Health and Human Services Committee
Interim Committee Meeting
October 25th, 2023, 10:00am

AGENDA

1. Committee introductions

2. Public Guardianship Presentations and Discussion

    - Probate Courts, Judge Mitchell
    - Disability Rights Maine
    - Office of the Attorney General
    - Office of the Chief Medical Examiner
    - Office of Aging and Disability Services, DHHS

3. General Assistance – Committee discussion

Broome, Anna

From: Senft, Samuel
Sent: Thursday, October 12, 2023 6:18 PM
To: Judge Libby Mitchell
Cc: Broome, Anna
Subject: Re: questions from the HHS committee

Hi Judge Mitchell

Apologies- I received a few more questions:

- When a hospitalized patient cannot be discharged to a nursing home or to another appropriate level of care without the appointment of a guardian, are the Probate Courts acting under the Emergency Guardianship statute (18-C MRSA §5-312) when possible within 24-48 hours of the petition?
- What is the average timeframe for the Courts to respond to a request for emergency guardianship?
- What is the average timeframe for the Courts to appoint a private guardian? A public guardian?
- How can the Clerks better assist petitioners with the filing of necessary documents, especially when a request for emergency guardianship may be appropriate?

Thank you again for your help

Sam

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From: Senft, Samuel <Samuel.Senft@legislature.maine.gov>
Sent: Thursday, October 12, 2023 9:50:45 AM
To: Judge Libby Mitchell <judgelibbymitchell@gmail.com>
Cc: Broome, Anna <Anna.Broome@legislature.maine.gov>
Subject: questions from the HHS committee

Good morning Judge Mitchell

We have gathered questions from the HHS committee members for you and your colleagues ahead of the 10/25 committee meeting. I have included those questions below. I recognize that some of these questions may be beyond your purview. Please just let me know if that is the case.

1. Are people that are assigned as public guardians required to be certified by the Probate Court, or are they assigned by DHHS?
2. Do case managers also serve as guardians?
3. Besides, relatives, how often are community members asked to serve as private guardians?
4. Could we have access to the reports written when deaths of people under public guardianship happen?
5. Our overall goal is to have standardized, regular, more transparent oversight of adult guardianship cases involving both the state of Maine as well private individual adult guardians.

    a. What steps can be done uniformly by the probate courts to help make this happen?
    b. What steps should be taken by DHHS and, or other Executive Branch agencies to help make this happen?

c. What legislation should the Legislature consider that wd help make this happen?
d. What is needed to improve our oversight and transparency?

6. The 2019 probate code changed the standard for awarding guardianship requiring a finding that the individual's needs cannot be met through less restrictive alternatives. (Basis for appointment: https://legislature.maine.gov/statutes/18-C/title18-Csec5-301.html)

a. Since the new law went into effect, how many guardianship petitions have been denied on the basis that a person's needs could be met through supported decision-making or other less restrictive alternatives?
b. Which less restrictive alternatives are considered by the court before awarding guardianship?
c. If a guardianship petition does not contain information about supported decision-making or other guardianship alternatives, what does the court do?
d. How does the court consider whether less restrictive alternatives such as supported decision-making can meet the person's needs rather than guardianship?
e. Since the 2019 law went into effect, how many guardianships have been granted? How many of them were full?
f. When a petition for guardianship is considered, how frequently is the individual potentially subject to guardianship present at the hearing?
g. How often is the individual potentially subject to guardianship represented by an attorney? How does the court determine whether it is necessary to appoint an attorney for an individual for whom guardianship is sought?
h. Since the probate code changes, how many requests for terminations have been received? Were these requests made formally through a petition, or informally, with the individual subject to guardianship contacting the court? How does the court handle informal requests made by individuals to terminate their guardianship? When a person asks the court to terminate their guardianship, does the court automatically appoint an attorney in every case?

Thank you so very much for your time.

Sam

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§5-301. Basis for appointment of guardian for adult

1. Appointment. On petition and after notice and hearing, the court may:

A. Appoint a guardian for a respondent who is an adult if it finds by clear and convincing evidence that the respondent lacks the ability to meet essential requirements for physical health, safety or self-care because:

(1) The respondent is unable to receive and evaluate information or make or communicate decisions, even with appropriate supportive services, technological assistance or supported decision making that provides adequate protection for the respondent;

(2) The respondent's identified needs cannot be met by a protective arrangement instead of guardianship or other less restrictive alternatives that provide adequate protection for the respondent; and

(3) The appointment is necessary or desirable as a means of enabling the respondent to meet essential requirements for physical health, safety or self-care; or [PL 2019, c. 417, Pt. A, §21 (AMD).]

B. With appropriate findings, and additional notice to persons the court determines are entitled to notice, treat the petition as one for a conservatorship under Part 4 or a protective arrangement instead of guardianship or conservatorship under Part 5, enter any other appropriate order or dismiss the proceeding. [PL 2019, c. 417, Pt. A, §21 (AMD).]

In making a determination on a petition under this section, including whether supported decision making or other less restrictive alternatives are appropriate, the court may consider the following factors: any proposed vetting of the person or persons chosen to provide support in decision making; reports to the court by an interested party or parties regarding the effectiveness of an existing supported decision-making arrangement; or any other information the court determines necessary or appropriate to determine whether supportive services, technological assistance, supported decision making, protective arrangements or less restrictive arrangements will provide adequate protection for the respondent.
[PL 2019, c. 417, Pt. A, §21 (AMD).]

2. Powers. The court shall grant to a guardian appointed under subsection 1 only those powers necessitated by the limitations and demonstrated needs of the respondent and enter orders that will encourage the development of the respondent's maximum self-determination and independence. The court may not establish a full guardianship if a limited guardianship, protective arrangement instead of guardianship or other less restrictive alternatives would meet the needs of and provide adequate protection for the respondent.
[PL 2019, c. 417, Pt. A, §21 (AMD).]

SECTION HISTORY

PL 2017, c. 402, Pt. A, §2 (NEW). PL 2017, c. 402, Pt. F, §1 (AFF). PL 2019, c. 417, Pt. A, §21 (AMD). PL 2019, c. 417, Pt. B, §14 (AFF).

§5-317. Guardian's report; monitoring of guardianship

1. Report; contents. A guardian for an adult at least annually shall submit to the court a report in a record regarding the condition of the adult and accounting for money and other property in the guardian's possession or subject to the guardian's control. Each report must state or contain:

A. The mental, physical and social condition of the adult; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

B. The living arrangements of the adult during the reporting period; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

C. A summary of the supported decision making, technological assistance, medical services, educational and vocational services and other supports and services provided to the adult and the guardian's opinion as to the adequacy of the adult's care; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

D. A summary of the guardian's visits with the adult, including the dates of the visits and the visits of agents designated by the guardian to visit on behalf of the guardian; [PL 2019, c. 417, Pt. A, §48 (AMD).]

E. Action taken on behalf of the adult; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

F. The extent to which the adult has participated in decision making; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

G. If the adult is living in a mental health facility or living in a facility that provides the adult with health care or other personal services, whether the guardian considers the facility's current plan for support, care, treatment or habilitation consistent with the adult's preferences, values, prior directions and best interest; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

H. Anything of more than de minimis value that the guardian, any individual who resides with the guardian or the spouse, domestic partner, parent, child or sibling of the guardian has received from an individual providing goods or services to the adult; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

I. If the guardian has delegated powers to an agent, the powers delegated and the reason for the delegation; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

J. Any business relation the guardian has with a person the guardian has paid or a person that has benefited from the property of the adult; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

K. A copy of the guardian's most recent plan and a statement whether the guardian has deviated from the plan and, if so, how the guardian has deviated and why; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

L. Plans for future care and support; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

M. A recommendation as to the need for continued guardianship and any recommended change in the scope of the guardianship; [PL 2019, c. 417, Pt. A, §49 (AMD).]

N. Whether any coguardian or successor guardian appointed to serve when a designated future event occurs is alive and able to serve; and [PL 2019, c. 417, Pt. A, §49 (AMD).]

O. The fees that are paid to the guardian for the year or still outstanding. [PL 2019, c. 417, Pt. A, §50 (NEW).]

[PL 2019, c. 417, Pt. A, §§48-50 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

2. Appointment of visitor. The court may appoint a visitor to review a report submitted under this section, interview the guardian or adult subject to guardianship or investigate any other matter involving the guardianship.
[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

3. Notice of filing of report; copy. Notice of the filing of a guardian's report under this section, together with a copy of the report, must be given to the adult subject to guardianship, all persons entitled to notice under section 5-310, subsection 5 or a subsequent order and any other person as the court determines. The notice and report must be given not later than 14 days after the filing of the report.
[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

4. System to monitor reports. The court shall establish a system for monitoring reports submitted under this section and review each report at least annually to determine whether:

A. The report provides sufficient information to establish the guardian has complied with the guardian's duties; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

B. The guardianship should continue; and [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

C. The guardian's requested fees, if any, should be approved. [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

5. Noncompliance; modification or termination. If the court determines there is reason to believe a guardian for an adult has not complied with the guardian's duties or the guardianship should be modified or terminated, the court:

A. Shall notify the adult, the guardian and all persons entitled to notice under section 5-310, subsection 5 or a subsequent order; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

B. May require additional information from the guardian; [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

C. May appoint a visitor to interview the adult or guardian or investigate any matter involving the guardianship; and [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

D. May consider removing the guardian under section 5-318 or terminating the guardianship or changing the powers of the guardian or other terms of the guardianship under section 5-319. [PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

6. Fees not reasonable. If the court has reason to believe that fees requested by a guardian for an adult are not reasonable, the court shall hold a hearing to determine whether to adjust the requested fees.
[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

7. Approval of report. A guardian for an adult may petition the court for approval of a report filed under this section. The court after review may approve the report. If, after notice and hearing, the court approves the report, there is a rebuttable presumption the report is accurate as to a matter adequately disclosed in the report.
[PL 2017, c. 402, Pt. A, §2 (NEW); PL 2019, c. 417, Pt. B, §14 (AFF).]

8. Application to existing guardianship. For guardianships established prior to September 1, 2019, in which there is no existing order to file an annual report, the guardian is not subject to the requirements for filing an annual report until so ordered by the court.

[PL 2019, c. 417, Pt. A, §51 (NEW).]

SECTION HISTORY

PL 2017, c. 402, Pt. A, §2 (NEW). PL 2017, c. 402, Pt. F, §1 (AFF). PL 2019, c. 417, Pt. A, §§48-51 (AMD). PL 2019, c. 417, Pt. B, §14 (AFF).

SECTION 15: ADULT PROTECTIVE SERVICES: GUARDIANSHIP/CONSERVATORSHIP

15.01 PUBLIC GUARDIANSHIP AND CONSERVATORSHIP: INTRODUCTION

(A) **Authorization.** DHHS OES is authorized by state law to act as public guardian and/or conservator for adults who are adjudicated incapacitated for reasons other than mental retardation. The authority of the public appointment rests with the Commissioner of DHHS who may delegate this authority to qualified Department staff. Adults with mental retardation or autism in need of guardianship or conservatorship will be referred to DHHS, Office of Adult with Physical and Cognitive Disabilities.

(B) **Intent.** Public guardianship appointments are made to provide continuing care and supervision of incapacitated adults, and public conservatorship appointments are made to protect, preserve, manage and apply estates of incapacitated adults, when it has been determined that no suitable private guardian or conservator is available and willing to assume responsibilities for such service.

15.02 NOMINATIONS AND REFERRALS

(A) **Capacity.** All adults are presumed to have full capacity, unless adjudicated otherwise by a court of law, in accordance with the Probate Code.

(B) **Nominations.** Persons identified by 18-A M.R.S.A. §5-604 may file a petition nominating DHHS to serve as guardian or conservator. The Department shall file a written acceptance or rejection of a nomination with the appropriate Probate court within thirty days. If the Department requires more time in order to respond, an extension must be requested from the court.

(C) **Referrals.** A request for a guardianship or conservatorship study is a referral. Referrals will be received in accordance with OES Policy Manual Section 11.03. On accepted referrals, an assessment of capacity and the need for guardianship/conservatorship will be completed in a timely fashion.

15.03 PRIVATE GUARDIANSHIP AND CONSERVATORSHIP STUDY

(A) **Investigation/Obtaining a Legal Appointment.** The caseworker will complete an investigation, in accordance with OES Policy Manual Section 12.01, to determine the need for guardianship, conservatorship and/or other protective arrangement and initiate the procedure for obtaining a legal appointment, when necessary. The caseworker will also determine if a temporary private appointment is needed.

(B) **Petition.** In order to ensure the least restrictive legal appointment of an allegedly incapacitated adult, DHHS may either:

(1) Recommend that the interested party independently seek a private appointment; or

(2) Petition the court for appointment of a suitable private guardian and/or conservator. The PPA may approve payment for the costs of an appointment in accordance with OES Procedure Section 15.03.

15.04 PETITION AND COURT PLAN

(A) Petition.

(1) The PPA, or casework supervisor after consultation with a PPA, shall review all documentation of the need for an appointment and required court forms before deciding whether to authorize a petition.

(2) A completed certificate of incapacitation (PP-505) or its equivalent (physician's or psychologist's report) will be obtained from a licensed physician or clinical psychologist prior to petitioning. If OES' findings are that the client is incapacitated, and the client refuses to undergo an examination by a physician or psychologist, DHHS may petition the court for an appointment but must also file a motion for a court-ordered evaluation.

(3) A petition for public appointment shall not be initiated under the following circumstances:

(a) Investigation findings do not support the need for guardianship or conservatorship;

(b) There is no supporting documentation of incapacitation after medical, psychological, or psychiatric exams or consultation have been completed;

(c) There is clear documentation as to incapacitation, but a suitable private individual is willing and able to serve in a private legal appointment; or

(d) An appointment is not necessary or desirable as a means of providing for the continuing care and supervision of the adult.

(B) Court Plan.

(1) Court plans will maximize self-reliance and independence to meet the needs of the allegedly incapacitated adult.

(2) Annual review and update of the court plan for every person in public guardianship and/or conservatorship shall be completed by the caseworker, reviewed by the casework supervisor, approved by the PPA, and filed with the appropriate court.

15.05 TEMPORARY PUBLIC APPOINTMENTS

(A) **Temporary Guardianships/Conservatorships/Other temporary Orders**. When all available less restrictive measures have been explored, the Department may seek temporary guardianship/conservatorship and/or other temporary orders pending a full hearing under the following conditions:

(1) In order to prevent serious, immediate and irreparable harm to the health of the allegedly incapacitated adult in situations that cannot be addressed by 17-A M.R.S.A. §106, this statute provides a licensed physician, or a person acting under his direction, may use force under certain circumstances in administering treatment when no one competent to consent can be consulted; or

(2) In order to prevent serious, immediate and irreparable harm to the financial interests of the allegedly incapacitated adult; or

(3) If an appointed guardian/conservator is not effectively performing his/her duties and the welfare of the incapacitated adult requires immediate action or if an appointed guardian/conservator is deceased; or

(4) DHHS may request that the public guardian's temporary powers include Do Not Resuscitate, Do Not Hospitalize and Comfort Measures Only authority, and/or the ability to authorize psychotropic medications.

The authority sought by DHHS under the temporary appointment will be limited to those powers necessary to address the emergency.

15.07 ESTATE MANAGEMENT

(A) **Estate Management Fees and other Administrative Expenses.**

(1) DHHS may recommend to the court that a management fee be assessed on the estate of a protected person. Court approval is necessary before payment can be authorized.

(2) The PPA must approve the use of the ward's/protected person's personal funds to pay for necessary legal expenses, ensuring that personal funds shall not be depleted by these payments.

(3) DHHS may file a Claim Against Estate on deceased estates in accordance with 18-A M.R.S.A., §5-612 and 18-A M.R.S.A., §3-801 *et seq*.

(B) **Retention and Disposition of Assets.**

(1) The PPA is responsible to ensure that assets and obligations of the ward/protected person are identified; and that assets are secured and used to the benefit of the client. The physical location of the ward/protected person does not alter the responsibility to protect the estate.

(2) Upon receipt or discovery of cash, checks, or savings, OES district staff will authorize Regional Operations account associates to immediately establish a DHHS account.

(3) The caseworker will complete a budget plan as soon as possible and within three months of the court appointment. The budget plan will identify income, assets and expenses.

(4) Case reassessments shall include review of and necessary revisions to budget plans.

(5) The caseworker, in consultation with the casework supervisor, will recommend a decision regarding the sale or disposition of assets. The decision must have PPA approval before action is taken.

(6) Designated OES staff in central office are responsible for carrying out or coordinating the sale or disposition of assets. When the sale of real property is proposed, the property must be appraised by an independent fee appraiser or receive a market analysis by a realtor. An appraisal or market analysis may also be required for the purposes of tax or asset valuation. Whenever possible, DHHS will inform and consult the ward/protected person about any plan to sell or dispose of assets. Sale or disposition of assets will be completed in accordance with procedure.

(7) Sale of any property to an employee of DHHS or any person who has an interest shall comply with 18-A M.R.S.A. §5-422, and 5 M.R.S.A. §18.

(8) AAG approval is necessary before obtaining any legal services in connection with the disposition of assets, except from the Department of Transportation.

(9) The public guardian and/or conservator may use funds from the ward's estate to bury the ward if no one else assumes this responsibility. In all other areas, the public guardian's and/or conservator's legal authority to dispose of assets terminates upon the death of the ward or protected person, except to the extent necessary to preserve the estate pending transfer to a Personal Representative or other person or agency authorized by law to take possession.

15.09 LEVELS OF AUTHORIZATION DELEGATED BY THE COMMISSIONER

The authority of the public guardian/conservator shall be exercised by the Commissioner or by persons duly delegated by the Commissioner to exercise such authority pursuant to 18-A M.R.S.A. §5-606 (b) & (c). Persons duly delegated by the Commissioner may include a staff of competent individuals qualified by education and/or experience. Caseworkers, casework supervisors, PPAs and designated central office staff employed by DHHS, OES are authorized to represent the DHHS in Probate Court proceedings as provided for in 4 M.R.S.A §807 and 22 M.R.S.A. §3473.

(A) **Commissioner Level Authority**. The Commissioner retains the authority to approve requests for sterilization pursuant to 34-B M.R.S.A. §7005 *et seq*., and abortions. In the absence of an advanced directive, the Commissioner retains the authority to approve withholding or withdrawal of artificially administered nutrition and hydration for a public ward. (See also Uniform Health Care Decisions Act.) In addition, the Commissioner retains the authority to delegate public guardianship responsibilities to another suitable person through a power of attorney pursuant to 18-A M.R.S.A. §5-104. In the Commissioner's absence, the Commissioner's authority will be delegated. The Commissioner's designees for the above authorizations are the Director of the OES, or if unavailable, the Deputy Commissioner for Integrated Services.

(B) **Delegated Authority**. Unless the Commissioner expressly reserves the right to make a decision in a given case, authorization to make other decisions not specified in "A" above is delegated by the Commissioner as follows:

(1) **Estate Management**. Except as otherwise provided, the Office Director and designated OES staff in central office may make decisions related to public wards/protected persons regarding estate management, including but not limited to the following:

(a) Signing sales contracts;

(b) Signing conservator's deeds and closing documents;

(c) Completing and signing legal documents related to inventories;

(d) Completing and signing legal documents related to accountings;

(e) Completing and filing tax returns;

(f) Petitioning to become personal representative;

(g) Petitioning to become special administrator;

(h) Filing a claim as creditor to an estate;

(i) Petitioning for estate share of augmented estate;

(j) Signing petitions for other special probate court activities, including termination of conservatorship; and

(k) Signing documents relating to non-Probate litigation (e.g. foreclosure, personal injury, Worker's Comp., and bankruptcy.)

(2) **Caseworkers - Routine decisions re: care of wards.** Except as otherwise provided in this policy, caseworkers may make decisions on behalf of public wards regarding routine care, including but not limited to the following:

(a) Approving transportation;

(b) Approving transfer to or from a facility such as a residential care facility, nursing home or hospital, including Riverview Psychiatric Center and Dorothea Dix Psychiatric Center;

(c) Signing contracts which admit a ward to a facility;

(d) Completing hospital emergency forms requesting names of persons to contact in an emergency;

(e) Approving care and treatment plans, recommended by an attending physician, psychologist, agency, or multi-disciplinary team and approving ISPs.

(f) Approving medication and medication changes (except experimental medications) recommended by the attending physician;

(g) Except as provided in OES Policy Manual Section 15.10, authorizing routine diagnostic procedures routine medical procedures and non-invasive surgical procedures;

(h) Authorizing visits with family or friends, and participation in other social or community activities; and

(i) Authorizing third parties to open the mail of a ward or to take photographs of the ward.

(3) Caseworkers-Routine financial decisions re: wards and protected persons.

Except as otherwise provided in this policy, caseworkers may make routine decisions on behalf of public wards and protected persons, including but not limited to the following:

(a) Releasing information needed by hospitals and nursing homes for insurance purposes;

(b) Applying for benefits and authorizing payment for care or treatment;

(c) Entering into mortuary trust agreements as part of an approved court plan; and

(d) Ensuring suitable burial.

(4) Casework Supervisors.

Except as otherwise provided, casework supervisors may make all decisions delegated to caseworkers above and in addition may:

(a) Authorizing routine surgical procedures for public wards;

(b) Determining when a second medical or psychological opinion should be sought on behalf of a public ward;

(c) After review and authorization by a PPA, signing petitions for the appointment of a public or private guardian or conservator or other protective arrangement, and related documents which may include public guardianship or conservatorship plans and acceptances.

(5) Office Director, Director of Adult Protective Services and PPAs.

Except as otherwise provided, the Office Director, Director of Adult Protective Services, and PPAs may make any decisions delegated to caseworkers and casework supervisors above and in addition may:

(a) Authorizing all non-routine medical and surgical procedures for public wards, except those for which the Commissioner has expressly reserved the right to make the decision;

(b) Signing other legal documents related to public wards and protected persons, to the extent allowed by law and court rule;

(c) Issuing an administrative subpoena. AAG consultation may be requested;

(d) In the absence of advanced directives, authorizing Do Not Resuscitate (DNR), Do Not Hospitalize (DNH) and Comfort Measures Only orders for public wards. This decision must be consistent with the advice of the ward's physician.

(i) DNR, DNH and Comfort Measures Only orders may be authorized when treatment would only serve to prolong the dying process with little possibility of benefit, or when the ward is irreversibly comatose or in a persistent vegetative state, or when cardio-pulmonary resuscitation is medically contraindicated.

(ii) Whenever a DNR, DNH and Comfort Measures Only order is requested or sought by DHHS or by an attending physician for a public ward, the physician shall be requested to provide verbal or written documentation justifying the order.

(iii) Once a DNR, DNH and Comfort Measures Only order has been authorized, the decision and written documentation must be shared with persons involved in the care and treatment of the ward, and entered in the ward's permanent case record.

