

COMMISSION TO STUDY DIFFICULT-TO-PLACE PATIENTS

MEETING AGENDA

**Friday, November 20, at 10:00 am
Room 216, Cross State Office Building, Augusta**

- 10:00 a.m. Welcome and introductions
Commission Chairs
- 10:05 a.m. Responses to and further discussion of requests for information made at last meeting
Richard Erb, Maine Health Care Association
Jeff Austin, Maine Hospital Association
Ricker Hamilton, Maine DHHS
Kim Moody, Disability Rights Maine
- 11:15 a.m. Staff overview of worksheet on identified issues and proposed recommendations,
followed by Commission discussion
- 12:00 p.m. Break for lunch (1 hour)
- 1:00 p.m. Public comment opportunity
- 1:30 p.m. Continued Commission discussion and voting on Commission recommendations
- 2:45 p.m. Future meeting planning
- 3:00 p.m. Adjourn

Requests made of Maine Health Care Association

- Can MHCA provide any information on the rates (i.e., what are the actual rates) that the 3 geropsych facilities are receiving from the State through SAMHS for holding open beds for geropsych patients beyond the 7 day federal limit when they decompensate and have to be hospitalized?
- What suggestions does MHCA have for expanding or improving/reconfiguring Appendix C PNMI facilities to better serve these patient populations (i.e., expanding capacity, staff training/availability/skill levels, etc.)?
- What is MHCA's position on the feasibility of implementing a presumptive eligibility standard/option, as described by Jeff Austin/MHA at the meeting (i.e., provider would have ability to presume Medicaid eligibility for a patient with later DHHS follow-up)? Is this a good idea; is it something that could work in Maine?
- What is MHCA's position on the proposal to implement a basic reporting requirement for facilities refusing patient placement (i.e., a facility refusing placement of a patient would be required to fill out and submit to DHHS a short form outlining the reasons for refusing placement, such as lack of available bed, appropriate staff, necessary resources/equipment, etc.)?

Requests made of Maine Hospital Association

- What additional specifics can you provide on the proposed "days awaiting placement" rate for hospital patients awaiting placement, including, what rate would the MHA consider appropriate for reimbursement (dollar figure?), when would the rate kick in; would there be a cap on the rate (# days, total reimbursement cap per patient) etc.?
- What approaches have other states taken in terms of reimbursement for this patient population (i.e., do other states reimburse hospitals in a similar fashion for these patients awaiting placement)?

Requests made of Maine DHHS

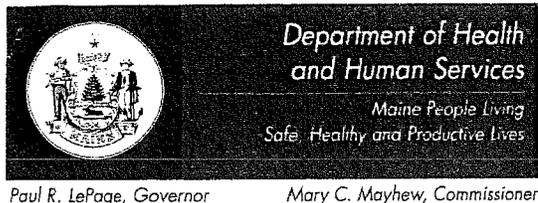
- At the second meeting, Commission members discussed the Department's process for referral of a patient to a geropsychiatric facility. It is our understanding that a team of individuals at DHHS make decisions regarding whether a patient meets the criteria for placement and which patient that meets the criteria will ultimately be placed in an available bed (i.e., a discussion of "placement priority"). There were suggestions that this process, from the time a bed at a geropsychiatric facility becomes available, to the time a patient is placed, can often take a number of weeks, despite the fact that there may be a number of patients who meet the criteria and would benefit from immediate placement. Could you outline for the Committee how this process is conducted at DHHS and what improvements, if any, could be made to the process to facilitate quicker placement of patients?
- At the first meeting, it was suggested (during public comment), that when the State places a MaineCare patient for treatment out-of-state, the State is only obligated to reimburse that patient's care for the first two years of placement out-of-state and then no longer has a financial obligation. As you may recall, this assertion came as a surprise to most members of the Commission, and given that we have received no clarification from the individual who made the comment, can the Department comment on whether or not this is in fact an accurate description of the State's financial obligation to patients placed for care out-of-state?
- At the second meeting, members discussed the Homeward Bound program, specifically the federal grant monies made available to support the program in Maine. It was suggested that one possible recommendation the Commission might make would be to support the expansion of this program, perhaps with the assistance of the Long-term Care Ombudsman, to place more than the current program goal of 26 placements per year. Can the Department comment on the feasibility of expanding the Homeward Bound program in Maine, specifically addressing the possibility of securing additional federal grant monies to support this expansion?
- At the second meeting, there was additional discussion about negotiated rates. Members have asked us to get the Department's perspective on the negotiated rate process and whether DHHS believes that this process is working to adequately and effectively serve these populations of patients with complex medical conditions, including whether expansion of the negotiated rate process for these populations is feasible or would prove effective?

Requests made of Disability Rights Maine

- What specific proposals does Disability Rights Maine suggest to address contract compliance and enforcement issues, including any statutory or regulatory changes that would assist DHHS in ensuring facility contract compliance as well as in enforcement when there are violations?

Requests made of EMHS

- What specific suggestions or proposals does EMHS have with respect to the different topics the Commission is reviewing?



Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax (207) 287-3005
TTY Users: Dial 711 (Maine Relay)

November 20, 2015

To: Senator Roger J. Katz, Chair
Representative Andrew M. Gattine, Chair
Members of Commission to Study Difficult-to-Place Patients

From: Mary C. Mayhew, Commissioner, Department of Health and Human Services

Re: DHHS Response to questions from the Difficult-to-Place Patients (Resolve 2015, c 44) meeting held on November 5, 2015

Question #1: At the second meeting, Commission members discussed the Department's process for referral of a patient to a geropsychiatric facility. It is our understanding that a team of individuals at DHHS make decisions regarding whether a patient meets the criteria for placement and which patient that meets the criteria will ultimately be placed in an available bed (i.e., a discussion of "placement priority"). There were suggestions that this process, from the time a bed at a geropsychiatric facility becomes available, to the time a patient is placed, can often take a number of weeks, despite the fact that there may be a number of patients who meet the criteria and would benefit from immediate placement. Could you outline for the Committee how this process is conducted at DHHS and what improvements, if any, could be made to the process to facilitate quicker placement of patients?

Response: Eligibility and placement is currently a multistep process and can be complex. The Department is reviewing the process to identify streamlining opportunities to ensure this vulnerable population receives appropriate and necessary care in a timely manner.

First, an individual has to meet eligibility criteria for Geropsychiatric Nursing level of care which consists of:

- A behavioral assessment;
- A GOOLD Medical Eligibility Determination (MED) Assessment to determine Nursing Facility Level of Care;
- A Pre-admission Screening and Resident Review (PASRR) Level 1 and 2 (PASRR is a Federal Requirement);
- And have a primary diagnosis on Axis I or Axis II of the multiaxial assessment system of the current version of the Diagnostic and Statistical Manual of Mental Disorders, other than one of the following diagnoses: Delirium, dementia, amnesia, and other cognitive disorders; Mental disorders due to a general medical condition, including neurological conditions and brain injuries; Substance abuse or dependence; developmental disabilities; Adjustment disorders; V-codes; or Antisocial personality disorder.

Once eligibility has been met, the procedure for application to a geropsychiatric unit includes:

1. All Geriatric-Psychiatric Unit (GPU) applications are faxed to APS Healthcare along with a current GOOLD MED Assessment for review along with a Release of Information. APS Healthcare will screen for appropriateness for Geropsychiatric Unit Level of Care (LOC) and screen in or out.

2. A Pre-Admission Screening and Resident Review (PASRR) Level 1 Screen shall be submitted to GOOLD Health Systems (GHS). GHS will complete a PASRR Level 2 on anyone who has been determined by the PASRR Level 1 to need a PASRR Level 2 assessment.
3. Screened applicants who meet Level of Care for the GPUs will be placed on the waitlist by date of application. Date of application of an individual on the waitlist may be superseded by prioritization of individuals in consultation with the Substance Abuse and Mental Health Services as follows:
 - a. Riverview Psychiatric Center and Dorothea Dix Psychiatric Center
 - b. Spring Harbor Hospital
 - c. Acadia Hospital
 - d. Maine Medical Center - P6
 - e. Community Hospital Mental Health Inpatient Units
 - f. Mental Health Residential Programs
 - g. Other Nursing Home Facilities or Medical Hospital Units

Question #2: At the first meeting, it was suggested (during public comment), that when the State places a MaineCare patient for treatment out-of-state, the State is only obligated to reimburse that patient's care for the first two years of placement out-of-state and then no longer has a financial obligation. As you may recall, this assertion came as a surprise to most members of the Commission, and given that we have received no clarification from the individual who made the comment, can the Department comment on whether or not this is in fact an accurate description of the State's financial obligation to patients placed for care out-of-state?

Response: The answer to these questions can depend on the specific member and situation. In general, Maine residency is a requirement to be eligible for MaineCare. That being said, if an individual is temporarily or involuntarily absent from the State, but intends to return, MaineCare eligibility will continue.

MaineCare can also continue for individuals placed in institutions outside of Maine, in certain situations:

- If we arranged for an individual to be placed in an institution located in another state, we continue MaineCare as the state making the placement.
- For institutionalized individuals under the age of 21 (incapable of indicating intent to reside in Maine), the state of residence is that of the individual's parents/legal guardian. MaineCare could continue if the legal guardian lives in Maine.
- For institutionalize individuals over age 21 (who became incapable of indicating intent to reside in Maine), MaineCare may continue if the individual was living in Maine when he/she became incapable of indicating intent to reside.

Question #3: At the second meeting, members discussed the Homeward Bound program, specifically the federal grant monies made available to support the program in Maine. It was suggested that one possible recommendation the Commission might make would be to support the expansion of this program, perhaps with the assistance of the Long-term Care Ombudsman, to place more than the current program goal of 26 placements per year. Can the Department comment on the feasibility of expanding the Homeward Bound program in Maine, specifically addressing the possibility of securing additional federal grant monies to support this expansion?

Response:

- Maine's Money Follows the Person Demonstration, known as Homeward Bound is overseen by Office of Aging and Disability Services, and delivered in partnership with Maine's Long Term Care Ombudsman Program, EIM and Alpha One.
- This statewide demonstration, serving elderly and disabled adults, helps to transition individuals who have been in Long Term Care settings for 90 days or longer, back to the community.
- The program supported 1 transition in CY2012, 15 in CY2013, 24 in CY2014, with a target of 26 for CY2015. In this fourth year of operations, even with more aggressive and targeted outreach and the number of people available to transition appears to be decreasing, with 13 transitions to date and up to 7 more projected by the end of the year.
- Maine has one of the highest nursing facility acuity rates in the nation. Compounding this, securing accessible and affordable housing and at the same time assuring reliable home care is exceptionally challenging at this time. These factors combined, influence the numbers of transitions.
- Homeward Bound will continue with federal funding for administrative elements and will receive enhanced FMAP for services accessed by participants who transition to the community through 12/31/2018, after which transition services will be incorporated in Home and Community Benefits for the Elderly and Physically Disabled Waiver (Section 19), the Other Related Conditions Waiver (Section 20) and the Brain Injury Waiver (Section 18).
- Federal grant monies have been requested for CY 2016 through September 30, 2020 with the annual budget request to CMS. This includes funds to support transitions at the current level, with enhanced FMAP and most grant funded administrative elements ending 12/31/2018. This request, submitted 10/5/2015 is under review by CMS and no additional funds can be requested.
- CMS requires that enhanced FMAP, which is called the "rebalancing fund," be reinvested into the community-based long-term care support system in order to increase the availability of HCBS. Rebalancing funds are only available for expenditures that enhance or expand access to home and community based services, build community infrastructure and capacity, etc. The best use of these funds is currently under consideration.
- Continuation of the services beyond 12/31/18, now available through the MFP Demonstration, will depend upon CMS approval of waiver amendments and legislative approval of required funding.

