost in our mind was improving patient care. The solution developed and within three weeks of decertification key legislatures were consulted regarding a proposed appropriation request and of our intent to implement action by funding positions from the Governor's Contingency Fund. This plan began the third week in June to immediately address some of the more serious problems at AMHI and we reported to the Governor of the year long that the year long planning process called for a comprehensive mental health system. The Governor made the decision to speed up the comprehensive planning process by requesting $6.6 million in the special session, which included $1.5 million and 65 staff positions for AMHI. Since then we've been forming we've been focusing on improving patient with the added pressure of needing to reapply to Medicare. And now I shall move onto the deaths in August.

During August, while implementing activities funded from the contingency fund and preparing for the special session 5 deaths occured. We ordered an internal examination by AMHI physicians and in mid-Sept. I appointed Dr. Ulrich Jacobsen to the post of Medical Director attached to the Commissioners Office. His

first assignment was to conduct a more in depth review of the cases and in Oct. he recommended to me that three of them be further investigated. I then appointed an Advisory Panel in Oct. which reported its finding in Dec. indicating that one death could well be attributed to the heat and making extensive recommendation to improve medical and phychiatric care. Three physicians in an unprecedented action also were referred to the Board of Medical Registration based on finding from the first two phases of our investigation.

And now onto the topic of the Department of Human Services assessment of wards at the institute.

In early Sept. I was informed by the Dept. of Human Services that it would be initiating an assessment of the safety and medical care of its 47 wards at AMHI under the care of the Adult Protective Services wing. In mid-Sept. DHS provided us with a preliminary results and informed us that it would be adding more investigators in order to speed up the assessment. Because preliminary results pointed to serious problems with care for the wards. Subsequent to these developments the two deparments have been working very closely together to identify the serious problems of the wards. The Sept. 1988 Special Session, that is on Sept. 15 and 16, the legislature appointed or approved the request of the $6.6 million dollar package which set in motion the state the building of the state wide comprehensive community and institutional mental health service plan. A new independent Commission on Mental Health was also created to replace the department advisory bodies. Currently our Part 1 budget includes the addition of $20.3 million dollars over the previous bienium to continue all acitivities initiated this fiscal year. We are now evaluating

4 mos gone by since them.

the effect of the Sept. package on AMHI's ability to deliver a higher standard of patient care.

And now, where do we go from here? The events since last May, the Medicare decertification, the patient death's, the panel investigation into patient care practices and the DHS assessment of care for the wards tell us that the years of neglect have indeed caught up. 91 additional staff over the past 18 months are helping us to cope with admissions that will continue to rise until community resources have begun to have their effect and until the VA hospital in Togus is able to restore it's previous level of service. Throughout the past year many affected groups have come forward to offer their solutions, each convinced that their solution is the best possible. In the absence of any widely accepted standard for care of institutional health care services, it is extremely difficult to judge among competing proposals. However, we have made a high level change in management and I will shortly convene a team to design and carry out a thorough review of patient needs and staffing capability. We intend to adopt standards which will provide a more solid base for arriving at such critical decisions. We'll look at all management options. What I urge this committee to keep in mind is, however, is that the long term solution is precisely what the Commission on Overcrowding has concluded. We need better care located in the communities, although not at the expense of Maine citizens living in the institutions. We will if we fail to do that we will never recover from chronic overcrowding.

And this concludes my statement. I would be pleased to respond to questions.

(MS = Male speaker)

-----Unknown speaker with unknown question (male)

Susan, umh in the course of questions will not in any way intimate decertifications personal views

SB: Right

federal dollars. Many people have it became recently apparent to you or others in your deparment that we were to recertification which, of course, would result in the loss of federal dollars. I know that 1988

When did you know question.

and the question was asked prior to that time were there warnings that we were likely to

SB: Because AMHI had periodically gone through it's difficulties with Medicare and had always marshalled staff, you know such a manner as to requalify for Medicare it was not thought that this particular review would result in anything that we needed to worry about. We knew that we were on thin ice with medical records but at the time of the review in Feb. we had no idea of the increased stringency with which existing standards were being interpreted. That did not become clear until much later, in fact, after May 29th. We were very optimistic in our efforts that we could do this, that we would

put all our efforts into it. I had great confidence in the abilities of the AMHI leadership, including Supt. Daumueller to actually do what was needed to be done. I think a fair statement to say that we were all exceedingly optimistic and had no information to cause us to be otherwise.

------Unknown male speaker

SB: I don't recall that we sent the actual correspondence's over. I do know that later we talked about many issues concerning the institutes, including the increasing once again increasing employee dissatisfaction at BMHI, the employees dissatisfaction within AMHI and the resulting effects of that. And because Medicare is one aspect of management that most certainly would have come up as a discussion topic.

--------Unknown male speaker
How many beds do we have at AMHI which are Medicare certified?

SB: Presently we have none.

That's right

SB: Under the optimal conditions as we are now looking at them, 30 beds would be certifiable by Medicare and they are all located on the Admissions Unit. One other point I would like to make about legislators being informed of Medicare. On March 10th the Governor's Mental Health Advisory Comm. had a meeting, it's monthly meeting, at which individuals, including Rep.

Manning attended the meeting and this was an annual event wherein the Governor's Mental Health Advisory Comm. invited members of the Human Resources Comm. to participate with them and at that time a thorough you know description of the Medicare situation was rendered.

Male speaker: Now as to that meeting one impression on those that you would be recertified.

SB: As of March 10th?

Yes

SB: We understood that we would be decertified but the usual and customary reaction to such a letter is: Well, alright, now we put together a plan of correction and the plan of corrections whole sole purpose is to let the Health Care Financing Agency Administrator's know what we intend to do in order to correct the deficiencies which they have cited.

Male speaker: I understand that recertification in 1986

SB: Right, and I even earlier than that.

MS: so your impression was that if we formulated a reasonable plan of corrections we would likely or could ward of decertification on time.

SB: Absolutely

MS: Now, you made reference to changing the standards or more

rigid interpretation Could you elaborate on this.

SB: Yes. Medicare as also Medicaid two programs within health care financing have recently undergone umh what best can be termed as re-medicalization. What that means is that the umh government is looking at it's standards and holding umh participants in the Medicare program more accountable for the medical aspects of participation. As you know, policy fluctuates during the years and for a long time in the field of mental health and particularly the private the public psychiatric hospital there has not been an emphasis on medical care, rather, there has been there was previously an emphasis on rehabilitation. Medicare has gone full circle. It has now begun to more stringently emphasize the medical aspects to their standards and that is why, when we discussed medical records and the different standards that were out under that particular condition umh we are forced to conclude that they are looking at us more stringently because what had passed before was no longer acceptable.

MS: specifically what plan of correction was formulated by the department to respond to the

SB: umh huh umh huh

Before I do that I would like to acknowlege that you are correct, that we did not receive notification from the government until March 23rd. There was a exit interview on Feb. 23rd. and it took them a month to write us the letter. So you were correct.

MS: So that you received formal notification March 23rd.

SB: 23rd of March

MS: but the verbal communication as of the 23rd. of Feb.

SB: what what they generally say they don't pin themselves down, they generally say umh we feel that this is out, this is out, this is out. They will go through a list of deficiences and then they will advise you that they will return to Boston umh and talk about this amongst their team and conclude you know whatever they will conclude and then let you know by mail So roughly there is a month in there where you're wondering if you made it or didn't make it but you know in the best spirit of planning what one tries to do is to anticipate umh based on what you hear from an exit interview and put the proper you know corrections in place.

MS: March 10th meeting with the Mental Advisory that there were concerns

SB: Was an intelligent conjecture.

MS continues: and based upon that intelligent conjecture what proposed plan of correction was formulated?

SB: Well, it was an extensive umh plan of correction and perhaps the best way depending on the level of detail that the committee wishes to hear I should call someone else up here who is who is more fluent with the actual technicalities. Is that acceptable?

MS:

SB: OK. Dr. Rohm. Umh this is Walter Rohm the acting Superintendent of the Augusta Mental Health Institute.

Dr. R: I would like to add to Comm. Harper's statement about the change between that occurred between 87 and 88 and professional standards. The main emphasis was that the of the standard that the treatment has to be was used literally was previously the psycho-social team approach was quite acceptable for a psychiatrist, could be a part-time participant in the treatment planning and the carrying out the treatment plan. The new interpretation demanded that the psychiatrist direct the team, be the prime mover of the treatment planning and carry out the major part of the treatment. This meant, immediately, that more psychiatrists' time was needed. Er as you probably all know psychiatrists are very difficult to recruit. At that time we were down minus 4 psychiatrists which we would consider a bare bone minimum psychiatric coverage. We are still short 2 at the present time, but we were able, by sheer luck, to hire a half time contract psychiatrist. So instead of having one psychiatrist and two physician assistants on the Admission Unit we were able to face the May visit with one of the half psychiatrist. Hoping that they would somehow relent in the literal interpretation of the psychiatrists position of direct supervision and treatment. The other plan of correction was that intensive training to improve standards for social services to review the way you are allowed to do assessments and examinations are recorded. The Medicare demands a much more stringent and

detailed examination documentation of the examination. Then in the average practice of would be required. The another aspect was that we did not sufficiently document the things you were doing. Supervision of physician extenders, we revised the admission format, the psychiatric assessment format; specifically making it mandatory to address issues that Medicare demands, which in the past Medicare would make a recommendation you should pay more attention to this and that. Now they say it isn't fair. You don't meet the standard. Considerable time and effort were spend in training programs with consultants to bring our treatment plan documentation in compliance with the rather elaborte Medicare standards and this is an ongoing process and er there were some shifts of acitivity staff because there was a lack of activity staff in the opinion of the Medicare surveyers, which actually went at the expense of other parts of the hospital, but at this time and during that time we couldn't take any steps to get additional staff. And we intensified our recruitment effort for psychiatrists which we are still doing at the present time. Any other questions?

MS: If you felt that your activity staff was suffering and you moved your activity staff of the institution to satisfy Medicare with the understanding that funded the hospital why didn't you request activity staff for the other people. You just indicated that you

Dr. R: I'm not quite sure the detail of this of this operation. I think what happened is, now that I recall correctly we changed the time assignment for the er for the er acitivty staff. That they would be available at times when there was a lack of acitivities and from this

reassignment I recall now, there was some resistence, reluctence and some complaints from staff because they would have to work evenings and weekends and this was (pause) and this was done.

I think my statement was incorrect, that it was strictly at the expense of other parts of the hospital. I think it was more efficient utilization of activity staff by our having less or fewer hours being worked between times when the patients were active with other things and having them work weekends and evenings where there were more, rate of acitivites.

MS: Why do you feel they didn't notify you standards.

Dr.R: The standards are the same, the only things the interpretation changed.

MS: The what changed?

Dr. R.: The interpretation changed.

MS: Were you notified by any other institutions that you know of mental health centers, anybody that Medicare all of a sudden changed their

Dr.R: I think we were one of the they changed their surveyer changed it from the National Institute of Mental Health who had the contract I think a few months we were surveyed to a private group in Baltimore. We were the first ones to be certified by the new group with the new directions the old standards. And we said look, 4 1/2 years ago we had the same things and this was adequate and

they said yes this is true but we are a different group now and we have different instruction.

MS: You felt at that time, you were on board at that time

Dr.R: Yes

MS:, you felt at that time you didn't need to come to the legislature for any additional dollars.

Dr. R: Well, you mean between Feb. and when they came again.

MS: yes

Dr. R: We were we were reassing the situation

Charles P. Pray
President of the Senate

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Senate Chamber
Augusta, Maine 04333

‾ORMATION ON SUSAN B. PARKER, NOMINEE FOR COMMISSIONER OF THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Ms. Parker is knowledgeable in both mental health and mental retardation. She has extensive experience working as an advocate for programs for the disabled and is currently the Executive Director of the New Hampshire Developmental Disabilities Council. In that capacity she supervises five full time staff and coordinates others who are working on grants outside of the agency. She is very well liked in her current position and respected for her many capabilities. "Remarkable" is the word that the Chairman of the Council used when describing her.

She also has a great deal of experience with federal agencies, grantsmanship, planning and negotiations, and management. Her educational background is superior and includes a Masters in Planning, a double-major Bachelors in English and French; a teaching certificate; and follow-up courses in planning.

She has been elected/appointed to a wide variety of Boards including the Board of the National Association of Developmental Disabilities Councils; The Executive Board of the National Association of Social Workers; Advisor to the Office of Health & Developmental Services in Washington, D.C,; and Advisory Committee member to the New Hampshire Governor in his personnel negotiations with the State Employee's Association.

In addition to her four year tenure with the DD Council, she has also worked for the Grafton County Human Services Council and as a mental health planner in Massachusetts.

In speaking with members of Maine's DD Council, no one had specific information on her or had worked directly with her. They did say they had heard favorable remarks on her abilities. Dean Crocker, former Director of the Advocates for the Developmentally Disabled in Maine, has worked with her in the past and said she is a good choice and is a very capable and competent person. He also felt she would be interested in looking at a "community" perspective for Maine's disabled as opposed to "institutional" approaches.

Ms. Parker's current supervisor indicated that Ms. Parker is a [redacted], but that she (the supervisor) was able to work with her very well in spite of that difference.

ember ← , the ...ther party."

The one weakness I can see is that Ms. Parker does not have experience supervising a large number of employees or running a large department. Her background is with managing small independent organizations. However, her management, planning, grantsmanship, and general administrative talents seem to be considerable. When I asked her current boss about her supervisory talents, she said she felt Susan was up to handling a large agency with many employees. She based this conclusion on Ms. Parker's abilities and intelligence.

Possible questions for Ms. Parker:

1. What is your background as a supervisor? Do you anticipate any differences between supervising a staff of five and supervising a staff of over 100? What do you think will be the difference and how do you expect to proceed?

2. Comment on the move to deinstitutionalize that began in the early 1970s. Do you feel that deinstitutionalization is still the best approach?

3. There is currently a discrepancy between the pay that direct care workers receive in our institutions and what is received in the community for the same work. How do you think this can be resolved?

4. Your experience appears to have been mostly in smaller organizations, advisory in nature. How do you feel your skills will carry over into a Department the size of the Department of Mental Health and Mental Retardation?

5. What is your experience in preparing, presenting and managing large budgets?

AUGUSTA MENTAL HEALTH INSTITUTE

WILLIAM C. DAUMUELLER, ACSW, SUPERINTENDENT

Central Office: Hospital Street, Augusta *Telephone:* 289-7200
Mail Address: Box 724, Augusta, Maine 04330

Established: 1834 *Sunset Review Required by:* June 30, 1992

Reference: Policy Area: 03; *Umbrella:* 14; *Unit:* 194; *Citation:* 34-B M.R.S.A., Sect. 3201

Average Count—All Positions: 614 *Legislative Count:* 633

Organizational Units:

- Admission Unit
- Young Adult Unit
- Adult Unit
- Older Adult
- Pre-Discharge Unit
- Forensic Treatment Unit
- Adolescent Unit
- Alternate Living Program
- G.R.O.W. Workshop Programs
- Medical Infirmary
- Nursing Home
- Evaluation/Research
- Staff Development
- Hospital and Business Services
- Health Sciences Library
- Professional Consultants
  - Nursing, Social Work,
  - Psychology, Activities

PURPOSE: The Augusta Mental Health Institute is mandated to treat adults who require intensive 24-hour psychiatric services from the following counties: Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, Waldo and York. In addition, the Institute provides inpatient psychiatric treatment to adolescents from throughout the State. All services are provided without regard to race, creed, color, sex, national origin, ancestry, age, physical handicap or ability to pay.

The Augusta Mental Health Institute is the only facility, for these counties, mandated and equipped to provide care and treatment in a hospital setting to the following categories of patients: those who require involuntary hospitalization; those who require a secure setting; those who require extended periods of inpatient treatment and/or rehabilitation; those committed under the criminal statutes for observation, care and treatment; and those who require certain highly specialized programs not available elsewhere. The demand for mandated services is such that voluntary admissions have to be refused, delayed or diverted to assure suitable accommodations for those most in need. In some cases, the lack of appropriate community alternatives requires that Augusta Mental Health Institute accept additional acute patients on a voluntary basis.

ORGANIZATION: The Augusta Mental Health Institute was established in 1834 as the Maine Insane Hospital, and was the only public mental hospital in Maine until the opening of a second hosptial in Bangor in 1901. In 1913, its name was changed to Augusta State Hospital and in 1973 to its present designation. Throughout most of its history the Institute provided the only public mental health services, except for the Veterans' Administration Hospital, to the people of southern and central Maine. The development of the community mental health centers in the 1960's resulted in a redefinition of the Institute's role. It stands today as a necessary and valuable part of the comprehensive mental health system which provides a broad range of services to Maine residents.

The Augusta Mental Health Institute is organized on a system of functional treatment units in order to meet, as effectively and efficiently as possible, the needs of mental health clients in the counties previously mentioned. Each of the functional units is responsible for the total treatment and rehabilitation of its patients:

A. Admission Unit: The 30-bed unit is primarily an intensive assessment, diagnostic and crisis intervention service, offering short term treatment such as chemotherapy, group therapy, activity therapy, and occupational therapy. Except for forensic patients and adolescents, approximately 50% of our patients are discharged within 7-9 days. This rapid stabilization and discharge function requires carefully planned aftercare services which are provided by various mental health agencies throughout the state.

B. Forensic Treatment Unit: At present, the 33-bed Forensic Unit is divided into an 8-bed high security section and a 25-bed medium security section. The 8-bed section provides short term intensive diagnostic and treatment services in a secure setting for individuals referred from the courts for observation, care and treatment and for civil admissions from state and county correctional facilities. Those found Not Guilty by Reason of Insanity (NGRI's) or Incompetent to Stand Trial are generally treated on the medium security area unless otherwise indicated. The staff of this Unit monitor all legal hold patients, regardless of treatment unit or release status.
C. Adult Program: This 45-bed program focuses on treatment and social intervention to adult psychiatric patients up to age 45. Most patients in this program are being served in a long term outpatient or community based programs with occasional inpatient episodes being necessary.
D. Young Adult Program: A 45-bed short term intensive psychiatric program designed to meet the needs of patients 18-30 years of age. Many of these patients are best described as the young chronic mentally ill with the special problems of substance abuse and other social problems.
E. Adolescent Unit: This 24-bed unit provides comprehensive diagnostic and treatment services in an inpatient setting to all those mentally ill Maine youths (ages 12-17) whose problems have not or cannot be resolved through less restrictive alternatives in the community.
F. Older Adult and Other Special Treatment Populations: A 40-bed milieu program for clients over 52. This program focuses on remotivation, improvement in basic functional skills and is individualized by additional treatment modalities specific to assessed needs. Services accommodate the needs of the head injured and hearing impaired who are part of this program.
G. Pre-Discharge Unit: Closely aligned with the Alternative Living Program, this unit houses patients needing little structure and supervision and emphasizes those skills related to living independently or in less structured group living situations. This unit also has the capacity to expand or contract as our patient population and staffing dictates.
H. Alternative Living Program: The Alternative Living Program consists of six houses or apartments on the grounds with a capacity of 40 patients. Each house provides a small, supportive, homelike group setting which more closely parallels the experiences that the patients are likely to encounter in the community. The goal for the individual is to reach the highest level of independent functioning possible, with the ultimate goal being community integration.
I. Therapeutic Activities: A multi-disciplinary group of action oriented therapies that provide a means for individuals to go from a dysfunctional to a functional state. Occupational therapy, recreational therapy, movement/dance therapy and art therapy, are among those professions currently represented at AMHI under the umbrella of Therapeutic Activities. Adult educators are available to provide skill development, formal academic training and many leisure time skill enhancement courses.
J. G.R.O.W. Workshop: This comprehensive workshop program utilizes any funds generated over and above the wages paid to workshop clients to expand rehabilitation opportunities. Clients with disabilities comparable to those of AMHI patients are referred from the community mental health centers, Divisions of Vocational Rehabilitation, Bureau of Mental Retardation and other mental health related agencies. By extensive utilization of this modality, patients who would have remained untreated or whose treatment may have been inappropriate and ineffective have reentered the world of productive employment in varying degrees of self-sufficiency.
K. Nursing Home Unit: The patients housed in this 70-bed Unit are impaired both physically and behaviorally. Their disabilities are such that they cannot currently be served in community nursing homes or other alternative settings. However, a social work and nurse team recently established by the Bureau of Mental Health and housed at AMHI will provide consultation and education services to community nursing homes with the goal of assisting them to maintain psychiatrically impaired patients in community nursing homes.
L. Infirmary: The 16-bed Infirmary provides a Medicare certified general hospital level of care, at less cost than would be incurred by a transfer to a general hospital. Those patients requiring surgery or intensive care are transferred to the Kennebec Valley Medical

tape # 2

Um, ----------- have to have a at least a high school education and uh we run them through um training programs it would -------- um a mandatory training would include things such as CPR, uh what we call Nappy wich is non abuse physical and psychological intervention uh they go through a CNA program which uh is I believe uh it's over a 100 hour program um they go through an introduction to mental Health which is kind of a basic um nursing skills program, which is an 88 hour program. So they have a fair amount of training in addition to whatever experience they might have had comming in.
The CNA training um our standard is that be completed within 6 months of employment. Uh, as an example just recently in September we were able to bring on 31 mental health workers um roughly the first week in October um we were able to complete their training, including CNA and CPR training and other training by November 22nd. So that and that was another massive effort to um

Female Parker

(can't decifer)
I'm talking this past fall.

different speaker-"What period of time did this trainig take place in?"

"Within the first six months of employment, but generally it would happen in the first three months.

different speaker" I have a question concerning patient care what percentage of the care of the patient is put upon this Mental Health workers, um what percentage of the time are they required to (can't decifer) of patients ? all the time ? out of contact all the time? what would you say would be the percent?

Uh it's a very high percentage, I don't have a time study, but I would say that it is the bulk of the direct eye-to-eye contact with the actual patients is carried out by our mental health worker, and other nursing personnel.

different speaker-"But what do you who suddenly come up with an unusual chronic problem (can't decifer) the discression of these nurses and mental health workers who know them (can't decifer)

The mental health workers are in the nursing, under nursing supervision under licensed supervision, uh when the patient comes into the hospital, the licensd nurse staff person uh completes the nursing care plan. And that essentially is the plan that the mental health workers follow for each patient. So that, they are given guide to patient care, by uh registered nursing staff who complete that assessment. And they are supervised regularly by a licensed nurse staff.

different speaker-"but feasably, at the end when several days go by,when you still need a mental health worker 3/4ths (can't decifer)

That certainly could happen with some patients, yes.

"um as far as treatment in packages of patients do you have treatment plans when the patient comes in, the patient is assessed and then a treatment plan is set up with a period of time the individual will be here. Assuming it's a certain estimated period(can't decifer)

where you have an assessment of the ability and the problems uh how are you going to deal with things, (can't decifer) Is this absolutely?

Yes it is, um for those patients who come into the admissions area proper, um they would have an initial treatment plan -----within the first five days of hospitalization. Uh that technically you can say that every patient has a treatment plan beginning at the time they come into the hospital which would consist of the initial uh phsician assessment, and the initial doctor's orders whatever that might be weather it is for medication um placement in constant observation so treatment begins in a sense, immediately. Prior to that initial conference to develop that treatment plan within the first five days assessments are done by social service, psychology, uh at times the activities staff may have uh had time to do an assessment also and those assessments, including the psychiatric evaluation that's been completed within the first, well a full pcychiatric evaluation is required within the first sixty hours of hospitalization. Those assessments are forwarded into that initial treatment plan, which includes uh theraputic rehabilitated modalities or treatment approaches beyond just kemotherapy, or medication which might include continuing social assessment uh group therapy with one of our chaplains or psychologists uh in a range of activity therapys.

different speaker (can't decifer)

other speakers? (can't decifer)too much noise.

speaker (can't decifer) My question would be um based upon initiation of it would appear (can't decifer)

Female new speaker" the answer to the first part of the question is yes, and i would also reiterate that the letter from Stanton Collins of April 15th 1988, wherein he says that a credible aligation exhists, that AMHI is now in compliance with the two special conditions for participation in pschriatic hospital program for medicade gave us good reason to be optimistic. At this time I would like to um ask assistant superintendent
Hamlin to continue with his discussion.

Could I, just interrupt here? I have some questions on the correspondence of Mr. Collins.

Female: Mr. Collins? yeah.

Male: yes um I have (can't decifer)

Female: My own interpretation of credible alligation means that the plan of correction contains adequate substance which would allow them to feel that they would not waste their time in resurveying a facility. They'll review it for content then match that content against the list of deficiencies and thought we were definately in the right(can't decifer)

Male: Um did you have any vote from Collins or anybody else at this point uh or any corespondence that in fact (can't decifer)

Female: No they never they, that's a practice, they never say that anything is forthcomming. What he did say, as we left the room, on that uh Teusday or Wedensday was that it looked to him

like the plan of correction was adequate. That's all he said, they never make promises.

Male: Susan now I understand you were present and Susan Collins was present together with Dr.Rohm

Female: No, Susan Parker was present with Dr. Rohm Susan Collins is (can't decifer)

Male: (can't decifer)

Female: oh no uh Linda Crawford, the assistant Attorney General

Male: that does make a (can't decifer)

Female: yes.

Male: now Dr. Rohm apparently represented the institution?

Female: as the clinical Director and (can't decifer) represented it as the Superintendant.

Male: (can't decifer)

Female: Yes he was.

Male: ok. Were there any other members or people present from our department?

Female: It was we four.

Male: Uh you also mentioned that (can't decifer)

Female: Um the mention that I made was not Marvin Chapman, although he has done extensive consulting work with the Augusta Mental Health Institute as well as BMHI the consultant in question that I think your, the question your posing, is Alvira Branns and she is a person who in fact, once worked for the health care financing administration, and now works for the National Institute of Mental Health. She wasn't just a worker at (can't decifer) she was a person in charge of such reviews. In she knows intimately, you know the policy shifts and the subtlties of HICVA reviewing and the personnel involved. And I had learned of her through contancting with other states and also the National Institue of Mental Health and had her up her to give us a critique of our review. This was a process critique um as apposed to content. She actually make the comment that she felt that our content was quite good. And that is how we first substantiated you know from a person outside of Maine that the stringency was uh the stringency of interpretation indeed had effected us.

Male: When you said she gave you a process critique-

Female: well she

Male: does that mean that she (can't decifer)

Female: No, she did this and we had her up the end of June. Not the end of June, but the first half of June. Now you may be reffering to another consultant who had come in, I did not mention Mr. Chapman in my cr-

Male: I'm not going to be very specific. I was referring to the, I thought there was a consultant to aid your department in crafting the plan of(can't decifer)

Female: That um we'll have to ask Rick Hamler about. It's a typical behavior that Institutes, when they have to go through a review actually do hire consultants.

male: OK, so your not personally aware of who you you(can't decifer)

Female: No I'm not

Male: OK thank you.

Female: It could well have been Mr. Chapman because he comes here frequently.

Male (can't decifer)

Female: Yup, yup, could I just risk the other five points and then call the assistant Superintendent up?

Male: (can't decifer)

Female: I shall. Um the second one is extensive work was done with medical staff to improve the documentation of physician involvement this occured during February and March of 1988. The third point is that Dr. Buck a ferensic psychiatrist was removed of his duties at the Maine State Prison thereby adding one day of psychiatric time per week for the pourpose of physician extended supervision and patient care. This happened on April 12th of I'm sorry, that happended on April 7th 1988. We added one psychiatrist of twenty hours through contract for the admission unit coverage with no nurse or other coverage do to duties. And this was on April 12th. Another point is that we revised and improved the socialwork documentation standards and set up social service audit system to monitor compliance. That was March 28th 88'. And lastly they increased the capacity of the theraputic activities department to provide regularly scheduled activities during evenings and weekends. This was April 19th 88.

Male: Can I ask(can't decifer) who was specifically was involved in(can't decifer) corrections?

Female: The oversight or they oversee of a plan of corrections is always the superintendant. Um assistant Superintendant Hamly can tell you to the degree in which he was involved.

Male: (can't decifer)

Female: No, we the way our department runs is that I am reported to by a Superintendant and he or she would simply convey the fact to me that this is happening.

Male: So it's fair to say that that's why Mr. Daumueller was the Superintendant of the institution.

Female: that's not-

Male: So it would be fair to say that you asked Mr. Daumueller

to in fact um appear (can't decifer)

Female: that's correct. Occasionally um if there are policy issues that need settling um I will dispatch I would and associate commissioner for programs or administration to the task.

Male: Um I know you've (can't decifer)

Female: I will have Associate Commissioner Welch answer those, he has done an analysis from the central office (can't decifer) of what's been done and when.

Male: Is it your impression (can't decifer) up and running now? or

Female: Yes.

Male: So you understand all these forms have-

Female: mmm, right.

Male: OK (can't decifer)

Female: The uh information that I have received as late as yesterday, is that we still have somewhat to do on getting the medical records shaped up in order to endour a successful review.

Male: Do you have the time frame at this point that you could give to the committe as to when (can't decifer)

Female: No. No. Um, Senator based on what information that I did receive yesterday, I really need to get back with the people who put it together at AMHI, and work with them to figure out what that time frame ought to be. They did a , we have had consultant help comming in from someone who is very skilled at reviewing records uh to determine weather or not they are acceptable to Medicare. And his report also has just landed on my desk. And I really need to reevaluate the various types of information that have come over from two quarters to find out weather or not um we can do it immediately is it one month away, two months away. As I did point out to the committee, uh the request to health care financing administration to come resurvey us um assumes that we must be perfect on all points.

Male: It was also my understanding that(can't decifer) Is that correct?

Female: that correct (can't decifer) 90 day period of compliance before we are able to actually um make application.

Male: No, when they come back for the uh what they call a focused survey, we had to have been in compliance for at least thirty days. Because what they do is they look at the prior thirty day period. So that (can't decifer)

Female: mmm. In order to answer the time frame question, I would have to (can't decifer) consensus back here. Uh I don't know the answer off the top of my head um what do you think?

Male: I think we can talk with you about what needs to be done

in our perspective probably within two to three weeks. Let me just state that (can't decifer)

Female: Thank you. Why didn't I get personally involved? you mean? because there are six institutions that we are running, in addition to the three community sets of programs. If I got involved in the development of every single plan of correction, I would lose the ability to exurt an oversight over all aspects of this department fuctioning. Therefore, I have people um who are members of my senior management team, who are people to whom the task is delegated of exerting that oversight. I always have to understand all things that function in this department for me to put a member of ours into the actual crafting of a plan of correction would take me away far too much from understanding the other pieces.

Male: I just, you know I just think (can't decifer)

Female: Peter this is... I was very ...

Male: (can't decifer)

Female: That I don't think things were neccessarily faring very well. Let's recap some of the um issues that have beset this department since July of 87. Um we very rarely lost medicade at Pineland and when I say we very rarely lost it, we came within a 1/2 an hour of having the guillitine go down on $10 million dollars and the way we pulled that out and this particular situation arose from the fact that happened in November of 1987. Pineland had gone through many surveys by Medicade.

Male: (can't decifer)

Female: well I'm going to...

Male: (can't decifer)

Female: that happened in November, then we moved up to January, February we're readying for a legislative season. By the time, by the time we got to February March and April, things at the Bangor Mental Health Institute are in a state of dissaray. I had, I had initiated very many management changes at BMHI and I made a change in the top management of BMHI the middle of March. I was extremely concerened about the patient quality care quality there, as I was at the Augusta Mental Health Institute. I had absolute faith in the Superintendant and his top staff, that they could put together quality plan of correction that would meet muster with the Federal government.

Male: These medical records? um what was the, how long did it take (can't decifer)

Female: The um

Male: (can't decifer)

Female: I would have to look back, I believe they are. Now

Male: (can't decifer)

Female: Do we have the (can't decifer) when everybody was filled? Pull that out.

Male: All three have been filled as of today um all but six had been filled as of the third week of November.(can't decifer)67.5 three of which were under contract. We currently have one of the contractor clients for a psychiatrist (can't decifer)

Female: That's the Medicare portion of the package.

Male: All those positions were filled uh

Female: July, August, September.

Male: Why is it that we're still having problems with (can't decifer)

Female: It has to do with the fact that staff on team A and team B within admissions, team A does not adequately understand yet how to put together a treatment plan that is written in behavioral terms what that means is, they don't know how to write a treatment plan that um that contains language that describes how they will know a patient attains certain goals. How has a patients behavior changed as a result of the intervention given by the clinical staff. It takes a great deal of trying to get to understand how to script how to write treatment plans in behavioral terms. They have had three training sessions. The first training session occured in September. The second one was later that fall and the last one, actually the last one was not a training session, it was a feedback session. That I attended on January 4 89' uh conveyed the fact to me that, only 1/2 of the treatment team understood how to write in behavioral terms.

Males: (can't decifer)

Female: I think that's fair.

Male: Susan, can you, you had indicated earlier that you had no (can't decifer)that was in a meeting?

Female: Right. March 10th.

Male: you were all there?

Female: Yes. yes. With your permission Mr. Chairman I can give you the minutes of that meeting.

Mr. Chairman: I'd appreciate it. Did you notify anyone else, besides the Human Resourse Committee (can't decifer) legislative leadership of Appropriations Comm.

SB: I do not recall that I notified the leadership. What we did was to explain the fact that we had you know suffered decertification but as I had mentioned previously we were very optimistic based on AMHI top staff history that we could regain Medicare through an aggressive plan of action or plan of correction and as I recall the meeting of the Governor's Mental Health Adv. Comm. those plans were described and I also recall that Dr. Rohm was the person describing.

MS: I'm sure you said you did notify appropriations.

SB: I do not believe we did because at that time we were very

optimistic that we could regain it. And as I had previously stated this was prior to understanding that an increased degree of stringency was being attached to the standards interpretations.

MS: I just wanted to follow-up on the letter since you gave us a copy of the April 15th letter. The reason I'm asking questions from these letter is because when I was going through the packet of materials, past reports and the things we've gotten over time and the new material, this particular letter that came March 23rd and we didn't have the April 15th letter but this seemed to me the most significant thing and an early notice of what the intent of the department was. They were definitely going to terminate April 22nd and that you had to address certain things, in fact, it got down to the point in the letter to paraphrase is that they weren't even asking you to correct things. They were just saying that there had been so many problems and so many deficiencies we are going to terminate April 22nd. Now you said in response to that questions I asked you before that you had received this April 15th letter and that it was very favorable. It's a very short letter and I mean on the basis of the meeting of April 12th apparently you had met or someone had met, maybe Mr. Daumueller had met with Stanton Collins on the 12th of April and corrective actions outlined in your plan of correction we have determined that a credible allegation exists at Augusta Mental Health Insti. is now incompliance with two special conditions of participation for psychiatric hospitals. End of paragraph. Second para. We will therefore arrange for an unannounced follow-up survey of AMHI sometime in the near future in order to provide sufficient time for this process we are extending, -----not eliminating,---- extending the termination date for AMHI from April 22nd. to May 22nd. Now they end up actually terminating on May 29th. and they give the name of Mr. Winerman and his phone number including the obviously you could call Stanton Collins. If I'm misunderstanding the letter correct me, but it seems to me they are saying you still a long ways to go. We are not eliminating the termination requirement we are just entending it in order for you to implement this plan and they say at this point you have only implemented two ......am I understanding this correctly.

SP: Let me clarify. There are only two conditions in the entire set of standards of Medicare. There are two conditions: Patient Records medical records and staffing. All the standards, every single standard falls out of each of those two conditions so if they say that a credible allegations exists that we can meet the conditions that is indeed exceedingly favorable.

MS: And if that is favorable and they do not do anything but extend the termination wouldn't that be a large sign to both you and whoever the Supt. was and any staff involved that we still have a ways to go to eliminate the terminatin.

SP: We always know we have a ways to go that is why we go to the you know the rigor of compiling a plan of correction. The interpretation of the March 23rd letter. You are correct. It doesn't make you feel very good when you read it as an administrator, but there were no surprises in there based on what they had told us in the exit interview. We knew that we had a long way to go and that we also knew from the exit interview one month prior what the defeciences were so by

that time we were already deep into the actual formualtion of a plan of correction. The Health Care Fin. Admin. is not know for sending love letters to any of us. They always, you know, paint a scenario that is not terribly positive and this of course sets the stage for you know any subsequent action which may occur that is not in our favor.

MS: I don't want

SP: There is if I could please point out there are certain phrasiologies in any letter from Health Care Fin. that are peculiar to that agency and you once you have experience with this agency you learn to interpret what those phrases are.

MS: I don't want to intimate that there not they can't be difficult to deal with. I can understand that but it is obvious that you had or Mr. Daumueller had a meeting at least with Mr. Stanton

SP: Collins

MS: and that there was some communications not only in written form but obviously in personal meetings and the possibilities of conversation with people with their questions and it seems to me that if you understood that possibility would be that they would be very strict with these rules that you would make the necessary communications with them either privately in meetings or publicly through correspondence that says, you know, what do we have to do to specifically, are we doing enough and just keep that conversation going.

SP: I believe I can't say for sure whether or not telephone communication did not happen between the Supt. or the Asst. Supt. and the Health Care Fin Agency. You know, as I said I had enormous confidence at that time in AMHI's ability to put together a plan of correction that would pass muster and also at that time as I just said I was not aware that there was a movement afoot, shall we say, that a more stringent interpretation of the standards would be levied on us. I learned that the first week in June.

MS: I would like to get back to the questions of the federal government stifening their requirements. And I'm looking at this chronology which, I don't know, where did this come from. Was this from your department.

SP: I don't know what you're looking at

MS: It's a chronology of events

SP: Yuh

MS: OK I'd just like to go back over it for a second because in July 1987 it says here that Medicare fully certified AMHI. Then the next indication that there seems to be some problem is that following Feb. for the Medicare annual visit it says AMHI not certified. Was it during that interim during July 1987 and Feb. 23rd. 1988 that the federal government sitffened their requirements was that the period when that happened?

SP: umn I'm not sure the precise date Rep. Rold I don't know that answer because I'm not privy to what happens in the

highest reaches of HICVA. I know

MS: but I mean the fact is that you were fully certified in July.

SP: Yes

MS: then in Feb.

SP: I see what you're saying

MS: in Feb. they moved they came here and they didn't certify us. I assume if the reason was one of the problems that you were having was that they had stiffened the regulations that by Feb. they had already done that. Is that correct.

SP: They certainly had done that by Feb. I think during the year or even 6 months to a year preceeding Feb. 88 they were in the process of stiffening the interpretation.

MS: So, but back in July we were meeting their standards

SP: Right

MS: and then between July and Feb. something happened so that we didn't meet them in Feb.

SP: Right

MS: so I assume that's when it happened.

SP: Right

MS: A couple of other questions about then. One, I just I would like to get your opinion of the stiffening of these standards umh. Was this just some bureaucratic Mickey Mouse thing or is this something that was terribly important for patient safety and and care.

SP: I wouldn't characterize it as bureaucratic Mickey Mouse. I think there was substantial concern on the behalf of certain Congressional members, I referenced what Lowell Weicker earlier that said that Medicare and Medicaid were not enforcing their own regulations strictly enought, therefore, the federal government was unwittingly privy to creating less than perfect conditions in institutions.

MS: but from your personal point of view as the Comm. of Mental Health then you feel that probably these stiffened regulatiopns were a good thing?

SP: I think they're a good thing if they're fairly interpreted and we the states are given ample time to get in compliance. I do not think it a good thing to force through an estate, unannounced and, you know, let the chips fall where they may.

MS: Ok, so by February 23 of that year you knew that those Federal things were in place and I guess one of the things that puzzles me a little bit, is some of the sensational things that we've heard, that the deaths at AMHI, the supposed abuse, and rapes and soforth, occured in August almost or more a half year after those were in place. I just wonder if there's any

relationship between uh, sticking to you standards, and the fact that that these sort of sensational things happen or the standards were stiff and I just...

SP: First of all one correction. I did not know that the stiffened until June.

MS: But in February...

MS& SP: (can't decifer)

SP: But I didn't make the connection, none of made the connection in Maine that this had happened because of incruel stringency. We did not neccessarily know that we just knew that we weren't in compliance.

MS: Weren't in compliance with what?

SP: That we were not in compliance with uh the medical records condition, and the staffing conditio.

MS: But when they came out in February, which (can't decifer)

SP: That's what I mean. We all renew after the February exit interview was, that we were not in compliance with those two conditions. At that time we had no notion, that things were being you know, more stricktly interpreted, therefore, when we put together a plan of correction it was done with the idea that we would formulate the plan of correction as we had in the past.

MS: Here in July, you get certified then you come to February and the Feds come and say we're not going to certify you, but you don't know why?

SP: Well yes we do know why. We know that the staffing condition and the medical record condition is not in. Now, I may be missing some information here, and perhaps...

MS: So are you saying that between July and February, that deteriorated?

SP: That what deteriorated?

MS: The staff and medical records because um, what your saying is, in July it was OK, February it wasn't, but you didn't know that the Feds had changed until the following June.

SP: Right. I am not willing to say that the staffing had deteriorated what I think we, I need to here is what the Assistant to the Superintendant might say about the differences in um look at how the Feds looked at the staffing, in February, compared to last July. Also how they looked differently at the medical records.

MS: OK but again I had assumed that you would have known in February, that they had made some changes in their standards.

SP: The standards...

MS: The reason why you were having a hard time dealing with it.

SP: Standards, again, did not change. The interpretation of

the standards changed.

MS: You did not know that in February?

SP: I did not know that in February.

Ms: OK.

MS: (can't decifer)

SP: yes.

MS: (can't decifer)

SP: You are saying that you were not present the do-, well I my reader would disagree with that point. Excuse me?

MS: Let me point out because it says(can't decifer)

SP: OK.

MS: and it says and subsequently Human Resourses Committee members began to arrive sharply (can't decifer) to allow everyone to arrive get coffee and settle down. (can't decifer)

SP: OK, you are correct Representative------

MS: (can't decifer)

SP: May I also point out that in previous administrations and perhaps we need to collaberate it from people before me. That the Legislature had not been routinely notified of pending Medicare decertification. Unless it was thought that the solution to remedy that involves staff. At that time, we did not believe that staffing was necessary.

MS: I just I would think, that if your inviting (can't decifer) Weather you do need money or you don't need money. If there's ----- to the Mental Health Advisory Council which has not people who are elected which are not people that you have to cut in front of to (can't decifer).

SP: Should we adopt a new policy between the department and -----

MS:It isn't a (can't decifer) the Governors Mental Health Council which (can't decifer) by Gov. Mckernen and Gov Brennan(cant't decifer) I heard this a couple days ago, (can't decifer) and I think most people who sit on the committee(can't decifer) I don't remember is because we were never told who had the meeting.

SP: Would also point out that the Governors' Mental Health Advisory Committee is created by statute and these people do have an oversight function over the department.

MS: They have the Advisory and that is the reason why my commission the one I formed last year was (can't decifer)

Female voice: (can't decifer)

SP: Do like a kind of (can't decifer) yeah ok.

MS: We had several staff members uh in the February time period that were actually punching (can't decifer) we were very much wondering if they would give us credit (can't decifer) one thing we did coactively, after they left we proceeded to convert the classification from Mental Health Worker to Correctors to properly recognize the (can't decifer)

SP: Would you like further explanation from Assistant Superintendent Hanley?

(can't decifer)

SP: What are you talking about? February 23rd? No I did not. I will have to ask the folks behind me who did.

Female: I (can't decifer)

SP: Representative Burke we have so many reviews by health care financing as well as the department of Human Services wich is the HICVA state agency in Maine. Now it would by ni impossible

Tape: 3

(FS = Female Speaker)

FS: When you lost the funds what happened next?

SP: We recongized that our plan of correction didn't do the trick. Now I'll tell you from the Comm.'s level what I did and then it may be seemly to ask Asst. Supt. Hanley to speak it from that perspective. What I did was to ask the Supt. for a solution. What do we need in order to 1: up the quality care but secondarily to allow us to recapture Medicare and the result of that was a staffing plan that called for 15 staff plus three under contract. The three under contract involved two physicians and one psycologist.

FS: So after you lost the recertification you realized that you needed more staff. More staff was not recommended prior to loosing?

SP: That is right

FS: And who's so so the Supt. never suggested more staff

SP: The questions levied to the Supt. was give us you know give us the plan for correction. He didn't necessarily say that we needed more staff in order to retain Medicare at that tune. However, after we lost it it became painfully aware that we needed to do something in order to regain Medicare for 30 beds out of a total facility of 383 beds and upon that kind of request he gave us what I just said. The staffing plan for 15 plus 3 contract. And thereupon we were obviously working very closely with the Administration and Governor McKernan made a decision to let not wait any longer on this and lets begin to fund this out of the Governor's contingency fund. I do recall on June 16th that I phoned various members of the Human Resources Comm. as well as the co-chairman of the Comm. to study overcrowding as well as the co-chair people of appropriations to let them know of this decision and what the dollar value was for that.

MS: So at that point in time were seen as first and foremost patients

SP: patients, that's right

MS: care and secondarily at regaining Medicare

SP: That's right

MS: Were you aware then of all of the horrendous things that have gone on since that time.

SP: No (pause) I was aware of you things, you know of patient incidences that are reported on a daily bais via our census form.