(iv) DNR, DNH and Comfort Measures Only orders shall be subject to review whenever there is significant change in a ward's medical condition, and the Department may be request that the physician rescind the order at any time.

15.10 HUMAN IMMUNODEFICIENCY VIRUS

(A) **Testing**. When appropriate, regional staff may authorize testing of public wards for Human Immunodeficiency Virus (HIV) after consultation with a PPA , Director of Adult Protective Services, or Office Director.

(B) **Confidentiality**. HIV related information shall be kept confidential except:

(1) HIV related information may be disclosed verbally only, if relevant and necessary to the functions and responsibilities of the following designated DHHS staff:

(a) The assigned caseworker;

(b) The assigned caseworker's supervisor;

(c) The PPA;

(d) The Director, Adult Protective Services;

(e) Other DHHS staff responsible for carrying out the OES' activities on behalf of a ward.

(2) PPAs or the Director of Adult Protective Services may disclose HIV related information either, verbally or in writing, only if relevant and necessary to the functions and responsibilities of the following:

(a) Those responsible for treatment of the ward, including medical and psychiatric personnel;

(b) Those responsible for care of the ward when the care includes nursing care;

(c) Those responsible for care of the ward if that responsibility includes twenty-four hour supervision of the ward;

(d) A court in accordance with 5 M.R.S.A. §19203-D(2) when that medical information is relevant;

(e) The attorney representing DHHS; and

(f) Under other circumstances permitted by 5 M.R.S.A., Chapter 501.

(C) **Coordination with other DHHS Offices**. The OES will cooperate with other DHHS Offices, to the extent permitted by law, to coordinate planning on behalf of a public ward who has been diagnosed with HIV infection.

15.11 CLASS MEMBER PUBLIC WARDS.

All public wards who were patients at the former Augusta Mental Health Institute (AMHI) or Riverview Psychiatric Center on or after January 1, 1988, as well as any wards who will be admitted to Riverview in the future are members of the Plaintiff class of the AMHI Consent Decree. DHHS, as the Defendant in this lawsuit, entered into a Consent Decree and Settlement Agreement which was approved by the Court.

(A) **Performance Obligations**. DHHS has the responsibility to assure that class member public wards are provided all the benefits of the Settlement Agreement. In addition, DHHS is to meet specific performance obligations outlined in paragraphs 254-261 and 281 of the Agreement, namely:

(1) DHHS shall provide casework services to its class member public wards. Services shall include the active monitoring of all ISPs or hospital treatment and discharge plans and attendance at all planning meetings.

(2) Caseworkers will give informed consent after reviewing necessary information and while acting in the ward's best interest. Informed decisions will maximize the ward's independence consistent with the ward's current circumstances.

Before authorizing treatment, DHHS will seek the counsel or opinion of an independent professional:

(a) When the risks associated with the proposed medical order or procedure are great; or

(b) When the proposed medical order or procedure limits the ward's independence and the prognosis for improvement as a result of implementing a proposed medical order or procedure is poor or guarded.

(3) Caseworkers shall visit all class member public wards at least twice monthly. Visits may be reduced to monthly in accordance with procedure.

(4) Caseworkers shall advise class member public wards of their right to name a designated representative or representatives and the availability of advocacy and peer advocacy assistance.

(5) Caseworkers shall additionally advise class member public wards at least annually of their right to petition the Probate Court for termination of guardianship. The advice shall be given both verbally and in writing and shall include information on the application and hearing procedure and on the availability of legal assistance.

(6) Caseworkers shall prepare annual reports on each class member public ward, or more often if requested by the Court Master. Reports will be submitted to the Court Master and counsel for the Plaintiffs.

(B) **Referrals for Community Support Services and ISPs.** Caseworkers shall refer each class member public ward for the assignment of a community support worker, or other support services, and an ISP. Caseworkers shall notify public wards annually of their right to receive the services of a community support worker or other individualized services in accordance with and ISP.

(C) **Advocacy.** DHHS staff participating in the development of an ISP and case plan for class member public wards will advocate for those wards to receive generic resources and services to the maximum extent possible. When there appears to be a wrongful denial of generic services, DHHS will refer the case to the Maine Disability Rights Center. DHHS staff with advocate to ensure that unmet needs are identified on the ISP. Advocacy may include filing a grievance in accordance with the Rights of Recipients of Mental Health Services.

15.12 DISMISSALS/TERMINATIONS

The Department may dismiss or terminate a public guardianship or public conservatorship under the following conditions:

(A) There is medical and/or psychological documentation that incapacitation no longer exists;

(B) A suitable private individual is willing to assume administrative or legal responsibility;

(C) A public appointment is no longer necessary or desirable as a means of providing continuing care and supervision of the adult;

(D) The ward or protected person has died;

(E) Income and/or assets, excluding the value of a mortuary trust, have been depleted so that the conservatorship is no longer required; or

(F) Where there is a joined guardianship and conservatorship appointment, a termination of the conservatorship only may be sought when assets fall below program guidelines excluding the

value of a mortuary trust, and there is little likelihood that assets will increase, or the purpose for the original conservatorship no longer exists.

Title 34-B: BEHAVIORAL AND DEVELOPMENTAL SERVICES
Chapter 1: GENERAL PROVISIONS
Subchapter 2: DEPARTMENT

§1207. Confidentiality of information

1. Generally. All orders of commitment, medical and administrative records, applications and reports, and facts contained in them, pertaining to any client shall be kept confidential and may not be disclosed by any person, except that:

A. A client, a client's legal guardian, if any, or, if the client is a minor, the client's parent or legal guardian may give informed written consent to the disclosure of information; [RR 2019, c. 2, Pt. B, §86 (COR).]

B. Information may be disclosed if necessary to carry out the statutory functions of the department; the hospitalization provisions of chapter 3, subchapter 4 (../34-B/title34-Bch3sec0.html); the purposes of section 3608 (../34-B/title34-Bsec3608.html); the purposes of Title 5, section 19506 (../5/title5sec19506.html); the purposes of United States Public Law 99-319, dealing with the investigatory function of the independent agency designated with advocacy and investigatory functions under United States Public Law 88-164, Title I, Part C or United States Public Law 99-319; the investigation and hearing pursuant to Title 15, section 393, subsection 4-A (../15/title15sec393.html); or the provision of mental health services by the Department of Corrections pursuant to Title 34-A, section 3031 (../34-A/title34-Asec3031.html), 3069-A (../34-A/title34-Asec3069-A.html) or 3069-B (../34-A/title34-Asec3069-B.html); [PL 2017, c. 475, Pt. A, §57 (AMD).]

B-1. [PL 2005, c. 397, Pt. A, §48 (RP).]

B-2. [PL 2007, c. 466, Pt. A, §56 (RP).]

B-3. [PL 2017, c. 475, Pt. A, §58 (RP).]

C. Information may be disclosed if ordered by a court of record, subject to any limitation in the Maine Rules of Evidence, Rule 503; [PL 1983, c. 459, §7 (NEW).]

C-1. Within 48 hours of a death reportable by the commissioner to the Chief Medical Examiner pursuant to Title 22, section 3025, subsection 1, paragraph E (../22/title22sec3025.html), the commissioner shall provide information on that death to the chairs of the joint standing committee of the Legislature having jurisdiction over health and human services matters. Within 30 days of the reportable death, the commissioner shall provide the members of the committee with a copy of the death report. Information and reports provided pursuant to this paragraph must maintain the confidentiality of the identity of all persons mentioned or referred to in the information and reports. [PL 1997, c. 605, §1 (NEW).]

D. Nothing in this subsection precludes disclosure, upon proper inquiry, of information relating to the physical condition or mental status of a client to that client's spouse or next of kin; [RR 2019, c. 2, Pt. B, §87 (COR).]

E. Nothing in this subsection precludes the disclosure of biographical or medical information concerning a client to commercial or governmental insurers, or to any other corporation, association or agency from which the department or a licensee of the department may receive reimbursement for the care and treatment, education, training or support of the client, if the recipient of the information uses it for no other purpose than to determine eligibility for reimbursement and, if eligibility exists, to make reimbursement; [PL 1989, c. 335, §2 (AMD).]

F. Nothing in this subsection precludes the disclosure or use of any information, including recorded or transcribed diagnostic and therapeutic interviews, concerning any client in connection with any educational or training program established between a public hospital and any college, university, hospital, psychiatric or counseling clinic or school of nursing, as long as, in the disclosure or use of the information as part of a course of instruction or training program, the client's identity remains undisclosed; [PL 2011, c. 691, Pt. A, §39 (AMD).]

G. [PL 2011, c. 691, Pt. A, §40 (RP).]

H. The names and dates of death of individuals who died while patients at the Augusta Mental Health Institute, the Bangor Mental Health Institute, the Dorothea Dix Psychiatric Center, the Riverview Psychiatric Center or the Pineland Hospital and Training Center may be made available to the public in accordance with rules adopted by the department. The rules must require the department to notify the public regarding the release of the information and to maintain the confidentiality of information concerning any deceased individual whose surviving relatives notify the department that they object to public disclosure. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A (../5/title5ch375sec0.html); and [PL 2015, c. 189, §1 (AMD).]

I. Nothing in this subsection precludes the disclosure of any information, except psychotherapy notes as defined in 45 Code of Federal Regulations, Section 164.501(2010), concerning a client to a state-designated statewide health information exchange that provides and maintains an individual

protection mechanism by which a client may choose to opt in to allow the state-designated statewide health information exchange to disclose that client's health care information covered under this section to a health care practitioner or health care facility for purposes of treatment, payment and health care operations, as those terms are defined in 45 Code of Federal Regulations, Section 164.501. A state-designated statewide health information exchange also must satisfy the requirement in Title 22, section 1711-C, subsection 18, paragraph C of providing a general opt-out provision to a client at all times.

A state-designated statewide health information exchange may disclose a client's health care information covered under this section even if the client has not chosen to opt in to allow the state-designated statewide health information exchange to disclose the individual's health care information when, in a health care provider's judgment, disclosure is necessary to:

(1) Avert a serious threat to the health or safety of others, if the conditions, as applicable, described in 45 Code of Federal Regulations, Section 164.512(j)(2010) are met; or

(2) Prevent or respond to imminent and serious harm to the client and disclosure is to a provider for diagnosis or treatment. [PL 2011, c. 347, §11 (NEW).]

[RR 2019, c. 2, Pt. B, §§86, 87 (COR).]

2. Statistical compilations and research. Confidentiality of records used for statistical compilations or research is governed as follows.

A. Persons engaged in statistical compilation or research may have access to treatment records of clients when needed for research, if:

(1) The access is approved by the chief administrative officer of the mental health facility or the chief administrative officer's designee;

(2) The research plan is first submitted to and approved by the chief administrative officer of the mental health facility, or the chief administrative officer's designee, where the person engaged in research or statistical compilation is to have access to communications and records; and

(3) The records are not removed from the mental health facility that prepared them, except that data that do not identify clients or coded data may be removed from a mental health facility if the key to the code remains on the premises of the facility. [RR 2019, c. 2, Pt. B, §88 (COR).]

B. The chief administrative officer of the mental health facility and the person doing the research shall preserve the anonymity of the client and may not disseminate data that refer to the client by name, number or combination of characteristics that together could lead to the client's identification. [RR 2019, c. 2, Pt. B, §88 (COR).]

[RR 2019, c. 2, Pt. B, §88 (COR).]

3. Use by the commissioner. Confidentiality of information and records used by the commissioner for administration, planning or research is governed as follows.

A. A facility or a provider that receives funds from the department to provide services for persons eligible for such services under this Title shall send information and records to the commissioner, if requested by the commissioner pursuant to the department's obligation to maintain the overall responsibility for the care and treatment of persons receiving mental health services funded in full or in part by the State. [PL 2011, c. 542, Pt. A, §61 (RPR).]

B. The commissioner may collect and use the information and records for administration, planning or research, under the following conditions.

(1) The use of the information is subject to subsection 1, paragraph C (../34-B/title34-Bsec1207.html).

(2) Data identifying particular clients by means other than case number or code shall be removed from all records and reports of information before issuance from the mental health facility which prepared the records and reports.

(3) A code shall be the exclusive means of identifying clients and shall be available to the commissioner and only the commissioner.

(4) The key to the code shall remain in the possession of the issuing facility and shall be available to the commissioner and only the commissioner.

(5) Members of the department may not release or disseminate to any other person, agency or department of government any information which refers to a client by name, numbers, address, birth date or other characteristics or combination of characteristics which could lead to the client's identification, except as otherwise required by law. [PL 1983, c. 459, §7 (NEW).]

[PL 2011, c. 542, Pt. A, §61 (AMD).]

4. Prohibited acts.

[PL 2007, c. 310, §1 (RP).]

4-A. Violation. Disclosure of client information in violation of this section is an offense under the licensing standards of the mental health professional committing the violation and must be promptly reported to the licensing board with jurisdiction for review, hearing and disciplinary action.

[PL 2007, c. 310, §2 (NEW).]

5. Permitted disclosure.

[PL 2007, c. 310, §3 (RP).]

5-A. Disclosure to family, caretakers. Under the following circumstances, a licensed mental health professional providing care to an adult client may disclose to a family member, to another relative, to a close personal friend or caretaker of the client or to anyone identified by the client, the client's health information that is directly relevant to the person's involvement with the client's care.

A. If a client with capacity to make health care decisions is either present or available prior to disclosure, the professional may disclose the information:

(1) When the client gives oral or written consent;

(2) When the client does not object in circumstances in which the client has the opportunity to object; or

(3) When the professional may reasonably infer from the circumstances that the client does not object. [PL 2007, c. 310, §4 (NEW).]

B. The professional may disclose the information if in the professional's judgment it is in the client's best interests to make the disclosure and the professional determines either that the client lacks the capacity to make health care decisions or an emergency precludes the client from participating in the disclosure. [PL 2007, c. 310, §4 (NEW).]

[PL 2007, c. 310, §4 (NEW).]

6. Duty to provide information.

[PL 2007, c. 310, §5 (RP).]

6-A. Disclosure of danger. A licensed mental health professional shall disclose protected health information that the professional believes is necessary to avert a serious and imminent threat to health or safety when the disclosure is made in good faith to any person, including a target of the threat, who is reasonably able to prevent or minimize the threat.

[PL 2009, c. 451, §7 (AMD).]

7. Disclosure to law enforcement. A licensed mental health professional shall disclose protected health information when the disclosure is made in good faith for a law enforcement purpose to a law enforcement officer if the conditions, as applicable, are met as described in 45 Code of Federal Regulations, Section 164.512(f) (2008).

[PL 2009, c. 451, §8 (NEW).]

8. Disclosure of knowledge of firearms. A licensed mental health professional shall notify law enforcement when the notification is made in good faith that the licensed mental health professional has reason to believe that a person committed to a state mental health institute has access to firearms.

[PL 2009, c. 451, §9 (NEW).]

9. Disclosure for care management or coordination of care. Notwithstanding any provision of this section to the contrary, a health care practitioner may disclose without authorization health information for the purposes of care management or coordination of care pertaining to a client as provided in this subsection.

A. Disclosure is permitted to a health care practitioner or health care facility as defined in Title 22, section 1711-C, subsection 1 (../22/title22sec1711-C.html). [PL 2013, c. 326, §2 (NEW).]

B. Disclosure is permitted to a payor or person engaged in payment for health care for the purpose of care management or coordination of care. [PL 2013, c. 326, §2 (NEW).]

C. Disclosure of psychotherapy notes is governed by 45 Code of Federal Regulations, Section 164.508(a)(2). [PL 2013, c. 326, §2 (NEW).]

D. A person who has made a disclosure under this subsection shall make a reasonable effort to notify the individual or the authorized representative of the individual of the disclosure. [PL 2013, c. 326, §2 (NEW).]

[PL 2013, c. 326, §2 (NEW).]

SECTION HISTORY

PL 1983, c. 459, §7 (NEW). PL 1983, c. 580, §4 (AMD). PL 1983, c. 626 (AMD). PL 1985, c. 495, §23 (AMD). PL 1985, c. 582 (AMD). PL 1989, c. 7, §N3 (AMD). PL 1989, c. 190 (AMD). PL 1989, c. 335, §§2,3 (AMD). PL 1991, c. 250 (AMD). PL 1993, c. 593, §1 (AMD). PL 1995, c. 497, §5 (AMD). PL 1995, c. 560, §K19 (AMD). PL 1995, c. 691, §4 (AMD). PL 1997, c. 422, §2 (AMD). PL 1997, c. 605, §1 (AMD). PL 2001, c. 354, §3 (AMD). PL 2003, c. 563, §§1-3 (AMD). RR 2005, c. 2, §22 (COR). PL 2005, c. 397, §§A47,48 (AMD). PL 2005, c. 683, §A57 (AMD). PL 2007, c. 286, §2 (AMD). PL 2007, c. 310, §§1-6 (AMD). PL 2007, c. 466, Pt. A, §56 (AMD). PL 2007, c. 609, §1 (AMD). PL 2007, c. 670, §17 (AMD). PL 2009, c. 415, Pt. A, §20 (AMD). PL 2009, c. 451, §§7-9 (AMD). PL 2011, c. 347, §§9-11 (AMD). PL 2011, c. 420, Pt. C, §§6, 7 (AMD). PL 2011, c. 542, Pt. A, §61 (AMD). PL 2011, c. 691, Pt. A, §§39, 40 (AMD). PL 2013, c. 132, §1 (AMD). PL 2013, c. 326, §2 (AMD). PL 2013, c. 434, §§7, 8 (AMD). PL 2015, c. 189, §1 (AMD). PL 2015, c. 329, Pt. A, §§21, 22 (AMD). PL 2017, c. 93, §1 (AMD). PL 2017, c. 147, §§6, 7 (AMD). PL 2017, c. 475, Pt. A, §§57, 58 (AMD). RR 2019, c. 2, Pt. B, §§86-88 (COR).

§200-H. Maine Elder Death Analysis Review Team

There is created, within the Office of the Attorney General, the Maine Elder Death Analysis Review Team, referred to in this section as "the team." [PL 2003, c. 433, §1 (NEW).]

1. Composition. The team is composed of 16 members as follows:

A. The Chief Medical Examiner, ex officio; [PL 2003, c. 433, §1 (NEW).]

B. The Director of Investigations for the Office of the Attorney General, ex officio; [PL 2003, c. 433, §1 (NEW).]

C. The Director of the Division of Licensing and Regulatory Services within the Department of Health and Human Services, ex officio; [PL 2007, c. 324, §1 (AMD).]

D. The Director of the Health Care Crimes Unit within the Office of the Attorney General, ex officio; [PL 2003, c. 433, §1 (NEW).]

E. The Director of Aging Planning and Resources Development within the Department of Health and Human Services, Office of Elder and Adult Services, ex officio; [PL 2009, c. 149, §1 (AMD).]

F. The Director of the Adult Protective Services program within the Department of Health and Human Services, Office of Elder and Adult Services, ex officio; [PL 2009, c. 149, §1 (AMD).]

G. The Director of Adult Mental Health Services within the Department of Health and Human Services, ex officio; [PL 2003, c. 433, §1 (NEW); PL 2003, c. 689, Pt. B, §6 (REV).]

H. The executive director of the long-term care ombudsman program, as established in Title 22, section 5106, subsection 11-C, ex officio; [PL 2003, c. 433, §1 (NEW).]

H-1. A sexual assault nurse examiner within the Department of Health and Human Services; [PL 2015, c. 267, Pt. GG, §1 (AMD).]

I. A representative of victim services, appointed by the Attorney General; [PL 2003, c. 433, §1 (NEW).]

J. A commanding officer of the Criminal Investigation Division within the Department of Public Safety, Bureau of the State Police, appointed by the Attorney General; [PL 2003, c. 433, §1 (NEW).]

K. A prosecutor, nominated by a statewide association of prosecutors and appointed by the Attorney General; [PL 2003, c. 433, §1 (NEW).]

L. A police chief, nominated by a statewide association of chiefs of police and appointed by the Attorney General; [PL 2009, c. 149, §1 (AMD).]

M. A sheriff, nominated by a statewide association of sheriffs and appointed by the Attorney General; [PL 2009, c. 149, §1 (AMD).]

N. A physician, a geriatrician or a primary care physician who works in the area of elder care, nominated by a statewide association of physicians and appointed by the Attorney General; and [PL 2009, c. 149, §1 (NEW).]

O. An emergency medical services' person, nominated by a statewide association of emergency medical services professionals and appointed by the Attorney General. [PL 2009, c. 149, §1 (NEW).]

[PL 2015, c. 267, Pt. GG, §1 (AMD).]

2. Designees; terms of office. An ex officio member may appoint a designee to represent the ex officio member on the team. A designee, once appointed, qualifies as a full voting member of the team who may hold office and enjoy all the other rights and privileges of full membership on the team. All

of the appointed members of the team serve for a term of 3 years. Any vacancy on the team must be filled in the same manner as the original appointment, but for the unexpired term.
[PL 2003, c. 433, §1 (NEW).]

3. Meetings; officers. The team shall meet at such time or times as may be reasonably necessary to carry out its duties, but it shall meet at least once in each calendar quarter at such place and time as the team determines, and it shall meet at the call of the chair. The Attorney General shall call the first meeting before January 1, 2004. The team shall organize initially and thereafter annually by electing a chair and a vice-chair from among its members. The vice-chair shall also serve as secretary.
[PL 2003, c. 433, §1 (NEW).]

4. Powers and duties. The team shall examine deaths and serious injuries associated with suspected abuse or neglect of elderly adults and vulnerable adults. The purpose of such examinations is to identify whether systems that have the responsibility to assist or protect victims were sufficient for the particular circumstances or whether such systems require adjustment or improvement. The team shall recommend methods of improving the system for protecting persons from abuse and neglect, including modifications of statutes, rules, training and policies and procedures.
[PL 2003, c. 433, §1 (NEW).]

5. Access to information and records. In any case subject to review by the team, upon oral or written request of the team, notwithstanding any other provision of law, any person that possesses information or records that are necessary and relevant to a team review shall as soon as practicable provide the team with the information and records. Persons disclosing or providing information or records upon request of the team are not criminally or civilly liable for disclosing or providing information or records in compliance with this subsection.
[PL 2003, c. 433, §1 (NEW).]

6. Confidentiality. The proceedings and records of the team are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The Office of the Attorney General shall disclose conclusions of the review team upon request, but may not disclose information, records or data that are otherwise classified as confidential.
[PL 2003, c. 433, §1 (NEW).]

SECTION HISTORY

PL 2003, c. 433, §1 (NEW). PL 2003, c. 689, §B6 (REV). PL 2007, c. 324, §1 (AMD). PL 2009, c. 149, §1 (AMD). PL 2015, c. 267, Pt. GG, §1 (AMD).