Question #4: At the second meeting, there was additional discussion about negotiated rates. Members have asked us to get the Department's perspective on the negotiated rate process and whether DHHS believes that this process is working to adequately and effectively serve these populations of patients with complex medical conditions, including whether expansion of the negotiated rate process for these populations is feasible or would prove effective?

Response: In the interest of fairness, transparency and fiscal prudence, the Department endeavors to standardize rates paid to providers for like services rendered. These rates are carefully constructed to ensure adequate funding for services. As a last resort, with patients who have more complex needs, the Department may negotiate rates with providers. These situations are rare, however, and often involve patients who require out-of-state placement due to the nature and/or level of their service need.

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Areas involving Possible Recommendations

1. PNMI Regulations:

DHHS still has not reconfigured PNMI's.

Vent dependent individuals and individuals with complex medical needs such as ALS:

There is a proposed regulatory amendment to enhance reimbursement to nursing homes for vent dependent individuals. There is some indication in the testimony that some facilities would accept vent dependent individuals. The supplemental payments must be adequate to cover all needed services.

See the testimony of Home, Hope and Healing regarding individuals with complex medical needs and their access to Private Duty Nursing services. The testimony states that individuals who do not have a residence or family support can't access PDN services and recommends development of a type of residence for these individuals. There does not appear to be a current restriction on delivery of PDN services in PNMI's and we know some clients have accessed them. The applicable PDN regulatory language:

Private Duty Nursing Services are those services that are provided by a registered nurse and/or a licensed practical nurse, in accordance with the Board of Nursing Regulations, under the direction of the Member's physician, to a Member in his or her place of residence or outside the Member's residence, when required life activities take the Member outside his or her residence (school, preschool, daycare, medical appointments, etc.). Reimbursement for services provided outside a Member's residence can include only authorized nursing services and authorized personal care services and may not exceed that which would have been allowed strictly in a home setting. For purposes of this Section, "place of residence" does not include such institutional settings as nursing facilities, intermediate care facilities for persons with mental retardation (ICFs-MR), or hospitals. If nursing services are covered under a private non-medical institution's per diem rate, then Level I, II, III, VI, VII private duty nursing services are not allowed under this Section.

Most PNMI's don't include nursing services in their per diem rates. The issue would be one of getting certain PNMI's to take individuals who have long term serious chronic conditions and to permit PDN.

Reconfiguration of the PNMI's should also address this.

2. Unlawful Discharges

Unlawful discharges from NF's and residential care facilities lead to patients spending excessive amounts of time in ED's and in acute care settings.

There are procedures available to residents to complain about unlawful discharges: a licensing complaint, an action in Superior Court pursuant to 22 MRSA 7948, for mental health residences - a grievance and a Maine Human Rights complaint when the unlawful discharge stemmed from disability based discrimination. The problem is one of obtaining prompt review and enforcement. Beds are often filled by the time the client gets a review.

The Superior Court action requires that the resident give 15 days notice prior to filing. We could consider a statutory change as follows:

2. Right of action limited. Except when a resident is complaining of a violation of rules governing discharge procedures, An action may not be commenced under this section until 15 days after the resident has given notice of the violation and an intention to bring suit under this chapter to the commissioner, the Attorney General and each party alleged to be violating the law or rule. The court may waive the 15-day notice requirement and issue a temporary restraining order when the plaintiff shows that the alleged violation presents an immediate threat to the plaintiff's health or safety.

Licensing can fine, can revoke a license but it claims it doesn't have authority to require that an individual be readmitted. What has to happen is for DHHS licensing to do an accelerated review of complaints regarding unlawful discharges and to add a clear remedy. They can do the accelerated review without any regulatory change, but the regulations could be revised to include language that says that when a complaint regarding an unlawful discharge is lodged, the department shall conduct and conclude a review within X number of days. As the department has the authority to stop or limit admissions and to impose a plan of correction, they actually could require that a bed not be filled (limit admission) and readmit the resident as part of a directed plan of correction.

Licensing has told DRM that they do not have this authority, so either they should agree that they do through negotiations or this Commission or add language to the enforcement section that makes this clear. DRM has some recommended revisions to regulations for both residential care and NF settings. (Attached as A & B) There are several separate assisted housing and residential facility regulations (Levels I through IV). Changed language could be added in each.

The language from paragraphs 69 and 277 of the Settlement Agreement must be in every single Mental Health residential contract and be applicable to all residents not just class members. These are paragraphs that require a residential program to admit clients referred by DHHS and to obtain approval for termination of services. (Obviously there are circumstances when a person can be lawfully discharged against his will but DRM is talking about the people

discharged unlawfully). And this is not about ALL involuntary discharges, but is just to protect those individuals who could return to their residences but are clearly denied reentry.

3. EMTALA

We generally think of the Emergency Medical Treatment and Active Labor Act as governing emergency departments. If they accept Medicare, they cannot refuse emergency medical stabilization services to any individual who has a medical emergency. If they cannot stabilize, they have to transfer to an appropriate facility, with medically appropriate safe transport. The law governs hospitals with specialized capabilities such as psychiatric units, irrespective of whether they have an emergency department. They are required to accept appropriate transfers. When they refuse it is sometimes called reverse dumping.

There are a lot of difficulties with the definitions of emergency and stabilization when applied to psychiatric conditions, but the law nevertheless applies. ED's need to be educated consistently, patients advised and complaints made and investigated.

4. PASRR AND Specialized NF's:

The department has relied upon the gero-psychiatric units (at Mt. St. Josephs, Hawthorne House, Gorham Manor) to meet the needs of individuals with mental illness who are nursing home eligible and who are determined to need specialized services through the PASRR review. This has been virtually the exclusive manner for providing those services. The department should explore providing other types of enriched specialized services in nursing facilities.

NF's also need to report changes in conditions when it is thought that an individual with a mental illness who was not determined to need specialized services under PASRR (or who develops a mental illness) so that they can be assessed for those services through PASRR. (Language attached as C)

As discussed the issue of the gero-psychiatric facilities, which were developed when we closed Greenlaw, presents some thorny issues. When a resident develops dementia (which is not a mental illness for PASRR purposes) and that dementia becomes the primary presenting condition, should the resident be moved to another placement or should the resident be permitted to remain in the facility? Because moving the resident can be highly disruptive and a move to a NF facility without specialized supports may not be successful, DRM has fought to keep people where they are and have been for years and has sometimes been able to show that the patient's mental illness is still primary or that there are "special circumstances".

5. Behavior Consultants:

There are several references to the behavior consultants in the testimony on the various bills. Use of these consultants was a recommendation that came out of the LD 339 committee. The consultant and the SAMHS UR nurses have been very helpful in preserving placements. Expanding this capacity would be welcome but probably can't be achieved within existing

resources. However, one of the functions that SAMHS UR nurses were performing was review of involuntary psychiatric admissions for compliance with the law, as required by the AMHI consent decree. These reviews did not yield much substantively. Perhaps this function can be discontinued and their time freed up to do more placement preservation and consultation. And shouldn't they be assigned to people with mental illness irrespective of whether or not mental illness is the primary diagnoses – Huntington's for example?

6. Rapid Response:

There are also several references to the rapid response team for assessing people with psychiatric conditions stuck in ED's. Recommendations from the work group for improving the involuntary commitment process might help trigger this response. See pages 4-6. This would be a statutory change. (Full report attached as D)

Many of the individuals stuck in ED's for psychiatric assessments are individuals with intellectual disabilities, people with dementia, and children. Appropriate personnel from DHHS should be included in the rapid response for these individuals. OADS needs to develop more specialized medically supported crisis services, possibly using PDN. Admission of individuals with intellectual disabilities to psychiatric hospitals for behavior stabilization leads to extended stays and medication.

7. Certain Neurological Conditions

There are neurological conditions that are frequently associated with behavioral discontrol, such as Huntington's and certain dementias. When these individuals are eligible for NF services, they are not eligible for specialized services pursuant to PASRR. The conditions are not considered an intellectual disability, other related condition or mental illness. The behavior consultant(s) can be of assistance in many of these cases, if trained to specific Huntington's disease treatment. The department could consider an add-on reimbursement, as it has for vent dependence, but would have to have a strict assessment and eligibility standard and designation of services/staffing or else the add-on would become the floor for all behavioral issues as became the case with mental health PNMI's and then the supposed specialized PNMI Supported Living Centers. (MedScape Article)

When Schaller Anderson was assessing patients in out of state facilities, who were sent there for special care unavailable in Maine facilities, they found that the care in a number of instances was not so specialized that it couldn't be delivered in Maine facilities or with HCBS waiver services.

Huntington's Disease. H.R.842 - Huntington's Disease Parity Act of 2015 introduced in February, would require the Commissioner of Social Security to revise the medical and evaluation criteria for determining disability in a person diagnosed with Huntington's Disease and to waive the 24-month waiting period for Medicare eligibility for individuals disabled by Huntington's Disease.

A

Residential Care

4.2 Frequency and type of inspections. An inspection may occur:

4.2.1 Prior to the issuance of a license;

4.2.2 Prior to renewal of a license;

4.2.3 Upon complaint that there has been an alleged violation of licensing regulations. *When the complaint alleges that a resident has been or is being discharged in violation of licensing regulations, the department shall conduct its inspection and conclude its investigation within X days;*

.....

4.4 Complaints. The department will accept complaints from any person about alleged violation(s) of licensing regulations. The provider shall not retaliate against any resident or his/her representative for filing a complaint. Complainants have immunity from civil or criminal liability when the complaint is made in good faith. Any licensing violations noted as a result of a complaint investigation will be provided to the assisted housing program in writing.

4.5 Enforcement process.

4.5.1 After inspection, an SOD will be sent to the licensee if the inspection identifies any failure to comply with licensing regulations. An SOD may be accompanied by a Directed POC.

4.5.2 The licensee shall complete a POC for each deficiency, sign the plan and submit it to the department within ten (10) working days of receipt of any SOD.

4.5.3 Failure to correct any deficiency(ies) or to file an acceptable POC with the department may lead to the imposition of sanctions or penalties as described in Sections 4.7 and 4.8 of these regulations.

4.5.4 Informal conference. If a licensee disagrees with the imposition or amount of any penalty assessed by the department, the licensee must submit a written notification to the department stating the nature of the disagreement, within ten (10) working days of receipt of an Assessment of Penalties. Upon receipt of this request, the Assistant Director of the Division of Licensing and Regulatory Services or his/her designee shall schedule an informal conference for the purpose of trying to resolve the dispute. The Director or his/her designee shall inform the licensee of the results of the informal conference in writing. If a provider desires to appeal the result of an affirmed or modified assessment of penalties following an informal conference, a written request for an administrative hearing, pursuant to Section 4.10, must be made. The department will stay the collection of any fiscal penalties until final action is taken on an appeal. Penalties shall accrue with interest for each day until final resolution and implementation.