MS: (can't make out)

SP: That's right, that's right umh, I was aware that

Office of Advocacy attached to the Commissioner's office. I was aware that that individual had been seeing things in the hospital and he had been working with the Supt. on a very regular basis to umh at least tell him what was going on. Now

MS: With the incidents that you were aware of because they come in a daily report.

SP: Um huh um huh

MS: so then you were aware of things like patients receiving beatings from other patients.

SP: I was not. I don't recall that I think you're referencing the Department of Human Services Report. I can't with certainty because I don't have photographic memory on my on my incident report I don't if anything like that ever appeared I just know occasionally incidences are reported there have been very few, you know, over the two years.

MS: Would it be appropriate for one of your senior staff people or someone (shuffling papers) that a 74 year old woman is raped on your on your

SP: Of course it would be. Yes

MS: control.

SP: The Supt. came to me several days after it had happened and told me about this incident and I believe we were in a meeting over at AMHI when I learned of it.

MS: And your response

SP: I was pretty shocked.

MS: what were your professional response, or administrative responses.

SP: My administrative response was find out why and find out who and take care of it. Make sure it doesn't happen again.

MS: did you intervene yourself at that point.

SP: That's a commissioner intervenes by saying you know, look into it, take care of it, let's not have it happen again. That is an intervention.

MS: Was that just purley a normal intervention. Did you call senior staff people togther.

SP: We several of us in senior staff were togther when we first heard about this and were uniformly shocked.

MS: No specific crisis intervention team was then

SP: alright I because my information is perhaps more superficial then you need I would need to have someone from AMHI come forward to tell you what it is AMHI's response was.

MS: Actually, I'm more looking for what your response, your as commissioner what your response was other than to say

not have this happen again.

SP: I asked I asked to know what the staffing was surrounding the incident, why was there a lapse, why was there no supervision.

MS: Was a written report every made to you to give you the answers to these questions.

SP: I don't recall, but it may well have. I just don't recall.

MS: Did you receive a letter in August from the Maine Advocacy Services.

SP: I received many letters from the Maine Advocacy Services.

MS: They cite a letter that they sent to you in August

SP: umh huh

MS: that was never responded to and then they wrote a subsequent letter on with numerous recommendations

SP: yup

MS: for action by you and I was wondering if response.

SP: I don't recall not responding. I know that Laura Petavello, the director, has been in my office several times and she also has been with us as we have reported out the finding of the so-called death panel or the advisory panel to look into the AMHI deaths and there has been communication back and forth. Now I don't recall specifically not answering letters. I know that several responses have been called for, in fact, there is one on my desk now that merits a response as soon as I have time to do it and it came in about three days ago.

MS: Is this the one that called for unh for example referrring Dr. Rohn also to the medical board for license repeal in that he was also involved with patient care and both patients died or

SP: I do believe that letter does contain that particular sentence.

MS: and your plan of action.

SP: My plan of action is that I will not refer Dr. Rohn to the Board of Medical Registration. The other three physicians that were referred to the board of Medical Registration came as a result of recommendations from other physicians reviewing the individual cases for which the three were individually responsible.

MS: internal review

SP: I am not, I am referring to two phases of a review carried out first by Dr. Jacobson and secondarily by people who are very much outsiders to the usual business of the department and

deaths that do occur in institutions not just institutions but in hospital. That second phase of the review was begun in Oct., concluded the middle of Dec.

MS: So now your peer review of the deaths of the patients within the facility. Was there any type of review initiated to review the cases where patients, other than Depart. of Human Services, where the patients were were alledgely receiving beatings from other patients, where a 74 year old woman was raped

SP: Yes I understand

MS: was there a review of these kinds of things.

SP: There was an internal review at AMHI.

MS: Ordered by you.

SP: It's a common AMHI when it has you know incidences going on reviews those incidences also we have an office of Advocacy that has a job to do. The job of the chief advocate who I think is sitting right back here, who is accountable directly to me is to bore in on these and to render umh an impartial, you know, view to me about what happened and they do numerous and I might may I also say, that it's not only to AMHI but it's advocates who are sighted at Pineland, and in our other facilities.

MS: So when they bring this to you as Comm. your response is?

SP: My response is that this is uh certainly descriptive of a bad situation and it is another source of information that leads me to feel that this institute is in trouble, I used I think someone Rep. Clarke used the word crisis earlier and that changes are most definetly in order. Now I said earlier, also, that I was in the process of evaluating several proposals that had come from groups who have been impacted you know, by the various things going on at AMHI over the last 18 months and I will tell you that solutions will rest in those proposals and we're needing to put together a group of people to you know, take a more thorough look at not the incidences, that for the record but how we can solve some of these very, very severe problems.

MS: My problem with this seems to be exceedingly slow. The problems, in fact, seem to go from bad to worse and your senior admin. staff

SP: no

MS: still only meets with you once a month. I have a real problem is the only word I can

SP: OK, well I think what we maybe want to do here is to look at the umh time frame during umh the time frame of these incidences that occurred for the different wards under DHS guardianship. Now all the incidences that are cited did not happen during the month of Sept. Yes the review happened during the month of Sept. but the incidences may have happened sometime before that I they I'm sure didn't cluster together neatly such that we are able to say umh that certain things are as problematic as they look. Yes there not good but we

need to be clear about time frames. Also you know, the deaths in August, which I did cite as one of the problems that umh has given us grave concern umh institutional deaths do occur. Now I do not say that to minimize the fact that 5 people did die during August, but I will share with you that the numbers of deaths for the last umh 10 years or so have ranged between perhaps a low of 18 a year to a high of perhaps 27. Now I can get you the precise numbers because

MS: I don't doubt that with the number of patient deaths

SP: right

MS: again umh I I am very well aware of some of the side effects of the psycho drugs and I am not a psychiatric nurse umh and I also know that you with patients who are receiving pshychtrophic drugs that certainly a psychiatrist and definetly people who work in psychiatric hopsital should be aware that patients who are receiving such drugs are at risk during a heat wave. Again administratively there seems to be no anticipation of that as a problem and very belated response after the facts.

SP: I would point out to you that it was I who convened this panel of outsiders to look into this. That was done on Oct. 19th and they took approximately 6 weeks to go through a very complex examination of three different incidences. The finding of this panel was that one death was clearly heat related. Now I know that Dr. Jachobson here can speak with much more depth and authority than I can on the medical reasons contained within these umh different incidences.

MS: I still again I go back to umh physicians, nurses, anyone dealing with that facility in which patients are receiving psychotrophic drugs have to be aware of some of the umh side effects

SP: yes

MS: of those drugs. Umh they they don't necessarily have to anticipate heat wave, but most psychiatric hospitals that again with which I am familiar umh have air-conditioned spots so that the patients who are at risk can can make use of those kinds of places.

SP: umh huh yup. OK, I am going to call Dr. Jachobson up here because I want the record exceedingly clear about the nature of the investigation into the heat related deaths and his findings.

Dr. J. I'm I'm very glad to be able to comment on this particular issue because I did make it a point of significant study including search of the literature, ah, a view of this issue in the larger context and particularly in the context of the very unusual weather of last August. Let me just say as an introduction that it is my belief that the people of Maine and that includes the average everyday citizen as well as the professional did not have an appreciation of how a heat wave like that could be dangerous to people. We live in vacation land, people come here to get away from the heat. I think most people in Maine just did not think it was dangerous. I happen to be on vacation the last two weeks in July and I regretted

having chosen those two weeks for vacation because even being on the lake was a very uncomfortable. I much preferred to sit in an air-conditioned room in my home. What I'm saying is that most Maine people would have said "I love this hot weather, I can't get enough of it". They did not really appreciate what this was doing to people in institutions. I don't think that the mental health system had a deep appreciation for how serious the situation was and I start from that premise to try to play out what really happened. I think there has been alot of distortion in the press about this very issue. The heat wave was a very real thing. People did develop heat stroke. It is my belief that it was a new phenomenum not previously encountered. We had no history of a patient actually suffering heat stroke at AMHI prior to Aug. prior to the summer of umh last year. I hesitated on Aug. because actually there was a case of heat stroke in July and it was treated very promptly and appropriately once it was recognized. There were a total of 5 patients in the hospital that suffered heat stroke. All were treated very promptly. One developed brain damage, wound up in coma at Mid-Maine Medical Center and eventually died of pneumonia, but there were 5 cases of actual heat stroke. That was recognized by the staff. The response once heat stroke was recognized was very rapid, very well carried out and it's my belief that the individuals involved should be commended for the kind of care they provided. But, nevertheless, the general preception was that this was not a dangerous situation. We did not know the actual heat on the wards. We did not know how dangerous this really was, and it wasn't until these events occurred, the actual deaths, in the early part of Aug. that there might be a real problem affecting directly the care of patients. That's my introduction.

FS: If I may,

DR.J: Please

FS: Before a nurse gives a medication to a patient he or she has to know the side effects of that medication and has to watch for those side effects. The fact that there was a long period of time before the the side effects were recongnized, in fact, the side effects umh or that the heat stroke was happening as a result of those side effects is is to me inexcusable. The psychotrophic drugs are known, and have been known for at least the past ten years to inhibit the ability of the body to sweat. People in institutions have long been recognized as being at risk in any kind of an institution when there is a heat wave. People in the general public are recognized for being at risk when there is a heat wave or else they would not print on the weather reports the ozone content and the pollution content of the air. Even in vacationland. Maine Maine get high temperatures like other parts of the country just happens to cool off at night most of the time but that was the problem this summer is that it did not cool off at night. Patients in any institution are recognized as being at risk and especially in a psychiatric institution. And if the nurses were not aware of this the physicians, the psychiatrists had to have been.

DR.J.: The panel discovered that they were actually not aware of it.

FS: And when the panel discovered that of course 5 patients were already dead by then

DRJ: No. Five patients did not die of heat stroke. One patient died of heat stroke. There were 5 cases of heat stroke and 4 recovered without any damage whatsoever.

FS: OK

DRJ: lets just get the facts on the table.

(SP: from background) She doesn't understand that there were 5 deaths and there not the same people.

DRJ: there not the same people.

UNKPER: right

DRJ: 5 deaths and 5 heat strokes are not the same people.

FS: The other 5 people who died had a complicating factor of heat.

DRJ: No they didn't. Two had absolutely no connection with the heat whatsoever.

FS: And this through an internal review you found this out or the external review.

DRJ: I did an external review. I did my review as medical director of the dept. I'm external to AMHI. I'm with the department but I'm external to AMHI. I did a preliminary review and based on my review I determined that 3 of the 5 patients that died in Aug. ought to have a further review. Now let me just say there have been some references to why were there five I thought there were four, and this argument has gone on in the press also. There were four initial patients that became the focus of attention. When I was given my assignment, I included the fifth patient, because he happened to die in the month of August and I said I might as well look at all the cases that died in August to be complete. Out of those five two, in my opinion, had absolutely nothing to do with the heat but totally seperate issues. But three were in some way in my mind related to the heat. Based on that, that determination my recommendation was for further study. And it was then that the open process began of naming a panel publically and having them charged with investigating those three deaths in detail. And the results of that were delivered to the public.

FS: and coroner reports on the patients who died cooberate your feeling that the patients, all the patients had no(can't decifer)

DRJ: Well it's a deficult finding to do post-op. The one patient who did die subsequent to heat stroke, who actually died of pneumonia uh, carries a secondary diagnosis of heat stroke but that was established as a result of the clinical record the medical examiner can not make a diagnosis of heat stroke because it's made on the basis of the elevated temperature. And unless he has a medical record that indicates what the actual temperature was then the post mortum findings are such that would point directly to the cause of death being the heat stroke. He'd do it on a clinical basis. There were

stroke in and of itself and in fact I had asked Dr.Ryan weather they actually were any cases of heat stroke reported to his office, and the answer was no. I had subsequently found out from vital statistics that there had been a number of heat strokes reported as secondary diagnosis in the state of Maine for the year 1988 and I'm still encouraging them to generate more statistics to get a better idea of what that is. So there were some distortions and I think some confusion about wich patients are we talking about what phenomenon is really going on. I hope it's clear now.

FS: Somewhat. My next question is then, have you made recommendations that air conditioning be installed that there be increased staff education about the effect of psychophobic drugs that the

DRJ: Representative Clark I made those recommendations when I happed to be present at a medical staff meeting at AMHI. Immediately after the incident occured that was I believe, August 10th.

REP.CLARK: Did you tell (can't decifer)that these were your recommendations?

DRJ: I indicated the need for air conditioning and cool areas in the hospital immediately and that was done on the following day. I subsequently told Commissioner Parker my concern that this was a poorly understood phenomenon, and that training of staff was going to be essential before next summer so that it does not repeat itself.

REP. CLARK: Thank you. Commissioner Parker, if I can talk to you for a moment again um, the question that I have is administratively and (can't decifer)

SP: Worker poor administrative staff together we don't put all administrative staff together because that would be an inefficient use of our sources we pull those chief people together who are directly responsible. And that included the Superintendant the doctors at the Augusta Mental Health Institute at that time were accountable to the Superintendant.

REP CLARK: and your senior administrative staff.

SP: My, would you like to, yeah. My senior administrative staff include the Superintendant of AMHI, the Superintendant of BMHI, the Superintendant of Pineland Center, the director of the Bureau of Mental Health, the director of the Bureau of Mental Retardation the Bureau of Children with Special Needs, the Assistant to the Commissioner and the two associate commissioners plus the Medical Director.

REP CLARK: OK, so you..

SP: We do not pull everybody together when a series of incidents like this or a similar incident happens we pull together the affected members and yes, we problem solve. There is a ventilation study going on now in the state government to look at the needs of AMHI. Now it's a known fact that burocrocies may not work terribly fast, but they do work. But we need to keep on them. The Bureau of Public Improvements is part of the Department administration whenever AMHI as a facility needs a change in its physical plan we can make the

recommendation that this change occur but we have a higher authority that we must go to, its called the Bureau of Public Improvements and they must sign off on the need for this sort of study. And that is what has happened and that is what they are doing.

REP CLARK: As Commissioner, do you essentially can expedite a number of things by emphasising them, by

SP: Believe me they have been emphasized.

REP CLARK: Well not too long ago you told me you were unaware of a number of incidents so how....

SP: And I said to you, that many of these incidences as exemplified in the Department of Human Services reports goes back several months to maybe even as much as a year. Now, when I learned of the findings of the DHS report which was let me see, probably last week when I saw the report in its fullness, I simply said this is another in- another set of instances that point to fact that we have major problems at AMHI and yes we need an aggressive solution and from an executive branch agency may I say that we're entertaining several different solutions and I would be most happy to involve this committee subsequent to this hearing in the discussion of those.

REP CLARK: Um, my last question you know, and I'll hand it back over to others, um if you mentioned the fact that we have you (can't decifer)

SP: Bureau of Public Improvements. It's called Bippy.

REP CLARK: So you have ---- for comming in, or (can't decifer)

SP: I am hopeful that it will result in that but first we must go through the assessment of what ventilation needs must go where. AMHI as an institution is a sprawling physical plant and perhaps some areas lend themselves to air conditioning, perhaps some areas lend themselves to air ventilation systems that are able to move vast currents. I am not an engineer. But just a minute, I am not an engineer who understands air flow and dynamics. Therefore, I must rely on people outside of our department to give us the reccommendations on what would be most effective to achieve a certain end.

REP CLARK: But you have now roots that patients on psychophobic drugs can be housed can be (can't decifer)

SP: Dr. Jacobson could you take that one? Because she's talking about individual patients and probably individual cases.

DRJ: Actually AMHI has had air conditioned rooms for some patients for a number of years constant observation rooms are at least two of them that I know of are air conditioned. And when a problem is identified, those rooms are used for air conditioning they were inadequate in size and number for the problem of the heat in August in the middle of July to the middle of August. Once it became apparent that there was a serious heat problem, AMHI was able to obtain a number of window air conditioners and install them. Unfortunately the heat wave was over a few days after that. It was one of those things where the correct response came but it was a little late. You know that the, even though it was terrible weather

it only lasted four weeks. It seemed like an eternity at the time. We really expected each next day to improve the situation but once the air conditioners were installed there was only a matter of a few days and we were back to normal Maine temperatures.

REP CLARK: So anticipating the result of your studies, of ventilation studies and things like that you had put money, um, requested money in the budget for...

DRJ: No. No money has been requested to my knowledge. What has been requested is an engineer study of what is needed to control the quality of the air in the buildings at AMHI that house patients. Because of the fact that it is a 150 year old building it's built of granite and you know granite retains heat there are some very special characteristics of the building and it's not enough to just put air conditioners in you really have to look at it as a larger engineering problem.

REP CLARK: Which is fine but did you include money to appropriatley intervene when the study is completed. In your budget.

DRJ: I don't think that's been targeted yet. Is that right?

MS: We've discussed, with the bureau of Public Improvements, the scope the possible dollar scope of that project. A (can't decifer) to determine what the cost will be and exactly what areas need to be ventilated more adequately. Um we heard as high a number as two and a half million dollars to air condition the entire facility. And so until we know exactly what the cost will be there is no specific request, that I'm aware of at this time.

REP CLARK: (can't decifer)

SP: Not necessarily because I think there is clear recognition in all phases of government that something must be done. Which leads me to a point. and that is that the litney of things you know you raised some very good questions there are plans for each one of those. You did not raise new information. But you raised some very good questions about each one of those items.

REP CLARK: Thank you. Actually when I (can't decifer)

SP: Well the panel the advisory panel that I appointed on October 19th resulted in a series of recommendations. Those recommendations have been passedon to the AMHI medical staff. The medical staff is assuming more leadership for the maintenance of AMHI the DHS report which you may have read about that was released yesterday contains a plan of action in it on how the department of Human Services and the Dept. of Mental health and Mental Retardation will work together to do a better job of monitoring those words under the guardianship of adult protective services.

FM: But as Commissioner, you have not really got a handle then on the specific plans of action that will result.

SP: Yes I do have a handle on it. It is a process. And the process in this sense is just as important as the content and I hold certain key individuals accountable for the execution of

each one of those recommendations. In the case of the panel that elicited its slanders in December concerning the three deaths that it investigated thouroughly I am holding the clinical directors, Owen Buck, and William Sullivan through the acting Superintendant Walter Rohm directly accountable for that implimentation and for moving up the chain, Dr. Jacobson has oversight of all areas of medical involvement in our institutions and he is a part of that process.

MS: Yes we're (can't decifer)

FS: (can't decifer)

SP: and my intention in passing out the minutes of that March 10th meeting was that I understood that chronology were important and I thought that particular meeting might identify a vehicle where legislators were involved.

FS: (can't decifer)

SP: OK OK. Dr. J. oh Rick Hanley, beg your pardon oops medical records and reporting.

FS: (can't decifer)

MS: I had talked earlier today about the plan that we started last March which is on going we have as far as medical records we have implemented a process wich I think should improve and is improving the documentation from the time the patient comes in the front door. The, one of the clerical staff persons that we were able to get through the legislature we have beefed up our medical records clerical component and so we now, and also very schedules so that admission notes, for example, are transcribed by 8:00 in the morning. So that when the physician for the admissions unit for example the overall clinical director comes in in the morning he has that admission note from the evening before in his hand when he sits down to reinterview the patient and review the work of the person who did the admission. We have developed a new neurological exam form and that is being monitored the use of that. Claudia Shultz coordinator has been part of her duties have been shifted to monitoring medical records compliance on the admissions unit as well as her duties throughout the rest of the hospital we have beefed up order recommendations. One of the deficiencies that was noted was that we were not building treatment plans that were based upon patients strengths and it's very easy when you work with acutely and chronically mentally ill people to focus on their deficit areas and that not look at the restraints that they posess. So we have been orienting our staff and monitoring the compliance with building treatment plans that are based upon the strengths the assets that that person brings with them to the hospital. Treatment plan procedures have been revised as I mentioned this morning to make it more likely that a solid assessment or group of assessments will feed into that comprehensive treatment plan we have had consultation going on for the last three months or so on the admissions unit also on our adolescent unit. As far as treatment planning and documentation and that has been I think extremely useful. We've been working with both the teams on the admissions unit to give a better sense of the disciplinary process, which is in part what Medicare is looking for. They want position direction of the process they want to see that the team comes together discusses, interviews the patient

discusses the assessments and comes up with some kind of a consensus plan so that the whole team is moving in the same direction, but under the direction of the medical staff. Those are a few of the things that we've done. We have several people now who are doing auditing and not just, like our patient care coordinator who reviews charts and gives feedback retrospectively to staff we are moving very quickly in the direction of getting an audit which means you have to look at a chart look for weather the strengths and assets are there weather the progress notes relate back to the treatment plan and so on and when we find a deficiency, we are going immediately to the person and correcting that deficiency. So theres not so theres (can't decifer)is shortened up a great deal. Now just one other example before I stop we've been of course in the medical staff area we have improved our monitoring of progress notes which are to accompany every physicians order. That is one of our standards. Recently we completed a medical review of 632 doctors orders and of those 632, 630 had a progress note. Now, that's not to say that every one of those progress notes was A-1 quality, but they were there and we're moving very strongly in the direction of assessing the quality not just quantity of notes and the time limits, but also the quality of our documentation.

FS: (can't decifer)

MS: Yes it does. For the new staff that come in we have enhanced the medical records documentation. A piece of our orientation program. We thought that that was an area where alot of staff were keyed into writing kind of daily care notes. Patient slept well, ate well and so on. We have included a stronger component in our initial charting orientation for new staff that goes really to the heart of quality observations and documenting based on those observations. Adressing the treatment plan and the nursing care plan.

FS: (can't decifer)

MS: I'm sorry, you mean when the patient moves from one floor to another or a staff person is pulled or moves to another floor? They are, the initial training that we have done reached all areas of the hospital we didn't want to focus just on the Medicare distinct part. and We used a train the trainers model. There was a group of 44 who are initially run throught the training and the intent has been that they would go back to their individual units and work with their treatment teams on documentation. So there is some kind of outreach in that sense.

FS: (can't decifer)

MS: We are on the admissions unit right now we are evaluating the teams on an ongoing basis. Both the team process and the product of the documentation. We I think have work to do, in other areas of the hospital. We don't want to neglect the rest of the institution.

MS: (can't decifer)

SP: 64.5 to AMHI

MS: (can't decifer)

SP: Yeah there were several physicians that (can't decifer) now there were a variety of mental health workers at through levels one physician three, that's the top level of physician allowable the state government. There was um, one psychologist too persuing your theme of psychiatrists once we knew that Medicare was gone MaY 29th, we did make arrangements for the bringing back of Owen Buck from the Maine state prison to you know, give his one day a week. And we also added a half time psychiatrist to help us out. Within the Medicare package itself there were two psychiatrist. they are under contract and that is what was referenced earlier that we have to, because there is such a possity of psychiatrists in Maine, we have to go through a national brokerage location farm to find people who can come in once it's an arduous process, but it is doable and we have found some good people that way, both at BMHI and at AMHI.

MS: (can't decifer)

SP: At this time... end of tape.

Tape #4

MS: I am not trying to tell you that there are no medical record deficiencies in the way that progress has reported. We've recognized that there are deficiencies. Within the resources that we have, we're trying to do our best tot correct those.

Female: I have just one more question(can't decifer)

MS: The patient to whom the secondary diagnosis was heat stroke? No.

FS: (can't decifer)

MS: No he was not. No.

can't decifer

MS: a general feeling that everyone felt the (can't decifer)as you know (can't decifer)

MS: Go ahead and ask and I'll tell you afterwards.

MS: (can't decifer)

MS: Boston is the regional office there technically disbursed from the Maryland central office.

MS (can't decifer)

MS: We get notice a matter of two to four weeks ahead of time.

MS:(can't decifer)

MS: Yes

MS: (can't decifer)

MS: It traditionally has been two or three people, most recently two, and we have had repeat visits from the same people I think one of wost surveys three or four successive reviews.

MS: you had these people show up on February 23rd (can't decifer)

MS: No. They were not.

MS: OK. So perhaps part of the fear was that (can't decifer)_

MS: Well, they were certainly certainly hardnose, I think there was some um indication in um that list a couple of the earlier surveys that certain things were acceptable one month, six months later were not acceptable.

It was not saying that you could say yes there was a definate trend, but it did appear that, for example, on survey would have gotten our nurse staffing back up to snuff that was I believe in May. May of '86. When the team came back, a different team came back in September of that same year for there anual survey we were certified, but they thought that our nurse staffing was not adequate and it was exactly the same number of registered nurses as we had had in May of that same year when we were fully certified. Again interpretation of the staffing versus the patient need kind of approach.

MS: (can't decifer)kind of reestablished the fact that there was (can't decifer) general feeling in the departments(can't decifer)

MS: I think there were some clues, I don't know that it really hit us over the head, that there might be this pattern but there were some clues along the way.

MS: evidently by the end of May (can't decifer)

MS: Yes.

MS: (can't decifer)I just want to (can't decifer) I wanted to change the subject slightly um, I (can't decifer) I think is of interest to me in your opinion someway to make your own judgement. If you could just set yourself(can't decifer) and deal with the following issues: one (can't decifer)time frames or particular issues that they might notify or even put in writing but you not be notified of that, and weather you feel (can't decifer)

SP: um, when you say communication, what do you mean by that?uh talk to her?

MS: well it seems to me by the documents I've asked you questions about before and the material that I've read, that there are some things that some staff members viewed as important and significant in terms of the way the regulations were being interpreted and the situation at the to yourself said many many times that one you didn't read that particular section and didn't expect the (can't decifer) and that you didn't actually come to that (can't decifer) until June. So there's either there either lacking a proper communication between those who vote those reccomendations, or their just not, have not been pushed enough to make sure that you are privy to those kinds of pieces of information.

SP: No. On the fact that I haven't read what it is, I didn't know what you were reading from. Once I figured out that it was an introduction to the plan of corrections, indeed I had read that. Um if hindsight was twenty-twenty, and I wish it was, I said that once before um perhaps we should in the department engage in more written communication you know one to the other. I am so mindful of the time bind on the senior staff that I rely on verbal communication a great deal. Between and amongst the various inner staff members to communicate what's happening and what's not happening.

The issue of the standards interpretation of the standards again if hind sight were twenty-twenty I wish that we had been tougher on ourselves at that point. But truely you know you have heard from Mr. Hanley and heard from Dr. Rohm and you've heard from me now there was constridation, perhaps, about the stringency or constridation about how stringent these standars would have been interpreted. And I would point out that that constination is shared by my peers across the country it still continues. You know I talked with a gentleman from Tennessee last week and there in the throws of a discertification I wish I had assumed a worse case senario and sort of layed it down and said damn it you know this is a tough situation and let's treat it like that. If we had done that, um perhaps things would have been different. But I can't predict. None of us can predict.

MS: Well I don't speak for the panel, but I think we're all concerned with not only fact finding in terms of what went wrong but also where do we go from here?

SP: Where we're going from here is that we're going to assume that it's a worse case senario and that they are interpreting the standards with this medicalized prism in front of their eyes and we will execute the preperations with that in mind.

MS: But in terms of communication between staff at the facilities, and you (can't decifer) Do you see, or do you desire any changes in the way it's worked(can't decifer)

SP: I am confident that the communication that happened last February and preceding last February as well as what happens now, that the communication is full of meaning and allows us to know what goes on. Now meetings are important that's true. But what's more important than meetings is the willingness and the ability of people who work under you to say gee, maybe I don't know how to do this after all. I think one of the absolute benefits of this hearing, and I say that having gone through a number of hours here is that we now have some you know collaborators perhaps in the legislative branch, who are more (can't decifer) of what Medicade, Medicare are all about, and what the you know the process is for the reviews. Having said that, I think if communication can approve, I'd like to use up more of your time , than I have in the past. I know on several occasions last year I talked to the co-chair people of this committee and I said I would like to come and do a briefing we did that a couple of times and I know that that becomes particularly important once appropriations sets it's schedule because this committee um with this level of information now about a program will be very much better fitted you know to see the policy side of the appropriations question. I would be looking for opportunities to do that with you all.

MS: and the last point of it, and the reason I mentioned that again between the various groups is that Dr. Rohm did when Representative Manning asked him a question he suspected a change, it obviously was (can't decifer) on you suspected that, and I would think that in terms if I had been in your position and found out at this late a date, someone directly involved in that he being clinical director and there were several others obviously that fought their big changes but I if I didn't know about it as Commissioner I would have been concerned as to what system was there (can't decifer) was apprised of those changes

I guess I'm just looking for something a little more specific on your part as to what you are going to do to avoid those situations in the future it was made pretty difficult. A different situation in terms of being aprised to various parts ...

SP: I think, you know particularly given what we've been through with AMHI and now the the honest knowledge that there is a change that has been inclimated Federally that will be much more strict, then how the reporting comes back. In my world of management, I call that a feedback group. I mentioned earlier that the Associate Commissioner for programs is in charge of monitoring all the external reviews. I think what we will do is to take steps to make sure that the feedback is given to me and all of us on a regular basis and regular doesn't mean once a year it would be more like twelve to fifteen times a year, on how we're doing meeting the certain standards as we have to think about undergoing another review. I know as we speak there is um, the Department of Human Services has scheduled two reviews at AMHI and I think they ar comming as soon as next week, the next two weeks. Definately we need to know you know this all um raises the question of the funding mix, that we're using to finance these multiple services um, the cost it actually takes to participate in Medicare and it is a cost, you've heard about it from staff uh, how we're doing on drying down Medicade you know, and our ability to do that depends directly on how well we're fitted you know to actually qualify for the money.

MS:(can't decifer) Is it a rule making process?

SP: No. It's not a rule making process it's an administrative decision that will then an Institues SuperIntendant can then put into motion. That Superintendant usually um, talks with individuals throughout the department to make certain decisions.

MS: Uh, when you presented the budget, for '88 in a special session, um, you recommended (can't decifer)

SP: Yes I did.

MS: and uh you were at that time(can't decifer)

SP: Yes we were.

MS: I'm surprised(can't decifer)

SP: Yes. and that was one position from each and what , the rational behind it is that we needed three positions to build a quality assurance unit that would benefit all the aspects of this departments functioning particularly the mental health units and Representative Penderson given me a great opportunity to talk about how several months after I arrived here I layed the plans for establishing a highly beefed up and strengthened unit that would put into place, methods that would allow us to answer the question how well are our services doing on behalf of people with mental illness and mental retardation,it's not a paper shuffle.

It is an actual evaluation that will occure that we that we sponsor to answer those questions. Now you may know that both BMHI and AMHI have quality assurance people. But they do the quality assurance internal to those institutes prior, there had been no mechanism for the product of those evaluations to answer the important question about patient care. They've been a vehicle for bringing that back to the central office. Consequently, here we were doing our budget, doing our policy stuff, with no direct feedback between the two. Not good. And that particular position that came from both AMHI and BMHI was used to create, you know, the positions that were needed in order to make sure that our internal evaluation system could get up and working, and I am very pleased to be able to tell you that last October we hired a highly qualified individual in quality insurance who is doing a remarkably well given you know, that we are spading the ground for the first time and putting together a system wide evaluation. Further this individual has spent much time at AMHI advising consulting with the um, AMHI quality assurance staff and is a great help because he is so knowledgeable about the Medicade Medicare regulation and also the JCAHI requirements. It's a good investment.

MS: At that time(can't decifer)requested previous positions(can't decifer)

SP: Well they came back, we came back in September and upped the anti by 130.

MS: The other thing I'd like to be a little more knowledgeable about is that right now we're only talking about (can't decifer) at AMHI..

SP: Yes. Yes. Thirty beds that um, are now without their Medicare funding out of 386.

MS: and previously the (can't decifer)

SP: We had 86 and there were a couple of decisions were made to not go after Medicare funding for those, primarily because on one unit there were I see, like four people who would be Medicare eligable and it was not deemed to be worth the staff effort because of the cost to go through it for four people, exuse me Ron Martel has the exact numbers.

Ron Martel: We had 86 beds certified after the May decertification we were left with sixteen. There were 78 cute psychiatric beds represented by two wards one a thirty bed unit, one a forty bed unit. A sixteen bed infirmary certified for medical surgical care. Which is certified as of today by Medicare.

MS: How does that affect the previous thing (can't decifer)

SP: The 125,000 lost per month? Why don't you talk for that one.

MS: These thirty beds come back, is that going to replace that one?

Ron Martel: Not entirely, no.

MS: The other thing is that what do you think about having, is that as far as we can go as far as involving federal funds for A(can't decifer)

Ron Martel: No. It is not. In terms of Medicare certification, uh, we think it is appropriate to certify or recertify just the admissions unit which is at now just how we have it at Bangor Mental Hospital and have had for many years uh, we working very strongly with a consultant to increase the Medicade reembursement to the general fund and over the past year 1.2 million dollars has come back in. Net federal dollars the general fund. As a result of that effort, in addition an additional three thousand dollars per year is being generated this year. As a result of that effort, our daily rate has gone from $62.00 to $86.oo so there was much that was able to be done in terms of Medicade what we've been discussing for many hours here today, has been primarily Medicare uh..

MS: (can't decifer)

SP: Well um, I think we're on the right track here. I earlier made reference to the fact that the comprehensive plan that we spent a year putting together resulted in a blue print that called for developement of additional positions at AMHI and BMHI as well as extensive developement in the community. Now the percentages, Rick help me out is it 60-40? That 60 percent of the admissions to AMHI are first time admissions and 40 percent are repeat.

MS: Roughly (can't decifer)

SP: Forty and Sixty

MS: How does that compare with say where we were a year ago? Is it in the same ballpark?

MS: Roughly the same, but it's considerably higher than we were say 70 or 80.

SP: And the reason is I think you'd agree Representative, that it's higher is that there has been an alarming possie of services in the community. Now if you like we can go through a status report on where we are at on community developement.

MS: I have some knowledge..

SP: Yes. I thought you might.

MS: I just have one other question I have some people that are interested in STIGMA and they (can't decifer)

SP: Well I am very embarrassed to own that and I must tell you that I am guilty, and it happened at a time when I was exceedingly nervous in my Old New England (can't decifer) came out. And I know better than that and I don't you know in my heart I don't feel that way. So that was an unfortunate remark and I apologize.

MS: (can't decifer)

Female Voice: Can't decifer)

SP: No. No no no um, we see all patients in need of care equally. I do not you know, none, neither I nor any of my people at the senior staff level differenciate you know, whose client is whose. I mean we need to deal with these people. If anything we understand that if a referral comes from child protector services, or adult protective services that um, that referral may or may not be appropriate but the larger problem may rest with weather or not the proper services is available in the state of Maine. It's that kind of question that we go through.

Female Voice: (can't decifer)

SP: I don't know where you got the figure Representative of two hundred and fifty.

Female Voice: I was subtracting the numbers(can't decifer)

SP: Oh, the thirty from everything else?

Female voice: yes (can't decifer)

SP: No. I see what you are saying. No let me be clear on that I said to you earlier when you persued your first line of questioning you asked me directly, weather or not I thought AMHI was in a direct state of crisis I said yes I do. And then I went back and reviewed why I thought that. Now I should tell you that the Commissioner of Human Services and the Commissioner of mental health meet, we meet regularly and we met I think it was last week on the issue of the DHS referrals and thinking about certain steps that need to happen and I am confident as Assistant Superintendant Hanly said, that there is good colaberation between those two agencies and the staff people who are doing it. Now, on the issue on my management style, I'm not just exactly sure of what you are referring to, but I believe in a style of management that does not distance me from what's going on at the grass roots level now we understand that I have a very large department to run and I can't know everything about everything I wish I could, I can't. I do absorb a fair amount of detail but I have put together, and I did this in July of '87 a senior management team I listed out the ten or eleven members of that team and each member of that team is intrigal to the total operation of that department and we operate by the crito that quality information has to get around to all of us and that is why we meet on a frequent basis. Also stylistically, we are very direct with one another if we have issues , if we have problems we understand that it is a no surprise mangement that's not something that we tolerate. We expect our peers to be upfront and to level. And it's also understood that, if I feel like I should visit a hospital at odd hours of the day or night, that I am able to do that and that is no regarded by members of the team as a threat. And that's part of the trust level we have to have in order to keep our courage in the face of fighting the real enemy which I'm sure you'll agree is mental illness.

Female: (can't decifer)

SP: No. How many have I had with Rollin Ives? Well we started on this I'm going to say late August early September, late August. Around this one DSH issue uh, Commisioner Ives and I have many things in common one of them is Medicade, Medicare. Children and Foster care.

MS: (can't decifer)

SP: I'll be there. Work it out.

MS: (can't decifer)

II

STATE OF MAINE

HUMAN RESOURCES COMMITTEE

Hearing on Augusta Mental Health Institute Issues held on January 31, 1989, in Room 228, State House, Augusta, Maine.

Carmen M. Thibodeau

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Augusta, Maine
January 31, 1989
9:10 a.m.

SEN. GAUVREAU - Good morning. My name is Paul Gauvreau, I am the Senate Chair of the Joint Standing Committee on Human Resources. To my immediate left is Rep. Peter Manning of Portland who shares the Committee from the House side. This is the second day of hearings the Committee is holding relating to the problems attendant at the Augusta Mental Health Institute.

Prior to resumption of the hearing, I'd like to address an issue which came up at the very end of Thursday amongst Committee members. There was some concern that some materials were not fully distributed to all members of the Committee. My understanding is that now all members of the Committee should be in the possession of similar documentation. There have been apparently ten of these briefing books prepared rather than thirteen, so what I suggest we do is make sure that at least we distribute them in a fashion so all members of the Committee can look on. There are two - there's one in from of Mark Sirois. Okay. Do all members have access to the briefing book? Okay.

I received this morning a document which purports to be the response of the AMHI medical staff giving a response to the AMHI advisory panel which dealt with the investigation of the various deaths at the facility and I will ask Committee staff during the course of the day to reproduce this document and make it available to members of the Committee as well. And I would suggest the protocol - that any documentation which is used

by any member of the Committee in the course of these hearings be available to all members of the Committee, that anything prepared outside the Committee format is your own separate work product, but if you introduce it and discuss it or make reference to it in the context of the hearings, it should be deemed Committee property and available to all members of the Committee.

Are there any questions regarding that protocol? Hearing none and seeing none, we have asked - we being Peter and I - have asked for leave to be excused from attending the sessions this morning at ten o'clock. I understand there are some roll call votes relating to confirmations in the Senate and we've asked those to be held until the very end of the Senate session so the Senators can be excused from the Committee for the purpose of voting on the roll calls. I do not believe there will be any roll calls in the House today, but I would ask the Staff of the Committee to check with the House to make sure there are - if there are roll calls, obviously, you'll be excused from the Committee responsibility for the purpose of going to the roll call. And I would be remiss if I did not introduce to the full members of the Committee our new Committee Clerk, Mark Sirois, welcome on board.

At this point, I think we are ready to resume the presentation of Commissioner Parker, unless there are any other questions. As you recall, when we broke on Thursday afternoon, the Committee had completed questioning relating to the issues of decertification at AMHI. Now today's focus with Commissioner Parker will be on

the whole class of issues referred to as quality of care. Now, Commissioner Parker has requested the Chairs and we have granted her request to allow Dr. Walter Rohm to return to the institution to make his rounds and attend to his medical duties this morning, so I would ask members of the Committee to refrain or hold your questions from Dr. Rohm until this afternoon when he will return, so we'll allow him to attend to his medical duties.

At this point we'll again - let's open up the hearing relating to issues on quality of care and, again, welcome Commissioner Parker.

COMMISSIONER PARKER - Thank you, Mr. Chairman. If you so permit, I would like to open up with a series of comments.

SEN. GAUVREAU - Certainly.

COMMISSIONER PARKER - Good morning, Senator Gauvreau, Representative Manning and members of the Committee.

Before we begin I would like to make some brief comments that I believe will help us to continue this dialogue in a way that will most benefit AMHI patients.

I'm sure that you understand that our staff are under a lot of pressure to get the new programs underway that will eventually help reduce AMHI's overcrowding. This is an especially stressful time for staff, because AMHI is functioning without a super-intendent. However, I do believe that the staff and the Committee can all use this time productively if we lay out for you what steps we have taken to get AMHI back on its feet and then receive reactions and input from this Committee.

The seven hours of questioning on Thursday truly resulted in a fragmented description of what we've been doing and I'd briefly like to paint for you the big picture.

As I said last week, AMHI is a very troubled institution. It's plagued by serious problems of overcrowding and years of inadequate attention and underfunding. We can't change those problems overnight. However, there's no question that this Administration and this Legislature are committed to making the changes happen as quickly as is humanly possible.

In the past fifteen months AMHI has received a level of direction and support which truly is unparalleled in the last decade of the hospital's history. In less than a year and a half we have approved ninety-one staff and millions of dollars in community resources to alleviate overcrowding in contrast to the seventeen staff in the preceding years.

If we take a look at this chart done in blue, what you'll see are the years from 1980 to 1989. The title of the chart for those of you in the gallery is AMHI Annual Admissions and Full-time Equivalent Positions. What we see is, looking at the blue bar, annual admissions have continued to rise. They dipped briefly in '86. However, what we see from the period of time 1980 through 1985, while the admissions went up, the staff full-time equivalents continued to go down. However, beginning in 1987 the trend clearly changed. While the admissions continued to go up and, yes, even further than the previous high in 1984, we also see that the numbers

of staff also continue to go up, following the trend of the admissions.

A total of $27 million is being appropriated for a thirty-three-month period between October, 1988, and June 1991. We have adopted Maine's first truly comprehensive mental health plan, the product of thousands of hours, very hard work by staff, by 1,200 volunteers and consumers. We have also created an independent commission to oversee the implementation of this plan.

An important question is, though, however, what plan do we have for putting these resources to work and getting AMHI back on its feet.

The plan for AMHI is dynamic. It is composed of a series of very concrete actions begun months ago and updated as other significant events have taken place. The long-term goal of our plan is summed up in the conclusions of the Commission on Over-Crowding in its interim report delivered to the Legislature in January, 1988. The aim - to develop the badly needed community resources for mentally ill persons and their families so that AMHI can fill its proper role as a public psychiatric hospital.

Certain actions in our plan are aimed at bringing AMHI's admissions unit into compliance with Medicare and are contained in the plan of correction prepared before Medicare decertification in May, 1988. These actions, as you heard Thursday, were amended and eighteen staff were added to AMHI and paid for out of the Governor's contingency fund during the period of June to mid

September, 1988.

The more comprehensive plan was completed incorporating all prior actions in the form of our state mental health plan distributed in July '88, which served as a basis for the additional staff request approved in the September, 1988, special session.

When an unusual number of deaths occurred in August during a short period of time, I ordered a series of internal and external investigations which resulted in recommendations which now have been incorporated into our plan. The plan has now been expanded to include yet another set of recommendations, those that have come out of the DHS, that is, the Department of Human Services investigation into the wards of adult protective service who reside at the Augusta Mental Health Institute.

All of the actions I am describing constitutes a plan for AMHI that has one purpose, to improve patient care and treatment. A critical question is how well are we progressing with it. The answer is not nearly as well as I would like. Over the past few months I have seen increasing evidence that AMHI has not had the kind of managerial direction and leadership that could get the institution back on its feet. So in early January I asked for Superintendent Daumueller's resignation to pave the way for some high level management changes.

We must remember that AMHI, a public psychiatric hospital, is the third largest hospital in the State of Maine and that in addition to the special psychiatric needs of patients, it has

many of the same complex needs that large hospitals have. It is a 380-bed hospital with nearly 700 staff of psychiatrists, psychologists, physicians, nurses, social workers, therapists, support people, which include dieticians, housekeepers and hundreds of others involved in patient care.

Strong managerial direction is absolutely vital to the development and implementation of sound operational plans for such a large hospital and I do not believe that we have had it.

When I referred to a crisis last week, I was referring to a current crisis in management. The serious underlying conditions at AMHI have been known to us for a long time and I believe they have actually improved over the past year and a half. However, my confidence in the plans we adopted for dealing with these conditions and the pace with which plans have been moved along has been undermined by the growing evidence of weak manament at the top.

To deal with this current management crisis we are in the process of identifying and bringing in outside expertise to analyze AMHI's management capability, focusing on such areas as organizational efficiency, staff deployment, administrative practices and communications systems. We need someone to come in who has a fresh perspective and who has experience in dealing with the complex needs of a very large specialty hospital. This analysis will provide us with a sound basis for evaluating the plans we have in place.

As I told you on Thursday, many affected groups have been proposing solutions to AMHI's problems. Until we have objective and expert analysis, however, it is not possible to determine whether our plans are flawed and in need of change, such as those proposed, or to determine whether progress is simply a matter of strong and aggressive leadership at the top to make our plans work. We can be assured that any recommendations that come out of this effort will withstand scrutiny by experts in hospital management and those others who are versed in mental health care and administration. Thank you.

SEN. GAUVREAU - Thank you, Commissioner Parker.

EXAMINATION OF COMMISSIONER PARKER BY SENATOR GAUVREAU

Q. Now, I understand that you have spent I guess the last eighteen months or so in working with various groups in crafting an overall mental health plan, the objective of which is to reduce the census at the state's acute care institutions and augment community base resources. Based upon the information the Committee received on Thursday, it would appear that there will be an interim period of time when those objectives in the short term would not be realized and that, in fact, there seems to be justifiable evidence that substandard levels of care exist to some degree at AMHI and so the question which I would posit would be, what in the short term would you propose that the Governor and Legislature do to raise the standard of care, to address the most salient concerns which have been discussed

frequently over the last few weeks until such time as the hoped-for benefits of the long-term plan are realized.