§264. Aging and Disability Mortality Review Panel

1. Panel established. The Aging and Disability Mortality Review Panel, referred to in this section as "the panel," is established to review deaths of and serious injuries to all adults receiving services. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

2. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Adults receiving services" means adults receiving home-based and community-based services under 42 Code of Federal Regulations, Part 441. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

B. "Panel coordinator" means an employee of the Maine Center for Disease Control and Prevention who is appointed by the commissioner. The panel coordinator must be a registered nurse, nurse practitioner, physician assistant or physician licensed or registered in this State and who has completed a nationally certified training program for conducting critical incident, including death, investigations or will complete the training within 6 months of appointment as panel coordinator. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

C. "Preventable death" means a premature death that could have been avoided. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

D. "Serious injury" means a bodily injury that involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a body part or organ or mental faculty. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

E. "Suspicious death" means an unexpected death in which the circumstance or cause is medically or legally unexplained or inadequately explained or a death in which the circumstance or cause is suspected to be related to systemic issues of service access or quality. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

[PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

3. Composition. The panel consists of up to 15 members and includes health care providers, social service providers, public health officials and other persons with professional expertise on the health and mortality of adults with disabilities and adults who are aging. The commissioner shall appoint the members of the panel unless otherwise specified. At a minimum, the panel consists of the following members:

A. The person who is lead staff attorney for investigations for the Office of the Attorney General or that person's designee; [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

B. The person who is lead staff attorney for health care crime investigations for the Office of the Attorney General or that person's designee; [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

C. A person within the department responsible for licensing and certification; [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

D. A person within the department responsible for aging and disability services; [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

E. The executive director of the statewide protection and advocacy agency for individuals with disabilities contracted by the department pursuant to Title 5, section 19502 or the executive director's designee; [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

F. The executive director of the long-term care ombudsman program as established in section 5106, subsection 5 or the executive director's designee; [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

G. A member of the Maine Developmental Services Oversight and Advisory Board as established in Title 5, section 12004-J, subsection 15 as nominated by that board; [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

H. A health care provider who is licensed under Title 32, chapter 36 or 48 and who has expertise and experience in delivering services to individuals with intellectual disabilities or autism nominated by a statewide association representing physicians; [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

I. A representative of the developmental service provider community who has expertise regarding community services for individuals with intellectual disabilities or autism; [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

J. A representative of the provider community serving older adults and adults with physical disabilities who has expertise in home-based and community-based services; [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

K. A representative of the provider community who has expertise in delivering home-based and community-based services to individuals with brain injuries or other related conditions; and [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

L. A person who has expertise in forensic pathology. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).] [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

4. Terms; meetings; chair. The term for each member of the panel is 3 years, except that members serve at the pleasure of the commissioner. A member may serve until a successor has been appointed. Members may be reappointed. A vacancy must be filled as soon as practicable by appointment for the unexpired term. The panel shall meet at least 4 times each year and sufficiently frequently to carry out its duties and to guarantee the timely and comprehensive reviews of all deaths and serious injuries as required in this section. The commissioner or the commissioner's designee shall call the first meeting. The panel shall elect a chair from among its members annually.
[PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

5. Panel coordinator; powers and duties. The panel coordinator has the following powers and duties.

A. The panel coordinator shall conduct preliminary reviews of all deaths of and serious injuries to all adults receiving services to determine whether to refer a case to the panel if the panel coordinator determines that any of the following circumstances exist:

(1) The death or serious injury was unexpected;

(2) The death was premature;

(3) The death or serious injury was preventable;

(4) Issues with the system of care are indicated;

(5) Facts and circumstances related to the death or serious injury indicate that the department or providers of home-based and community-based services to adults receiving services could implement actions that would improve the health and safety of those adults receiving services; or

(6) Other issues or facts related to the death or serious injury indicate the case should be reviewed by the panel.

The panel coordinator shall also refer cases based on the need to review particular causes and circumstances of death or serious injury or the need to obtain a representative sample of all deaths.

The panel coordinator shall conduct preliminary reviews within 7 days of the date the death or serious injury was reported. Preliminary reviews of a death may not be officially closed until the death certificate has been received and reviewed by the panel coordinator. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

B. The panel coordinator has access to the following records:

(1) Death certificates;

(2) Autopsy, medical examiner and coroner reports;

(3) Emergency medical personnel reports and documentation;

(4) Health care information of an adult receiving services who is deceased pursuant to section 1711-C, subsection 6, paragraph V. For the purposes of this subparagraph, "health care information" has the same meaning as in section 1711-C, subsection 1, paragraph E; and

(5) Notwithstanding any provision of law to the contrary, information or records from the department determined by the panel coordinator to be necessary to carry out the panel coordinator's duties. The department shall provide the panel coordinator with direct access to the information or records or provide the information or records necessary and relevant as soon as is practicable upon oral or written request of the panel coordinator. Records that must be provided include, but are not limited to, the following:

(a) Personal plans and treatment plans of an adult receiving services when that adult is deceased or injured;

(b) Service plans and agreements developed on behalf of an adult receiving services;

(c) Documents from providers of home-based and community-based services and case managers;

(d) Documents related to an adult protective case or investigation; and

(e) Reports relating to incidents or reportable events of an adult receiving services that occurred in the 12 months prior to the adult's death or serious injury. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

C. The panel coordinator may conduct voluntary interviews with parties that may have relevant information for a preliminary review pursuant to paragraph A, including a guardian of, the family of or the provider of services to the adult receiving services who has died or experienced serious injury, in accordance with this paragraph.

(1) For interviews pertaining to serious injury of an adult receiving services, prior to conducting any interview, the panel coordinator shall obtain the permission of the adult or the adult's guardian, if the adult cannot consent.

(2) For interviews pertaining to preventable death or suspicious death of an adult receiving services, prior to conducting any interview, the panel coordinator shall obtain the permission of the adult's personal representative if one was appointed or, if there is no personal representative, the adult's guardian if the adult had a guardian.

(3) The purpose of an interview must be limited to gathering information or data for the panel, provided in summary or abstract form without family names or identification of the adult receiving services.

(4) The panel coordinator may delegate the responsibility to conduct interviews pursuant to this paragraph to a registered nurse, physician assistant, nurse practitioner or physician licensed or registered in this State and who has completed a nationally certified training program for conducting critical incident investigations. If the interview pertains to a preventable death or

suspicious death, the person conducting the interview must have professional training or experience in bereavement services.

(5) A person conducting an interview under this paragraph may make a referral for bereavement counseling if indicated for and desired by the person being interviewed. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

D. The panel coordinator shall endeavor to minimize the burden imposed on health care providers, hospitals and service providers. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

E. A case of death of or serious injury to an adult receiving services may be referred to the panel coordinator by the commissioner, the statewide protection and advocacy agency for individuals with disabilities contracted by the department pursuant to Title 5, section 19502, a member of the panel or any other person who presents credible evidence that a death or serious injury warrants referral to the panel as determined by preliminary review by the panel coordinator. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

F. The panel coordinator shall prepare a summary and abstract of relevant trends in deaths of the population of adults receiving services for comparison to cases reviewed by the panel pursuant to subsection 6. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

G. The panel coordinator shall prepare a review summary or abstract of information regarding each case, as determined to be useful to the panel and at a time determined to be timely, without the name or identifier of the adult receiving services who is deceased or who has experienced a serious injury, to be presented to the panel. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

H. The panel coordinator shall, in conjunction with the department, establish and maintain a state mortality database that includes, but is not limited to, the following:

(1) Name, age, sex, race or ethnicity and type of disability or condition of the adult receiving services who is deceased;

(2) Community-based services received by the adult receiving services who is deceased and the name of the service provider;

(3) Description of the events leading to the death of the adult receiving services and the immediate circumstances of the death;

(4) Location of the death, such as the home of the adult receiving services, community setting, hospital or hospice;

(5) Immediate and secondary causes of death of an adult receiving services, including if the death was:

(a) Expected due to a known terminal illness;

(b) Associated with a known chronic illness;

(c) A sudden unexpected death;

(d) Due to an unknown cause;

(e) Due to an accident, including the type of accident;

(f) Due to a self-inflicted injury or illness, including suicide or serious self-injurious behavior;

(g) Due to suspicious or unusual circumstances; and

(h) Due to suspected or alleged neglect, abuse or criminal activity;

(6) Whether an autopsy was conducted and a narrative of any findings from the autopsy;

(7) Findings of the preliminary reviews of all deaths by the panel coordinator pursuant to paragraph A;

(8) Findings of the comprehensive reviews by the panel pursuant to subsection 6; and

(9) Recommendations pursuant to subsection 6, paragraph B issued by the panel and information related to the implementation of those recommended corrective actions. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

I. The panel coordinator shall determine the records that are made available to the panel for the purposes of reviewing cases of death or serious injury. The panel coordinator shall maintain custody of all records. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

[PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

6. Panel; powers and duties. The panel shall conduct comprehensive multidisciplinary reviews of data presented by the panel coordinator, with a particular focus on preventable deaths, suspicious deaths and serious injuries.

A. The panel shall review all cases of death or serious injury that are referred by the panel coordinator. A review of a case by the panel is a comprehensive evaluation of the circumstances surrounding the death of or serious injury to an adult receiving services, including the overall care of the adult, quality of life issues, the death or serious injury event and the medical care that preceded and followed the event. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

B. The panel shall submit an annual report, no later than January 2nd of each year beginning in 2022, to the Governor, the commissioner, the joint standing committee of the Legislature having jurisdiction over health and human services matters and the Maine Developmental Services Oversight and Advisory Board established in Title 5, section 12004-J, subsection 15. The report must contain the following:

(1) Factors contributing to the mortality of adults receiving services;

(2) Strengths and weaknesses of the system of care;

(3) Recommendations for the commissioner to decrease the rate of mortality of adults receiving services;

(4) Recommendations about methods to improve the system for protecting adults receiving services, including modifications to law, rules, training, policies and procedures; and

(5) Any other information the panel considers necessary for the annual report. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

C. The panel shall offer a copy of the annual report under paragraph B to any party who granted permission for an interview conducted by the panel coordinator pursuant to subsection 5, paragraph C. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

D. Following the submission of the annual report to the commissioner and the joint standing committee of the Legislature having jurisdiction over health and human services matters pursuant to paragraph B, the report must be released to the public. [PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

[PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

7. Access to information and records. In any case subject to review by the panel under subsection 6, upon oral or written request of the panel, notwithstanding any provision of law to the contrary, a person that possesses information or records that are necessary and relevant to a panel review shall as soon as practicable provide the panel with the information or records. Persons disclosing or providing information or records upon request of the panel are not criminally or civilly liable for disclosing or providing information or records in compliance with this subsection.

[PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

8. Confidentiality. Records held by the panel coordinator or the panel are confidential to the same extent they are confidential while in the custody of the entity that provided the record to the panel coordinator or the panel. Records relating to interviews conducted pursuant to subsection 5, paragraph C by the panel coordinator and proceedings of the panel are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The commissioner shall disclose conclusions of the panel upon request but may not disclose information, records or data that are otherwise classified as confidential.
[PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

9. Rulemaking. The department shall adopt rules to implement this section, including rules on collecting information and data, selecting and setting any limits on the number of terms for the members of the panel, managing and avoiding conflicts of interest of members, collecting and using individually identifiable health information and conducting reviews. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2021, c. 398, Pt. MMMM, §2 (NEW).]

SECTION HISTORY

PL 2021, c. 398, Pt. MMMM, §2 (NEW).

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Maine Center for Disease Control and Prevention
286 Water Street
Augusta, Maine 04333-0011
Tel; (207) 287-8016; Fax (207) 287-9058
TTY: Dial 711 (Maine Relay)

REPORT TO THE LEGISLATURE

TO: Joint Standing Committee on Health and Human Services
FROM: Maine Center for Disease Control and Prevention, Maine DHHS
DATE: February 2023
RE: 2022 Annual Report of the Aging and Disability Mortality Review Panel

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INTRODUCTION AND BACKGROUND

The Aging and Disability Mortality Review Panel is a multidisciplinary panel established by Maine law (Public Law 2021, Ch. 398, part MMMM) to review the patterns of death of and serious injury to all Maine adults receiving home- and community-based services under 42 Code of Federal Regulations, Part 441. The Panel is charged with analyzing mortality trends in these populations to identify strengths and weaknesses of the system of care and to recommend to the Commissioner ways to decrease the rate of mortality and improve the system of protection for adults receiving services, including modifications to law, rules, training, policies, and procedures. The Panel is required to meet at least four times per year and, by January 2nd of each year, submit a report of its activities and recommendations to the Governor, Commissioner, and to the Legislature.

Section 1915(c) of the Social Security Act permits States to offer, under a waiver of statutory requirements, an array of home- and community-based services (HCBS) that an individual may utilize to avoid institutionalization. In Maine, there are five waiver sections as described in the MaineCare Benefits Manual (10-144 CMR chapter 101), sections 18, 19, 20, 21 and 29.

- Section18: Home and Community-Based Services for Adults with Brain Injury;
- Section 19: Home and Community Benefits for the Elderly and for Adults with Disabilities;
- Section 20: Home and Community Services for Adults with Other Related Conditions;
- Section 21: Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder; and
- Section 29: Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder.

Under section 1915(c) of the Social Security Act, successful waivers must provide assurances to Centers for Medicare and Medicaid Services that the state has necessary safeguards to protect the health and welfare of participants receiving services.

In response to audits by Department of Health and Human Services (HHS) Office of Inspector General (OIG) Reports, United States Government Accountability Office (GAO) Reports, and Centers for Medicare & Medicaid Services (CMS), the need for a multidisciplinary incident management system

was identified which would augment and coordinate with the existing robust system for safeguarding those populations here in Maine. Please refer to the first annual report for a thorough outline of the efforts of Adult Protective Services (APS), Office of Aging and Disability Services (OADS) and the Maine Center for Disease Control and Prevention (Maine CDC).

IMPLEMENTATION OF THE PANEL

Title 22 MRS §264 specifies the composition for the Aging and Disability Mortality Review Panel and the qualifications of the coordinator. The panel coordinator, employed within the department of Public Health Nursing (PHN), is responsible for identifying and investigating incidents of death and serious injury occurring to HCBS participants and for referring to the Panel, in a de-identified manner, those cases which meet criteria for full review. A panel coordinator, Ann Lovegren, MSN, RN, FNP-BC, was hired and began work at the end of May 2022. In compliance with the requirements of the position, the panel coordinator completed a death investigation training with Labor Relations Alternatives Inc. in July 2022.

The process of identifying Panel members took place over the first half of 2022. The Commissioner then formalized those appointments with a September 1, 2022 start date. The Panel met for the first time on November 1, 2022. A cadence has been established for future meetings and panel members have been notified of meeting dates for the upcoming year.

Panel Membership

- Brenda Gallant, Executive Director, Long-term Care Ombudsman Program
- Heather Hyatt, Associate Director, DHHS Division of Licensing and Certification
- Lauren Michalakes, Program Consultant, Office of Aging and Disability Services
- Thomas Newman, Executive Director, AlphaOne
- Cara Orton, Director of Brain Injury Programs, RiverRidge Center
- Kelly Osborn, Senior Vice President of Client Services, Goodwill Northern New England
- Patricia K. Poulin, Assistant Attorney General, State of Maine Office of the Attorney General
- Jennifer Putnam, Executive Director, Waban Projects
- Katrina Ringrose, Deputy Director, Disability Rights Maine
- Matthew Siegel, Child and Adolescent Psychiatrist, Maine Behavioral Healthcare
- Taylor Slemmer, Medicolegal Death Investigator, State of Maine Office of the Chief Medical Examiner

The Department is actively drafting a routine technical rule to implement the responsibilities of the Aging and Disability Mortality Review Panel and clarify collection and reporting of HCBS member mortality information, including maintaining a state database for HCBS member death and serious injury reviews; selecting and setting any limits on the number of terms for the panel members; avoiding conflicts of interest of members; managing individually identifiable health information; and reporting findings and recommendations following reviews of death and serious injury.

REVIEW PROCESS

The panel coordinator has been working closely with OADS and APS to ensure receipt of every case of death and serious injury occurring in the state. Sections 18, 20, 21 and 29 share a reportable events system called EIS. A spreadsheet of reportable events is emailed daily to the panel coordinator from OADS. The coordinator has been given access to EIS and may review service authorizations, reportable events and person-centered plans in detail as needed to perform a more comprehensive review of reported incidents.

Section 19 incidents are reported by secure email. The panel coordinator has been given access to MeCare, the system used by Section 19, and may view authorizations, assessments and care plans as needed. Additionally, the coordinator has been working with APS to ensure that all cases warranting their review are communicated to the coordinator for panel review.

As outlined by statute, the panel coordinator has established a process to request and receive outside records necessary to conduct a preliminary review of all serious injuries and deaths. In addition, the coordinator conducts voluntary interviews to assist in investigating further any cases deemed to be unexpected, premature, preventable, or suspicious.

HCBS MORTALITY DATABASE

The Aging and Disability Mortality Review Panel coordinator is charged with developing and maintaining a HCBS mortality database. This database has been developed as a spreadsheet and the compiling of HCBS member deaths began on July 1, 2022, aligning with the start of SFY23. The coordinator is partnering with Maine CDC and OADS colleagues to establish a server engine database using SQL and it is expected that data will be migrated to the new system by mid-2023. Other future options include an extension of preexisting systems, such as Evergreen used by APS, and will be explored as well.

CASES REFERRED FOR PANEL REVIEW

Per statute, the panel coordinator must refer to the Panel those deaths which are medically or legally unexplained, or inadequately explained, and any death in which the circumstances or cause is suspected to be related to systemic issues of access to or quality of care. In addition, deaths or serious injuries which are deemed to have been preventable after a comprehensive review are referred to the Panel. Case summaries are compiled for and shared to the Panel in a deidentified manner.

The determination of expected or unexpected/unexplained death is based on initial report and death certificate. Additional information is sought by the panel coordinator as needed to determine the need for full panel review including reports provided by direct service providers, support coordinators, family members, hospital records, physician reports, hospice, or home health plans of care (when these services were used) and coroners' findings whenever available.

DATA

Deaths of waiver participants

There were 185 deaths of members receiving waiver services reported between 7/1/22 and 12/9/22. The panel coordinator completed a preliminary investigation of each death. 16 cases were categorized as unexpected or unexplained and underwent, or are undergoing, a comprehensive investigation to determine if these require full panel review. And 2 cases were referred to and reviewed by the Panel at their first meeting on 11/2/22. The two cases reviewed by the Panel raised many important questions and illustrated opportunities for increased awareness of cross-departmental operations.

Comparable data for previous years is not available. Data gathered between 7/1/22 and 12/9/22 includes the following:

Deaths by Waiver Section	
Section	*Total*
Section 18	1
Section 19	148
Section 20	0
Section 21	33
Section 29	3
Total	185

As would be expected, the largest number of deaths was experienced in the Section 19 population, largely an older population most of whom carry chronic or terminal diagnoses.

Waiver Participant Deaths by Age		
Age Range	*Total*	*Percent*
<19	1	.1%
20-29	3	.2%
30-39	3	.2%
40-49	11	5.9%
50-59	18	9.7%
60-69	60	32.4%
70-79	38	20.5%
>80	51	27.6%

Waiver Participant Deaths by Gender		
Gender	*Total*	*Percent*
Female	111	60%
Male	74	40%

Waiver Participant Deaths by Race/Ethnicity		
Race/Ethnicity	*Total*	*Percent*
African American	0	0%
Asian	1	.5%
Hispanic	2	1.1%
Native American	0	0%
Not Listed	7	3.8%
Other	5	2.7%
White	170	91.9%

Waiver Participant Deaths by Type	
Type	*Total*
Accident	5
Acute Illness	13
Known Chronic Illness	85
Known Terminal Illness	66
Unknown*	16

**pending receipt of death certificate or undergoing investigation by OCME*

Accident Types	
Type	*Total*
Acute Intoxication	1
Choking	1
Drowning	1
Fall	1
Motor Vehicle Accident	1

Waiver Participant Deaths by Maine County	
County	*Total*
Androscoggin	16
Aroostook	16
Cumberland	32
Franklin	5
Hancock	4
Kennebec	12
Knox	2
Lincoln	0
Oxford	7
Penobscot	36
Piscataquis	2
Sagadahoc	1
Somerset	9
Waldo	6
Washington	12
York	24
Out of State	1

Serious injuries to waiver participants

Serious injury as defined by the statute means a bodily injury that involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a body part or organ or mental faculty. The data, as received from each waiver section, includes events or injuries which may not strictly meet these criteria; and it is possible that incidents which do meet criteria are not coded as serious injury in the EIS or MeCare system and are not included in this data. There may be more than one event involving an individual; each event is recorded separately. The process of gathering and filtering data continues to be refined by OADS and Maine CDC in order to offer the most meaningful trend analysis.

Maine has a robust system for safeguarding our most vulnerable populations which includes the work of Adult Protective Services (APS), a unit within OADS that investigates reports of abuse, neglect, or exploitation, or the substantial risk of abuse, neglect, or exploitation for incapacitated and dependent adults, including individuals with intellectual disabilities or autism. Because the purpose of the Panel is trend-focused and cases are referred in a deidentified manner, the panel coordinator performs a preliminary investigation of serious injury cases and collaborates with APS to ensure that all cases of serious injury which involve restraint use, suspected abuse or neglect, or are suspicious or concerning in any way have been referred to by that office.

Comparable data for previous years is not available. Data gathered between 7/1/22-12/9/22 includes the following:

Serious Injury by Waiver Section	
Section	*Total*
Section 18	2
Section 19	56
Section 20	0
Section 21	96
Section 29	11
Total	165

Waiver Participant Serious Injury by Gender		
Gender	*Total*	*Percent*
Female	98	59.4%
Male	64	38.8%
Other	3	1.8%

Waiver Participant Serious Injury by Race/Ethnicity		
Race/Ethnicity	*Total*	*Percent*
African American	0	0%
Asian	1	.6%
Hispanic	2	1.2%
Native American	2	1.2%
Not Listed	55	33.3%
Other	2	1.2%
White	103	62.4%

Waiver Participant Serious Injury by Type		
Type	*Total*	*Percent*
Accident	87	52.7%
Acute Illness	15	9.1%
Acute Injury	31	18.8%
Known Chronic Illness	4	2.4%
Restraint Use	9	5.5%
Self-Inflicted	12	7.3%
Self-Neglect	1	.6%
Suspected Abuse or Neglect	5	3.0%
Suspicious Circumstances	1	.6%

Accident Types	
Type	*Total*
Burn	1
Fall	77
Motorized Vehicle Accident	3
Seizure Resulting in Injury	6

SUMMARY

In the first several months of its existence, the Aging and Disability Mortality Review Panel, with the full support of OADS and Maine CDC, has established effective data sharing and storage processes. The importance of compiling death and serious injury data from each of the five waiver sections in a central database is heightened by the fact that there are currently two separate systems, EIS and MeCare, in which event reporting occurs. The panel coordinator will continue to work with partners across the State to sharpen the quality of data to identify and react to preventable trends in our HCBS waiver populations.