4.6 Grounds for intermediate sanctions. The following circumstances shall be grounds for the imposition of intermediate sanctions:

4.6.1 Operation of an assisted living program or residential care facility without a license;

- 4.6.2 Operation of an assisted living program or residential care facility over licensed capacity;
- 4.6.3 Impeding or interfering with the enforcement of laws or regulations governing the licensing of assisted housing programs, or giving false information in connection with the enforcement of such laws and regulations;
- 4.6.4 Failure to submit a POC within ten (10) working days after receipt of an SOD;
- 4.6.5 Failure to take timely corrective action in accordance with a POC, a Directed POC or Conditional License;
- 4.6.6 Failure to comply with state licensing laws or regulations that have been classified as Class I, II, III or IV pursuant to Sections 4.8.2 & 4.8.3.

4.7 Intermediate sanctions. The department is authorized to impose one or more of the following intermediate sanctions when any of the circumstances listed in Section 4.6 are present and the department determines that a sanction is necessary and appropriate to ensure compliance with State licensing regulations to protect the residents of an assisted housing program or the general public:

4.7.1 The assisted living program or residential care facility may be directed to stop all new admissions, regardless of payment source, or to admit only those residents the department approves, until such time as it determines that corrective action has been taken.

4.7.2 The department may issue a Directed POC or Conditional License. *When the department concludes that a resident has been or is being discharged in violation of licensing regulations it shall issue a directed POC that requires the facility to discontinue discharge proceedings and, if the resident is not currently living in the facility, readmit the resident.*

4.7.3 The department may impose a financial penalty.

4.8 Financial penalties.

4.8.1 Certain provisions of these regulations have been classified as noted below. Financial penalties may be imposed only when these regulations are violated.

4.8.2 Certain provisions of the regulations have a single classification. Such regulations are followed by a notation (i.e., "Class I"). Classifications have been established according to the following standards:

4.8.2.1 Class I - Any failure to comply with a regulation where that failure poses an immediate threat of death to a resident(s).

4.8.2.2 Class II - Any failure to comply with a regulation where that failure poses a substantial probability of serious mental or physical harm to a resident(s).

4.8.2.3 Class III - The occurrence of a repeated deficiency that poses a substantial risk to the health or safety of a resident(s).

4.8.2.4 Class IV - The occurrence of a repeated deficiency that infringes upon resident rights.

4.8.3 Certain regulations have been given alternative classifications. Such regulations are followed by an alternative notation (i.e., Class I/II or Class II/III). When these regulations are not complied with, the department will determine which classification is appropriate, on a case-by-case basis, by reference to the standards set forth in Section 4.8.2.

4.8.4 If the department assesses financial penalties, an Assessment of Penalties will be issued. The Assessment shall describe the classification of each violation found to have been committed by the facility, the regulation or law that has been violated and the scheduled amount of time corresponding to that violation. If the provider does not contest the imposition or amount of the penalty, the provider must pay within thirty (30) calendar days of receipt of the Assessment of Penalties. If the provider disagrees with the imposition or amount of the penalty, the provider must notify the department, in writing, stating the nature of the disagreement, within ten (10) working days of receipt of the Assessment of Penalties. The department will schedule an informal conference to resolve the dispute and a written decision based upon this conference will be provided. If the provider is still dissatisfied with the written decision, an administrative hearing may be requested in accordance with Section 4.10.

4.8.5 The amount of any penalty to be imposed shall be calculated according to the following classification system:

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| 4.8.5.1 Any failure to comply with regulations classified as Class I, pursuant to Section 4.8.2.1; | \$6.00 per |
| resident per occurrence | |
| Operation of an assisted living program or residential care facility over licensed capacity, or | per day |

Impeding, interfering or giving false information in connection with the enforcement of laws or regulations governing licensure.

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|---|------------|
| 4.8.5.2 Any failure to comply with regulations classified as Class II, pursuant to Section 4.8.2.2; | \$5.00 per |
| resident per occurrence | |
| Failure to submit a POC within ten (10) working days after receipt of an SOD; or | per day |

Failure to take timely corrective action in accordance with a POC, Directed POC or conditional license.

| | |
|--|------------|
| 4.8.5.3 The occurrence of a repeated deficiency in complying with regulations classified as Class III, pursuant to Section 4.8.2.3; occurrence | \$4.00 per |
| resident per day | |
| The occurrence of a repeated deficiency in complying with regulations classified as Class IV, pursuant to Section 4.8.2.4. | |

program or residential care facility, or conduct or practices detrimental to the welfare of persons living in or attending the facility/program. When the department believes a license should be suspended or revoked, it shall file a complaint with the District Court as provided in the Maine Administrative Procedure Act, Title 5 M.R.S.A., Chapter 375 §10051.

4.9.5 Pursuant to Title 22 M.R.S.A. §7931 et seq., the department may petition the Superior Court to appoint a receiver to operate the assisted living program or residential care facility in the following circumstances:

4.9.5.1 When the assisted living program or residential care facility intends to close, but has not arranged for the orderly transfer of its residents at least thirty (30) calendar days prior to closure;

4.9.5.2 When an emergency exists which threatens the health, security or welfare of residents;
or

4.9.5.3 When the assisted living program or residential care facility is in substantial or habitual violation of the standards of health, safety or resident care established under State or Federal laws and regulations, to the detriment of the welfare of the residents.

4.10 Appeal rights. Any assisted living program or residential care facility aggrieved by the department's decision to take any of the following actions, or to impose any of the following sanctions, may request an administrative hearing to refute the basis of the department's decision, as provided by the Maine Administrative Procedure Act, Title 5 M.R.S.A. §9051 et seq. Administrative hearings will be held in conformity with the department's Administrative Hearings Regulations. A request for a hearing must be made, in writing, to the Assistant Director of the Division of Licensing and Regulatory Services, Community Services Programs and must specify the reason for the appeal. Any request must be submitted within ten (10) working days from receipt of the department's decision to:

4.10.1 Issue a conditional license;

4.10.2 Amend or modify a license;

4.10.3 Void a conditional license;

4.10.4 Refuse to issue or renew a full license;

4.10.5 Refuse to issue a provisional license;

4.10.6 Stop or limit admissions;

4.10.7 Issue a directed POC. *When the department concludes that a resident has been or is being discharged in violation of licensing regulations it shall issue a directed POC that requires the facility to discontinue discharge proceedings and, if the resident is not currently living in the facility, readmit the resident;*

4.10.8 Affirm or modify an Assessment of Penalties after an informal review;

4.10.9 Deny an application to reduce the amount or delay the payment of a penalty; or

B

4.10.10 Deny a request for a waiver of a rule.

NURSING FACILITY:

22.B. General Procedures for Enforcement

22.B.1. Licensing Inspections

Each nursing facility will be inspected prior to being issued its initial license and annually thereafter prior to renewal of a license. The Division may also inspect at any other time to determine compliance with State licensing regulations. *When the inspection is undertaken on a complaint alleging that a resident has been or is being discharged in violation of licensing regulations, the department shall conduct its inspection and conclude its investigation within X days;*

For nursing facilities providing both nursing home and assisted living services, the Division will ensure that a single coordinated licensing and life safety code inspection is performed.

22.B.2. Statement of Deficiencies

After any inspection, a Statement of Deficiencies will be sent to the facility if the inspection discloses any failure to comply with State licensing regulations. A Statement of Deficiencies will be accompanied by either a Plan of Correction form or a Directed Plan of Correction.

22.B.3. Plans of Correction

Eff. 2/1/01 If mailed a Plan of Correction form, the provider must complete it by indicating how and when any deficiency will be or has been corrected, and submit it to the Division within ten working days of receipt of any Statement of Deficiencies. The Division will have ten (10) days after receipt to determine whether it accepts the Plan of Correction.

22.B.4. Failure to Correct Deficiencies

The failure to correct any deficiency or deficiencies or to file a Plan of Correction with the Division may lead to the imposition of sanctions or penalties as described in this Chapter.

22.C. Intermediate Sanctions

The Division is authorized to impose one or more of the following intermediate sanctions when any of the circumstances listed in Section 22.D., below, are present and the Division determines that a sanction is necessary and appropriate to ensure compliance with State licensing regulations or to protect the residents of a nursing facility or the general public.

22.C.1. The Division may direct a nursing facility to stop all new admissions regardless of payment source or to admit only those residents the Division approves, until such time as it determines that corrective action has been taken.

22.C.2. The Division may issue a Directed Plan of Correction.

22.C.3. The Division may impose a financial penalty upon a nursing facility.

C

PASRR Manual on specialized services for mental health: This has been updated as to APS reference but otherwise remains the same.

Specialized Services. Specialized services are those that are provided in addition to the routine care provided by an NF, and that result in the continuous and aggressive implementation of an individualized plan of care for mental illness.

DHHS considers specialized services to be appropriate in an NF when they:

- i. are developed and overseen by an interdisciplinary team that includes a physician and mental health professionals, and, as appropriate, other professionals; and
- ii. prescribe specific therapies and activities supervised by trained mental health personnel; and
- iii. are directed towards diagnosing and reducing the person's behavioral symptoms, improving the level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services at the earliest possible time.

The prescribed therapies and activities in the individualized care plan may include, but are not limited to the services of a psychiatrist, nurse practitioner, psychologist or other qualified mental health professional, psychological testing or evaluation, occupational therapy testing or evaluation, psychotherapy, medication education, crisis planning and intervention services, day hospitalization or acute care hospitalization and case management necessary to coordinate the services described in the plan.

d. Services of Lesser Intensity than Specialized Services. The NF must provide mental health services that are of a lesser intensity than specialized services to all residents who need the lesser services.

PASRR Manual 2012 8

e. Specialized Community NFs (geropsychiatric NF level of care). DHHS supplements the services of three NFs in the state, to provide more intensive specialized services than would be provided at a community NF. Contact APS Healthcare to discuss this option.



Recommendations for Improving the Involuntary Commitment Process

Report to the Maine Supreme Judicial Court and
the Joint Standing Committee on Judiciary by the
Judicial Branch Mental Health Working Group

December 15, 2014

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EXECUTIVE SUMMARY

Pursuant to Resolve Chapter 106 of the 126th Maine Legislature, the Chief Justice of the Maine Supreme Judicial Court chartered a Mental Health Working Group. A copy of the Legislative Resolve and Charter are available in Appendices A and B. Co-Chaired by the Chief Justice of the Maine Superior Court and the Chief Judge of the Maine District Court, the fourteen-member working group included individuals representing various stakeholders, including community hospitals, medical professionals, psychiatric hospitals, the Department of Health and Human Services, as well as patient and family advocates.