A. I would propose that we continue with the persent schedule and action plan that we have concerning the community programs. Many of you know that in September we presented you a time line for the actual development of those community programs. We are still in observance of the time lines that you were given.

Secondly, I would propose that we, as I just said in my opening remarks, that we continue with our discussions with management firms that are highly skilled in hospital administration and work with them to help us evaluate the different solutions that will come on the table. We are in absolute recognition of the fact that the issues at AMHI are those of a large, highly complex organization and those pertaining to a speciality hospital.

Q. Well, I guess the concern that the Committee members have at this point, which I have heard from a number of people in the community who do not ordinarily involve themselves in any matters of politics or government, there seems to be a developing perception in the community that we are tolerating and expensing substandard level of care at AMHI and that, frankly, I don't believe people are prepared to wait much longer before the State takes concerted action to address those concerns. And I can - it's fair to predict that if that's the perception of the community, those same concerns are shared by the membership of

the Legislature. And last week I did ask you in terms of your time frame or had you a particular plan proposed to this Legislature and you indicated that you would be planning on meeting with the Committee and developing in a collaborative vein a response, but I think it's important that we have a definite time frame and that the Committee knows when specific proposals will be forthcoming. I understand you apparently have engaged a consultant to offer an independent perspective in terms of the problems that AMHI has, but we need to know specifically when would you be ready to come to the Legislature and offer a particular plan of action.

A. Senator, so that the public record does show, in the Department we have interviewed three possible firms that are very versed in psychiatric hospital management. We have two other interviews to conduct. I have two proposals sitting in my office now. We are waiting to get the full picture via the other interviews. It would be timely, I would think, in two to three weeks to come - to meet with your Committee to discuss the various options in these proposals and to work with you on what the recommendations are.

Q. So, is it your understanding that within that two or three week time frame you would have had an opportunity to select a firm to assist the department in restructuring AMHI with a service delivery system and then in that time frame to make focused proposal to this Committee as far as where do we go from

there?

A. Recommendations, that's right.

Q. And have you - is it your position that you may approach the Governor or you may recommend funding or modifications in the budget based upon the discussions with this Committee and based upon the discussions with your consultant?

A. From what we see now, Senator, the actual cost for the consulting is affordable and we can handle that through internal means. As far as financing of possible recommendations, that is, solutions to extant problems, I think it's a bit premature to speculate how that may work, but we would be happy to work with you on what those recommendations are.

Q. I just mention this because it seems to me that there'll be strong sentiment in the Legislature to have a particular plan of action with the specific funding proposal before appropriations to consider during this Legislative session.

A. Yes.

Q. I'd like to call your attention, if I might, to the report which was prepared by Commissioner Ives relating to the assessment on public wards who are residing at AMHI. That report, I believe, is dated 11/9/88. Do you have in your materials - Susan, do you have that report?

Now, in the past concerns have been raised regarding individual identifying materials contained in the Department Report and I understand that the report has been redacted to excise the

particular names of any residents. And, frankly, although I'm very much concerned, of course, with the individual cases, I think my concerns are at this point directed toward the specific response to the Department with respect to the recommendations. Now, the recommendations can be found, I believe, at Page 8 of the DHS Report and there are, in fact, some ten specific recommendations to the public ward - regarding public wards rather. And then there are nine specific recommendations to then Superintendent Daumueller and then there are recommendations, two in number, pertaining to training and policy development at the institute. Can you indicate to the Committee what the formal departmental response was to this report and what actions have been taken to date to address or respond to the various recommendations?

A. The first thing that happened, the leadership of AMHI were asked to put together a response to the DHS full report and they have done that. They posit and I concur that this report does not yet include the results of independent consultants who are also engaged by the Department of Human Services to actually examine various clients in question here. I know in particular there is a report from a psychiatric consultant and the results of that particular report have not found its way into this report.. And we feel that we would rather wait until the entire finding, you know, which does include the consultant report, is part of the record here and then to make a formal response.

That is not to say that certain highly specific and concrete actions have not occurred, because they have. For example, the - let me pick out one here. Number 9, this particular recommendation emanated from what I will call Case #9. This individual - individual's teeth were knocked out in 1984. At the time this particular individual did refuse treatment and at that time also the Department of Human Services was not guardian for this individual. This individual also, when queried, wishes to remain a resident of AMHI. She - the individual continues to refuse dental care and most treatment and she has the opportunity to move about AMHI very freely. That is not to say that dental care and the use of dentures is not something that has not been addressed. However, in this particular case that is the background.

Q. So your understanding is that the resident has declined dental services?

A. Correct.

Q. With respect to the others, putting aside the whole issue of making institutional changes, these are all patient specific and address particular problems in their care. Has the Department - aside from #9, has the Department responded or changed the environment or made particular corrective procedures to address the needs of the other nine patients that are listed here in this report?

A. Regarding Number - Recommendation #10, as I alluded to and referenced in my opening statement, there are several solutions

that have come forth from the affected parties at AMHI. And as I also stated, we are in the process of reviewing thoroughly each one of those and I also stated that in order to evaluate correctly, we need the assistance of a firm that has an outside perspective before we're willing to recommend sweeping environmental changes. Now, there is another level of environmental change and that concerns, for example, #1, recommendation that emanated from #1. I believe that individual, which is Case #17, was the subject of intense questioning last Thursday by Representative Burke. We allow as how this particular incident was not handled particularly well and we concur with most of the recommendations made by DHS. We will collaborate fully in actually meeting them. Policies that define staff role and responsibility are indeed well defined and the nurse on evening duty did not state that she has supervisory responsibilities over physician assistants.

We also reiterated, and I believe it was Dr. Rohm that did so, the male patient involved was removed to forensic where he now stays. It is part of that individual's treatment plan that he should not reside on a co-educational unit.

Training sessons have also been scheduled with Adult Protective Services staff regarding how actually to handle situations like this, including the reporting requirements. Training is planned with the Augusta Police Department on managing potential legal violations. Human sexuality as a topic area has been added to

the training curriculum for staff. And perhaps most importantly of all, inexperienced registered nurses will not be - will no longer be placed in charge of specific wards and I don't mean wards of Adult Protective Services, I mean wards as living units.

Q. So if I understand, we've gone now from the cases dealing with public ward specific problems to the generic recommendations on training and policy development.

A. That's right, that's right. And in so doing under A on Page 8 I have referenced Recommendations 1 and 3.

Q. Recommendation 1 on the bottom of Page 8 and Recommendation 3 on the top of Page 9, is that -

A. Well, perhaps we have different versions, Senator. I'm working off the complete recommendations dated November 9.

Q. I have that. We're referring again to the public ward recommendations.

A. Right.

Q. One and three. Okay. Now, if I understand correctly, regarding the public wards, the Department has taken some action with respect to Cases #1, #3

A. Nine and ten.

Q. And 9 and 10, and 10 being a rather generic recommendation, the first nine being patient specific. Does that mean by implication that the Department has taken no action at this juncture regarding Cases 2, 4, 5, 6, 7 and 8?

A. Let's see. On the instance of Recommendation #8, which shows as Case #22 in my summary sheet, this particular individual - the

recommendations that she needs a recliner in order to ease the swelling, I believe that has been done.

Q. When you make reference to Patient #22, perhaps there's a document we don't have, we have the summary, we don't have the full report.

A. It's probably - it's the same person, but it's just a different way of numbering. You've got - these are Recommendations 1 through 10 and the case numbers that I'm reading are for the actual case numbers as assigned by the Department of Human Services so I'm transposing when I respond to you.

Q. Okay. Now, this report was dated the 9th day of November. Can you indicate to the Committee or do you have information as far as the time frame on when a particular corrective action was brought to bear by your department?

A. Let's see. In regards to the case regarding the recliner, that - I think that question was raised about May 26 and the issues having to do with that person were begun to be resolved in September of 1988.

On the - let's see, Case Nos. 1 and 3, that particular incident occurred on a Friday evening. That was April the 21st and on 4/15 remedial actions began to be taken. Actually remedial actions began to be taken earlier than that as far as understanding how the reporting ought to be a little different, but they waited until Monday morning to begin to understand how it is the different events needed to play out so that the event would not

repeat itself.

Now, I have given you kind of a manager's overview of this particular case and I know the more specific dates as far as, for example, the sexuality training and the date by which the decision was made to no longer place inexperienced RNs in charge of wards, that information, I think, would be had by Assistant Superintendent Hanley, if you're wanting a precise date.

Q. Well, I'm just trying to get a general overview in terms of what action we've taken to date. Now, I understand that you've refrained in part from responding pending the filing of reports from the consultants of the Department of Human Services.

A. That's right.

Q. And my concern here is that although we may, in fact, affect broad based generic changes in the institution upon technical reports yet received, obviously we should immediately address problems identified as far as patient-specific cases are concerned. And so I guess what I would be very interested in today is whether we have - specifically how we have responded to these various - these cases.

A. Okay.

Q. And if we haven't taken appropriate response, I would like an explanation of why we haven't and I would like immediate action taken on these issues. I understand that apparently some of these issues were not - were known to the Department prior to 11/88. You

made reference to the rape case we know is different with April of '88, but there were other cases, the Case #8 with the - the lady with the recliner, that was known as of May 26 of '88, is that correct?

A. Hm-mm.

Q. And so I guess if these problems were of some long-standing nature, I think we'd like an explanation from Mr. Hanley or someone as far as why the prolonged delay in responding to apparently meritorious complaints regarding the level of care being administered.

A. Let me start, Senator, to give you an overview of the actions taken and I will then ask Rick Hanley to amplify should I have inadvertently left anything out. On - first of all, the AMHI staff who have been concerned with all of these patients have not had ample time to fully respond. However, that has not stopped the process from moving forward, which is several key meetings have actually happened with the Department of Human Services personnel to review what we consider to be a preliminary report. And we began the review actually referencing the twenty-one referrals noted above and which are the subject of this report.

On the issue of staff shortages, which is Recommendation #10 on your Page 8, there is acknowledgement that perhaps staffing is not sufficient for carrying out sophisticated programs such as that needed by one individual with extreme head injuries. That

individual now, however, has either been transferred or is about to be transferred to a more appropriate facility in Massachusetts and our people worked very hard to piece together what the funding for that placement would look like.

For another individual who was noted in the report as suffering due to staff shortages, this patient has been referred to the Senior Rehabilitation Unit where he can be more closely observed and his medical needs addressed in a more comprehensive manner.

The other two instances of staff shortages which were cited occurred on the Nursing Home Unit and this unit has staffing that is well in excess of what the Medicare requirements are for the unit. However, given the numbers of Level 3 patients, there still are times when there's insufficient staffing for individual feeding programs and the like and we're working on that.

Now, a second point is regarding the notification that was actually rendered to the public guardian regarding medication and behavioral changes to allow for proper authorizations, staff have been reminded of the need for such notification prior to actual changes in treatment. A memo will be sent to key staff along with the latest copy of the DHS authorization guidelines. For the precise date we'll have to ask Rick Hanley for that.

A third point is of the three cases in which current placement of AMHI was not felt to be optimal, one of these individuals has been placed in a boarding home. For the second individual, the actual AMHI staff disagree that an outside placement should be attempted as this patient has a poor medical prognosis and has

expressed his desire to remain at AMHI where the staff have a very caring relationship with him. In fact, this is the patient that I earlier referenced has been transferred to the Senior Rehabilitation Unit for oversight of this medical condition. There are other medically fragile people who do reside on this unit.

And the third instance in which the recommendation was made for a more highly structured ward for a person who is highly disorganized, this does not appear feasible and efforts are being made to adjust medication, and so forth, to allow perhaps for some compensation for this patient's incontinence, but the hoped-for approach would be to relieve overcrowding on the current unit so that more structure can be applied within the ward setting.

A fourth action concerns progress notations. There's at least one case in which follow-up treatment appears to be inadequately documented in the progress notes section. In the other two instances there's some confusion on the part of the DHS review team as to the required frequency of documentation, particularly on the Intermediate Care Facility Unit.

On the fifth item, and this regards terminology, the types of language that one uses to communicate the meaning of "long term care status" has been clarified with DHS and another term, medicinal misadventures, has been clarified. There is an additional record referenced which we would agree is inappropriate and this also will be addressed.

Now, a sixth item concerns follow up on doctors' recommendations,

development of a system for follow-up after the physician issues his or her order. The AMHI people believe that this citation represents an isolated case and an adequate system currently does exist for monitoring the physician's orders.

A seventh action which AMHI staff have done, in the one instance where medical follow-up was felt to be inadequate, in fact the two issues noted had already been attended to by the time the review took place and apparently this was not picked up by the review team.

And the eighth entry involves incident reports and it was an incident report that the DHS people could not locate. The report, in fact, that was not able to be found in the case record was, in fact, located in another location but was not in the proper place.

Q. Let me just pose a few more questions and then open it up to the full Committee. With respect to the survey or the assessment which was done by DHS of AMHI, is that an ordinary action taken by the Department routinely? Does it monitor or assess the care given to its wards or, if you know, was this rather extraordinary occurrence based upon the controversy and the issues relating to AMHI?

A. I believe that the Adult Protective Services Unit of the Department of Human Services has the responsibility to periodically oversee the various statuses of the clients under their charge. I am not sure whether this particular survey at this particular time was the product of other events or - the product of other events in public perception. What I would rather believe is that

the Adult Protective Services staff feel very strongly about monitoring the care of their clients that they deemed it timely to go in and carried out the survey. We are looking forward to a productive partnership with them and we do not regard interest and surveying by Adult Protective Services as anything except the proper thing to do.

Q. Has anyone from the Department of Human Services expressed reluctance at placing other wards at AMHI as a result of the apparent concerns regarding the quality of care at the institution?

A. Commissioner Ives and I have met several times and our respective staffs in our two central offices have met several times and we do agree that the results of the Human Services assessment have pointed out issues that we know are at AMHI. We are in concurrence, but I do not believe that DHS has decided to not refer its clients to AMHI.

Q. Is it fair to say that DHS has major concerns or reservations about the quality of care, but has not yet finalized its response dealing with shortcomings?

A. That's fair.

Q. And do you have a particular time frame when you would expect to receive from the Department of Human Services the completed survey with the psychologist's recommendations?

A. I would think that that is only a few weeks away, several weeks, two to three.

Q. Finally, we've heard in the press apparently the Probate Judge

in Kennebec County, Mitchell, has taken a rather extraordinary action of sending wards under his custody to other facilities than AMHI and do you - have you received any reports specifically with the - from the Probate Court relating to the particular cases he was concerned about or do you understand - what is your understanding as far as the reason that Probate Judge Mitchell has taken that course of action.

A. First of all, the Probate Judge's office has not communicated directly with my office and as far as I know what I know about his position is what I've read in the newspaper.

Q. Is there any effort being taken by your department now to inquire of the Probate Court as to the reasons he took that rather drastic action?

A. We feel that the thorough assessment that was rendered by the Department of Human Services and the resulting recommendations have augmented our own information and understanding about care and quality of care at AMHI for these twenty-one people and we feel that working with DHS and, yes, in concert with the Probate Judge's office that we best get about the task of solving the problems, so we do not take issue with the report that his office issued.

Q. If I understand you correctly, a lot of what we're talking about we're in the process of establishing new protocols and a new service delivery system, but the concerns that I've heard this morning is that to some particular patients their needs have

not yet been addressed and wouldn't it be logical to refrain from referring individuals to AMHI for the time being until we can put in place immediate corrective action to make sure that until the final reforms are brought to bear we raise the level of care to a decent level at AMHI.

A. Senator, I would disagree with you that of the individuals and the presenting problems that have been identified, many of these needs are now being met. However, that is not to say that all needs are being met and, yes, I think that we have a critical policy decision before us as a department and the policy decision involves who is AMHI best suited, you know, to take care of.

Q. It just seems to me that to a significant extent the public faith in the institution has been shaken over the last few weeks and, I mean, a number of people have approached me who do not ordinarily involve themselves in any public policy matters and expressed major reservations about the institution and I think that when actions are reported like the Probate Judge's action or perhaps the DHS survey, it only bolsters or exacerbates the concerns that we are not perhaps providing now the kind of care we feel we must as stewards of that institution, and although are mindful that we're working toward long-range reforms, I still have concerns at this moment that we haven't taken all appropriate measures to address the immediate concerns which were identified in the DHS survey report.

A. As I said in my opening remarks, Senator, AMHI indeed is a

very troubled institution and it's plagued by serious problems of overcrowding and years of inadequate attention and neglect and we can't change those conditions overnight. I further stated that we are in process of interviewing various firms that are highly skilled in the running of a specialty hospital and one of some magnitude and when those interviews are finished and the recommendations are completed, we will be most happy to discuss with you steps that can be taken to improve patient care and by you I clearly mean the Human Resources Committee.

A. Thank you. Are there any questions of the Committee at this time of Commissioner Parker?

BY REPRESENTATIVE MANNING

Q. Susan, a follow-up on that, have you gone out to bid with these consultants?

A. Not yet. We are in process of interviewing them, just looking at them, seeing what they have to offer. Because they are highly - because they're engaged in highly specialized work, it's worth it from a manager's perspective to thoroughly interview and understand what they might have to offer. That is down the road.

Q. How far down the road? I mean, I know how state government works and that's the problem with me.

A. As I also said in the opening remarks, Rep. Manning, the first look at potential costs here are that, one, it's affordable, and, two, we can quite likely handle the bringing in of such a firm internally and that should speed up the process, given the

nature that the work will be contained within the Executive Branch.

Q. Do you have the ability to go right straight out, get that consultant, go through state government?

A. There is such an ability. I believe it's called a sole source contract.

Q. I want to get back to your 1989 supplemental budget, in other words, what's going to carry you through from - till June 30th, 1989. What have you put in for the supplemental budget?

A. Are we talking for the entire Department or for AMHI in particular?

Q. AMHI in particular and the community.

A. Okay. The supplemental budget is what's being heard next Thursday and what I will have to do is ask for a sheet of paper that's behind me. Rep. Manning, do you want the request or the recommendations?

Q. Well, the supplemental budget from what I understand and I'm not -

A. Are you talking about the supplemental budget as in Part II or the -

Q. Supplemental budget is something that gets you through the year 1989.

A. Yeah. We need the emergency request.

Q. Well, the emergency request.

A. All right. What I have here is the Part II that we referenced last Thursday. All right. Would you like all items?

Q. Well, obviously - well, I don't know. Yeah, run down the whole item - the whole list of items.

A. Okay. The title, Fiscal Year 1989 Emergency Request, which we will present -

Q. And I'm assuming when you say request, the Governor has okayed these requests.

A. Pineland Center, 310,000, reinstating of several positions. Pineland Center, Workers' Comp, Bangor Mental Health Institute, Worker's Comp, lab equipment for JCAHO compliance, Bureau of Mental Health, Medicaid state share to compensate for some federal adjustments in the block grant, the central office, state forensic service processing evaluations, central office, what's called the food account, that's food in the six institutions, central office, the fuel account, Bureau of Children with Special Needs, Medicaid seed and block grant reductions, the Elizabeth Levenson Center, Worker's Compensation, Military & Naval Children's Home, which is in Bath, if you don't know, Worker's Compensation, Military & Naval Children's Home, pre-adolescent housing, it's a refurbishing of part of that facility to begin to take some of the hard to handle kids who are on the street, but age eighteen and above.

Q. So there's nothing for AMHI at all then in there.

A. Not in the emergency request.

Q. And you don't think there should be anything in there - let me ask you this. Did you request anything for AMHI?

A. Excuse me, I'm conferring. There's an issue with the all other budget and the addition of 500,000 and we're still evaluating whether or not we need more, we need less, and I truly think for amplification on that what we would need to do is to talk about the function of AMHI in the all other budget and to go into some - maybe more description about the all other budget at the facility.

Q. Okay. If my face is strange, there are about a hundred strange faces out here. Do you want to explain that again?

A. Yeah. I'm going to have Ron Martel do it, because it goes into the highly technical nature of an all other budget and some of the costs and, you know, overruns that happen and then we will talk about why it's not in an emergency request.

EXAMINATION OF MR. MARTEL BY REPRESENTATIVE MANNING

MR. MARTEL - Good morning. In September there was an appropriation to AMHI in the all other category which included slightly over $500,000. Half of that appropriation was the projected cost of three additional professionals, the other half, approximately $250,000, was the amount that we projected we would be short this year in the all other category, having nothing to do with additional professionals. Having, for the most part, everything to do with Worker's Compensation. So half of the amount appropriated in September would have appeared in this emergency request had there not been a special session in September.

Q. So what you're saying now is when we okayed $6.75 million last

year, we were making up for emergency pieces that normally go sometime between now and about the middle of April to get us through the rest of the year?

A. Well, we took a look at AMHI's budget for the year and clearly it was because of overcrowding and because of the additional costs it was not adequate, and so the request was made at that time and funded.

Q. The question is now that's six month ago, there is nothing now in the all other account that you're asking for for AMHI or community base corrections - yeah, community base mental health.

A. As an emergency request.

Q. As an emergency request.

A. That is correct. L.D. 24 does not have any request for Augusta Mental Health.

Q. Were you asked to deappropriate anything in the 19 - the budget that would end in 1988 to help out in any way, shape or manner this - any money that you're getting now in this supplemental - in this emergency budget.

A. The budget that - the year that closed in June of '88?

Q. The current budget we're in now, were you asked to deappropriate anything?

A. Not that I can recall.

Q. Okay.

A. I would have to check, but I don't remember anything, no.

Q. So in other words, to make up for the shortfall, the emergency,

you weren't asked to deappropriate anything.

A. No, not that I'm aware of, no. Our total request in L. D. 24 totaled approximately $2.2 million for the Department.

Q. Were there other requests that you had for the emergency budget that were not funded by the Governor's Office?

A. No, every request we submitted in October was recommended at the level that we requested except for one, food. We requested $100,000 and the recommendation, as reflected in L. D. 24, is $75,000. That was the only difference from our request as submitted in October of '88.

Q. Okay. So it's safe to say then to get us through this - from now until June 30th, you're not looking for any additional - at this stage of the game you're not looking for any additional people, monies, not only at AMHI, but at the community mental health areas.

A. No, we're not looking for any additional funds for community mental health in the current year. We are looking at AMHI's all other to see if the original projection as done last September, in advance of the September 15th special session, will be adequate to meet the needs for the entire year. That is the 250,000 additional that was appropriated in September, we are currently looking at that to see if that will be sufficient.

Q. And when will you let Appropriations know that?

A. Thursday.

Q. Thursday.

A. If there is indeed a need for any additional funds -

Q. Well, I mean, we're forty-eight hours away, I mean -

A. I understand that, but the problem is that some of this information takes time to gather. We are taking a look at it now and if there is a need for additional resources that are not reflected in L. D. 24, the Committee will be advised on Thursday.

Q. At this stage of the game you don't - you can't say whether you're going to go for additional dollars.

A. That's right.

Q. Forty-eight hours away from the hearing at one o'clock on Thursday?

A. I don't know why forty-eight hours would make a difference.

Q. Well, I mean, it just seems to me that -

A. As long as we know the information prior to the hearing.

Q. I would just seem to me, Ron, that, you know, at this stage of the game you people would need to know - you would know.

A. I want to make sure that the information is as accurate as possible.

Q. So there's nothing in the supplemental budget or what I call the supplemental budget, Part II and Part I or down the road, supplemental or emergency, I guess, so there's nothing really in there for community mental health.

A. For the current fiscal year, no.

Q. Let me ask you a question. Word has gotten back that some of

the monies had gone out in September to the community mental health. Have you held any of that money up to anybody because of this hearing?

A. No, but - no, not that I'm aware of.

Q. I'm under the impression that a phone call went to the Department last week wondering where the money would be and that it was stated that because of this hearing that monies would be held up for the time being because maybe we would shift.

COMMISSIONER PARKER - Absolutely not.

MR. MARTEL - No, absolutely not.

Q. In 1989 - 1988 emergency budget, January '88, last week you stated you submitted a budget, but the budget, from what we understand, was only for Worker's Comp.

A. The emergency request for FY '88?

Q. Yeah, to finish you out till June 30th, 1988.

A. For AMHI?

Q. AMHI and community base.

A. I don't remember. I really don't. I may have the information here with me if you'd like me to dig it out. That sounds right, but I don't know.

Q. Okay. I'd like to speak to Susan.

EXAMINATION OF COMMMISSIONER PARKER BY REPRESENTATIVE MANNING

Q. Susan, if that's the case, if no money was put in last year, can you tell us why?

A. When you say last year that is FY -

Q. Well, to get us through to June of 1988.

A. Yeah.

Q. I mean, the only thing that was emergency was the - was the Worker's Compensation.

A. Well, to get us through June, 1988. We must remember where we were at in our planning process and to reiterate some - or to say again what I've said before, the commission that studied overcrowding began its work - I think it was September 10th, 1987, culminating in a recommendation to the Legislature January -

Q. But Susan -

A. Yes.

Q. To correct you one statement. The supplemental budget or the emergency budget is usually gone over in the Governor's Department and in yours early in the fall.

A. That's right.

Q. Our final recommendation did not come out until December, so what I'm saying to you - and that's a legislative recommendation and not an executive and what I'm saying is are you relying on the legislative branch of government or are you relying on the executive branch of government.

A. What I'm doing is trying to work collaboratively with the legislative branch of government using the best expertise that we have in the executive branch with the best expertise the legislative branch has.

Q. In 1987, the fall of 1987 you were putting your emergency budget

together.

A. Right.

Q. Were you requested from the Governor's Department to deappropriate $3.9 million from your budget?

A. I don't recall.

Q. You weren't asked to find ways to - savings of $3.9 million?

A. I - without going back and consulting, you know, all the file materials, it's not something that comes out to me. I do know that we were asked as department heads to look at all ways of using our dollars more efficiently and one of the ways that we chose to do that was to look at how extensive - how extensively Medicaid and Medicare, particularly Medicaid with its favorable match, how extensively it was being used to actually pay for needed services in the field of mental retardation and mental health. And what we did was to look at services that we were providing and what we discovered was that many of these services that were 100% paid for by general fund also qualified for Medicaid match. Therefore, we were able to stretch the use of general fund dollars further by coming up with creative ways to expand the Medicaid participation in the financing of services.

Q. Okay. I'm going to ask you - then you were not asked to find roughly 4% of your budget or roughly 3.9% of your - $3.9 million in your budget to cut out of your budget to use for other priorities.

A. We were asked to look and we were asked to look at possibilities

of how we could identify savings and we were greatly encouraged because general fund dollars are relatively scarce to be creative with how it is we could free up general funds and I just explained the method that we did, but, yes, we were asked.

Q. I understand, but what I'm wondering is the Governor's Office did not say to you, I need to have you go back, I need to have you take a look at your budget, I need to have you see if you can shave $3.9 million.

A. That kind of direction is done routinely as a way to make sure that we are managing in the best way we can with the use of general fund dollars.

Q. If that's the case then, what you're saying is the Governor wants you - wanted you to take a look at ways that we could cut and yet you've already mentioned that we are - this Department has - over the years has not put in - or I should say, not the Department, this Legislature has not put any money that was needed as you indicated by those charts.

A. No, to say again, Rep. Manning, he did not say cut, cut, cut. What he said was are there ways we can make general funds go further, which is a very sound basis for - or a very sound directive that is given to top managers.

Q. Decertification in 1988. After the surveyors left AMHI, they went to BMHI.

A. Yes.

Q. The question - he's not here and he asked me this the other

night - is if AMHI felt - Dr. Rohm said that he felt that when they left that things had changed, if AMHI had felt it, how come BMHI - we never heard anything about BMHI?

A. Up at Bangor Mental Health Institute the surveyors looked at the Admissions Unit. That is there - as I said last week, a distinct part. That is the only area of the hospital Medicare looked at. The admissions pressure on BMHI is very much less than the admissions pressure on AMHI, therefore, it was a bit easier for them to actually engage in the preparations for the reviewers.

Q. I'd ask you another question concerning decertification. You had indicated on Friday - or Thursday that one of the reasons why you feel that they were tough on us is because the Governor interceded in 1987, went over their heads and went to Baltimore to HCFA, is that right? And if that's the case, why did the Governor go over their heads in the AMHI situation?

A. Perhaps I was a bit too candid, Rep. Manning, in telling you, you know, the full story on what happened at Pineland. At Pineland we were in perfect compliance with where we needed to be in order to preserve that Medicaid funding. AMHI, as I stated to you very clearly on Thursday, we were not in compliance. I did say that the deficiencies cited were not inappropriate.

Q. Have we used all the administrative means with HCFA? In other words, do we have appeal - have you - I'm not that familiar, but there's usually, as in state government, if you pull money from

somebody, they have an appeals process and things like that.

A. Hm-mm.

Q. Same way I would assume with HCFA. Have you used every means possible to appeal what -

A. There are - there is only one other means possible if you do not like the findings and that is to go through an administrative law judge. Our Assistant Attorney General, Linda Crawford, investigated the case law using the vehicle of an administrative law judge. She determined that the cost of doing that and the time required would be inordinate and her recommendation to us was that we proceed, you know, with the April meeting in Boston on April 12th and see what came of that. And because there is a substantial body of case record on working with administrative law judges within the Social Security System, her recommendation was well founded on data and hard experience by other states.

Q. So you felt, one, that it would take too long.

A. And that the cost -

Q. And the cost would be prohibitive.

Q. Prohibitive, correct, and it was not just a matter of cost. It was the issues of staff time and taking staff away from the problems at hand.

Q. At this stage of the game why don't we adjourn.

SENATOR GAUVREAU - No, keep on going. We'll just go up and vote

REPRESENTATIVE MANNING - Okay. The senators have to go vote. Are there any other questions? Rep. Dellert.

BY REPRESENTATIVE DELLERT

Q. Yes. Thank you. Commissioner, I'd like to hear from someone who was in a senior management position under the prior administration. Does the current management in fact permit the Department to deal anymore quickly or effectively with the problems at AMHI?

A. Okay, then I would need to call on Ron Welch for that, who was also Associate Commissioner for Programs under my predecessor Kevin Concannon.

EXAMINATION OF MR. RONALD WELCH BY REPRESENTATIVE DELLERT

MR. WELCH - I guess the essence of your question is to compare management approaches. I think I describe - I would think I'd describe the approach in the previous administration as one of giving managers pretty much a free hand in managing their individual institutions or bureaus. They were administrative islands I guess would be a good way to desscribe it. However, if there was an issue of concern, of smoke or fire flared up, the Commissioner would get involved routinely in those cases. I guess if I'm comparing that to today, the approach Commissioner Parker takes is one of a more pro-active nature. She employs a management team that has more day-to-day working relationships with the various superintendents and bureau directors. And in terms of its efficiency I think was part of your question, how well does it work?

Q. Yes.

A. Well, I guess the upside of having an involved management style is that you're on top of the issues of the day, more on a regular basis. The downside is that you discover problem areas perhaps sometimes more quickly than you can address them. That's part of the nature of having an open system, I guess. I guess by and large my assessment would be that the approach to managing the Department today is very appropriate for the demands of the day. The Department has grown dramatically in recent years and requires this type of hands on mangement. Does that -

Q. Yes, thank you.

BY REPRESENTATIVE MANNING

Q. Ron, stay up, please. If that's the case, you're talking about hands on administration, i.e., senior management, i.e., clinical director, i.e., superintendent, i.e., you, Ron Martel. If those are the cases and the clinical director on Friday indicated to us that he had a feeling that things had changed in February when they came and supervised and did this survey, then why is that any - I mean, I don't understand. Those are the people you're supposed to be listening to. That's hands on. It seems to me that - he admitted that things had changed and yet the Department is saying that we never knew things changed until June. I mean, you can't have it both ways. You can't have hands on and know what's going on and then say to me that in June - when people admitted last Thursday that things had changed and the

thing that went to HCFA back on April the 12th said things had change, why all of a sudden things change in June when hands on people know things have changed, why didn't you people listen?

A. I was at the exit conference at AMHI in February and heard the results of the surveyors and it was clear to me at that time that there was a new emphasis on how surveys would be conducted and that was an emphasis that was understood increasingly by all of us in the senior management team. I think what you're referring to is a comment that Commissioner Parker made on Thursday that it wasn't until June that we called around other states to confirm whether or not our observations were accurate and it was then that we said, yes, indeed, after talking with four or five other states, this is a new development. So we need -

Q. Why did you wait until June? I mean, why didn't you start in February?

A. Because we had just come out of a survey that really put us against the wall.

Q. But, I mean, according to the narrative, and I indicated on the other day, in terms of Medicare certification we are convinced that many state facilities such as ours are having to make difficult adjustments. This is your - this is the Department sending this material to HCFA saying on April 12th, you know, it just seems to me that when you've got hands on people and hands on people say to you in February, hey, things have changed, that things have changed and if that's the style that this Commissioner

has and this Administrative has, then they ought to listen to the people at the time and not wait until June and call up other states and say, hey, did things change in your state? I mean, you had a feeling in February, you put it down in April, you got booted out in May and in June you're calling other states and saying something's changed here, how about you?

A. If all of our assumptions were accurate, I think the ultimate testimony to that is the letter from HCFA of April the 12th were they tell us there's enough reason for them to come back and take a look at the hospital. So until they did come, we had no reason to believe that we couldn't do the job with the planner correction prepared by the superintendent and his staff.

Q. I might add senior staff?

A. We were involved in critiquing the final document.

Q. So senior staff had the same -

A. We were briefed on it.

Q. You were briefed, but you didn't have any expertise to put into it.

A. No, that - most of that plan was developed in the hospital.

Q. By one man.

A. I believe there probably was additional staff input in that process.

Q. And who would those staff input be?

A. I don't know. I would have to defer to the former superintendent.

Q. Well, Rick, were you involved with that?

MR. HANLEY - To some extent, yes, I was.

Q. Okay. Any other questions? Representative Pendleton.

EXAMINATION OF COMMISSIONER PARKER BY REPRESENTATIVE PENDLETON

Q. I just have one question for Commissioner Parker, if I may. Commissioner Parker, last week there was some concern that this Committee -- about how you could be on top of a situation that was going on at AMHI and still only have monthly meetings with your senior staff. Could you explain that a little better to us?

A. I'd be pleased to. First of all, I did explain to you that we have a structure that's called the senior management team. There are approximately eleven members. Those members are each of the superintendents of the large facilities, the two associate commissioners, my assistant and the three bureau directors and the medical director. I depend on a personal relationship with each one of them in order to sustain active dialogue. Now it's totally in error to think that I only talk with each one of my superintendents once a month. That's totally inaccurate. Telephone, meetings, projects, there is a constant two-way dialogue going on between and amongst all of us.

We have numerous examples. For example, Pineland two weeks ago was the subject of a rather intense discussion concerning use of one of its buildings. Despite other activities, despite a high priority in mental health, I met with the superintendent and the board of visitors. We resolved the problem. I would

estimate that approximately six hours of my work week was spent in the resolution of that issue. Many phone calls occurred before, many phone calls occurred after, correspondence passed back and forth.

There are daily communications. Each day I receive a daily census that identifies by facility and by ward the numbers of people. Attached to the census sheets are any notations that may describe an incident that the Commissioner should know about and I should say an incident that does not fall into a Classification 1 which is the type of incident that I hear about immediately. There are several occurrences that I need to know about immediately.

Frequently in the last eighteen to twenty months I have received phone calls over the weekend. Perhaps the most telling phone call was the night that Bill Twarog, the mental retardation administrator from Norway was shot. I received a phone call at 4:00 a.m.

On several instances I have received phone calls from superintendents no matter the time or day or night, no matter whether it's a working day or not, concerning individuals who may be absent without leave and into some sort of difficulty, incidents that may have resulted in some type of accident or other matters. Other matters may concern the environment of the facility.

I also require a weekly report. Each superintendent and bureau director must write a weekly report that is short, to the

point and it is in my office by approximately eleven o'clock on Friday morning. I read the text of the weekly report. It gets folded in with the other weekly report and sent off to the Governor's office. I have weekly management team meetings. They generally occur Monday morning unless the Legislature has superceded the time. I also have meetings of the entire senior management team on a monthly basis. We each as a team member have responsibility for devising the agenda. Issues of the day, issues of the month are put onto the agenda. Indepth discussions occur. And to cite an example, our working with the Health Care Financing Administration. I stated that we regularly meet on policy issues. Not everything falls into a neat agenda, not everything falls into or can wait for a particular schduled meeting.

The institutes, both of them have boards of visitors. They will be phased out as of June 30th. However, the boards of visitors and the governing body, the boards of visitors met quarterly, the governing body met monthly. We get together on a regular basis for agenda items that are appropriate to those two structures. The board of visitors at the Augusta Mental Health Institute was composed of people who are citizens and interested others to the workings of the Mental Health Institute and I met regularly with that body.

Another way of staying in touch with the events and with the issues of patient care quality is the fact that we have

established as of last spring an office of quality assurance and quality assurance is a function that, when executed properly, will result in our ability to answer the question, how well are our programs working to make life better for the people in the institutions. There are people whose job it is within AMHI to do nothing but quality assurance. We have a director of quality assurance in my office. He reports directly to Ron Welch and from there to me. I hear firsthand his perspective about how well quality is moving and he is here today.

I also listen to the chief advocate. If - I have organizational charts with me which may help you. The chief advocate is attached directly to my office and he has several people working for him, one of whom is stationed at the Augusta Mental Health Institute and the findings and the different cases that the advocate works on are given to the chief and from the chief to me and that occurs on a regular basis. I have met several times with the chief advocate - not several, probably more than several - to discuss what the patient care situations are within our large facilities.

Lastly, I receive very regular input from staff. Yes, there's a superintendent, yes, a superintendent has many people reporting to him or her. I also talk to other staff who work there. I talk on a regular basis with the clinical director, with the president of the medical staff. In fact, in an unprecedented move by a Commissioner, I met directly, beginning two months ago, with the entire AMHI medical staff and the

president of the medical staff and I have determined that we will meet on a regular basis for as long as we need to do it.

I also hear - when I do visits to facilities I hear directly from staff and I must say that these staff are not shy about getting to the point fast and telling me their perspective and I very much value that. So that is ten ways I stay in touch with what's going on throughout this 2,300 member department that is flung all over the State of Maine.

Q. So in other words, if I were the superintendent of one of the facilities, I would have some kind of direction, I'd have a job description or some kind of direction on when to call you and you said there were different levels of critical elements that you'd be called, like Level 1 call, Level 2 call, Level 3 call?

A. The incidents that happen within AMHI are classified into one of four classifications and depending upon the severity of the incident, I may or may not be called and this is a protocol also that applies to notifying the Attorney General as well as other members of the wider law enforcement community.

Q. So in the case that we discussed before about the rape, if I were a nurse at that facility and I discovered that the situation had occurred, I would then, by protocol, call who, the superintendent, doctor, who would I call as a nurse and then how would it go up the line to get to you.

A. Depending on the time of day, you - the nurse would be

notifying the NOD, you know, the nurse on duty, the person - if it's after 6:30, that person would be notified by the chief of the ward, if it was an RN in charge of the ward. From there it goes directly to the superintendent.

Q. And then he in turn would call you?

A. Right.

Q. Thank you.

REP. MANNING - Michael?

REP. HEPBURN - Mr. Chairman, thank you.

BY REPRESENTATIVE HEPBURN

Q. Continuing with the case of the rape a little bit here, I guess that hits home a little bit with me because it's my understanding that the individual who was the victim of that lived in Skowhegan for a while. I heard somewhere that - I think I saw it in one of the documents here that the rape occurred on April 12th, is that correct?

A. Correct.

Q. That was Friday night? It was in the evening or -

A. Evening, eleven thirtyish.

Q. And you were called shortly thereafter?

A. I was not. I did not hear about it until at least Monday.

Q. You didn't hear about it until Monday. Do you know if the superintendent was notified? What happened? Does anyone know?

A. I think you'd have to ask the former superintendent those

questions.

Q. I see. Is that something that - I would imagine that a crime of that magnitude would be reported to the police in a fairly timely manner, too, and was that - do you know if that was done Friday night or -

A. I think that may have lapsed into Saturday. I need to pull out the incident sheet. It was not done as soon as it might have been done. The case record here references the fact that the nurse on duty, given this was a weekend and after 6:30, never received the call until 11:30 a.m. The incident happened between 11:20 p.m. and 11:45 p.m. And I'm going to call on Rick Hanley to tell me when the police were involved, time and place, please.

MR. HANLEY - It was late morning, September 10th, the Saturday following.

COMMISSIONER PARKER - September - we're talking about April?

MR. HANLEY - No, actually it was September 9th that it occurred and the following morning, late in the morning, the police were notified after the patient advocate had been called to come to the facility.

Q. Okay. I picked the wrong date, I guess. Is it a September event, is that what it was? This occurred in September?

COMMISSIONER PARKER - We're fixated on April 12th and 15th.

Q. Yes, that's right, it must have been -

A. I beg your pardon, it's September.

Q. Now, you mentioned someone was notified, Commissioner, I heard you say someone was notified at 11:30 a.m. the next day. Who was notified at 11:30 a.m.

A. What I said was that the nurse on duty was notified at 5:30 a.m. the succeeding morning. This happened on a Friday night, the incident happened between 11:20 and 11:45.

Q. Now, the nurse on duty, is that an individual that's actually on the premises or can -

A. Yes.

Q. That person being on duty at home.

A. No, no, that is a person who was on premises, who sits at the front near the main entrance to the facility.

Q. Okay, thank you.

REP. MANNING - Any other questions? Bonnie.

BY SENATOR TITCOMB

Q. I have several questions. In that particular case, in the rape case, were appropriate individuals present for the victim of that rape, psychiatric counseling after this happened? What was the medical procedure, psychiatric procedure after it was understood that she had in fact been rape?

A. That evening the victim stayed in her room and somewhat later was visited by one of the ward staff people and the clothes were changed. The clothes were sent down to the laundry. For the exact time of medical intervention and examination, I'm going to ask Rick Hanley that.

Q. I'm looking for some sort of psychiatric counseling, comforting after this took place. I'd like to know what the time frame was, if and when that did take place.

MR. HANLEY - The medical intervention, first of all, I think took place at roughly 5:30 or so the following morning. As far as supportive counseling, I believe that one of our psychiatric therapy instructors did meet with this woman on that Saturday morning. I couldn't tell you exactly the time. So there was some support offered. And I would also point out that while we had already acknowledged that the entire incident was not handled as well as it could have been that staff did attend to this woman immediately afterwards. Some of the things that they did would not have been recommended by the police in terms of protocol, preserving evidence, and so on, but staff did immediately attend to this patient out of their concern for her and offer support and care, cleaned here up, and so on.

Q. So she actually did not receive medical attention from a doctor or a psychiatrist or psychologist until the next day.

MR. HANLEY - I believe that's correct. The incident occurred around change of shift on Friday night. I believe that the medical - the first medical attention would have been early that next morning.

Q. Okay. Thank you. I have several other questions, not specifically relating to that issue, but you spoke before about budget requests and Medicaid. I have a question, Commissioner, concerning Medicaid

on your free standing non-residential programs. Now, am I correct in information that has been given to me that as of November 30th that the federal government will no longer be paying two-thirds of those costs?

A. Free standing what, Senator?

Q. Your non-residential community programs.

A. No, that's in the field of mental retardation.

Q. Yes.

A. Yeah. I understand that a letter saying something similar to that has been received by DHS. What is the date you referenced?

Q. November 30th would be the retroactive -

A. 1988, the retroactive date?

Q. Yes.

A. That's the date that you corroborate, Ron Martel?

MR. MARTEL - Yes.

COMMISSIONER PARKER - Yes, we understand that that represents a policy change by Region 1 Health Care Financing Administration and this policy change was made after that very same Region 1 set of decision makers decided that free standing day habilitation programs could be financed by HCFA.

Q. So what are we looking at? And I know that's not directly connected to AMHI, but what are we looking at for costs that have not been budgeted to meet that two-third lapse that we now have in those services?

A. First of all, although the letter has been received, what I'm

going to do is refer to Ron Martel. There, I think, is some talk of an appeal action. Would you care to elaborate?

MR. MARTEL - Several of our staff in the Bureau of Mental Retardation which have met with the Bureau of Medical Services within the Department of Human Services and have concluded that the action taken by HCFA, that is freezing payments as of November 30, they haven't denied them. They've frozen them, which is a slightly different approach, that their action is inappropriate. It's - a position paper has been prepared and is going to be presented to Commissioner Ives and Commissioner Parker either this week or next and various approaches are being explored, one of which would be an outright appeal of that position.

Q. I was under the impression that this particular procedure for utilizing Medicare funds is one that was not recommended, that it's one that other states have run into problems with and, in fact, New York State had to go to court with to get those funds.

COMMISSIONER PARKER - I think if we look at all fifty-four states and territories, we find that other states have successfully worked with Health Care Financing Administration to seek - you know, for financing of day habilitation. It's an example of uneven policy, although, yes, there are not many states that have availed themselves of that opportunity.

Q. How many exactly are there?

A. Nineteen.

Q. And how many at this point have been cleared to receive those

funds?