The Panel has been appointed by the Commissioner and met for the first time in November. The group is engaged and enthusiastic about the mission. Comprehensive reviews of cases of death and serious injury will continue at least quarterly as the Panel refines their processes with the aim of making actionable recommendations to further strengthen Maine's vital system of HCBS care.

Related resources:

The 2018 report is issued by the U.S. Department of Health and Human Services, Office of Inspector General (OIG); Administration for Community Living (ACL); and Office for Civil Rights (OCR) to help improve the health, safety, and respect for the civil rights of individuals living in group homes[1]. The joint report provides suggested model practices to the Centers for Medicare and Medicaid Services (CMS) and States for comprehensive compliance oversight of group homes to help ensure better health and safety outcomes. In addition, the joint report provides suggestions for how CMS can assist States when serious health and safety issues arise that require immediate attention. (Note in particular, Appendix C Model Practices for State Mortality Reviews.)

[1] https://oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf

§1223. Maine Developmental Services Oversight and Advisory Board

1. Composition. The Maine Developmental Services Oversight and Advisory Board, as established by Title 5, section 12004-J, subsection 15 and referred to in this section as "the board," consists of 15 members appointed by the Governor from a list of nominees proposed by the board pursuant to procedures established in the rules of the board.

A. The board shall submit nominees to the Governor at least 90 days prior to the expected date of each vacancy. [PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

B. In making nominations, the board shall endeavor to ensure adequate representation at all times from different service regions of the State and from interested stakeholder groups, including but not limited to:

(1) The protection and advocacy agency designated pursuant to Title 5, section 19502;

(2) A statewide coalition that works to support and facilitate the ability of local and statewide self-advocacy organizations to network with each other and with national organizations;

(3) A nonprofit organization that serves teens and young adults in the State with emotional and intellectual disabilities;

(4) A statewide coalition that works to support and facilitate the ability of local and statewide self-advocacy organizations to network with each other and with national organizations; and

(5) The Maine Developmental Disabilities Council. [PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

C. In making the nominations and appointments, the board and the Governor shall endeavor to ensure that at least 8 of the members of the board are persons with intellectual disabilities or autism or family members, guardians or allies of persons with intellectual disabilities or autism who receive services funded by the Department of Health and Human Services. Of these members, at least 4 must be persons with intellectual disabilities or autism, referred to in this section as "self-advocates." [PL 2011, c. 542, Pt. A, §66 (AMD).]

Members of the board must include stakeholders involved in services and supports for persons with intellectual disabilities or autism in the State and other individuals interested in issues affecting persons with intellectual disabilities or autism. Employees of the Department of Health and Human Services may not be appointed as members of the board.
[PL 2011, c. 542, Pt. A, §66 (AMD).]

2. Terms. Members of the board serve 3-year terms. A member serves until a successor is appointed. A vacancy must be filled as soon as practicable by appointment for the unexpired term.
[PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

3. Chair. The board shall elect a chair from among its members.
[PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

4. Compensation. Members of the board are entitled to reimbursement of reasonable expenses incurred in order to serve on the board as provided in Title 5, section 12004-J, subsection 15. Members not otherwise compensated by their employers or other entities whom they represent are entitled to receive a per diem as established by rule or policy adopted by the board for their attendance at authorized meetings of the board.
[PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

5. Staff. The board may hire an executive director and clerical support staff.
[PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

6. Budget. The Department of Administrative and Financial Services shall administer the budget of the board. The board shall provide to the Commissioner of Administrative and Financial Services a proposed budget in accordance with a schedule agreed to by the chair and the Commissioner of Administrative and Financial Services. The Department of Administrative and Financial Services shall include in its estimate of expenditure and appropriation requirements filed pursuant to Title 5, section 1665 sufficient funds, listed in a separate account as a separate line item, to enable the board to perform its duties.
[PL 2021, c. 686, §4 (AMD).]

7. Maine Tort Claims Act. The board members and staff act as employees of the State, as defined in Title 14, section 8102, subsection 1, when engaged in official duties specified in this section or assigned by the board.
[PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

8. Oversight and advisory functions. The board shall:

A. Provide independent oversight over programs and services for adults with intellectual disabilities or autism that are provided, authorized, funded or supported by the department or any other agency or department of State Government. The board shall focus on systemic concerns affecting the rights of persons with intellectual disabilities or autism, including but not limited to issues surrounding health and safety, inclusion, identification of needs and desires of persons eligible for services by the department, the timely meeting of the identified needs and effective and efficient delivery of services and supports; and [PL 2011, c. 542, Pt. A, §66 (AMD).]

B. Provide advice and systemic recommendations to the commissioner, the Governor and the Legislature regarding policies, priorities, budgets and legislation affecting the rights and interests of persons with intellectual disabilities or autism. [PL 2011, c. 542, Pt. A, §66 (AMD).]
[PL 2011, c. 542, Pt. A, §66 (AMD).]

9. Powers and duties of the board. In order to carry out its oversight and advisory functions, the board has the following powers and duties.

A. The board shall hold at least one hearing or other forum each year that is open to the public in order to gather information about the availability, accessibility and quality of services available to persons with intellectual disabilities or autism and their families. [PL 2011, c. 542, Pt. A, §67 (AMD).]

B. The board may accept funds from the Federal Government, the State, a political subdivision of the State, individuals, foundations and corporations and may expend those funds for purposes consistent with the board's functions, powers and duties. [PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

C. The board shall establish priorities for its oversight and systems advocacy work. In establishing priorities, the board shall consider the results of its work in addressing the priorities established in previous years. [PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

D. The board shall report at least annually to the Governor and the Legislature on its activities and recommendations regarding policies, priorities, budgets and legislation affecting the rights and interests of persons with intellectual disabilities or autism. The board's annual report must include the board's assessment of its operations and progress in addressing the priorities established pursuant to paragraph C. The board's annual report must be made public and widely disseminated in a manner designed to inform interested stakeholders. [PL 2011, c. 542, Pt. A, §67 (AMD).]

E. The board may provide reports and recommendations to the commissioner on matters of systemic concern arising from the board's oversight role. The board may recommend that the department undertake the study of specific systemic issues as part of the department's annual quality assurance activities and strategies, and the board may collaborate and cooperate with the

department in the conduct of any such studies, if feasible. The commissioner shall provide a written response no later than 30 days following receipt of the recommendations from the board. [PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

F. The board may refer individual cases that require investigation or action to the department, the protection and advocacy agency designated pursuant to Title 5, section 19502 or other appropriate agency. [PL 2011, c. 657, Pt. EE, §2 (AMD).]

[PL 2011, c. 542, Pt. A, §67 (AMD); PL 2011, c. 657, Pt. EE, §2 (AMD).]

10. Access to information. The board is entitled to access to information from the department necessary to carry out its functions. Except as provided in paragraphs D and E, information provided pursuant to this subsection may not contain personally identifying information about a person with intellectual disabilities or autism.

A. Within existing resources, the department shall provide the board, on a schedule to be agreed upon between the board and the department, reports on case management, reportable events, adult protective and rights investigations, unmet needs, crisis services, quality assurance, quality improvement, budgets and other reports that contain data about or report on the delivery of services to or for the benefit of persons with intellectual disabilities or autism, including reports developed by or on behalf of the department and reports prepared by others about the department. [PL 2021, c. 686, §5 (AMD).]

B. Within existing resources, the department, when requested by the board or pursuant to a written agreement with the board, shall release to the board information pertaining to alleged abuse, exploitation or neglect or an alleged dehumanizing practice or violation of rights of a person with intellectual disabilities or autism. [PL 2021, c. 686, §5 (AMD).]

C. [PL 2013, c. 310, §1 (RP).]

D. The board may examine confidential information in individual records with written permission of the person or that person's guardian. If the person or that person's guardian provides the board with written permission to examine confidential information, the board must maintain the confidentiality of the information as required by section 1207. [PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

E. A member of the board or the board's staff may receive and examine confidential information when otherwise authorized to do so by law, including but not limited to when serving on a committee established by the department or other entity for which access to such information is necessary to perform the function of the committee. [PL 2021, c. 686, §5 (AMD).]

[PL 2021, c. 686, §5 (AMD).]

11. Rulemaking. The board shall adopt rules governing its operations, including rules establishing its bylaws. Rules adopted pursuant to this subsection must address:

A. Procedures for nominating persons to fill vacancies on the board; [PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

B. Procedures for holding annual hearings or other alternative means of receiving input from citizens throughout the State pursuant to subsection 9; [PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

C. Procedures for exercising its powers pursuant to subsection 10, paragraph D in a manner that is respectful of the rights, interests and opinions of persons whose records are at issue; [PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

D. Procedures concerning the hiring of an executive director, including the method for selection and the role of the executive director and procedures concerning the supervision, compensation and

evaluation of the executive director; and [PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

E. The provision of per diem stipends for members not otherwise compensated by their employers or other entities whom they represent for their attendance at authorized meetings of the board. [PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2007, c. 356, §7 (NEW); PL 2007, c. 695, Pt. D, §3 (AFF).]

SECTION HISTORY

PL 2007, c. 356, §7 (NEW). PL 2007, c. 356, §31 (AFF). PL 2007, c. 695, Pt. D, §3 (AFF). PL 2011, c. 542, Pt. A, §§66-68 (AMD). PL 2011, c. 657, Pt. EE, §§2, 3 (AMD). PL 2013, c. 310, §1 (AMD). PL 2021, c. 686, §§4, 5 (AMD).

Public Guardianship for Adults

Paul Saucier, Director
Office of Aging and Disability Services
October 25, 2023

Office of Aging and Disability Services
What We Do

Mission

We promote the highest level of independence, health, and safety for older adults and adults with disabilities throughout Maine.

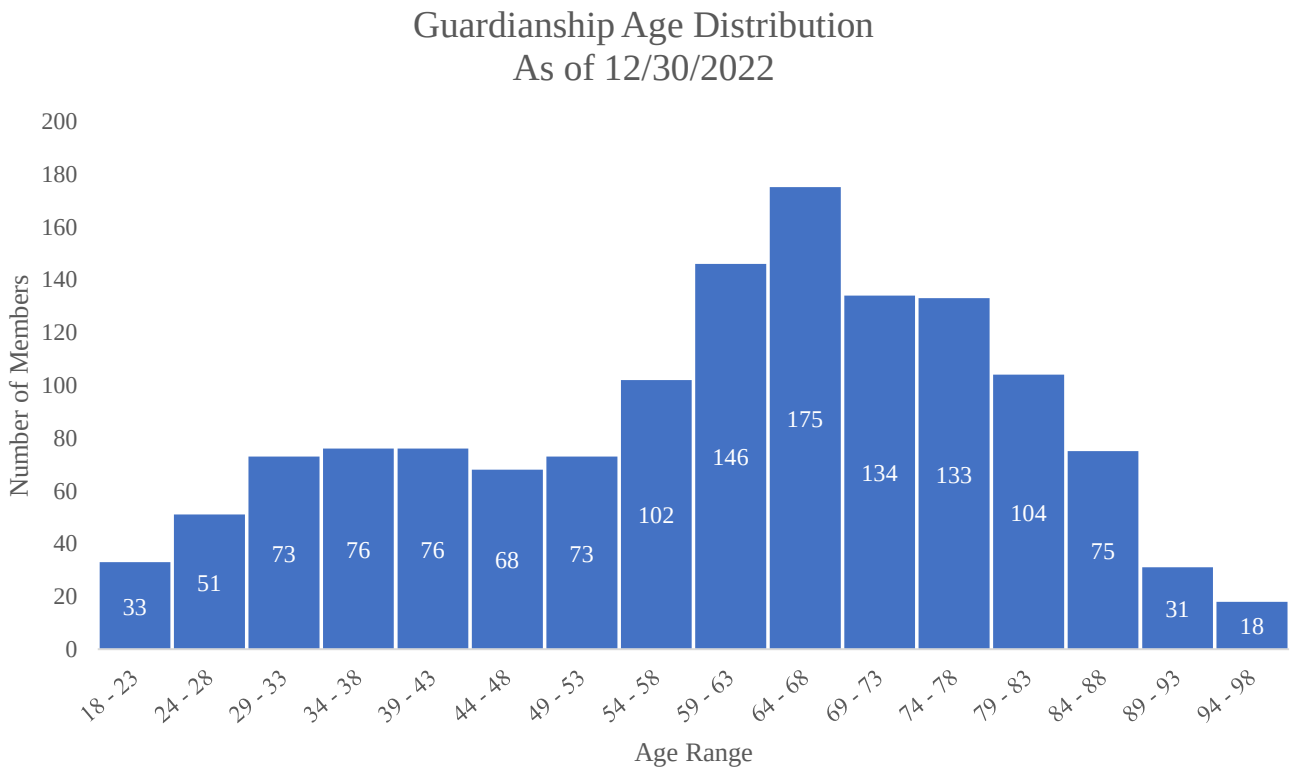
Office of Aging and Disability Services Public Guardianship Key Statistics

1,368	• Number of adults subject to public guardianship or conservatorship in CY 2022
$16.9M	• Assets under management on behalf of guardianship/conservatorship clients as of June 30, 2023.
41%	• Percent of adults subject to public guardianship in HCBS waivers in CY 2022
33%	• Percent of adults subject to public guardianship with serious mental illness in SFY 2022

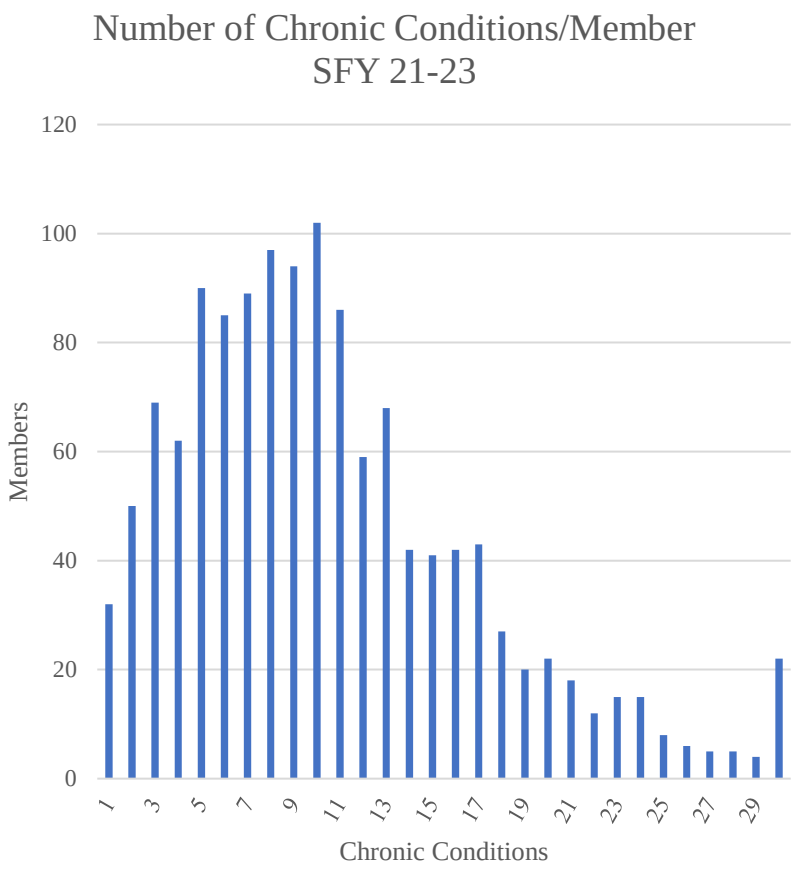
What are the demographic and health characteristics of individuals served by Maine's public guardianship program?

Adults Subject to Public Guardianship CY 2022

- In CY 2022, 1,368 adults were subject to public guardianship
- Just over half (54%) were men and 46% were women
- 60% (816) were 59 years of age and older

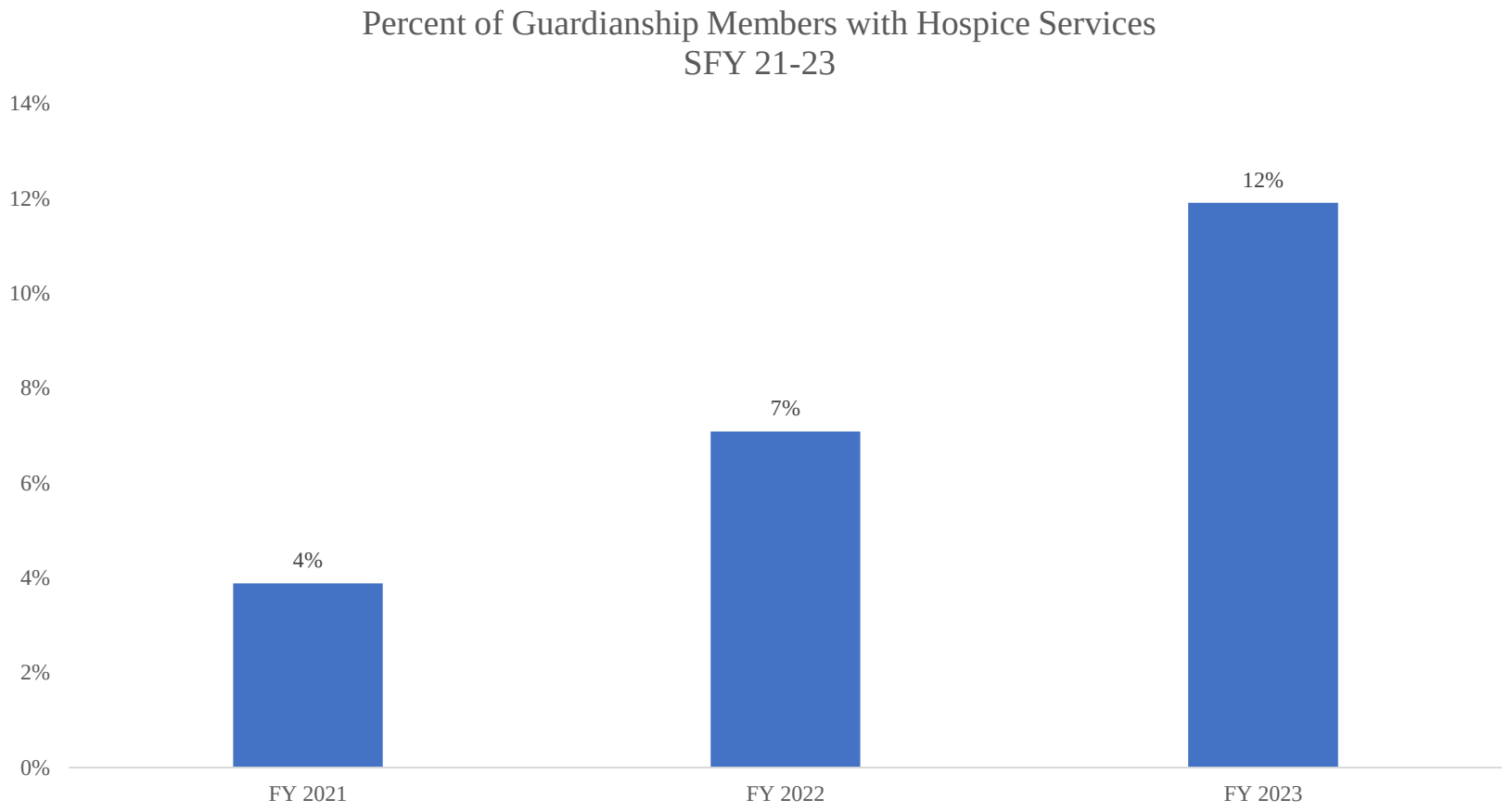


98% of adults subject to guardianship have chronic conditions, with most having multiple conditions

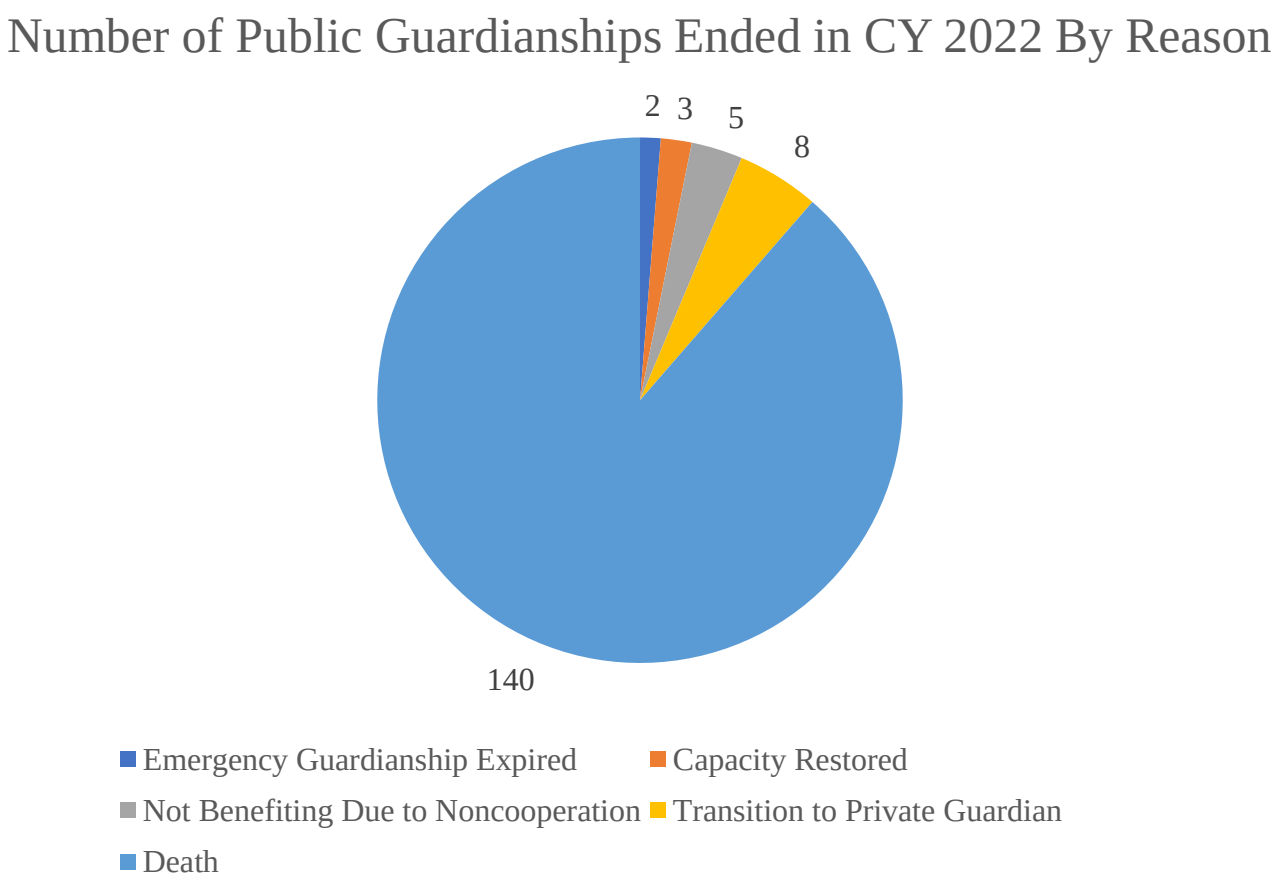


Top 10 Principal Diagnoses
Mild intellectual disabilities
Urinary incontinence
Hypertension
Moderate intellectual disabilities
Type 2 diabetes mellitus
Schizophrenia, unspecified
Schizoaffective disorder, bipolar type
Hypothyroidism
Autistic disorder
Dementia

As the guardianship population ages, the percent using hospice is rising



Most public guardianships end due to individuals passing away



How is a public guardian appointed?