The Working Group met four times. Immediately recognizing that the problems associated with treating acute mental illness in Maine extend far beyond the scope of Working Group's Charter, members offered an array of comprehensive suggestions set forth in Appendix D to this Report. Within the confines of the task established by its Charter, The Working Group divided its conversations into the following two important areas of focus: first, the emergency detention, examination, and treatment of patients experiencing psychiatric crisis who are in community hospitals awaiting an inpatient psychiatric bed or community-based services and second, the recruitment, appointment, and compensation of independent examiners at the judicial stage of the involuntary commitment process.

After great and lively discussion among all parties attending, the Working Group recommends that the Legislature consider amending the statutory involuntary commitment process in Title 34-B of the Maine Revised States in order to:

- authorize hospitals to extend the current 24-hour emergency hold when an appropriate placement and resources for a patient are unavailable:
 - by up to 48 hours when heightened standards are met; and
 - for one additional 48-hour period provided that the heightened standards continue to be met and DHHS agrees to assist the hospital with securing an appropriate placement and resources for the patient.
- authorize hospitals to provide involuntary treatment to patients awaiting appropriate placements in specific, limited circumstances
- permit the use of telemedicine when conducting mental health examinations
- explicitly permit family input in certifying examinations; and
- provide independent examination services through a public entity either located in or modeled upon the state forensic service.

The Working Group appreciated the opportunity to meet and would be happy to provide additional details to the Legislature or to the Supreme Judicial Court regarding these recommendations.

I. INTRODUCTION

By Resolve, the 126th Maine Legislature recognized that there are often inadequate resources available for a hospital to respond to an individual who arrives at the emergency department in need of psychiatric treatment. A copy of Resolves 2013, chapter 106, is attached as Appendix A. Due to the number and utilization of inpatient beds at state psychiatric hospitals, community hospitals face both practical and legal challenges as they hold and attempt to treat patients in psychiatric crisis. Moreover, a statewide shortage of trained health care providers willing and able to serve as independent examiners has added strain to the judicial portion of the involuntary commitment process. The Resolve therefore directed that "the Chief Justice [of the Supreme Judicial Court] or the Chief Justice's designee shall convene a working group to review the current situation for both individuals and hospitals when individuals present emergency psychiatric needs in hospital emergency departments and to develop recommendations for addressing immediate and long-term needs of individuals, hospitals, psychiatric hospitals and health care providers."

Accordingly, on August 15, 2014, the Chief Justice of the Maine Supreme Judicial Court established and appointed a Mental Health Working Group "to review the judicial process for involuntary commitment and treatment; examine immediate and long-term needs; and develop short-term and long-term solutions that address both legislative changes needed and resource improvements." The complete charge to the Working Group is included in Appendix B.

Co-Chaired by the Chief Justice of the Maine Superior Court and the Chief Judge of the Maine District Court, the fourteen-member working group was comprised of representatives of Maine entities and groups interested in the detention of individuals for emergency observation, involuntary treatment, and involuntary commitment, including representatives from the Attorney General's office, the Department of Health and Human Services (DHHS), the National Association of Mental Illness (NAMI), the Maine Hospital Association (MHA), the Maine Medical Association (MMA), the Maine Nurse Practitioner's Association (MNPA), the Consumer Council System of Maine (CCSM), and the Disability Rights Center (DRC), as well as a patient attorney, family advocate, mental health institution representative and Treatment Advocacy Center representative. A list of Working Group members is included in Appendix C.

The Working Group met four times from September to November 2014. From the outset, there was complete and full agreement among Working Group members that the long-term solutions for many of the issues complicating the care and treatment of individuals experiencing an acute need for mental health services in Maine include:

- Increasing the attention and resources given to individuals experiencing mental health issues in the State of Maine;
- Evaluating the amount and type of community resources as well as inpatient psychiatric treatment resources available for patients with mental illness in Maine as compared to the community and inpatient resources needed by these patients; and

- Increasing the financial resources available to compensate medical professionals who provide the independent examinations that are crucial to protecting the due process rights of patients during the judicial involuntary commitment process.

Unfortunately, many of the fundamental issues and potential solutions are beyond the scope of the Charter governing this Working Group. The Working Group nevertheless felt strongly that the Legislature should carefully review the list of major issues and potential solutions prepared by several members of the group, which is attached as Appendix D to this report. Critically, although the Working Group believes that adopting the recommendations in this report will likely relieve to some degree the current crisis facing the provision of acute mental health services in Maine, the issues discussed in Appendix D should also be addressed and resolved in order to achieve long-term resolution.

II. AREAS OF FOCUS

The Working Group agreed at the first meeting to divide its work into two main areas of focus, which served as topics of discussion for each of the next two meetings.

The first area of focus involves the emergency detention, observation, and treatment of patients in community hospital emergency rooms prior to location of appropriate community resources or an inpatient psychiatric bed and initiation of the judicial involuntary commitment process. Dr. Steven Diaz, emergency room physician and Chief Medical Officer at Maine General Medical Center in Augusta, graciously presented the Working Group with an overview of the protocols for and challenges of providing emergency room evaluations, treatment and care for patients in psychiatric crisis at the outset of the meeting.

The second area of focus involved independent medical examinations of patients during the judicial involuntary commitment process. This discussion was informed by statistics gathered by the Judicial Branch regarding the current appointment process.

III. EMERGENCY DETENTION, EXAMINATION, AND TREATMENT OF PATIENTS IN COMMUNITY HOSPITALS

A. Overview

Individuals experiencing psychiatric symptoms arrive at the emergency departments of community hospitals both voluntarily and involuntarily, oftentimes through the efforts of law enforcement. Upon arrival a “medical practitioner”—defined by statute as a licensed physician, registered physician assistant, certified psychiatric clinical nurse specialist, certified nurse practitioner or licensed clinical psychologist—must perform a certifying evaluation of the patient to determine whether he or she is mentally ill and, because of that mental illness, “poses a likelihood of serious harm.” If the medical practitioner concludes that the patient meets these criteria and that

community resources are inadequate to treat the patient, emergency department staff begin seeking an inpatient bed for the patient at a psychiatric hospital. Current law only authorizes emergency department staff to detain patients for "a reasonable period of time, not to exceed 24 hours" while a psychiatric hospital opening is sought.

Unfortunately, due to the unavailability of inpatient psychiatric beds in Maine, community hospitals frequently are presented with the following untenable situation: the 24-hour emergency hold period has elapsed but the medical practitioner cannot ethically discharge the patient because the patient continues to pose a likelihood of serious harm to him/ herself or others. Dr. Diaz of Maine General Medical Center reported that currently his hospital has difficulty locating an inpatient bed within the statutory 24-hour timeframe up to 40% of the time. Moreover, it is not unusual to have as many as 16 patients at a time waiting in hospital emergency rooms for inpatient psychiatric beds in Maine.

As a result of the unavailability of inpatient psychiatric beds, patients in psychiatric crisis remain in community hospital emergency departments for significant periods of time, being treated and cared for by medical personnel who may not be experts in the care of mentally ill patients. The Maine Hospital Association (MHA) proposed measures to address this situation by introducing L.D. 1738 during the Second Regular Session of the 126th Legislature. Had it been enacted, that bill would have made several changes to the involuntary commitment laws, including:

- Authorizing hospitals to detain patients meeting the criteria for emergency psychiatric hospitalization for up to 4 days when supported by daily medical evaluations;
- Authorizing hospitals to detain patients for an additional 3 days after obtaining judicial endorsement of an emergency involuntary commitment application;
- Authorizing health care practitioners to administer involuntary treatment to detained patients if the patient's condition poses a serious, imminent risk to the person's physical or mental health and creating an expedited process for judicial review of these treatment plans;
- Permitting hospitals to conduct involuntary commitment examinations and consultations using telemedicine or similar technologies; and
- Affording hospitals and medical practitioners detaining a patient while awaiting the availability of an inpatient bed both civil immunity and an exemption from the licensing standards applicable to psychiatric hospitals for the detention, care, and treatment of psychiatric patients.

Ultimately, L.D. 1738 was amended to create the Resolve that led to the establishment of this Working Group, whose members have examined and discussed at length the issues surrounding emergency detention, examination, and treatment of patients in psychiatric crisis in detail, reaching consensus on several key recommendations for improving the current statutory framework.

B. Working Group Recommendations

After extensive, thoughtful discussion and debate, the Working Group respectfully recommends that the Legislature amend the involuntary commitment statutes in Title 34-B in the following ways:

1. Authorize Hospitals To Extend Emergency Holds When Appropriate Placements and Resources for Patients are Unavailable And Heightened Standards Are Met

A. Allow An Extension of up to 48 Hours, if Necessary, To Provide Hospital Staff Additional Time To Secure an Appropriate Community or Inpatient Placement

The Working Group unanimously recommends that that the initial 24-hour emergency hold time frame for detaining a patient in a community hospital based upon a medical practitioner's initial certifying examination should be retained. Section 3863 of Title 34-B should be amended to permit hospitals to extend the emergency hold for up to 48 additional hours, however, if the patient continues to pose a likelihood of serious harm but an appropriate placement has not yet been secured.

The Working Group discussed at length the appropriate procedural safeguards to be applied when a patient is held in a community hospital's emergency department for more than 24 hours. The Working Group considered requiring judicial endorsement for extending an emergency hold, but concluded that such a process would impose additional unacceptable strain upon the State's limited judicial resources. Instead, because not all emergency department medical personnel have sufficient experience and expertise with mental health issues to coordinate care for patients in psychiatric crisis for extended periods of time, the Working Group agreed that patients should be evaluated by professionals with heightened psychiatric expertise before an emergency hold is extended. The Working Group encourages hospitals that do not have professionals with the required expertise on staff to obtain the necessary evaluations through the use of telemedicine, a practice recommended later in this report.

Accordingly, the Working Group unanimously recommends that hospitals be permitted to extend an initial 24-hour emergency holds for up to an additional 48 hours if and only if the hospital certifies the following in writing:

(a) an additional evaluation performed by an "appropriately designated individual" demonstrates that the person poses a likelihood of serious harm due to mental illness;

(b) despite its best efforts, the hospital has been unable to locate an inpatient psychiatric bed or other appropriate alternatives; and

(c) the Commissioner of DHHS has been notified of the situation.

B. Allow One Additional Extension of up to 48 Hours, if Necessary, and Require DHHS To Assist the Hospital in Securing an Appropriate Community or Inpatient Placement

Unfortunately, while hospitals should be able to secure the necessary community resources or inpatient placements for most patients within the extended timeframe proposed above, circumstances might arise where necessary resources do not become available as quickly as they are needed. The Office of Substance Abuse and Mental Health Services reported, for example, that approximately 3% of patients who were involuntarily committed to a psychiatric hospital between July 2013 and October 2014 had been held in an emergency department for greater than 72 hours before an inpatient placement was secured. Although Working Group members unanimously agreed that in these situations the community hospital should be authorized to extend the patient's emergency detention for a second 48 hours by certifying that the criteria for extended detention continue to be met, they felt it necessary to require that DHHS step in at this point and lend its expertise and assistance to the hospital for the purposes of securing the necessary placement and resources for the patient.