MR. MARTEL - There were nineteen states as of either October or November of '88 that were, in fact, receiving funds for the Medicaid program for that service.

Q. My last question concerning this is have - in anticipation that we may not indeed get those funds and we may not know until later in the spring, do you have any anticipation of what the cost might be to the State that at this point we're not planning on?

COMMISSIONER PARKER - I think it seemly to say that we are planning on ameliorating this issue. However, the steps that we need to take first need to be discussed between two departments; that's the Department of Human Services and the Department of Mental Retardation. Commissioner Ives and I are scheduled to meet the - I believe it's the first of next week to discuss this issue. Now, the outcome of our conversation I can only speculate about, but there is considerable feeling that we need to remember the track that we had as far as decisions and to at least talk with Health Care Financing as representatives of two departments to see what the score is.

Q. I assume you'll be keeping us updated on -

A. I would very much like to do that.

Q. Thank you. In reference to the outside consultation that you are presently seeking, could you let me know when you began seeking this service and - well, basically, when did you begin

looking into an outside consultation?

A. The middle of December.

Q. I have kind of a question that I know has been raised a number of times and it's one that I would really - it would help me in the hearings as we proceed. It would be my perspective that two years ago that you were the outside consultation coming in with a fresh perspective on the whole situation. Now, two years later with many problems that have continued, we're looking for an outside consultation. Could you tell me what exactly your role as Commissioner is and where your responsibilities lie and how much indepth into the problems that have existed for some time at AMHI, do you feel you are responsible to go.

A. When you were out of the room as a Senator attending to other affairs I went through what the nature of my interaction is as a Commissioner with members of the - with members of the team that works together to actually do the affairs of the Department and I predicated my statement - or prefaced my statement by saying that anything that happens in the Department is overseen by a trusted individual who is a member of the senior management team and I underscored the fact that I have solid professional relationships with each member of the senior management team and with the degree of trust that we have, there is a constant two-way dialogue going on between me and the remaining members of the different pieces of the system. I also said that because of this openness and because of the fact that there is a great

many opportunities for two-way conversations there is very little of a policy setting nature that escapes and we frequently interact, the different members of the team and me, on - concerning issues of the day, issues of the week, issues of the month. Now, there are a variety of vehicles that we use to accomplish this communication. One is the daily census sheet and I told your peers on the Committee that incidents are reported on that sheet which do not fall into the most serious category. Those incidents are reported to me immediately.

I also hear on a weekly basis in concrete language descriptions of what went on in the three institutions, the three bureaus. We also have weekly staff meetings in the central office. Very often the weekly staff meetings are followed up by project meetings where a superintendent may attend if the project concerns his or her actual facility. I gave as an example a couple of weeks ago Pineland went through an issue concerning the use of one of its buildings. Approximately six hours of my time was spent the first week in January in working with not only that superintendent, but also the boards of visitors of the Pineland facility in ameliorating that set of issues. We also, in the large facilities, have a monthly governing body meeting and we have boards of visitors meeting on a quarterly basis. The agenda for the governing body meetings get into issues that clinical staff have, issues that occur due to, you know, a manager's interest. We discuss a great many things indepth at these meetings.

I've also established an office of quality assurance, the sole purpose of which is to develop information designed to answer the question how well are these programs working on behalf of the clients entrusted to our care. I have a director of quality assurance that is attached to the central office who also works directly with quality assurance staff within the large facilities. The information that he has is given to me and it complements the information that I received from the office of the chief advocate. As you know, the office of the advocate contains people who are out stationed within the facilities such as AMHI. Direct information descriptive of patient care status comes to me via the chief advocate.

Now, your other question that you referenced had to do with how involved am I. I would say very.

Q. So my last question would be, in light of the fact that if I had ten children and one was particularly troublesome, not neglecting any of the others, I would pay particular attention to the one child that needed help. How frequently do you actually get onto the floor at AMHI and work with the people there, seeing what the problems are firsthand.

A. Due to the management structure, I wish to reiterate for this Committee that I place full trust in the office of superintendent and I depend on the superintendent to have what I call hands on management grasp of situations on the various wards. I have - that is my perspective as a manager. That is the way business

should be done. I augment that position with visiting wards myself. Now, the visits that I make often are impromptu and by impromptu I mean unannounced and I have done that, as you would say, more frequently now that we have determined that one of the ten children is having some problems. Before last summer I visited and did extensive touring perhaps a half dozen times in the course of, you know, nearly a year. Since that time I have come to the wards when I thought it appropriate.

Q. Thank you.

A. Fridays, Sundays, late night.

SENATOR GOUVREAU - Before we go further, I've made inquiries whether we can open the windows to try to alleviate the heat and apparently all the windows are sealed for the winter season and I was told that the air conditioning, if it exists, is to be activated. I don't feel the presence of it, but I've been told that steps are being made to activate that. I would also suggest that if there is not any noise coming from the hallway perhaps we would leave the outside doors open to at least supply some degree of ventilation in the room.

Representative Burke.

BY REPRESENTATIVE BURKE

Q. Commissioner Parker, good morning. I have a few questions regarding basically what you have just been outlining as you are in contact with AMHI, and so forth. You detailed this morning very articulately how often you meet with managerial people,

and so on, my question then is do you feel as though you were always apprised of exactly what was going on at AMHI?

A. Exactly what was going on? I feel that I was - I have been in the past adequately informed about the major events that go on at AMHI and similar - let's leave it at major events. I trust my members of the senior management team. We have a protocol in place that allows for a free flow of information. They're generally - there is no caveat on what can't be said, therefore, it's incumbent on anyone who is one of the appointed top managers to let me know if something unusual has occurred and that goes for incidents in the Classification #1 area as well as other things that may fall through, you know, any attempt to classify.

Q. So you feel as though you were always kept up to date on that information?

A. I do, with some exceptions.

Q. Would you care to elaborate on those -

A. The exception that has come to the fore is the situation about the woman who was raped.

Q. But all the other situations were, in fact, accounted to you.

A. Situations concerning patients unless there was an incident or the superintendent deemed it of such a nature that I should know about it, I would not have known about it. I rely on the judgment of the superintendent when it's necessary to let me know about what's going on with individual patients.

Q. And you were happy with or you were satisfied that the

superintendent was, in fact, letting you know during his tenure?

A. Not during the entire tenure.

Q. When did you become dissatisfied?

A. Late fall. I became disenchanted late fall, because at that point new information had come to the fore, new information in the form of the findings from the advisory panel and the findings from the DHS assessment.

Q. And did you at all at that point in time counsel the superintendent as to how you wanted things handled?

A. The superintendent visited our office on a regular basis and we would talk about the - we would talk about events of the month, in this case the DHS assessment, and he would describe to us how the reviewers were doing their job, how the survey process was going, how the communication was between AMHI staff and DHS staff.

Q. I'm not sure that that quite answered what I was looking for. When you became dissatisfied, when you were becoming disenchanted with the way that the superintendent was conveying information to you, did you, in fact, counsel him on how you wanted information conveyed?

A. It was not so much how the information was being transferred, it was more a confidence in the command of information that was possible. And I counseled on several occasions the fact that I felt that a more hands on approach could benefit him in his understanding of all the activities that may be happening on the ward. I counseled that getting out of the office and spending

significant time on the wards was a desirable thing to do.

Q. So if I'm understanding you correctly, up until late fall you were satisfied with the way he handled things and felt he was out of the office and on the wards enough and then in late fall became disenchanted.

A. I made the comment to him about gaining a better grasps of what was happening on the wards perhaps as early as last summer. The dissatisfaction does not happen overnight. It is a slowly evolving process and it's a painful process and it's painful because in order to stand up and face the rigors of running an institution as well as running a department of this magnitude and scope, it's necessary that we trust each other to a very, very high degree. Therefore, when information comes to the fore that causes you to begin to rethink and to question the trust that you have placed, it's extremely - it's an extremely slow moving evolution and it needs to be that way because one doesn't wish to be unfair. One wishes and hopes that what you are beginning to perceive is not so. Therefore, every effort at benefit of the doubt is given.

Q. Certainly. And I'm sure that every benefit of the doubt was given. What I'm questioning then is if you were not confident that your superintendent was providing you with the information that you needed or responding appropriately to incidents that might have happened, how did you receive this information?

A. It varies. The - we have to look at the information on the

table as coming to my office sequentially, beginning with the findings of the May 29th decertification and understanding the full implication of the deficiencies cited. Following that came Dr. Jacobsohn's first phase report dated October 19th of issues pertaining to certain aspects of medical practice and intervention. Following that came the results on December 16th of the advisory panel made up of many outsiders to look at the physician practice and handling of three particular cases identified by Dr. J. As I began to look at more and more of the information, I began to see that there were some repeats, repeat observations. By the time the Department of Human Services assessment came, many of the observations, recommendations in there did resonate with findings that had already been brought to my attention December 19th. And at that time by the middle of - end of November, middle of December I very much felt that my sense of confidence was shaken.

Q. So in essence then you were meeting with various people all the time about - frequently about the AMHI situation and meeting with the superintendent and working out solutions with the superintendent for the AMHI crisis.

A. As I stated earlier, AMHI's crisis is a crisis in management. Further, regarding a DHS assessment, when surveyors come in from another agency, it is the superintendent's job to actually - or superintendent's job to oversee how that process is going, but not to be invasive, because the process is owned by another agency and that was his job. He did that. It was also his job

to come up with responses to the DHS assessment and give me a status report concerning, you know, the actual implementation of those recommendations.

Q. So through various means you understood what was going on at AMHI.

A. Yes, I did.

Q. And you conferred with the superintendent about ways to correct the situations.

A. We must remember the management structure in the Department. If I was not doing it personally, I cannot do everything personally, then the two associate commissioners deal with certain aspects of AMHI. The associate commissioner for administration would - on a typical issue would deal with matters of personnel and administration. The associate commissioner for programs would deal with issues of patient care quality that may have surfaced through, for example, in Medicare survey and a resulting decertification.

Q. Again my question is more you felt as though you knew what was happening and you were meeting regularly with the superintendent and both sharing back and forth ways to remedy the situation, is that correct?

A. We were sharing back and forth either through me - to me directly or through associate commissioners' different events that had gone on and we understood together that certain remedies needed to be put in place.

Q. And some of those remedies were suggested by you or by the

superintendent?

A. It depends which ones we're talking about.

Q. Well, no, I'm just asking who - in essence then there was a repartee, there was a dialogue between the two of you that indicated what kind of corrective measure should be taken.

A. Representative Burke, there is an intensive dialogue that goes on between the Commissioner's office and the superintendent and the principal people within the Commissioner's office are privy to the information that describes the status of facilities such as AMHI.

Q. So the superintendent then - well, let me rephrase this. Why then specifically was the superintendent dismissed?

A. It is impossible to run a department such as this when issues that are of supreme importance such as patient care when a chief executive officer does not have 100% confidence in an individual's ability to lead an institution through the throes of intensive problem solving and it was my observation that Superintendent Daumueller, while a very compassionate and caring and a very nice person, is better suited not to lead a complex hospital with the types of issues that it has and the specialty - the specialty interventions that are needed to put it back on its feet. He is better suited to, I think, working in an environment that doesn't have quite so many problems that need to be addressed all at once and it's an issue of management - management style, how he wishes to do business, how he is most comfortable doing business.

Q. Given then that he was dismissed but that you have a working knowledge then of the situation there and the corrective measures that you essentially wanted taken, I'm a little bit confused then as to why it's taking - what the management teams that you have taken - I assume you've taken RFPs for these management teams to come in and look at your situation.

A. We are not at that stage yet.

Q. What stage are you at?

A. I will reiterate my response to Rep. Manning about ninety minutes ago and that response described the outside - the outside help that we are gaining. We are at the stage where we are talking, we the executive branch, are talking to various firms who are very skilled in the specialty of running a large psychiatric facility and we, at the same time, are looking at solutions that have been proffered by various groups who are affected by AMHI's situation. What we will do is to finish the discusion and we have to date talked to three consulting groups. We will finish this discussion and we will then understand what vehicle we need in order to acquire this help. In fact, do we need to, you know, use a certain method of contracting versus another method of contracting. And I also stated to Sen. Gauvreau that I would expect to have recommendations available and be able to present those recommendations coming from such a consulting firm fairly soon and I said two to three weeks.

Q. My question then comes again, you felt that the superintendent

was, in fact, not implementing the recommendations or the policies that you wanted implemented, didn't have the management style that was required to implement new policies or to maintain AMHI in the condition that it should be maintained and yet you're now taking studies or -

A. Not studies.

Q. You're taking ideas or looking for ideas from various management teams to figure out what's needed.

A. Not exactly.

Q. Okay.

A. What we are not looking for is to pay for another study. We don't need that. I described in my opening remarks that AMHI is the third largest hospital in the State of Maine. It has ten different departments. It has 693.5 staff. It is by anyone's observation a specialty hospital. It also has a unique set of problems that need to be solved. It is our observation that the best expertise available rest with people who are also engaged in the operation of specialty hospitals of a psychiatric nature and who understand hospital administration. This is not a study that we're talking about. This is bringing in specialists who know inside and out hospital administration who can take a look, who provide an objective view and who can recommend to us steps to take on the short term. This is not a long-term affair. This is something we can do on the short term and intend to do.

Q. So again -

A. This is general management. Many of the issues that this Committee has raised in the last nine hours of questioning and responses have concerned unique situations going on at AMHI that have resulted in certain issues, such as the DHS assessment, the advisory panel that I convened in October. What we now need to do is to look at the total operation of the facility and understand how to do business in a more - I think a more productive way. Many of the issues that have been raised in Medicare by DHS, by the advisory - in the advisory panel findings concern issues of documentation, communication and general record keeping. That is general management - the scope of the solution rests with general management and we must bring in someone who has a track record who understands how to do this perhaps in a better way than we now know how to do it. We are doing our darnedest and the staff there are doing their darnedest to keep up with the demands on them for patient care.

Q. Then again if you know exactly what you need from a management team, why is there no RFP done yet.

A. We are not at that stage and to reiterate, we are not at that stage because we need to finish talking with these individuals and then to determine, based on their observations, remember they're specialists, their observations will be those of a specialist. It could be that there is one unique firm out there that is unlike the other three or four, therefore, because they do possess a unique set of characteristics, perhaps a request for a

proposal may not be necessary in accordance with the Administrative Procedures Act.

Q. I fail to understand how, if you know what you are looking for that you cannot put out an RFP.

A. I feel very strongly that as a stewart of public funds in the State of Maine and also as a top executive person that we need some outside expertise that has a track record in the specialty of mental hospital administration and that is the expertise that has yet to come in and give us its perspective and subsequent recommendations. We have not yet had the benefit of that.

Q. So although you know - you feel you know what your problems are and where they lie, you are not - still not ready to put out an RFP.

A. There's a certain amount of, I think, information that gets passed when a specialty group comes in and asks you very, very drilling questions about management in a large hospital and it's a process that I believe as a chief executive officer that we must go through in order to understand how a consultant group - not a consultant group, but how a specialty group might feel. This is - this is part of responsibly evaluating all options. After that is done, and I - to reiterate, this is not a long-term process, to responsibly do it, we must talk to this individuals, obtain their recommendations and then, as I offered Sen. Gauvreau, come and talk to your Committee.

Q. It seems that it is - that there are very lengthy delays in this whole process, that you become dissatisfied or disenchanted with your superintendent in the summer, early fall -

A. I didn't say late summer. I said late November, early December.

Q. I believe that, in fact, you did mention the summer months that there was some disenchantment there and then you became significantly disenchanted in late fall and then he was subsequently dismissed in January. Here we are at the end of January and we still are not in a position where we're submitting RFPs. This - if you have been in touch with exactly the problems that AMHI has had for the length of time that you say you have been, I see this as a lengthy delay.

A. I don't share that view, Rep. Burke, and to reiterate, to say again for the public record, unhappiness, disenchantment, whatever the word, with a top manager that you have become very close to is a slowly evolving process and extreme dissatisfaction did not register until much beyond the summer. Extreme dissatisfaction registered late November, December, and I wish that put on the public record. It's a short period of time from December to the very first week in January.

SEN. GAUVREAU - Representative Cathcart?

BY REPRESENTATIVE CATHCART

Q. Commissioner, going back to the rape in September, I'd like to ask some specific questions, but you have admitted that that

was not handled well, so I'm willing to just not pursue that and waste any time. But since that time have you put a rape protocol in place at AMHI and also at the other institutions under your Department?

A. I've got to ask you a question. Is that permissible?

Q. Hm-mm. Okay with me.

A. I don't know what a rape protocol is.

Q. Most hospital emergency rooms that I've had experience with have rape protocols. They don't do a thing such as take the patient's clothing to the laundry and they do notify the police that a felony has been committed, etc.

A. All right. There is an established procedure, you know, within AMHI for that and the - subsequent to this particular event a written policy was developed.

Q. And is that true for all the institutions, Pineland, BMHI where a rape might occur?

A. I'm trying to see my policy book. I can't answer that. I will have to look for the information and get back to you.

Q. I'd just say - I'd like to say that there is that kind of protocol. Onto the staffing shortage again, I have read so much stuff in the last week, back to the decertification - HCFA that claims there's a staffing shortage at AMHI. The reaccreditation report, though AMHI got its reaccreditation, they did mention shortage of staff there. I spoke last night at length with a woman from our district who works at BMHI and she stated the same

kinds of things that I read in a letter here that I have - I don't know if you've seen it - from Charles Ferguson, the president of the local at AMHI and from Charles - what's his name - Sherbourne, the Maine coordinator of the American Federation of State County and Municipal Employees. All of this testimony about people having to work overtime when somebody is sick or out for some other reason, workers getting burned out, difficulty of hiring more nurses because they can go to work at Eastern Maine Medical down the street for more money, I'm just convinced that there is a staffing shortage and that this is an emergency situation and wonder if you really believe that there is a shortage of staff at these two institutions. And if you do, then how and why have you decided not to seek emergency funding this year to hire more staff, pending, of course, outside consultants and a real plan for making things different. I mean, I don't want to hear that again, but to me this seems like an emergency -

A. Well, I think you just answered your question.

Q. Situation and I don't understand why you're not seeking funding for right now to -

A. Rep. Cathcart, I am waiting for the results and the recommendations from an outside and objective view on hospital administration and particularly administration and patient care vis a vis the defined patient need that exists at the Augusta Mental Health Institute. Earlier on I did say that several solutions have come forward, you know, from various quarters within

the Augusta Mental Health Institute. Some of those solutions include need for staffing. At this time need for staffing, increased staffing is not being ruled out.

Q. But you are not planning on Thursday to ask for any money this year -

A. The nature - no, no, no no. The nature of Thursday's hearing for the Department is one of three budget hearings that we will go through. This is technically - correct me, Ron Martel, the first hearing is for the emergency funding, the second hearing that will be sponsored by Appropriations is on Part I, that's ongoing funding, and the third hearing probably to be scheduled in March is for Part II. That's the changed portion of the budget.

Q. I understand that.

A. All right.

Q. But it seems more of an emergency situation that you do need more staff now.

SEN. GAUVREAU - Are there other questions of the Committee, please raise your hands if you have several questions. Rep. Pederson and then Rep. Boutilier.

BY MR. PEDERSON

Q. Commissioner Parker, I'd like to go back. Some of the information that I have on the instance of the patient that was raped, what specific actions did you take with the person - the perpetrator?

A. Rep. Pederson, I've been over this once, but with the

indulgence of the Committee Chairman, I will do it again.

Q. Well, let me just say then the information I have might differ with yours. I understand that the man was placed in the Forensic Unit after the September assault, is that correct?

A. Correct.

Q. Where he received no treatment for his assaultive behavior other than two or three talks with a social worker. This resident was subsequently returned to his regular unit for fifteen-minute periods which were then lengthened to one hour, visits with one on one supervision. For unknown reasons he was returned to his unit from the Forensic Unit in November or December and the one on one supervision was discontinued. This resident then sexually assaulted another female resident, but was thankfully discovered in the act so the resident was not actually raped -- that the - it was entered in the woman's record that she was promiscuous and the man again was placed in the Forensic Unit. Is that true?

A. What I will have - what I will do after I make the following remark is to ask the assistant to the superintendent to come forward. My understanding is that this individual currently resides on the Forensic Unit and within the treatment plan there has been sufficient mention of the fact that he should not reside on a co-educational unit. Now, Rick, could you amplify that, please?

MR. HANLEY - Rep. Pederson, your information is primarily accurate. After the rape - the alleged rape, this individual was placed on

the Forensic Treatment Unit where his medications were assessed, and so on. The plan at that time was to begin transitioning, reintegrating him to his home unit. That began in short blocks and had extended to hour blocks at which time he was under close observation with fifteen-minute checks. There was another incident, a very unfortunate incident, in which he was found in a bedroom with a female patient who was also a DHS ward and it was substantiated that nothing had occurred. But following that incident he was permanently transferred to the Forensic Treatment Unit.

Q. Okay. Thank you. I have another question for Commissioner Parker. I was interested in the article in the Maine Times which indicated that you had a meeting with the Governor's Commission on Mental Health and it indicated that you had two different copies of a report and that somebody had a copy that wasn't so-called sanitized?

COMMISSIONER PARKER - Yes.

Q. Can you comment on that?

A. I would thank you, Rep. Pederson, for giving me the opportunity to report on the text in that editorial. First of all, the fact - the inference that one is a sanitized version, hence covering information, is absolutely inaccurate. More to the point, the verson that does not contain certain descriptions was essential because, as we know, the - there are three patients whose cases were put under the microscope by highly qualified

medical people. The material that was in the so-called sanitized - so-called real version contained very descriptive information about those individuals and we would have been outside the - we would have gone against our own rules of confidentiality had we made public that particular version and that is absolutely inappropriate to do when you have people entrusted to your care governed by rights, rules, etc.

Secondarily, there are other issues in that editorial that I feel were the product of an outsider observing and do not reflect the truth. One of them is that I was in disfavor of David Gregory assuming the post of chairpersonship. In fact, I am delighted that David Gregory is in the post of vice chairpersonship because of his sound advocate status and reputation and I would point out to the members of the Committee here that the Maine Commission voted on whom they wanted to fill the vice chairmanship and it was - his selection was the product of a vote.

Thirdly, it was reported out in that editorial that I appeared to be upset when I left, that nothing could have been further from the truth. I had to leave for another scheduled meeting.

And a last piece of information, I am looking forward to going to the next meeting. Thank you.

Q. I have a comment. You say that certain information cannot

be given to the Commission on Mental Health and yet you do have a setup where they can go into the institutions unannounced and look at - see what's happening?

A. Yes, they can. They are part of a statutorily established body and they may, with the proper arrangements, visit anytime day or night. The issue at hand, Rep. Pederson, is the written description that would identify the three patients in question who are the subject of this advisory panel's probe.

Q. I would like to ask another question about the - your plan, in other words, when you had the - Mr. Daumueller and you decided that he should - you were disenchanted, did you have an action plan to state exactly to him what had to be done and how to correct the situation so that perhaps your relationship with the director could have been perhaps repaired or he would have better positively known exactly where he stood and what he needed to do?

A. There is a job description pertaining to the Office of Hospital Superintendent and that's the guiding document, if you will, that determines who does what, why, and to whom they're accountable. As I earlier stated, the former superintendent and I and/or members of my top management team, the two associate commissioners, met on a regular basis to talk about issues that needed repair and we often came together to talk about how to, you know, fix Medicare. However, I will close by saying that I put a great deal of trust and faith in the expertise that a superintendent has and I must do that. And if patient care quality

and the ability to lead are foremost concerns of a chief executive officer, then we must have people who can do that.

Q. And I have another question as to the people - you have many services, as you've stated, that work with you to help you to - your management team, the other advocacy services and I have information that the Maine advocacies have written you a letter, very concerned about the incidents and what was happening at AMHI and they had gone a very long time without a response. Is there any reason for that?

A. I don't know which letter you're referring to, Rep. Pederson. I know that - let me see, reconstructing time. In September and October and I think one other time I met personally with Laura Pedovello, the Director of Maine Advocacy Services, and we talked through the content of at least one letter.

Q. Okay. I believe I read about the fact that you did have a meeting and that after that forthcoming they've never had a response.

A. That also appeared in the Maine Times and they also referenced an issue concerning Pineland and the consent decree and how the consent decree is out of compliance as we speak and that simply is not so. They also referenced failure to respond to a couple of letters having to do with Pineland, that also is not so.

Q. Thank you.

SEN. GAUVREAU - Representative Boutilier?

BY REP. BOUTILIER

Q. Commissioner, I have several questions I first want to

address. Is Dr. Rohm going to be back later this afternoon?

SEN. GAUVREAU - Yes. We had agreed, the Committee did, prior to your arrival, Representative, that we would allow Dr. Rohm to make his rounds at the hospital this morning.

REP. BOUTILIER - Several of the questions, if you need to, you can defer to Dr. Rohm, but I'd prefer you take a shot at them if you can and Rick Hanley is obviously welcome to step in if he feels the need. The first one, in determining - when you have a slot open for an RN position, what tends to be the length of time to recruit that position and to fill it? Have you estimated how long it takes you to do that?

A. I don't even think we need to estimate. I think we can ask people who may know more precisely than that. We are beginning to see an increasing difficulty in recruiting RNs to not only AMHI but BMHI, which is part of a statewide and nationwide nursing shortage. Let me refer directly back here. Ron Martel, can you answer that more precisely?

MR. MARTEL - I don't have the information with me.

Q. Would it be safe to say that you could do everything from one day to one year to fill a position?

MR. MARTEL - I think one year would be extreme, although I'm sure it has happened.

Q. Would it be extreme to say seven months, eight months?

MR. MARTEL - I guess if I were to give you an estimate of the time frame it normally takes to fill RN positions is what we're

talking about. I would say anytime from a month to six months and I think you'd capture the majority of the vacancies.

Q. A continuation of that question, if through accreditation processes it was determined that you needed to fill a number of RN positions and you knew that those accreditation standards needed to be met, wouldn't it be safe to say that you'd have to begin the process of recruiting and filling positions at least six months prior to make sure that you would cover all of that area?

COMMISSIONER PARKER - That's assuming that the lag is six months. I think we can cite to a recent experience when the Legislature did give us sixty-five positions with three contracted plus another sixty-four or five at BMHI and the experience at BMHI was that we did fairly well in recruiting for those nurse positions and were filling pretty much on schedule, maybe a little bit off.

Q. On schedule being what length of time?

A. What I want to do is to reference a phase-in sheet that shows column by column by position the date we wanted to fill it and the date actual and I know that we have that supporting information here.

Q. Okay.

A. I now have it. Nurse III, we were looking for three of them. The effective date by which we could have filled was October 1, we filled it October 3. On the issue of a Licensed Practical Nurse, there was one, the effective date was October 15th, we filled

it the same day. This is a status report of January 13th '89. This shows another LPN. Effective date was 10/15, that position is vacant.

Q. Was the reason for the quick recruitment and placement of those the fact that the only thing lacking was not the person, but the funding for the position? There were people there to fill those positions, there just was no money to pay them?

A. I think it was a combination of things, the first being that the personnel department at AMHI worked very hard to do all the paper work that's necessary in a business or a bureaucracy and had the paper work ready to go the minute the Legislature sounded the gavel for acceptance and I think their foreward thinking and advanced preparation went a long way in our ability to fill these in a very timely fashion.

Q. We've obviously received a lot of material concerning all of these things, but I was just struck by the superficiality of some of the material. We really weren't getting into the heart of the matter on some of the items, especially those dealing with staff and patient care and I wanted to bring up something having to do with two cases. One, some colleagues of mine on the Committee have already asked about the rape case, but I was concerned about staff that were dealing with that instance. It's my understanding in some of the background checks that I did that there was a Nurse I position that was in charge that particular night and that they individual was very new, extremely new, and that they had already

performed an eight-hour shift and were in the middle of the second shift, actually and hour and a half, two hours into their second shift, which they had been forced to take, told that if they did not take that second eight-hour shift that their position would be frozen. I have two questions. One, in the case of nursing shortages around the state, obviously for someone to fill a second shift immediately following with the threat of having their position frozen is not conducive to quality care or quality performance and I'm wondering how rampant that type of incentive is used to keep staff on more than one shift.

A. Taking apart your question into a couple of comments, first of all, you are correct that the nurse in charge of that particular ward was inexperienced. We stated earlier, perhaps before you came into the room, that this incident was not handled particularly well and concur with most of the recommendations made by DHS and will collaborate fully in actually doing what we need to do to fix it. The policy that emanated, came out of this particular incident is that inexperienced nurses such as the Nurse I will not be placed in charge of a ward. To your point of freezing positions, and so forth, we - through the word that we did at the Bangor Mental Health Institute beginning August of '87 where we convened ten task forces, one of which was to look at expressly at some of the practices of mandated staff from one ward to a second ward or freezing staff, because we went through an intensive examination of BMHI and personnel practices, we fully

understand that such practices do often represent a disincentive.

Now, to a third point which is what did AMHI do in response to this particular nurse who was frozen and had to pull a subsequent shift, I will call on Rick Hanley to answer that piece of it.

MR. HANLEY - The nurse who was involved in that particular situation was moved to daytimes and worked under the supervision of an experienced nurse. And as the Commissioner just mentioned, we have established a clear policy in nursing that inexperienced nurses will no longer cover those kind of evening shifts or any shift before they have the requisite experience.

If I could just go a little further, although I'm not the staffing expert at the hospital, the issue of freezing and mandating overtime and pulling staff from their home units to work in other units to cover situations that are seen as being critical, that still does occur among the mental health worker ranks and to some extent among the licensed nursing and LPN coverage. One of the pieces of the staffing allocation that we received in September was used to establish a 13-member float pool and I won't stand here and tell you that that has completely eliminated freezing and pulling, but our staffing coordinator substantiates that it has had a positive impact. It has not eliminated mandatory overtime, but we have used the float pool to fill in areas where formerly a staff person might have been pulled off their regular unit to go and cover.

Q. Again, Susan or you can answer the next question. In a

recent Wall Street Journal article it was stated that JCAHO was - how do I use the term - making more strict, rigidly enforcing, however you want to put it, their regulations and that that effective date for that new interpretation of current regulations would occur approximately July 1. There is some difference of opinion as to when it will actually be implemented, that's correct, because of some concerns on Capitol Hill. But, having had that, the fairly well publicized change, and it's been in several periodicals since the Wall Street article, do you feel there's any change that's significant enough in joint commission's regulations to merit additional requests for staff or any changes on your end as far as dealing with those changes?

COMMISSONER PARKER - In fact, we've already begun to deal with those changes and in our testimony Thursday you heard from Dr. Jacobsohn about the remedicalization of standards, both JCAHO's and Medicare. The instruction last June that was given to the superintendent regarding needs for staffing was phrased thusly. Give us a solution that will result in the regaining of Medicare as well as the retaining of JCAHO, given, you know, the implication being given the changes that are in the offing and that is what was done. The 65-person staffing package was predicated on the assumption that JCAHO was in the midst of changing.

Q. Do you - you are currently - the hospital - AMHI is currently accredited by the joint commission.

A. Yes, it is.

Q. Do you feel that you are in danger of losing accreditation?

A. We went through a rigorous review with these new standards being applied on December 1st and 2nd and I can only speculate what the outcome is. I am cautiously optimistic that we will retain our JCAHO accreditation, however, there are no rose-colored glasses on.

Q. I would hope not, because it is my understanding that in one particular area in accreditation in terms of JCAHO's feelings concerning 24-hour coverage by RNs that AMHI would have serious difficulties in meeting that particular requirement and, in fact, would have to hire an additional forty RNs to meet that requirement. It would seem to me that if that is necessary, that almost immediately you'd have to request funding and begin to implement a recruiting tool and retaining those existing people in those positions to meet that criteria.

A. I understand that the standards applied to AMHI by the joint commission on that particular issue were the so-called hospital HAP standards, Hospital Accreditation Program. What I am concerned about that, I am concerned enough to have talked to the head of probably the largest mental health system in the world and that's the Commissioner in the State of New York. I know from him, and he was the test case in the country, that it is possible and the joint commission is accepting of the fact that the general hospital standards must be cautiously applied to

a publicly funded psychiatric facility and because New York has just undergone a survey or if it has not just undergone or perhaps it's in process, we are anxiously awaiting to see how they fare, because the State of New York was able to negotiate the type of standard that was applied to their public facilities and I say this as added information for your Committee, because I think we have some future planning to do for JCAHO and how to work more collaborative with it, given its changes.

Q. You are also aware that if we do happen to lose JCAHO accreditation even momentarily that we would also be forced to decertify in terms of Medicaid, is that correct?

A. That is the situation called deemed status.

Q. So it would seem to me that if we are even close to losing accreditation through the joint commission that that would be a very serious - serious instance and we'd take -

A. I concur that that would be serious.

Q. And would necessitate the direct implementation of some plan by the Commissioner, correct? I think you've been very consistent in your stand that the Commissioner should take a more oversight view and not a direct management style in terms of the various institutes, whether it be BMHI or AMHI, but I think you would have to agree that in terms of prioritizing your own budget, in terms of determining where monies are best spent within all of your institutions, in terms of how you deal with specific cases that affect accreditation in terms of where you're spending those

requirements, that would be under your purview.

A. That would be what, I'm sorry?

Q. That would be under your purview. You believe that would be definitely -

A. As far as what -

Q. The party to charge?

A. Pots of money go to pay for what in a prospective budget package?

Q. Yes.

A. That is under my purview.

Q. In terms of prioritizing - and I understand you have gone through the budget prior to coming in today, but I'm not going to need to get back in the specifics. In terms of community resources and alternative placements, you obviously had to prioritize, if you wanted to put money into those things versus additional money at AMHI or BMHI, correct?

A. Are you referencing Part II or back on Part I?

Q. I'm not referencing either budget specifically. It's not a hypothetical, but I am saying when you sit down and deal with your budget, you have to look at do I want to spend a lot more money at AMHI, BMHI or do I want to spend a lot -

A. That's right.

Q. And some at community -

A. That's right.

Q. So you prioritize depending on what the impact is going to be.

A. You make policy decisions.

Q. Have you sat down to determine what the impact of extensive financing of community based services or alternative placements would be on your institution at AMHI?

A. When we put together the plan that resulted in becoming the budget request, the legislative document presented to the Legislature in September of '88, calculations were made on the net effect of certain community services and the net effect of those services on admissions at AMHI.

Q. What did you see that net effect to be?

A. Well, looking specifically at one of the services that is very much on schedule though not fully implemented because the start-up time is such, if we look at the community in-patient - the in-patient service to be placed in the community, we asked the Legislature and received a request built on the fact that if we had a 20-bed facility and the average stay was two weeks, we could quite likely divert a substantial number of referrals coming from York and Cumberland County. The plan is to establish a community in-patient capability in those two counties and we are on track with doing that. For specific numbers I would call on - if you're interested, I would call on Robert J. Harper who is the Bureau Director of Mental Health.

Q. And when he speaks to that I'll just mention what the number is I have found to be stated by many people affiliated with AMHI and that is that if you had proper funding of those community

resources that due to the acuteness of many of the patients, only approximately twelve in the current census we'd be able to put into alternative settings and I want him to address that particular concern.

A. Okay. Jay are you here? This is Jay Harper, the Bureau Director for Mental Health.

MR. HARPER - Thank you. If I understand your question correctly, as part of our community package we requested $500,000 to make available one or two options for us to pursue. One is the direct purchase on a case-by-case basis of clients who were suitable for an in-patient care facility, but rather than provide them as the only facility choice AMHI, provide them beds that may be available in the community.

The other option we're pursuing, and I think it represents the long-range option for the State to pursue, is the actual construction and involvement of contracting for specific facilities for those patients. The twenty beds that we could purchase with that money on an ongoing basis would be for clients that would be acceptable for AMHI or for this facility. It's not limited to twelve that would be drawn down from the AMHI population as it stands now.

Q. Would you agree that in relative terms that there's a very small portion of the population at AMHI that could be removed and placed in alternative settings?

MR. HARPER - Absolutely not.

Q. You do not agree with that?

A. Absolutely not.

Q. I would ask through the Chairs that we be provided by you and by the Commissioner with a little more information as to what specific programs you think would address a substantial portion of the AMHI population. I'd be very interested to see that. I still have some more questions for the Commissioner.

SEN. GAUVREAU - Rep. Boutilier, as a matter of logistics, Appropriations will begin a hearing on the budget at 1:00 p.m. and I spoke with their staff person and understand that they need around one hour, I guess, to get the room somewhat in shape for the afternoon session. I know that Jean had a question as well. Are you going to be short or long do you think? I've just got to manage this -

REP. MANNING - Why don't we adjourn.

SEN. GAUVREAU - Why don't we adjourn at this juncture so that it will allow the people here to set up the room for Appropriations at 1:00 p.m. This is their room after all. And we will formally reconvene and allow Brad to finish his questioning at 1:30 p.m. Now, I believe we're going to move to Room 105 of the State Office Building, because Appropriations has already booked hearings on the budget for this afternoon, so we will resume at 1:30. However, I would caution members of the Committee to remain for a few moments to discuss some other procedural matters and we will resume the formal hearing as such as 1:30 p.m.

in Room 105.

COMMISSIONER PARKER - May I make a closing statement? Is that acceptable?

REP. MANNING - Well, you've still got plenty of time to talk this afternoon, because if you do it so something else is going to be brought up or are we just going to continue -

COMMISSIONER PARKER - No, it's not new information, it's just reintroduction.

SEN. GAUVREAU - And how long -

COMMISSIONER PARKER - Thirty seconds.

SEN. GAUVREAU - Sure go ahead.

COMMISSIONER PARKER - Thank you, Mr. Chairman. I would like to conclude this morning's testimony by simply stating again that there are several different plans in effect, namely, about six of them, and they are built on the idea that patient care quality and the improvement of same is absolutely vital if we're going to continue to do a responsible job. I wish you to know that I am in - you know, I accept full responsibility for what's happening and I look forward to continuing this discussion this afternoon so that we can look further towards solutions.

SEN. GAUVREAU - Thank you, Commissioner. We will then recess the hearing portion of the Committee meeting for today until 1:30 p.m. at Room 105 of the State Office Building which is down across the tunnel.

HEARING ADJOURNED AT 12:00 NOON

III

STATE OF MAINE

HUMAN RESOURCES COMMITTEE

Hearing on Augusta Mental Health Institute Issues held on January 31, 1989, State House, Augusta, Maine.

Norma Morrisette

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Augusta, Maine
January 31, 1989
1:30 p.m.

EXAMINATION OF DR. ROHM BY REP. BOUTILIER

Q. I wanted to ask you about two specific cases, one being the rape case. It's my understanding, and you weren't here in the morning, but I asked the question of the Commissioner concerning the experience of the nurse who was on at that particular time, and that it was a fairly new nurse, very new nurse in a Nurse I position. It's my understanding in some work that I did checking into this case that that particular nurse, after hearing of the alleged rape, did not report that for six and a half hours until after the occurrence of that. Now that contradicts your statement the other day, last week, when you said that there was an immediate response to the rape, and I'm wondering if you could address that and -

A. The immediate response was to the rape victim, I think. The rape victim was appropriately taken care of. What was not taken care of was the forensic police aspect of it. There was a complete lapse of several hours on that.

Q. Okay, because I also was under the impression from some work that I had done to find out more specifically about the case is that not only was the reporting of the alleged rape six and a half hours late but that the assessment of that patient, the person who was allegedly raped, was actually more than six hours after the fact and, again, that contradicts what you said. You said that immediate attention was paid to the victim, that's not what -

A. Well, she was given psychological support, she was examined,

she was cleaned, but the actual examination determined - to determine the forensic aspect of it, this was delayed.

Q. The second issue was - there was an article and I don't know whether it was the Sunday paper or the Kennebec Journal or one of those papers, but it talked about a patient who had severe incontinence and was placed in a room the farthest away from the toilet facilities. Now in the case of short staffing and an individual is not getting the supervision that they need, that can be related to short staffing, there's no doubt about that, but if someone comes in with incontinence and is assessed to be that, that it would clearly be a management problem if that person is put in an area of the facility that's the farthest away from the bathroom facilities. Can you address that issue?

A. I think it was corrected after it was brought to the attention of the staff.

Q. That same person apparently had some intestinal disorder. Were they given clinical treatment in a reasonable length of time?

A. I cannot answer this question.

Q. What is the ongoing assessment of patients as they come in as to whether they need clinical assistance, if any?

A. The ongoing assessment of patients, they are seen by the admitting psychiatrist or the physician assistant at night. In the morning I go over with the - my physician assistant over every admission, determine the appropriateness and the immediate management. Then around eight o'clock, the admission unit psychiatrist, or one with the admission unit psychiatrist sees the patient. At that time, the admission note is dictated by the

night - evening/night physician, typed and in his hands, and he can determine the immediate treatment needs, condition, after - on the ward. Then there is a physical examination if it's not performed right on admission. It will be performed within 24 hours.

Q. Although that's the policy, do you think you are staffed appropriately to meet that policy of yours?

A. We meet the policy in 90 percent of the time.

SEN. GAUVREAU: What was that response again, please?

REP. BOUTILIER: He said he met it 90 percent of the time.

SEN. GAUVREAU: Thank you.

REP. BOUTILIER: My last concern is a case where an individual was given an anti-psychotic, Sorental*, are you familiar with that drug?

A. Yes.

Q. In this particular case, again it was cited by a newspaper and it was something that I'd been looking into already, but the newspaper stated that the individual was being given 300 milligrams per day, and this is - primarily it's a treatment for alcoholism, correct? Sorental*, correct?

A. No.

Q. It's not - Sorental* is not a treatment for alcoholism? They were given 300 milligrams a day. Then were then off of Sorental* for four days, and then came back onto the drug at a much higher dosage. Are you familiar with the case that was cited in the paper?

A. I don't recall that.

* Spelled phonetically.

Q. And this individual - the same individual, a female, had been observed and documented to be involved in sexual conversations with staff members?

A. I think I know who the patient was. What's your question?

Q. Well, the question is that Sorental* usually causes a great deal of disorientation and dizziness as one of the side effects, would you agree with that?

A. Not necessarily.

Q. Not necessarily.

A. Disorientation, no.

Q. This same person, though, was documented to have fallen asleep while on the toilet, they were documented to be disoriented in the hallways, experiencing a lack of balance. Are you familiar with that? Is that what happened in that particular case?

A. This can happen, but this is not a frequent side effect.

Q. But in this specific case that you just recalled, did that happen?

A. I don't think so.

REP. BOUTILIER: Okay. I have no further questions of Dr. Rohm.

EXAMINATION OF COMMISSIONER PARKER BY REP. BOUTILIER

Q. Susan, I wanted to go back onto the questions I was mentioning before in regards to what you played as your role, and that has been as a supervisor of all of the department rather than involved in the day-to-day administration. And along that line, I think in terms of a facility that has clearly had staffing problems, that funding for education of staff would be something that you would

prioritize as being very important, would that be - would I be correct?

A. Yes. I feel that an often left out component of management and, you know, paying attention to the staff is staff development and training.

Q. Do you know what the account - and Ron can step in and answer - do you know what the exact amount is of monies that are set aside within the AMHI budget for education?

A. I'll have to defer that one to Ron Martel, but first I would like to mention that AMHI, under the aegis of Dr.Jacobsohn in his current role as Medical Director but formerly as the Director of the Forensic Service has an interest - a special interest of his is the fact that education must occur for various clinical people practicing the disciplines, and several years ago he started a program called Grand Rounds in which he has been able to collaborate with the residency program from the University of Vermont that is sited down at the Maine Medical Center in Portland, and between Maine Medical Center and AMHI, they can combine resources and bring in some very, very good people and provide these Grand Rounds programs on a monthly basis and the results are then video-taped and forwarded to BMHI. But for the particular cost, I would refer to Ron Martel, if you have that in your -

MR. MARTEL: I don't remember what it is, but not counting staff time on the clock, I would guess that it's probably twenty or twenty five thousand dollars a year.

Q. That you have set aside in the AMHI budget for education. How

much of that money to date has been used?

MR. MARTEL: I haven't the foggiest idea.

Q. Okay, no idea. I'd be interested to see your figures for what that is.

Susan, there are two programs that were implemented under Commissioner Concannon, and I believe that Frank O'Donnell and Peter Ezzy would know specifically, and Peter Ezzy's job was to be a contact between two particular programs, St. Joseph's College and the University of Maine in Augusta and your department in terms of educational funding and programs.

COMMISSIONER PARKER: Hm-mm.

Q. In terms of the St. Joseph's program, there were three parts to that, and they provided for courses to be provided at the Augusta - in the Augusta area. It allowed for tuition reimbursement for ten slots for people being an RN to go to the --, and it provided for a continuing ed, which would be non-credit courses but would be continual education of the staff. The cost of that program on an annual basis for ten slots and the two other things that I mentioned was $5,000 a year.

A. Yes.

Q. You chose to defund that and to not redo the contract that had been consistent under Kevin Concannon. You haven't explained to me what you -

A. Okay, let me update you.

Q. But I understand you have not reiterated the contract.

A. I'm familiar with the program you are talking about. In fact,

the nursing consultant, Vera Gillis, and I have spoken on at least three occasions recently, and as you quite likely know, she is a proponent of that, as we are.