Petitioning for Adult Guardianship (Public or Private)

Title 18-C MRSA §5-301. Basis for appointment of guardian for adult (emphasis added)

1. Appointment. On petition and after notice and hearing, the court may:

A. Appoint a guardian for a respondent who is an adult if it finds by clear and convincing evidence that the respondent lacks the ability to meet essential requirements for physical health, safety or self-care because:

(1) The respondent is unable to receive and evaluate information or make or communicate decisions, even with appropriate supportive services, technological assistance or supported decision making that provides adequate protection for the respondent;

(2) The respondent's identified needs cannot be met by a protective arrangement instead of guardianship or other less restrictive alternatives that provide adequate protection for the respondent; and

(3) The appointment is necessary or desirable as a means of enabling the respondent to meet essential requirements for physical health, safety or self-care

Public Guardianship

- When a request for public guardianship is received by the Department, a guardianship study is conducted by Adult Protective Services (APS)
- If APS determines through the guardianship study that public guardianship is appropriate, a petition to the probate court is prepared, parties are notified and the court holds a hearing
- If the court agrees, DHHS is appointed guardian and a Public Guardian Representative is assigned for the individual
- Public guardianship is a last resort. Considerations:
  - ✓ Basis for appointment criteria (same for public and private)
  - ✓ Suitable private guardian available and willing?
- Public guardianship status does not entitle an individual to services above and beyond similarly situated adults who are subject to private guardianship or without a guardian
- Public Guardian Representative and APS Investigator are separate roles with separate supervisors. When abuse, neglect or exploitation of a person subject to public guardianship is alleged, an APS Investigator is assigned the case.

What are the responsibilities and authority of a public guardian?

Guardianship Authority and Duties

- **Title 18-C MRSA §5-313 lists the duties of a guardian for an adult:**
  - ✓ Fiduciary
  - ✓ Promote self-determination
  - ✓ Reasonable care, diligence, and prudence
  - ✓ Decisions the adult would have made
  - ✓ Decisions in best interest of the adult if "would have made" is not known

- **Guardianship Order contains individualized information/limitations**
  - **Statute directs court to consider "**only those powers necessitated by the limitations and demonstrated needs of the respondent and enter orders that will encourage the development of the respondent's maximum self-determination and independence." **(18-C MRSA §5-301, sub-§2)**

Guardianship Representative Duties

- Public guardianship representatives:

  - ✓ Act on behalf of and as decision-maker for incapacitated adults subject to public guardianship and/or conservatorship
  - ✓ Support self-determination to the greatest extent possible (making decisions the adult would make if able to do so)
  - ✓ Report to the probate courts at least annually on each adult
  - ✓ Visit each adult face-to-face every 30-60 days
  - ✓ Understand and abide by the individualized guardianship order, and propose changes as needed (e.g., reduce or expand decision making; terminate guardianship)

Guardianship representative authority is limited by the probate code

- Public guardianship representatives may not take the following actions without securing approval from the probate court:

  - ✓ Revoke or amend a power of attorney or advance health care directive executed prior to the appointment of a guardian
  - ✓ Move the place of dwelling outside the state of Maine
  - ✓ Move the place of dwelling to a nursing home, mental health facility or other facility that restricts the ability to leave or have visitors
  - ✓ Sell or surrender the lease to a primary dwelling
  - ✓ Petition for divorce, dissolution or annulment of marriage

- Public guardianship representatives may not restrict the right to marry or to vote

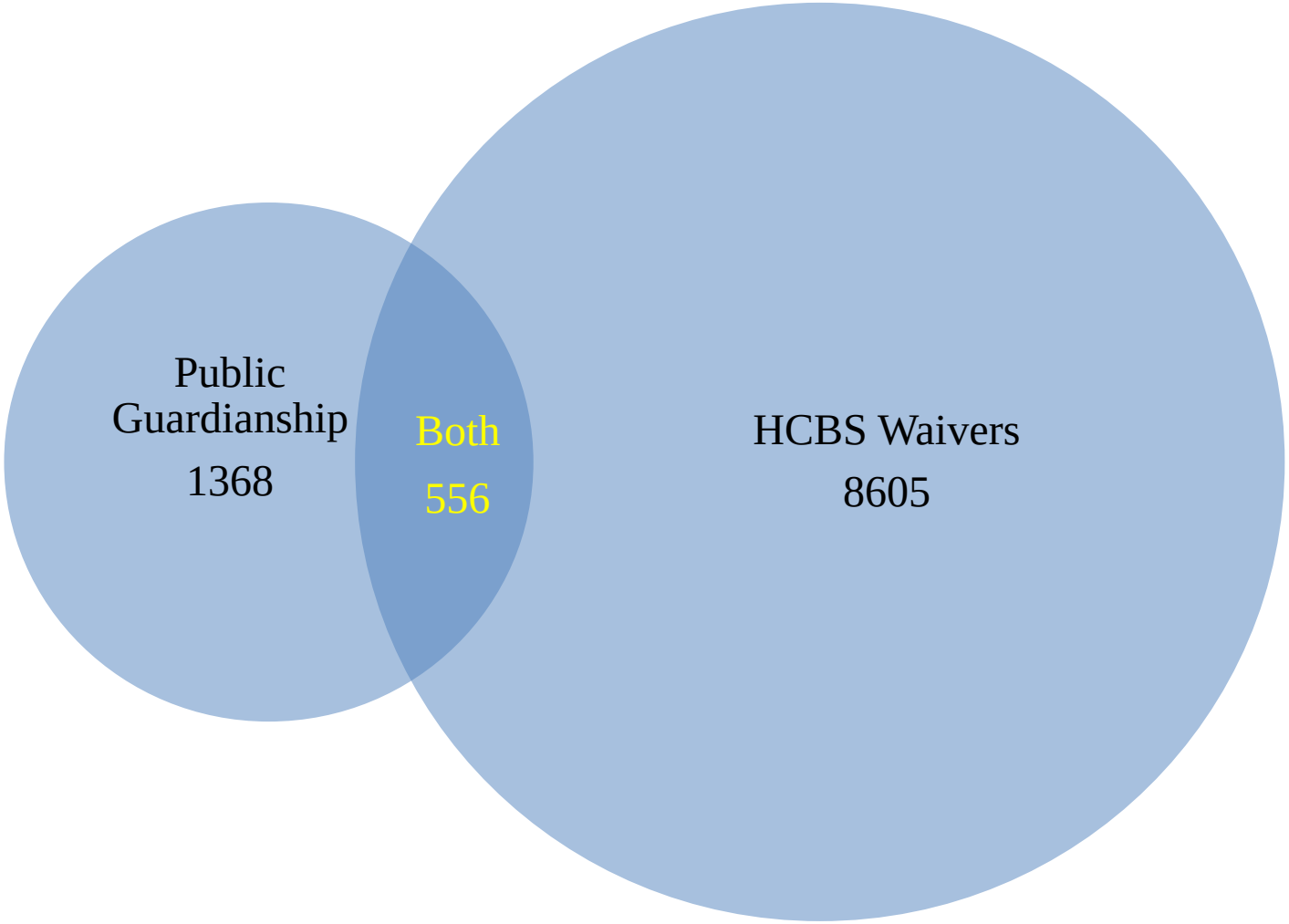
What happens when an adult subject to public guardianship dies?

When an adult subject to public guardianship dies:

- If abuse, neglect or exploitation is suspected, the guardian representative files a report with APS, a field investigation is opened and the Office of the Chief Medical Examiner (OCME) and law enforcement are alerted if not already involved
- All adult guardianship deaths are submitted to OCME for review regardless of circumstances
- The probate court is notified of all adult guardianship deaths through transmittal of the death certificate
- Additional steps are taken if the adult was enrolled in an HCBS waiver program

What is the relationship between public guardianship and the Aging and Disability Mortality Review Panel?

In CY 2022, 556 adults subject to public guardianship were enrolled in HCBS waivers



Public guardianship deaths and HCBS waiver deaths are reviewed by various external entities

Review of Public Guardianship Adult Deaths	Review of HCBS Waiver Adult Deaths
Guardian representatives review all deaths. If abuse, neglect or exploitation is suspected, a report is filed with APS, a field investigation is opened and the Office of the Chief Medical Examiner (OCME) and law enforcement are alerted if not already involved.	APS supervisor reviews all deaths. If abuse, neglect or exploitation is suspected, a field investigation is opened and OCME and law enforcement are alerted if not already involved.
All are submitted to the Office of Chief Medical Examiner for review regardless of circumstances. The probate court is notified through transmittal of the death certificate.	All are submitted to the Aging and Disability Mortality Review Panel for staff review regardless of circumstances.
Deaths of adults who are both subject to public guardianship and enrolled in HCBS waivers are submitted to both OCME and ADMRP.	

What is the relationship between the Aging and Disability Mortality Review Panel (ADMRP) and the Maine Elder Death Analysis Review Team (MeDART)?

MeDART and ADMRP: Case studies v. review of all deaths

	Maine Elder Death Analysis Review Team	Aging and Disability Mortality Review Panel
Target Group	Any older adults who died due to suspected abuse or neglect	All adults who died when enrolled in HCBS waiver programs
Review Body	Multi-disciplinary team coordinated by the Office of Attorney General since 2003	Multi-disciplinary panel coordinated by the Maine Center for Disease Control since 2021
Approach	Case study approach examining deaths nominated for review by members of the team	Comprehensive CDC staff review of all deaths, with staff identifying a subset for review by members of the panel

Recent Elder Justice Initiatives

Elder Justice Roadmap

- Elder Justice Coordinating Partnership
  - ✓ Established by Governor Mills by Executive Order, the Partnership is made up of government and private sector experts in law enforcement, advocacy and services
  - ✓ The Partnership met in 2020-21 and delivered the Elder Justice Roadmap to Governor Mills in December 2021
  - ✓ The Governor proposed and the Legislature approved key Roadmap priorities in the 2024-25 biennial budget:
    - Wrap-around services for older adults experiencing abuse, neglect, and exploitation (Elder Services Connections Program)
    - An APS Goods and Services program, to address emergency needs of clients experiencing abuse, neglect, and exploitation
    - Increased staffing capacity within the APS program
- In addition to the budget items, the Department proposed and Legislature approved a bill to require training for mandated reporters (PL 2023, chapter 36, sponsored by Sen. Moore)

JOINT STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

OCTOBER 25, 2023

Senator Baldacci, Representative Meyer and Honorable members of the committee.

I am Elizabeth Mitchell, Judge of Probate of Kennebec County, a position I have held for 7 years. For the past three years, I have served as President of the Probate Judges Assembly and have come to know much about the courts of all the 16 counties.

Thank you for inviting me today to share with you some information about the role Probate Courts play in Adult Guardianships with a focus today on Public Guardianship. Probate Courts also grant private guardianships for adults as well as guardianships for children. We are happy to share that information with you on another day if you wish.

Maine adopted the Uniform Probate Code in 2019 covering all aspects of the court: guardianships of adults and children plus wills, trusts and estates. Please see 18-C MRSA §5-301 for the current statute governing the appointment of a guardian of an

adult. The highest legal standard of clear and convincing evidence applies determining whether or not an individual lacks the ability to meet essential requirements for physical health, safety or self-care. The statute clearly requires the least restrictive alternative.

Of interest to you as you search for better monitoring of guardians is the 2019 requirement that all guardians must file an annual report to the court. I have provided the committee a copy of a required report with the name redacted; all reports must follow this form. Please note the number of visits the Public Guardian makes—every 30 to 60 days. Public Guardians have eyes on the individual throughout the year although the Court receives the report annually. All Probate Judges review the reports and can ask for additional information if concerns are raised and even call for a hearing.

Before the Court can adjudicate a person's incapacity and need for a Guardian, the Court must provide due process and protection of that individual in each proceeding.

- Adult required to attend hearing in person unless excused
- Highest legal standard of proof—clear and convincing evidence required
- Court must consider least restrictive guardianship
- Court must consider Supportive Decision Making
- Visitor reports to Court

- Attorney appointed if person requests or objects to guardianship
- Evaluation by medical professional required
- Appropriate plan of care required
- Annual reports required or immediate report if person is moved or has problem court needs to address
- Adult has power to request a termination if conditions change
- Court can order a hearing at any time if new information affecting the guardianship comes to light

You have raised many questions and I will try to answer some of those related to the Court. DHHS can best answer others. Catherine Moore, chair of the Registrars, is also here to answer questions from the perspective of those who ensure the proper functioning of our system.

I do have a handout with some of the answers and can expand on any questions you wish.

Thank you for the opportunity to share this information with you.

QUESTIONS FROM COMMITTEE

- GOAL TO HAVE TRANSPARENT UNIFORM OVERSIGHT OF ALL ADULT GUARDIANSHIPS.
    1. ENSURE COURTS GET ANNUAL REPORTS ON TIME AND THAT THE REPORTS ARE CURRENT—NOT CUT AND PASTE
    2. PUBLIC GUARDIANS HAVE VISITS EVERY 30 TO 60 DAYS. **REQUIRE IMMEDIATE REPORT TO COURT IF ANYTHING OBSERVED DURING ANY VISIT RAISES QUESTIONS ABOUT WELL BEING. FACILITIES NOT ALWAYS SERVING NEEDS OF ADULT**
    3. **PUBLIC GUARDIANS SHOULD REPORT FACILITY CONCERNS TO LICENSING DIVISION**

- LESS RESTRICTIVE CONSIDERATIONS
    1. SUPPORTIVE DECISION MAKING
    2. LIMITED GUARDIANSHIP: EXAMPLE MEDICAL ONLY
    3. HOME BASED CARE WHEN AVAILABLE AND APPROPRIATE
    4. SHORTER TERM REVIEW TO SEE IF ADULT HAS IMPROVED

- INDIVIDUAL SUBJECT TO GUARDIANSHIP
    1. REQUIRED TO PARTICIPATE EITHER IN PERSON, ZOOM, OR PHONE UNLESS EXCUSED FOR VALID REASON
    2. HAS ATTORNEY APPOINTED IF OBJECTS TO GUARDIANSHIP OR IF REQUESTS ONE. THE COURT REVIEWS CONCERNS RAISED BY PETITION, VISITOR, PROPOSED PLAN AND DOCTOR'S REPORT
    3. COURT APPOINTS INDEPENDENT VISITOR TO REPORT ON STATUS AND CONDITIONS.
    4. A QUALIFIED MEDICAL PROFESSIONAL MUST PRESENT EVIDENCE TO THE COURT.
    5. FULL EVIDENTIARY HEARING REQUIRED

- TERMINATION
    1. INDIVIDUAL OR GUARDIAN CAN REQUEST
    2. SAME PROCESS FOR DETERMINING CAPACITY/SAFETY
    3. ATTORNEY APPOINTED
    4. VISITOR APPOINTED
    5. PERSON UNDER GUARDIANSHIP CAN REQUEST HEARING ON OWN WITHOUT ALL REQUIRED FORMALITY

- EMERGENCY GUARDIANSHIP (EX PARTE)
    1. JUDGE REVIEWS FOR STATUTORY REQUIREMENTS
    2. REVIEW OF EMERGENCY REQUESTS OCCURS SAME DAY OR WITHIN 24 HOURS IF DISCHARGE FROM HOSPITAL TO MORE APPROPRIATE SETTING REQUIRE GUARDIAN. JUDGE GRANTS BASED ON EVIDENCE/FACTS OF CASE.
    3. JUDGE REVIEWS EMERGENCY GUARDIANSHIP TO DETERMINE IF IT SHOULD STAY IN PLACE UNTIL FULL EVIDENTIARY HEARING CAN BE HELD
    4. EMERGENCY GUARDIANSHIPS ARE NOT DETERMINITATIVE OF FINAL GUARDIANSHIP

- PRIVATE GUARDIANSHIPS
    1. ALL THE SAFEGUARDS APPLY
    2. STATUTE LISTS PRIORITY FOR APPOINTMENT
    3. GUARDIANS REQUIRED TO BE QUALIFIED.
    4. **GUARDIANS NEED A BASIC HANDBOOK**

POTENTIAL IMPROVEMENTS

1. VISITOR TRAINING
2. VISITOR MANUAL
3. REQUIRE ADULT PROTECTIVE SERVICE TO NOTIFY PROBATE COURT WHEN COMPLAINT IS LODGED AGAINST A GUARDIAN
4. REQUIRE DISTRICT COURT TO SHARE WITH PROBATE COURT THAT AN INDIVIDUAL IS UNDER COURT COMMITMENT WHEN SOMEONE IS SEEKING GUARDIANSHIP OF THAT SAME PERSON FOR MEDICAL REASONS AT THE DIRECTION OF THE MENTAL HEALTH FACILITY
5. ADDRESS THE SHORTAGE OF APPROPRIATE PLACEMENT OPPORTUNITES FOR ADULTS WHO NEED VARING LEVELS OF CARE
6. INCLUDE PROBATE IN DISCUSSIONS ABOUT SOLUTIONS.
   EXAMPLE: ELDER JUSTICE COORDINATING PARTNERSHIP MENTIONED IN DHHS PRESENTATION INCLUDES NO ONE FROM PROBATE YET MAKES THIS RECOMMENDATION:
   STUDY THE ABILITY OF THE PROBATE COURTS TO MONITOR AND ENFORCE STATEWIDE STANDARDS AND TRAINING FOR GUARDIANS AND EVALUATE OPTIONS FOR MAINE TO CREATE A PROGRAM FOR GUARDIANSHIP SCREENING.
7. UNDERSTAND AND FOCUS ON THE ROLE PROBATE COURTS CURRENTLY HAVE IN OUR SYSTEM OF CARE FOR INCAPACITATED ADULTS AS WELL AS FOR CHILDREN WHOSE PARENTS ARE TEMPORARILY UNABLE TO CARE FOR THEM. INCLUDE THEM IN ANY STAKEHOLDER GROUP SEEKING POSITIVE CHANGE FOR OUR VULNERABLE POPULATIONS.

DISABILITY RIGHTS MAINE

October 25, 2023

Senator Joe Baldacci, Chair
Representative Michele Meyer, Chair
Committee on Health and Human Services
Cross Office Building, Room 209
Augusta, Maine 04333

Re: Guardianship

Dear Senator Baldacci, Representative Meyer, and Standing Members of the Committee On Health and Human Services:

Senator Baldacci, Representative Meyer, and Standing Members of the Committee On Health and Human Services:

I'm Staci Converse, a Managing Attorney at Disability Rights Maine (DRM), Maine's designated Protection and Advocacy Agency. Our mission is to promote justice and equality by defending the rights and expanding opportunities for people with disabilities in Maine. Thank you for the opportunity to discuss our work towards a safer, more inclusive, and equitable future for people with disabilities, especially regarding our observations and efforts in guardianship. We value the Committee's inquiry into the myriad issues surrounding guardianship, which we believe are numerous in both concept and practice.

Before joining DRM, I had minimal awareness of adult guardianship. However, my perspective shifted significantly fifteen years ago when I began exclusively working with individuals labeled with intellectual and developmental disabilities, most of whom have guardians. Over the past 12 years, I've had the privilege of leading a team of 8 dedicated advocates and attorneys. Our efforts encompass representing more than 500 clients annually, providing training to numerous individuals and their staff, and maintaining a consistent presence in locations where people with developmental

disabilities labels reside, such as group homes and community support programs. Although data on guardianship in Maine is limited, our estimates indicate a striking fact: over 70 percent of individuals receiving developmental services in Maine are under guardianship, double the national average.

We are here due to a series of Maine Monitor articles shedding light on various issues faced by citizens under guardianship. These issues include the prevalence of guardianships in Maine and the limited utilization of alternatives, such as supported decision-making. These articles clearly indicate that guardianships are not always used as the last resort, are often lifelong and are extremely challenging to terminate. Most concerning, the Monitor reported eight deaths of Maine citizens under public guardianship, with causes that were undermined by the medical examiner's office, which also noted that several were because of overmedication. Although many details about these deaths remain uncertain, it's evident that guardianship failed to prevent them. We are determined to understand why and to find solutions to prevent such tragedies in the future.

Guardianship takes the away the ability of one person to make decisions about their lives and gives it to another. Guardianship essentially strips an individual of their legal identity as a "person." In our work we often find that people assume that a guardianship can protect a person in ways it cannot. While a guardian is able to make decisions, unless they are with the person every second of every day, it is impossible to protect them from abuse, neglect, and exploitation. In our experience, guardianship undermines an individual's ability to protect themselves – it is an institution that tells people their voices don't matter and that their decisions don't matter.

Drawing from our decades of experience, two actions can aid individuals under guardianship and prevent needless deaths, abuse, neglect, and exploitation. First, we must reduce the number of people placed under guardianship in Maine. Second, we must bolster oversight of providers assisting individuals with developmental disabilities.

Guardianship often falls short of its presumed benevolence. Recent media attention highlights its detrimental impact on those it's meant to protect, exemplified by Britney

Spears who recently ended her 13-year conservatorship (known as a guardianship in Maine). Ms. Spears has been vocal about the toll of her guardianship on her mental well-being, isolation, career decisions, personal relationships, and the ability to make choices about her reproductive and medical matters.

While we recognize this may seem counterintuitive to many, guardianship, while intended to protect people, often leads to silencing the voice of people subject to guardianship to such a degree that it leads them to be at significantly more risk of abuse, neglect, and exploitation. Guardianship makes them believe their words do not matter. This leaves them vulnerable. They lack a say in significant decisions that directly affect their lives. To illustrate, in one case I represented an individual who sought to terminate his guardianship. During the guardianship termination hearing, I asked their doctor to assess their capacity to make medical decisions. The doctor couldn't provide an opinion because they had never engaged in a meaningful conversation with the individual, emphasizing the profound silencing of their voice and the vulnerability that results from guardianship.

There's no need to silence someone's voice because they, like all of us, need support with making decisions. It's not an all-or-nothing choice; there are a multitude of tools available to provide support for individuals in making decisions, such as powers of attorney, advance healthcare directives, social security rep payees, technology, releases of information, and supported decision making. Supported decision-making a valuable alternative to guardianship, that respects an individual's autonomy and allows them to make choices about their own life. It encourages collaboration with trusted supporters who assist in understanding options and making informed decisions, ultimately fostering self-determination while maintaining a safety net of supporters. Unlike guardianship it presumes capacity of the individual and teaches them what they say matters – whether that's saying no to psychotropic medications the person doesn't believe they need or saying no to someone who wants their money.