For these reasons, the Working Group unanimously agreed that after the expiration of 72 hours (the initial 24-hour emergency hold period and one 48-hour extended hold), the hospital should be authorized to detain the patient for an additional period of up to 48 hours when the following criteria have been met:

1. The hospital certifies that:

(a) an additional evaluation performed by an "appropriately designated individual" demonstrates that the person poses a likelihood of serious harm due to mental illness;

(b) despite its best efforts, the hospital has been unable to locate an inpatient psychiatric bed or other appropriate alternatives; and

(c) the Commissioner of DHHS has been notified of the situation.

2. The Commissioner of DHHS, or the commissioner's designee, certifies that:

(a) the commissioner has been notified that the hospital utilized its best efforts to locate an inpatient psychiatric bed or other appropriate alternative and has been unable to do so; and

(b) DHHS will use its best efforts in the next 48 hours to assist the hospital in locating an inpatient psychiatric bed or other appropriate alternative.

2. Authorize Hospitals To Provide Involuntary Treatment to Patients Awaiting Appropriate Placements In Specific, Limited Circumstances

Unlike situations where an unconscious patient arrives at a hospital emergency room after a motor vehicle accident in need of emergency surgical treatment, current

law does not provide clear standards regarding the involuntary treatment of patients with mental illness who are being held by a hospital on an emergency basis while an appropriate placement is sought. The Working Group spent a lengthy period of time crafting statutory language that will provide guidance for professionals when emergency mental health treatment is necessary as well as procedural protections for patients with mental illnesses. This statutory amendment is designed to authorize and to regulate the provision of involuntary treatment for patients with mental illness only as long as the patient is being held by the community hospital in accordance with the requirements of Title 34-B. The Working Group therefore unanimously recommends that the Legislature enact the following language, perhaps as a new subsection (4) to 34-B M.R.S. § 3861:

4. Emergency involuntary treatment. Nothing in this section precludes a medical practitioner from administering involuntary treatment to a person who is being held or detained by a hospital against the person's will under the provisions of this subchapter if the following conditions are met:

A. As a result of mental illness, the person poses a serious and immediate risk of harm to that person or others;

B. The patient lacks the decisional capacity either to provide informed consent for treatment or to make an informed refusal of treatment;

C. A person legally authorized to provide consent for treatment on behalf of the person is not reasonably available under the circumstances;

D. The treatment being administered is a recognized form of treatment for the person's mental illness and is the least restrictive form of treatment appropriate in the circumstances;

E. For purposes of evaluation for emergency involuntary treatment, the medical practitioner shall consider available history and information from other sources considered reliable by the examiner including, but not limited to, family members;

F. A reasonable person concerned for the welfare of the patient would conclude that the benefits of the treatment outweigh the risks and potential side effects of the treatment and would consent to the treatment under the circumstances.

3. Permit the Use of Telemedicine When Conducting Mental Health Examinations

All members of the Working Group agreed that the current dearth of medical practitioners both qualified to perform and comfortable performing critical psychiatric examinations could best be addressed by permitting emergency room practitioners to consult with qualified professionals at remote locations or by having those remotely-located professionals perform the examinations through the use of available video technology.

To this end, the Working Group unanimously recommends that the Legislature add a new section to Title 34-B, which provides:

Medical examinations and consultations conducted via telemedicine or similar technologies. Notwithstanding any other provision of this subchapter, a medical examination or consultation required or permitted to be conducted under this subchapter may be conducted using telemedicine as defined in Title 24-A, section 4316, subsection 1 or similar technologies that enable the medical examination or consultation to be conducted in accordance with applicable standards of care.

4. Explicitly Permit Family Input in Certifying Examinations

Family members sometimes have important, relevant information upon which a medical practitioner may wish to rely in performing an examination in the emergency room at the initial stage of the involuntary commitment process; yet, current law does not clearly permit such consultation and reliance. The current language in Section 3863(2) of Title 34-B does not provide medical practitioners with explicit authorization permitting consultation with family members, where appropriate, as part of the examination process. The Working Group realizes that it may not be appropriate for medical practitioners to consult with family members in some situations, for example, if the family member is suspected of having subjected the patient to sexual abuse or other forms of domestic violence.

Accordingly, the Working Group unanimously recommends that the following sentence be added at the end of § 3863(2)(B): "The opinion may be based on personal observation or on history and information from other sources considered reliable by the examiner including, but not limited to, family members." In addition, § 3863(2)(D), which contains repetitive language, should be deleted.

5. Miscellaneous Helpful Amendments to Title 34-B

In addition, the Working Group unanimously recommends the following minor amendments that will serve to clarify and to enhance the statutory involuntary commitment process:

- Amend 34-B M.R.S. § 3863(4)(B) to clarify that, when a judicial officer has endorsed an emergency involuntary commitment application ("blue paper"), DHHS is only responsible for the patient's "reasonable" transportation expenses;
- Amend 34-B M.R.S. § 3864(2) to clarify that a hospital may discontinue the judicial involuntary commitment process if the patient voluntarily submits to psychiatric care; and
- Amend 34-B M.R.S. § 3868 to clarify that when the Commissioner of DHHS transfers a patient to a different psychiatric hospital in Maine, both the order of

involuntary commitment and the order of involuntary treatment (if any) are automatically transferred to the receiving psychiatric hospital.

C. Issues Requiring Further Legislative Examination

The Working Group's unanimous agreement to the recommendations outlined above is premised on an assumption that all of the existing standards of care for hospital patients apply to patients who are held on an emergency basis while awaiting inpatient psychiatric placements. Moreover, because the recommendations outlined above include built-in mechanisms for protecting patient rights, the Working Group does not believe that the Legislature should promulgate additional judicial processes for challenging the detention and treatment of patients in community hospitals. Should a patient believe his or her statutory or constitutional rights have been violated, he or she can file a habeas corpus action pursuant to existing Section 3804 of Title 34-B.

The Working Group was unable to reach agreement on several important issues, however, and respectfully suggests that the Legislature explore the following:

- What qualifications must an "appropriately designated individual" possess in order to perform examinations authorizing a community hospital to hold a patient beyond 24 hours?
- Should a community hospital holding a patient for more than 24 hours be required to provide the patient with social work services (*e.g.*, to assist the patient with notifying landlords or employers or in taking care of pets)?
- Under what circumstances should family members be notified of the patient's situation during an extended emergency hold (*e.g.*, how can the law ensure that domestic violence perpetrators are not notified of a victim's location)?

IV. RECRUITMENT, APPOINTMENT, AND PAYMENT OF INDEPENDENT EXAMINERS

A. Overview

In fiscal year 2013, a total of 921 involuntary commitment cases were filed in the Maine District Court. In a significant number of these cases the psychiatric hospital also requested judicial authorization to provide involuntary medical treatment to the patient. An independent medical examiner must be appointed immediately in each case. Currently, Title 34-B requires the District Court to appoint the independent examiner, who will examine the patient, submit a report to the court, and provide testimony at the involuntary commitment hearing. Questions have been raised regarding the propriety of having the court—the neutral arbiter of fact—appoint the expert witness upon whose testimony the outcome of the case likely will hinge.

Despite its best efforts, the court system has encountered significant difficulty locating qualified experts willing to serve this crucial role. Due to fiscal constraints, the

Judicial Branch pays examiners \$100 per hour, with a 2.5-hour cap imposed for each examination. The courts have generally been forced to exceed these limits in order to find willing examiners, however. Currently examination costs average approximately \$500 to \$600. Even if the court could find more professionals willing to perform examinations at this level of compensation, the evaluations are extremely disruptive to the professional's schedule. Independent examiners must on quite short notice visit the patient at the psychiatric hospital, review the patient's records, draft a written report addressing statutory criteria for commitment and/or treatment, appear in court on the date of the hearing, and sometimes wait several hours before being called to testify. During this time the professional is called away from his or her patients, who also need medical attention and care.

By statute, a licensed physician, registered physician assistant, certified psychiatric clinical nurse specialist, certified nurse practitioner or licensed clinical psychologist may serve as an independent examiner for involuntary commitment cases. Yet, if the psychiatric hospital seeks an order of involuntary treatment, an independent examination must be performed by a professional "qualified to prescribe medication relevant to the patient's care." The courts have been unable to find experts with the necessary prescribing authority who are also able to complete necessary evaluations within the mandatory fourteen-day statutory time frame for holding involuntary commitment hearings. Thus, the courts have had to bifurcate the proceedings and appoint two independent examiners in cases where both involuntary commitment and involuntary treatment orders are requested, further driving up costs.

B. Working Group Recommendation

The Working Group unanimously agreed that the current statutory model of having the Judicial Branch hire private evaluators to perform independent mental health examinations is both inadequate and possibly inappropriate. It therefore recommends that the Legislature take the following steps to resolve these issues.

1. Provide Independent Examination Services Through A Public Entity Either Located In or Modeled Upon the State Forensic Service

The Working Group believes that having a State agency hire qualified staff to perform independent medical examinations in involuntary commitment and involuntary treatment proceedings represents the most cost-efficient method for providing these services. The State currently pays professionals to conduct these examinations through the Judicial Branch, but in a fractured, inefficient way. These funds should be reallocated from the Judicial Branch to a separate State agency, which will hire professionals specifically dedicated to this task. The members of the Working Group agreed that the current model under which the Judicial Branch hires professionals on a case-by-case basis on short notice, interrupting their private practices, is untenable. The current model's failings will be eliminated by hiring professionals who can dedicate their time to these critically important evaluations.

Moreover, as state employees the professionals will be freed to provide their services across a wide geographic area, reaching traditionally underserved locations in the State.

The public agency responsible for hiring and supervising independent examiners should not be located either within the Judicial Branch or the psychiatric hospitals. The Working Group agreed that it might be appropriate to locate these professionals within the State Forensic Service, which currently provides mental health competency and capacity examinations in criminal and juvenile court proceedings. Alternatively, the Legislature could establish a separate agency to provide these examinations, using the State Forensic Service as a model of how government employees can provide truly independent professional evaluation services to assist the court system. The Judicial Branch is willing to transfer the funds currently budgeted for independent involuntary commitment evaluations to whichever agency is tasked with assuming this responsibility.

Most members of the Working Group believed that it might be possible for two full-time professionals to serve the independent examiner role required by the involuntary commitment and involuntary treatment processes. The Legislature may wish to explore whether it would be best for the state agency recruiting independent examiners to contract with several medical professionals across the State, hire a number of part-time independent medical professionals, or hire full-time staff who could, during time periods where fewer involuntary commitment applications are filed, work on other projects for the State agency.

V. CONCLUSION

Working Group members appreciated the opportunity to meet and to develop recommendations that, if adopted, will provide a necessary first step toward alleviating the difficulties currently experienced by patients in need of acute mental health care in Maine.

The Working Group suggests that Title 34-B be amended to create clear statutory authority for the care and treatment of patients detained in emergency departments while appropriate community-based or inpatient resources are being secured, as well as guidelines ensuring that patients are not detained unnecessarily. In addition, the proposed legislative amendments will ensure that medical practitioners performing involuntary commitment evaluations have both the necessary expertise and relevant information necessary to accurately assess the patient's mental health needs. Moreover, community hospitals will be provided the additional time and assistance they need in circumstances where it is especially difficult to secure appropriate community or inpatient resources for patients.