Q. And isn't Frank O'Donnell and Peter Ezzy and several people at St. Joseph's -

A. Both Frank O'Donnell and Peter Ezzy, some of their responsibiliti have changed a good bit since my predecessor was commissioner. However, Peter Ezzy still has an interest in staff development and training, and Frank O'Donnell does carry out some of the staff development and training programs. I have switched his accountability to that of Ron Martel, because much of the staff development and training function is an outgrowth of taking care of various personnel matters. Back to the point, however, the St. Joseph program is an important one, and I'm losing track of time because I've been here so much, but either last week or the preceding week I gave the directive to Ron Martel to see what we could do for the St. Joseph's program, and I can't speak to whether or not there is a contract in place, but I recognize the value of this project and there are - in fact, I spoke with an RN who was assigned to admissions, and this was a Friday that I visited AMHI, who was doing the eleven o'clock shift, and he spoke to me directly about the worthwhileness of this program and he sure hoped that I could get it back onto a track. Subsequent to that, or the next Monday, I spoke with Ron and asked him to see what we could do.

Q. So you have come to the conclusion that it is a worthwhile program and that it should be reinstated?

A. Absolutely, it should be reinstated. I'm just not sure whether or not it totally lapsed. What is the status?

MR. MARTEL: The contract itself with St. Joseph expired June 30, 1988, along with the funding. It was federally funded under a manpower grant, so it was a funding issue. Many of the individuals that were previously enrolled in the program have continued to be enrolled in the program. As recently as two weeks ago -

COMMISSIONER PARKER: Right.

MR. MARTEL: We processed an invoice - or two weeks ago or whatever it was - representing the cost through the date of that invoice.

Q. And what was that total cost?

MR. MARTEL: I don't remember.

Q. Approximately $1,500 or so?

MR. MARTEL: Give or take.

Q. And why has the department refused to pay it up to this point? Are you in the process of paying it?

MR. MARTEL: It's a question of not having the resources that were in place beyond June 30, 1988.

Q. It seems to me that when you have a total program that costs $5,000 a year for ten slots, plus several other programs associated with it, that there is some way to pay that. I mean, you've already told me you have $25,000 set aside in education. It's my understanding that there's at least $20,000 remaining in that account. If that's the case, you could pay at least for the reinstatement of the program for the next biennium easily, if not continuation beyond that, and that's ten slots that could help alleviate your staffing shortage. Fifteen hundred dollars is a

very minute bill compared to the costs we're going to get from decertification because of lack of staffing. The same goes for the UMA program that has the same program for mental health workers and LPNs that want to increase their education. That has a similar low cost versus what the benefit is, and again you've not chosen to reinstitute the contract for that.

MR. MARTEL: My only comment to that is, the funds that we're utilizing to pay the invoices are coming out of the central office account, which is substantially lower than the All Other budget within the institution itself. It's certainly within the superintendent's authority to expand the staff development budget by $5,000 or $10,000 by transferring from other places within the hospital, so I think it's a little bit -

Q. Or take unused funds within that account and pay for that service.

MR. MARTEL: Well, it's a little bit misleading to suggest that the $5,000 couldn't be paid. We have a $2.2 million budget at AMHI, and I would submit that if it's as high a priority as people seem to believe it is, then you're right, somehow, some way it could be paid.

Q. The last thing I want to bring up, Commissioner, is, again, consistent with your statement that you've been primarily prioritizing and overseer of the whole department and not been involved in the day-to-day goings on at the department - at the institution. It would seem to me in that instance that if staff and the superintendent came to you and said we need X-amount of staff to meet our requirements, we need this kind of staff level to be

properly certified and properly covered for patient care, but if you do not have a direct role on a day-by-day basis and you put more emphasis in terms of what their role is and their abilities to call the shots, that you would take their recommendations with a great deal of security in knowing that they're doing the right thing and fund them at that level and not say, well, I'm sorry, we can't afford that, we can't do that, when you've not involved yourself in the day-to-day operations. Could you explain to me and to the Committee members that are interested, if the superintendent, Daumueller, or whoever the superintendent prior to he or after he comes to you and says we need this amount of staff to be properly staffed, would you feel your role would be to accept it as it came to you or to cut it beyond that without having that day-to-day role.

COMMISSIONER PARKER: I feel if I don't have a day-to-day role, it is logical - it is logical that I would, as I said earlier this morning, rely on other expertise, and in point of fact, that's what happened. To cite an example, after we lost Medicaid certification on May 29th, two weeks later, in June, I sent the directive to the superintendent and said, please put together a package that will allow us to regain Medicare and retain JCAHO. That staff at AMHI, in fact, put together a package citing a certain number, and the number that they presented us didn't change and still has not changed, and that was the package resulting in the 65 additional staff, so you are correct in that, making the observation that I do rely on people who are in key management positions to come forth with solutions.

Q. Is Dr. Rohm involved in the preparation of the budget for the institution? Is he involved in the budgetary meetings determining the priorities of funding?

A. He is involved to an extent. I think the exact extent we ought to ask him about.

Q. Dr. Rohm, have you in the past been directly involved in the preparation of the budget?

DR. ROHM: In the past, no.

Q. Previous to Commissioner Parker's position, were you involved directly in the implementation and the preparation of the budget?

DR. ROHM: No.

Q. There has been no Commissioner that you have ever served under that you have had a direct role in preparation of the budget?

COMMISSIONER PARKER: Representative Boutilier, he has been appointed to his post since February of '87.

Q. As acting superintendent?

A. No, February '87 as clinical director and then January as acting superintendent.

Q. And my last question, in terms of the institution's importance and the amount of monies that we talk about with any kind of decertification that occurs at AMHI or BMHI, do you not think it would be appropriate to have the superintendents of the institution, which you place a lot of power in their hands in terms of running the facilities, don't you think it would be appropriate for them to come directly to the legislature and speak on what requests they would like to see and be able to answer

questions and justify those requests, rather than going through your office and having you come up and speak for what is not - has been in the past not your day-to-day contact and allow them as superintendents to give the justification for the funds requested?

A. I look at this department as a department that is made up of many operational components. The field of mental health requires many varieties of service in order to make it work. The primary tenet to making a mental health system work well for people with mental illness and their families is the fact that all parts of the system work together. A critical part of that system is, one, the institution and, two, the communities. The programs that are designed in the communities and also the programs that exist in the institution, particularly those programs that relate to transition, that is people moving from the institution back to the community, or vice versa, must work together. Therefore, I think that much more cohesion, that is the ability of a program to work with another program will be reinforced if the institution is a part of a larger system. Consequently, I think it's highly advantageous to have a superintendent function as part of a larger team wherein general mental health and mental illness issues are discussed and to come with us to the legislature to directly present the case before Appropriations. That is not to say, however, that superintendents ought not to sit on committees, such as the Commission to Study Overcrowding, or other policy oriented committees charged with coming up with solutions. They

should do that, and they should do that and be forthcoming with whatever information is necessary for that committee's activity.

REP. BOUTILIER: Thank you.

SEN. GAUVREAU: Thank you. I really hate to do this, but we now are aware that the meeting which was going on in Room 113 has ended and that there are apparently many people who are in the halls who are unable to obtain access to this hearing, and as a courtesy to the public, I think we should utilize the largest hearing room available.

REP. MANNING: Also, for the public knowledge, there is amplification in that room, so everybody in back will hear what is being said.

SEN. GAUVREAU: It may take us a while, so we'll reconvene at approximately ten past two.

(OFF RECORD)

REP. MANNING: Jean, you have a question?

REP. DELLERT: Yes, I have several questions. Thank you. I'd like to ask some questions of the Commissioner, if I may.

REP. MANNING: Sure, go right ahead.

EXAMINATION OF COMMISSIONER PARKER BY REP. DELLERT

Q. I'd like to talk about management plans, including the transfer of patients, standards for restraining, taking of patients' vital signs, and if we had a management plan, who would be in charge of that plan? Would all levels of the staff and all shifts be made aware of these protocols and really whose responsibility is it to see that all these are in place?

A. It's the superintendent's responsibility to make sure all of

these are in place. You had several parts to your question.

Q. Yes. Do we have a plan for the transfer of patients, the standards for restraining patients.

A. Is there a policy in place?

Q. Yes.

A. The finding of the advisory panel, composed of the medical experts, one of their recommendations, particularly using one of the patients as the example, was that there was not an adequate transfer policy in place for moving a patient from one ward to the infirmary and from the infirmary vice versa. With that transfer policy also was the recommendation that certain communication issues be improved. The other one was the restraint policy?

Q. Yes.

A. Yes, at AMHI there is a restraint policy on the books. There is also a department-wide restraint policy.

Q. Was it being followed carefully or was it - did all the staff know about this policy?

A. I don't believe that - at least judging from the findings of the advisory panel, that all the policies were actually being practiced, despite the fact they were on the books.

Q. Then I have another question. Some states, like Massachusetts, have a plan for refusing certain patients, like a dementia patient -

A. Yes.

Q. That would be better served in some of the community settings. Do we have - have we filed that kind of a plan?

A. As a management team in the central office and also the acting superintendent at AMHI, we are just beginning to discuss the fact that there are possibly diagnostic categories that do exist that are inappropriately served at the Augusta Mental Health Insitute, and several weeks ago I did direct the medical staff to draw up a listing of those diagnostic categories.

Q. Then if we had such a plan, then we might move more patients, or as they come in we might even move patients into the communities then. So there is a need for the community based -

A. There is very definitely a need for the community-based services. In fact, one of the cornerstones of the design underpinning o the community package and the institutional package that was presented to the legislature in September '88 was the fact that they must work together, and there are several programs in the community piece of the mental health package that are designed expressly to divert admissions from AMHI to the community, and the idea is that diversion occurs before someone arrives at the front door. An example of one of those types of services that can act as a diverting agent would be intensive case management and also crisis services. Crisis services must be available 24 hours a day, and the idea is that a crisis worker would be very knowledgeable about resource and would be able to direct that individual to the resource that would help the individual when the need was there, not to wait until Monday morning at 8:30.

REP. DELLERT: That's all I have at the moment.

REP. MANNING: Michael?

REP. HEPBURN: Yeah, just as a matter for the committee here, throughout a lot of the morning I've been hearing a lot of the same answers that we had been hearing on Thursday and earlier this morning. Perhaps it might be wise if we set some kind of limit on as far as how long we want to go with these people. We've got an emergency budget request on Thursday, and a lot of the criticism this morning had been that perhaps they weren't moving fast enough with some of the reforms that maybe we should be doing, and maybe we're part of the problem rather than part of the solution in the fact that we're keeping them here all day. Do you suppose we could look to something like that, maybe ending with the department at three or something?

REP. MANNING: Well, Michael, to respond to you, quite frankly, if they're not ready for their emergency budget now, they'll never be ready, but yes, we'll try to make this - try to get this going.

REP. HEPBURN: I'm not trying to block out the debate here. Maybe we could even submit questions in writing or something if we had to if we have additional questions. I'm sure, certainly, some will continue. I'm just a little bit concerned that's all.

REP. MANNING: Go right ahead and ask your questions.

REP. HEPBURN: I'm all set. I just wanted to make that -

REP. MANNING: Any other questions? Bonnie?

EXAMINATION OF COMMISSIONER PARKER BY SEN. TITCOMB

Q. Trying to get a perspective on whose responsibility is what and whose responsibility is not, I'd like very much, Commissioner,

if you would be willing to draw out for me, and I requested the blackboard, my past history as a teacher, I like to see things in writing, I would like to have a hierarchy written from the basic mental health workers up, who is accountable to who?

A. Okay. What I would like to do, Senator, is to pass you out two organizational charts. The first represents the department's organizational chart, and the second one is the AMHI organizational chart. Now, who has the backup here on the AMHI org. chart?

Q. My second question would be, looking at all of these papers here, on which page would we find those workers from the hospital who were involved, say - let's take the rape instance. Where would those workers be on all of these pages, so I can see whose responsibility the decisions of that day really were and where those decisions were being made?

A. Let's turn to the last page. This is the one concerning the Augusta Mental Health Institute itself. The first - separate out your Augusta Mental Health Institute one. Then look at the sheaf of papers that started with the first page called the Commissioner's Office. Turn to Page 2 of that and I'm going to walk you through. It's Page 2. The second page should be DMH and MR government structures. The first page is Commissioner's Office. If we start with the first page and the Commissioner's Office, you'll see that the residential facilities are listed. You see Pineland, Augusta, Bangor, etc. There is a solid line that goes straight up to the Commissioner. That is descriptive of a direct relationship between the superintendent and the commissioner. Turning to Page 2, you see the - again, a box that denotes the Commissioner's

Office. You see three fingers off to the left, AMHI, BMHI and MNCH, Military and Naval Children's Home. This shows the citizen advisory committee to AMHI. Just separate that out for a moment. Now let's move to the Augusta sheaf, the AMHI sheaf. You will see that at the top of the page, holding it on the horizontal, is the superintendent. A straight line connects the Superintendent's Office with four prongs, the Chief of Hospital Services, the Clinical Director, the Assistant to the Superintendent, and the various treatment programs. The treatment programs go down to the right, on the right-hand side of your page. The unit in question would have been on the right-hand side of the page. You will see that whoever is in charge of that unit would have a reporting responsibility to a unit director. The unit director, in turn, reports up to the superintendent. That's a solid line that follows all the way through. You also note that there's a dotted line between the unit directors and the clinical executive board. I have just described for you what the reporting path should be. Look again on the right-hand side of your page. These are various programs down the right-hand side, Admissions Unit, Young Adult Unit, Adult Unit, Forensic, After Care, Nursing Home, Clinic and Infirmary. Those are each of the treatment programs. Again, each of those units has a director. We heard earlier testimony this morning that said that an RN was on duty from the eleven o'clock shift change on. That person - that RN would have reported to a unit director. The unit director would report up to the superintendent.

Q. That was quite an answer. I expected something rather simple.

A. It's not a simple organization, it's a complex hospital.

Q. Well, it may not be a simple organization, but I think there are some simple facts, and that is somewhere along the line there are some holes in this program and there are people that are being raped and people that are suffering poor mental health care because of it, and I'm having a very hard time getting all the papers and not getting down to the specific reasons why these holes are existing, and it seems like nobody is accountable. It's easy to see it on paper, but I want to know who is accountable. Does the buck stop with you? If those patients were my constituents, I would want to know who I was going to blame for a lack somewhere in this system that is laid out very beautifully on paper.

A. Well, Senator, the buck clearly stops with the Commissioner, we know that, no one disagrees with that. I don't disagree with it.

Q. Then I have some questions.

A. But there are several checks and balances in this complex organizational design that are there for very good reasons, and those good reasons are that accountability needs to occur very close to the action where the patient care occurs.

Q. I think that's probably very -

A. And we have discussed this morning that this RN who was inexperienced was a major - she represented a weak link in that accountability. Due to her inexperience, she may have not been cued in to the necessary attention. We have taken the blame, and

by saying for the public record this incident was not handled well. We concur with most of the recommendations made by DHS and will continue to collaborate with them.

Q. I understand that there was a weak link there, but my concern is that I'm seeing so many weak links, I'm wondering who is going to be responsible to pull this whole thing together and how long are we going to wait to ask for the budget request to make it possible. I still haven't heard about air conditioners, we're still doing a study. We suffered upstairs for a very short amount of time with a very relatively low degree of heat, and this next summer, I guess I have some questions about will there be money for air conditioners. Will there be money for the changes that are going to have to take place to fix the links that are risking people's safety.

A. I would very much like to comment on what we're doing around quality, and I can assume that yours was a question as well as a statement. First of all, we're in the process of choosing an engineer. We are working with the Bureau of Public Improvements to do so. It will require - we should have an engineer who can be hired to actually do the survey. We will hire in two weeks. The survey will require approximately one month, and the report will include recommendations regarding cost estimates, still within the time that this legislature is in session.

Q. So we can expect a request for an air conditioning funding?

A. Mid March cost estimates and recommendations will be available.

Q. Now am I not correct in stating that a certain amount of

research has already been done on the costs of putting air conditioning even in just one area of the hospital?

A. We stated last Thursday, also for the record, that some very preliminary examination had been done of aspects of the hospital. It's a complex engineering task to look at the entire physical layout of a facility that has been around since 1840, particularly a facility that is made with granite that is no longer in use, particularly with the actual design of wards that are not of modern construction, and we need the special talent of an engineer who knows about some of the physics concerned with air circulation within facilities of this nature to come in and take a look at it.

Q. What is the time frame you're looking at for installation?

A. Mid March, Mid March, the cost estimates and the recommendations. I have not seen installation estimates, and I do believe that any installation projection for time is totally based on the assessment results for the engineering task itself.

Q. I understand what you're saying and I appreciate all of the routes that we have to go to get these things done. But, very frankly, if there are people that are still - and I'm sure that isn't even an if - the people who are still on these psychotropic drugs that so dangerously interact with severe heat, if there isn't a system in place, then we're going to go through another summer with the same sort of risks and hopefully not tragedies that we had last summer, and I, frankly, think that sometimes the bureaucracy of the whole system needs to be put aside and look

at the human elements where we have a body count. And I appreciate all you've been through Thursday and today and all of the technicalities, but I would like to put some of them aside every now and then and think about the human element, and it seems that too often we are not doing that, and that's the part I have a problem with, because I have to go home to constituents who might one day be at that hospital, and I feel as if we're missing the boat, we're not touching on the real people aspect, that is the issue that's hitting the newspapers and we're being held accountable for, and I feel real uncomfortable with it.

A. I disagree we are not concerned about the real human element. The reason I am here, I believe, is because the legislature has an interest in the human element and I am giving you as much descriptive information as you care to have concerning what we're doing to improve patient care quality. This morning I iterated six points that are designed expressly to take care of the human element. I began with a discussion of what we did in February of '87 regarding the addition of extra staff, as well as the creation of community alternatives. The last point I made in that series was to discuss the DHS findings and some of the recommendations that we are engaged in. However, what I would like to do now is to tell you two other elements that we are engaged in regarding meeting - or anticipating a heat wave for next summer. This I am reading. It's a memo, dated today, January 30, from the clinical director to the medical director of the department, in which it states that the nursing consultant, one Vera Gillis, is

putting the finishing touches on an addition to the mandatory employee orientation curriculum, and I referenced it this morning dealing with the recognition and management of the manifestations of heat-related disorders, and for the nursing policy manual, a similar item is in the works and here is some information concerning it.

On thermometers, if we remember the findings of the advisory panel, there were some issues about taking the ambient temperature, that's the temperature of the air, and there were apparently a lack of thermometers in the facility in order to do this strategically. One hundred were purchased and are installed in all wards. Except for the infirmary, there are approximately ten thermometers per ward. Development of a policy is now in progress.

Secondly, air conditioners. Sixteen were purchased in July and early August and three were reconditioned. The two constant observation rooms on admissions have had air conditioners for many years. In addition, all other ward areas have or will have two or three air conditioned areas.

Fans, third point. Fifty were purchased in July of 1988. I believe there is a date, according to Dr. Jacobsohn, on the date of the first training.

DR. JACOBSOHN: That's correct, yes, March 28th.

Q. Just a couple of questions specific to the budget. When you are drawing up your budget, do different departments - we asked this a bit earlier and I'm still not sure I understand completely

the procedure - do the various departments within AMHI become involved in the structure of that budget, what the needs are, what priority these needs are going to have when you go after monies?

COMMISSIONER PARKER: It is my understanding that the superintendent is in charge of how his or her budget might be developed and it varies -

Q. So actually the departments are not involved in - necessarily?

A. The central office portion of the department does not get involved with, at the early stages of development, a budget process that is evolving within an institution.

Q. So, basically, the decisions for AMHI would be left in the hands of the superintendent as to what the budgetary needs are?

A. There are various weigh stations along the process of actually developing a budget. You know, it's a give and take process once it gets through the steps within the institution. Do you understand -

Q. I understand what you're saying. I'm just wondering what direct role those people who are most affected by budget lacks within the hospital have in budgetary requests for the next year, or for the next session.

A. I have been assured that there is some input but it varies by institution, and I think Rick Hanley would be better suited to giving you a description of AMHI in particular.

Q. Well, I'm just - I'm curious mostly about your philosophy as a Commissioner in how these budget requests should take place, if not,

in fact, that those people that are working on the floors should not have some input in determining what things are needed and make sure that there's a vehicle in place to get those requests to you.

A. The vehicle in place for getting the budget to me goes up through the chain within an institution and it's a real comment on a manager's style, how he or she might involve people who are working at the direct patient level.

Q. So basically your policy -

A. I would favor that, yes, as a point of philosophy as a manager I would be most interested in promoting, and I am most interested in promoting budgets that reflect needs, real needs, and real needs as defined by patients.

Q. But that is not a policy right now, that that is part of a process that should and will take place, that it's up to the discretion at each institution of the superintendent?

A. The assurances that I am given by superintendents at all facilities reflect how they best see a budget development process. A budget development process from an institution is also based on history and how communication works in those particular institutions. When I receive a budget from a top manager, I always ask, does this reflect what you need.

Q. I guess that's the point where I begin to have a problem. In education, when we do our budgets, we put in requests for those things that we think we're going to need to work into our programs, and if there was no one there who routinely would take those

requests, it would be very difficult for us to know that the coming year, when we go into our classrooms and face a hundred some students, would those supplies that we need to provide good quality eduction be there, and I would think that it would be a priority that a budget philosophy and plan be in place so that those people who are providing the care on a basic level have some input into what their needs will be. I guess that's just a difference I understand what you're saying.

A. That is exactly -

Q. But it's evidently not a policy that is routinely adhered to, it's left to the discretion of the superintendent.

A. And that is precisely why in a management approach such as mine why it is vitally important to have people who are your appointees who share your value structures, who share to some degree a treatment philosophy that puts patients first.

Q. Well, I appreciate that. I have just one more question I would like to ask, if time allows.

SEN. GAUVREAU: Proceed.

SEN. TITCOMB: On the instance of the rape, who was the person who ultimately reported that rape to the authorities? Who was the person who got medical attention for the victim of that rape? And who was on duty at the time that might otherwise have been the person to do that?

A. When you say authorities, do you mean the police?

Q. I mean both the police and those members of the hospital administration or hieraracy that should have been notified.

I just would like to see a scenario of what took place and perhaps use that as a case study of where some of the problems are, because it appears to me that if the next day this woman was being treated for something that I believe should have been treated immediately, then there seems to be another weak link, and I would like to know where that - how that scenario took place.

A. Okay. In the course of this day, I have been - I have referenced this case three or four times. In order to not repeat the information that I have said, I would like Rick Hanley to offer a chronology of who said what and to give you the time element on that.

Q. Well, I understand it and I do recall your referencing it, but I'm still - after several times I still don't get a clear picture of how it took place.

A. Yes, you want the chronology.

MR. HANLEY: I'll try to be brief.

Q. Not necessarily, just complete, thank you.

MR. HANLEY: After the incident was discovered, we've already established that the nurse on duty did not immediately notify the NOD, the nurse who was on duty on that shift. The next piece in the sequence, the victim was cleaned and her clothing placed in bags and taken care of. The next piece in the sequence, as I understand it, is that at 6:30 in the morning on the 10th of September, the following morning, the woman was awakened by a mental health worker and again - and was bathed at that time, and

this - my understanding is that this occurred prior to an internal medical examination. The physician assistant who was on duty was notified of the incident at approximately 5:30 in the morning, and approximately 6:45 is my understanding, the woman received a medical examination.

The next piece in the process is that I believe the physician who was coming on was informed of the incident, and also the assistant OD who came on that next morning, and in the DHS account which I am looking at there are a couple of pieces missing, but my understanding is that - and I think that former Superintendent Daumueller could also flesh this out a bit, that he was notified by the NOD and came to the ward. At that point, my understanding is that he instructed that the patient advocate, Tom Ward, be notified. Mr. Ward came to the hospital, I believe, around eleven o'clock on that Saturday morning and at that point he became aware that the police had not been notified, and I believe also the guardian at that point, the public guardian, had not been notified. And my understanding is that Mr. Ward instructed that that occur.

SEN. TITCOMB: So my next question is what was the scenario for the man who was then taken to the forensic ward? What was the whole scenario with him?

MR. HANLEY: He had been seen that night by a mental health worker who had just come back from another unit, and about quarter of twelve on the 9th of September he was found by the staff person. He -

Q. Excuse me, who was the staff person? What role did that

person play? Was it a mental health worker?

A. He was a mental health worker, yes, I believe a Mental Health Worker II. The male patient was showered and changed, but that did not occur, I understand, until early the next morning, approximately five o'clock in the morning. And I am not exactly sure of the point at which he was transferred to the forensic unit.

Q. Do you know who made that decision?

MR. HANLEY: No, I do not.

Q. Okay, after he was up there, what length of time was he in the forensic unit before it was decided that he would be sent back? You said at intervals he came back onto the ward, but exactly what happened then?

MR. HANLEY: I cannot off the top of my head or from this - the description that I'm looking at give you exact dates of when he was first integrated back.

Q. Not dates, I just want generalizations at this point as to what period of time was he in the forensic unit and at what point and by whose authorization was he allowed to come back onto the ward, at which time another incident occurred?

MR. HANLEY: Well, it would have been, I believe, within the next three to four weeks that he was gradually being re-introduced to the ward, and that would have been a clinical decision that would have been made jointly between the clinical leader on the forensic unit and the attending physician on the North Psychiatric Unit.

Q. So those would have been the two individuals who made the decision that he was, in fact, ready to come back to the ward?

MR. HANLEY: I am not sure what involvement the clinical director had in that - in that decision.

Q. Does anyone know for sure exactly what - this is where the foggy area starts for me again. I hear too many well, I'm not sure and I think, and if we're setting up protocol for where we're going from here, do we know where we've been and what mistakes we've made, and this is - every time we come to this point and I don't feel as if I'm getting a specific answer to my question. Who was the person that decided that this male patient was ready to come back onto the ward where he then went on and attempted another sexual action, whatever it would have ultimately been?

MR. HANLEY: We can obtain the medical record and give you exact dates.

Q. I would like to have that.

SEN. GAUVREAU: I understand that will be provided to the committee.

MR. HANLEY: Yes.

SEN. GAUVREAU: Thank you.

SEN. TITCOMB: Thank you. That's all I have.

SEN. GAUVREAU: Thank you. Representative Rolde?

EXAMINATION OF COMMISSIONER PARKER BY REP. ROLDE

Q. Susan, you may already have answered this, and if so, I apologize for having to be in and out, but when we were in one of the rooms that we were in this morning there was a chart in front

of me and looking at that chart, and correct me if I'm wrong, but it looked like right now, in 1989, you have the highest census that you've had so far at AMHI, is that correct?

A. In 1989?

Q. Yeah.

A. Right. This one right here, that would still be census, wouldn't it?

A. Admissions are the number of people who actually physically come in. A census is who actually is staying there.

Q. All right, then you have the highest number of admissions?

A. That's right, and the point that I made this morning is that the - in the period 1980 through 1985, while the admission rate was going up the number of full-time equivalent staff, that's one staff person, were going down. However, in 1987 the trend began to change and the numbers of full-time staff began rising as the number of admissions were rising.

Q. Okay. What I wanted to get at is whether it's admissions or census or whatever, what does that portend, the fact that the admissions, after all this talk about an overcrowding commission and concern about the overcrowding and the legislature giving some money to beef up community resources, what does that portend for the future, the fact that despite all of these activities, the admissions are the highest that they've been since at least 1980.

A. Right.

Q. Is that a trend, is that because of population pressures, is it that the communities' resources haven't taken hold yet? What

do you see as happening?

A. It's a complex set of occurrences that are happening simultaneously, and the admissions are continuing upwards. In fact, given that we have one more day of January, it's looking as though we may have the second highest month on record for numbers of admissions. The admissions are coming from - or the majority are coming from the southern part of the state, combined with the Lewiston-Auburn area. We're seeing an increase in the acuity, that is the actual severity of the illness.

Q. So they're staying longer once they're admitted?

A. Not necessarily. Some of them are coming in, staying an average of six or seven days and then moving back out, often not even being referred from the admissions unit out onto the wards. We did a study in the statistician's department of AMHI to see if there was a correlation between population increase in York County and Cumberland and the numbers of admissions, and we found that there was not a direct statistical relationship between the two, which you think there would be given the behavior of populations. Many of the people coming in have polysubstance abuse issues, not necessarily, you know, a simple - not that psychosis is simple, but solely a psychotic condition.

Q. So what do you see happening? I mean, does this mean that the problems that we've been having are going to get worse?

A. I think that admissions are going to continue upward. They may begin to plateau off a bit. The community services that we are establishing via the legislative package last September will

begin to have their effects felt in April and May.

Q. Refresh my memory. How much was in that $6 million package for community services?

A. The total was 3.5 million.

Q. Okay. Has that already been spent or sent out to the -

A. Yeah, it's earmarked for the different services per the plan that we first presented to the legislature in July and the different tasks that needed to be done in order to establish crisis services --

Q. Do we have a list of that among all this mountain of paper?

A. We can get you a list if you don't have it.

Q. If we don't have it, I think it would be interesting to know how that money is being spent.

A. I thought we had forwarded you a list that showed the effective date of contracts that we're letting out. We're in the process now of publishing a number of requests for proposals. For your information, the January admissions figure, as far as number, is 146. Nineteen of those for the month of January are people who would otherwise have gone to the Veterans Administration Hospital. I know that last Thursday we did talk a bit about the potential effect of closing the psych wards at Togus on AMHI and we are seeing the effect. The percentage of veterans is increasing month by month by month, more so than in years previous.

REP. ROLDE: That's all. Thanks.

SEN. GAUVREAU: Thank you. Representative Manning?

<u>EXAMINATION OF COMMISSIONER PARKER BY REP. MANNING</u>

Q. Susan, you just indicated - you said something that caught

my fancy. Did I hear you just say that the RFPs for the community just went out?

A. They have gone out on - at several different dates, Peter. They - I can't remember the exact month they started, but I think it may have been as early as January. Each service, such as case management or crises, or the psych boarding homes have all been developed at a different rate of speed, and the request for proposals have been published on various dates.

Q. Could you tell me why it took so long? I was under the impression that when you came to us with a budget of 6.75 in September, that you were ready to roll at that particular time with community, some of which, I think, was, for instance, case managers, of which Holy Innocence in Portland has already got a proven track record and basically all they needed to have was additional people, I mean things like that. Why are we almost five months later still waiting?

A. I am very pleased to report, Representative Manning, that we are absolutely on target with the schedule. And I recall that in the process of briefing the Human Resources Committee in August, that we talked to you about that schedule. We gave you projected time lines. I will now read again what those time lines are. Regarding case management, a sum of 511,750 was allocated to that. The effective date of the various contracts is February 1, '89. The contracts have been awarded in York County, the Tri-County area, that is Lewiston-Auburn, Kennebec County and Bangor. The existing contract in Portland, and that's your

Holy Innocence reference, was amended to expand services, and the result of these actions will be to provide case management services for up to 525 mentally ill consumers.

Moving on to rehabilitation, which is a very -

Q. Can I stop you right here? Are you saying Holy Innocence got theirs quicker?

A. When there is a contract amendment, it means that you take an existing contract and you simply make a few changes in it, which will be quicker than issuing an RFP.

Q. So, any idea when Holy Innocence got their -

A. Jay Harper, do you know the answer to that precisely?

MR. HARPER: We did the contract amendment notification of them about 48 hours after the end of the session, and I think we finished the actual contract negotiations and changed the language and did new tables for their budget.

Q. So they've had theirs since roughly October, the first of October?

MR. HARPER: Yes, and as far as I know, they had one position vacant about a month ago and I think they have that filled now --

MS. PARKER: Another critical component of any service in the community involves crisis services. The Bureau of Mental Health has hired an additional six crisis workers to provided expanded services in York, Cumberland and Kennebec, and you heard me reference a couple of times that the bulk of admissions to AMHI come from York and Cumberland. These new staff will be joining the various projects by February. The money available for the

crisis services was made effective November 1, '88, as far as moving into the community.

Let's see, on the idea of basic support services, and this has to do with supported living, that was a sum of 423,000, and there are two dates here, February 1st and March 1st of '89. The Bureau anticipates amending existing contracts for services in Portland and Tri-County to establish one six-bed group home in each region. In addition, purchase of service money will be used to provide support services for up to 30 consumers. As we have discussed in briefings past, it is vital not only to have a bed in which to place someone, but you must place a variety of services around that individual so that they will have the necessary support in order to maintain life in the community. A bed is not simply enough. One of those important services that needs to be available, particularly for individuals that have not had ever the opportunity to go to work is in the - is along the idea of vocational support, and a sum of 397,500 was awarded to that effective February 1, '89. The Bureau requested proposals for supported employment coordination and the proposals have now been received and a contract will be awarded in the next two weeks, and we anticipate that the coordination for supported employment will be on line in March and these coordinators will match and link consumers with the actual variety of vocational rehabilitative services that are available in the different parts of Maine. Vocational rehabilitation as a service is something that receives a mix of federal and state funding. It is administered out of the Department of Human Services and there

is an interest by VR, as it's call, in working with people with psychiatric disabilities.

One of the most important components of this community package is in the area of maintaining staff people and making sure that your direct service staff people are taken care of. A sum of 1,186,250 was effective January 1, 1989, and the purpose of these dollars was to allow us to amend direct care contracts in order to provide increased salaries for direct care workers. A legislative committee, I guess it's been working approximately two years on the issue of staff retention and certain of the human services, found that the staff turnover is exceedingly high amongst direct service workers. When you have a high staff turnover, your ability to provide continuity of services is quite compromised. It is compromised because it takes time to, one, fill the position, and two, get that staff person up to speed. Consequently, raising the minimum wage, or the minimum salary level to an individual who is doing the all important direct service work has happened, and it has now been raised to $6.30 per hour. The money has also been used to help in recruitment, staff development, increased benefits and retirement programs in order to improve the quality of services by making it a more attractive option to work in direct services.

There's another area that has been given little mention through the years, and that's in the area of family support, and that was funded to a level of 20,000 effective February 1, '89. We have not but will issue a request for a proposal to provide

family support liaison services in the next week, and we anticipate a contract award by the second week in February. Families of people with severe and prolonged mental illness are often the unsung heros in service delivery, and the ability of an individual to maintain him or herself in the community is often assisted by families, but families also need some support, and in this state, we need to look at family needs and look at how we can continue to strengthen a family's ability to work with their family member who has the mental illness. If I can continue -

Q. Well, my concern is that some of these I thought were going to be out a little quicker, but that's all right.

A. But as I said, Representative Manning, the time lines that appear here are the very same time lines that we presented to individuals, such as the Human Resources Committee, who are interested in this package, before we went to the legislature in September.

Q. Okay. You talked about the air conditioning earlier from Senator Titcomb. Then what we're anticipating, that will not be in the Part II Budget but that will be in the Emergency Budget?

A. We have - as I said to Senator Titcomb, by mid March we will have the cost estimates and the recommendations from the engineering firm.

Q. But what I'm getting at is, you're going, did you say Thursday, in front of the Appropriations Committee?

A. Thursday to talk to our supplement budget request, and sometime in March for Part II.

Q. Okay, supplemental. The emergency budget proposal, when you do the emergency - you have an emergency budget proposal that gets

you by June 30th, right?

A. Right.

Q. Will you be anticipating asking for more money in that?

A. Not for air conditioning.

Q. Why?

A. In state government, the Bureau of Public Improvements has the administrative responsibility for buildings and what happens in buildings. I need some technical -

Q. Well, will they be asking in their emergency budget for the air conditioning?

A. I can't answer for them, Representative Manning. I was just looking around because I wanted some clarification from Ron Martel as to the responsibility of the Bureau of Public Improvements to initiate such a request. I don't know the answer to that.

Q. Could we find that staff, because the concern would be that if it's in Part II, by the time Part II is voted on and put into place July 1st, and quite frankly, I think you people did a heck of a job trying to find 15 air conditioners, because from what I understand, you couldn't find anything in Maine at all last summer, and where you found them, maybe we ought not to know because you can go back to them, but that's a concern I have, that it's an emergency piece of legislation, that it's funded before we leave here in July, and it's funded so that the RFPs or whatever needs to be done, it goes out so that when it starts getting hot, and it gets hot here, believe it or not, and sometimes in June, you know, I want to make sure we have air conditioning in that place this

summer, and that's something I think we need to - maybe Ron can - Ron, can you help me on something? On the air conditioning, that goes through the BEP or BIP or -

MS. PARKER: BPI.

MR. MARTEL: BPI.

Q. Do you know whether or not they will address that in their emergency budget?

MR. MARTEL: No. We had some discussions with them in the fall about attempting to estimate the cost of doing such a project, and they had one of their people do some rough estimates, and I think I mentioned last Thursday it was in the millions as a rough guess, and that's all it was.

Q. Well, what about just buying air conditioning?

MR. MARTEL: We did, we bought -

Q. Have we got enough?

MR. MARTEL: Have we got enough, I don't know.

Q. In other words, what I'm - I'm concerned that we're going to go through another summer. I think Senator Titcomb talked about the air conditioning, but I'm concerned we're going to go through another summer and it's going to be - and I know how state government works, it's going to be January, it's going to be 13 below zero over in AMHI and they're going to be putting an air conditioning unit in and that isn't going to help this summer. They're not going to do anything then this year; apparently.

MS. PARKER: I don't think we can say that for sure.

MR. MARTEL: The report is due on our desk in mid March.

Q. Are you going to be pushing to have that funded in an emergency

piece though?

MR. MARTEL: It's too early to tell, don't know. It depends on what the recommendations are. We're going to take a look at those and work with the Department of Administration and talk with this committee and administration.

MS. PARKER: Representative Manning, if the recommendations come forth that it is feasible and there is something that we can do, rest assured that we will push very hard to make that happen.

Q. I don't know whether you need central air conditioning, but I know you can get 18,000 or 20,000 BTUs and it can cool down a heck of a lot of areas, and stick them right in windows. There's enough windows over there.

Susan, back in September, did you indicate to us anything about the possibility - this is a followup to Brad's talk this morning, the possibility of losing JCAH and the new stringent requirements, were you -- at that time was more a concern about just dealing with the Medicare?

A. In September, I think we - when asked the question, you know, by various legislative bodies, we mentioned that the design of the package, you know, the 65 for AMHI was done in response to a question that I laid out, and the question was, give us a program design, a staffing pattern that will allow us to regain Medicare and retain JCAHO, because we are anticipating, you know, a tough review. We discussed the fact that JCAHO was an upcoming event and that we needed to prepare for it.

Q. Apparently that was something I didn't hear, so I apologize if you said it, because that's why I questioned it. When you said it

this morning, it was the first time I had remembered hearing it.

A. Representative Manning, could I make one comment?

Q. Sure.

A. Okay. I want all of you to know that it is frustrating not to move faster, but I can't emphasize enough that every single day another step is actually being taken to improve patient care and another staff person is hired, another training session is held and another procedure is modified. And after years of problems, we really are making progress, and I think the course and discussion of this hearing and the content that has come before you shall illustrate that. However, I do take full responsibility for the pace of our progress. Consequently, since I do take that responsibility, I instituted a high level management change primarily because I felt we were moving too slowly, and I'm anxious to move ahead. I told you we were in a management crisis and I share with you the need to move ahead, and I believe we are.

Q. Susan, you talked about the hospitals. What is being done about working with the hospitals on the outside to take patients, i.e., Cumberland and York. What has -

A. The Bureau Director of Mental Health, in conjunction with the associate commissioner for programs and me, initiated some contact first through the commission to study overcrowding and their hospital subcommittee, and secondarily through our own work, and we have made contact with the Maine Hospital Association and have received indications from them that there are some general hospitals that are interested in working with us. However, there are systemic health care concerns that we need to work on. One would

concern physician liability; another one is the very real concern harbored by general hospitals, trustees often, concerning the nature of work with a patient who carries an involuntary status, but rest assured, we are moving ahead.

Q. Will we need to address the liability, as we talked about back in the fall of 19 - or the summer of last year when we talked - when I gave you the idea about putting some of those doctors right on the state rolls?

A. At some point we will need to address that. I should like to mention that Dr. Owen Buck, who is president of the AMHI medical staff, has just come in and he's here to answer questions on the - concerning the perpetrator of the rape case that Senator Titcomb raised. Would you like to speak with him?

Q. I'll defer to him, and I've got other questions. Do you want to come right up to the microphone, Dr. Buck, please?

MS. PARKER: May I introduce to you Owen Buck.

EXAMINATION OF DR. OWEN BUCK BY SEN. TITCOMB

Q. I guess we're stepping back to my request that took place a few moments before you evidently came in. What exactly was the scenario with the male patient? Who authorized what was done and what were the grounds upon which that authorization was given?

A. Okay, this particular patient has been a client of mine off and on for years. I presently run the forensic unit at AMHI and have done that for about two years. Prior to that I was working on a different unit at the hospital, and I have known this particular individual for nearly five years. He had been my patient on the

other unit before the forensic unit. This particular individual is very mentally ill, a very sick fellow. He had no prior history of sexual assaults. I have taken care of him through many bouts of severe illness, and this sort of thing was completely out of character for him. Let me just refresh my memory on dates. At the time of the initial episode he was not my patient. I had since moved from the unit where this fellow was to the forensic unit. After the initial episode where he sexually - allegedly sexually assaulted a female patient, he was placed in a constant observation room on the admissions unit, and the date on that was Setpember 10, according to the chart, and that was on a weekend. Two days later, on September 12, he was transferred to the forensic unit.

Q. Now at that point did he become your patient again?

A. Yes, he became my patient once again.

Q. But during the time of the incident, he was not - who was his physician at the time, his mental health worker?

A. I believe it was Dr. Victor Pentlarge.

Q. How frequently was he seeing this doctor? I mean what's the typical procedure? How many times a week would you expect that he would be seeing his doctor?

A. I'm not really sure. I know that we - we will have to priortize how often we see each particular patient. A patient who is quite ill, who is having a lot of needs might be seen daily. Someone else who seems to be fairly stable would be seen much less frequently.

Q. What would you guess would have been the frequency of this individual's visits?

A. I really couldn't even guess, I don't know how frequently he would

have been -

Q. Could a patient go two weeks without seeing his doctor?

A. Certainly.

Q. Three, four weeks?

A. Hm-mm. It's possible for the patient to be seen about the ward and you would say hello to the patient in passing, but several weeks might easily pass before you sit down and have a more formal evaluation session with the patient.

Q. How long could pass? What would be the maximum amount of time that could pass?

A. Well, the ceiling on it would be a period of - I believe one month, at one month intervals at that time on Stone North middle, I believe, we would have a formal disciplinary case conference.

Q. But would the patient be involved in that?

A. The patient would be involved, the patient's guardian, the whole treatment team.

Q. So it could be a month. Do you have any reason to believe that it had been that long with this male patient?

A. I could look to see if there are any notes. It will take a moment.

Q. I would like to know that, and I would also like to know, if there are records there, who was seeing the patient, what category of mental health worker was seeing the patient and was responsible for day-to-day treatment or therapy, if there was such a thing.

A. I only have progress notes here going back to December 20th of '88. The notes prior to that would have been taken out of this

binder and sent to our Medical Records Department just because there's so many pages here that they wouldn't fit.

Q. So you don't know?

A. I couldn't tell you. I would have to get that other binder out from our Medical Records Department.

Q. I think there's someone in the background who would like to comment on that.

A. Okay. Let me look one more place here.

Q. This is very important to me. It may seem like I'm just harassing you over one issue, but not even being in the medical field, I find it very hard to envision that someone can go into a mental health institute and not actually have a complete package of care, with regular visits by a doctor, with a specific program set out with an ultimate goal.

A. No problem, your question is a reasonable one. There are orders written by Dr. Pentlarge on September 9th.

Q. Now were those orders written by him after he had seen the patient or when there was a physician extender on hand or just a mental health worker?

A. This is a note written by him, so he -

Q. Can you tell, and I'm not asking you to read the note, but can you look at that and tell if that was written during an evaluation of the patient?

A. I don't believe this - this was not written during a formal evaluation. This looks like an order that would have been written on an as-needed basis.

Q. So having looked at some of the Medicare concerns, that was one of those specific concerns that was the most glaring upon my reading it, that those sorts of physician directives were often given offhand, not with direct physician contact with the patient, and I'm asking if that could have been a situation?

A. Could you repeat the question? I'm not sure I understand.

Q. Looking back at the report of Medicare concerns that brought about the discreditation of the institute, one of the most glaring reports I read over and over again were patient records, or lack thereof of patient records, and lack of a physician being present to make those records legitimate, that there was that contact with many patients, and I guess my big question is, how long had it been that a physician had actually had eyeball to eyeball contact with this man who then went on to rape an innocent patient, and if there's that gap there, if you don't have records of it, that's certainly reflective of the reports we got from Medicare. If you do have records, I would like to know what they say.

A. I would think that Dr. Pentlarge saw this fellow on September 9th. Our policy is that when an order is written about a patient, there should be a corresponding progress note, and I would expect that he saw the patient at that time. Very frequently we will see patients on an eyeball to eyeball basis, which is a very different thing from a formal sit-down conference with lots of team members. Very often it will happen that I'm walking down the hallway and I'll see this patient who doesn't look like he's doing so well, or some other patient will approach me with a problem, and I might

address something that way, even though their official case conference might be several weeks away.