The preference for supported decision-making or other alternatives over guardianship isn't just DRM's or my personal viewpoint. In 2019, the Maine legislature overhauled its probate code to mandate that guardianship should only be an option if less restrictive methods, including supported decision-making, prove inadequate. Supported decision-making has been endorsed and promoted by the American Bar

Association, the National Guardianship Association, the American Civil Liberties Union, several federal bodies and agencies, including the US Department of Education, the Department of Health and Human Services, and the National Council on Disability, the Autistic Self Advocacy Network, the ARC, and several other prominent groups in the legal, advocacy, and governments sectors.

While supported decision-making is a model widely endorsed, its utilization in Maine remains tragically limited. The 2019 revision of our probate code was a pivotal step, crystallizing what was previously implicit: guardianship should be the final recourse, only ordered when every single other less restrictive alternative have been exhausted. The law now mandates our courts to conclusively rule out all such alternatives before ordering guardianship. Yet, based on anecdotal accounts, there seems to be a gap between legislative intent and practical application, particularly when guardianship is initiated by family or friends, which constitutes the majority of such cases. The Maine Monitor's recent article further underlines this disparity, highlighting that in the almost four years post the law's enactment, Maine's probate judges have seldom opted for supported decision-making. The reporter attributed this to limited training judges received on this alternative, leading to a lack of clarity on its implementation.

Those of us who attended Maine Law might be familiar with the phrase "law is a lawyer-driven process." This means that law and the legal process do not develop without lawyers to develop it on behalf of the clients they represent. Guardianship, at its core, is a legal process. It requires advocacy and argument to ensure it works correctly. In one of its articles, the Maine Monitor noted that probate court judges remained unsure how to implement less restrictive alternatives like Supported Decision-Making in lieu of guardianship. It is the job of lawyers to make these arguments to the court. When a lawyer represents a person for whom guardianship is sought, it is the attorney's job to say "I have met with my client and done my research, and here is something that is less restrictive that will work." When there are no lawyers to make these arguments, and there almost never is, there is no wonder the court is left unsure whether the burden to eliminate the possibilities of less restrictive alternatives has been met. Just like the criminal justice process does not work when there are not attorneys on both sides, guardianship law, no matter how good it is, does not work when there are not attorneys, at least to ensure that petitioners are forced to prove that the most extreme deprivation of a person's rights is warranted.

Appointing an attorney in every single case in which guardianship is sought is the best and most effective way to ensure the law is followed and to minimize and eliminate unnecessary guardianships.

Another way to reduce the number of people subject to guardianship and increase court oversight would be to stop awarding them without an end date. Or to require a hearing, where the parties appear in person, to examine the need for guardianship after 5 years. By ending indefinite guardianships and/or introducing mandatory five-year review hearings, we ensure that the process remains fair and just. This approach could help unwarranted, long-lasting guardianships while providing a safety net when genuinely needed. It's an important step towards a more accountable guardianship system that respects the rights of those it serves. Maine residents, notably those under private guardianship, are wary of challenging their guardians for fear of alienating those who have supported them throughout their lives.

Drawing from our extensive experience in case work, ongoing provider monitoring, and addressing rights violations, we've pinpointed significant issues in the Department of Health and Human Services (DHHS) oversight system, as well at the oversight of provider agencies who are paid to adequately support people. A recurring concern is the inadequate training of staff, both in general and concerning the specific needs of the individuals they support. Additionally, there's a notable lack of support and supervision from agency leadership for frontline personnel. To effectively tackle these challenges, agencies like the Office of Aging and Disability Services (OADS) and licensing authorities must enhance provider regulation and accountability mechanisms. These entities should also implement a hands-on approach, directly visiting service recipients and actively engaging with them to ensure their needs and rights receive proper attention and protection.

Maine stands at a critical juncture where immediate action is needed to address the pervasive and deeply concerning issue of psychotropic medication usage among individuals subject to guardianship. The sobering revelation that overmedication was cited as the cause of several deaths by the medical examiner, as reported in the Maine Monitor, should serve as a glaring red flag. The system assessment conducted by the Center for START Services on behalf of the Office of Aging and Disability Services (OADS) further underscored the urgency of this matter. The report's findings, based

on an analysis of Medicaid claims data, are nothing short of alarming. It disclosed that a staggering 56% of individuals residing in group homes are prescribed psychotropic drugs, with an additional 29% receiving antipsychotics despite lacking a psychiatric diagnosis. As noted in the report, these practices are not only controversial but also potentially harmful, given the lack of conclusive evidence supporting their efficacy and the risk of debilitating side effects. The report recommended that to protect the well-being and rights of individuals under guardianship, DHHS conduct a comprehensive review of polypharmacy practices, the implementation of robust policies and procedures to ensure appropriate medication use, and the wide dissemination of prescribers' guidelines. DHHS's intervention is not just advisable; it is an ethical imperative to ensure the safety of those they provide services.

In closing, it is evident that significant reforms are urgently needed to address the critical issues surrounding guardianship, psychotropic medication use, and the oversight of service providers in Maine. We are at a pivotal moment where we must prioritize individual empowerment and autonomy while strengthening safeguards to protect individual receiving services. By reducing the number of indefinite guardianships and implementing mandatory five-year review hearings, we can strike a balance that respects both the rights of individuals and the need for protective measures when necessary. Additionally, the systemic problems identified within the Department of Health and Human Services (DHHS) demand immediate attention and action. The overmedication of individuals with developmental disabilities is a grave concern, and DHHS must take a proactive role in addressing this issue through thorough review, policy implementation, and adherence to prescribers' guidelines. We have a collective responsibility to create a future where all individuals, can exercise their rights, live with dignity, and be safe from harm.

Thank you for your time and attention to these matters.

Sincerely,

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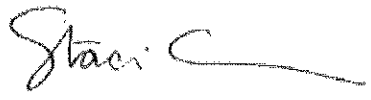

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MARK FLOMENBAUM, MD, PHD
Chief Medical Examiner

LINDSEY CHASTEEN, MBA
Office Administrator

October 25, 2023

Joint Standing Committee on Health & Human Services
Maine 131st Legislature

Re: Deaths while Under Public Guardianship

Esteemed Committee:

Senator Baldacci, Representative Meyer, and members of the Health & Human Services Legislative Committee, I am Lindsey Chasteen, the Office Administrator for the Office of Chief Medical Examiner (OCME). I hope to provide some background information on the language used by the OCME, and how we operate.

The statutory responsibility of the Medical Examiner's Office is to determine the cause and manner of death in individuals whose death fall into our jurisdiction. Cause and manner of death are considered opinions, and judgment is required when making these determinations. The Chief and Deputy Chief Medical Examiner, who are board certified forensic pathologists, determine cause and manner of death.

A "cause of death" is the physiologic reason or mechanism by which an individual died. An example of this may be "hypertensive cardiovascular disease", or "gunshot wound of head". The manner of death is a "classification ... based on the circumstances of the death and how that cause came into play (National Association of Medical Examiners, A Guide for Manner of Death Classification, 2002)". In Maine, a death may be classified as "Natural", "Accident", "Homicide", "Suicide", or "Undetermined".

A homicide is usually defined as a death resulting from a willful act committed by another person. The manner of death makes no implication as to whether a *criminal* act was committed. When one person shoots another person, the death is classified as a "Homicide", but that manner of death does not mean the death was the result of a *criminal* act. Examples of this might be self-defense; or if law enforcement is in an armed confrontation and the assailant is shot and killed; or if an individual with dementia pushes down another individual who sustains a traumatic head injury and

subsequently dies. In each of these examples the manners of death would be classified as a "Homicide", but identifying a criminal element might prove difficult.

Other examples where the manner of death *is* the result of another person's willful act, but *not* classified as a "Homicide" are infant deaths due to co-sleeping or deaths resulting from multi-vehicle accidents.

In 2021 the Office of Chief Medical Examiner saw an increase in the number of death referrals from the Department of Health & Human Services – Adult Protective Services unit, for people who had been under public guardianship. At that time, the OCME implemented a policy change to take jurisdiction and investigate all deaths of individuals under public guardianship. At a minimum, the OCME will conduct an external examination with toxicology.

In deaths of individuals under public guardianship, a manner of death determination is made after reviewing the decedent's circumstances of death, medical records, Medical Examiner Report of Examination, and the toxicology results. The OCME determination of cause and manner of death is a description of the mechanism and circumstances of the death, and emphatically does not imply any criminal act took place.

If you need further clarification or additional information, please reach out to me either by phone [624-7188] or by email [Lindsey.Chasteen@Maine.gov].

Thank you.

Supported Decision-Making

A User's Guide for People with Disabilities and Their Supporters

Promoting Independence as an Alternative to Guardianship in Maine

Acknowledgements

Disability Rights Maine would like to sincerely thank the South Carolina Developmental Disabilities Council, Protection and Advocacy for People with Disabilities, Inc. (the Protection and Advocacy Agency in South Carolina), and the South Carolina Supported Decision-Making Project. This Guide is based in large part upon the Supported Decision-Making manual created through their collaboration.

DRM would also like to thank Supported Decision-Making New York (SDMNY) and Honorable Kristin Booth Glen for their invaluable training and inspiration.

DRM also extends warm thanks to our partners for their support of this handbook: the self-advocates of Maine's Developmental Disabilities Partners for Positive Change, the Maine Developmental Disabilities Council, the Center for Inclusion and Disability Studies, Maine Parent Federation, and Speaking Up for Us.

DISABILITY RIGHTS MAINE

Maine Parent Federation
Since 1984 . . . because every family matters

Maine Developmental Disabilities Council

1865 THE UNIVERSITY OF MAINE
Center for Community Inclusion and Disability Studies
University Center for Excellence in Developmental Disabilities

SUFU TWENTY FIVE YEARS STRONG

Introduction

Purpose of this Manual

This Guide was created by Disability Rights Maine to provide information about Supported Decision-Making to individuals with disabilities and their families and supporters. The goal of this Guide is to illustrate how Supported Decision-Making can be used to help people with disabilities in making their own decisions, and in reducing more restrictive means of support such as guardianship. Supported Decision-Making can help preserve a person's autonomy and independence, while still providing the person with support from family, friends, and community.

For questions or more information, please contact Disability Rights Maine at 1-800-452-1948, send an email to advocate@drme.org, or visit our websites at www.supportmydecision.org and www.drme.org.

Disclaimer

This material is presented for educational purposes only. It is not and does not take the place of legal advice in any specific situation, nor is it offered as such by the author. The information contained herein is based on the law at the time this Guide was produced. If you have questions about your legal rights, please consult an attorney.

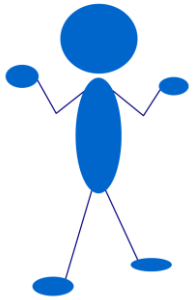
Table of Contents

A sample Supported Decision-Making Agreement appears at the end of this Guide.

Chapter 1: Overview of Supported Decision-Making

What is Supported Decision-Making?

Supported Decision-Making (sometimes referred to as SDM) is "a series of relationships, practices, arrangements, and agreements of more or less formality and intensity designed to assist an individual with a disability to make and communicate to others decisions about the individual's life."[1]



Put more simply, Supported Decision-Making is a model to support people with disabilities in making and communicating their own decisions about their lives.

We all use Supported Decision-Making. For example, many people consult with family and friends before making big decisions, such as where to live. Sometimes we consult with experts to help us make complicated decisions, such as talking to our doctors about medical decisions. Talking to experts can help us understand complicated information, even though the final decision is up to us, not the doctor.

Supported Decision-Making emphasizes the importance of all people deciding what their lives should look like.

At the center of SDM is the **Decision-Maker**. The Decision-Maker chooses people whom she would like to help her make decisions. These people are called **supporters**, and they can be family, friends, service providers…anyone that the Decision-Maker chooses, as long as the supporters agree to serve in this role.

The Decision-Maker decides **what kinds of decisions** she would like help with. Examples include decisions about how to spend money, where to live, education, relationships, or healthcare.

The Decision-Maker also decides **what kind of help** she would like in making certain types of decisions. For example, the Decision-Maker may want help with gathering information. Or, she may want help with understanding information. Or, she may want help with communicating a decision to others. The possibilities are endless.

Supported Decision-Making can be as formal or as informal as the Decision-Maker would like it to be. The individual and her supporters may sign a Supported Decision-Making Agreement (SDMA). This is a written plan, developed by the Decision-Maker and her team, that gives information about who the supporters will be, what kind of decisions will be supported, and what kind of support is requested. An example of a Supported Decision-Making Agreement can be found at the end of this Guide. It can be filled out as written, or it can be changed to suit the needs of the individual.

HOW DOES

Supported Decision Making

WORK?

1 choose

The individual decides who will be involved in supporting them. The supporters must also agree to be involved

2 discuss

The individual and supporters talk about how the individual will be supported, which can include finance, healthcare, employment, and others. The individual can choose to have support in some areas but not others.

3 make a plan

The individual and supporters create a document that outlines how the individual will be supported. This is the Supported Decision Making agreement.

4 sign

The individual and supporters sign the Supported Decision Making agreement. The agreement can be revised if necessary in the future. Everyone reveives a copy of the agreement.

Benefits of Supported Decision-Making

Supported Decision-Making is based on the idea of **self-determination**. This means that an individual directs the plan for her own life. She decides what is most important to her, sets goals, and, with the help of those around her, works to achieve those goals so that she can live the most fulfilling life possible.

All people deserve a life of independence, gainful employment, and fulfilling relationships with friends and romantic partners. Supported Decision-Making is based on the idea that making decisions is a skill that can be learned. Supported Decision-Making helps people learn to manage and avoid risks. This is known as "dignity of risk," and it means that taking reasonable risks is a necessary part of self-determination and self-esteem. Supported Decision-Making preserves dignity of risk.

Several studies have found that people who exercise more self-determination are more likely to live independently, have greater financial independence, be employed at higher paying jobs, and make greater advances in their employment.[2] In addition, self-determination has been shown as a predictor of post-high school success in employment and independent living.[3]

Supported Decision-Making in Maine

Supported Decision-Making has been gaining momentum in the United States and internationally. In the U.S., Supported Decision-Making has been endorsed and promoted by the American Bar Association, the National Guardianship Association, and a number of federal advisory bodies and agencies, including the Department of Education, the Department of Health and Human Services, and the National Council on Disability.

Likewise, in Maine, people have been utilizing the concept of Supported Decision-Making more and more. Disability Rights Maine was a founding partner of the Supported Decision-Making Coalition, which sought to bring SDM to Maine. Other Coalition members included individuals with disabilities, the Maine Department of Education, Legal Services for the Elderly, the Maine Long-Term Care Ombudsman Program, the Maine Department of Health and Human Services (DHHS), the Maine Developmental Disabilities Council, the Maine Parent Federation, the Maine Center for Community Inclusion and Disability Studies, and adult and children service providers. DHHS has been promoting Supported Decision-Making for transition-age youth in its Guide to Transition Services since 2016.

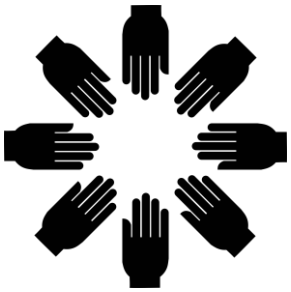
As of September 2019, Maine's new Probate Code is in effect. It specifically requires that less-restrictive alternatives, including Supported Decision-Making, be attempted before a probate court will consider granting a guardianship. The adoption of this new Probate Code shows that Maine is recognizing the importance of self-determination, and that guardianship is to be used only as a last resort. If a guardian is appointed, Maine law requires that a

guardianship be limited to only those areas in which the individual needs assistance. Overly restrictive measures can limit an individual's development of important independent living skills.[4]

Supported Decision-Making As an Alternative to Guardianship

It's never too early to start thinking about Supported Decision-Making. Asking an individual where and with whom she'd like to live, or what kind of job she would like, can help set the foundation for Supported Decision-Making. Practice consent by having the person make decisions for herself. **Note that because an individual makes a poor decision does not mean he or she is unfit to make decisions altogether.** We all make bad decisions sometimes. All people should have opportunities to learn from failure. Sound decision-making is a skill that must be learned and practiced over time, like many other skills that are necessary for independence.

Explore least restrictive supports first. Instead of focusing on what a person is unable to do, pay attention to her strengths. A person with a disability should experience responsibility instead of being shielded from decision-making. Explore informal supports and seek assistance from disability agencies that may offer skill-building and technical assistance. Medicaid waiver services and case managers can help connect people with supported employment services, independent living skills training, and other resources.



When considering the barriers to independence, ask whether they can be lessened by measures like assistive technology, training, opportunities to socialize, role-playing, and other means. Consider the person's communication methods, mental state,

access to stimulating environments, adequacy of supports, and side effects from medication before deciding that an individual is unable to make decisions.

Chapter 2: Other Alternatives to Guardianship

In addition to Supported Decision-Making, there are many other options to consider that address needs and promote safety and are less restrictive than guardianship. Below are some examples. They can all be used to promote independence and can be part of a Supported Decision-Making plan.

Power of Attorney

A Power of Attorney is a document that allows one person (an "agent") to make certain types of decisions on behalf of another person (the "principal"). The principal signs a document, called the Power of Attorney, to allow the agent to make certain types of decisions for the principal. A Power of Attorney does not take away decision-making authority from the principal; it merely shares the decision-making authority with the agent. The title "Power of Attorney" can be confusing, because neither the principal nor the agent needs to be an attorney. A Power of Attorney usually authorizes an agent to make medical decisions (called a Healthcare Power of Attorney) or financial decisions (called a Financial Power of Attorney).

A Power of Attorney can be customized depending on when and under what circumstances a principal would like assistance. For example, a principal might only want his agent to be able to make healthcare decisions if the principal is unable to do so himself. A Healthcare Power of Attorney might specify what kind

of end-of-life decisions a principal would like taken if the principal is unable to make those kinds of decisions himself. In Maine, this is called an Advance Healthcare Directive. Some people also refer to this type of document as a Living Will.

A Power of Attorney is less restrictive than a guardianship because it involves a principal sharing decision-making authority with an agent, whereas a guardianship takes away decision-making authority from one person and transfers it to another. The principal can revoke the Power of Attorney at any time, meaning it can be canceled. Powers of Attorney generally do not require court approval to create or to cancel.

Release of Information

It is against the law for certain types of providers such as medical providers, banks, or schools, to share personal information about their clients with others. Signing a release allows a provider to share information with another person of an individual's choosing. For example, a patient may sign a release to allow his doctor to speak to his parents about his health care information. Or, a person may sign a release with his school to share certain information with his parents. A release does not allow the other person to make decisions for the individual; it only allows information to be shared. A release can be changed or revoked by the person at any time by letting the provider know.

Trust

Trusts allow a third party to hold money and assets on behalf of someone else (called a "beneficiary"). There are many different ways to set up a trust, and some are tailored specifically for those with disabilities so as not to impact other benefits. These are called Special Needs Trusts. Because of the many different ways a trust may be arranged, it is best to speak with a financial

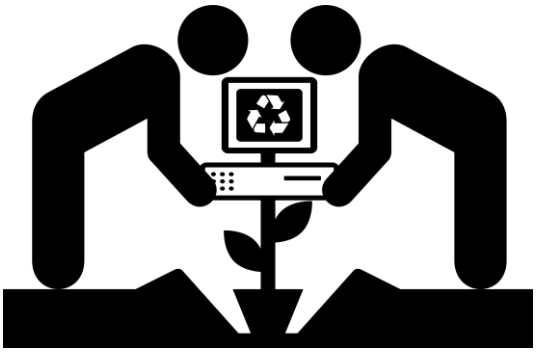
manager or an attorney who can accurately assess a person's needs.

Representative Payee Program

Offered through the Social Security Administration, this program allows a representative to manage a beneficiary's Social Security or SSI payments. A representative may be responsible for using benefits to pay an individual's expenses and keeping track of expenditures. Typically a family member or other trusted adult is chosen to act in this role. However, one may be appointed through the Administration.

Assistive Technology

Today, there are more kinds of technology than ever before that can help people be more independent. Some types of technology are very simple, such as devices that help people manage their medication by organizing medication and providing reminders. There is also financial technology that can be automated to help people pay recurring bills, or learn to budget and manage their own money. There is technology to help people communicate and technology to help people with everyday tasks such as cooking. Chances are, if a person needs assistance with a certain task, there is a type of technology that can help that person complete that task independently.



Examples of Options to Address Various Needs Related to Decision-Making:

Need	Task	Can this be accomplished by:
Money Management	• Learning to recognize and prevent exploitation • Managing accounts, assets, and benefits	• Money-managing app on phone • Seeking financial counseling • Representative Payee Program • Conservatorship or trust
Healthcare	• Taking medications as needed • Maintaining hygiene and diet • Avoiding high-risk behaviors • Making decisions about medical treatment	• Using apps to help remember to take medication and perform hygiene tasks • Getting advice from professionals • Visiting a healthcare professional to discuss information regarding prevention and safety • Allowing a home health aide to assist in daily living tasks • Having individual sign HIPAA release • Obtaining Healthcare Power of Attorney or Living Will
Employment	• Looking for, gaining, and retaining employment	• Enrolling in job coaching services, such as supported employment programs • Using Vocational Rehabilitation, Medicaid waiver services, or other employment providers to become job-ready

Relationships	• Behaving appropriately with friends, family, and co-workers • Making decisions about sexual relationships	• Role-playing and practicing appropriate behavior • Visiting a health center to learn more about contraception • Speaking with loved ones about healthy relationships
Community Living	• Living independently • Maintaining habitable conditions • Accessing community resources	• Incorporating adaptive and assistive technology • Setting reminders to complete home maintenance tasks • Making a list of community resources, such as transportation
Personal Decision-Making	• Understanding legal documents (contracts, leases, powers of attorney) • Communicating wishes • Understanding legal consequences of behavior	• Allowing supporters to help explain contracts and other legal documents • Having the individual demonstrate understanding of consequences, such as through role-playing • Seeking advice from professionals
Personal Safety	• Avoiding common dangers • Recognizing and avoiding abuse • Knowing what to do in an emergency	• Role-playing scenarios, such as what to do in case of fire • Discussing signs of healthy and unhealthy relationships and abusive behaviors • Writing down emergency numbers

Chapter 3: Self-Advocacy in Supported Decision-Making

Sometimes, the most valuable support is helping a person with a disability advocate for herself. Advocating for yourself means letting others know what you want and need. All people have civil rights. All people have the right to make decisions about their own lives, including where they work, live, and with whom they spend time. All people have the right to vote and get married if they choose. All people have the right to make decisions about medical treatment and medication.

Most of us need help making decisions, so we turn to those we trust to guide us. For example, you might want your parents to be able to come into the exam room with you at the doctor's office so they can ask any questions you may forget to ask. Or, you may want a family friend to help you with finances because paying the bills and keeping track of how your money is spent can be complicated. You don't have to have a written agreement for people to assist you in decision-making, but it may be helpful so everyone is clear on how you want to receive this support.