Finally, the delays and expense the State incurs in a process that requires the Judicial Branch, often without success, to timely locate and pay for independent medical evaluations for patients during the judicial portion of the involuntary commitment process will be greatly reduced by reallocating the current funds spent on these evaluations from the current, fractured system to a more streamlined system housed outside of the Judicial Branch.

While the Working Group feels confident that the proposals offered in this report will assist in the short run with the acute problems examined, the group also felt strongly that more permanent resolution could be achieved by implement of the suggestions made in Appendix D.

APPENDIX A
Resolves 2013, ch. 106

**Resolve, Concerning Maine's Involuntary Treatment and Involuntary
Commitment Processes**

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, resources to respond to an individual who presents an emergency psychiatric situation at a hospital are currently inadequate; and

Whereas, hospitals currently face both practical and legal challenges in responding to individuals who arrive in emergency departments in need of psychiatric treatment when insufficient psychiatric beds are available; and

Whereas, the Legislature recognizes the necessity for remedies while protecting the rights of individuals and attempting to address their medical and psychiatric needs; and

Whereas, the best solution involves the participation of all those interested in the judicial process concerning detention for emergency responses, involuntary treatment and involuntary commitment; and

Whereas, the Chief Justice of the Supreme Judicial Court has offered to convene a working group to examine the immediate and long-term needs and develop short-term and long-term solutions to improve the judicial involuntary commitment and treatment process; and

Whereas, it is imperative that this resolve take effect immediately so that the working group can complete its work in time for the committee of jurisdiction to submit legislation to the First Regular Session of the 127th Legislature; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1 Working group convened. Resolved: That, in accordance with the offer extended by the Chief Justice of the Supreme Judicial Court in her letter to the Joint Standing Committee on Judiciary dated March 3, 2014, the Chief Justice or the Chief Justice's designee shall convene a working group to review the current situation for both individuals and hospitals when individuals present emergency psychiatric needs in hospital emergency departments and to develop recommendations for addressing immediate and long-term needs of individuals, hospitals, psychiatric hospitals and health care providers. Specifically, the working group shall address the following issues:

1. The timing and length of preliminary and follow-up holding and commitment periods and requirements for involuntary treatment during such periods;
2. Process improvements for holding and commitment period determinations;

3. The current lack of health care providers available to address compliance with due process requirements and any procedural changes recommended by the working group; and

4. Any additional recommendations for improvement in the judicial commitment and involuntary treatment process; and be it further

Sec. 2 Participants. Resolved: That the Chief Justice of the Supreme Judicial Court or the Chief Justice's designee may invite the participation of the following in the working group convened under section 1:

1. A representative of an organization representing hospitals with emergency departments and hospitals with psychiatric units;

2. A representative of the Department of Health and Human Services;

3. Attorneys who represent patients in the judicial commitment process;

4. Disability rights advocates;

5. Medical and mental health professionals;

6. Mental health advocates;

7. Family advocates;

8. The Attorney General; and

9. Other interested parties; and be it further

Sec. 3 Report. Resolved: That the working group convened under section 1 shall submit a report of its findings and recommendations, including any legislative recommendations, by December 15, 2014 to the joint standing committee of the Legislature having jurisdiction over judiciary matters. The joint standing committee of the Legislature having jurisdiction over judiciary matters may report out legislation to the First Regular Session of the 127th Legislature to implement matters relating to the report.

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

**APPENDIX B
JUDICIAL BRANCH
MENTAL HEALTH WORKING GROUP**

Type: Short-Term Working Group
Established: August 15, 2014
Chair: Chief Justice Thomas E. Humphrey and Chief Judge Charles LaVerdiere
Report Date: December 15, 2014
Reports to: Supreme Judicial Court and the Joint Standing Committee on Judiciary
Completion Date: June 30, 2015

I. Purpose:

At the request of the 126th Maine Legislature, the Chief Justice calls together this stakeholder Working Group to review the judicial process for involuntary commitment and treatment; examine immediate and long-term needs; and develop short-term and long-term solutions that address both legislative changes needed and resource improvements.

II. Authority:

Authorized by Resolves 2013, ch. 106, § 1, which provides that “the Chief Justice or the Chief Justice’s designee shall convene a working group to review the current situation for both individuals and hospitals when individuals present emergency psychiatric needs in hospital emergency departments and to develop recommendations for addressing immediate and long-term needs of individuals, hospitals, psychiatric hospitals and health care providers.”

III. Issues to be Considered:

A. Hospitals—Liability and Resources

A complete review of the judicial process for proposed involuntary commitment and treatment will be undertaken to determine whether improvements and clarification in the procedures and communication of those procedures can be identified, with the goal of providing appropriate due process, greater clarity for treatment providers, and improved public safety.

B. Judicial Branch—Independent Examiners—Due Process

An update on professional resources for evaluations, preliminary examinations, and full mental health exams will be undertaken. There is a growing lack of independent examiners available to timely evaluate individuals for court

hearings related to involuntary commitments and/or medications; as a result, either the involuntary medication request is unable to be heard, or there are inordinate delays in scheduling such hearings

C. Other—Independent Examiners—Responsibility and Resources

Independent examiners perform services and appear as witnesses for parties in court cases and hearings related to involuntary commitments and/or medications. As a result of historic budgeting processes, the payment of those individuals is channeled through the Judicial Branch, which has no expertise in setting appropriate professional rates, in seeking third-party contributions, or in seeking Medicaid reimbursement. Consideration must be given to reallocating responsibility for engaging and maintaining a sufficient roster of independent examiners for court proceedings. In addition, increases in costs must be addressed in order to assure prompt assignment of cases and timely resolution.

IV. Tasks of Working Group:

(1) Review the current process for both individuals and hospitals when individuals present emergency psychiatric needs in hospital emergency departments;

(2) Develop recommendations for addressing immediate and long-term process improvement for individuals, hospitals, psychiatric hospitals, and healthcare providers regarding involuntary commitments and involuntary medication; and

(3) Address the following:

(a) Timing and length of preliminary and follow-up holding and commitment periods and requirements for involuntary treatment during such periods;

(b) Process improvements for holding and commitment period determinations;

(c) Current lack of healthcare providers available to address (i) compliance with due process requirements, and (ii) any procedural changes recommended by the Working Group;

(d) Establish responsibilities for (i) engaging and maintaining a

sufficient roster of independent examiners to timely perform services and appear as witnesses for parties in court cases and hearings related to involuntary commitments and/or medications, and (ii) paying all costs and fees associated with their services, including court appearances; and

(e) Any other recommendations for improvement in the judicial process for involuntary commitment and treatment.

V. Membership:

The Working Group shall be comprised of various stakeholders in the judicial process for involuntary commitment and treatment.

Its members shall include representatives of persons and entities interested in the judicial process concerning the detention of individuals for emergency responses, involuntary treatment, and involuntary commitment in connection with the medical and psychiatric needs of such individuals.

- A. Members of Stakeholders Group:
 - Trial Court Chiefs
 - Attorney General's Representative
 - DHHS Representative
 - NAMI Representative
 - Patient Attorneys Representative
 - Maine Hospital Association Representative
 - Maine Medical Association
 - Maine Nurse Practitioner's Association Representative
 - Mental Health Institution Representative
 - Consumer Council System Of Maine (CCSM) Representative
 - Disability Rights Center Representative
 - Family Advocate Representative
 - Treatment Advocacy Center Representative

- B. Subgroups of the Stakeholders Group:
 - (i) Due Process Subgroup
 - (ii) Providers & Costs Subgroup

**APPENDIX C
JUDICIAL BRANCH
MENTAL HEALTH WORKING GROUP**

Membership Roster

Trial Court Chiefs

Chief Justice Thomas E. Humphrey
Chief Justice Charles LaVerdiere

Attorney General's Representative

Katherine Greason, Esq.

DHHS Representative

Jasmil Patillo

Maine Hospital Association Representative

Jeffrey Austin

Maine Medical Association

Gordon Smith, Esq.

Maine Nurse Practitioner's Association Representative

Constance Jordan, ANP, PMHNP

NAMI Representative

Jenna Mehnert

Mental Health Institution Representative

Dr. Michelle Gardner

Patient Attorneys Representative

William Lee, Esq.

Consumer Council System Of Maine (CCSM) Representative

Charlie Ames

Disability Rights Center Representative

Helen Bailey

Family Advocate Representative

Jeanie Coltart

Treatment Before Tragedy

Joe Bruce

**APPENDIX D
JUDICIAL BRANCH
MENTAL HEALTH WORKING GROUP**

Long-Term Issues for Individuals Experiencing Mental Illness in Maine

While the changes proposed in this report are important, they will not solve all the underlying problems associated with providing the necessary support to individuals experiencing an acute need for mental health services. It is very important to the members of the Working Group that the Legislature understand that more work needs to be done to help individuals with mental illness. Following is a list of issues that different members identified as factors to the underlying problem.

- **Lack of inpatient psychiatric beds.**

Several Working Group members voiced concern that a lack of inpatient psychiatric beds contributes to the problem of extended stays in emergency departments. The Working Group was unable to obtain comprehensive information on the length of time that individuals are spending in emergency departments. The statistics DHHS and MHA were able to compile did not include data from all community hospitals. Nor did we obtain information systematically collected on the specific needs of individuals awaiting admission to psychiatric hospitals. One emergency department physician who provided information to the task force stated that the patients who have extended stays are primarily elders, juveniles, and individuals displaying violent behaviors. Other members stated that individuals with dual diagnoses of intellectual disabilities and mental illness also experience extended stays. As all psychiatric hospitals may not be appropriate for all patients, it may be that there is a need for increased numbers of specialized psychiatric beds. The Legislature may wish to ask DHHS or another entity to collect data detailing the exact number of individuals who experience extended stays in all emergency departments during a set time period, the duration of those stays, and the type of any specialized psychiatric needs with which those individuals present. This information would better inform the Legislature and DHHS as to the number and type of inpatient psychiatric beds needed.

- **Clearinghouse of available inpatient psychiatric beds and community services**

There was a sense among Working Group members that the current "census" process used to identify available inpatient psychiatric beds is helpful, but could be greatly enhanced. An electronic database, updated in real time, identifying the number of inpatient beds available and types of patients accepted (dual diagnoses, geriatric, juvenile, etc.) could greatly assist community hospital providers, crisis workers, and DHHS staff in locating appropriate facilities for patients in a timely fashion. Moreover, the database should include similar information regarding the availability of community resources for patients with mental illness. This latter functionality may help reduce patient stays in hospital emergency departments by alleviating the over-identification of patients for inpatient services (discussed below).

- **Over identification of need for beds by hospitals/providers.**

There was some suggestion that given the pressures experienced by emergency departments and the inconsistent availability of psychiatric expertise in emergency departments, involuntary hospitalization may be recommended unnecessarily in some instances. If psychiatric expertise were consistently available in all emergency departments, through telemedicine, for example, more proper utilization of existing inpatient psychiatric hospital beds might be enhanced.

- **Rapid Response**

In the past, DHHS has taken part in a “Rapid Response” protocol when a patient has spent eight or more hours in a community hospital emergency department awaiting an inpatient psychiatric bed. In 2011, DHHS ceased its participation in these teams, indicating that it found the process to be of limited utility and that it was shifting its focus toward the use of regional crisis systems. Several Working Group members expressed a belief that the Rapid Response teams provided needed assistance and request that DHHS review whether or not it should reinstate this program.