Q. What if he looked like he was doing well. Would you feel that it was appropriate to grab his file and maybe make a notation about I saw so and so and he looked pretty good?

A. I would like to be able to do that. Usually, however, I'll be so flooded with more acute problems that I simply don't have the luxury of pulling out charts of patients who are doing well and writing down that so and so is doing well. If I do that, I'm taking away time to attend to more acute needs.

Q. I don't want to take away time to continue with what we started, but I do feel that there's still a good deal of question in my mind as to when that patient last was observed and evaluated by a physician. So on September 12th, this patient was brought - was taken to you in the forensic ward.

A. That's correct.

Q. And that was the first time you had seen him for some time?

A. It actually had been only a period of, oh, I think - it had been a relatively brief period, like a matter of months. I don't remember exactly the dates of the moves.

Q. But he was not in your charge?

A. He was not in my charge on that date.

Q. So at this point he went into your charge?

A. At this point he's back in my charge.

Q. Okay, what happened?

A. He's on the forensic unit, doing relatively well. As a matter

fact, to me he seemed to be doing about the best mentally that I'd ever seen the fellow. Let me check dates again here. On October 11, given the fact that this patient was doing quite well, and also given the fact that we have a mandate to treat patients in the most restrictive setting, we started transitioning him back to the unit from which he came. Now on the forensic unit we generally treat people who are legal holds. This would be persons who have been found not guilty by reason of insanity on various offenses, people who are incompetent to stand trial, inmates from jails or prisons. We have - we also provide a service to the hospital in that we will also house a non-legal hold patient who for one reason or another has been behaving too dangerously to be managed elsewhere in the hospital. This fellow was one of those, and our policy and procedure on those is that we take these people, stablize them if we can, and return them to the ward from which they came. And that seemed to be the case with this fellow, so we made a decision that we were going to try to transition him back. On October 11th, we started that process and what we did was we had him going back to Stone North Middle from one to three P.M. each day, and he was on 15 minute checks the entire period of time he was there, which means someone was checking on his whereabouts, keeping an eye on him.

Q. Was he receiving therapy, psychotherapy at that time?

A. Psychotherapy was not indicated for this particular patient.

Q. Was there some treatment for him other than a chemical treatment?

A. Chemical treatment was the treatment for this particular person.

Q. That was it, no psychotherapy. So basically if there -

A. The nature of this person's condition was such that psychotherapy would have not been a productive use of time.

Q. Okay, and not knowing his condition, it's hard for me to know what questions to ask, but did you feel that -

A. We did spend - let me just - one other. We did spend time discussing with him what had happened and reviewing with him about what he did to this female patient and how that was wrong and that was a totally inappropriate thing for him to have done, and he was able to express some remorse for what he had done. I just wanted to add that. That was not - I wouldn't call that formal psychotherapy but we did address the issue as best we could given this fellow's condition.

Q. Did you feel that there was something in his own development or his own state of mind that had brought on this type of behavior? If it wasn't a normal behavior for him, was there something that you could point a finger at that might have brought this on, or did it just occur out of nowhere?

A. I don't know why it occurred. I think it just came out of nowhere. As I mentioned, I have known this fellow for years and I've seen him be very sick and he would occasionally make some inappropriate comments to females or some inappropriate minor touching, but in terms of a violent assault, it's totally out of context here. He has no history of anti-social behavior, no criminal proclivities.

Q. How long was he there in the forensic ward?

A. Well, he arrived with us on September 12. He started this transitioning period on October 11th, as I mentioned, and then he attempted another - well, there was another alleged assault on - it was November 23rd, and at that point we cancelled our efforts to transition this fellow back to Stone North-Middle at all, and he's still on the forensic unit.

Q. I'm having a - at what time - on November 23rd you said he attempted another assault. Where was he at that time?

A. He was on Stone North-Middle during one of his visits over there, transitioning visits.

Q. So at no time was it ever decided that for any more than just a brief stay he would be in Stone North. Who made the decision that he was ready to go back to that ward even for a short period of time?

A. I did.

Q. So Dr. Pentlarge at no time was making the decisions for this patient?

A. Once he arrived on the forensic unit, I made the decisions on the basis of my evaluation of this fellow. In my opinion, weighing the risks and the benefits, the risks of a repeat episode of this sort of behavior and the harmful effects of keeping this fellow locked up in a maximum security unit, given the fact that we need to treat people in the least restrictive setting that we can, it was my decision that this was an appropriate thing to do and that we had done this in an appropriately cautious manner with appropriate safeguards. You know, there was a bad episode

in spite of those efforts, but it was my decision to go ahead with this effort to transition him back.

SEN. TITCOMB: Okay, I'll let someone else have a turn now.

SEN. GAUVREAU: Thank you. Representative Cathcart?

EXAMINATION OF DR. BUCK BY REP. CATHCART

Q. Dr. Buck, I believe I heard you say that as far as you knew the male patient had no history of sexual assaults or that kind of thing.

A. That's correct. I don't believe he had a prior history.

Q. Well I'm confused. I'm reading from Page 3 of the November 9th DHS report and under their findings, Item No. 2, the patient, an incapacitated male, under private guardianship, had a history of inappropriate sexual activity with the female staff and female patients. This behavior was well documented in his progress notes and and in the inter-shift report book. Other than changes in his medication there appeared to be no attempt to address this dangerous behavior in his treatment plan. No. 3, staff repeatedly removed Mr. (Blank) from female patient bedrooms, redirected him elsewhere, placed him in the quiet room or in SRC. This action taken by our staff served to protect other patients and Mr. Blank on an immediate basis but there was no plan for prevention of future incidents. I know that you are not the physician primarily responsible for him at this time, but it's hard to understand how if that was documented in his records at the hospital you weren't aware that there had been other instances of -

A. I think the instances being referred to here are verbal things, touching, an inappropriate behavior, to be sure, but not violent assaults.

Q. I suppose it's a judgment call; however, I would say a patient found in female patient bedrooms and touching inappropriately should be considered a danger to an incapacitated 76 year old woman patient.

A. Well, again, the sorts of things that he had done in the past were certainly inappropriate things, but they were not things that I would consider dangerous on the order of assaults, sexual assaults.

Q. Once he had committed allegedly rape, did you then consider him possibly dangerous?

A. I considered him possibly dangerous.

Q. But you felt that his freedom to go back on the regular ward was more important than the possible threat to the other females on that ward?

A. Well, it's not a question of importance. I think both are important. I had to weigh out how likely was it that he would do something like this again, how likely was it, that we could at least try him out and see how he did. My thinking was that there is a very good likelihood that we could successfully transition him back with some additional precautions.

REP. CATHCART: Thank you.

SEN. GAUVREAU: Are there other questions? Representative Burke.

EXAMINATION OF DR. BUCK BY REP. BURKE

Q. When you had the patient on the forensic unit, did you see him?

A. Yep.

Q. How often?

A. I probably saw him almost every day on the forensic unit.

Q. For formal sessions?

A. Not for formal sessions. Sometimes it would be a formal session, sometimes he and one or two other staff and I would go sit in the conference room, sometimes I would go down to his room, sometimes we would talk in the day room, a whole spectrum of intensity of contacts.

Q. With each contact was there a notation made in the chart?

A. I would usually make a note in the chart, yes.

Q. Were the nurses' notes or the mental health worker notes reviewed at that time?

A. Yeah, I would take a look at notes.

Q. Did any of those notes reflect this continued inappropriate touching?

A. Yeah, I think there had been some notes about it.

Q. So in light of the fact that the patient went from inappropriate touching to allegedly raping a patient on one unit, and he goes to your unit and, in fact, continues inappropriate touching, you still saw no reason to believe that he may, in fact, escalate to this behavior again in the near future?

A. Well, I didn't say that I saw no reason to believe, but I thought

it was unlikely that he would do something like this again. As I mentioned, this particular fellow had been doing these minor inappropriate things for a very long time, years, and had been on that unit for years without - the forensic unit is an all-male unit, by the way, so there wouldn't be any females there.

Q. There are no female staff members?

A. No female staff, no female patients on the forensic unit.

Q. Then I fail to understand how you can evaluate whether or not the patient will, in fact, escalate again.

A. Well, this is exactly the reason that we try transitioning somebody back with some precautions. I can't just leave him locked up in the forensic unit for the rest of his life and not try to get him back to at least a restrictive setting.

Q. In the least restrictive setting, did he again begin inappropriate touching, inappropriate comments, stopped only by authority figures?

A. My recollection is that that did happen on occasion. Let me check to make sure. Again, the progress notes in the chart here only go back to December 20th. I'd have to pull the previous records out of Medical Records.

Q. But a recollection of -

A. My recollection is that there were some of these minor things which were old behaviors, not associated with violence for this particular fellow, and it was certainly grounds to keep an eye on him and continue precautions

Q. How informed would you say the upper echelon - the upper management was of the - of the situation of this patient in particular

in that he might be a problem for the institution?

A. I think they were well aware that he was a problem for the institution.

Q. So you would say then that both the superintendent and the commissioner were aware that this was a tough situation?

A. Yes.

REP. BURKE: Okay, thank you.

SEN. GAUVREAU: Senator Titcomb?

SEN. TITCOMB: I just have a couple of questions that I forgot to ask before, and I don't know if you're even the person to answer then them. If you're not, I'm sure you can pass them on.

EXAMINATION OF DR. BUCK BY SEN. TITCOMB

Q. Do you have any figures on how many patients have died at the hospital since August?

A. August, no, I don't.

Q. Does someone here?

COMMISSIONER PARKER: We can get those.

DR. JACOBSOHN: Approximately 20 patients die every year at the Augusta Mental Health Institute.

COMMISSIONER PARKER: And in calendar year 1988, actually 18 died.

DR. JACOBSOHN: On the average of 20 a year.

SEN. TITCOMB: How many have died since August?

DR. JACOBSOHN: Well, I don't know but -

SEN. TITCOMB: Do you have any -

DR. JACOBSOHN: I would imagine a little over one per month, one to two a month. We can add it up. But that's a constant.

Q. So it comes to what, about 7 percent of the population?

DR. JACOBSOHN: Oh, no.

Q. No, excuse me, I'm sorry. What is the percentage of the population that dies yearly, of the present population?

MR. WELCH: We would base it on the admissions for the year. That's the total number of people served.

Q. Well, if you place it on admissions, I think I would like to have it based on population at the hospital, because people leave - do people leave? I mean, is this something that happens occasionally?

DR. JACOBSOHN: You have to understand that there are some elderly patients.

Q. Oh, I do understand.

DR. JACOBSOHN: Especially in the nursing home and there are always some patients that do eventually die, like all of us. That's part of the process, you know. It is unusual to have someone die at a younger age, that becomes an unusual event. So if you ask how many patients died, I can say, well, roughly 20 a year, because that's part of the attrition of any aging population.

Q. I understand that and -

DR. JACOBSOHN: It might be a different question, I don't know.

COMMISSIONER PARKER: Senator, 1.3 percent. It's 18 divided by 1,400.

Q. But 1,400 is?

COMMISSIONER PARKER: The number of admissions.

Q. Admissions, but I was looking for population which - okay,

that's another question. It would come up with a different figure, buy my question was really going to be what is the procedure that this hospital follows when a patient dies? What is the notification procedure? Do you - perhaps the Commissioner could answer that.

COMMISSIONER PARKER: That should be directed to Dr. Jacobsohn, the medical director of the department.

DR. ROHM: If I could add just one thing to Dr. Buck's presentation. This case was discussed at length with me and Dr. Pentlarge and after long consideration we decided this course of action, two hours a day with 15 minute checks, for the reasons Dr. Buck outlined.

Q. Thank you.

DR. JACOBSOHN: When a patient at the Augusta Mental Health Institute suffers from an illness or old age and is expected to die, then no formal procedures are involved other than a death has occurred in the hospital. When a patient dies on a psychiatric ward as a psychiatric patient that is routinely reported through a series of procedures to the Commissioner, to the Attorney General's Office, and as of the last couple of months, to me, so I want to know whenever there is that kind of a death. That's a new procedure because my position is new, but we've had a rather strict procedure for quite a long time, I think it's close to two years now, where any death under unusual circumstances, in other words, unanticipated death, will be reported to the Attorney General's Office and is also reported as a major incident.

Q. And what would be the procedure after that? I mean, are there

ever autopsies done?

DR. JACOBSOHN: That depends on the medical examiner, whether the medical examiner makes a determination that he will accept a case, or he may determine that there is no need for him to become involved, that becomes a judgment call of the medical examiner. My hope, my desire, is that all such patients should receive autopsies and it helps to resolve, it helps to clarify the cause of death. However, families are involved, and if the medical examiner does not accept a case, we cannot insist on an autopsy if the family objects. And unfortunately, quite often families do object. We are past the age where we took it for granted that anyone who died in the hospital should have a complete autopsy. It used to be a standard, it used to be a JCAH standard. It is no longer a standard, and I personally would like to see such a standard returned, but we have no authority to perform an autopsy unless we get permission of the family, and families traditionally have objected.

Q. Do you feel comfortable now that if there were a death such as took place last summer from the heat, that there would be a specific procedure followed immediately?

DR. JACOBSOHN: I believe so. I have had a number of conversations with Dr. Henry Ryan, he and I have a nice working relationship, we know each other, have known each other for years, and it's absolutely clear in my mind that if I had any doubts and wanted a medical examiner's - examination, complete autopsy with all toxicology, Dr. Ryan would do that for me. I have absolutely no hesitation in saying that.

Q. So do you feel that now, in the position that you're in, do you feel more comfortable with the procedure than you did pre-August, perhaps?

DR. JACOBSOHN: I think the events of August have helped clarify what we should be doing, and it has given some impetus to the standard that I've wanted for years, and that is to do complete autopsies in questionable cases, and I think I have that assurance from Dr. Ryan. There are not many cases that are like that. That's a rare event, relatively speaking, maybe two, three cases a year, no more than that, and that is not a burden on the medical examiner's office. They can handle that additional load without any difficulty. I think it would be a different matter if we were to apply that standard to everybody who died, and if every hospital in the state were to request that of Dr. Ryan, but certainly not these special cases.

Q. I appreciate your answering the question. I have one more question that I'm not sure who will answer it, but it has been told to me that in March of 1988 that there were 20 incidents of sexual assault in AMHI, is that true?

DR. JACOBSOHN: I have no - I don't believe there is a separate reporting of sexual assault. I've never heard that figure before. I don't know where that came from. Certainly I'm not aware of it.

Q. Well, I didn't think probably that you could be the person to answer. Is there anyone that would have indications as to whether or not that is an accurate figure? Could someone check on that

for me? I would appreciate that very much. Do you record and do a census on assaults?

DR. JACOBSOHN: Yes, all assaults have an incident report, and those incident reports can be looked at to see how many are in various categories. I think if there had been 20 sexual assaults, I would have heard about it. We would have all known about it.

Q. Well, could you let us please have a copy of that assault record?

DR. JACOBSOHN: Certainly.

Q. Do you classify rapes as assaults?

DR. JACOBSOHN: Absolutely.

Q. Is that the only thing that you -

DR. JACOBSOHN: Beg your pardon.

Q. Is that the only thing that you classify as an assault?

DR. JACOBSOHN: Oh, no, hitting would be considered an assault. Just one person hitting another person is an assault, that's an assault incident and we would record it.

Q. But you'd differentiate between the two, between a hit or an attack?

DR. JACOBSOHN: Well, I think if there was a sexual assault, it would rise to a higher level of awareness. It's just - it goes without saying that in a hospital such as the Augusta Mental Health Institute, where you have patients who are there because of major mental illness and who are considered as dangerously mentally ill, that you will have a certain number of assaults, that comes with the territory, that happens. However; if we were to see

something like a sexual assault, that's an entirely different situation than an occasional assault between one or another male patient. You know they do get into fights.

Q. So if I request that information from you, when I get it, I'll be able to clearly differentiate between somebody rapping someone else or an aggressive assault?

DR. JACOBSOHN: Absolutely, yeah.

Q. I would like that information, if I could have it, please.

DR. JACOBSOHN: I don't think that would be difficult.

SEN. TITCOMB: Thank you.

SEN. GAUVREAU: Representative Manning?

EXAMINATION OF COMMISSIONER PARKER BY REP. MANNING

Q. Susan -

A. Yes, I would like to clarify part of the answer regarding the different incidences, and AMHI does have in place incident reporting and classifications. I referenced those this morning, and what I am going to do now is to go through these categories with you, and I think Senator Titcomb will see how her question about categorization regarding different types of violence within institutions fits in.

The first category concerns fires and false alarms. There is a great deal of differentiation and description under here regarding the different types of nuisances of such a, you know, fire and false alarms. All these are carefully documented.

Secondly would be environmental disasters; thirdly would be criminal behavior by AMHI patients or on AMHI grounds; for example,

murder, rape, physical assault, brandishing weapons, burglary, robbery, major vandalism, stolen vehicles, drug sales, abuse or exploitation of patients, minor theft or vandalism. The fourth category references self-abusive behavior, suicides, serious suicidal gestures, serious suicidal gestures without injury, self-abusive behavior requiring medical attention. Fifth is injuries to patients, staff or visitors. Sixth is death, and this includes any suicides, any death in the nursing home or infirmary which is unattended, any death on the psychiatric unit, death of any staff or visitor on the grounds of AMHI and death of any staff member.

Another category is the miscellaneous problems or incidences, an incidence which is high profile or likely to bring immediate press attention, other problems account which affect patient care or AMHI's public image.

The last category concerns those individuals who may be absent without leave, and there are subsets under here, including legal hold, a person who is a legal hold, i.e., a resident on the forensic unit who is absent beyond the time allotted, any involuntary patient who is not accounted for, a voluntary patient who is considered dangerous to self or others, a voluntary patient who is not considered dangerous, and someone who is absent and all point bulletin notice has gone out.

SEN. TITCOMB: So I'll have some extensive reading when I get those records. Are those records complete? I mean, I'm listening to how difficult it is to keep records, and those are a lot of

categories.

COM. PARKER: There are a lot of categories and there would be a spearate file in here regarding those incidences.

DR. JACOBSOHN: They are not clinical records, they're statistics, they are of a different nature.

MR. HANLEY: We have an incident reporting form which has several different categories, and you're fortunate that we were just able to computerize those and they're much easier to sift out.

SEN. GAUVREAU: Representative Manning?

BY REPRESENTATIVE MANNING OF COMMISSIONER PARKER

Q. Susan, earlier in the day, whether it was this afternoon or this morning, I guess it must have been this morning according to my notes, you indicated that all of your staff members, including institution heads, reported to you weekly by memos and that you read all those memos and sent the memos also on to the Governor's Office so the Governor's Office would be aware of what's going on in each institution.

A. I described them by saying that they report to me weekly the events within their different area of responsibility, and we call them weekly reports. They do not have a format called a memo format.

Q. Well, I mean, whether they're memos or reports, basically you get them every week, read them every week and then send them on to the Governor's Office, is that right?

A. That's right.

Q. In reference to the superintendent's memos, did he at any time

ask for additional staff last year, like in February or January or March.

A. The weekly report would not have been the vehicle in which to propose additional staff. Rather, the typical entry would be a description on the census, the admissions, any unusual events on the wards, perhaps a description of the severity of illnesses that would be on admissions, particularly those requiring one-to-one constant observation or use of seclusion. He would typically report out progress on Medicare, or preparations for a particular survey, be it Medicare, JCAHO and on and on. There was quite a variety of material that got included in as part of the weekly reports.

Q. When you saw the weekly reports and you started to see the increase in census at AMHI, what was your reaction at that time and what was the Governor's Office reaction at that time?

A. I will speak to my reaction. First of all, the weekly report is not the only avenue I had to understand that the census was rising and the admissions were rising. We frequently talk about such matters. We did a lot of talking about that last May, last June and through the summer months, although the census and the admissions began to tail off in July. My reaction is, as any administrator, it's why is it happening, what do we need in order to deal with it, how long will it continue, what has the history been, and how does this compare to the preceding month, six months ago and to the same time last year.

Q. Did the superintendent at any time send you memos, not weekly

reports but memos, asking for additional staff or asking for additional dollars to be put in for staff in February, March, April, May, June, as the census started climbing?

A. There was no memo sent to me directly concerning that.

Q. So he never asked for additional staff at all?

A. During that time frame, that is correct. I never received a memo directed to me asking for more staff.

Q. Okay. Earlier in the day you had talked about one of the areas that I guess you were - I guess the word is not disappointed but were a little upset with the management style of the superintendent, and that happened to be at the time, I think, I forget who it was, they brought you back - you said, you know, was it in December, was it in January, you went back as far as - I think you said even in August, or July or August or September, I'm not quite sure.

A. I specifically stated, if I might clarify, and I did not use the word upset, I first used the word disenchanted and I never used the word distressed - I specifically stated for the public record that I began to be disenchanted later on in the fall, I went on and said late November, early December, and it was after -

Q. But you also said that you were disenchanted a little at the time of the rape incident, which was in September.

A. I had some quite pointed questions about that, yes.

Q. Did you send a memo to the superintendent at that time indicating your disenchantment?

A. I do not use memos to convey disenchantment, I use direct conversation.

Q. Today, you basically have opened up your statement by saying that we're in a crisis situation, and the crisis situation is management rather than what you had anticipated last week, and last week we never heard the word management crisis, we heard just plain - I think they asked you whether or not - one of the members asked you whether or not we were in a crisis, and you had indicated yes, right now we're in a crisis.

A. That was Representative Clark, and the context in which the word use clearly conveyed the fact that it was a management crisis. In my opening remarks today, I decided to use the phrase management crisis because that accurately depicts the situation.

Q. Okay. So what you're saying is then, with a new management style, that the hospital will get back to some semblance of normality, I would imagine, and I say that because I know it's very difficult, and that includes without any additional staffing or without any additional monies going into AMHI, am I right in saying that?

A. What I stated this morning, Representative Manning, was that several proposals are on the table. They have come from people from various - in various places within AMHI who have suggested solutions. I said that our next management step is to bring in a consulting - a consultant who is well versed and has a proven track record in running psychiatric hospitals or general hospitals who can properly assess with us how to get AMHI back on its feet

again.

Q. They could basically come back and say that there needs to be a wholesale restructuring and also basically laying off of certain personnel, right?

A. I don't know that that's true. I think to speculate is entirely premature at this point. I also stated that I am open to all recommendations, and I would be pleased to come before this committee three weeks hence, when these recommendations are in hand, and talk with you about them.

Q. So you're anticipating then to go back to the Governor's Office, if need be, if this consultant comes back in and says there needs to be another massive infusion of money at AMHI, you're anticipating going back to the Governor's Office and informing the Governor that that's what the consultant is saying, and that we need to put it in this year?

A. I will absolutely inform the Governor of these recommendations, whatever they may be.

Q. I'd like to bring you back to another thing that you talked about earlier in the day, and that was at the time of decertification you had indicated, and I guess it was the time probably in May when they finally came back and took the certification away from us, you had indicated that you talked to Linda Crawford, who was the Assistant AG representing you, and at that time Linda Crawford indicated that the - I remember I asked you whether or not you should appeal that, whether or not Linda Crawford - she indicated that, I guess, it would be (1) too long and (2) costly to do that. Am I right in saying that? And this was in June -

A. You are right in saying it as far as you have gone, and I further stated that Linda Crawford based her opinion on the experience in other states of pursuing the avenue of going through an appeals process with an administative law judge.

Q. Okay, so she basically went on past records of other states that it would be too costly and that it would take a long time to do?

A. That was her opinion. She said that it was a very - it took an enormous amount of time and that it would take a great deal of staff time away from the facility that already needed, you know, some assistance with staffing. Remember, we're talking summer here, June, and we felt at that time it would not be a prudent management decision to pursue it.

Q. Did she think we had - did she think at that time we had the ability to win an appeal?

A. She made no observation about that one way or the other.

Q. Did you think that was strange?

A. No, not at the time.

Q. I think it's strange. I think if I've got an AG, the first question I'm going to ask him is have I got the ability to win this appeal. Was that question ever asked - did you ever ask her whether or not we could win an appeal?

A. We talked generally about an appeal, and she, again, reiterated the hardships that other states had been through in pursuing such a course. We didn't talk specifically win/loss and percentages attached to both.

Q. Okay. I'd like to bring up one more thing, and this is my gut reaction and it's a reaction that was expressed to me by somebody who I looked towards mental health issues in this legislature, and they had a concern, and maybe Dr. Rohm, if he could address it, is whether or not at this particular time, while we are in a management crisis at AMHI, whether or not Dr. Rohm has the ability to not only (1) be the clinical director, (2) be the ongoing acting superintendent and still - as you pointed out this morning - do 40 patients. I mean, are we stretching Dr. Rohm to the point where even at this time that's a tough job to do right now, I mean both acting director and clinical director and holding that down?

A. Dr. Rohm has kindly consented to take on the responsibilities associated with an acting superintendent. To the post of clinical director, he has asked Dr. Owen Buck and Dr. William Sullivan to share those duties. A succinct answer is that, yes, it's a tough assignment to move from one position to another.

Q. So he's not really doing all what he's - he's not doing as much clinical, we have other doctors sharing it? I think that needs to be cleared, because when people start to hear that, and I heard - you know, I expressed that. Just as - while I was walking in, while I was late, I had somebody who said to me, isn't that an awful lot for one person to do, and I said, geez, I never thought about it, but as I went on today - so he is sharing the clinical areas now with two other doctors?

DR. ROHM: Yes --

Q. Okay, and the role that you had this morning, for instance, you were on rounds and I guess you said you had - Susan said you had 40 to 50 patients?

DR. ROHM: Well, I've given those to Dr. Buck, but I have other duties to do.

Q. Do you have any patients under you right now that's assigned to you like Dr. Buck had talked about?

DR. ROHM: No, not directly.

Q. Not directly.

DR. ROHM: But I still have to supervise their physician extenders, they're under my supervision, and I do this the first thing in the morning.

Q. Okay. That was just a concern, because I don't think it was clarified for us, and at least it wasn't for me. I was assuming (1) you were doing clinical, (2) doing the acting superintendent's work, and (3) having - I thought you said she had a caseload - somebody told me this morning they had a caseload of 40 people and I assumed that that's - that's not right then, that's good, I'm glad to hear that, because I don't know how one man could do that in a 24-hour period.

DR. ROHM: The other aspect is that - the present arrangement is predicated that we will be able to hire under a short-term contract -- to do some of the work - Dr. Sullivan's work, so he gets relief from that.

Q. We keep talking about these part-time contracts. Are these people who are in the community who are willing, for instance, to

give eight, ten, twelve, fourteen hours a week?

DR. ROHM: No, we are talking, these contract people, through national agencies.

Q. The head hunt is found for us?

DR. ROHM: That's right.

Q. Are they willing to come up here and spend 40 hours a week?

DR. ROHM: I was looking for a minimum of three months to six months, and I found one, who works on the admissions unit, and she has agreed to work - to stay for an extended period of time. They are difficult to find. The one month psychiatrists are easy to find. Many of these take sort of busman's holidays. They come for a month, they are usually highly qualified - (inaudible). I was assured it would be much easier to find the one-month psychiatrists. We are negotiating for one right now.

Q. Let me ask you a question. Susan, maybe you could answer, or somebody. I think Ron had been involved - Ron Martel, you've been involved with the head hunters, right? You indicated back in -

MR. MARTEL: Through the contract process.

Q. Yeah. Is one of the things we need to do is take a look at increasing the salaries of these people? I mean, can we - you know, we keep talking about the quality of life in Maine, but the quality of life, if it were not - if they're getting ten or twenty thousand dollars less, I mean, do we need to take a look at - for instance - if psychiatry is so hard to get - across the board, including Dr. Rohm and everybody else in the system, do we need to take a harder look at that to give them like we did -

for instance, we talked about, I think, nursing, we gave more money to nursing last year, we gave more money to the mental health workers and others. Has there been any thought about trying to take them a block ahead, to where we can - you know, it's competitive to, say, New York State but yet you're in the great State of Maine and life is a little easier in Augusta compared to, say, the middle of Queens, New York, or something like that? I guess, Dr. Jacobsohn, you're ready to answer that.

DR. JACOBSOHN: I'm actively involved right now in the survey of actual hiring conditions throughout the nation, and it's a very mixed bag. I always thought people wanted to come to Maine, but it turns out not everybody wants to come to Maine. There are a few exceptions, like myself, who do want to come to Maine but most people don't. Now we have to compare more with states like North Dakota, Nebraska, that are seen as cold, far away places.

Q. Have you gotten the tourist bureau involved with this, so they would know today it's 50 degrees out and it's January 31st?

DR. JACOBSOHN: I know, it's a wonderful day, it really is, but it is hard to recruit psychiatrists. Part of the reason is there's a national shortage, there actually is a shortage of well-qualified psychiatrists, and Maine has had a tradition, over the last ten years at least, of hiring only well-qualified psychiatrists. We will not compromise on that and I don't think we should. So we are attempting to reassess what ought to be the salary scales, and I'm involved with the personnel department right now on that issue.

Q. So salaries could be - could help play in bringing some in?

DR. JACOBSOHN: It might, it might very well. As I say, it's a mixed picture. It ranges all the way from where we are now to much higher than where we are now. Some states have a much larger system that's more entrenched. They are able to get by with lower salaries. Some states that have smaller systems, that have less of a pool of professionals, who don't have their own medical schools, such as Maine has, we have no natural source of physiciatrists, we have to import them from outside.

Q. Have we worked at all with any of the educational forgiveness loans? Have you looked into that field where we could actually -

DR. JACOBSOHN: We actually have a three-pronged approach.

Q. I mean we did - this committee dealt with the nursing issue last year where the Governor's program basically was paying for three years the student loan program. I mean, is there any thought of doing -

DR. JACOBSOHN: There is a history of that not working out too well across the country. NIMH used to do that, the Public Health Service has done it, some of the larger states did that. The history is not very good. You find out that most physicians who have gone through that will buy out of the program rather than do the service. So it's not a reliable way of doing it. My own view is that we need to develop a long-term relationship with the residency training program. That, I think, is years down the road but it could be done, theoretically it could be done, it may actually be done in practice. I think there's a lot of sentiment that

psychiatrists in training ought to be getting some of their training in the public sector. We have an intermediate problem of finding line psychiatrists that are well qualified to occupy the positions that we have and those positions that have just been added, and then we have an immediate requirement of getting psychiatrists on board to fill the spots until we're able to do the recruitment. Recruitment with psychiatrists usually means six months to a year in developing a single application. It's very complicated. They move, they have families to move, they relocate, they have major decisions to make about their careers. It's very difficult to bring somebody on board. It takes about six months to a year of negotiation and of advertising and promoting in Maine. In the meantime, we have to have a rapid fix, and that's the one that Dr. Rohm has been talking about, the rent-a-doc approach of trying to filling the gaps on a temporary basis until we're able to get the full-time psychiatrists. I still feel that it's basically sound to have full-time psychiatrists as part of a regular stable medical staff in our institutions. I think that is good for the institution and it provides stability and a good standard of care.

Q. On Thursday night we talked about - on Thursday we had our meeting and Thursday night the Governor's State of the State address. He talked about $20 million. I just want to make sure that the $20 million that he's talking about is the same $20 million that we talked about earlier today, that there is really no infusion of new monies, it's just a continuation of the $6.75 million.

COMMISSIONER PARKER: That is correct.

Q. So there's absolutely no infusion, okay, because I had people come to me and say why - you know, isn't there going to be $20 million, and unfortunately, I said, no, there isn't - there is but there isn't. The $20 million would have been in there anyways because they had to have it in there, but I just wanted to make sure that that -

COMMISSIONER PARKER: Representative Manning, a point of clarification for you. At my request, I had Ron Welch telephone Linda Crawford to see if she might be available to give you added information concerning the possibility of an appeal. We find that she is out of state attending a family matter and, consequently, we can give you any other information later.

Q. Okay, maybe later we can talk to her.

SEN. GAUVREAU: I have a few questions and I hate to ask them because the day has been so long. I don't think I'll take too much longer, and forgive me if this topic area was discussed in some detail, because I have been running back and forth to another committee during the course of the afternoon.

COMMISSIONER PARKER: First, can I thank you for the table that I'm sitting at after 14 hours?

SEN. GAUVREAU: Certainly.

COMMISSIONER PARKER: My right knee has gone, knee lock from standing at a podium. Thank you.

EXAMINATION OF COMMISSIONER PARKER BY SEN. GAUVREAU

Q. I'd like to go back just briefly to the whole issue of staffing, and if it were discussed before, please refresh my recollection, but

can you tell us what is the current staffing configuration at AMHI, and I'm referring specifically to a breakdown of nursing to patient ratios, psychiatric nurses, medical nurses, mental health workers, OTs, recreational aides, as well as social workers.

A. Here we go. AMHI has a total of 693.5 staff, total positions. There are 12 psychologists, 23 social workers, 60.5 registered nurses, 28 licensed practical nurses, 10 physicians, 306 mental health workers, 18 occupational -

REP. BURKE: Excuse me, you're going way too fast.

COMMISSIONER PARKER: All right, I'll start at the top and I'll give you percentages - 12 psychologists, 1.7%; social workers, 23, 3.3%; RNs, 60.5, 8.7%; LPNs, 28, 4.0; physicians, 10, 1.4; mental health workers, 306, 44.1; occupational therapists, 18, 2.6; ward clerks, 3, .4%; physician assistants, 9, 1.3%; clerical, 37, 5.3%; custodians, 33, 4.8; dietary, 38, 5.5; other direct care, 28, 4.0; and support services, 88, 12.7. May I point out, this does not include the three lines that are under contract, two physicians and one psychologist.

SEN. GAUVREAU: And in terms of our ratios, are those congruent with applicable HCFA or JCAHO standards, or are those standards institution specific so that there is no one set of - one set ratio?

A. There are no nationally accepted standards, but what I would like to point out is that in your L.D. 2685, passed last September, which also created the Mental Health Commission, in that L.D. there is the expectation that this department will develop standards

that will result in our ability to give you what the staff to patient ratios ought to be given the particular needs of patients in a particular ward. We are in the process of developing those standards.

Q. And in terms of that legislation, is there a specific time frame in which the department is to proffer the recommended ratios?

A. I believe we were given in excess of a year, and the deadline is July 1, 1990.

Q. And is the department to work in tandem with the Commission on Mental Health in fashioning those standards?

A. The Commission on Mental Health has a Subcommittee on Institutions, and, yes, we would be involving them in the review of things at various stages in the drafting stage.

Q. And I understand that the burden of the complaint from HCFA's point of view dealt with lack of documentation, record keeping and lack of physician/patient contact, there was too much use of intermediaries. But did HCFA criticize the current staff ratios which we had in force at AMHI as of February and March of last year? Was that a factor which led towards decertification?

A. The Health Care Financing Administration, in its standards, does not use numbers that say you need X-number of psychiatrists to work with X-number of patients; rather, they look at the indicators, which are standards, but the indicators of care, and that is how they come to look at medical records, the treatment planning process, the progress notation, and in actually looking - when a surveyor actually looks at those three categories under the

medical records condition, they look at the quality and they - once they reach a judgment about that quality, they posit that if things aren't up to their standards, then it must be due to a lack of staff. But there are - to say again, there are no standards that say for every 30 patients there should be one psychiatrist.

Q. So what you're saying is that it's more of a qualitative assessment than it is a quantitative assessment per se?

A. Yes.

Q. Now obviously this committee is being asked by the legislature to provide meaningful guidance in terms of where do we go from here. Although we've heard some concerns regarding perhaps specific individuals over the last couple of days, the real question, I suspect, which is on people's minds in this state is not who did what but what do we do now to get ourselves out of this mess, and so just to summarize, I guess, you had mentioned that you hope within a period of two to three weeks you would have completed the process whereby you would contact the various management firms and be in a position to make some concrete and specific recommendation to this committee on how to improve the situation at AMHI, is that correct?

A. Yes.

Q. And if I understand correctly, when you meet with Appropriations on Thursday, you will not recommend new money items but you will not categorically rule that out, is that correct?

A. If asked the question.

Q. And basically what you're saying, if I'm correct, is that you will defer to the advice of the management team or the consultants with whom you contract before you make specific recommendations?

A. As I said, I am open to all recommendations at this point.

Q. Now currently, obviously, there is a vacancy in the superintendent position at AMHI. We have an acting superintendent, a Dr. Rohm. At this point, do you have any particular timetable when you would plan to nominate or name a new superintendent of that institution?

A. I am eagerly awaiting the recommendations of a firm skilled in the management of a specialty hospital. I think it premature to name anyone, because we can liken AMHI to a patient and this patient does have a management crisis, and I think we are best suited to directing energies to stablize the patient and understand together what the necessary interventions are in order to get AMHI back on its feet. Then, I think, it's time to start about - to start to think about a search process that would result in finding another superintendent.

Q. The concern I have, and I guess I voiced it earlier in the day, was that there appears to be some glaring gaps or we're providing in some areas, at least, what could be categorized as substandard care to some patients, and my primary concern now would be that we take prompt action to upgrade those standards. We have to take a look at the long view in terms of upgrading the overall institution, but I wouldn't want to lose sight of the fact that we have, as we discussed this morning, complaints regarding particular patient care, and they apparently haven't been fully addressed, so I just want to

leave you with that concern. And it would seem that given the great deal of attention which this particular problem has aroused in the Maine press, as well as the people in Maine, it seems that it would be beneficial to proceed quickly with naming a new superintendent so that we would have a specific direction and specific guidance in terms of the stewardship of this particular institution.

A. Senator, I feel quite strongly that the management direction of AMHI needs to be charted anew. We are in the process of doing that. I listed earlier the different plans that we have in place that are working on aspects of AMHI management. In order to identify what characteristics we might be looking for in a superintendent, it is first necessary to assess all aspects of AMHI's need. Some people are strong in one area, some people are strong in other areas, and I think we really need the advice of an outside objective party to give us facts and various options about how we might proceed, and then we can develop a profile of what the superintendent might look like based on not only that but the other inputs that must come to us from advocacy groups, from family groups and from patients themselves, as well as the workers.

Q. In terms of this consultant to whom you refer, do you contemplate that within two or so weeks you would have that firm or that entity on board?

A. Two weeks -

Q. I'm not in any way saying 14 days. I don't want to set a time frame in terms of what your plans are.

A. As I said to you this morning, we are prepared to move very quickly on this. We have interviewed three possibilities so far. We have another possibility to interview, then we need to decide how actually to get them on board. We are looking at working with them very, very soon. Yes, I think it's possible. I won't promise it, it's very possible.

Q. And that once we do contract with this entity, we would then go about the task of constructing a plan of correction?

A. That's right. We probably won't call it a plan of correction, because it sounds a bit like Medicare.

Q. But whatever the critter is -

A. It will be a plan.

Q. We'll have to get to work on it with --

A. That's right.

Q. I think it's fairly safe for me to speak on behalf of the other members of the committee that we would certainly be interested in meeting with that entity, whomever it might be, and providing our input in terms of whatever help we can offer in terms of getting AMHI back on its proper footing. Thank you very much, Commissioner Parker, for answering a wide-ranging number of questions, some of them very focused, over the last few days. It's certainly difficult, I'm sure, for you and your staff to have to have undergone this process, as it is for the committee. It's a very important process. I think we all share the notion that there will be a salutary end that will improve the system of mental health in the state as a result of these hearings. Are there any other questions

of committee members or Commissioner Parker at this time? If not, once again I thank Commissioner Parker. Since it is now twenty five minutes past four, it would not seem appropriate to call anybody else before the committee at this time.

(OFF RECORD REMARKS)

ADJOURNED AT 4:25 p.m.

IV

STATE OF MAINE

HUMAN RESOURCES COMMITTEE

Hearing held on Augusta Mental Health Institute issues
February 1, 1987

Maralee L. Kaler

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Augusta, Maine
February 1, 1989
9:10 A.M.

SENATOR GAUVREAU - This is the third day of hearings into the status of conditions at the State's acute care mental health facility in Augusta. This morning we have asked the former Superintendent of AMHI, William Daumueller, to make a presentation to the Committee. The hearing today will run from nine A.M. until noon; and at this juncture we are still uncertain as to whether or what the schedule will be for the Committee for tomorrow. As you recall, at the close of the hearing yesterday the Department had requested our intervention with the Appropriations Committee to perhaps postpone the Department's budget presentation and I understand that that request has been communicated to the Appropriations Committee. We have yet to receive a response. We hopefully will have that this morning so we'll know more as we go along.

I would also point out that this afternoon in Appropriations the Department of Human Services will be presenting its supplemental budget and there will be a major announcement at that time dealing with use of residential facilities. So, for those on the Committee that have time this afternoon, it may be worthwhile to go down to Appropriations and hear Commissioner Ives' presentation.

At this point I am pleased to recognize Mr. William Daumueller, as I say, the former Superintendent of the facility at AMHI. Good morning, Mr. Daumueller. We have your prepared statement. And, do you wish to make a statement prior to questions from the Committee?

MR. DAUMUELLER - May I make the prepared statement?

SENATOR GAUVREAU - You certainly may.

MR. DAUMUELLER - Thank you. I'll start there and of course I'll answer any questions you have after that.

Senator Gauvreau, Representative Manning, Members of the Human Resources Committee, my name is William Daumueller, former Superintendent of Augusta Mental Health Institute. I'm here today because I'm convinced that the needs of Augusta Mental Health Institute require the immediate, personal and collective attention of the Legislature.

AMHI faces many serious problems and pressures, few of which are within the facility's ability to control. The unique role of the state hospital, the extreme workload, the physical plant, mental health system and internal organizational issues are a few of the areas that I'd like to touch on.

First, the State Hospital role. As you know, the State Hospital is the safety net for the mental health system and as such can't hang out a "No Vacancy" sign when things get tough. This "court of last resort" function, while frustrating is clearly a necessary one until appropriate alternatives are developed.

Workload pressures. There have been dramatic increases in workload consisting of substantial increases in admissions, a continuing high census and the increasing number of severe medical problems and other labor intensive care needs being identified and having to be accommodated.

Unfortunately, the workload reduction expected to result from the establishment of a 20-bed - 20 inpatient beds in southern Maine which would admit acute, involuntary parients has not

materialized and appears stalled. This inpatient program, combined with other funded options, was designed to reduce the AMHI population from last year's average of 361 to an average of 319 patients.

Simply stated, current staffing is not sufficient to provide the documented high quality care and treatment which meets all the standards and expectations placed on the facility.

The result of this understaffing is the use of shortcuts in documentation and care provided; less individualized attention and care; high levels of overtime, stress, burnout and turnover. Good competent and caring staff can look bad when overwhelmed.

Physical Plant Issues. The physical plant at AMHI while being cited for its beauty and upkeep is generally inefficient, has serious deficiencies in terms of risk management and has a large number of patient rooms which would not meet current state licensing standards. In addition, both JCAHO and Medicare have pointed out the problem of exposed pipes which are evident throughout the facility and for the need for remedial action. The events of this summer also point out the necessity for cooling of AMHI buildings during hot weather.

System Issues. Unfortunately, there is no real incentive for local providers to divert patients from AMHI, just as there is no system of care where the funding of mental health services is directly tied to those doing the planning, contracting and gate-keeping. This incentive issue may be the most difficult part of the puzzle to solve but probably is well worth the effort.

Obviously, Medicare standards are now being vigorously enforced and JCAHO is also under pressure to become more aggressive in their surveys. Some would argue the motivation is quality. Some will argue that it's money. But, the fact is the surveys will not get easier in the near future.

Internal Issues. The Admission Unit, given its increased workload, limited physical space and relatively large staff has become a resource drain and a bottleneck. The patient living areas, office space and program area is severely limited. Patients not directly discharged from that unit then must transfer treatment tems causing some very real problems with continuity of care and the documentation of that care required by Medicare and JCAHO. The situation begs for change.

Recommendations. While much has been made of AMHI's loss of Medicare and the timetable for regaining that funding, the problem at AMHI is not the loss of Medicare. The problem is providing quality and service in an atmosphere of high demand and high tension. I contend that in these circumstances you should put Medicare at the bottom, or at least the middle of your list of priorities. Concentrate instead on the overall quality of care and what it will take to restore it. Actually, you've already made a tremendous start by funding a historic piece of legislation last September. It was a great beginning that all can be proud of but it was only a beginning. Given the current circumstances, I think it is imperative that action be taken quickly and in a bipartisan manner to alleviate problems which are all too painfully

obvious. Mental illness has no party lines and the importance of doing the right thing far outweighs the need for finding ultimate blame. I'm convinced that there is more than enough blame to be placed all around. The important consideration is what will be done now. And obviously I have some thoughts on that subject.

First of all, it is vital that the Legislature be fully informed of the problems at its facilities on a regular and timely fashion. Results of all surveys and plans of correction should be forwarded to the Human Resources Committee for your review and analysis. Given the immediate situation and the various points of view, it may be very appropriate to hear directly from AMHI medical, professional and other representative staff regarding problems, needs and solutions.

Secondly, it is time to set standards of care which translate into staffing ratios based on admissions, number of patients and their care needs. This is one way of taking the subjectivity out of staffing requests. As you are probably aware, the State Hospitals are not licensed by the State of Maine, setting them apart from all other hospitals. Licensing state operated facilities would be another method of keeping informed and setting quality thresholds. The danger is that once these standards are set, the true cost of quality inpatient care will be all too graphically clear.