A Supported Decision-Making Agreement lets others know who will help you, with what areas you need support, and what kind of support you would like. Remember, just because you may need help in some areas does not mean you are unable to make decisions for yourself! Like any skill, decision-making takes practice.

Supported Decision-Making and Transition Planning

Supported Decision-Making is intended for children, adolescents, and adults. The earlier a person and her supporters start

learning about and using Supported Decision-Making, the better! It is never too early to begin learning the skill of decision-making.

Supported Decision-Making can and should be part of the process of transition planning for young people entering adulthood. In Maine, turning age 18, also called the "age of majority," means that all of the rights and responsibilities formerly held by the young person's parents or guardians are transferred to the young person. The young adult can now legally consent to medical care, make financial decisions, get married, and enter into legal contracts such as leases. When they turn 18, young adults who receive special education services are now the decision-makers with regard to IEPs and transitioning to adult services.

Turning 18 does not mean that a young adult can't access supports. To the contrary, Supported Decision-Making encourages young people to identify areas where they need support and to identify people to help them make decisions. A student can use Supported Decision-Making as part of an IEP, notify her team who her supporters are, request that the school share information with her supporters, and inform her supporters of upcoming meetings.

Supported Decision-Making for People Already Under Guardianship

Supported Decision-Making may be a tool that can prevent a person from coming under guardianship, but it can also be a useful tool for people already under guardianship. Supported Decision-Making can help a person under guardianship be more involved in decision-making. The end result might be ending the guardianship, limiting the guardianship, or otherwise giving people subject to guardianship more control and self-determination over their own lives.

Chapter 4: Identifying Which Types of Decisions Need Support and What Kind of Support Is Wanted

There are many areas of life in which a person might need help with making decisions. Some examples might be decisions involving finances, healthcare, education, employment, housing, social life and relationships, or legal matters. A person might want help with other kinds of decisions not listed here. The Decision-Maker needs to think about which kinds of decisions he can make alone, and which might require some support.

Thinking about what kind of decisions you might need support with leads to thinking about what kind of support you would like. There are many types of support available to help a person make decisions. Some kinds of support are:

- Support in gathering information needed to make a decision
    - For example, you might want help with gathering information about available apartments in order to make a decision about where to live.
- Support in understanding information
    - For example, you might want help understanding the language in a lease in order to decide whether to sign it. Or, you might want help understanding what a doctor is recommending in order to decide on medical treatment.
- Support in understanding the consequences of different decisions

    - For example, it might be helpful to make a list, or discuss pros and cons to making a particular decision.
- Role-playing activities to help understand choices
- Bringing a supporter to personal appointments, such as doctor appointments, in order to take notes and help you remember information and discuss your options
- Advocating for extra time to think about choices and make decisions
- Taking classes to learn about healthy choices, such as classes about healthy relationships, or learning about finances
- Identifying technology that might increase independence
    - For example, there are payment apps that can make automatic payments to regular bills, budgeting software, or calendar reminders.
- Helping you communicate your decision to others
- Helping to make sure your decisions are carried out

You might want different types of support with different types of decisions. For example, you might want a higher level of support in making medical decisions than you do in making housing decisions. Supported Decision-Making Agreements are meant to be individualized so that the Decision-Maker is getting exactly the type of support he or she would like to have.

When Do I Want Support and What Kind of Support Do I Want?

The following chart can help you decide what kind of decisions you would like support with, and what kind of support you would like.

Check the boxes to say if you need support in each area, though not every category may be applicable to you. When you check the "I need some support" box, you should think about who you

might want to support you, and write what kind of support you need under the corresponding box. You can use the information in this form to help you fill out a Supported Decision-Making Agreement.

	I can do this alone	I need some support	What kind of support do I need?
 **Money Management**			
Paying the rent and bills on time (for example, cell phone, electricity, internet)			
Keeping a budget so I know how much money I can spend			
Making big decisions about money (for example, opening a bank account, signing a lease)			
Making sure no one is taking my money or using it for themselves			
 **Healthcare**			
Choosing when to go to the doctor or the dentist			

	I can do this alone	I need some support	What kind of support do I need?
Making medical choices in everyday situations (for example, check-up, medicine from the drug store)			
Making medical choices in serious situations (for example, surgery, big injury)			
Making medical choices in an emergency			
Understanding how healthcare costs are covered (for example, Medicaid, private insurance, etc.)			
Making choices about birth control or pregnancy			
Remembering to take medicine			
Making decisions about maintaining a healthy lifestyle			
 **Education**			
What classes I will take			

	I can do this alone	I need some support	What kind of support do I need?
What accommodations I need at school			
Deciding what college to attend or what to do after high school			
Telling people what I want and don't want			
Telling people how I make choices			
Making sure people understand what I am saying			
 **Employment**			
Choosing if I want to work			
Understanding my work choices			
Choosing classes or training I need to get a job I want, and taking these classes			
Applying for a job			
Going to my job every work day			
Knowing what accommodations I need at work and how to request them			

	I can do this alone	I need some support	What kind of support do I need?
Understanding the employee handbook or work policies			
Relationships			
Making choices about sex			
Choosing if I want to date, and who I want to date			
Making choices about marriage			
Community Living			
Choosing where I live			
Choosing who I live with			
Choosing what to do and who to see in my free time			
Keeping my room or home clean			
Finding support services and hiring and firing support staff			

	I can do this alone	I need some support	What kind of support do I need?
Traveling to places I go often (for example, getting to work, stores, friends' homes)			
Traveling to places I do not go often (for example, doctor's appointments, special events)			
Choosing what I wear			
Getting dressed			
Taking care of my personal hygiene (for example, showering, bathing, brushing teeth)			
Choosing what to eat, and when to eat			
 **Legal Matters**			
Talking to an attorney if I need one			
Help understanding my rights			
Signing contracts and formal agreements			

Personal Safety			
How to plan for an emergency			
Making safe choices around the house (for example, turning off the stove, having fire alarms)			
Making safe choices in the community			
Understanding and getting help if I am being treated badly (abused, neglected, or exploited)			
Other			
Choosing who to vote for and voting			
Making choices about alcohol and drugs			

WHEN DO I NEED SUPPORT?

There are many areas of life where a person may need help with making decisions. Some examples are below:

FINANCES

Do you need help understanding your bills (cell phone, electricity, rent, internet, etc.)?
Do you need help with buying items (understanding which products are going to work best for your needs, knowing if you can afford the item)?
Do you need help setting up a checking or savings account?

HEALTHCARE

Do you need help scheduling and remembering doctor's appointments?
Do you know what medicines you take, how to find out the proper dosage amount, and understanding what the side effects may be? Do you understand how your health care costs are covered (Medicaid, private insurance) and what your co-pays are?

EDUCATION

Do you know what accommodations are in your IEP and school?
Do you need help deciding what college you should attend?

WORK

Do you know what accommodations you need at work and how to request them?
Do you need help understanding your employee handbook or work policies?

LIFE PLAN

Do you know where you want to live and what you should know before choosing a home?
Do you know how to find transportation to places in your community?
Do you know the difference between healthy and unhealthy relationships? Do you know how to plan for an emergency?

LEGAL MATTERS

Do you need help understanding your rights?

Do you know what to do if you think someone is violating your rights?

There are just some examples. You may think of other times you may need support in these areas, or you may think of new areas not listed above.

Chapter 5: Choosing Supporters

Choosing supporters might be the most important part of Supported Decision-Making. For some people, this might be the easiest thing to choose, and for some people, this might be the most difficult. The most important thing to remember is that it is the Decision-Maker who chooses who to use as supporters. Supporters should be people that the Decision-Maker knows and trusts to provide the type of support he wants for the types of decisions he wants support with. In other words, good supporters will follow the plan set forth in the Supported Decision-Making Agreement and will never substitute their own choices for those of the Decision-Maker.

Supporters can be family members, friends, neighbors, service coordinators, advocates, church members, professionals in the community, or anyone else the Decision-Maker wants involved. Decision-Makers can assign certain supporters to certain types of decisions and not others. For example, a person may want his friend to provide support for decisions about housing, but may want his sister to provide support for decisions about finances. A person can choose as many supporters as he wants. Decision-Makers can fire their supporters at any time, and supporters have the option of quitting as well. No one should force the Decision-Maker into choosing him or her as a supporter. Supporters should not help make decisions in areas that the Decision-Maker did not agree to, and they should never make decisions *for* the Decision-Maker. The Decision-Maker is at the center of the Supported Decision-Making Agreement at all times!

Talking to Potential Supporters

Once a person chooses whom he trusts to help him make decisions, he will need to find out if the potential supporter is able and willing to help. The Decision-Maker might:

- Share what areas in which he would like support
- Share how he would like to get support
- Share a sample Supported Decision-Making Agreement

It is important that the potential supporter understand what is involved, and be able and willing to fulfill the role of supporter.

Sometimes it can be difficult for people to identify supporters. Not everyone has a solid network of support in place. If this is the case, it will be important to consider how to create relationships and build up a network of people that could provide support. Think about ways in which relationships are made. Is there family who might make good supporters? What about attending community events, seeking out organizations that match people up with mentors, looking for supports at places of worship or school, or other places where relationships can be made? It can take time to build healthy and trusting relationships with potential supporters, but it can also be very worthwhile. Everyone benefits from having community support, whether or not it is for the purposes of Supported Decision-Making.

Chapter 6: Filling out a Supported Decision-Making Agreement

Once a Decision-Maker has thought about what kind of decisions she would like support with, what kind of support she would like, and who her supporters will be, it's time to complete the Supported Decision-Making Agreement. You can find a sample Supported Decision-Making Agreement at the end of this Guide.

The Decision-Maker should meet with her supporters, either one at a time, or all at once, depending on what works best. They should go over the Agreement page-by-page and make sure that everyone understands and agrees upon what is in the Agreement. It is as important for supporters to understand what kind of help the Decision-Maker does *not* want as it is for them to understand what kind of help is wanted.

Once the Agreement is completed, everyone should sign the Agreement. Signing the Agreement means that everyone understands and promises to do their best to honor what it says. The Decision-Maker should not sign the Agreement until she is in front of a **notary**. A notary is a type of witness when official documents are signed. The notary makes sure that the person signing the Agreement is who she says she is, and also makes sure that the person signing is not being pressured or forced to sign something that she does not want to sign. Banks, post

offices, and law offices usually have people who are able to **notarize** documents. Sometimes they charge a small fee, but many times you can find one to do it for free.

Remember that a Supported Decision-Making Agreement is a "living document." This means that it can be changed as needed. A Decision-Maker may want to change a supporter, or have a different type of help in making a certain kind of decision. A supporter may decide to drop out. Or, a new supporter may be identified. The Supported Decision-Making Agreement is meant to be easy to change. The most important thing is that the Decision-Maker is getting the kind of help she wants in the areas she wants the help, from the people that she wants to help her.

Once the Supported Decision-Making Agreement is signed, the team is ready to use Supported Decision-Making! The Decision-Maker and the supporters should each have a copy of the Agreement. It's also a good idea to share the SDMA with doctors, banks, or others who will be expected to acknowledge and honor the Agreement. Some people like to celebrate this milestone!

Supported Decision-Making Guide

for

Individuals

1

I think about the people I trust. I ask them to support me. They have to agree to support me.

2

I think about how I want them to support me. I think about the areas that I want support in, like healthcare, education, money, getting a job, or relationships. I can ask for support in other areas too.

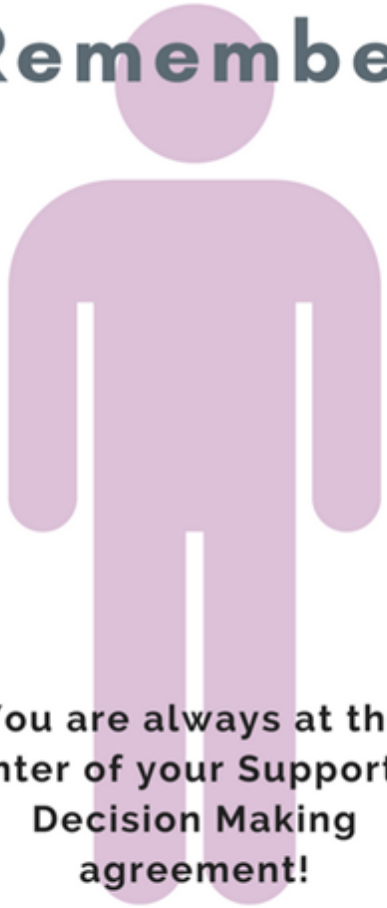
3

My supporters and I discuss how they will support me. We all agree in the ways I will be supported. I might have to ask to other professionals to help me too.

4

My supporters and I sign the agreement. I can change my mind at any time. My supporters can change their minds too.

Remember



You are always at the center of your Supported Decision Making agreement!

Additional Resources

National Resource Center for Supported Decision-Making
National and local resources and information about Supported Decision-Making
http://supporteddecisionmaking.org
202-448-1448

American Civil Liberties Union Disability Rights Program
www.aclu.org/supported-decision-making-resource-library

Center for Public Representation Supported Decision-Making Pilot Project
www.supporteddecisions.org

Autistic Self-Advocacy Network (ASAN)
The Right To Make Choices, a series of very detailed, Easy Read documents ASAN put together to provide self-advocates with an overview of SDM and some of the many different options available.
https://autisticadvocacy.org/2016/02/the-right-to-make-choices-new-resource-on-supported-decision-making/

PRACTICAL Tool for Lawyers: Steps in Supported Decision-Making
Helps lawyers identify and implement decision-making options for persons with disabilities that are less restrictive than guardianship.
www.ambar.org/practicaltool

I'm Determined Project
Focuses on providing direct instruction, models, and opportunities to practice skills associated with self-determined behavior. Look under the "resources" tab for activities and worksheets.
www.imdetermined.org

ENDNOTES

[1] Robert D. Dinerstein, Implementing Legal Capacity Under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road from Guardianship to Supported Decision-Making, 19 Hum. Rts Brief 8, 10 (2012).

[2] Wehymeyer, M.L., & Palmer, S.B. (2003). Adult outcomes for students with cognitive disabilities three-years after high school: The impact of self-determination. *Education & Training Developmental Disabilities*, 38(2), 131-44.

[3] Test, D. W., Mazzotti, V. L., Mustian, A. L., Fowler, C. H., Kortering, L., & Kohler, P. (2009). Evidence-based secondary transition predictors for improving postschool outcomes for students with disabilities. *Career Development for Exceptional Individuals*, 32(3), 160-81.

[4] Brief of Quality Trust of Individuals with Disabilities et al. as Amici Curiae Supporting Respondents in In Re: Guardianship of the Person and Estate of Ryan Keith Tonner, an Incapacitated Person. Case No. 14-0940 (TX, 2015).

Supported Decision-Making Agreement

This is the Supported Decision-Making Agreement of:

Name: _____ DOB: _____

Address:_____

Phone: _____

This Agreement is used for the appointment of supporters to help me make my own decisions. This Agreement is effective because I am at least 18 years of age and am able to understand the nature and effect of this Agreement.

I want to have people I trust help me make decisions. The people who will help me are called **supporters**.

My supporters are not allowed to make choices for me. I will make my own choices, with support. I am called the **Decision-Maker**.

This Agreement can be changed at any time. I can change it by crossing out words and writing my initials next to the changes. Or, I can change it by writing new information on another piece of paper, signing that paper, and attaching it to this Agreement.

Designation of Supporters

I, _____ (*Decision-Maker*), choose the following people as my supporters:

Supporter #1:

Name: _____ DOB: _____

Address: _____

Phone: _____ Relationship to Decision-Maker: _____

Supporter #2:

Name: _____ DOB: _____

Address: _____

Phone: _____ Relationship to Decision-Maker: _____

Supporter #3:

Name: _____ DOB: _____

Address: _____

Phone: _____ Relationship to Decision-Maker: _____

Supporter #4:

Name: _____ DOB: _____

Address: _____

Phone: _____ Relationship to Decision-Maker: _____

Add more pages as needed.

Areas and Types of Support

(1.) _____ (*names of 1 or more supporters*) will provide me with support in the area of _____.

S/he will provide me the following kinds of support (check only the kinds of support the Decision-Maker wants):

- □ Gathering information;
- □ Helping me to understand information;
- □ Identifying possibilities and alternatives;
- □ Helping me weigh my options;
- □ Helping me to understand consequences;
- □ Communicating my decisions to others;
- □ Helping me to carry out my decisions;
- □ Other: _____.

(2.) _____ (*names of 1 or more supporters*) will provide me with support in the area of _____.

S/he will provide me the following kinds of support (check only the kinds of support the Decision-Maker wants):

- □ Gathering information;
- □ Helping me to understand information;
- □ Identifying possibilities and alternatives;
- □ Helping me weigh my options;
- □ Helping me to understand consequences;
- □ Communicating my decisions to others;
- □ Helping me to carry out my decisions;
- □ Other: _____.

(3.) _____ (*names of 1 or more supporters*) will provide me with support in the area of _____.

S/he will provide me the following kinds of support (check only the kinds of support the Decision-Maker wants):

- □ Gathering information;
- □ Helping me to understand information;
- □ Identifying possibilities and alternatives;
- □ Helping me weigh my options;
- □ Helping me to understand consequences;
- □ Communicating my decisions to others;
- □ Helping me to carry out my decisions;
- □ Other: _____.

Add more pages as needed.

Declining Support

I DO NOT want support in the area(s) of _____

_____. I will make decisions in this/these areas without support.

I will make decisions in any other areas not listed in this Agreement without support.

Releases of Information

In order to give me the kind of support I am requesting, some of my supporters may need access to information about me that is confidential, such as medical information or school records. I will be signing the following types of releases to allow certain supporters to access this information for the purposes of this Supported Decision-Making Agreement. My supporters may access this information only for the purposes of supporting me in making decisions, and may not share this information with anyone else. I understand that a signed release does not allow another person to make decisions for me, and that I may cancel the Release of Information at any time by notifying the provider.

Types of releases that I may sign include releases for education records (a "FERPA" release), medical information (a "HIPAA" release), or a release for financial information (such as a release for bank records).

A Release of Information is a separate document that must be signed by the Decision-Maker and filed with the proper organization to be effective.

_____	_____
Type of Release	Supporter(s)
_____	_____
Type of Release	Supporter(s)
_____	_____
Type of Release	Supporter(s)
_____	_____
Type of Release	Supporter(s)

Other Instruments

I already have a: (check all that apply)

□ Financial Power of Attorney

□ Medical/Healthcare Power of Attorney

□ Advance Healthcare Directive

□ Social Security Representative Payee

Acceptance by Third Parties

I want third parties to rely on this Supported Decision-Making Agreement. I accept the actions of my supporters who act in accordance with this Agreement.

Effect and Revocation

This Agreement takes effect as soon as it is notarized and signed by the Decision-Maker and Supporters. This Agreement can be revoked at any time by the Decision-Maker by written or verbal notice to the Supporters. If a Supporter can no longer assist the Decision-Maker in the duties outlined above, s/he will provide the Decision-Maker with at least seven (7) days written notice.

<u>**Attestation and Signature of Supporters**</u>

I, ___________________________ (*name of supporter and relationship to Decision-Maker*), have read and understand this Agreement. I agree to provide support in accordance with this Agreement and not act as a substitute Decision-Maker. In that role, I agree to avoid conflicts of interest and not to exert undue influence.

____________________________ ________________

Signature of Supporter Date

I, ___________________________ (*name of supporter and relationship to Decision-Maker*), have read and understand this Agreement. I agree to provide support in accordance with this Agreement and not act as a substitute Decision-Maker. In that role, I agree to avoid conflicts of interest and not to exert undue influence.

____________________________ ________________

Signature of Supporter Date

I, ___________________________ (*name of supporter and relationship to Decision-Maker*), have read and understand this Agreement. I agree to provide support in accordance with this Agreement and not act as a substitute Decision-Maker. In that role, I agree to avoid conflicts of interest and not to exert undue influence.

____________________________ ________________

Signature of Supporter Date

Add more pages as needed.

Designation and Oath of Decision-Maker

I hereby designate the above-signed individuals to be Supporters on my Supported Decision-Making Team. It is my understanding that my Supporters are resources to me and that I make all final decisions concerning my life. I also understand that I can remove a Supporter from my team, or change his or her access to my confidential information at any time.

_____
Printed Name of Decision-Maker

_____ _____
Signature of Decision-Maker Date

Notarization

STATE OF MAINE
_____, ss.

Personally appeared the above-named individual and acknowledged the foregoing instrument to be his/her free act and deed.

Before me,

_____ _____
Attorney at Law/Notary Public Date

Notes

131st MAINE LEGISLATURE

FIRST REGULAR SESSION-2023

Legislative Document **No. 1426**

H.P. 922 House of Representatives, March 30, 2023

An Act to Secure Housing for the Most Vulnerable Maine Residents by Amending the Laws Governing Municipal General Assistance

Reference to the Committee on Health and Human Services suggested and ordered printed.

Robert B. Hunt

ROBERT B. HUNT
Clerk

Presented by Representative MATHIESON of Kittery.
Cosponsored by Senator BALDACCI of Penobscot and
Representatives: CRAVEN of Lewiston, GATTINE of Westbrook, GRAMLICH of Old Orchard Beach, HASENFUS of Readfield, MADIGAN of Waterville, MILLETT of Cape Elizabeth, SARGENT of York, Senator: BRENNER of Cumberland.

7. Assistance with processing applications; hotline. The department shall provide assistance to municipalities with regard to processing applications for the general assistance program. The department shall establish a hotline that is available 24 hours per day in order to provide consistent, accurate advice to overseers. The department shall respond to requests for assistance within 24 hours.

SUMMARY

This bill:

1. Requires an overseer, no later than the 120th day following appointment or election, to complete training on the requirements of the municipal general assistance program;

2. Replaces, for determining the maximum level of assistance, the fair market value determination with setting the assistance at the equivalent amount of rental assistance provided for tenant-based housing choice vouchers under Section 8 of the United States Housing Act of 1937 except that the benefit level may not be less than the difference between the applicant's income and 110% of the area's fair market rent;

3. Provides that if general assistance is being used to pay rent for an applicant whose rent is subject to a lease an overseer may redetermine the applicant's eligibility annually;

4. Increases from 70% to 90% the amount of state reimbursement for the costs of general assistance incurred by a municipality and each Indian tribe;

5. Directs the Department of Health and Human Services to reimburse each municipality for 5% of the direct costs of paying benefits incurred through its general assistance program;

6. Directs the Department of Health and Human Services to establish and provide overseers with access to a statewide database for tracking applicants for the general assistance program and expenses relating to the program; and

7. Requires the Department of Health and Human Services to provide assistance to municipalities with regard to processing applications for the general assistance program and directs the department to establish a hotline that is available 24 hours per day in order to provide consistent, accurate advice to overseers. It also requires the department to respond to requests for assistance within 24 hours.