- **Failure by hospitals/providers to assist patients who seek voluntary treatment.**

There was the sense among several Working Group members that there is inconsistency in how individuals who present to emergency departments are assessed or referred for *voluntary* treatment. Individuals may present repeatedly at emergency departments over the course of several days, yet they do not meet admission standards. When the individuals’ conditions finally deteriorate, they might then be admitted to the psychiatric hospital because they are more acutely ill. Working Group members believe resources should be made available to all emergency departments to help link patients to needed community-based services and resources when they first arrive at community hospital emergency departments.

- **Limited availability of existing community resources (peer support, ACT teams etc.)**

Working Group members reported that peer support services and ACT teams can be effective in assisting individuals with mental illness to live successfully in the community and avoid hospitalization. These services, however, are not sufficiently available across Maine.

- **Unavailability of other community resources.**

Working Group members also noted that other mental health services are insufficiently available in Maine and that individuals are waitlisted for basic services such as community integration and medication management services.

Lack of available resources not only leads to increased numbers of patients in need of inpatient treatment but also results in individuals remaining in a psychiatric

hospital beyond the time when they could be safely discharged. Those inpatient psychiatric hospital beds are then unavailable to others in need of acute psychiatric hospital services, thus compounding the problem of extended patient stays in emergency departments.

- **Ineffectiveness of other community resources.**

Working Group members noted that several providers of needed services do not offer those services after 5:00 p.m. or on weekends, which unfortunately are oftentimes the periods of greatest need. Many community providers direct individuals who do not need medical care or inpatient hospitalization to hospital emergency departments rather than fully exploring the needs of the person. In addition, several community providers are inconsistent in their approach to persons experiencing mental illness to the degree that different employees of the same community provider disagree about whether hospitalization is needed.

- **Inappropriate refusals by community residential housing providers to permit patients to return home**

Working Group members noted that the extended stays in emergency departments can arise when hospitals are unable to discharge emergency department patients to their residential settings even though the individuals are medically and psychiatrically cleared to return. Other individuals who have been in a psychiatric hospital are unable to return to their residential settings even though they are ready for discharge. If community residential providers refuse to meet their obligation to provide housing to individuals with mental illness, psychiatric hospitals are unable to meet their obligation to provide inpatient services to the individuals truly in need of those services. The legislature may want to explore implementing processes for accelerated licensing or other administrative review of the processes whereby the residential facilities decline to allow the individual to return home.

- **Delays in processing involuntary commitment applications**

Currently, once a patient who is in need of inpatient hospitalization has been transferred from a community hospital to a psychiatric hospital the formal, judicial involuntary commitment process is initiated. Maine's statutes give the courts 14 days to conduct the involuntary commitment hearing. During that 14-day period, a court-appointed medical practitioner (psychiatrist, psychologist etc.) must conduct an independent evaluation of the patient and submit a written report. The hearing is then held to review the evaluation.

It is very difficult for the judicial system to meet this current timeframe due to the lack of available medical professionals to conduct the hearings. Nevertheless, the patient is in limbo for up to two weeks and is being held in an inpatient bed without an approved treatment plan. Accordingly, optimal treatment is delayed. The longer the treatment is delayed, the longer recovery is delayed. The longer recovery is delayed, the longer the inpatient bed is occupied. One way to make beds more available is to

implement strategies to accomplish a quicker turn-around time for patients who need treatment.

Any truly successful long-term solution will only be achieved if the issues identified above are addressed.



The Cianchette Building
43 Whiting Hill Road
Brewer, Maine 04412
207.973.7050
fax 207.973.7139
www.emhs.org

MEMO

To: Members of the Commission to Study Difficult to Place Patients
From: Lisa Harvey-McPherson RN, MBA, MPPM
Subject: EMHS Recommendations
Date: November 13, 2015



EMHS MEMBERS
Acadia Hospital
Beacon Health
Blue Hill Memorial Hospital
Charles A. Dean
Memorial Hospital
Eastern Maine Medical Center
EMHS Foundation
Inland Hospital
Maine Coast Memorial Hospital
Mercy Hospital
Rosscare
Sebasticook Valley Health
TAMC
VNA Home Health Hospice

Thank you for the opportunity to provide comment at the November 5th meeting. As requested I have summarized recommendations noted in my verbal presentation to the committee.

DHHS/MaineCare

DHHS to work with hospitals to address guardianship and Adult Protective Services processes that do not add value to the patient/individual and cause unnecessary extended hospital stays. Develop “temporary guardianship” status so hospitals can work on discharge while the longer timeframe for permanent guardianship is finalized.

MaineCare to expedite application process for hospitalized patients to reduce the timeline down from the current 45 day (or longer) timeframe to approve an application for nursing home coverage.

MaineCare to pay hospitals a “day awaiting placement” rate as recommended by MHA.

For patients who have been waiting 30 days for placement, waive the 60 mile radius restriction allowing the hospital to place the patient in an accepting facility beyond the restriction.

Supporting Hospital Discharge

DHHS to fund LTC Ombudsman positions to facilitate transition in care for difficult to place patients.

DHHS to fund LTC contracts for behavioral health support at the facility for care plan consultation, treatment and staff education.

Addressing Gaps in Community Based Options

CON unit to exempt the following from budget neutrality caps for MaineCare beds – gero-psych unit in greater Bangor region, development of vent units, bariatric units and Huntington Disease units. MaineCare to pay for specialized units with negotiated rates.

Data Collection –

LTC providers (Nursing Facility and Residential Care) to report to licensing when patients are denied re-admission back to the facility and the cause for the denial. Licensing to report out data on re-admission challenges and LTC Ombudsman to work with providers and DHHS to implement data driven solutions.



November 20, 2015

RE: Testimony to LD 155 Commission

Thank you, once again, for receiving our testimony. My name is John Gregoire and I'm here with my wife, Linda. We live in Windham, Maine, and we're here once again, to ask you, Ladies and Gentlemen, to include neurodegenerative diseases as a category in whatever recommendations you make to the DHHS Committee.

The conversations we've witnessed have been, understandably, focused on moving staff, patients and money within the current system. However, and with all due respect, there's been very little discussion about new models or innovation outside of the current system. We've heard comments from Commission members and public comment saying the current system is broken and before we can expand upon it, we need to fix it. We've all heard the adage: "The definition of insanity is doing the same thing, over and over, and expecting a different result". I would encourage this Commission, in its recommendations, to be mindful of laying the foundation to encourage and enable, paradigm breaking, innovative thinking regarding housing options for the classes specified in LD155. Sometimes, systems and cultures are beyond repair. And that's when we need to think differently about the problem.

We realize this may go against the grain of some of the special interest groups represented in this room. We hope not. We would like to think what we are proposing presents an opportunity for for-profit entities to expand into new areas of growth and for non-profits to better serve their constituencies.

We also recognize in proportion to the mental health and other affliction specific needs the Commission is wrestling with, the neurodegenerative disease population is small. But that doesn't mean the need is not there. At the last meeting, Sheila Pechinski gave a heart wrenching testimony, telling her family's story of fighting Huntington's Disease. She spoke of her son, now deceased and her daughter, having to go into nursing homes in Massachusetts, because no home in Maine would take them. We've heard many stories like this. Maine can do better.

But, I submit to you, that Maine won't do better for this underserved population, by simply adding staff to existing nursing homes or changing rate structures, both of which are clearly needed in many cases. The care of patients with diseases like ALS, MS, and Huntington's goes beyond simple labor calculations. These afflictions require a degree of specialized and individualized care best met by models other than a traditional nursing home, where paralyzed patients are typically confined to a bed for long periods. Maine, can do better.

Many, many patients, with neurodegenerative diseases, can be cared for at home. The issue there is, these diseases are progressive in nature. Therefore, the current caps on allowances for home healthcare quickly become insufficient for the increasing needs, which then puts pressure on families and the healthcare system to find appropriate placement outside the home. We understand after the new year DHHS and/or the legislative DHHS Committee will be looking into including disease like ALS in the "Other Related Conditions" category for home health services. A move we whole heartedly support.

The original purpose of LD155, as stated in the draft bill, and I quote: "The purpose of this bill is to help ensure that patients with complex medical conditions who are in hospitals are placed in more appropriate non-hospital settings." There are obviously categories of complex needs which can be addressed appropriately by traditional nursing homes and/or existing specialized facilities for mental health, substance abuse, or spinal cord injuries. There are no such facilities for neurodegenerative diseases.

Let me be clear: We are *not* asking for funding for construction of the ALS/MS Residence we are proposing. We plan to build and significantly fund the operation of this residence through philanthropy, ongoing fundraising, and endowments. Our only request of this Commission is to ensure the regulatory framework exists to enable innovative models such as we propose. As tired as the phrase may be, it's time "to start thinking outside the box".

Ladies and Gentlemen, you have an unprecedented opportunity, thanks to Representative Malaby's forward thinking vision. An opportunity to enable Maine's entrepreneurial spirit. An opportunity to allow mission driven, non-profits such as our foundation, to change the face of long term care in Maine, forever. If DHHS and foundations like ours, can agree that the legislature has provided the regulatory framework of which I speak, in our opinion, this is a win-win for the families of Maine who are afflicted with these incurable, financially and emotionally, devastating diseases. It's also a win for an overburdened hospital and long term care system.

Most important of all, it sends a message of hope, not just to the hidden families in our midst who are fighting these rare and incurable diseases. It's a message of hope to every family in Maine fighting diseases, rare or not, that this body, representing the people of Maine, is willing to say to the rest of the country that "business as usual" isn't always best when it comes to caring for our most vulnerable friends, neighbors and family members. Hope, they are in fact, no longer hidden. Please tell them "We see you. And we care."

Thank you so much for your time today. Linda and I remain at your disposal.

Sincerely



John A. Gregoire
Co-Founder
The Hope-JG Foundation
hope-jg.org

ADDENDUM A
(From: H.P. 113 - L.D. 155
Resolve, To Establish the Commission To Study Difficult-to-place Patients
Section 5 - Duties of the Commission)

1. Identification of categories of patients with complex medical and mental health conditions who are unable to be discharged from hospitals because there are no facilities or providers who are able to care for them or to accept them for care;

As stated in our commentary (attached) it is our sincere hope that the Commission will recommend inclusion of neurodegenerative disease as a class addressed by this legislation. Not only for alternative housing options, but also recommending to DHHŠ that, for home care, neurodegenerative disease be included in the OTR (Other Related Conditions) category.

2. A description of how patients with complex medical and mental health conditions are placed currently, including the involvement of staff from the Department of Health and Human Services;

As far as our research can tell, patients with neurodegenerative diseases, especially ALS, are not wanted by traditional nursing homes in Maine. Our foundation knows of one vented ALS patient, from Bangor, who was eventually placed in a home in Biddeford. We were told by that home's manager, that they wouldn't do it again. We were approached by a family who has a non vented relative with ALS in a small, 8 bed nursing home Downeast, that the patient was asked to leave because "his care was too intense". Most important is the fact that the traditional nursing home is not equipped to provide quality care for an individual who remains cognitively aware but is completely, or partially paralyzed and perhaps vented. There is a specialized quality of care the traditional nursing home cannot provide profitably. That is why our plan includes partnering with a like-minded, mission driven non-profit, already operating along term care facility.