Thirdly, AMHI staff are currently formulating what they feel are their staffing needs. I would urge you to ask to see

those requests. Look at the justification from AMHI professionals and monitor their progress through the system. Lowering the workload would of course be a much better solution to the AMHI staffing problems and would generally make for a much more therapeutic environment; but the promise of less workload will not care for the patients currently residing in our facilities. Exploring the reorganization of AMHI into geographic programs should also be pursued as a way of dealing with the Admission Unit "bottleneck" problem and reducing the need for professional staff. At the same time, this would address many continuity of care and documentation issues.

Fourth, continue the pursuit of a facility in Southern Maine which could take all the admissions from Cumberland and York Counties currently going to AMHI. This facility could provide all the acute care for this catchment area and only transfer those patients needing longer term or more specialized care. If private facilities can't or won't do it why not a public facility?

In a realted matter, it may make sense to look closely at the trade-offs between office space needs of the State and the physical plant problems such as exposed pipes and summer cooling. This would be particularly fruitful if new construction is being contemplated as a means of solving office space problems. Conversion of AMHI to office space and building new patient care facilities would open up a number of options including three smaller state hospitals. Obviously, cooling of buildings and the covering of exposed pipes require some affirmative action.

Finally, I would suggest that you struggle with the very real need to find ways to tie together the funding, gate-keeping, planning and budgeting for a given catchment area or at least find some workable incentives for mental health providers to utilize the least restrictive forms of care and minimize the utilization of the state hospitals. This will, of course, be a challenge but may very well be worth the effort.

To close, I would like to thank you for this unique opportunity to express my views to you and I urge you to build on what you already have started in last fall's special session by immediately patching the 'safety net' until a true system of care comes together.

That's the long and short of my prepared text. I assume there will be questions here on.

SENATOR GAUVREAU - Thank you, Mr. Daumueller. Let me start off the questioning and others may follow.

EXAMINATION OF MR. DAUMUELLER BY SENATOR GAUVREAU

Q. It is apparent from your comment this morning that you are in concurrence with the long range plan as embodied in the legislation adopted last fall regarding augmenting the community mental health system, is that correct?

A. Absolutely. From practically the day I set foot in Maine, I've been expousing exactly the kinds of things that you see in the budget package. So, I fully support what the direction is. Full utilization of community-based services, providing care in the least restrictive setting possible and maintaining quality

in our institutions at the same time.

Q. It would appear to me, based upon the last two days of hearings, that the Department remain strongly committed to that same goal toward augmenting the community-based mental health facilities in our state. So in that area you are in total agreement.

A. I would say if we were trying to stack up where I agreed and disagreed with the Department and the people who work in the Department, I would say you would find a 95 to 98% agreement in what should be done.

Q. That's an important point, I think, to stress is that you are basically supportive of the initiatives which the Department has brought forth. Now, you did make reference though in your prepared statement for need to immediately address staffing ratios and other urgent patient care issues. And, I think that might be one of the areas where perhaps you might depart from the current thinking of the staff at AMHI. Now, who would you recommend to set up the various standards of care or the staff ratios which you suggest?

A. Well generally I think you have to ask the people who do the work, the professionals that are involved. So, for physician coverage I think you'd ask physicians at Augusta Mental Health Institute and Bangor Mental Health Institute. What is it the physician is expected to do and about how much time does it take and basically back into staffing ratios that way. One thing that may not be factored in just taking that approach would be what kinds of expectations do you have that the patients see a physician

or how often should a patient see a physician. How often should a patient see a social worker in addition to looking at what they're already doing. I think you have to factor in what you want them to do over and above what they're currently doing. But, - so, I think you can back into staffing ratios in that manner.

One thing about staffing ratios. There are basically three things - I'm oversimplifying - that play into the need for staff: how many patients you have; what's the turnover, admission and discharge rate; and, the acuity or the level of care need. So, you have to factor in each of those. I think you can make a rudimentary start and it's not as sophisticated by factoring in admissions and census. I do think the care needs are very important, but I think if you had to pin your hat on something, I think turnover and number of patients and the expectations that you have for them to deliver a certain amount of service to a given patient. That would be what I would concentrate on.

Q. I understand and appreciate your concern that in articulating various standards we obviously have to - as a predicate we have to establish overall objectives and goals for our facility. And, I think that's what Commissioner Parker was saying the last couple of days that she wanted to contract with a management firm or consultant for getting into the nitty-gritty in terms of restructuring patient services at AMHI. Are you suggesting that we do this in an interim setting until we can agree upon long-term goals?

A. Yes.

Q. Now, what type of time frame would you think is reasonable or would be needed for the State to develop meaningful standards delaing with staff ratios and whatnot at the facility?

A. Well, there is some work going on in that area. But, I think medicine, social work, psychology and nursing. I think using the staff there, I think you could come up with a well reasoned approach in 30 days.

Q. Well, if I understand you correctly, within a month or so you feel we would be able to come up with a meaningful set of standards by which to deliver patient care services at AMHI?

A. A set of standards for how many people should be at AMHI, yes.

Q. So that the Legislature in deciding whether or not we need to augment the staffing complement at AMHI, you're saying we should be able to get a meaningful idea or direction within 30 to 45 days.

A. Yes. Now, the problem of course always is when you ask the people who are working on the inside and they're coming to you with a request, the argument can always be made 'well, they're just feathering their nest or just padding their needs' or 'how do we know that that's what you really need'. So, using external individuals to provide oversight to the kinds of staffing suggestions that are being recommended is, I think, a matter of - it certainly makes sense to do so. So I'm not particularly opposed to that.

Q. Let me ask you this. A concern which I have is that in our

justifiable desire to engage in a thorough review of the management team at AMHI and reassess our goals, we are perhaps not putting enough time and attention on immediate patient needs as we look at long-term objectives. And, I would be loath to sacrifice any quality in current patient care. So my primary concern is to devise a strategy whereby we can ensure the people of Maine that current residents at AMHI are receiving appropriate care while we embark on this worthwhile objective to do long-range planning.

A. Well, it's my understanding that the current staff at AMHI are looking at their immediate care needs either as we speak or prior to our speaking. I believe that process is either in place or finished.

Q. Then you have made reference to - you approved the idea of engaging in an outside consultant to come in and critique the system to add, I suppose, a degree of credibility so no one can be accused of 'feathering his or her nest'.

A. I think that is - the level of outside involvement is really the level to which you feel, in my opinion, is the level to which you feel it needs to be. So that whatever staffing ratios or levels are set that you can agree with and you can say yes this is what we want. This is the kind of facility that we feel we want to operate in Maine and these are the staffing levels that we're going to support. So, if we have 'X' number of patients in admissions of a certain level of acuity, this is the number of people we expect to fund. And, if - you need, I think, to have

some level of comfort with that concept. So, if you find out it costs - would cost you an extra four million dollars, let's say, to run Augusta Mental Health Institute to meet all the standards that you would like to have met, you have to have some comfort with that.

Q. So, just to paraphrase what you're saying is we could devise a set of interim standards and then refer to an outside consultant. This is all something we could do in the course of this particular legislative session in your judgement.

A. Yes. And, even if you don't do the standards. I would like to see that. That's been something I've wanted to see for a long time. But, even if you didn't do the standards you can deal with the interim request which is based on the collective wisdom of the management team at AMHI. Current team. I think you have to have some faith in the people who are doing the work.

Q. You had mentioned at the outset of your statement that - on page 1 - you mention that a workload reduction which is expected, because we had thought that roughly 20 or so inpatient beds would be established in Southern Maine that has not materialized.

A. Right. This is something - again we've talked about it for some time as being an excellent idea and I guess various providers have been contacted at various times. This is something that would have direct and immediate impact on AMHI and a direct and immediate impact on the number of staff that are needed. If you take away roughly 400 admissions and drop the census, the problems at AMHI are going to be minimized substantially.

Q. You feel that if we establish some 20 or so inpatient beds in York or Cumberland Counties that would translate into a yearly reduction of around 400 in a sense?

A. I prefer to have a 40-bed unit in Southern Maine; but 20 beds would be a great help. And I'd like to - if every admission from York and Cumberland would go to that facility it would take a lot of what we're dealing with at AMHI out of the AMHI situation. In other words, a State Hospital such as AMHI is now an acute facility providing acute care for 800,000 people - a population of 800,000. That's a big job. And, what's happening is that people are having to go - you know, travel miles up the road for maybe a three-day or a five-day stay. Half the people who come to Augusta Mental Health Institute are out within ten days. So, there's a tremendous number of people who are there for ten days or less and a significant number of people who are there for let's say three days or less; and certainly, those three-day admissions - you still have to do the admission physical, all the assessments, throw together some semblance of a treatment plan and discharge plan. That's a tremendously labor-intensive piece of work. So, that acute admission discharge work is something that's been our Achilles heel.

Q. Now, perhaps you can help me and the Committee. Was this 20-bed piece ever submitted to the Legislature for consideration for funding?

A. It's in the - the funding for that is in the September package. It's five or six hundred thousand. I could be corrected on that

and due to be on line February 1, I believe.

Q. February 1 of this year or next year. Today?

A. Today.

Q. Do you have any knowledge on what factors might have stalled the development of those 20 beds?

A. Well, okay. There's two things. One is - in Southern Maine there's a private provider, Jackson Brooke Institute, which is a special hospital and there are a number of general hospitals. The one that probably is most readily able to do it - you'd have to talk to them about this, but I understand there is some willingness, would be Jackson Brooke. They are a special hospital as is AMHI. We're classified as an institute for mental disease. Anyone who is eligible for Title 19 Medicaid is not eligible for services provided in an institution for mental disease. So, anyone between the ages of 22 and 64. That's a federal statute. If you're in a general hospital, in the psychiatric unit of a general hospital and you're between the ages of 22 and 64 and eligible for medical assistance, then you do get funding. So, the advantage of having a general hospital provide this acute service is a financial one and it would be less burdensome to the State. The private might be able to get up and running faster and would probably require a special CON process.

Q. A special CON process?

A. I believe so. I believe it's part of it.

Q. So, there are two different options we would have. We could either contract with JBI or we could encourage the development

of a private facility for that population.

A. Yeah, or you could decide to do something public. But, there again, that would be a major undertaking. And, it would take longer than having someone who is currently in existence to start.

Q. Okay. And, I guess I had asked what factors had retarded the development of those inpatient beds.

A. In a general sense I think general hospitals are reluctant to take that role on and there are issues of liability and, quite frankly, want to. Not every general hospital wants to get into the business of taking involuntary patients. So, it's not something that every general hospital feels is part of their mission. In fact, there'd be very few that I think feel it's part of their mission.

Q. I think it would probably be a larger medical center that would be able to take on that responsibility. They would have perhaps diverse labor populations available to them to meet that population's need.

A. Right. And there's all sorts of - there are other issues. This was discussed fairly extensively in the Commission on Overcrowding. Issues of training and recruitment exist in the private sector as well as the public sector. I think recruitment issues may be even stronger and the recruitment more difficult in the public sector. But, recruiting psychiatrists for inpatient care is not an easy task, even for the private general hospitals.

Q. We appreciate that. Let me just switch the topic a little bit here. And, I understand and appreciate that your overall concern is to enhance quality of care; but part of our concern in these hearings is to explore the reasons for the decertification of our 30 or so beds at AMHI and whether we could have taken action earlier to foreclose that possibility or prevent that from happening.

Now, as I understand it, the State received formal written notice on or about the 23rd of March of last year from HICFA that as the result of recent surveys AMHI would be decertified for Medicare as the result of problems with record keeping, staffing and I believe there was a problem with the admissions unit as well.

A. Yes. We had sought certification for basically 86 beds, for the Admission Unit which was 30 beds, the infirmary which is 16, and the older adult program which was categorized as a 40-bed unit.

Q. Now, it's my understanding from Department presentations earlier in these hearings that there was a shift in emphasis at the national level and the standards were more rigidly applied. And, basically focused - veered from a team approach to more of a physician-oriented approach. And, as a result of that the Department has told us 'we were found lacking' and that was a primary factor in our decertification. The question I would have to you is since you were Superintendent at the facility I believe from 1985 through -

A. April, 1986.

Q. Through January '89. When was your earliest knowledge or awareness that HICFA would be moving to a different interpretation

of its standards on certification?

A. Well, I think in September/October - the last day of September/ first day of October in '86 - we were being - we were one of the first hospitals to be surveyed under a new process essentially. Where it gave the surveyors more latitude. Frankly, I don't understand completely what the difference is myself, but they'd talked about that and they did say that they had more latitude and they did say that they were finding us in compliance but they weren't happy with our staffing and we did not meet the standard for nusing staffing at that time. And, so they would then be scheduling a follow-up visit. Actually it turned out to be two follow-up visits - one I believe in April and one was in June I believe.

Q. Of '87?

A. Yes.

Q. And, as the result of those follow-up visits the State, I understood, did take sufficient corrective action. We did add additional positions and we did address enough concerns to retain the certification status.

A. Yes. As a matter of fact, like I told you, I came in April of - April 22nd I started as Superintendent. On the second of May - actually, go back a little bit. My job interview was on February 11th which just happened to be the exit conference for Medicare. So, my job interview was delayed even - and that was the Medicare conference. I started in April.

Q. Did you have a warning, perhaps, of things to come?

A. No. Actually, no I didn't. And, so on the 2nd of May we got the notice, the written notice, that we were being decertified. But, in that notice what they said was if you feel you're in compliance, turn in a plan of correction and we'll come back and do a resurvey. So, what happened there is a request for staffing was put together with the Department assistance and it just so happened that you were in a session - the end of May it was - I guess it must have been - and did approve a section of staffing which was given and then the surveyors came back on May 29th and found us back in compliance. Then the September/October survey came about and we were found to be in compliance but barely so and that the nursing staffing was out and they would do a follow-up.

Q. This was again in '87 - the fall of '87.

A. Yes. This is '86. Then you move to '87 and that's where in January we started having a census and admission spike - fairly unusual and fairly rapid escalation in the numbers of patient census. At the same time we were in the midst of establishing the medium security unit you had authorized in the Legislature; so we had just completed a reorganization in February and established -

Q. That's the forensic unit?

A. That's the forensic unit. It used to be an 8-bed unit with up to at times 14 or 15 people in it. We then converted that to a 33-bed unit with a high security and medium security section. Then in early March things were getting pretty bad and Kevin Concannon and Ron Welch asked the Governor to come through and take a tour. At which time he had a chance to see beds in the

hallways, severe overcrowding and he was told of understaffing. We worked on a proposal. Actually, myself and staff worked pretty much that weekend and Ron Welch was there also; and we put together a series of proposals and made a strong recommendation for one that included 58.5 positions. This was taken forward and ended up being a request for 54 limited-period positions. Then, that request was taken to the Legislature, but instead of being 54 positions it was turned into 27 permanent positions and 30.5 limited-period positions which would evaporate on September 26th of 1987. So, in addition to those limited-period personnel, there was a community piece built in and that was I think it was 31 community residential beds. And, that was designed to bring our population down.

Q. In terms of the deficiency being cited back in '86 and '87, were they of the same nature which were cited in 1988 or were they different?

A. Partially. The big emphasis in anything prior to February of '88 was nursing and records - nursing and documentation. And, I think people will tell you that everybody has trouble with records and documentation in Medicare surveys. However, we seemed to maybe have a little more trouble than others. They had not been enamored with our treatment planning process for some time. So, there was an emphasis change in the February survey; and although they gave us a couple of hints about medical leadership in the last survey saying they like to see a little more leadership in the physicians leading the team. But it wasn't anything

like the kinds of comments we got in February.

So, Medicare - we got our 54½ positions and we recruited a goodly number of them, I guess. On May 28th Medicare came back as a follow-up to the previous survey. They found us still not in compliance in May. Then, in June - coming back in May we were still coming off this tremendous rash of census and admissions and the conditions, of course, were perfect for not getting certified at that time. Well, in June things settled down very nicely and for most of the summer of '87 things were in pretty reasonable shape and there were really only a couple of spikes in the fall which concerned us. There were some significant spikes, but they were only spikes and they didn't last a great deal of time. So, our population and everything went down in June. In July they came back and did the follow-up survey and found us back in compliance. This was primarily nursing that they were looking at.

Q. Are you saying it was primarily due to the fortuitous decline in the census at AMHI that we managed to -

A. Two things: staffing and decline in census. So then in September of '87, the limited-period personnel that we had evaporated. There wasn't any real way of making a case to not have them evaporate when you look at the numbers - the census - and what we had told the Legislature what would happen and so forth. So, we had - in a way it was good luck and in a way it was bad luck. We had a decline and a fairly easy summer. So,

things were not that difficult over that summer.

Coming into the fall, then, we had a situation where Susan was informed that we needed to look at cost savings. Find methods of saving funds. And, the Department of Mental Health and Mental Retardation's share of that cost savings was, I believe, 3.9 million dollars.

Q. When you say Susan was informed for the need of cost savings, I assume that means that someone from the Executive Branch informed the Department that there was an effort to try to effect savings.

A. That's my understanding.

Q. Now, Commissioner Parker told us that basically she interpreted that as a request to perhaps leverage federal dollars to Medicare or Medicaid more prudently.

A. I think she made a real - I think she did some really good work in that time period; but initially what happened was - well, one of the things that I was asked to do is what would I say to a four percent across the board cut at AMHI. Of course, I said that there's no way that we could - that I could do that professionally or ethically. There's no way that I could conceive of cutting back on staff at AMHI. Subsequently, all of us in the senior management team were asked to look for ways of saving costs. So my assignment was to look at how we might save costs in contracting various options out, various departments and combining the forensic unit at AMHI and Bangor. And, there was a couple of other things that we looked at - none of which looked very good to me. So, my recommendations were pretty lukewarm.

I didn't think we should do any of it.

Now, what Susan did, and much to her credit, was she emphasized revenue enhancement and very much focused on obtaining more federal revenue for what was already going on. And, saved, I think, all of her departments from having to make the cutbacks. I think they were all saved. I don't recall - I only fully recall what happened at AMHI.

Q. So basically you're saying that because the Department was able to maximize a leverage of federal dollars, that warded off any requests for cutbacks in the department, to your knowledge.

A. Also, though, what it did is kind of set a backdrop of how staffing requests might be viewed.

Q. You mean that perhaps requests for additional staff would not be viewed in the best favor?

A. Might not be welcomed. And in fact that was the message.

Q. Now, if I understand, we did in July of '87 secure a recertification.

A. Yes.

Q. And the following September those 30 or so temporary positions evaporated.

A. Yes.

Q. So, as of fall of '87 without attention to the request for parsimony in the Department, were you of a mind to recommend additional staffing as you were putting together the budget for the next year?

A. Well, I would say that there was - I broached the subject of the possibility of continuing the LPEs - limited period - or going back to them; but, again, it was not something that we could demonstrate that the need was there. We were at or below what we said we'd be at or below when we gave you the proposal. So we would be coming back saying we need more staff but we've accomplished what we said we would accomplish. It didn't make sense to us that the case could be made at that time and I could see the reasoning in that. So, I don't think there was anything untoward about not requesting staff in 1987.

Q. And, when was the next significant development regarding our problems with HICFA?

A. Like I said, there were a couple of spikes in November. Susan mentioned the Friday Reports which is one of the things that we all faithfully do either on Thursday night or Friday morning the first thing to essentially communicate the pulsebeat of what's going on in your operation. In November - November 13 of '87 - our census at that time was 372 and I did say that from past experience we know that there should be steady increase from now through March with potentially more difficult discharges due to cold weather and more difficulty in staffing units because of the holidays. This is an adverse trend of significant proportion. Now, I would also say that in subsequent weeks that things settled down also. So while there were a couple of those spikes, and I do mention them in my reports that these are adverse trends, they were momentary spikes. We did know that we should expect an

increase in the fall and in the early months of the year. At least the first quarter had been the pattern.

In January I think things started looking a little more grim. For example, on January 8th the weekly report talks about, 'On the last day of December we had 334 inpatients as of midnight. January 4, the Monday of the holiday weekend, there were 363. As of Thursday there are 364.' So, it's 334 to 363 - it's a 29 patient increase. If you look at the largest general hospital unit in the State - I think it's Maine Medical Center - I think that's 26 beds. I could be corrected, but it's right in there. So when you talk about 26 beds, you're talking about - it's like having a whole hospital pop in on you in a week. So, as of Thursday there were - admissions were running about 129 a month. 'This type of pressure does cause some degree of overcrowding, particularly in the young adult and adult units and occasionally on the admission unit. More significantly we have a number of difficult patients and fairly high degree of sick leave usage. Hopefully, by mentioning these problems in the report they will miraculously evaporate as they have tended to do in the last month or two. At the same time we're living on the edge of our ability to handle the numbers and types of patients we currently have.' That was January 8th.

January 15th - the same thing - the Friday Report. 'Census and admissions still remain high for the month with significant crowding issues on our young adult and older adult treatment units. We've had a great deal of acting out amongst the patient

population due to the presence of a large number of very difficult personality disordered patients who are experts at pushing all the right buttons.' Indeed, that is the case. 'To help staff members regain a sense of control, a number of meetings have been held and training sessions are being conducted to help the staff work through the dynamics that are going on. The interventions so far seem to have stabilized the situation.'

January 22. 'Past week the patient population spiked briefly creating some difficult situations regarding overcrowiding and staffing. Staff frustrations were high in that conditions were overcrowded and we were dealing with some extremely difficult patients who were successfully pressing all the right buttons. At times like these staff feel out of control and it is encumbered upon the unit leadership and administration to show a commitment to maintain control of the facility and design the strategies both on a unit basis and an individual basis. While things are still very busy, crowded and stressful, the situation has improved through some managerial interventions. At the same time we continue to stretch the limit of our capacity when census figures break the 360 level. Of course, depending on patient mix.' Then there's another note: 'Medical staff continues to be stressed - it should be stretched - very thinly. One solution under consideration is the reduction or eliminating the coverage of Maine State Prison by Dr. Owen Buck who is personally under great pressure because of his assignments. We are all working on some other options for consideration by the Department.'

So, then - so we're running into some problems. On January 27th we had a meeting that's called the 'Governing Body Meeting' and this is basically the Commissioner, the Associate Commissioners and the Clinical Director and myself and the Bureau of Mental Health comprise this. At this meeting the Commissioner and the Associate Commissioner for Administration was there as well as myself and Walter Rohm. Ron Welch wasn't there and at the time the Bureau Director position was vacant. Jay Harper hadn't been hired yet. At that meeting we had a conversation entitled 'Contingency plan to deal with high census acuity admissions and crowding' and discussion of reoccurrence of high census and the likelihood of this continuing through March or April took place with the additional issues of overtime, staff morale and attitude factors also being taken into account during the discussion. Action - it was decided that the Commissioner and Associate Commissioners would set a date for a meeting to deal with this issue by mid-February and that the Superintendent would supply concise illustrated documentation of current conditions.

January 29 is another weekly report. Census at 355, 11 short leaves, and let's see, the adult program had 60 patients with 8 on short leave and a maximum census of 55.

Just as a word of explanation, we - our treatment units - we have a bed count and then like a maximum count, our own internal maximum. So, the 45-bed unit had a 55-bed maximum and the 40-bed unit had a 45-bed maximum, our theoretical view of the most that you should put on the unit.

The adult program had 60 patients with 8 on short leave, which means they would probably return, with a maximum census of 55. So, that unit has been overcrowded for some time, but 60 patients is an awful lot for that area.

Back to Medicare. February 5th Friday report, we hear from Medicare during this week that they're coming on the 22nd and 23rd. Now, that's a surprise to us because the last survey was in June and we were thinking it would probably a year. In fact, we had made some phone calls to try and find out when it might be, but the response was they won't tell you. They'll decide when they come. So, we had kind of put together a process whereby we were revising and retooling our treatment planning process with the idea it would probably be close to June and that would be the end of this process. So we were a little bit disconcerted when they said that they would be coming because we were kind of in the middle of piloting a treatment planning system. So, that just causes some extra scurrying is what it did.

February 11 we had a meeting with - at the central office and I supplied them with basically a fact sheet and a packet of materials which indicated that a number of things - CORs, one to ones, 15-minute checks, SRC incidents, sick time and census on different units and mental health worker overtime and the amount of floating that was going on. All these indicators were up in significant proportions. And, the written material that I gave out said "that conclusions during the month of January our patient

census increased, our admissions increased and patient acuity increased. Staff sick time also increased as did our mental health worker overtime. During this period of time patient treatment, safety and security, documentation and staff morale deteriorated. At the same time we have historically had high admissions and census during the first quarter of the year and staff do remember how nice it was when we had our extra mental health workers on LPE status. They and I feel trapped with no reasonable resource response should our census again peak. The Cumberland involuntary treatment option is also on hold. Data shows that our staff is working very hard at keeping our census stable and individuals out of the hospital longer; but we are still on the edge of disaster coming into our critical period. The residential options seem to be finally be coming on line but there's no current contingency plan for another large influx of patients. Objective: determine how we will respond to overwhelming patient influx and options intermittent LPEs - limited period - project workers, diversion, deflection, reorganization other.' So the idea was what is it we can do. The bottom line is always - it's been the same theme since I can remember. Less patients or more staff when things like this happen.

The outcome of that meeting was generally to attempt to work better with the existing resources at hand and any diversions or any additional things that could go on in the community would be attempted and we would continue to monitor and move along the

placement options that had been funded.

So, we're coming into the Medicare time now. February 12 I do say 'after a fairly extreme January, things seem to have calmed down for the first two weeks in February. From previous years, however, we have every reason to expect substantial increases in admissions and high census through the first quarter.' Then I talk about the Medicaid survey for the psych hospital and their findings. They had some concerns with medical records.

Q. At this point, before you get to the 22nd, which I guess is the time of the census, you had voiced concerns about over-crowding; but had you made any specific - you told us about the - possibly transferring Dr. Buck from MSP to AMHI. But, had you made any other focused recommendations to the Department regarding additional staff?

A. Yeah. I had asked about the possibility of going back to the LPE - basically the same thing we had had in the fall.

Q. The 30 temps?

A. Yeah. And, if that wasn't reasonable, you know, could we do it contractually. Those things - basically, those things that would - that were in the purview of the Executive Branch to control and deal with in a short period of time.

Q. What was the answer?

A. Well, the answer is obvious - no.

February 19th. Now, we're starting to come to the survey time. 'After a heavy weekend in terms of admissions we're back up to 365 census level. The acuities are consistent with recent

past and we're a bit more crowded than we'd like coming into a Medicare survey. Medicare will be here on 22 February and will give their first exit conference on the 23rd. We expect staffing to be okay, although these surveyors might notice the reduction of mental health workers and the increase in census and acuity. Hopefully, this will not be a significant problem. The area of medical records will probably cause us more difficulty. As a matter of fact we are in the midst of changing our treatment planning process through the use of a pilot project and Medicare's early appearance is creating some additional scurrying.'

So, we were basically trying to reorganize our treatment planning and kind of got caught in the middle of reorganizing. But - so that causes some - it complicated our life. Medicare came on the 22nd and 23rd.

On the Friday report of the 26th, and then I'll go back a little bit. 'This week's census remained high at 366. As of today admissions are running about equal to the previous six or seven months. Our acuity has been high particularly in the infirmary area. Staff continues to handle these large in a very professional manner. Medicare survey - Medicare was here for their annual review on Monday and Tuesday indicated to us that the staffing and medical record conditions were out of compliance. Physician coverage and physician supervision of physician extenders, inadequate documentation and monitoring of patient records, active treatment and the amount of activity time on the Medicare

distinct parts were all cited as problem areas. A plan of correction will be developed with a close oversight involvement of the Commissioner and the Associate Commissioners during the next seven to fourteen days. The long-term issue is, of course, the extent to which AMHI participates in the acute and short-term hospitalization for rather substantial mid and southern Maine catchment area. Lack of involuntary options of the major population the size of Portland, Lewiston/Auburn and Augusta put AMHI in the position of being a very much active rather than secondary tertiary facility. It is this acute short-term hospitalization that most readily lends itself to public / private partnership and utilization of general hospitals.'

Q. If I can just stop you. This is your February 23rd note - February 26th Friday report.

A. Yes. It's right after the survey.

Q. If I heard you correctly, at least in your mind there was a credible threat of decertification as of - a verbal notice at least - in February of '88.

A. We knew that we were not going to be certified at the time of that exit conference. They always give you a real good idea. What they do say, however, is that before we can give you official notice we have to send this back to the office and they'll give you the official notice. They always leave themselves room for changing or if they found a gross error in something - one of the surveyors did or whatever - they could change it. I would say you're 95% sure when they leave.

The other thing that we - Dr. Fong, who was the physician/ surveyor, was heading up to Bangor and forgot his materials. And, so like any dutiful superintendent would do, I happened to notice the typed report that he was sending to his superiors and so I copied that off and we gave the - he may have come down or we may have it sent up. I forget how we did that; but we made sure he got his material in tact of course. We had a copy of it which made it a little easier for us to develop a plan of correction. It was kind of humerous at the time; maybe less so now.

So, we started working on a plan of correction. Now, you have to keep in mind that we were cited for not having enough psychiatrists and not having enough activity staff. And, in my mind, there was a problem in clerical staff. That was not a citation from Medicare. That was my own conclusion and the conclusion of the administrative staff. So, on March 4, the weekly report, 'census remains high ranging from 369 to 358. Admissions contine to be fairly even at 120. March figires to be our heaviest month with some previous history of heavy April workload.'

'Medicare survey. We're currently in the process of addressing the medical record deficiencies highlighted in the Medicare exit conference. We have set up a plan of correction with the tag numbers - that's according to the standards - with the tag numbers for the standard, the deficiency, the plan of correction, the responsible person, the time frame for completion. We are working with the Department on matters relating to resource allocation.'

March 7th - the next week - 'our census is running extremely high. Patient acuity is very high due to the small number of very difficult individuals. As of today we are at 376 patients and residents. There were 42 admissions in the first nine days of the month which would equal 145 admissions if the pace continued; and there were numerous patients needing one-to-one coverage and 15-minute checks. The weekend is coming up and could bring us back near the 400 level if we would have an influx of current admissions that are severely ill and not homeless street people needing shelter.'

'Medicare. Our activities to correct Medicare deficiencies are in full swing with a substantial plan of action in various stages of implementation. The most ticklish area at the present time is staffing requirements and activities which mandates evening and weekend activities on a seven-day week basis.'

March 14 - 'census is still almost 370. Medicare plan of corretion: work continues in correcting deficiencies not yet officially cited from our last Medicare survey. Staff seem to be pitching in to solve the medical records portion of the problem. Shortages of activities, psychiatry and clerical staff are the most troublesome, but various options are being developed with the involvement and assistance of the Commissioner and Associate Commissioners.'

March 25 - 'census in mid to high 60s.'

April 1 - 'for the month of March there were a record number of admissions - 144. Census was 366 for the month which is up

16 from the previous month. We have admitted a number of individuals who have significant medical problems. This is a continuation, and in fact an acceleration of previously record high admissions for the last six months or so. We are extremely concerned about this trend; and although we expect a peak during the first quarter of the year, our current numbers are more than we would have anticipated. Over time AMHI's overtime has been quite high and growing rapidly and we are doing everything we can to maintain it at a reasonable level. At the same time we're dealing with significant increases in numbers and high levels of acuity. As an example, we're having difficulty finding patients for our Alternative Living program in our inpatient population.' Alternative Living is the half-way house setting.

'Medicare. We received notice that our provider agreement with Medicare would be terminated as of - this is April 1 - as of April 22 and that a notice would appear in the Kennebec Journal on April 8 indicating the same. This was expected. What was unexpected was the fact they did not mention any possibility of corrective action in their letter and only referred to a hearing before an administrative law judge.' So, this was a surprise. We sort of expected to see 'if you disagree with this, send us a plan of correction'. 'A subsequent call has yielded a visit with HICFA Regional Office in Boston to attempt to remedy the situation. We have made great strides in terms of record-keeping, but there are still some areas that are troublesome and they're not easily corrected by changes in procedure and

closer monitoring. They cite what they consider to be serious manpower shortages in the area of psychiatric - in the psychiatric area and in activities. We have addressed that area of psychiatry through a 20-hour contract with Dr. Veragay* which will begin April 12 and we have revised the activity schedule effective April 18, '88, to provide for weekend coverage and evening coverage. There are, however, no additional resources directed to that area and we will attempt to make the case that our current staffing is adequate.'

April 8 - 'census is 370. Older adult unit is over its census. A large number of patients require ADL support and basic nursing care. A number of incontinent patients among this group. Preparation for oral review. Much work has gone into preparing for HICFA meeting in Boston on April 12. Each deficiency has been analyzed and we are colating the efforts which have been made towards a plan of correction for each of those deficiencies. Meetings have been held between AMHI personnel department and unions regarding the impact of changes resulting from reconfiguring the therapeutic activities department. Much work has gone into revising the therapeutic activity schedule to allow for evening and weekend coverage. And, some of the staff has been quite upset over these changes. Every effort has been made to minimize the impact of what we feel are necessary changes.'

What this is saying is basically the option for additional staff was not there; and it was suggested.

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* spelled phonically

Q. Why don't you elaborate. You say the option for additional staff was not there. What do you mean by that?

A. Well, what I'm saying is we were cited by HICFA for inadequate psychiatric staff, inadequate activity staff and my view was clerical staff was a problem. Those specific areas were recommended for additional staffing by me and the decision was to not go for staffing.

EXAMINATION BY REPRESENTATIVE MANNING

Q. Excuse me. Is that - what you just said - in that weekly report?

A. Well, you have to understand that this is a weekly report that goes to the Commissioner and the Governor's Office. It's not a real good -

Q. In other words you feel intimidated asking the Governor's office -

A. You just don't paint a person in the corner. It's just not good form to - I mean, this is - my work goes to the Commissioner, okay, and to communicate too directly to the Governor would not be proper - proper protocol.

Q. Call it teamwork.

A. Yeah, I guess that's what you'd call it.

EXAMINATION BY SENATOR GAUVREAU

Q. Outside of the context of that so-called Friday Report, you were involved in devising a plan of correction to submit to the Boston office.

A. Yes.

Q. And, is it your statement that you were recommending augmenting staffing patterns in the psychiatric, social and clerical?

A. Yes, those three areas. It would have probably been less than what originally came out. I think we were looking at it would probably take five additional people to run the evening/weekend schedule. And - in terms of activity staff. The request after the May survey was, I believe, 15. So, it was a slightly smaller - in looking at what do think you need, it would be like 5 for the weekend coverage and some clerical help and physician coverage. There's some real problems - even if given a physician, there's the recruitment problem. So I mean there were some issues in terms of what you could do how fast.

Q. My recollection was that we had added some 18 people in July. The Governor used discretionary funds for that purpose. I'm not clear on what you're saying. You had recommended five weekend individuals and then adding a psychiatric component and clerical?

A. Five people would be sufficient to cover evenings and weekends. That would cover that section of programming. They cited us for insufficient staff and they cited us for not having any program on evenings and weekends. The number of people it would take to put a program in for evenings and weekends only would be five; then we did make some internal reallocations to beef up from other areas.

Q. Dr. Buck was transferred to AMHI.

A. Yes. That was - actually that suggestion was made before Medicare. That was part of the plan of correction as written.

Q. Are you saying you were gonna recommend five new staff positions as of going to HICFA for the April 12th meeting? You were recommending five new positions?

A. Yeah.

Q. And that wasn't acceptable?

A. Right.

Q. So now you're at the April 12th meeting. And, what did your plan of correction consist of?

A. I think you may have copies of this. A training effort - a substantial training effort which did - you have the material and I think you've discussed it somewhat. I believe I personally wrote every word on this, but I may have had some help from Rick Hanley. This was my writing. I thought we - you know, I think we made a pretty good attempt to do with - gave the best shot that we had. That was the task - take the best shot we could with what we had.

Q. This is the six-prong plan which we should have on page 2 of our Medicare narrative.

A. Yes. So, basically, it's the training effort, extensive work that Dr. Rohm did with his staff in beefing up the supervision of physician extenders and tightening up various aspects of medical documentation. Dr. Buck - taking him off the Maine State Prison so that he could supervise physician extenders better. The addition of a 20-hour contract with a physician, the revision and some work with the social work department and their documentation, and revising the therapeutic activities schedule to include evenings

and weekends.

Q. And, did you believe that that plan had a reasonable chance of securing approval from the Boston HICFA?

A. Well, I think we were giving it our best shot. I guess we - you know, it was like a 50/50 at that time. That's about what I was thinking. Maybe, maybe not. Maybe 60/40. We were working very hard and we tried to put together the best thing we could. We did make some progress. In fact, when you come to the May survey you see substantial improvements in the area of documentation and there were many things that were cleared up; but there were still many things that were left.

Q. Now, as I understand Commissioner Parker's presentation, it was shortly after the April 12th meeting in Boston that the Department received correspondence to the effect that the State of Maine had proferred a plan which deserved consideration. That, in fact, would prompt the followup survey in May. Is that your understanding?

A. Yes. The term 'credible allegation' is basically what moves HICFA to do something. If they receive a complaint against a facility, they call - and they get what they call a credible allegation, that means they'll go and inspect the facility. They'll do - the other thing is if there's a credible allegation that we were in compliance, that they could come out and look at it. My view is that given the circumstances it would have been very foolish for them not to give us another look see. That we did prepare a nice presentation for them. And, it would put them in

a position of appearing to be unfair if they didn't do it. So, I was - they didn't give us any assurances that they'd come up, but I think we were all pretty confident that they would come out again.

Q. So what's the next significant development, then, in this story the May survey itself?

A. Yes, I think so.

Q. And when did that occur?

A. May 27. Well, there are some other significant things, I guess. The census - the April 15th Friday Report - census was 375. And we didn't have a lot of luck with our census and admissions and the kinds of things that were going on during the survey. It was not the best of circumstances that we were working with. We were working with a heavy workload prior to going into a very significant survey. So, the conditions were there for getting knocked off. 'Census was high on April 15. ARC episodes were a concern last month and remain a concern. It seems clear that SRC usage is related to the hospital census, number of admissions, staffing levels and patient acuity.' I mention that HICFA did not indicate one way or another whether they would be resurveying us, but it's our opinion that they will. Stanton Collins indicated that the follow-up survey would be unannounced and that if they did survey us, Dr. Fong who did us the first time would come back and do it again for continuity.

Again, April 22, 'census was 377. Stone North Middle, our older adult program - that's one of the units we're trying to

get certified - which is a Medicare distinct part, is ten beds over census and episodes of single care usage were up dramatically during the last reporting period. Physical assaults were also at a high during March and for the last nine months. Going into the weekend we have 28 patients on our 30-bed Admission Unit with only one transfer out. Only one possible transfer out. Admissions is a three-day period and the Admission Unit tends to build up and after Monday they're transferred to the other treatment units. Admissions, again - April 29 - census remains uncomfortably high at 373. Acuity levels remain fairly constant, although constant these days means high. The adult and older adult program continue to be overcrowded having 57 patients on a 45-bed unit.' That's the one we're trying to get certified. 'And, 53 patients on a 40-bed unit. Respectively the rest of the hospital is at or near census. It is increasingly difficult to find appropriate patients for minimal levels of supervision - in terms of crowding, Stone North Upper with only 12 staff has a patient population of 24 patients. We've been running this unit as an overflow area and as an extension of the alternative living program. It is increasingly difficult to find appropriate patients for the minimal levels of supervision in these two areas, however.' So, there was some physical space up there. You could put 40 patients on Stone North Upper, but that's the staff that was deleted - limited period - back in September.

'Preparation for Medicare survey. We continue in our preparation for Medicare survey and we've made substantial improve-

ments in our medical records. Our certification will probably boil down to the adequacy of psychiatric staff, adequacy of activity staff. We now have seven day a week schedule and evening schedule and active treatment.'

May - 366 census, 130 a month was the pace of admissons. We received a new deadline from Medicare. They moved it back. I think it's because they couldn't get the physicians to come in.

May 20 - 'admissions are running at a pace of 130. Census is 367.'

May 27 - 'as of May 26 census is 377. Nine people on short leave. Admissions are on a pace of approximately 130 a month. Patient areas are crowded once again and overtime will no doubt be unusually high this month as will incidents and usage of single room care. Dr. Fong and Dr. McCann, doctor of nursing, arrived Tuesday and will be conducting an exit interview - exit conference at one today. They have been reasonably tight-lipped as to outcome. However, they have also been honing in on admissions, acuity level, and weekend coverage. Conditions are perfect for non-certification as they have a recent suicide, some patient deaths, higher levels of incidents and overcrowding are distinct parts to point to. Our record-keeping has improved greatly. However, there will be plenty of gaps found as these surveyors are quite meticulous and very competent. Regardless of the outcome I think our staff has put forth extraordinary effort and have made massive changes in a short period of time. For this they should be commended.' And, that takes us thorugh Medicare's May survey.

Q. It sort of seems that based on that last note, you were not too optimistic as far as the prospects for reattaining -

A. Well, you have to remember that note's written on the 27th. That's the day they're gonna leave us. So, we had some signals - non-verbal cues - comments to go by. So it would be unfair to say my crystal ball was on that report. But, I think the general problem is if HICFA's coming in telling you you're short on - you have staffing problems. Staffing is a problem at your facility. And, in activities we didn't add anything. We did some reorganization and so forth, but they were suspicious of us in that area. In nursing on the first go-round they suggested that sometimes we were doing - our nurse staffing was smoke and mirrors. And, I'm not quite - I honestly don't know what they meant by that and we were all kind of wondering what that meant. It just sounded like they didn't trust us and we were trying to pull something over on them. I didn't feel we were doing that. So, I really didn't know what the heck they were referring to. I personally feel that sometimes they don't give you enough credit for the assignments that - and the people they consider indirect care, they don't always give you any credit for those type of nurses. So, that's a minor point.

Q. When did we finally get confirmation from HICFA that - May 27th?

A. Yeah, because they had already given us notice that we were decertified. So, that was it. When we didn't pass that day - now they may have followed up with a - they did follow up with an official written report. I don't know if I have the cover letter

on that or not. I don't have the date that it came to us.

Q. I recall reviewing that. It just said they did note some significant improvements. I believe there were improvements in record - in documentation I believe it said. But, ultimately, they felt we would not pass muster.

A. Right.

Q. Now, the next significant action I can recall occurring is that in approximately June of last summer the Governor recommended I believe an additional 18 people work at AMHI. Now, I guess I'd ask you what was your response after you had been confirmed - we knew that we would not attain recertification. What was your next step after that?

A. Well, there were - June 3 - on June 3rd, just for your information, we're at 379 in terms of census. Admissions for the month of May is 125. That's fairly substantial when you get that level of admissions. Twenty people on 15-minute checks, five in constant observation, eight receiving one-to-one. What that tells you is if you have a bunch of people on 15-minute checks and you have a bunch of people on one-to-ones, then you have a bunch of people on COR, which those are all overtimes. So, if you have ten or 15 of those going on at one time - let's say you had 10 - and two shifts probably for sure, that's 20 people and whatever you had to carry through the evening shift. You might have up to 30 people needing to be called in for overtime to take care of that type of acuity. So, we were having that type of acuity in the summer period.

Medicare. 'Obviously the major projects for this week and coming months will be dealing with Medicare decertification issues. We will of course be working with the Department to formulate a reinstatement plan; and given the current census and unrelenting admission load, this should be a challenge.'

So, June 7, we prepare a - there are numerous meetings and conversations and I can't tell you - either my calendar doesn't have all the entries in because there was significant back and forth on this primarily with Ron Welch and the Commissioner and somewhat, I guess, with Ron Martel. But, what I did is I believe it was June 7 - I prepared a packet of material for presentation which included a table of contents, which I am reading from; a general narrative, and this is the outline of my presentation; setting and what happened - explaining what happened. Census didn't follow the trend, admissions were extremely high - no let up, acuity very high, staff working high overtime, Medicare/Medicaid survey more stringent, preparing for JCH, new standards, more stringent, more medical, patient rights rules, compliance and pull string, having documentation. So, what's the problem - the crisis, census and admissions, loss of Medicare/Medicaid for 65 and over - so they were tied together. The thread of Medicaid loss in the adolescent unit. That is kind of a side issue, but there was some work needing to be done over there and trying to gear up for JCH. Problem definition, quality of care and reimbursement, approach. So, the approach I'm suggesting is aim for the

114th as the major fix. Keep AMHI afloat for another two years to get any significant community impact. Maintain reimbursement and deal with some of the crowding issues. So, in the packet, in addition to this, is admission and census charts which show the admission and census, the cost sheets for what I'm recommending, and then the narratives for psychiatry, the psychiatric placement sheets with - Dr. Rohm and I have worked on, by the way - does have input into the staffing and development of budget, particularly the medical staff. The activities narrative and activities placement sheets which were put together with Carol Donnally and Rick Hanley who's her boss. And, a narrative on clerical services. Attached was basically a request from me which had the 18 positions in it; but there is also another request attached to deal with what I felt was even more severe which was the problem of overcrowding. We call it overcrowding all the time but it's really a matter of overcrowding equals understaffing. So, the true word in reality probably should have been understaffing. Crowding was easy. Everybody understood what that meant. So, deal with the crowding issues. And, that was a significant proposal - between the three of them would be about 60 staff which -

Q. This was made in one month?

A. I'm sorry?

Q. What time period are you in now?

A. This was all together. My suggestion for the 18 staff and the overcrowding was at the same time. It didn't come afterwards.