131st MAINE LEGISLATURE

FIRST SPECIAL SESSION-2023

Legislative Document **No. 1675**

H.P. 1073 House of Representatives, April 13, 2023

An Act to Amend the Laws Governing the General Assistance Program Regarding Eligibility, Housing Assistance and State Reimbursement and to Establish a Working Group

(EMERGENCY)

Reference to the Committee on Health and Human Services suggested and ordered printed.

Robert B. Hunt

ROBERT B. HUNT
Clerk

Presented by Representative BRENNAN of Portland.
Cosponsored by Senator PIERCE of Cumberland and
Representatives: CLOUTIER of Lewiston, COLLINGS of Portland, CROCKETT of Portland, GEIGER of Rockland, MEYER of Eliot, PERRY of Calais, SALISBURY of Westbrook, ZAGER of Portland.

Beginning July 1, 2023, when a municipality incurs net general assistance costs in excess of 0.008% of that municipality's most recent state valuation relative to the state fiscal year for which reimbursement is being issued, as determined by the State Tax Assessor in the statement filed as provided in Title 36, section 381, the Department of Health and Human Services shall reimburse the municipality for 90% of the amount in excess of these expenditures when the department finds that the municipality has been in compliance with all requirements of this chapter.

For the purposes of this subsection, "Indian tribe" has the same meaning as in section 411, subsection 8-A.

Sec. 4. Working group. The Department of Health and Human Services shall establish a working group of stakeholders and interested parties, as determined by the department, to study and make recommendations related to a uniform intake process and the conversion of the general assistance program under the Maine Revised Statutes, Title 22, chapter 1161 into a housing assistance program. No later than December 6, 2023, the department shall submit its report and recommendations to the Joint Standing Committee on Health and Human Services. The committee may report out legislation related to the report to the Second Regular Session of the 131st Legislature.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

SUMMARY

This bill amends the law governing the general assistance program to provide that a municipality must calculate housing assistance equivalent to the amount of rental assistance provided for tenant-based housing choice vouchers under Section 8 of the United States Housing Act of 1937. The bill extends the period of eligibility from one month to 6 months. Beginning July 1, 2023, when a municipality incurs net general assistance costs in excess of 0.008% of that municipality's most recent state valuation relative to the state fiscal year for which reimbursement is being issued, the Department of Health and Human Services must reimburse the municipality for 90% of the amount in excess of these expenditures.

The bill also directs the department to establish a working group to study and make recommendations related to a uniform intake process and the conversion of the general assistance program into a housing assistance program.

131st MAINE LEGISLATURE

FIRST SPECIAL SESSION-2023

Legislative Document	**No. 1732**
H.P. 1111	House of Representatives, April 20, 2023

An Act to Expand the General Assistance Program

(EMERGENCY)

Reference to the Committee on Health and Human Services suggested and ordered printed.

R(t B. Hunt

ROBERT B. HUNT
Clerk

Presented by Representative MEYER of Eliot.

municipality from which that person is moving continues to be responsible for the support of the recipient ~~for 30 days~~, including processing applications and determining eligibility for assistance, unless otherwise agreed upon by the affected municipalities, for 6 months after relocation. As used in this paragraph, "assist" includes:

(1) Granting financial assistance to relocate; and

(2) Making arrangements for a person to relocate.

B. If an applicant is in a group home, shelter, rehabilitation center, nursing home, hospital or other institution at the time of application and has either been in that institution for ~~6~~ 12 months or less~~,~~ or had a residence immediately prior to entering the institution ~~which~~ that the applicant had maintained and to which the applicant intends to return, the municipality of responsibility is the municipality where the applicant was a resident immediately prior to entering the institution and that municipality continues to be responsible for the support of the recipient, including processing applications and determining eligibility for assistance, unless otherwise agreed upon by the affected municipalities. For the purpose of this paragraph, a hotel, motel or similar place of temporary lodging is considered an institution when a municipality:

(1) Grants financial assistance for a person to move to or stay in temporary lodging;

(2) Makes arrangements for a person to stay in temporary lodging;

(3) Advises or encourages a person to stay in temporary lodging; or

(4) Illegally denies housing assistance and, as a result of that denial, the person stays in temporary lodging.

Sec. 4. 22 MRSA §4311, sub-§1, as amended by PL 2015, c. 267, Pt. SSSS, §1, is further amended to read:

1. Departmental reimbursement. When a municipality incurs net general assistance costs in any fiscal year prior to July 1, 2015 in excess of .0003 of that municipality's most recent state valuation relative to the state fiscal year for which reimbursement is being issued, as determined by the State Tax Assessor in the statement filed as provided in Title 36, section 381, the Department of Health and Human Services shall reimburse the municipality for 90% of the amount in excess of these expenditures when the department finds that the municipality has been in compliance with all requirements of this chapter. If a municipality elects to determine need without consideration of funds distributed from any ~~municipally controlled~~ municipally controlled trust fund that must otherwise be considered for purposes of this chapter, the department shall reimburse the municipality for 66 2/3% of the amount in excess of such expenditures when the department finds that the municipality has otherwise been in compliance with all requirements of this chapter.

The department shall reimburse each municipality and each Indian tribe 70% of the direct costs incurred by that municipality or tribe on or after July 1, 2015 and until June 30, 2023 for the general assistance program granted by that municipality or tribe. ~~For the purposes of this subsection, "Indian tribe" has the same meaning as in section 411, subsection 8-A.~~

Beginning July 1, 2023, the department shall reimburse each municipality and each Indian tribe 90% of the direct costs incurred by that municipality or tribe for the general assistance program granted by that municipality or tribe. If a municipality elects to determine need

9. Database. Beginning on July 1, 2025, the department shall provide overseers access to an Internet-based, real-time database containing the information necessary to properly determine an applicant's eligibility.

Sec. 10. Application. That section of this Act that enacts the Maine Revised Statutes, Title 22, section 4302-A applies to all overseers and municipal officials serving on and after the effective date of this Act.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

SUMMARY

This bill changes the municipal general assistance program in the following ways:

1. It requires overseers and designated or appointed municipal officials administering the program to complete training within 120 days of election or appointment;

2. It requires municipalities to accept applications for general assistance during regular business hours;

3. It amends provisions governing the municipality of responsibility to increase the provision of assistance from 30 days to 6 months when a municipality assists an applicant in relocating to another community and from 6 months to 12 months when an applicant is residing in a group home, shelter, rehabilitation center, nursing home or hospital or in a hotel, motel or other temporary housing;

4. It increases, from 70% to 90%, the amount of state reimbursement for the costs of general assistance incurred by each municipality and Indian tribe. It also provides that, if a municipality elects to determine need without consideration of funds from a municipally controlled trust, the State is required to reimburse the municipality for 66 2/3% of the amount in excess of expenditures;

5. It provides state reimbursement for additional program costs, including emergency general assistance, temporary housing, interpreter services and administrative expenses; and

6. It requires the Department of Health and Human Services to provide the services necessary to support municipalities, including education and training for certain state employees, 24-hour technical assistance, written decisions and a database.

MAINE MAYORS COALITION
Strengthening Our Cities & Our State

Senator Baldacci, Representative Meyer and distinguished members of the Joint Standing Committee on Health and Human Services, thank you for your ongoing discussions about the General Assistance program and, in particular, the impacts on municipalities. The Maine Mayors Coalition appreciates this opportunity to provide you with information.

We are a nonpartisan group representing the mayors of nine Maine communities – Auburn, Biddeford, Lewiston, Portland, Rockland, Saco, Sanford, South Portland and Westbrook – and approximately 250,000 residents. The Coalition advocates on behalf of our citizens and municipalities for policies that recognize the vital services Maine cities provide and the positive impact Maine cities have on our state. The Coalition seeks to work in partnership with state and federal elected officials to meet the needs of Maine people.

Our Concerns

Our most immediate concerns are providing essential support and housing to people who need it. As you're well aware, the General Assistance program provides a lifeline for many who find themselves in dire financial situations. This has been especially true over the last several years with more people than ever relying on the program. You understand the reasons – the impact of the pandemic, lack of housing supply and rising costs of homes and rents, and increased prices for food, clothing, energy and other essentials.

Like you, we must balance the competing interests of what our citizens need with what we, and they, can afford and what the law requires. To that end, we scrutinize every program and expenditure in an effort to keep our cities' property taxes as low as possible. With GA costs steadily increasing, additional burdens are being placed on our property owners, our staffs and our ability to provide other critical services.

Administering the program has become increasingly challenging. Our staffs talk with people who are experiencing financial hardships, domestic abuse, homelessness, mental health issues and substance misuse. Among those turning to GA are individuals and families seeking asylum. The program was not originally designed to support asylum seekers, and by federal law they are not permitted to obtain work authorizations for 180 days.

Our staffs often have difficulty accessing information on unemployment benefits and child support payments from state agencies and veterans benefits and social security payments from federal offices. They also receive conflicting guidance from the state, often verbally, with some decisions appearing to be more arbitrary than what is actually in the law.

The 30-day residency requirement is an issue that has arisen. There can be confusion about the municipality of record, especially as people gravitate to our cities in order to access services. There can also be issues when GA clients find housing in a second community, which then must absorb the costs.

When temporary housing is not available, 30-day hotel stays have become necessary. As you know, these are very expensive. In the last few years, permanent housing solutions have been harder to find, leading to longer temporary stays and a growing unhoused population across the state.

City of Portland | Executive Department
Danielle P. West, *City Manager*

To: Senator Tim Nangle, Representative Holly Stover, and Members of the Committee on Health and Human Services
From: Danielle P. West, City Manager
Date: October 24, 2023
Re: City of Portland General Assistance Information

PatriThe following information is shared to assist the Maine Legislature's Health and Human Services Committee in its consideration of changes to the General Assistance Statute.

General Assistance (GA) in City of Portland

It is a well-known fact that the City of Portland is the largest service provider in the State, responding to a growing demand for shelter year over year (see table below). This growing demand, particularly in recent years, is attributed to the arrival of an increasing number of asylum seekers, as well as the end of the Emergency Rental Assistance (ERA) Program.

Fiscal Year	People Served	City Cost	State Cost
2023	4,141	$9,822,193	$22,918,451
2022	4,103	$9,768,347	$22,792,811
2021*	2,925	$5,040,044	$11,760,102
2020	3,296	$2,980,872	$6,955,369
2019	3,146	$2,195,393	$5,122,583

Between FYs 2019 and 2023, the number of people who received GA through the City of Portland increased by about 32%. Costs to the City and State have increased by about 347%, due to the increased reliance on hotel rooms to temporarily shelter GA-eligible individuals and families, which began in April 2020.

**In FY21, the total number of people served by GA in the City of Portland declined, due to the impact of COVID-19 and social distancing requirements on shelter capacity. The City continued to accommodate many individuals by providing temporary shelter in hotel rooms, resulting in a significant increase in expenses.*

Between FYs 2019 and 2023, the average length of an individual's stay at the City's emergency shelter increased by approximately 23%. This data does not include the average length of stay of families at the City's Family Shelter, or individuals / families temporarily sheltered in hotels.

Fiscal Year	Average Length of Stay at Shelter (days)
2023	54.23
2022	59.06
2021	54.90
2020	48.32
2019	44.26

Fiscal Year	Total Shelter* Guests	Clients with Last Known Address in Portland	Clients with Last Known Address in Other Maine Municipality	Clients with Last Known Address Outside of Maine
2023	1,549	313	354	882
2022	1,391	395	515	481
2021	926	327	359	240
2020	1,258	401	497	360
2019	1,765	516	699	550
TOTAL	6,889	1,952 (28%)	2,424 (35%)	2,513 (36%)

**These numbers are related to clients at the emergency shelter for individuals only, and do not include Family Shelter clients or those sheltered temporarily in hotels.*

Implementation Challenges with Current Statute

Challenges recognized in the implementation of the existing GA statute include, but are not limited to: 1) inconsistency in municipal administration across the State; 2) insufficient reimbursement rates, given the broad eligibility criteria and growing demand in each municipality/state-wide; and 3) the lack of a centralized, state-wide database to facilitate information sharing between GA offices throughout the State.

Unaddressed Need: Transitional Housing

By default, due to a shortage of supportive/transitional and permanent housing in Maine, emergency shelter has become a de facto transitional housing resource, resulting in overwhelming increases in cost to the City of Portland and the State.

We recognize the many barriers to the development of transitional housing. Until there is a meaningful change in the availability of transitional housing, however, it is likely that GA costs will continue to reflect the unmet need.

Recommendations

As part of its consideration, we respectfully request that the Committee consider the unintended consequences that changes to the GA Statute may have. For example, changes intended to restrict individuals' eligibility, the items that are eligible for reimbursement (i.e. housing, etc.) or reimbursable costs are likely to result in an increase in the number of unsheltered individuals in the State of Maine.

To prevent such consequences, we recommend that the Committee consider compensating for such changes with other or new State-created and administered programs and funding.

Earlier this year, the Portland City Council's Legislative/Nominating Committee had expressed support for LD 1664 (*An Act to Increase Reimbursement Under the General Assistance Program*) and LD 1732 (*An Act to Expand the General Assistance Program*), both of which would address core weaknesses in the statute and its implementation. We respectfully suggest that the Committee reconsider the merits of those policy proposals.

MaineHousing
MAINE STATE HOUSING AUTHORITY

Development Department Memorandum

To: **MaineHousing Board of Commissioners**

From: **Mark C. Wiesendanger, Director of Development**

Date: **October 24, 2023**

Subject: **Monthly Report**

2024 LIHTC (9%) Applications

On September 21, MaineHousing received 8 Full Applications for the 2024 round of 9% Low Income Housing Tax Credit (LIHTC) funding. Scoring is underway.

Project Name	Developer	City	Family/ Senior	Total Units
3i Home at The Downs	POAH/ 3iHoME	Scarborough	Family	51
Avesta Seavey Street	Avesta	Westbrook	Senior	61
Equality Community Housing	Equality Community Center	Portland	Senior	54
Essex View	Penquis CAP	Bangor	Family	40
Martel School Apartments	LAAHDC	Lewiston	Senior	44
Oak Ridge Apartments	Realty Resources	Bath	Senior	30
Sunset Avenue	Bangor HA	Bangor	Senior	50
Varney Heights	Freeport HA	Freeport	Senior	42

2023 Rural Affordable Rental Housing Program

We have released an updated Requests for Proposal (RFP) for the Rural Affordable Rental Housing Program. The new program will be different from the last iteration in that it is a competitive funding round due to limited resources. Additional changes include an updated paying loan interest rate, increased subsidy amounts, and a program-specific Design and Construction Process and Requirements guide. A meeting was held at MaineHousing with the Genesis Fund on October 12 to discuss the new program with potential applicants.

Development Pipeline

Below you will find the Development Pipeline updated as of October 18. We expect that a small number of these projects will not see completion, and that predicted construction starts and completions will change as projects move forward.

Project Name	Developer	Program	City	Family/ Senior	Total Units
Completed in 2023					
155 Danforth	Developers Collaborative	4%	Portland	Family	30
Blake & Walnut	Raise-Op	4%	Lewiston	Family	18
Milliken Heights	Szanton	4%	OOB	Senior	55
The Uplands II	Developers Collaborative	4%	Scarborough	Senior	39
Mary Street Apartments	KVCAP	4%+State	Skowhegan	Family	40
Phoenix Flats	CHOM	4%+State	Portland	Senior	45
Front Street Re-Dev I	Portland HA	9%	Portland	Family	60
Sr. Living at the Marketplace	Tim Gooch	9%	Augusta	Senior	42
Washington Gardens	Portland HA	9%	Portland	Senior	100
West End Apts. Phase II	Avesta	9%	So. Portland	Family	52
Highpines Village Condos	Highpine Properties LLC	AHOP	Wells	Family	3
Stearns Farm	S.E. MacMillan Co, INC	AHOP	Hampden	Family	5
89 Olive Street	Penquis CAP	HTF	Bangor	Family	6
Tucker's House	LB Dev Part.	RHP	Bridgton	Supportive	10
Total Projects	**14**			**Total Units**	**505**
Under Construction - likely completed in 2023					
Brunswick Landing	Developers Collaborative		Brunswick	Family	36
Blueberry Ridge	Bangor HA	4%	Bangor	Senior	32
Jocelyn Place	SoPo HA	4%	Scarborough	Senior	60
Mountain View Apts	Bateman	4%	Fairfield	Senior	28
The Schoolhouse	CHOM	4%	Bangor	Family	66
Porter Station	Avesta	4%+State	Portland	Family	60
Great Cranberry Island	Cranberry Isles Realty Trust	Islands	Cranberry Island	Family	2
100 Ohio Street	CHOM	SHP	Bangor	Family	4
Total Projects	**8**			**Total Units**	**288**
Under Construction - likely completed in 2024					
One Edgemont Drive	ACAP	SHP	Presque Isle	Family	13
99 Western Ave	Mastway Development LLC	4%	Augusta	Family	38
Harrison Ridge	Developers Collaborative	4%	Bridgton	Senior	48
Hartland II	KVCAP	4%	Hartland	Senior	30
Millbrook Estates	Westbrook HA/EBM	4%	Westbrook	Senior	100
Stacy M. Symbol Apts	Westbrook HA	4%	Westbrook	Senior	60
Stroudwater Apartments	Westbrook HA	4%	Westbrook	Senior	55
Snow School Apartments	Avesta	4%+HTF	Fryeburg	Senior	28
Congress Square Commons	Developers Collaborative	9%	Belfast	Family	36
Front Street Re-Devt 2	Portland HA	9%	Portland	Senior	45
The Uptown	Szanton	9%	Bath	Senior	60

Village Commons	Avesta	9%	Scarborough	Senior	31
Highpines Village Condos	Highpine Properties LLC	AHOP	Wells	Family	17
Stearns Farm	S.E. MacMillan Co, INC	AHOP	Hampden	Family	18
Theresa Bray Knowles Place	Penquis Cap	HOME-ARP	Bangor	Family	36
18 Central Ave	Home Start	Islands	Peaks Island	Family	3
CICA 2022 Island Housing	CICA	Islands	Chebeague Island	Family	4
ICDC Town Acquisition	ICDC	Islands	Isle au Haut	Family	4
NHSH Affordable	NH Sustainable Housing	Islands	New Haven	Family	4
Reeby Road	Islesboro Affordable Property	Islands	Islesboro	Family	2
18 Green Street	Motivational Svs	HTF	Augusta	Family	8
55 Weston Ave	55 Weston Avenue LLC	Rural	Madison	Family	18
Total Projects	**22**			**Total Units**	**658**

Under Construction - likely completed in 2025

The Equinox	CHOM	4%+State	Portland	Family	43
Winter Landing	CHOM	4%+State	Portland	Senior	52
Berry Park Apartments	Northland Enterprises	4%	Biddeford	Family	46
Betsy Ross Crossing	SoPo HA	4%	So. Portland	Senior	52
Edgewater Village	Avesta	4%	Farmington	Senior	25
Fairview Commons	Brunswick HA	4%	Topsham	Family	38
Harbor Terrace	Portland HA	4%	Portland	Senior	120
Lambert Woods North	Maine Coop. Dev. Partners	4%	Portland	Family	74
Lockwood Mill	North River Co.	4%	Waterville	Family	65
Meadowview II	Avesta	4%	Gray	Senior	27
North Deering Gardens	Wingate Dev.	4%	Portland	Family	164
Wedgewood	Lewiston HA/Avesta	4%	Lewiston	Family	82
Adams Point	Biddeford HA	9%	Biddeford	Family	39
Landry Woods	South Portland Housing	9%	So. Portland	Senior	43
Milford Place	Penquis CAP	9%	Bangor	Senior	40
Oak Grove Commons	Realty Resources	9%	Bath	Family	34
Peasley Park	Developers Collaborative	9%	Rockland	Senior	49
Picker House Lofts	Szanton	9%	Lewiston	Family	72
Rumford Senior Living	Developers Collaborative	9%	Rumford	Senior	33
Sturgeon Landing	Augusta Housing	9%	Augusta	Family	32
Wildlands	Greater Portland Habitat	AHOP	Standish	Family	12
22 Shapleigh Road	Fairtide	Home ARP	Kittery	Family	6
Colonial Valley & Mt Blue	WMCA	Home ARP	Farmington	Family	33
Tucker's House Harrison	LB Development Partners	Recovery	Harrison	Supportive	10
Total Projects	**24**			**Total Units**	**1191**

Preliminary Underwriting

45 Dougherty	Szanton	4%	Portland	Family	63
Farwell Mill	Realty Resources	4%	Lisbon Falls	Family	96
Munjoy South	Avesta	4%	Portland	Family	106
Place St. Marie	Brisa Dev with Andy J	4%	Lewiston	Family	40
Riverton Park	Portland HA	4%	Portland	Family	182
Seton Tower	Kevin Mattson with Andy J	4%	Waterville	Family	68

Summer Block	Bateman	4%	Saco	Senior	32
89 Elm Apartments	Tom Watson & CO LLC	4% PLA	Portland	Family	201
3i Home at The Downs	POAH/3iHoME	9%	Scarborough	Family	51
Avesta Seavey Street	Avesta	9%	Westbrook	Senior	61
Equality Community Housing	Equality Community Center	9%	Portland	Senior	54
Essex View	Penquis CAP	9%	Bangor	Family	40
Martel School Apartments	LAAHDC	9%	Lewiston	Senior	44
Oak Ridge Apartments	Realty Resources	9%	Bath	Senior	30
Sunset Avenue	Bangor HA	9%	Bangor	Senior	50
Varney Heights	Freeport HA	9%	Freeport	Senior	42
19 Bodwell Street	Androscoggin Homes LLC	AHOP	Sanford	Family	9
Alexander Way	Boothbay Harbor Land Trust	AHOP	Boothbay Harbor	Family	7
Beals Ave WF Housing	LB Development Partners	AHOP	Ellsworth	Family	23
Clarks Bridge Crossing	Patco	AHOP	Waterboro	Family	9
Windward Estates	Penquis CAP	AHOP	Searsport	Family	7
OddFellows Apts.	Archer Properties LLC	Rural	Norway	Family	13
Berry's Block Apts.	Lake City Investments	Rural	Rockland	Family	9
520 Centre Street	Bath HA	Rural	Bath	Family	18
The Elm Estates	East Town Rentals	Rural	Presque Isle	Family	18
Mechanic Street	WLR Properties	Rural	Houlton	Family	18
Firefly Fields	Midcoast Habitat	Rural	Rockland	Family	10
Charles Jordan House	ME Prisoner Adv Coalition	SHP	Auburn	Supportive	11
Lupine Landing	Safe Voices	SHP	Farmington	Supportive	6
Seavey House	Biddeford Housing	SHP	Saco	Supportive	8
Total Projects	**30**			**Total Units**	**1326**
Total Projects All Stages	98			Total Units	3968
Total Projects in Underwriting & Construction	**84**			**Total Units**	**3463**