3. Identification of primary barriers to placement of patients with complex medical and mental health conditions currently;

For neurodegenerative diseases, our take is that the most significant barrier is that these diseases are progressive by definition. Therefore, the care needs evolve over time, increasing in intensity of care. A patient may progress slowly, and have needs which remain stable for years. Conversely, a different patient may progress from needing a walker, to a wheelchair and being bedridden and totally paralyzed and ventilator dependent within 18 months.

4. A description of facilities in which patients with complex medical and mental health conditions are currently placed, including whether the facilities are in-state and the costs associated with the patients' care;

We are modeling our proposed residence after the 10 person Steve Saling ALS/MS Residence, housed in the 100 person Leonard Florence Center for Living in Chelsea, MA. The Leonard Florence Center is the nation's first urban Green House. The Green House model was developed by Dr. Bill Thomas and is the care model we plan to deploy in our residence. It was designed as an elder care model but has proven to be highly effective with the disabled population as well. We strongly encourage members of the Commission to tour the Leonard Florence Center and the Saling Residence. We would be happy to arrange a tour.

5. Options for increasing availability of residential care and long-term care facilities, including conversion of existing facilities such as hospitals, nursing homes and the Dorothea Dix Psychiatric Center to long-term care facilities for specialized populations that are difficult to place for care, such as ventilator-dependent patients, geropsychiatric patients and bariatric patients;

Again, specific to neurodegenerative disease, we feel strongly that, to effectively deploy the innovative care model required to best serve this population, new construction is required. The cost to retrofit an existing facility with the residential and technical amenities which make this model work, would be cost prohibitive.

6. Rates of reimbursement necessary to operate facilities to manage patients with complex medical conditions, including psychiatric conditions and neurodegenerative diseases;

We do not have data for the state of Maine as of this time. We do have the following Medicaid numbers for the ALS/MS residence in Chelsea, MA:

The Medicaid rate for Leonard Florence Center:

Case-mix rate T:

MS and ALS (non-vented) - \$301.83

ALS Vent program - \$530.54

7. Any other issue identified by the commission; and be it further

COMMISSION TO STUDY DIFFICULT-TO-PLACE PATIENTS

SUMMARY OF ISSUES RAISED AND PROPOSED SOLUTIONS

| Problems/Issues Raised | Identified/Proposed Solutions | Notes |
|---|---|-------|
| <p><i>Hospital patients awaiting discharge</i> – numerous hospital patients meet discharge criteria but remain hospitalized due to lack of appropriate/available placement. Hospitals are currently caring for these patients in a NF type way without reimbursement as patient awaits placement in appropriate facility with capacity.</p> | <ul style="list-style-type: none"> ✓ Pay PPS hospitals a daily “days awaiting placement” rate for the care of patients following the conclusion of medical care identical to what is paid to CAH hospitals under the current Medicaid manual. ✓ Payment should be paid pending MaineCare determination and/or guardianship determination. Accordingly, some payments will be outside of Medicaid and not available for federal match. ✓ DHHS to work with hospitals to address guardianship and APS processes that do not add value to the patient/individual and cause unnecessary extended hospital stays. Develop “temporary guardianship” status to facilitate hospital discharge while permanent guardianship process is completed. | |
| <p><i>Staffing issues</i> – not enough adequately trained staff to serve patient populations across all facilities.</p> | <ul style="list-style-type: none"> ✓ Address the need for mature staff to handle complex needs of residents by focusing on reducing the costs of education (financial costs, length of program, ease of participation, etc.) and making it easier for people to get training for jobs in this field (work in conjunction with the DOL and explore public/private partnerships). | |

| Problems/Issues Raised | Identified/Proposed Solutions | Notes |
|---|---|-------|
| <p><i>Placement issues</i> – insufficient resources to assist patients, families and providers in placement of patients with complex medical conditions.</p> | <ul style="list-style-type: none"> ✓ Authorize certain facilities to implement staff certification programs (CNA, etc.), currently overseen by the DOE. ✓ Add additional staff to Long-term Care Ombudsman program to assist in placing these complex patients in in-state facilities (including assistance post-placement). See proposal submitted by Brenda Gallant. ✓ Augment similar resources already provided by DHHS, such as nurse education consultant. ✓ Generally augment these types of resources across the spectrum of treatment. | |
| <p><i>Facility capacity issues</i> – generally, there is a greater demand for available facility (NF, SNF, PNMI, etc.) placement than there is capacity in Maine.</p> | <ul style="list-style-type: none"> ✓ Expand/reconfigure appendix C PNMI facilities. ✓ Expand or improve community placement, including Homeward Bound program (explore possibility of expanding federal grant funds). ✓ Consider home care staffing problems (staff availability, training, reimbursement rates, etc.). | |
| <p><i>Compliance/enforcement</i> – insufficient contract compliance and enforcement by DHHS against facilities violating patient rights.</p> | <ul style="list-style-type: none"> ✓ Statutory or regulatory changes to address these issues are being reviewed by Disability Rights Maine to enhance compliance and enforcement efforts. | |

| Problems/Issues Raised | Identified/Proposed Solutions | Notes |
|--|--|-------|
| <p>60 mile rule – patient can refuse placement at facility greater than 60 miles from residence.</p> | <ul style="list-style-type: none"> ✓ Consider exception to rule in certain, specialized cases. Suggestion (EMHS) to waive 60 mile rule for patients who have been waiting 30 or more days for placement. | |
| <p>Medicaid eligibility – application approval process takes a long time (45 days average).</p> | <ul style="list-style-type: none"> ✓ Consider implementing “presumptive eligibility” option for facilities to, in certain circumstances, presume a patient’s Medicaid eligibility before application approval. ✓ Work with DHHS to expedite application process for hospitalized patients awaiting NF or other placement. | |
| <p>Refusal of placement – insufficient data is collected regarding basis for facility refusal of placement to effectively evaluate issues surrounding patient placement.</p> | <ul style="list-style-type: none"> ✓ Establish method for data collection to increase understanding of these problems: if long term care facility (SNF, NF, PNMI, etc.) refuses an admission from a hospital for any reason, facility should file a one-page form with DHHS identifying barrier(s) to admission (e.g., no bed available for any patient; no payer is in place; no guardian is in place; behaviors cannot be safely managed; complex medical condition cannot be safely managed, etc.). Exclude PHI from reporting requirement. Make submitted forms available for public inspection/analysis or require licensing to report out data on readmission challenges (Ombudsman work with providers and DHHS to implement data-driven solutions). | |

| Problems/Issues Raised | Identified/Proposed Solutions | Notes |
|---|---|-------|
| <p><i>Elder abuse</i> – family member or other theft of patient assets complicates Medicaid eligibility and delays provision of necessary services.</p> | <ul style="list-style-type: none"> ✓ Increase efforts for prosecution of these types of cases. ✓ Better address these types of situations in MaineCare application process. | |

PROPOSALS RELATED TO SPECIFIC COMPLEX PATIENT POPULATIONS

| Problems/Issues Raised | Identified/Proposed Solutions | Notes |
|---|--|-------|
| <p><i>Facility capacity issue</i> – currently only 50-55 geropsych beds in Maine (3 facilities – Gorham, Freeport, Waterville). Usually most beds are full.</p> | <ul style="list-style-type: none"> ✓ Expand existing facilities or add new capacity at other existing facilities (e.g., nursing homes); PNMI level 4 facilities may need to have additional rooms for geropsych. ✓ Put out RFI/RFP for construction of new facility (demand in Northern Maine/Bangor area?) - DHHS could issue RFP for 15-25 bed geropsych residential unit in Northern Maine. Reimbursement structure should be similar to the three existing providers. ✓ CON unit to exempt from budget neutrality caps for MaineCare beds: geropsych unit Bangor/Northern Maine, development of vent/bariatric/Huntington’s Disease units. MaineCare to pay for specialized units with negotiated rates. ✓ Determine the current cost for existing geropsych facilities in order for the State to determine an estimated cost for new facility (room differential and reimbursement of facility for actual costs). | |

| Problems/Issues Raised | Identified/Proposed Solutions | Notes |
|--|--|-------|
| | <ul style="list-style-type: none"> ✓ Consider additional advanced specialized services in NF. | |
| <p><i>Placement/ referral process</i> – despite an often immediate need for placement in an available geropsychiatric bed, the DHHS placement process often takes around 6 weeks to fill that bed.</p> | <ul style="list-style-type: none"> ✓ Conduct a review of the referral process from the top down. ✓ Options for improving/speeding up the cycle of movement in geropsych units by addressing the unique issues present in mental health review process. ✓ Also, address application of criterion that patient have “long history of mental illness” (i.e., typically requires long history of receiving mental health services). ✓ Change the Pre-Admission Screening Resident Review (PASRR) review process to increase focus on psychiatric problems. | |
| <p><i>Step-down options</i> – insufficient capacity/placement for geropsych patients who no longer require that level or type of care.</p> | <ul style="list-style-type: none"> ✓ Consider additional options for facilities to address geropsych patients developing dementia (transition to primary diagnosis of dementia). ✓ Consider residential care options at same facility that houses geropsych patients. ✓ Also address problems with assessment criteria for both admission and discharge (PASRR vs. Goold review). | |

| Problems/Issues Raised | Identified/Proposed Solutions | Notes |
|--|---|--------------|
| <p><i>Psych services</i> – geropsych facilities often have difficulties in obtaining regular and adequate psychiatric treatment services for their patients; if more beds are added, this will add to the current demand for psych services.</p> | <ul style="list-style-type: none"> ✓ Encourage hospitals to provide this service to surrounding or nearby facilities. ✓ DHHS to fund LTC contracts for behavioral health support at facility for care plan consultation, treatment and staff education. | |
| <p><i>Staffing issues</i> – hard to find appropriate, trained staff for these facilities.</p> | <ul style="list-style-type: none"> ✓ Efforts need to be made to increase the availability of specialized and well-trained staff for specific patient populations with specialized needs. Increased training opportunities need to be made to encourage entrance into this field of employment. | |
| <p><i>Rate issues</i> – does current regulatory process for reimbursement support provision of services for geropsych population and other specialized populations?</p> | <ul style="list-style-type: none"> ✓ Proposed DHHS RFI address this problem for now? ✓ New vent rate process now in effect (does this adequately address for ventilator-dependent patients?). | |
| <p><i>Equipment/facility/staffing issues</i> – specific patient populations (bariatric/ventilator-dependent and others) require specialized equipment and specially-trained staff, and may require facility modifications for the facility to accept the resident.</p> | <ul style="list-style-type: none"> ✓ Current reimbursement rate process may adequately meet facility needs (e.g., facility testimony at last meeting that DHHS worked with them to provide specialized equipment and adequate rate to treat a bariatric patient), but additional work needs to be done with the Ombudsman and other relevant agencies to facilitate a better understanding of patient-specific needs and how facility concerns can be adequately addressed to facilitate in-state placement of complex patients. | |