It was the same time.

Q. So, what time - this is 1988?

A. 1988 - June 7 - and there were numerous meetings on this.

Q. Okay. Well, we know that ultimately 18 new positions were funded on a temporary basis to get us through until the special session in the fall.

A. Yes.

Q. Is it your commentary or testimony today that you were recommending some 60 positions of which 18 ultimately were approved?

A. I had a couple of things sectioned out. One was 18 positions for the Medicare. The other was an overcrowding piece which was basically restaff the Stone North Upper. It's like going back in time to '87 with a little additional augmentation and putting the professional staff on there. Then a float pool, so there'd be a 13-person float pool. And, my comment was if you can't do this, at least do the float pool because of - I was hoping that they'd want to go for the whole package.

Q. So what ultimately got approved though was not the staffing on Stone North of the float pool, but the positions to help us regain certification for Medicare.

A. Yes. Now, I am very clear about the level of enthusiasm I had for that proposal - the overcrowding. And, that one was one that was vigorously supported by myself. And, right up until the end that there was a refusal to bring that about.

Q. Now as it turns out, the 18 additional people that were added in the summertime of '88, where were they assigned?

A. I'm sorry?

Q. What were their duties?

A. The 18?

Q. Yes.

A. Okay. The 18 staff consisted of ten people in the therapeutic activities department.

Q. I beg your pardon?

A. Ten people for the therapeutic activities department, two recreational therapists and four OTAs and four RTAs, which are somewhat like mental health workers. They're not licensed or certified, but may have special training.

Q. Let me just focus in a bit here. We know that we've been decertified due to concerns about our admissions unit, recreational programming, our physician contact with clientele and - I guess that was it. Now, those positions, did you support those 18 positions?

A. Yes.

Q. Did you believe at the time that was a meaningful and appropriate response to the certification?

A. Yes. In hindsight I underestimated, but at that time, yes.

Q. Was there another overture by the State of Maine in the summer of '88 to HICFA to again come back in and survey us to look at our certification?

A. Not to my knowledge, no.

Q. When did we next ask HICFA to come in and take a look at us?

A. We haven't. We have not.

Q. So why did we wait from - if you felt in June of '88 we had added 18 new people and you felt that was a meaningful response to the certification problems, why between June and January when you left the institute, why wasn't there an effort made to again approach HICFA and regain certification for Medicare?

A. Well, we were not ready to do it. There was a number of things - continuing high census and admissions and remember my comments earlier about the admission unit becoming a resource drain and a bottleneck. That's part of the backdrop here. And, the other part is just the stabilization of medical staff was not accomplished until October and then that isn't particularly stable even yet. There are still two - basically two unfilled psychiatry positions at AMHI. While the Medicare - all the positions for Medicare were filled fairly rapidly, the backfilling wasn't necessarily done in the other areas. So, for example, the recreational aides and all that, they were mostly taken from inside. So, while we hired all those people, then we had to rehire mental health workers to backfill the people that were promoted to -

Q. Let me ask you this. When you left the institute in January of 88 - 89, did you believe we were then in a situation to go back to Boston and have recertification considered?

A. No.

Q. Well, then the question of the day, I guess, is what still must be done so we can approach HICFA and try to get recertification for our Medicare loss?

A. In my view it can be best done in one of two ways - I hate to keep going back to it. I don't think the Admission Unit is really able to handle the number of admissions that it's getting. It's a small unit. It's got 30 people. It's just not a very good place. It's jammed up. It's crowded. And, when someone's sick or off, like Dr. Arness who's on the admission unit. He had a surgery and he was out for awhile. The new doctor that's here from the rental firm - she's working extremely hard and very well and probably - her documentations probably would rate as outstanding. But, she was working 12-hour days, too, to keep up - to do that. So, I think the workload, the pace and quite frankly the events of the summer. You had - in my opinion you have HICFA coming in and citing quality of care. You have the patient deaths in the summer. You have Joint Commission coming in in December and saying some of the very same things that HICFA's saying and some of the advocates are saying and saying that we have large resource needs. The Joint Commission was telling us we had resource defecits.

Q. In layman's parlance, you mention that the Admission Unit you feel is overcrowded and a real impediment to regain the certification.

A. With the staff that exists there now, the best shot in my opinion, although it might cause some problems in the area of nurse staffing would be to split off and have two geographic units basically. So, you would split your admissions in half and the treatment teams would release the patient to another unit, so you'd have continuity of care, you'd have one doctor and one professional team working

with a patient through their hospitalization. Right now you have roughly 1,200 people come into the Admission Unit. Guess what - 600 or 500 more go to the treatment units and they hand them off. Let's say somewhere between three and ten days - somewhere in that time period. So, you got one treatment team that greets the patient and admits them and then if they're going to stay they're handed off to another treatment team who has to learn what the patient's about and either operate on a treatment plan that someone else has devised and they hadn't devised; or, develop their own treatment plan very quickly because the time frames for developing treatment plans are fairly rigid. So in ten days you have to have a comprehensive treatment plan.

Now, if you divide the thing into two areas so you got three doctors on the majority - the three major treatment units. You've got three doctors on admissions, okay, so that means roughly 400. It doesn't work out that way but it's even numbers for simplicity. 400 admissions per doctor. You take six doctors and 1,200 patients, that's 200 admissions per doctor. You've got six social workers for 1,200 admissions, that's 200 for them. You've got 13 social workers the other way, that would be about like a hundred. So, in my opinion, you would get a lot better mileage out of your professionals if you cut out that because it's such a short-term thing. Cut out that triage unit and develop the two geographic units.

Q. Now, if we did that, are you saying that that in tandem with the additional staffing that we added over the summer as well as

with the special session reforms, would that be enough in your judgement for us to go back to HICFA and ask for recertification?

A. You might have to do something with nursing staff.

Q. Specifically what?

A. Well, you have to have - you need at least one nurse on each distinct part; and to have an admission unit you'd have to have a little heavier admission - little better nursing coverage than you might have on a unit where the stay was longer. So, there could be some options. We did not go forward with looking at that. That was something that we were expected not to do simply because there was emphasis on getting the admission unit certified. So, we put aside what I think might have been the longer range positive option - a more positive option for the short-term need to acquire Medicare rapidly.

Q. But, if I'm not mistaken, we've failed in that nothing is certified at this point.

A. That's true.

Q. My problem is having sat here for two and a half days - I don't have a real good idea on what we're doing at this moment to advance to our goal to reattain certification.

A. Well, you have - a lot is being done, but I think the problem is that it may or may not be a high probability shot to try to certify the Admission Unit given the bottleneck that I mentioned earlier. That that unit, the way it's configured, does not particularly lend itself for accreditation because it gives - built into that unit are a number of continuity of care problems

given the rapid turnover. And, the need for having timely records kept.

Q. Can you just summarize what else has happened between the June or July of '87 and the time you left the institute - I'm sorry. June or July of '88 and the time you left the institute, what action was taken to your knowledge to work towards the recertification? I know you didn't agree with the admissions unit. But, what action was taken?

A. Well, we hired the staff. We assigned an individual to the Admission Unit for training and teaching of documentation - review charts and to provide training for staff on the Admission Unit. A lot of work was done by the medical staff in terms of their documentation. We attempted - in the summer between June and the special session we were running into some substantial problems, so what we did there is we took three of our positions and deleted them and turned them into 12 intermittent personnel to form a float pool. Basically, 12 people. So what we did is we took three positions, divided them into 12 people and burned them up in a three-year, four month period essentially to create a float pool to get us through the summer months, because we were running out of - we were essentially running out of staff. That's - one of the things that's happening in the summertime is things were really out of sight - out of synch. On July 18th there's a note from the NOD - the NOD is like the administrative nurse in charge and so forth. This is a note to Vera Gillis. "By now you will have heard from many about the crazy weekend of understaffing.

Something needs to be done immediately or something terrible could happen. Some are exhausted and discouraged. We're killing them with overtime and freezing. We cannot wait for a special session of Legislature or it will be too late. I will be calling you as I really need to talk with you about it. I had volunteered to work three weekends this month. Now I wonder if I can really do it. This weekend has taken quite a toll on me and the sadness I feel for the staff hurts me very deeply. I've almost cried several times as I had to tell staff they were frozen. I feel helpless. I'm hoping the administration can ask for emergency help. What else can be done? More CORs in place of one to one. Most likely not as the one to ones are problems and peers need to be separated. Anyway, she's basically saying she ran out of options. She ran out of people to draft for overtime. So what we did is this intermittent personnel business, so we had to delete three of our mental health worker positions and to create essentially intermittent mental health worker positions. That was a quick way of getting a float pool together, although it did cost us three positions.

Q. Let me ask you, when we came back in session - special session in the fall - in September of '88, and I think many members of the Legislature felt that by infusing some 6½ million dollars into the mental health system we were doing two goals: We were long-range planning; but we also were addressing what was referred to as AMHI overcrowding and I think many of us felt that the bottom line would be that we would be in a position to go back to HICFA

and ask to get recertified for Medicare. Now, were there recommendations which you had made prior to the special session over and above what you've told us which you felt were reasonable or you felt were related to us getting Medicare certification?
My question is, we had the package available to us in the special session in September of '88 and many of the legislators, myself included, felt that this was a reasonable effort to work toward, among other things, recertification. Were there - had you made requests for other items in that package which were not accepted which you felt were related to regaining recertification?
A. No. The one thing that I did talk about as a strategy is what about the proposition of having our - basically having our arms twisted and somehow allowing the union proposal to go through as a hedge against the possibility that the deinstitutionalization, the depopulation or the workload relief wouldn't come on line. And, so that was not acceptable. We were gonna go with the administration's proposal. And, I guess I was right in there pitching as well as everybody else because I do believe if - I think it was a good package. So, the only part - where I found myself, you know in the paper I sometimes felt guilty because I wasn't maybe telling the whole truth is when in selling the package I found myself sometimes arguing aginst the position that I would have easily bought into like well wouldn't it make sense to have additional mental health workers and then when - the union was proposing this and I was talking to the union rep. They said well, if you look at it, the deinstitutionalization or the work-

load reduction equals your staffing request, which it would. And, in the preparation of the briefing paper for the Commission, I think that's one of the things that I could live with myself by emphasizing that point, is that the solution in that package was one of balance. And, there was an infusion of staff to deal with workload and a reduction of workload. And, that workload reduction hasn't occurred. Not only has it not occurred, the workload has increased; and not only has the workload increased, everything that transpired over the summer happened and makes it less likely for a body who is going to come in and give you a stamp of approval made it much less likely of certifying or accrediting body to give you a stamp of approval under those conditions. I mean, they - when you have negative patient outcome they're going to be extremely picky. So, all of this leads up to not a very good picture for regaining accreditation.

Q. Let me just - one final question here. As of January, '89, when you left the institute, how far away do you think we are now from regaining certification with Medicare?

A. Well, I gave my best guess - when was it, October - and I might have to go back and modify that; but, it's a function of - in my opinion it's a function of workload. In other words, if we're running 1,200 admissions lickety-split and we're sitting there with doctors who are here on short term which could leave here or there - if everything's in place, we could probably get accredited in three or four months I would say - get Medicare - maybe. If it can be gotten at all.

Q. If everything's in place, maybe, if it can be gotten at all. I'd like a little more precision there.

A. Wouldn't we all. Everybody wants precision. Everybody wants to know when it is. Give me a date. What I've been saying all along is it's a function of staffing and workload. And, if the workload isn't going to change and the staffing isn't going to increase, you're gonna have to be a little lucky to get it. Now, you reduce the workload, you're gonna get Medicare. If you increase the staffing the way it's organized now, you might get Medicare. You might have to reorganize just to spread things out. I do think that that 30-bed unit makes it difficult. There might be some easier ways to -

Q. What you're saying basically is the model we have now you don't think is a very logical model in terms of delivering services and if we reorganize we might - that's a more logical way to go about our task.

A. Drop the total admissions of the hospital down to about a thousand, then I think that 30-bed unit can do its job. It may make more sense to split them off even under those conditions. What I'm saying is if you drop the admission load on the admission unit, it probably wouldn't be overwhelmed.

Q. And to do that we would have to bring to bear the southern Maine inpatient beds.

A. That's your most immediate way of doing it.

Q. So, would it be fair to say your advice to us as far as working recertification would be to make sure that we brought those inpatient

beds on line as soon as possible.

A. I think that gives you the best shot. Just in terms of Medicare only it gives you a better shot than even maybe adding some staff to the Admission Unit as currently constructed. Some of the people at AMHI may or may not agree with that, but I think that's fair to say. But, the other thing is if you get all swept up in worrying about Medicare, then you're in danger of forgetting all the other patients who are at AMHI and there are a hell of a lot more patients on those other units than there are on the 30-bed unit that's still in crisis stabilization triage essentially. And, if you look at where the problems are coming from, there are some problems that come from the Admission Unit. It's a lot of the other units. You could have maybe longer term patients and patients who have care needs that don't pop right out at you. I think the staff do a real good job trying to triage problems as they come to them. But, what happens in that kind of setting is you deal with what's hot and what's acvtive at the time. You may not fully implement a treatment plan for someone who is less of a problem on a unit. A person could - I think in some of the reports use psychiatric wallflower is a term that's used occasionally. But if a person isn't causing trouble, they may not get much attention. And, I don't think that's a matter of the staff not wanting to do it. I think it's having to attend to what's the most immediate. And that's how your treatment plans occasionally break down is that people are dealing with what's immediate and right in front of them and they may not get to the more sophisticated or less

immediate aspects of treatment plans.

Q. Thank you. Are there other questions by the Committee? Representative Rolde?

EXAMINATION BY REPRESENTATIVE ROLDE

Q. Mr. Daumueller, I'd like to get back to this 20-bed unit in Southern Maine.

A. Yes.

Q. Now, where does that stand? During the special session we gave six million dollars approximately, of which three million was to go for community programming. Was this one of the community programs that we were funding at that time?

A. Yes.

Q. Where is it to be located? Has the planning gone that far ahead?

A. There were a number of options that were being worked on. The last update - the last official update I had on this was probably the - something like the 9th of January - and the plan at that point was to - because there was no provider available at that point in time, to give case managers pots of money that could be distributed and utilized by those case managers for inpatient care in a fairly distributed fashion. That is much a much less acceptable solution than having an inpatient program in one place in terms of diversion and deflection in my opinion. If there are recent developments beyond that -

Q. What was the original plan? Was it to establish a new inpatient unit? Was it to use existing inpatient units and have them expanded somehow? It all seems pretty amorphous at this point.

A. Well, I think it was written to give flexibility so that it wouldn't be necessarily pinned down; but my understanding was to develop an inpatient unit in a general hospital, first choice; or -

Q. Another P-6 in a sense?

A. Yeah, only this facility would take inpatients who are involuntary. The only other - the places that take involuntary are the State hospitals, Togus and some at Jackson Brooke, although it's a small percentage of their business.

Q. All right. Now, were they in touch with other hospitals? Were they talking about Southern Maine Medical? Was there anything that specific or was it just kind of a fuzzy -

A. Well, there were two hospitals that were mentioned as potentials.

Q. Can you name them or is this all confidential?

A. I just - well -

Q. What I'm trying to get at is was there a plan? Is there something - you said it was stalled.

A. It was - in the fall it looked pretty good. It looked like something was going to happen fairly shortly. So, we were a lot more enthusiastic at that time. Then, I'm not sure when things went downhill.

Q. What happened? Why did it go downhill?

A. I think people said they didn't want to do it. They weren't interested. Other options were exercised in the facilities that were under consideration.

Q. Why didn't they want to do it? Did they have to go through

Certificate of Need? Was this a problem with the Maine Health Care Finance Commission?

A. Okay. I can only relay those negotiations were not - I was not at all involved in them.

Q. Was that being done through the administration?

A. Yes.

Q. So, at this point we don't know where that program is. But, you say it's critical to our getting recertification.

A. I'd say that would be a real boone, yes.

Q. All right. Let me ask an obvious question. The fact that we have lost Medicare certification, how was the difference of monies made up? Presumably that was money coming in to pay for patients under Medicare. What happens now that we don't get that $4,000 a day? Who picks that up?

A. Well, I think the Department has increased the revenues in other areas, first off.

Q. Increased revenues?

A. Yes. Primarily, I believe it's Title 19.

Q. I don't understand.

A. In other areas of - I think the Department as a whole has increased its acquiring of Title 19 revenues.

Q. From the federal government?

A. Yes. Not at AMHI, but in other ways.

Q. So you're saying that federal money that we're losing is being made up with federal money?

A. You're losing the money that you should be getting at AMHI

but there have been improvements in other areas of the Department's programs. That's my understanding. That they offset those dollars that are being lost at AMHI. And, at AMHI one of the things that has been done is - as a response to a number of things. We've had a lot of problems wiht medical illness and people being physically ill at AMHI. We also have had problems with patient to patient assaults. One of the things is you have frail elderly and medically ill people housed with people who are quite ambulatory and able to take care of themselves. We created - coexistent with the infirmary - added 20 beds, what is now known as the senior rehab unit and those 20 beds are designed to care for frail elderly and medically ill patients. To put them in a more protective - protected environment. So, I think that's one way of meeting a lot of the things that were being identified. In addition to that, if that area is certified as a SNF-ICF dual license nursing home - the infirmary and that area - that should bring in a significant revenue by itself. So, there should be a significant monetary increase when that comes on line as a nursing home.

By the way, you asked me a question about did I ask for anything - make any additional requests. Were you talking about before the special session or after?

REPRESENTATIVE MANNING - I think what I asked was back when you stated that the roof was falling in back in February and the census was going up. I think at that - I think maybe during your - going through your chronological order of events - I think that's what I was referring to. Whether or not at that time you - inaudible

phrase - knowing fully well that the previous year we had - it seems that every - that at that time of the year we always had a high increase of census and we - the previous year the administration gave you additional staff on a short-term basis. You're still getting the same increases the next year around. They seem to die down in the summer but back up. And, at that time did you ask for additional dollars?

A. In the February period?

Q. The February period.

A. Yeah.

Q. And the answer was there wasn't any money available.

A. There would not be any additional staff for AMHI.

Q. But that wasn't in the weekly report. You didn't ask anything in the weekly report because you - you wouldn't ask that because knowing fully well that would go to the Governor's office.

A. Yeah. That's not the kind of thing you would put in there because it would paint someone into a corner.

Q. It's called teamwork. I think we heard it yesterday.

A. Right. There was - it's something, though, you shouldn't - there was a discusison on September 22nd regarding Part 2 for the coming year.

Q. This coming year?

A. Yeah. So it would be for the session right now, where I did make some requests of the Department.

Q. And that was denied?

A. Yes. I'd asked for training funds, a subsidy for the

grow workshop, air conditioning, covering of exposed pipes, a person - call it, for lack of better term, standards, patient rights and environmental monitoring control as a position. Money for the budget shortfall and workers' comp, which we didn't even need to talk about because that's already covered. Then there were three other items in that package. One was a $90,000 item to I call it maximize head count. Basically it's taking positions - part-time positions and building them up to full-time positions which would not require the adding of head count. The reason being to minimize the appearance at least of asking for more staff. In addition to that, for the senior rehab program that I was describing, I had asked for about 15 positions to put that thing up and running so that it wouldn't take away from some of the other areas and it would also strengthen us in some of the areas we were weak in, particularly in the area of physical illnesses not being detected and so forth. One of the positions that was asked for was a Physician III, which is - would be a medical doctor that would primarily be assigned to that particular area. And, in addition to that, I gave her what basically amounted to almost like a position paper which outlined the - it's the concept of staff need versus workload reductions. In terms of staffing needs. And, what it is it's a memo that's designed to frame the context for discussing - for concerning staff needs. I go through and say that there's no definition - no exact definition of staffing need. A number of things play into it - admissions and so forth. I also say it's in my opinion it's

virtually impossible to try to keep pace with rising admission pressures and census by continually adding staff. It is clear that census reduction through augmenting community programs is in AMHI's best interests. Therefore, I am also pleased with the passage of the Department's emergency package, especially with the apparent receptivity of the Legislature to look at further system development during the next biennium. So that kind of anticipates additional requests. Our hospital's annual average population last year was 361 with a potential of driving the population down to 319 with the September package, and somewhere in the 275 to 300 area with the next biennium. This rapid depopulation will make a tremendous difference in what our staffing need will be. As you are aware, the Joint Commission has indicated that Bangor Mental Health Institute is significantly understaffed in many areas. If this is the case at BMHI it will be even more the case at AMHI until such time as admission and census pressures are reduced. Let me assume for the moment that the Legislature didn't pass the 6½ million dollar package and we're not interested in further population reduction through the enhancement of community resources. AMHI would be expected to be staffed for approximately 383 patients. Past JCH show cleanly be Medicare certified and provide high quality active and temporary treatment services. In order to do all these things in the way that they should be done I have prepared the number of staff that would be needed which is attached to this memo. As you can see, the number is quite substantial; the dollar cost staggering. These

potential costs, of course, need not concern us if we can successfully implement the plans already funded by the Legislature in a timely manner.

So, what I'm saying is I'm all in favor of deinstitutionalization and reducing the workload. If that doesn't occur there may be some - we want to do everything the way we're supposed to do it. But there may be a heavy impact in terms of staffing. And, I gave her some off the top of my head estimates; and they were off the top of my head estimates and they were not distributed because this was just between us. I had 206 staff to do everything just right for 383 patients. That would yield an overall staff to patient ratio of 2.35, which as a matter of fact is less than in Pineland, as I understand it, and it just seemd to me that that's not a bad benchmark and not an overinflated view of what a staff/ patient ratio might be in a contemporary hospital using contemporary standards and with all the expectations as currently coming on line.

Q. I just want to - quickly - you had indicated one of the ways we were gonna make up the money was to take a portion of the rehabilitation and make it into ICF.

A. Yes. That would increase revenues. That was one of the - most of the patients there would come from the older adult program which was currently a Medicare distinct part.

Q. And the way you did that it would shift people from one part of the hospital to another part?

A. Right.

Q. So that if that's the case, to make up for additional dollars

that we're losing because of Medicare, then other parts of the hospital are now gonna be suffering.

A. No. No. This would be - this is a good move. We did it already. I mean, we've already established that unit - November 28th.

Q. But, do we need to increase the staff to supplement those who went into that new area?

A. Well, I think it would make sense to do so. There are some inefficiencies in creating another area and that's why I asked for 15 people. Two things: one is it very much looks like a new program even though there are additional staff and it is a new program. And, it's one that makes sense and would bring in revenue and would increase the quality of care and provide a safer environment. So I just thought there was good reason to fund that. And, it was a reasonably modest request - 16 people.

EXAMINATION BY REPRESENTATIVE BOUTILIER

Q. First of all, can we gat a copy of that memo?

A. Actually, if you want, you can have everything that's in here.

Q. What's the date of that particular memo?

A. September 22.

Q. Okay. I'll come back to that in a bit. First thing, I think you reading through your Friday memos was helpful, but I'm curious as to what the real purpose of the Friday memo is if it isn't a true understanding of what some of the problems are about what the solutions should be. If you send a memo that isn't truly respective of not only what the pulse of the facility is in terms of

census and admissions, but also ways to deal with that, what's the purpose?

A. I think those Friday memos are a pretty good pulsebeat. What isn't put in a memo like that is that I'm recommending 'X' number of staff or just simply because that should go through the department and not straight to the Governor's office and then to the Department. So, what you would see in a memo is that I'm working closely with the Department on matters of resource allocation and then I would be talking to them about what the numbers might be or should be.

Q. Obviously there are other communications, either verbal -

A. Oh yes. Most - actually, paper, contrary to this book, is probably the least of the communication that goes on. I don't write a lot of memos to tell you the truth. It just may look like it because you're seeing a whole bunch of them together; but I'm not a very paper-memo-oriented person. I think that'd be quite clear. A stack of memos for the year is probably that thick.

Q. Well, the Legislature is not the best mind readers either, and if we don't have it documented it's difficult for us to understand what you need to survive let alone be certified and provide proper patient care. So if your Friday memos to the Commissioner and to the Governor do not appropriately cite things that need to be done in reaction to what is census and admissions, but you do it through verbal communication, how strong is the verbal communi-

cation? It seems to me when you went through the Friday memos something that struck me was at the end of the Friday memo always seemed to be well, we're coping and the staff is doing well and we set up this plan and we're implementing it. So, if the Commissioner wanted to - didn't have any other communication, had no verbal communication whatsoever and went strictly by the Friday memo, he or she, whoever the Commissioner was - in this case Susan Parker - could say at the end well, he seems to be coping and I won't step in at this point because things seem to be happening over there and they're trying to deal with the problem.

A. I think what you saw was the January meeting of the Governing Body and then the special meeting to deal with staffing issues in February - on February 11th - where those issues were communicated directly and verbally.

Q. Did you also have - and those primarily had to do with the fact that Medicare was gonna be close to being decertified if not imminent, correct? As well as trying to deal with the overall long-term problem of high admissions, high census.

A. Well, Medicare is in the background, of course, but this was - the primary focus of the January and February communications were crowding and staffing and patient care issues.

Q. Obviously, though, the Medicare funding issue is important.

A. Yes. Yes.

Q. We received copies of some letters that you received. One was dated March 23rd which talked about HICFA's feeling about

the Medicare funding and that they were very concerned about the medical records requirement, the special staffing requirement and we're going to decertify. And that was prior to them receiving a plan of correction. I guess I was more interested in the second letter as far as after we received a copy of it; but you basically inferred it was more of a formality than anything that was - truly could be cited as being HICFA's approval of a correction plan. It was more of just them not wanting to do the wrong thing and giving you the shot; but not truly corresponding to an excellent corrective plan. Did I understand you correctly?

A. Yes. I think - I'm just trying to put myself in their position. I think the last thing they want to do is be accused of being unfair because I don't think they felt they needed to be.

Q. Obviously, there was a meeting on April 12th in which you gave the Medicare narrative concerning some of the problems as you saw them. And in the second paragraph you cited that there were growing pains and it was clear that the Medicare certification - we're convinced that many state facilities such as ours are having to make difficult adjustments required of continued participation in the Medicare program, as Medicare standards need to be more and more rigidly interpreted. Difficulties in the certification process are common and to be expected as multidisciplinary treatment teams orient the psychiatric facilities and attempt to integrate themselves in the more traditional medical model. So, it's obvious to me, and at least in written documentation, you

probably knew and you admitted you knew prior to this, but at least in written documentation you stated clearly there was a difference in interpretation and that was going to affect your facility. This memo - did you discuss and present this memo to the Commissioner and to other sources?

A. Yeah. We had a meeting prior to going down to Boston.

Q. What date was that?

A. To prepare for the meeting. What day was the meeting? I think it was the day before. Let's see - one o'clock, Monday, April 11th, I believe. Yeah, with Dr. Rohm. Dr. Rohm, myself, Linda Crawford, Susan Parker.

Q. This says the meeting agenda for April 12th.

A. Yeah. That was in Boston.

Q. So, April 12th was in Boston.

A. Yeah.

Q. And the day prior to you having this cover letter and the narrative printed you had probably had some copies and you handed it out at a meeting on the 11th.

A. I'm not sure if I handed it out then or if it was already over there.

Q. You discussed the Medicare narrative.

A. Yeah, and we discussed what we were going to say.

Q. One of the confusions I had in the testimony we've heard so far is that there was a feeling that although decertification might be imminent, there was a lack of understanding as to why decertification was imminent and that the Commissioner felt although

it was possible they would be decertified, that when it happened she was not aware as to why they were gonna be decertified and she later learned that it wasn't because stndards had changed but because the standards were interpreted differently. Now in this memo you're saying very early on, actually the day before even in written communications, that standards were interpreted differently and that you were gonna have a tough time transitioning to that.

A. When you look - the actual standards I don't think have changed very much at all over the years. The interpretation yes has changed. The aggressiveness of the survey and maybe even to some extent the purposes of the survey has changed. It used to be more of a consultation and they would never really pull your chain. They'd just keep telling you that this is wrong and this is wrong and, you know, keep either improving or not improving or whatever the case may be and they'd keep taking a consultive role. With HICFA doing the surveys, and they've always supervised the surveys, with them doing it there's much more of a stick and carrot approach. In other words, if you don't meet the standards they're going to put you into the decertification mode, okay. That doesn't mean they're going to decertify you right away. They'll treat someone else just like they would treat us. State hospitals generally have had some transition and growing pain problems and because of the way they provide care and because of the role of the physician being one of a head of a large group and working more as a consultant amongst a treatment team and not having as much direct treatment involvement.

Q. Above and beyond your written communications - you obviously were there in a private meeting to discuss the next day's meeting with HICFA - did you at that time say they're really being much more strict in the interpretation of the regulations and these are the things we have to do and name specific things?

A. I think we just discussed the - how we would present ourselves and familiarize ourself with a plan of correction to give it our best shot. This was not the time we would argue about anything other than getting the survey.

Q. So pretty much you left it to the Commissioner to make judgement calls on monies and types of priorities and you, although you had your personal feelings about what the staffing level should be and what the reduction of workload should be and what things should be done to do that, you presented them - you had always had to come back with contingency plans when faced with the reality that that's not gonna happen.

A. Well, any plan of correction we did would be within the - let's say the guidelines that would be established in terms of resources.

Q. Again, I get back to the Legislature can't read minds. I think in the special session the temperment of the Legislature was they really wanted to deal with the problem and it's tough when we're given a scenario that this is how to deal with the problem and then you do that. I think I'm echoing what the Senator said before that the Legislature's feeling was that was going to deal with the problem. It's obvious that by the time it got to the

Legislature, it had already been changed many times. The changes were not appropriate. And, you stated that you didn't feel that you thought the chances were 50/50 or 60/40 that those changes would be appropriate, correct? In terms of the program that you mentioned, you talked about community based services and supplementing those and dealing with it. I brought up something the other day in terms of the current census. Not in terms of admissions. In terms of the current census, if we fund properly community based services, and that's not in the hypothetical saying there's gonna be two admission units. Under the current situation, how much could you reduce the current census in terms of people currently in the census if you had properly funded community based services?

A. Well, given the - given unlimited resources you can take anybody out of an institution.

Q. Absent of setting up a new acute care setting.

A. What I'm saying is you can put services - you can surround a person with all the services they can get in a hospital. It might cost you five times the cost of a hospital stay to put them together. So, you can take virtually anybody out of an inpatient care; but if you put a limit on, let's say, at equal or better quality of life care and equal or better costs, I think you could take a substantial number out.

Q. What's substantial to you?

A. Oh, I would imagine - I think we were projecting bringing the census down to 300 or 275 and I think that's not an unreasonable estimate.

Q. That's at the most a hundred people.

A. Yeah. And I think - you can - it's just -

Q. That's projecting now. In the current census you think there's a hundred that could be served in the community for equal or better -

A. Now, in the community, no. I'm saying it's a long development process. There'd be a heck of a lot of time and effort that would have to go into getting a hundred people out. The inpatient adding to it would be fast; but to get - throw the inpatient out, it would take substantial time and effort. It would be a couple of years process before you could do anything like that.

Q. Also, I was very curious when you mentioned the memo you talked about some of the proposals that you had mentioned at the end. And, I was interested here you mentioned training as one of those. Something I brought up yesterday was the fact that the contract had not been extended for trainings at St. Joseph's and UMA. Are those two programs the monies that you were requesting in that training portion that you made in that memo?

A. No. That was a separate. What we were trying to do there was get a decision made on whether that nursing venture would come out of central office funding. We were going to do it out of our funds if they wouldn't do it out of theirs. The big hang-up there was basically getting an answer.

Q. You are aware of the St. Joseph's and UMA programs.

A. Yes. It's three-level funding. One is the individual, it's 5,000; one is the department which was 5,000; and there was another fundraising effort.

Q. Usually the student themselves.

A. Yeah.

Q. It would be the student, the State and AMHI - it would pick up 1/3, 1/3 and 1/3.

A. Well, a fundraiser - an independent fundraiser, the student and the Department were the three.

Q. The independent fundraiser being monies coming to AMHI to supplement the education of those people.

A. Yes.

Q. Do you feel confident that those programs in the past have been successful?

A. Well, they've been very well received and I think that's the kind of thing that should be encouraged. And, the flap, if you will, about this one was just getting a decision as to whether this was gonna be one of the Department's priorities for what was HRD funds or not.

Q. What was your recommendation?

A. My recommendation was that they pay for it, of course; because - also, because when that program went into existence it was designed to be a long-term commitment and there was the expectation there be a long-term commitment with the school. This wasn't gonna be a shot in the dark kind of thing.

Q. It's my understanding that the St. Joseph's program had ten slots that would be used. Every time there was an individual utilized one of those slots, 100% of them maintained their status at AMHI and eventually stayed even after the training occurred.

And, it also involved continuing ed courses and service training in the Augusta facility, correct?

A. Yeah.

Q. And that the UMA program was for mental health workers and for LPNs who wanted to increase their educational basis which again would assist AMHI and that 100% of the people involved in that program maintained their status at AMHI.

A. Yeah. There's a real advantage to home-grown - growing your own nurses from the facility out of the mental health worker/LPN ranks because you're finding people there who know AMHI and basically like to work there and I think there's a good chance of maintaining -

Q. I would reiterate that that's true of every health care facility. That health care facilities that participate in training and tuition reimbursement are successfully maintaining those nurses who participate. Is it also true that a substantial portion maybe 35, 40 nurses or mental health workers currently at AMHI that would have been in that program but are not able to do that because the contract has been defunded?

A. Vera did take a poll and that sound right. I can't give you a precise first-hand knowledge estimate. I think that's close.

Q. If your requests for staff - you mention 206 - and I tried to look into how many direct care staff - of that 206 are you including also housekeeping, dietary, physicians and so forth - of that 206, would you approximate that 100 are direct care staff that you would need in addition to what you have now, above and beyond the special session?

A. Yeah, um-hm.

Q. So, -

A. Mental health workers. Now that one would roughly give you a mental health worker staff to patient ratio overall of 1 to 4 - one staff for four patients on days, one for four on evenings and one for eight on nights. And that would be a 1 to 1 ratio. So, you got one patient, you'd have one mental health worker. That's how that works out in terms of staffing.

Q. Obviously, that's a - absent of any tremendous increases in community services and lack at least for now in any long-range very expensive and developing process for the community services you had mentioned when I first asked you the question, a hundred direct care staff is a huge increase. That's obviously substantially less than, say, 18 part-time equivalents that then become full-time equivalents or 64.5 that then becomes 33 full-time.

A. What that assumes is a single - what that kind of rhetoric or conversation - or the implication is you're gonna have a single level of care across the program and that there wouldn't be a difference - substantial difference between a Medicare unit and any other unit. So, basically, it's equivalent care.

Q. My last group of questions, and maybe I'll come back later after some other comments you make, but I'm concerned about the JCAHO accreditation. Have you participated in any meetings prior to your leave which put in your hands the feeling that that accreditation was in limbo?

A. My best judgement is that our accreditation would be granted with a substantial number of contingencies and I would expect many of the same contingencies which were cited at Bangor's facility. The one thing that did concern us is they were very concerned about the pipes and they were - one of the surveyors did mention - Dr. - I can't think of his name - anyway, one of the physicians - surveyors - did mention a potential for a tentative nonaccreditation decision. I think that's probably not in the style of JCH. I think what would happen is they would cite a number of contingencies and give us accreditation. But, the number of contingencies might be fairly substantial, and to meet all the contingencies, I think, you're looking at some resource areas that were cited. There may be some significant staff needs as a result of -

Q. Obviously you're dealing with the problem of exposed pipes - that's something that doesn't necessarily require emergency legislation or emergency funding from the legislature. Sometimes you can find funds in the Department and just allocate them temporarily and deal with that problem in the short term. In terms of one of JCHO's more strict requirements in the medical model is 24-hour coverage by RNs, correct?

A. Right. Yes.

Q. What is your estimation of how many RN's you would need in addition to what you have now to satisfy that crucial requirement in their new stricter interpretation of the regulation?

A. It's - I believe it's 50.

Q. So you would need 50 additional RNs in order to meet a very important criteria that JCAHO is now -

A. You might be able to massage that number downward slightly; but it's somewhere in that range - between 30 and 50. It would fall in that area.

Q. Wouldn't you say that if you are - and when did this feeling by JCAHO, though they've never given you formal determination as to date?

A. December 1st.

Q. So as of December 1st you could say you pretty much knew that you - let alone all the other criteria that they might give you - that you at least needed between 30 and 50 RNs to meet a very important quality of care issue that JCAHO was asking for, correct?

A. Yeah. The nurse - the HAP-nurse surveyor suggested we needed about twice as many nurses as we have. I think in looking at it it turned out to be somewhat less than that using a combination of full-time and 24-hour personnel. One of the things that we have going for nurses at AMHI is the number of weekends that they have to work. But that causes some drains and some needs on weekends. So, if you give people one in four or one in six off, then you have holes to fill on the weekend. So, when I say it's a combination of needs between full-time and part-time, some of those part-time are 24-hour positions are needed to backfill on weekends. But, 50 is not a bad guess. I don't know how we'd recruit 50 nurses and how long it would take to do that quite frankly.

Q. I asked the question the other day as to what seemed to be the length of time to recruit one RN and put them in that position. I was told between 30 days and six months, although they have had good results in filling some positions that were funded during the special session. Would you agree with that assessment?

A. Yeah. We've had fair results. I think it would take a while, but you might get there. There's different levels of confidence on that point. I'm a little bit pessimistic. I think Vera Gillis might be a little more optimistic in terms of filling them. I think enhancing the environment and the staffing levels would make people more willing to work at AMHI, 'cause one of the - in terms of turnover and exit conferences and word of mouth that goes through there, AMHI's not necessarily an easy place for people to work.

Q. I hate to say this 'cause I probably should know this exact date, but what's the exact date in January that you left?

A. The 11th.

Q. Between December 1st and January 11th did you approach the Commissioner and say our JCAHO accreditation might be in jeopardy and there are several things that we specifically have to do including but not exclusive to hiring a significant complement of RNs?

A. Yeah. December - I sent a memo on December 9 and then we talked about it another time somewhere around that time.

Q. Did you send it to anybody else besides the Commission?

A. I don't believe so.

Q. Did you receive a response by Commissioner?

A. We met and discussed it.

Q. And what was the response by the Commission and consequently what was your recommendation?

A. Well, basically it was what was the impact of the Joint Commission on our Medicare readiness and I did talk about what the HAP nurse had said in our - actually it was in the pre-exit conference. The Commissioner's opinion was that we didn't manage the Joint Commission's survey process properly and she mentioned the New York - where they had done this - and that we should have gotten a different kind of nurse surveyor had we been on the ball. And, I guess the assumption would be that that recommendation then wouldn't have been made.

Q. That comment says to me that there was more concern about the relationship between JCAHO to your Medicare certification rather than something that may be even more substantial and that is if you lose that accreditation you lose your Medicaid funding as well.

A. Yeah. Basically, what I was saying is that the short-term threat is Medicare. However, long-term the Joint Commission is a bigger threat in fact because if you look at Joint Commission, one of the things they want to ensure that there's a single level of care across all units and they're looking at the same kinds of things that Medicare is looking at. They're looking for to see

in the record the physician involvement on a regular basis; and, a lot of quality assurance on the part of medical staff and other departments. So, in - it was my opinion that while Medicare is the short-term threat, Joint Commission is a long-term threat although you'll have more time to correct the Joint Commission and Medicare you won't have any time to correct.

Q. But if you were - when in JCAHO - when do you anticipate them in rough terms. You can never say the exact date, I know.

A. Ballpark guess is that they would tell us that congratulations you get accreditation for three years provided you meet - correct the following contingencies. I would expect a substantial packet of material in a substantial number of areas and they would then put a survey team back - let's see - approximately nine months from the date of the survey which would be probably October - somewhere around October - maybe in the summer.

Q. So, October of this year you would anticipate getting some kind of notice in that regard.

A. Between six months and nine months.

Q. So, if the Legislature wants to read minds again, because there's no increase in this budget for those types of changes, we could expect to come back in for a special session to deal with an emergency money allocation for additional RNs, at least 40, and also deal with all the contingencies that they are probably gonna mention in October, but we already know about as of December 1st, correct?

A. You may get different opinions on that, but yes I would say

that's true.

Q. Thank you.

SENATOR GAUVREAU - Thank you. Just a note to the Committee. I was reminded by staff we have to vacate this room at noon because the Speaker of the House has scheduled a press conference at 12:15, so we will only have ten more minutes today to proceed with the hearing. So, we will invite Mr. Daumueller to return tomorrow morning for further testimony. I believe the order of questions is Representative Pederson, Representative Burke and Representative Dellert.

EXAMINATION BY REPRESENTATIVE PEDERSON

Q. Mr. Daumueller, the Governor was asking you to be able to return some money to the State Government. I believe one of the big items - one of the big ticket items was the land sale at BMHI and you also had a piece of land here and we had a building down in Portland. I think probably that was the big part of that amount of money that was gonna be involved.

A. Actually, I think it probably wasn't the biggest - well, there was a substantial portion, but it was one that got a lot of attention.

Q. Right. The other question - I want to make this as quickly as possible - is has the overtime changed any from over the past year? In other words, is the overtime higher now than it was in the summer and are we still demanding that the staff stay over when we can't find a replacement we demand them to continue to work?

A. Overtime is high. If you go back in time - this is total overtime - it was 1,700 hours in '85, 3,900 hours in '86, '87 3,300 hours,

and '88 5,700 hours.

Q. So, presently we probably have the same level of overtime.

A. Higher. Higher.

Q. Okay.

A. I think one of the - clearly one of the things that we're doing is making sure that we pay attention to needs that are identified. If a physician says I need a COR or a one-to-one, we're not arguing about it. We're providing it.

Q. So we're still putting a lot of stress on the staff.

A. Yes.

Q. The other thing that I was a little bit concerned about and wasn't clear was the capacity of the hospital. We have a design capacity of 250 and we have an optimal capacity of 350? How does this work. I want a little clarification there.

A. Well, I always feel like a babbling idiot when someone says how many beds do you have because we aren't licensed for any certain number of beds; and it's a matter of how many people you have and how many you want to call it on any given particular day. When you - if you say how many beds we have set up and staffed, you're - I think it's 367, but are we really staffed for 367 I don't think so. I think we're staffed for more like 300. So, I've always had - like I say, I've always felt like a babbling idiot when trying to explain to people how many beds we're set up for because I don't think - we've never been set up to handle the patients the way we wanted to handle them and provide the treatment that we felt we ought to provide, given the numbers that we've had.

Q. Would you say that we'll have a very difficult time solving the revolving door type of admissions - out and in again - unless we have community services?

A. Yes. That's critical. The linkage - the discharge planning from the hospital end, a good solid discharge planning on the hospital end and linkage with case management. So, I'm very much in support of what you've done for case management and as things go that case management will - as a person comes in - they'll have a case manager and as they exit they'll have a case manager, so more and more community input will be into the treatment planning. And, discharge planning.

Q. My last question is do you think we've utilized the advocates - the hospital advocates, the Maine advocates, the family advocates? Do you think we've utilized them in the role - in the problems that we've had?

A. Well, frankly I think probably the advocates are one of the reasons we're here today - and not in a negative sense - in a positive sense I think. They've been very faithful in pointing out what they feel are deficiencies. They, in many respects, drive me crazy but they're doing their job and they were pointing out all our flaws and our dirty laundry and that's their job. They were doing their job.

Q. Thank you.

SENATOR GAUVREAU - Unfortunately, we're going to have to break unless your question is very, very short. We have to vacate the premises.

REPRESENTATIVE BURKE - I'll try and keep my first question short. The next time we meet I can start again.

EXAMINATION BY REPRESENTATIVE BURKE

Q. Basically, you listed a number of times when you indicated to Commissioner Parker that there were serious deficiencies in staff situations. When did you realize you had lost or were in danger of losing Medicare assignment completely? What resources did - were you told that you had in order to pull yourself into compliance?

A. We could contract for psychiatry. We had a person in mind who we did contract with. Other than that we pretty much had to do with what we had.

Q. Who told you that?

A. That would be the Commissioner.

Q. That was right from Commissioner Parker that you could not hire more staff at that point in time - that you could contract with one psychiatrist?

A. Yes.

Q. Okay. So, that's basically at this point what I'd like to clear up. Commissioner Parker had a hands-on understanding of exactly what was happening and told you in so many words, or directly - not just in so many words - directly that you could not hire more staff. That that was not a resource that was open to you.

A. We also looked at some other options of would it be possible to maybe pull from another facility for a short time, too. I won't say that one contract was the only option that was ever discussed.

Q. Okay.

A. We were scrambling for other options in terms of contracting for psychiatry.

Q. Okay. I'll pick up again next time. Thanks.

SENATOR GAUVREAU - We now have to break. The Committee will reconvene in this room tomorrow morning at nine A.M. to continue the hearing and presentation of Mr. Daumueller. Thank you.

HEARING CONCLUDED AT 12:00 P.M.